BOARD OF DIRECTORS
MINUTES

Thursday, December 11, 2025 at 4:00 pm held virtually via Zoom

PRESENT:				
Elected Directors:	Dave Uffelmann	Carla Clarkson-Ladd	Bruce Schouten	Michael Righetti
	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	Diane George
Executive Support:	Alasdair Smith	Mary Silverthorn	Tammy Tkachuk	
Guests:	Stephanie Lucas			
REGRETS:	Beel Yaqub	Dr. Rohit Gupta		

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. Bill Evans provided a brief overview on the four sacred medicines used by Indigenous peoples (tobacco, sage, cedar, and sweetgrass) and their ceremonial use in smudging for purification and healing. The Board was also advised that MAHC has a smudging policy coordinating ceremonies with spiritual care representatives and Indigenous elders to respect cultural practices while managing safety concerns like smoke exposure and fire risks.

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

Stephanie Lucas joined the meeting to share the care experience of her daughter related to abdominal pain and the challenges faced in accessing timely diagnostic imaging. After two visits to the emergency departments and multiple trips between sites for ultrasounds and CT scans, the daughter was diagnosed with mesenteric lymphadenitis rather than appendicitis. The hospital quality and clinical teams conducted a full analysis that identified process improvements for diagnostics as well as communication to mitigate future similar events. Appreciation was expressed to Ms. Lucas for sharing her story and being part of the journey to identify solutions to some of the diagnostic-related issues.

Stephanie Lucas left the meeting at 4:20 p.m.

2.0 BUSINESS ARISING

There was no business arising for this meeting.

3.0 REPORTS

3.1 CHAIR'S REMARKS

The Chair acknowledged the retirement of Diane George and noted her significant contributions to the board and the organization, highlighting her direct communication style, operational expertise, and impactful involvement in community engagements, especially around capital redevelopment.

Appreciation was extended to those members that were able to participate in the tour of the Gravenhurst Health Hub in October. A key takeaway noted was the high percentage of unattached patients in the Gravenhurst area and the importance of initiatives to bring in more physicians. Directors that were unable to attend the tour and remain interested in a tour were directed to connect with the Board Liaison.

In follow up to the education session provided by the Foundations in November, the Chair emphasized the vital role of the hospital's foundations in community outreach and communication, noting their significant presence and advocacy on behalf of the hospital.

Additionally, the importance of webinars and podcasts for board members was highlighted, with examples of recent sessions on capital projects, AI governance in healthcare, and leadership characteristics for future healthcare organizations. Directors were encouraged to participate in these learning opportunities when able.

Finally, the Chair shared a key insight from the Quality and Patient Safety Committee regarding performance targets: it's normal and appropriate not to meet all targets early in the year if the goals are ambitious. Missing some targets indicates that the organization is aiming high and striving for meaningful progress.

3.2 Report of the President and Chief Executive Officer

The report of the President and CEO was presented and operational successes highlighted included occupancy rates, patient flow, and outbreak management during respiratory illness season. Challenges persist in diagnostic services, especially ultrasound availability. New initiatives such as a geriatric emergency nurse program were introduced to improve patient outcomes. The recent Code Orange drill exercise prepared staff well for a real multi-vehicle accident that occurred shortly thereafter. It is anticipated that the options related to obstetrical services will be communicated in January. The progress regarding the human resource information systems and the launch of the employee/physician engagement surveys were also noted. The floor was open for questions.

It was confirmed that the wait time for MRI is currently at six months due to the high demand. However, it was noted that urgent inpatient scans are prioritized and performed quickly. Referral appropriateness is reviewed centrally to manage waitlists and recently a comprehensive presentation was provided to credentialed staff at a Grand Rounds session. The geriatric emergency nurse divides time between two sites, supporting staff and physicians with both patient care and education. Point-of-care ultrasound by emergency physicians and community paramedics was discussed but is not a substitute for full diagnostic imaging in the hospital setting; further discussion offline was encouraged as it relates to community paramedic recent training.

Discussion also focused on the recent outbreaks, highlighting existing infection control protocols and the role of public health in investigating transmissions. Hand hygiene was emphasized as a key preventive measure, with ongoing efforts to improve compliance and re-educate staff. Immunization rates among staff were noted as lower than previous years, currently at about 28%, compared to historical averages of 30-40%. Efforts to increase immunization uptake include additional clinics and encouragement from leadership. Despite challenges, vaccination remains strongly recommended to reduce severe flu outcomes.

There were no follow up actions identified from the questions and discussion.

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. Highlights included a maintaining a complete schedule for the emergency departments and improvements to internal medicine coverage at South Muskoka with only a few uncovered days each quarter. These unfilled shifts are managed through cross-coverage by Huntsville internists. Recruitment efforts for additional and long-term physicians continue and will be discussed further in an upcoming board education session. There has been notable year-over-year and quarter-over-quarter improvement in acute and alternative level of care (ALC) length of stay, particularly in Huntsville, with Bracebridge also showing positive trends. Southern Muskoka's ALC length of stay has decreased by about 50%, though further progress is needed. A new utilization report format is now regularly reviewed by the Medical Advisory Committee. Lastly, a full-day physician leadership retreat held on October 30th fostered collaborative discussions among physicians, senior team members, and some board members. A follow-up meeting is planned for early in the new year to review outcomes and updates from the retreat discussions.

Dr. Dempster provided brief comments on behalf of the Credentialed Staff Association. Since the last board meeting, there has not been a credentialed staff association meeting; the next is scheduled for January 20th and will be held virtually. A recently held medical education teaching conference on November 14th was well attended and positively received. Clinical activity in the hospital remains high, with surge units frequently in use and showing significant improvement over last winter, although there is still room for operational enhancements. A major ongoing challenge is limited access to ultrasound, which is especially important for pediatric care and cases where radiation is undesirable. The addition of extra hospitalist service lines has benefited patient turnover and quality, although staffing remains tight and further recruitment is needed. The last medical staff meeting at Bracebridge was in person and well attended, while the next in-person meeting will be held in Huntsville in March, with potential attendance from the Ontario Medical Association president. Overall, appreciation was expressed for improvements, and continued efforts in staffing and service expansions that are underway.

A question was raised regarding the implementation of AI scribes for Emergency Department physicians, inquiring concerns about controls, privacy, and accountability in case of errors. The response clarified that only AI scribes approved by the Ontario Medical Association and Ontario Health, which have met quality standards, are being used as part of a Northern Ontario research study. Compatibility and potential errors are being carefully monitored, and so far, the tool has proven useful and secure, with minimal risk identified. Importantly, the AI scribe does not retain patient information after it is transferred to the hospital's system. Additionally, it was emphasized that physicians remain responsible for reviewing, adjusting, and approving the transcriptions produced by the AI scribe, maintaining full accountability for the documentation.

4.2 Report of the Quality and Patient Safety Committee Chair

On behalf of the Quality and Patient Safety Committee, Dr. Evans provided highlights from the November 27th meeting. A presentation regarding the accreditation process was received; Board members, especially those new to accreditation, were encouraged to review the slide deck available on the board portal. The board's oversight role emphasizes ensuring readiness, managing risks, and maintaining resources for accreditation, with a focus on quality, patient safety, transparency, and continuous improvement. The Committee discussed the importance of clear data reporting and are considering graphical trends to help streamline the reports to reduce redundancy with the briefing note. Additionally, the new Patient and Family Advisory Council recruitment video was shared, aiming to increase patient representation on committees, ideally with two patient representatives per group to strengthen the patient voice. Further updates regarding accreditation preparations and governance practices will be provided as the process moves forward.

4.3 Quality and Patient Safety Report Q2

Upon presentation of the quarterly report, highlights of several notable successes, particularly in emergency department performance were provided. There have been improvements in the 90th percentile time from arrival to initial physician assessment, as well as in the time from decision to admit to actual admission to an inpatient unit. Additionally, the average daily number of patients waiting for an inpatient bed at 8:00 AM has decreased. Although these improvements are modest, they are significant given that Q2 experiences higher patient volumes due to an influx of seasonal residents and increased acuity levels. The efforts and initiatives that contributed to these positive changes were also outlined.

Importantly, there were no critical incidents reported in Q2, the second consecutive quarter with this outcome. The committee is considering expanding its review to include lower acuity events to further enhance learning and quality improvement. The Committee also reviewed the Enterprise Risk report and an increase in identified clinical risks was noted, now totaling 71, largely due to itemizing specific personnel shortages in areas such as pathology and echocardiography.

On the patient satisfaction front, the number of completed surveys in Q2 rose sharply to 484 from 192 in Q1, with overall satisfaction ratings remaining high and stable. However, emergency department patient experience survey participation remains low. To address this, initiatives like installing feedback tablets and encouraging staff to remind patients to complete surveys at discharge are underway. There were no questions or comments from the floor.

5.0 STRATEGIC DIRECTION

5.1 Report of the Capital Redevelopment Steering Committee

On behalf of the Capital Redevelopment Steering Committee, it was reported that Stage 1.3 submission to the Ministry of Health is nearing completion, with only a few outstanding items remaining. The attention of the Committee is now turning to the upcoming Stage 2 Project Charter, which will guide the next phase of planning, procurement, and implementation. Land acquisition negotiations for 300 Pine St. with local authorities are ongoing and progressing without significant issues. The project retains over $7 million in planning funds, and discussions are underway to begin architectural planning ahead of official Phase 2 approval to ensure readiness.

Looking ahead, the team plans to initiate the development of the architect Request for Proposal (RFP), aiming to utilize a design-bid-build model that encourages collaboration between architects and contractors for project efficiencies. While provincial financial constraints have slowed the process, the project remains on schedule with no current risks identified, and preparations continue to ensure a smooth transition to the next stages once approvals are secured. The floor was open for questions and comments.

A question was raised regarding the site selection, specifically whether it remains a risk. It was clarified that the site selection itself is not in question; the issue lies with the purchase of the land at 300 Pine St. The main challenge involves ongoing discussions with the town and the district about the definition and allocation of local share contributions; particularly ancillary costs needed for site development. Legal negotiations are nearing conclusion to finalize the sale.

Additionally, it was explained that while the town owns the property, the district is responsible for providing essential services such as water, sewer, and electrical connections to the site boundary.
It was also noted that the Senior Leadership Team (SLT) will now assume the responsibilities of the Capital Redevelopment Operations Committee. To ensure continued physician involvement, the physicians who

previously served on the committee will be included as ad hoc members of the SLT when capital redevelopment topics are discussed. This decision aims to maintain valuable clinical input and clear communication with the physician community. The importance of physician participation was emphasized, both for practical and perceptual reasons, and confirmed that two physicians will retain voting rights on the Capital Redevelopment Steering Committee. The SLT will handle operational matters, inviting these physicians on an ad hoc basis as relevant topics arise, ensuring significant ongoing physician involvement.

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 for three meetings on October 31st, November 11th, and November 28th, with an additional Audit Subcommittee session held on December 5th. Key topics discussed included HIROC insurance coverage, notably cyber security insurance exclusions and industry practices. The committee requested management provide further details in a future report, and a specialized group involving committee members and directors with IT cyber security expertise will meet outside the committee to report back on these matters. Other notable agenda topics for the Committee included the daily electronic funds transfer limit, annual operating budget and the Electronic Medical Record solution. The committee examined quarterly people metrics, clarifying the vacancy rate as 4%, and acknowledged efforts to stabilize staffing. The Q2 financial report and agency reduction strategies were also reviewed, with follow-up meetings planned to discuss staffing models and their impact on agency use. Lastly, the committee addressed the disposition of the Fairvern property, with a financial summary to be presented at a future meeting. There were no questions from the floor.

6.2 Enterprise Risk Management Report

The Enterprise Risk Management report was tabled and the floor was open for questions. It was clarified that the term "gridlock" as referenced in the report, within the hospital context refers to a shortage of available beds for incoming patients, which can escalate to a regional level requiring inter-hospital support. Discussion ensued regarding the human resources section of the risk heat map with a concern about whether all human resource shortages warranted their high-risk placement, noting that not every shortage carries the same level of criticality. Management clarified that the critical risk designation is based not only on potential for harm but also on financial impacts, service disruptions, and failure to meet objectives. The importance of evaluating each human resource risk individually, rather than categorically placing all in the highest risk tier, was emphasized. It was agreed that further discussion should occur at the committee level as to the categorization of these risks.

6.3 Annual Operating Budget

The assumptions for the 2026/2027 annual operating budget were presented and it was noted that these assumptions are primarily dictated by the Ministry of Health, leaving no room for discretionary changes. It was clarified that, unlike past years, the Ministry has prescribed specific adjustments for the three-year balanced budget plan, which removes the usual practice of conducting environmental scans or consulting with peers. Potential risks were highlighted, especially in the categories of drug costs and medical-surgical supplies, due to rising prices and new market entrants. Concern was raised about their realism and the actual financial impact they will have on the organization's budget. The importance of identifying any areas of potential risk and communicating these concerns in the budget submission, even though limited flexibility for these issues was noted.

It was moved, seconded and carried that the assumptions for the 2026/2027 Annual Operating Plan be approved.

6.4 Board Award of Excellence Policy

The revised Board Award of Excellence Policy was presented to increase the number of awards from four to eight and introducing the option for group nominations. A friendly amendment was discussed regarding award criteria wording and being specific that the leadership award is a “Staff Leadership Award”. Comment was provided regarding the addition of recognition pins for nominees as a positive initiative.

It was moved, seconded and carried that the revised Board Award of Excellence Policy be approved.

7.0 LEADERSHIP

7.1 Quarterly People Metrics and Results

The second quarter metrics were presented and improvements were acknowledged. A significant challenge discussed was the ongoing difficulty in recruiting physiotherapists. Barriers such as compensation and competition with private clinics were highlighted. While some success was noted in recruiting for other rehab positions, the shortage of physiotherapists remains problematic. It was also mentioned that lack of physiotherapy can lead to longer hospital stays, emphasizing the need for innovative recruitment strategies.

Discussion occurred on interpreting the Occupational Health and Safety and Wellness metric regarding a decrease in reported workplace violence incidents. It was noted that increased staff training in de-escalation could contribute to fewer incidents, but concerns remain that a significant portion of workplace violence in healthcare goes unreported due to staff normalization of aggressive behavior. Ongoing education and encouragement around reporting incidents are necessary to ensure accurate data and continued safety improvements. There were no follow up actions arising.

7.2 Report of the Performance Management Committee Chair

In addition to the performance goals for the CEO and Chief of Staff, the Committee also discussed the process and timeline performance evaluation of the CEO and Chief of staff as outlined in the consent agenda.

7.3 President and CEO Annual Performance Objectives Progress Update

Upon presentation of the progress update for the CEO goals, Key highlights included the ongoing employee and credentialed staff engagement survey, which has seen an increase in participation and is viewed as a positive sign for organizational culture improvement. The importance of quality boards throughout the facilities was emphasized, Directors were encouraged to review and engage with staff about their impact when in hospital. Notable progress was reported in reducing Alternate Level of Care (ALC) length of stay and agency costs, marking significant achievements in performance. The report concluded with an invitation for questions, though none were raised.

7.4 Chief of Staff Annual Performance Objectives Progress Update

Upon presentation of the Chief of Staff goals, two key areas were highlighted. First, stability in internal medicine at South Muskoka has been maintained, although there is hope to recruit one or two more physicians by the end of March. Second, a physician leadership workshop was noted for its excellent planning, broad engagement, and productive discussions. There were no questions or comments.

8.0 BOARD EFFECTIVENESS

8.1 REPORT OF THE NOMINATIONS COMMITTEE

Carla Clarkson-Ladd informed the Board that the Nominations Committee conducted a thorough review of the board's nominations policy as part of its scheduled three-year policy evaluation. The review resulted in several minor updates to align the policy with current practices and clarify certain terminology, especially regarding board member skills and experience. The most substantial recommendation is to replace the existing skills and knowledge matrix with the Ontario Hospital Association (OHA) skills matrix. The OHA matrix is recognized for its comprehensive definitions, clarity, and use as a standard across hospitals. Pending approval, all directors will be required to complete the new skills matrix by January. Additionally, the committee discussed beginning to collect diversity data for new board members but recommended that this be done during the onboarding process, rather than at the application stage, to avoid potential concerns about selection bias. The floor was open for questions and comments.

Questions were raised about whether employees of Ontario Health, in addition to those from the Ministry of Health and Long-Term Care, should be explicitly noted under the definition of Excluded Persons. It was clarified that Ontario Health acts as an intermediary in funding flows between the Ministry and other organizations, making it reasonable to consider excluding their full-time employees as well.

Discussion ensued regarding the expanded board knowledge and experience matrix. Concerns were raised about the increasing number of criteria possibly diluting their effectiveness and making it difficult to measure candidates' quality. Questions were also raised regarding the process for prioritizing and weighting the criteria, and whether the expanded matrix could lead to diminishing returns. It was explained that the Nominations Committee prioritizes skills that are currently lacking on the board at the start of each nomination cycle. It was acknowledged that there is some overlap among new skills but noted that the addition of specific areas, such as cybersecurity, allows for more targeted recruitment relevant to the current needs of the Board. It was also emphasized that not all board members are expected to possess every skill; instead, the committee highlights those most needed each cycle. Confidence was expressed in the Nominations Committee's ability to identify and recruit suitable board members under this new model.

It was moved, seconded and carried that the revised Nominations to the Board Policy be approved.

8.2 REPORT OF THE GOVERNANCE COMMITTEE CHAIR

Colleen Nisbet reported that the Governance Committee met on November 18th. Highlights include a review of accreditation criteria, focusing on unmet areas and a plan to address them, with further updates expected in February. The committee discussed planning for the upcoming board education retreat, forming a small working group to refine ideas and set the agenda; Directors were reminded that the retreat is tentatively scheduled for April 16, 2026. Additionally, there was productive discussion on officer and committee appointment processes, all detailed in the meeting minutes. The annual policy review schedule and Board Governance Improvement Goals were included in the consent agenda. There were no questions or comments from the floor.

8.3 BOARD WORK PLAN

The board work plan was presented as circulated in the board package and it was highlighted that it now includes a new "as required" column to address past confusion regarding committee items that may not need full board decisions or discussion. This addition ensures such items are tracked, keeps the board informed, and allows committees flexibility in making recommendations. There were no questions or comments.

It was moved, seconded and carried that the 2025-2026 Board Work Plan be approved.

9.0 CONSENT AGENDA

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

- *9.1 Approval of the Board of Director Meeting Minutes of September 11, 2025*
- *9.2 Approval of the Board of Director Meeting Minutes of November 11, 2025*
- *9.3 Approval of the revised Capital Redevelopment Steering Committee Terms of Reference*
- *9.4 Approval of the Capital Redevelopment Steering Committee 2025/2026 Work Plan*
- *9.5 Receipt of the 2025/2026 Q2 Compliance Report*
- *9.6 Receipt of the Annual Policy Review Schedule*
- *9.7 Receipt of the Board Governance Improvement Goals Status Report*
- *9.8 Receipt of the Executive Performance Evaluation Process 2025/2026*
- *9.9 Receipt of the link to view the PFAC Recruitment Video (https://youtu.be/LaVz6EpI-54)*

10.0 WRAP UP & ADJOURNMENT

It was moved that the meeting be adjourned at 6:13 p.m.