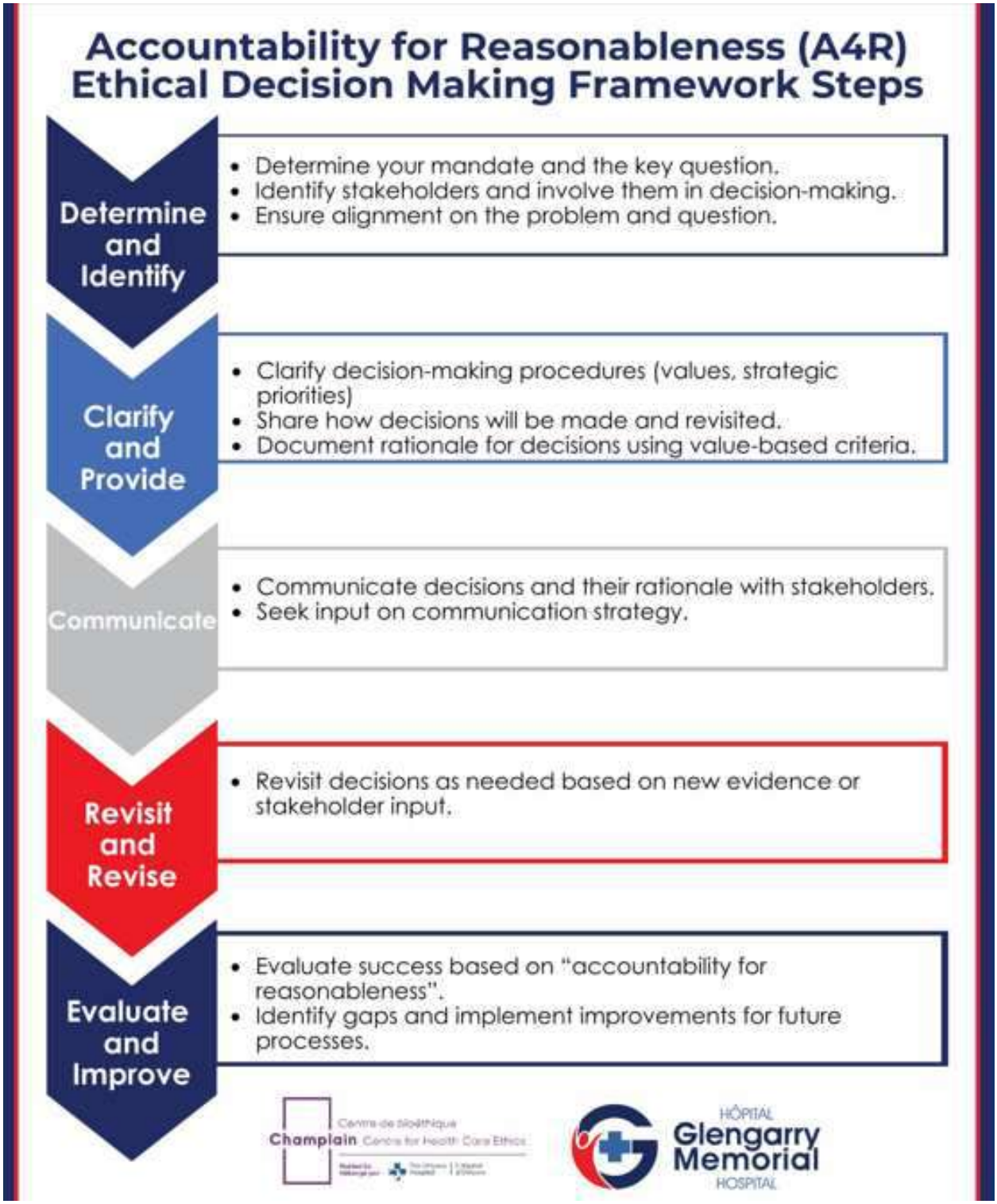
Board of Directors Meeting Agenda

Date: Thursday, March 27, 2025
Time: 8:45am – 10:00am
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Attachment
8:45	**1. Call to Order** (Dr. S. Robertson)	
(1 min)	1.1 Confirmation of Quorum	
(1 min)	1.2 Land Acknowledgment	
(1 min)	1.3 Adoption of the agenda	P. 1-2
(1 min)	1.4 Declaration of Conflict of Interest (Policy BOD.01.013.X.XX)	
8:49	**2. Minutes** (Dr. S. Robertson)	
(1 min)	2.1 Approval of previous meeting minutes – February 27, 2025	P. 3-7
(1 min)	2.2 Business arising from minutes	
8:51	**3. Equity, Diversity & Inclusion**	
(5 min)	3.1 Unconscious Bias (K. MacGillivray)	
8:56	**4. Matters for Discussion/Decision**	
(5 min)	4.1 Report of the Board Chair (Dr. S. Robertson)	
(5 min)	4.2 Report of the President & CEO (R. Alldred-Hughes)	P. 8-9
(5 min)	4.3 Report of the Chief Human Resources Officer (K. MacGillivray)	P. 10-11
	4.4 Report of the Chief of Staff (Dr. L. MacKinnon) - ***Defer***	
(5 min)	4.5 Report of the Patient and Family Advisory Committee (J. Shackleton)	
(5 min)	4.6 Board Peer-to-Peer Survey Questionnaire (L. Boyling) **THAT the Board of Directors approve the Board Peer-to-Peer Survey Questionnaire as presented.**	P. 12-22
(10 min)	4.7 Board and Committee Meeting Schedule (L. Boyling) **THAT the Board of Directors approve the proposed adjustment to the committee meeting schedule as presented.**	P. 23-28
(5 min)	4.8 Financial Statements – January 2025 (C. Nagy/R. Alldred-Hughes) **THAT the Board of Directors review and receive the financial statements for January 2025 as presented.** **That the Board of Directors approve the transfer up to $ 125,000 of parking income into capital reserves should the Hospital finish in a surplus of more than $ 150,000.**	P. 29-34
(5 min)	4.9 HSAA Extending Agreement (C. Nagy/R. Alldred-Hughes) **THAT the Board of Directors approve the signing of the HSAA Extending Agreement as presented.**	P. 35-76
(10 min)	4.10 Capital Plan 2025-2026 (L. Ramsay) **THAT the Board of Directors approve the Capital Plan for 2025-2026 as presented.** **That the Board of Directors approve the use of the Endowment fund to purchase up to $ 107,621 of capital expenses.**	P. 77-81
9:50	**6. Consent Agenda** (a formal request is to be made with the Board Chair to move an item out of the consent agenda for it to be discussed)	
	6.1 Draft Governance & Nominating Committee Report	P. 82-84
	6.2 Roles and Responsibilities of the Board Policy (BOD.01.005)	P. 85-92
	6.3 Nomination and Election Policy (BOD.01.016)	P. 93-97
	6.4 Roles of a Director and Code of Conduct Policy (BOD.01.017)	P. 98-102
	6.5 Roles and Responsibilities of the Board Chair, Vice Chair and Treasurer (BOD.01.018)	P. 103-106
	6.6 Framework for Ethical Decision-Making Policy (BOD.03.001)	P. 107-113
	6.7 Board Mentorship Policy (BOD.01.012)	P. 114-115
	6.8 Draft Finance, HR and Audit Committee Report	P. 116-118
	THAT the Board of Directors approve and receive all documents as presented in the consent agenda.	
9:51	**7. Correspondence (Dr. S. Robertson)**	P. 119
	8. Date of Next Meeting – April 24, 2025, 9:00am	
9:52	**9. Closing Remarks & Adjournment (Dr. S. Robertson)**	


Accountability for Reasonableness (A4R)
Ethical Decision Making Framework Steps
Determine and Identify
• Determine your mandate and the key question.
• Identify stakeholders and involve them in decision-making.
• Ensure alignment on the problem and question.
Clarify and Provide
• Clarify decision-making procedures (values, strategic priorities)
• Share how decisions will be made and revisited.
• Document rationale for decisions using value-based criteria.
Communicate
• Communicate decisions and their rationale with stakeholders.
• Seek input on communication strategy.
Revisit and Revise
• Revisit decisions as needed based on new evidence or stakeholder input.
Evaluate and Improve
• Evaluate success based on "accountability for reasonableness".
• Identify gaps and implement improvements for future processes.
Champlain
HÔPITAL Glengarry Memorial HOSPITAL

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS

Date	Thursday, February 27, 2025		
Time	9:00-12:00		
Location	Boardroom / Microsoft Teams		
Present:	Dr. S. Robertson, Chair	L. Boyling, Vice-Chair	Dr. R. Cardinal
	F. Wetering	G. McDonald	G. Peters
	H. Salib	F. Desjardins	Dr. G. Raby
	C. Nagy	C. Larocque	W. Rozon
	R. Alldred-Hughes, CEO	K. MacGillivray, CHRO	L. Ramsay, CFO
	R. Romany, CNE	Dr. L. MacKinnon	J. Shackleton (PFAC)
Regrets:	None		

1. Call to Order

Dr. S. Robertson, Chair, called the meeting to order at 9:52.

1.1 Quorum

A quorum was present.

1.2 Land Acknowledgment

L. Boyling read the land acknowledgment.

1.3 Adoption of the Agenda

The agenda was reviewed.

Moved By: H. Salib
Seconded By: F. Wetering
THAT the agenda be adopted as presented.

CARRIED

1.4 Declaration of Conflict of Interest

There were no conflicts of interest declared at this time.

2 Minutes

2.3 Approval of the Minutes

The minutes of the last meetings held on January 30, 2025, were presented.

Moved By: C. Larocque
Seconded By: Dr. G. Raby
THAT the minutes of the January 30, 2025, meeting be approved as presented.

CARRIED

2.2 Business Arising from the Minutes

There was no business arising from the minutes.

3 Equity, Diversity & Inclusion

The mini training for EDI was assigned, titled Unconscious Bias. The Board discussed their thoughts on the training.

4 Strategic Actions Review

The Strategic Actions for Q3 were reviewed.

Moved By: G. McDonald
Seconded By: C. Larocque
THAT the Board of Directors review and receive the Q3 Strategic Actions Report as presented.

Things are progressing well with no barriers to completing the remaining strategic actions. Given the upcoming change to the Health Information System, implementation of the surgical module in Meditech cannot be done at this time. An options analysis was completed to support a short, medium and long-term investment in surgical programming at the hospital which will be presented at the next Quality & Patient Safety Committee meeting.

CARRIED

5 Matters for Discussion/Decision

5.1 Report of the Board Chair

Important dates were shared of upcoming events such as the Annual Board BBQ which is set to take place June 28th, 2025, and the Board Retreat October 4th, 2025. F. Wetering is currently serving his last year as active Past Chair and as such, discussion will take place at Governance as to whether or not the Board will be looking to recruit for the upcoming Board cycle.

5.2 Report of the President & CEO

A kick off meeting took place with the team from RPG for pre-capital development. A visioning session will be taking place on March 27th with the Board Directors directly following the Board meeting.

Pre-election advocacy was done with some of the candidates.

Planning has begun to identify next years operational priorities through an engaging session with Leadership in which the focus was on what must be done with a realistic approach seeing as there are big projects already in the works. This will be brought to the Board.

As of March 17th, 2025, there will be a change in the outpatient lab collection hours to allow a tech to be on site one hour earlier to help with the morning rush as the bulk of the volume is in the morning. The hours will now be from 7:30am-4:00pm Monday to Friday.

5.3 Report of the VP of Clinical Services, Quality & CNE

Implementation of the cardio server was successfully done in January. This is the central hub for heart data and stores the ECG results in one place, making it easier for doctors to monitor patients heart health both in the hospital and remotely.

Ontario Health provided funding through the Specialty Training Fund to help ED nurses develop essential emergency department nursing skills. With this, we were able to provide 3 ACLS training days and 2 Simulation days. Pediatric training will be offered in March.

5.4 Report of the Chief of Staff

The focus right now is on physician recruitment. The hospital attended the Rural Ontario Medical Programs 20th Rural Family Medicine Retreat in Blue Mountain on February 21st, 2025. This retreat brought together first- and second-year Rural Stream Family Medicine

Residents from across the province in which we are hopeful some will consider HGMH as a future place to work.

There are currently a few holes in the schedule for the Emergency Department as well as on the inpatient unit which work is being done to recruit new physicians and fill these holes.

A Simulation Training Day was organized by nursing on February 14th and Dr. MacKinnon as well as Dr. Read were able to participate. This was a great session, and work is being done to secure funding through the Professional Staff Association to offer a similar session for physicians.

5.5 Report of the Patient and Family Advisory Committee
The committee was asked to help co-design a Family Space within the hospital which will be a multipurpose room used for different things like spiritual ceremonies and as a quiet room for grieving families.

The committee will also be helping plan Patient Experience Week which is taking place in April.

5.6 Financial Statements – December 2024
The financial statements for December 2024 were reviewed.

Moved By: C. Larocque
Seconded By: W. Rozon
THAT the Board of Directors review and receive the financial statements for December 2024 as presented.

The Hospital received $ 469,833 of global funding in January, which was 10 months of the remaining total of the Bill 124 current year funding which was announced in late December. The hospital is projecting a small surplus for the end of the year.

CARRIED

5.7 Review Draft Budget 2025-2026
The draft budget was reviewed.

Moved By: F. Wetering
Seconded By: F. Desjardins
THAT the Board of Directors approve the draft budget for 2025-2026 as presented.

Ontario Health normally provides firm direction as to how to proceed with the budget, however, with the current uncertainty around Bill 124, the HSAA was extended instead. A budget is still to be drafted as a guide. The Epic project is not reflected in this budget as its on the capital plan which will be reviewed by Finance, HR and Audit Committee next month and then be brought to the Board.

CARRIED

5.8 Q3 HR Metrics Report
The Q3 HR metrics were reviewed. With only one yellow and one red, things are going very well. Professional development is red as there was a decrease in training hours with the shortage in Professional Practice due to a leave of absence in the department. This should see some improvement going forward as the department will be back to regular staffing in

the next few months. Student placements is currently yellow as we only had one student in Q3. This is due to students not being able to choose where they want to go. Work will be done to build more relationships with colleges in an effort to get more students placed here.

5.9 Quality improvement Plan 2025/2026
The Quality Improvement Plan for 2025/2026 was reviewed.

Moved By: L. Boyling
Seconded By: C. Nagy
THAT the Board of Directors approve the Quality Improvement Plan for 2025/2026 as presented.

The themes remain the same this year, Access & Flow, Equity, Experience, Safety. The suggested indicators are as follows:
Percent of patients who visit the ED and left without being seen by a physician. The target was set at 8%.
90th percentile emergency department wait time to physician initial assessment (PIA). The target was set at 4.6.
Percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity, and accessibility (IDEA) education. The target was set at 25%.
Percentage of respondents who respond positively to the following question: Were you involved as much as you wanted to be in decisions about you or your family member's care and treatment? The target was set at 89%.
Rate of workplace physical violence incidents resulting in lost time injury. The target was set at 0.
Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5). The target was set at 10.

CARRIED

5.10 Review Q3 Quality Improvement Plan Results 2024/2025
The Quality Improvement Plan results for Q3 were shared.

Moved By: F. Wetering
Seconded By: Dr. G. Raby
THAT the Board of Directors review and receive the Quality Improvement Plan results for Q3 2024/2025 as presented.

Things are trending well in all areas except for the percentage of respondents who responded positively to receiving enough information about what to do about condition after leaving the hospital which ended with 84.1% which is slightly below the target of 86%. The strategy that will be worked on to improve this target is to ensure that discharge instructions are clear and thorough.

The other metric that needs work is the number of reported near misses related to controlled substances within the organization which ended with 24 incidents in Q3, well over the target of 12. Continuous evaluation will be done of dispensing and documentation processes, including narcotic count, investigations of potential losses and gathering feedback from staff.

CARRIED

5.11 Q3 Quality & Safety Scorecard Results
The Quality & Safety Scorecard results for Q3 were reviewed.

Moved By: F. Wetering
Seconded By: F. Desjardins
THAT the Board of Directors review and receive the Quality & Safety Scorecard results as presented.

The results are trending positively. The area for opportunity is around Hand Hygiene compliance, specifically moment 1 which did not meet the target of 92%. The results for Q3 were 73.7%. Ongoing reminders to staff about key hand hygiene moments and fostering a culture of accountability through regular monitoring and feedback will be done.

CARRIED

6 Consent Agenda

The following were included in the meeting package under consent agenda and reviewed by members prior to the meeting:

6.1 Draft Finance, HR and Audit Committee Report
6.2 Cyber Security Report
6.3 Draft Quality & Patient Safety Committee Report
6.4 Quality of Care Information Privacy Act Policy
6.5 Q3 Patient Satisfaction Survey Results
6.6 Q3 Violent Incident Report
6.7 Q3 Complaints and Compliments Report

Moved By: C. Larocque
Seconded By: Dr. G. Raby
THAT the Board of Directors approve and receive all documents as presented in the consent agenda.

CARRIED

7 Correspondence

Correspondence was shared.

8 Date of Next Meeting

Thursday, March 27, 2025, at 9:00am

9 Closing Remarks & Adjournment

The meeting adjourned at 11:00.

K-L. Massia, Recording Secretary

Report of the President & CEO

March 27, 2025 Board Meeting

HOOPP 2024 Performance

The Healthcare of Ontario Pension Plan (HOOPP) remained financially strong in 2024, ending the year fully funded at 111%, with net assets rising to $123 billion and a solid one-year return of 9.7%. This stability ensures the long-term security of our employees' pensions.

HOOPP's strong financial position allowed the Board to approve key decisions benefiting members, including a benefit formula improvement for eligible active members, stable contribution rates until at least the end of 2026, and a full cost of living adjustment (COLA) for retired and deferred members. These measures reinforce HOOPP's commitment to supporting healthcare workers now and in the future.

Supply Ontario Request

Supply Ontario has requested all hospitals to document any contracts for services and equipment sourced from the U.S. in response to the ongoing trade dispute and potential tariff impacts. This initiative aims to assess and mitigate risks related to increased costs or supply chain disruptions that could affect hospital operations. HGMH is reviewing its contracts to ensure compliance with this request and to better understand any potential implications.

Rural Ontario Medical Program – Discovery Week

HGMH is pleased to participate in this year's Discovery Week with the Rural Ontario Medical Program, providing medical students with valuable exposure to healthcare in a rural setting. In addition to offering hands-on learning experiences within the hospital, we are collaborating with the Township of North Glengarry to create a welcoming and engaging environment for the students, and we are currently seeking physicians to support the learning opportunity for 3rd and 4th year medical students. Together, we are planning social activities to help them connect with the community and experience the benefits of living and working in our region. The weeks generally happen at the end of May and early June depending on the University.

60 Year Anniversary with Community Engagement Session

On May 10th, HGMH will celebrate its 60th anniversary with a special evening event including potential live entertainment. This milestone offers an opportunity to engage with our community, highlight the services we provide, and share our vision for the future of the hospital. In collaboration with the HGMH Foundation, we will also use this event to promote opportunities for community support and philanthropy.

Stakeholder Engagement Activities

Below is a list of key meetings with external partners and stakeholders that have been conducted to enhance working relationships, collaboration, and share information about our hospital's performance, and future plans. Going forward to support the Board of Directors awareness, I will share this type of information to inform the board of ongoing work related to stakeholder engagement.

- *Meeting with CAO of North Glengarry and South Glengarry*
- *Meeting with The Palace Executive Director, and Director of Care*
- *Meeting with Leaders of Centre de santé communautaire de l'Estrie*
- *Meeting with Leadership of Community Mental Health Association*

Upcoming Events/Special Dates

April 13-19 – National Medical Laboratory Professionals Week
April 20-26 – National Organ and Tissue Awareness Week
April 22 – Earth Day
April 23 – Administrative Professionals Day
April 28 - May 2 – Patient Experience Week
April 28 – Health and Safety Day

Report of the Chief Human Resources Officer

March 27, 2025 Board Meeting

Valentine's Day Candygrams

For Valentine's Day 2025, we decided to try candygrams. Candygrams are asmall card or message with a piece of cancy attached, that are sent to someone as a sweet treat or a way to express a message. A total of 140 candygrams were purchased which raised $280 for the Foundation.

Employee Appreciation Breakfast

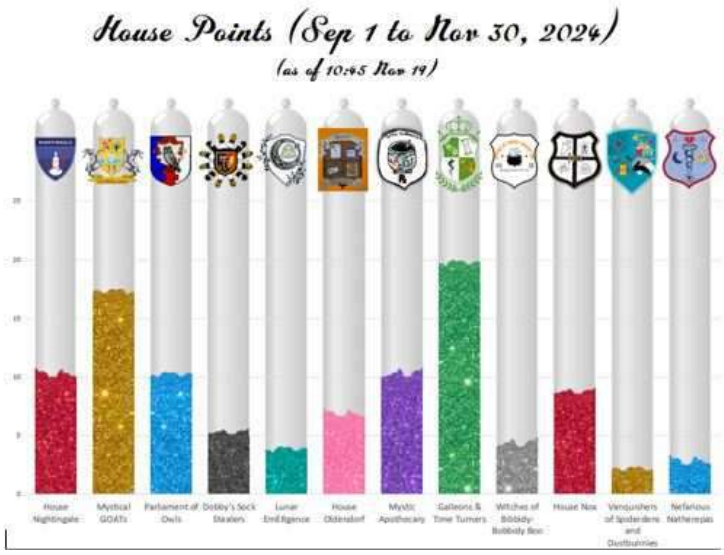
We celebrated Employee Appreciation Day on Friday March 7th by hosting a breakfast prepared by our wonderful kitchen staff and served by leadership. Everyone enjoyed the delicious meal! This recognition is on top of our professional designation recognition program.

Leadership Retreat

We had our annual leadership retreat over two days in February and March. The leadership team gathered to discuss the priorities for 2025-2026 which will become the basis for our operation plan. On a separate day, we gathered at Laura's B&B just outside Alexandria where we bonded together over a personality activity called Type Coach and a fun team building art project. We also had a massage therapist that did 15 minutes massages on the managers that wanted to.

Accreditation Update

Although Accreditation Canada brought some significant changes to the Required Organizational Practices (ROP), we were able to update our tackers, address the new ROPs and continue our work resulting in an 80% compliance rate with just under a year till our accreditation. Our staff still remain very engaged in the Harry Potter theme. We have had monthly themed assignments that employees complete and get points for their "House". Since the assignments started in November 2023, there have 645 assignments submitted with 76 staff participating in 12 "Houses"/teams.



ONA Negotiations

ONA local negotiations were completed on March 19, 2025. No outstanding proposals remain for the employer or union which means we will not need to go to interest arbitration which represents a large cost saving (time, counsel fees, participation fees, etc.).

2024 Job Posting & Applicant Data

In 2024, we had a total of 858 applications to a total of 62 job postings (internal and external job postings, permanent and temporary) with 29 new hires. 27 of those employees are still with the hospital.

DECISION SUPPORT DOCUMENT FOR

☒ Board of Directors ☐ Board Committee – ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: December 16, 2024 Meeting Date Prepared for: January 15, 2025 – Governance
February 27, 2025 – Governance
March 27, 2025 - Board

Subject: Board Peer Assessment Survey

Prepared by: Robert Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

The purpose of this briefing note is to provide an overview of the Board Peer Assessment Survey which is completed annually. The Governance committee annually reviews the survey questions and recommend any changes to the Board of Directors.

RECOMMENDATION

THAT the Board of Directors approve the Board Peer-to-Peer Survey Questionnaire as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

The Board Peer Assessment Survey is conducted annually to evaluate the effectiveness and performance of our board members. As part of our commitment to ensuring excellence in governance practices, it is imperative that we periodically review and refine the assessment questions to ensure they remain relevant and aligned with our organizational goals and values.

The Board Peer Assessment serves as a valuable tool for fostering accountability, transparency, and continuous improvement within our governance structure. It provides an opportunity for board members to reflect on their individual contributions, as well as their collective effectiveness in guiding the strategic direction of the hospital. These surveys are anonymous, and results are compiled and shared with the Board Chair who then meets with each Director individually and confidentially.

Please consider any feedback or adjustments to the questions being asked in the survey questions. An opportunity to share your thoughts will be provided at this Governance committee meeting.

*Suggested revisions made at the January 15, 2025 meeting:

- Change N/A to Unknown
- Reword free text to say *Please explain using examples*
- Remove questions 6, 8, 10, and 12

*Suggested revisions made at the February 27, 2025 meeting:

- Keep only Fully Satisfactory, Could Improve and Unknown categories

- Add question at end of survey as to whether Director could be considered for an Executive position of the Board or still need more time.

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

- Review Survey Questions at Governance – March 12, 2025
- Review at Board - March 27, 2025
- Email to be sent out for survey completion – April 25, 2025
- Surveys due May 16, 2025
- Results compiled and shared with Board Chair
- Board Chair to conduct individual meeting with each member to review assessment results

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Board Peer Assessment Survey 2024-2025

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Board Peer Assessment Survey 2024-2025

Score each Board member on the below evaluation criteria.

SCORE YOURSELF, AS WELL AS YOUR COLLEAGUES

Scoring:
Fully satisfactory - Consistently demonstrates the quality at a standard expected of a director; a solid performer.

Could Improve - Would benefit by modifying this aspect of their behaviour to conform to expectations.

Unknown - Cannot assess the individual on this question; lack of exposure to, or knowledge of, demonstrated behaviours or traits.

1. What is your name? (Your responses will be kept strictly confidential)

2. Reads materials and comes prepared for meetings.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

3. Participates and is actively engaged at meetings.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynals Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

4. Communicates ideas and concepts effectively.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

5. Listens well and respects those with differing opinions.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

6. Thinks independently - will express view contrary to the group.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasuer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

7. Inquisitive - asks appropriate and incisive questions.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

8. Thinks strategically in assessing the situation and offering alternatives.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Laroqcue	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

9. Exhibits sound, balanced judgement for the benefit of all stakeholders.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

10. Develops and maintains sound relationships - a team player.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

11. Understands the role of board committees.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

12. Understands and respects the role of the chair.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

13. Demonstrates financial literacy, though not necessarily an expert in the field.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

14. Effectively applies and contributes their special skills, knowledge, or talent to the issues.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

15. Supports board decisions - acts as one on all board actions once the decision has been made.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larcoque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

16. Contributes effectively to board performance.

	Fully Satisfactory	Could Improve	Unknown
Dr. Stuart Robertson, Chair	○	○	○
Louise Boyling, Vice Chair	○	○	○
Charlotte Nagy, Treasurer	○	○	○
Carole Larocque	○	○	○
Francois Desjardins	○	○	○
Dr. Genevieve Raby	○	○	○
Gerard McDonald	○	○	○
Gordon Peters	○	○	○
Heidi Salib	○	○	○
Dr. Raynald Cardinal	○	○	○
Wendy Rozon	○	○	○

Please explain for each Director, using examples, if you said Could Improve:

17. Would you recommend any of the following Directors for executive positions of the Board when available?

	Yes	Not at this time
Carole Larocque	◯	◯
Francois Desjardins	◯	◯
Dr. Genevieve Raby	◯	◯
Gerard McDonald	◯	◯
Gordon Peters	◯	◯
Heidi Salib	◯	◯
Dr. Raynald Cardinal	◯	◯
Wendy Rozon	◯	◯

DECISION SUPPORT DOCUMENT FOR

☒ Board of Directors ☐ Board Committee ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: March 3, 2025 Meeting Date Prepared for: March 12, 2025 – Governance
March 27, 2025 – Board

Subject: Board and Committee Meeting Schedule

Prepared by: R. Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- The purpose of this briefing note is to review the meeting schedule for the next Board cycle and discuss adjustment to meetings to ensure a more balanced workload and efficient use of time. This is being brought forward now in preparation for the possible recruitment that will be taking place next month.

RECOMMENDATION

THAT the Board of Directors approve the proposed adjustment to the committee meeting schedule as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*

- Finance, HR and Audit Committee
- Quality & Patient Safety Committee

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Currently, the standing committees of the Board meet as follows:
  - Finance, HR and Audit Committee: 8 times per year
  - Governance & Nominating Committee: 6 times per year
  - Quality & Patient Safety: 4 times per year
  - French Language Services: 1 time per year
- This uneven distribution of meetings has led to challenges in balancing workload and time commitment for board directors. The current setup results in some meetings being packed with extensive information, limiting the time available for in-depth discussion, while others are relatively brief due to the frequent meeting schedule.

OPTIONS CONSIDERED & ANALYSIS

Outline alternatives that were contemplated in coming to a recommendation. If no viable alternatives exist, include that information as well.

- It is proposed that all committees (with the exception of French Language Services) meet six (6) times per year, aligning the meeting frequency across committees. This adjustment aims to:
  - Distribute the time commitment more evenly among board members;
  - Allow for more balanced and effective meetings;
  - Improve the efficiency of committee discussions by ensuring that each meeting has a substantive agenda without being overloaded with content or, conversely, too light on discussion items;
  - Ensure equal focus and attention for all meetings, allowing for thorough discussion and decision-making across all committees.
  - Ensure that all directors sit on one committee rather than multiple, reducing the strain on individual members and allowing them to dedicate their full attention to their assigned committee. The

exception to this will be the director who sits on the Foundation Committee, as that committee meets ten (10) times per year. The Board Chair will continue to sit on multiple committees as per the bylaws.

- The Finance Committee will see a reduction in meetings from eight to six, necessitating a slight restructuring of agenda items to ensure key financial reporting and decision-making remain timely.
- The Quality Committee will increase its meetings from four to six, allowing for more frequent engagement on critical quality and safety matters.
- The Governance Committee remains unchanged in frequency but will benefit from improved alignment with other committees.
- Draft Committee Workplans were prepared to outline what the meetings would look like. These need to be approved by committees in September where additions can be made at that time.

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

- Review at Governance March 12, 2025 – ***approved recommendation to the Board***
- Board of Directors March 27, 2025
- Committee meeting schedule would be shared at Board Orientation
- Updated on the Board Portal in August for the new Board cycle

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Draft Board and Committee Meeting Schedule
- Draft Committee Meeting Workplans

Committee Meeting Schedule | 2025 to 2026

Aug 2025						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Sept 2025						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Oct 2025						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Nov 2025						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

Dec 2025						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Jan 2026						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Feb 2026						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

Mar 2026						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Apr 2026						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

May 2026						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Jun 2026						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Jul 2026						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Board of Directors

5:00pm-7:30pm

Board Committees

5:00pm-8:30pm

AGM

Last Thursday of June

Committee Schedule

Governance and Nominating:	October, November, January, March (recruitment in April if needed), May, and June
Finance, HR and Audit:	September, November, February, March, May, and June
Quality & Patient Safety:	September, November, January, February, April, and May
Executive:	October and April
French Language Services:	June

Board Retreat

Board Orientation (if needed)

Board Open House (if recruitment is needed)

Governance and Nominating Committee
Annual Work Plan 2025-2026

Deliverable	MRP	Occurrence	OCT	NOV	JAN	MAR	MAY	JUN
STRUCTURE/PROCESSES								
Review Committee Effectiveness Survey Results	Chair	Annually	X					
Review/Recommend Governance Annual Committee Work Plan to BoD	Chair	Annually						X
Review/Recommend Committee Terms of Reference to BoD	Chair	Annually	X					
Review Board Education Plan for following Board Cycle	Chair	Annually						X
Revise Skills Matrix	Chair	Annually			X			
Review/Revise Corporate and Professional Staff Bylaws (as needed)	Chair	Annually		X				
Review Board Member Attendance	Chair	Twice yearly			X		X	
Plan AGM	Chair	Annually					X	
Review Board Orientation	Chair	Annually						X
Review CEO and COS Succession Plan	Chair	Annually			X			
DIRECTOR RECRUITMENT AND SELECTION								
Administer Board Personal Assessment Survey (results due in March)	Admin	Annually			X			
Identification of number of new members required	Chair	Annually				X		
Identification of selection criteria based on skills matrix	Chair	Annually				X		
Start recruitment process (April)	Admin	Annually				X		
Recommendation of New Directors to the Board		Annually						X
Review Following Years Committee Schedule and Membership		Annually						X
ACCREDITATION								
Governance Standards Review	Chair	Every meeting	X	X	X	X	X	X
Equity, Diversity & Inclusion Update	Chair	Bi-Monthly	X		X		X	
Review Communication Plan	Chair	Annually		X				
PERFORMANCE								
Review Performance Evaluation Questionnaire for CEO and COS	Chair	Annually		X				
Review Committee Effectiveness Survey Questions	Chair	Annually			X			
Administer Committee Effectiveness Survey	EA	Annually					X	
Review Peer to Peer Survey Questions	Chair	Annually				X		
Administer Peer to Peer Surveys	EA	Annually						X
POLICY REVIEW								
Two policies reviewed per month	CEO		X					
	CEO		X					
	CEO			X				
	CEO			X				
	CEO				X			
	CEO				X			
	CEO					X		
	CEO					X		
	CEO						X	
	CEO						X	
	CEO							X
	CEO							X

Revisions since prior report:

Finance, HR & Audit Committee Work Plan 2025-2026

Deliverable	MRP	Occurrence	Sept	Nov	Feb	Mar	May	June
STRUCTURE/PROCESSES								
Review Committee Effectiveness Survey Results	Chair	Annually	X					
Review/Recommend Annual Committee Work Plan to Governance	Chair	Annually						X
Review/Recommend Committee TOR	Chair	Annually	X					
Declaration of Compliance	CEO	Monthly	X	X	X	X	X	X
FINANCIAL OVERSIGHT								
Review Financial Statements and Statistical Information	Chair	Monthly	X	X	X	X	X	X
Review/recommend Audit Plan	Chair	Annually				X		
Review/recommend Audited Financial Statements	Chair	Annually						X
Recommendation of Auditor	Chair	Annually						X
Review/Recommend Draft Budget 2025-26	Chair	Annually			X			
Review/recommend Capital Plan 2025-26	Chair	Annually				X		
Review Executive Expense Report	CFO	Quarterly		Q1/ Q2			Q3/ Q4	
PEOPLE/PARTNERSHIPS								
Review HR Metrics Report	CEO	Quarterly	X	X	X		X	
Strategic HR Plan	CEO	Annually			X			
Employee Engagement Survey Results	CEO	Annually		X				
Enterprise Risk Management Review	CEO	Annually		X				
Board Award of Excellence Call for Nominations	Chair	Annually				X		
Board Award of Excellence Selection	Chair	Annually					X	
BUILDING/PROPERTY/INFRASTRUCTURE								
Ongoing Projects	CFO	As Occurs						
Epic Project	CEO	As Occurs						
Capital Redevelopment Planning	CEO	As Occurs						
Cyber Security Report	CFO	Annually			X			
REGULATORY COMPLIANCE								
Complete Related Parties' Transaction Email – due May 31	EA	Annually						X
HSAA Declaration of Compliance	CFO	Annually						X
BPSAA Attestation	CFO	Annually						X

Quality & Patient Safety Committee
Work Plan 2025-2026

Deliverable	MRP	Occurrence	Sep	Nov	Jan	Feb	Apr	May
STRUCTURE/PROCESSES								
Review/Recommend Committee Terms of Reference	Chair	Annually	X					
Review Committee Effectiveness Survey Results	Chair	Annually	X					
Review/Recommend Annual Committee Work Plan to Governance	Chair	Annually						X
Professional Staff Appointment and Re-appointment Review	COS	Annually		X				
Review Professional Staff HR Plan	COS				X			X
EDUCATION								
Patient Story	CNE		X		X		X	
Quality Initiatives	CNE			X		X		X
QUALITY OVERSIGNT AND IMPROVEMENT								
Review QIP Dashboard	CNE	Quarterly	Q1	Q2		Q3		Q4
Recommend QIP Dashboard 2025-2026	CNE	Yearly				X		
Quality & Safety Scorecard	CNE	Quarterly	Q1	Q2		Q3		Q4
Review Patient Satisfaction Survey Results	CNE	Quarterly	Q1	Q2		Q3		Q4
Violent Incidents Report	CNE	Yearly/ As Occurs					X	
Review Life or Limb Results	CNE	When available						
Review Complaints & Compliments Report	CNE	Quarterly			X		X	
PFAC Update	CNE	Quarterly	X		X		X	
Review Critical Events and Never Events Report	CNE	Yearly			X			
BPSO Update	CNE	Quarterly	X	X		X		X
Review Patient Safety Plan	CNE	Yearly				X		
Review Status of Patient Safety Plan Actions	CNE	Quarterly	X	X		X		X
Review Provincial Stroke Report Card	CNE	When available						
Review Ethics Committee Updates	CNE	Yearly					X	
Review HIROC Report	CEO	Yearly						X
Review Emergency Preparedness	CNE	Yearly					X	
ACCREDITATION								
Accreditation Updates	CEO	Quarterly	X		X		X	
Accreditation Standard Review	CNE	Quarterly	X		X		X	

Revisions since prior report:

DECISION SUPPORT DOCUMENT FOR

☒ Board of Directors ☐ Board Committee – ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: February 22, 2025 Meeting Date Prepared for: March 12, 2025 – Finance
March 27, 2025 - Board

Subject: January 2025 Financial Statements

Prepared by: Linda S. Ramsay

☒ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

Financial Statement explanations of variances between Actual and Budgeted amounts for the month of January 2025. Note: Budget figures presented are based on the annual amount divided by 12 months.

RECOMMENDATION/MOTION

That the Finance, HR, and Audit Committee recommend to the Board of Directors the January 2025 financial statements as presented.

That the Finance, HR, and Audit Committee recommend to the Board of Directors to transfer up to $ 125,000 of parking income into capital reserves should the Hospital finish in a surplus of more than $ 150,000.

ANALYSIS OF FINANCIAL INFORMATION

January

- The Hospital received $ 469,833 of global funding in January, which was 10 months of the remaining total of the Bill 124 current year funding announced in late December ($ 563,800).
- Out of province volume were significant lower than the previous 6 months, explaining the decrease in out of province revenue.
- The new year has started, which means that employer portion of CPP and EI beginning will be more than was has been seen in the previous months.
- Balance sheet: Cash and investments: The increase is due to above having been received on January 31Due to the timing of when funding is received by the Ministry (December 31) and when payments are made month-end payables are usually high.

ANALYSIS OF STATISTICAL INFORMATION

- As mentioned above, out of province volume were at 16 % of total visits, compared to previous months average of 19 %.

FUTURE ITEMS TO CONSIDER

- As the Hospital looks to the future with multiple costly projects such as EPIC, Capital Redevelopment and CT, It would be prudent to transfer up to $ 125,000 to capital reserves for future use. Reserves would be taken from parking revenues, which is local income generated. With this in mind, we expect to have a small surplus of $ 150,000.
- ONA collective agreement will expire on March 31, 2025. There has been no resolution between both parties, the OHA and ONA. The matter has been referred to arbitration.

SUPPORTING DOCUMENTS/ATTACHMENTS

- Financial Statements
- Statistical Information

HOPITAL GLENGARRY MEMORIAL HOSPITAL
STATEMENT OF OPERATIONS
FOR THE PERIOD ENDING JANUARY 31, 2025

ACTUAL Dec-24	BUDGET Dec-24	VARIANCE Dec-24	ACTUAL Jan-25	BUDGET Jan-25	VARIANCE Jan-25		ACTUAL YTD - JAN 2025	BUDGET YTD - JAN 2025	VARIANCE YTD - JAN 2025
						Revenue:			
1,569,656	1,353,683	215,973	1,934,952	1,353,682	581,270	MOHLTC Base Allocation	15,131,570	13,536,827	1,594,743
12,500	0	12,500	12,500	0	12,500	MOHLTC Base Allocation - one time funding	126,724	0	126,724
12,178	0	12,178	0	0	0	MOHLTC Special HHR programs	95,126	0	95,126
206,828	152,083	54,745	219,446	152,083	67,363	Alternate Emergency Funding Payments	2,096,558	1,520,833	575,725
32,483	16,667	15,816	32,483	16,666	15,817	Physician Payments	324,826	166,666	158,160
212,748	199,271	13,477	197,036	199,271	(2,235)	Patient revenues from other Payers	2,172,573	1,992,685	179,888
29,223	16,666	12,557	29,838	16,666	13,172	Differential and Co-Payment	185,119	166,666	18,453
(3,273)	(3,333)	60	(3,417)	(3,333)	(84)	Bad Debts	(33,349)	(33,333)	(16)
91,479	79,041	12,438	55,161	40,076	15,085	Recoveries and Miscellaneous	619,215	517,644	101,571
14,167	17,917	(3,750)	14,167	17,917	(3,750)	Amortization Grants/Donations - Equipment	141,670	179,167	(37,497)
2,177,989	1,831,995	345,994	2,492,166	1,793,028	699,138	Total Revenues	20,860,032	18,047,155	2,812,877
						Expenses			
1,007,388	1,011,581	(4,193)	1,126,615	1,011,571	115,044	Compensation - Salary and Wages	10,382,315	10,115,712	266,603
214,789	274,844	(60,055)	258,023	274,815	(16,792)	Employee Benefits	2,612,118	2,748,297	(136,179)
283,468	197,210	86,258	277,545	197,210	80,335	Medical Staff Remuneration	2,809,875	1,972,085	837,790
21,827	32,851	(11,024)	27,559	32,841	(5,282)	Medical and Surgical Supplies	255,315	328,466	(73,151)
23,284	21,685	1,599	20,208	21,673	(1,465)	Drugs and Medical Gases	242,141	216,814	25,327
390,284	385,969	4,315	403,990	346,974	57,016	Other Expenses	3,682,145	3,586,834	95,311
18,167	18,167	0	18,167	18,167	0	Amortization of Software License and Fees	181,670	181,667	3
32,291	32,293	(2)	32,291	32,293	(2)	Amortization of Equipment	322,910	322,918	(8)
1,991,498	1,974,600	16,898	2,164,398	1,935,544	228,854	Total Expenses	20,488,489	19,472,793	1,015,696
186,491	(142,605)	329,096	***327,768***	(142,516)	470,284	Surplus/(Deficit) From Operations	***371,543***	(1,425,638)	1,797,181

ACTUAL Dec-24	BUDGET Dec-24	VARIANCE Dec-24	ACTUAL Jan-25	BUDGET Jan-25	VARIANCE Jan-25	ACTUAL YTD - JAN 2025	BUDGET YTD - JAN 2025	VARIANCE YTD - JAN 2025

Loss of Revenues compared to Budget

Out of province							
137,396	139,217		113,906	139,217		1,332,746	1,390,734	(57,988)
In Patient O/P							
1,314	6,250		5,256	6,250		84,096	62,500	21,596
Rental Income							
4,856	4,667		4,856	4,667		48,075	46,665	1,410
Foundation							
0	0		0	0		0	0	0
Interest - income							
0	0		0	0		7,076	0	7,076
Parking							
24,259	19,167		24,031	19,167		209,777	191,665	18,112

Details of Other Expenses

Supplies (4000)							
84,718	90,268		115,967	90,259		941,585	902,726	38,859
Services (6000)							
112,489	97,558		68,669	58,589		712,242	702,782	9,460
Equipment, R & M and software support (7100)							
79,841	95,484		92,386	95,479		920,609	954,828	(34,219)
Contracted Out services (8000)							
99,915	95,795		104,618	95,794		1,001,998	957,957	44,041
Building and grounds (9000)							
13,321	6,854		22,349	6,854		105,710	68,542	37,168
390,284	385,959		403,989	346,975		3,682,144	3,586,835	**95,309**

HOPITAL GLENGARRY MEMORIAL HOSPITAL
BALANCE SHEET
AS AT JANUARY 31, 2025

	JANUARY 31, 2025
Current Assets	
Cash and Investments	1,966,751
Accounts receivable	829,339
Inventory	176,357
Prepaid Expenses	212,151
	3,184,598
Capital assets minus accumulated depreciation	10,143,298
Total Assets	13,327,896
Current Liabilities	
Accounts payables and accrued liabilities	2,359,245
Employee future benefits	1,170,368
Deferred income	74,500
	3,604,113
Deferred contributions	6,828,268
Net assets	
Restricted	573,334
Unrestricted	1,469,873
Capital Fund reserves	852,308
	2,895,515
Total Liabilities, Deferred contributions and Net assets	13,327,896

GLENGARRY MEMORIAL HOSPITAL
STATISCAL INFORMATION
January 2025

	April	May	June	July	August	September	October	November	December	January	Actual Total 2024/25	% as per Benchmark	*BENCHMARKS* 2024/25	Actual Total 2023/24
INPATIENTS														
OCCUPANCY RATE in %														
ACTIVE UNIT - 22 beds	69.09%	59.09%	47.27%	43.11%	67.16%	69.70%	70.23%	75.30%	73.61%	60.85%	**63.52%**		**82.00%**	**74.14%**
(2023-2024)	96.82%	65.98%	66.82%	71.85%	65.25%	81.21%	85.34%	77.88%	55.57%	75.51%				
REHABILITATION - 15 beds	89.11%	85.81%	76.44%	77.63%	79.35%	72.22%	84.95%	91.56%	79.14%	92.04%	**82.73%**		**80.00%**	**69.30%**
(2023-2024)	61.11%	54.41%	74.67%	72.04%	66.24%	74.67%	54.41%	68.00%	78.06%	89.46%				
OVERALL OCCUPANCY - 37 beds	77.21%	69.92%	59.10%	57.11%	72.10%	70.72%	76.20%	81.89%	75.85%	73.50%	**71.35%**		**81.00%**	**72.18%**
(2023-2024)	82.34%	61.29%	70.00%	71.93%	65.65%	78.56%	72.80%	73.87%	64.69%	81.17%				
OUTPATIENTS														
EMERGENCY/OUTPATIENT														
# OF VISITS - Res.	1,214	1,333	1,234	1,317	1,285	1,375	1,423	1,347	1,312	1,355	**13,193**		**10,500**	**12,586**
Out of province	239 16%	309 19%	253 17%	303 19%	349 21%	304 18%	325 19%	331 20%	309 19%	255 16%	**2,979**	18%	**3,750**	**3,039** 19%
	1,453	1,642	1,487	1,620	1,634	1,679	1,748	1,678	1,621	1,610	**16,172**		**14,250**	**15,625**
(2022-2023)	1,473	1,650	1,664	1,767	1,551	1,545	1,627	1,434	1,578	1,336	**15,625**			
SPECIALTY CLINICS														
# OF VISITS - Res.	250	248	227	190	201	224	268	184	194	191	**2,177**		**2,471**	**2,202**
Out of prov./country	0 0%	0 0%	0 0%	1 1%	1 0%	1 0%	2 1%	0 0%	1 1%	1 1%	**7**	0%	**29**	**2** 0%
	250	248	227	191	202	225	270	184	195	192	**2,184**		**2,500**	**2,204**
(2022-2023)	202	325	234	183	202	227	236	221	161	213	**2,204**			
RADIOLOGY														
# OF STUDIES	1,117	1,119	932	947	973	1,048	1,228	1,222	1,277	1,285	**11,148**			**9,926**
(2022-2023)	949	1,016	985	972	982	989	983	1,040	954	1,056	**9,926**			
ULTRASOUND														
# OF STUDIES	192	205	166	185	166	160	217	148	158	165	**1,762**			**1,863**
(2022-2023)	174	192	198	208	183	175	178	186	187	182	**1,863**			
BONEDENSITOMETRY														
# OF STUDIES	39	39	39	51	39	53	48	20	37	25	**390**			**443**
(2022-2023)	49	13	77	63	62	13	38	64	38	26	**443**			

☒ Board of Directors ☐ Board Committee - ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: March 4, 2025 Meeting Date Prepared for: March 12, 2025 – Finance
March 27, 2025 - Board

Subject: Notice and Extension of Hospital Service Accountability Agreement

Prepared by: R. Alldred-hughes, President & CEO

☒ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

To provide the Board of Directors with an update on the notice and extension of the Hospital Service Accountability Agreement (HSAA) from Ontario Health and to seek authorization for the required signature.

RECOMMENDATION/MOTION

THAT the Finance, HR, and Audit Committee recommend to the Board of Directors the signing of the HSAA Extending Agreement as presented.

SITUATION & BACKGROUND

The Hospital Service Accountability Agreement (HSAA) is a legislatively required agreement pursuant to the *Connecting Care Act, 2019* that outlines funding, performance obligations, and service expectations of the hospital. The agreement ensures accountability and alignment with provincial health system priorities.

Ontario Health has issued a formal notice of extension for the current HSAA, which is set to expire on March 31, 2025. The proposed extension will be in effect from April 1, 2025 to March 31, 2026, maintaining existing terms and conditions while allowing for continued service delivery.

After the 2025/26 funding confirmations are released, Ontario Health will request a 2025/26 forecast from health service providers. This will provide Ontario Health with an opportunity to understand provider plans and further support feedback for Ontario Health's 2025/26 fiscal year planning. More details regarding the forecast process will be communicated at a later date.

Once 2025/26 funding details are confirmed, Ontario Health will work with providers on planning and updating the agreements to add the new funding and targets as required.

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

- The extension ensures continued funding and service provision without interruption.
- No changes to the existing agreement have been proposed, ensuring continuity in hospital operations.
- Ontario Health has requested a formal signature from the hospital's President & CEO and Board Chair to finalize the extension.
- Timely execution of this extension is necessary to comply with provincial requirements and maintain accountability for service delivery.
- Upon Board approval, the extension will be signed and submitted to Ontario Health.

SUPPORTING DOCUMENTS/ATTACHMENTS

- Notice and Extension of Hospital Service Accountability Agreement ("Extending Letter")
- Hospital Service Accountability Agreement

SENT ELECTRONICALLY

February 13, 2025

Mr. Robert Alldred-Hughes
President and Chief Executive Officer
Glengarry Memorial Hospital
20260 County Rd 43
Alexandria, ON K0C 1A0
Email: ralldred-hughes@hgmh.on.ca

Dear Mr. Alldred-Hughes,

Re: CCA s. 22 Notice and Extension of Hospital Service Accountability Agreement ("Extending Letter")

The *Connecting Care Act, 2019* ("CCA") requires Ontario Health ("OH") to notify a health service provider when OH proposes to enter into, or amend, a service accountability agreement with that health service provider.

OH hereby gives notice and advises Glengarry Memorial Hospital (the "HSP") of OH's proposal to amend each hospital service accountability agreement (as described in the CCA) currently in effect between OH and the HSP (each "SAA").

Subject to the HSP's acceptance of this Extending Letter, each SAA will be amended with effect on March 31, 2025, as set out below. All other terms and conditions of each SAA will remain in full force and effect.

The terms and conditions in each SAA are amended as follows:

1) **Term** – In section 2.2, "March 31, 2025" is deleted and replaced by "March 31, 2026".

2) **Schedules** – The Schedules in effect on March 31, 2025, shall remain in effect until March 31, 2026, or until such other time as may be agreed to in writing by OH and the HSP.

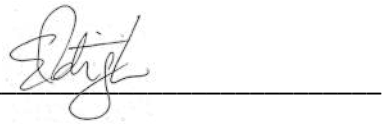
Unless otherwise defined in this letter, all capitalized terms used in this letter have the meanings set out in each SAA.

Please indicate the HSP's acceptance and agreement to the amendments described in this Extending Letter by signing below and returning one scanned copy of this letter by e-mail no later than the end of business day on **Friday, March 28, 2025** to: OH-East_Submissions@ontariohealth.ca.

The HSP and OH agree that the Extending Letter may be validly executed electronically, and that their respective electronic signature is the legal equivalent of a manual signature.

Should you have any questions regarding the information provided in this Extending Letter, please contact Lena Gervais, Lead, Performance, Accountability and Funding Allocation at lena.gervais@ontariohealth.ca or at 647.953.4292.

Sincerely,



Signature

Eric Partington
Vice President, Performance, Accountability and Funding Allocation
Ontario Health East

c: Stuart Robertson, Board Chair, Glengarry Memorial Hospital
Scott Ovenden, Chief Regional Officer, Toronto and East, Ontario Health
Tunde Igli, Director, Performance, Accountability and Funding Allocation, Ontario Health East
Lena Gervais, Lead, Performance, Accountability and Funding Allocation, Ontario Health East

Signature page follows

AGREED TO AND ACCEPTED BY

Glengarry Memorial Hospital

By:

_____ Date:_____
Robert Alldred-Hughes, mm/dd/yyyy
President and Chief Executive Officer
I have authority to bind the health service provider.

And By:

_____ Date:_____
Stuart Robertson, mm/dd/yyyy
Board Chair
I have authority to bind the health service provider.

ONTARIO HEALTH

("**OH**")

and

GLENGARRY MEMORIAL HOSPITAL

(the "**Hospital**")

Hospital Service Accountability Agreement for 2023 - 24

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SCHEDULES

BACKGROUND

This service accountability agreement is entered into pursuant to the *Connecting Care Act, 2019* (the "CCA").

The Hospital and the Funder are committed to working together, and with others, to achieve evolving provincial priorities including building a connected and sustainable health care system centred around the needs of patients, their families and their caregivers.

In this context, the Hospital and the Funder agree that the Funder will provide funding to the Hospital on the terms and conditions set out in this Agreement to enable the provision of services to the health system by the Hospital.

In consideration of their respective agreements set out below, the Funder and the Hospital covenant and agree as follows:

ARTICLE 1. DEFINITIONS AND INTERPRETATION

1.1 **Definitions**. The following definitions are applicable to terms used in this Agreement:

Accountability Agreement means the accountability agreement, as that term is defined in the Enabling Legislation, in place between the Funder and the Ministry during a Funding Year;

Agreement means this agreement and includes the Schedules, as amended from time to time;

Annual Balanced Operating Budget means that in each Funding Year of the term of this Agreement, the total expenses of the Hospital are less than or equal to the total revenue, from all sources, of the Hospital when using the consolidated corporate income statements (all fund types and sector codes). Total Hospital revenues exclude interdepartmental recoveries and facility-related deferred revenues, while total Hospital expenses exclude interdepartmental expenses, facility-related amortization expenses and facility-related interest on long-term liabilities;

Applicable Law means all federal, provincial or municipal laws, regulations, common law, any orders, rules, or by-laws that are applicable to the parties, the Hospital Services, this Agreement and the parties' obligations under this Agreement during the term of this Agreement;

Applicable Policy means any rules, policies, directives, or standards of practice issued or adopted by the Ministry or other ministries or agencies of the Province of Ontario that are applicable to the Hospital, the Hospital Services, this Agreement and the parties' obligations under this Agreement during the term of this Agreement and that are available to the Hospital on a website of a ministry or agency of the Province of Ontario or that the Hospital has received from the Funder, the Ministry, an agency of the Province or otherwise;

Board means board of directors;

CCA means the *Connecting Care Act, 2019*, and the regulations under it, as it and they may be amended from time to time;

CEO means chief executive officer;

Chair means the chair of the Board;

Confidential Information means information disclosed or made available by one party to the other that is marked or otherwise identified as confidential by the disclosing party at the time of disclosure and all other information that would be understood by the parties, exercising reasonable judgment, to be confidential. Confidential Information does not include information that: (i) is or becomes available in the public domain through no act of the receiving party; (ii) is received by the receiving party from another person who has no obligation of confidence to the disclosing party; or (iii) was developed independently by the receiving party without any reliance on the disclosing party's Confidential Information;

Days means calendar days;

Digital Health refers to the use of digital and virtual tools, products, technologies, data, and services that enable improved patient experience and population health outcomes, care quality, access, integration, coordination, and system sustainability when they are leveraged by patients, providers and integrated care teams.

Effective Date means April 1, 2023;

Enabling Legislation means the CCA;

Explanatory Indicator means a measure of the Hospital's performance for which no Performance Target is set. Technical specifications of specific Explanatory Indicators can be found in the HSAA Indicator Technical Specifications;

Factors Beyond the Hospital's Control include occurrences that are, in whole or in part, caused by persons or entities or events beyond the Hospital's control. Examples may include, but are not limited to, the following:

(a) significant costs associated with complying with new or amended Government of Ontario technical standards or guidelines, Applicable Law or Applicable Policy;

(b) the availability of health care in the community (long-term care, home care, and primary care);

(c) the availability of health human resources;

(d) arbitration decisions that affect Hospital employee compensation packages, including wage, benefit and pension compensation, which exceed reasonable Hospital planned compensation settlement increases and in certain cases non-monetary arbitration awards that significantly impact upon Hospital operational flexibility; and

(e) catastrophic events, such as natural disasters and infectious disease outbreaks;

FIPPA means the *Freedom of Information and Protection of Privacy Act*, Ontario and the regulations made under it, as it and they may be amended from time to time;

Funder means Ontario Health;

Funding Year means, in the case of the first Funding Year, the period commencing on the Effective Date and ending on the following March 31, and in the case of Funding Years subsequent to the first Funding Year, the period of 12 consecutive months beginning on April 1 following the end of the previous Funding Year and ending on the following March 31;

Funding means the funding provided by the Funder to the Hospital in each Funding Year under this Agreement;

GAAP means generally accepted accounting principles;

Hospital's Personnel and Volunteers means the directors, officers, employees, agents, volunteers and other representatives of the Hospital. In addition to the foregoing, Hospital's Personnel and Volunteers include the contractors and subcontractors and their respective shareholders, directors, officers, employees, agents, volunteers or other representatives;

Hospital Services means the clinical services provided by the Hospital and the operational activities that support those clinical services, that are funded in whole or in part by the Funder, and includes the type, volume, frequency and availability of Hospital Services;

HSAA Indicator Technical Specifications means the document entitled "HSAA Indicator Technical Specifications" as it may be amended or replaced from time to time;

Indemnified Parties means the Funder and its officers, employees, directors, independent contractors, subcontractors, agents, successors and assigns and His Majesty the King in right of Ontario and His Ministers, appointees and employees, independent contractors, subcontractors, agents and assigns. Indemnified Parties also includes any person participating in a Review conducted under this Agreement, by or on behalf of the Funder;

Improvement Plan means a plan that the Hospital may be required to develop under Article 9 of this Agreement;

Interest Income means interest earned on Funding that has been provided subject to recovery;

Mandate Letter has the meaning ascribed to it in the Memorandum of Understanding and means a letter from the Ministry to the Funder establishing priorities in accordance with the Premier of Ontario's mandate letter to the Ministry.

Memorandum of Understanding means the memorandum of understanding between the Funder and the Ministry in effect from time to time in accordance with the Management Board of Cabinet "Agencies and Appointments Directive".

Minister means such minister of the Crown as may be designated as the responsible minister in relation to this Agreement or in relation to any subject matter under this Agreement, as the case may be, in accordance with the *Executive Council Act*, as amended;

Ministry means, as the context requires, the Minister or the Ministry of Health or such other ministry as may be designated in accordance with Applicable Law as the ministry responsible in relation to the relevant matter or the Minister of that ministry, as the context requires.

"***Monitoring Indicator***" means a measure of Hospital performance that may be monitored against provincial results or provincial targets, but for which no Performance Target is set;

Notice means any notice or other communication required to be provided pursuant to this Agreement or the Enabling Legislation;

Ontario Health means the corporation without share capital under the name Ontario Health as continued under the CCA;

Performance Corridor means the acceptable range of results around a Performance Target;

Performance Factor means any matter that could or will significantly affect a party's ability to fulfill its obligations under this Agreement;

Performance Indicator means a measure of Hospital performance for which a Performance Target is set;

Performance Standard means the acceptable range of performance for a Performance Indicator or Service Volume that results when a Performance Corridor is applied to a Performance Target (as described in the Schedules and the HSAA Indicator Technical Specifications);

Performance Target means the planned level of performance expected of the Hospital in respect of Performance Indicators or Service Volumes;

person or entity includes any individual and any corporation, partnership, firm, joint venture or other single or collective form of organization under which business may be conducted;

Planning Submission means the Hospital Board-approved planning document submitted by the Hospital to the Funder. The form, content and scheduling of the Planning Submission will be identified by the Funder;

Post-Construction Operating Plan (PCOP) Funding and ***PCOP Funding*** means any annualized operating funding provided under this Agreement, whether by a funding letter or other amendment, to support service expansions and other costs occurring in

conjunction with completion of an approved capital project, as may be set out in ***Schedule A*** and further detailed in ***Schedule C4***;

Program Parameter means, in respect of a program, any one or more of the provincial standards (such as operational, financial or service standards and policies, operating manuals and program eligibility), directives, guidelines and expectations and requirements for that program that are established or required by the Ministry; and that the Hospital has been made aware of or ought reasonably to have been aware of; and that are available to the Hospital on a website of a ministry or agency of the Province of Ontario or that the Hospital has received from the Funder, the Ministry, an agency of the Province or otherwise;

Reports means the reports described in ***Schedule B*** as well as any other reports or information required to be provided under the Enabling Legislation or this Agreement;

Review means a financial or operational audit, investigation, inspection or other form of review requested or required by the Funder under the terms of the Enabling Legislation or this Agreement, but does not include the annual audit of the Hospital's financial statements;

Schedule means any one of, and ***"Schedules"*** mean any two or more, as the context requires, of the Schedules appended to this Agreement, including the following:

Schedule A:	Funding Allocation
Schedule B:	Reporting Requirements
Schedule C1:	Performance Indicators
Schedule C2:	Service Volumes
Schedule C3:	Local Obligations
Schedule C4:	Post Construction Operating Plans Targeted Funding & Volumes
Schedule D:	Home and Community Care Services Terms and Conditions

Service Volume means a measure of Hospital Services for which a Performance Target has been set.

1.2 **Interpretation**. Words in the singular include the plural and vice-versa. Words in one gender include all genders. The words "including" and "includes" are not intended to be limiting and mean "including without limitation" or "includes without limitation", as the case may. The headings do not form part of this Agreement. They are for convenience of reference only and do not affect the interpretation of this Agreement. Terms used in the Schedules have the meanings set out in this Agreement unless separately and specifically defined in a Schedule in which case the definition in the Schedule governs for the purposes of that Schedule.

1.3 **HSAA Indicator Technical Specification**. This Agreement will be interpreted with reference to the HSAA Indicator Technical Specifications.

1.4 **Denominational Hospitals**. For the purpose of interpreting this Agreement, nothing in this Agreement is intended to, and this Agreement will not be interpreted to, unjustifiably, as determined under section 1 of the *Canadian Charter of Rights and Freedoms*, require a Hospital with a denominational mission to provide a service or to perform a service in a

manner that is contrary to the denominational mission of the Hospital.

ARTICLE 2. APPLICATION AND TERM OF AGREEMENT

2.1 **A Service Accountability Agreement**. This Agreement is a service accountability agreement for the purposes of the Enabling Legislation.

2.2 **Term**. The term of this Agreement will commence on the Effective Date and will expire on March 31, 2024, unless extended pursuant to its terms.

ARTICLE 3. OBLIGATIONS OF THE PARTIES

3.1 **The Funder**. The Funder will fulfill its obligations under this Agreement in accordance with the terms of this Agreement, Applicable Law and Applicable Policy.

3.2 **The Hospital**.

3.2.1 The Hospital will provide the Hospital Services and otherwise fulfill its obligations under this Agreement in accordance with the terms of this Agreement, Applicable Law, Applicable Policy and Program Parameters. Without limiting the foregoing, the Hospital acknowledges:

(a) that all Funding will be provided in accordance with the requirements of the Enabling Legislation, including the terms and conditions of the Accountability Agreement;

(b) that it is prohibited from using Funding for compensation increases prohibited by Applicable Law;

(c) its obligation to follow the Broader Public Sector Procurement Directive issued by the Management Board of Cabinet as the same may be replaced or amended from time to time; and

(d) its obligation to post a copy of this Agreement in a conspicuous public place at its sites of operations to which this Agreement applies, and on its public website if the Hospital operates a public website.

3.2.2 When providing the Hospital Services, the Hospital will meet all of the Performance Standards and other terms and conditions applicable to the Hospital Services that have been mutually agreed to by the parties.

3.2.3 The Funder will receive a Mandate Letter from the Ministry annually. Each Mandate Letter articulates areas of focus for the Funder, and the Ministry's expectation that the Funder and the health service providers it funds will collaborate to advance these areas of focus. To assist the Hospital in its collaborative efforts with the Funder, the Funder will share each relevant Mandate Letter with the Hospital.

3.3 **Subcontracting for the Provision of Hospital Services**.

3.3.1 Subject to the provisions of the Enabling Legislation, the Hospital may subcontract the provision of some or all of the Hospital Services. For the purposes of this Agreement,

actions taken or not taken by the subcontractor and Hospital Services provided by the subcontractor will be deemed actions taken or not taken by the Hospital and Hospital Services provided by the Hospital.

3.3.2 The terms of any subcontract entered into by the Hospital will:

(a) enable the Hospital to meet its obligations under this Agreement; and

(b) not limit or restrict the ability of the Funder to conduct any audit or Review of the Hospital necessary to enable the Funder to confirm that the Hospital has complied with the terms of this Agreement.

3.4 **Conflict of Interest**. The Hospital has adopted (or will adopt, within 60 Days of the Effective Date) and will maintain, in writing, for the term of this Agreement, a conflict of interest policy that includes requirements for disclosure and effective management of perceived, actual and potential conflict of interest and a code of conduct, for directors, officers, employees, professional staff members and volunteers. The Hospital will provide the Funder with a copy of its conflict of interest policy upon request at any time and from time to time.

3.5 **French Language Services**. The Hospital shall comply with the requirements and obligations set out in the "Guide to Requirements and Obligations Relating to French Language Health Services". This obligation does not limit or otherwise prevent the Funder and the Hospital from negotiating specific local obligations relating to French language services, that do not conflict with the guide.

3.6 **Designated Psychiatric Facilities**. If the Hospital is designated as a psychiatric facility under the *Mental Health Act,* it will provide the essential mental health services in accordance with the specific designation for each designated site of the Hospital, and discuss any material changes to the service delivery models or service levels with the Ministry and the Funder.

3.7 **Digital Health.** The Hospital shall make best efforts to:

(a) align with, and participate in, the Funder's digital health planning, with the aim to improve data exchange and security, and use digital health to enable optimized patient experience, population health and wellbeing, and system sustainability;

(b) assist the Funder to implement the provincial digital health plans by designing and modernizing digital health assets to optimize data sharing, exchange, privacy and security;

(c) track the Hospital's Digital Health performance against the Funder's plans and priorities;

(d) engage with the Funder to maintain and enhance digital health assets to ensure service resilience, interoperability, security, and comply with any clinical, technical, and information management standards, including those related to data, architecture, technology, privacy and security, set for the Hospital by the Funder and/or the Ministry; and

(e) operate an information security program in alignment with reasonable guidance provided by the Funder.

Despite Article 9 of this Agreement, to the extent that the Hospital is unable to comply, or anticipates it will be unable to comply with the foregoing without adversely impacting its ability to perform its other obligations under this Agreement, the Hospital, in consultation with the Funder, may refer the matter to the Ministry for resolution.

ARTICLE 4. FUNDING

4.1 **Annual Funding**. Subject to the terms of this Agreement, the Funder:

4.1.1 will provide the Funding identified in *Schedule A* to the Hospital for the purpose of providing or ensuring the provision of the Hospital Services; and

4.1.2 will deposit the Funding in equal installments, twice monthly, over the term of this Agreement, into an account designated by the Hospital provided that the account resides at a Canadian financial institution and is in the name of the Hospital.

4.2 **Funding Limited**. The Funder is not responsible for any commitment or expenditure by the Hospital in excess of the Funding that the Hospital makes in order to meet its commitments under this Agreement, nor does this Agreement commit the Funder to provide additional funds during or beyond the term of this Agreement.

4.3 **Limitation on Payment of Funding**. Despite section 4.1, the Funder will not provide any Funding to the Hospital in respect of a Funding Year until the agreement for that Funding Year has been duly signed on behalf of the Hospital, whether by amendment to this Agreement or otherwise. Despite the foregoing, if:

4.3.1 the Hospital is unable to obtain necessary approval of its Board prior to the beginning of a Funding Year; and

4.3.2 the Hospital notifies the Funder:

(a) that it requires this Agreement to be extended to enable the Hospital to obtain the necessary approval of its Board; and,

(b) of the date by which the Hospital Board's approval will be obtained,

then, with the written approval of the Funder, this Agreement and Funding for the then-current Funding Year will continue into the following Funding Year for a period of time specified by the Funder.

4.4 **Rebates, Credits, Refunds and Interest Income**. The Hospital will incorporate all rebates, credits, refunds and Interest Income that it receives from the use of the Funding into its budget, in accordance with GAAP. The Hospital will use reasonable estimates of anticipated rebates, credits and refunds in its budgeting process. The Hospital will use any rebates, credits, refunds and Interest Income that it receives from the use of the Funding to provide Hospital Services unless otherwise agreed to by the Funder.

4.5 **Conditions on Funding**.

4.5.1 The Hospital will:

(a) use the Funding only for the purpose of providing the Hospital Services in accordance with the terms of this Agreement and any amendments to this Agreement, whether by funding letter or otherwise;

(b) not use in-year Funding for major building renovations or construction, or for direct expenses relating to research projects; and,

(c) plan for and maintain an Annual Balanced Operating Budget.

A. **Facilitating an Annual Balanced Operating Budget**. The parties will work together to identify budgetary flexibility and manage in-year risks and pressures to facilitate the achievement of an Annual Balanced Operating Budget for the Hospital.

B. **Waiver**. Upon written request of the Hospital, the Funder may, in its discretion, waive the obligation to achieve an Annual Balanced Operating Budget on such terms and conditions as the Funder may deem appropriate. Where such a waiver is granted, it and the conditions attached to it will form part of this Agreement.

4.5.2 All Funding is subject to all Applicable Law and Applicable Policy.

4.6 **PCOP**. The Hospital acknowledges and agrees that, despite any other provision of this Agreement, unless expressly agreed otherwise in writing, all PCOP Funding is subject to all of the terms and conditions of the funding letter or letters pursuant to which it was initially provided and all of the terms and conditions of this Agreement. For certainty, those funding letters are attached as ***Schedule C4***.

4.7 **Estimated Funding Allocations**.

4.7.1 The Hospital's receipt of any "Estimated Funding Allocation" in *Schedule A* is subject to section 4.8 below and subsequent written confirmation from the Funder.

4.7.2 In the event the Funding confirmed by the Funder is less than the Estimated Funding Allocation, the Funder will have no obligation to adjust any related performance requirements unless and until the Hospital demonstrates to the Funder's satisfaction that the Hospital is unable to achieve the expected performance requirements with the confirmed Funding. In such circumstances the gap between the Estimated Funding and the confirmed Funding will be deemed to be material.

4.7.3 In the event of a material gap in Funding, the Funder and the Hospital will adjust the related performance requirements.

4.8 **Appropriation**. Funding under this Agreement is conditional upon an appropriation of moneys by the Legislature of Ontario to the Ministry and funding of the Funder by the Ministry pursuant to the Enabling Legislation. If the Funder does not receive its anticipated funding, the Funder will not be obligated to make the payments required by this Agreement.

4.9 **Funding Increases**. Before the Funder can make an allocation of additional funds to the Hospital, the parties will: (1) agree on the amount of the increase; (2) agree on any terms and conditions that will apply to the increase; and (3) execute an amendment to this

Agreement that reflects the agreement reached.

ARTICLE 5. REPAYMENT AND RECOVERY OF FUNDING

5.1 **Funding Recovery**. Recovery of Funding may occur for the following reasons:

5.1.1 the Funder makes an overpayment to the Hospital that results in the Hospital receiving more Funding than specified in this Agreement and any funding letters;

5.1.2 a financial reduction under section 13.1 is assessed;

5.1.3 as a result of a system planning process under section 7.2.6;

5.1.4 as a result of an integration decision made under the Enabling Legislation by the Funder; or

5.1.5 to temporarily reallocate Funding to cover incremental costs of another provider where the Hospital has reduced Hospital Services outside of the applicable Performance Corridor without agreement of the Funder and the services are provided by another provider; and

5.1.6 with respect only to Funding that has been provided expressly subject to recovery,

(a) contractual conditions for recovery of such Funding are met; and

(b) if in the Hospital's reasonable opinion or in the Funder's reasonable opinion after consulting with the Hospital, the Hospital will not be able to use the Funding in accordance with the terms and conditions on which it was provided.

5.2 **Process for Recovery of Funding Generally**.

5.2.1 Generally, if the Funder, acting reasonably, determines that a recovery of Funding under section 5.1 is appropriate, then the Funder will give 30 Days' Notice to the Hospital.

5.2.2 The Notice will describe:

(a) the amount of the proposed recovery;

(b) the term of the recovery, if not permanent;

(c) the proposed timing of the recovery;

(d) the reasons for the recovery; and

(e) the amendments, if any, that the Funder proposes be made to the Hospital's obligations under this Agreement.

5.2.3 Where a Hospital disputes any matter set out in the Notice, the parties will discuss the circumstances that resulted in the Notice and the Hospital may make representations to the Funder about the matters set out in the Notice within 14 Days of receiving the Notice.

5.2.4 The Funder will consider the representations made by the Hospital and will advise the Hospital of its decision. Funding recoveries, if any, will occur in accordance with the timing set out in the Funder's decision. No recovery of Funding will be implemented earlier than 30 Days after the delivery of the Notice.

5.3 **Process for Recovery of Funding as a Result of System Planning or Integration**. If Hospital Services are reduced as a result of a system planning process under section 7.2.6 or an integration decision made under the Enabling Legislation, the Funder may recover Funding as agreed in the process in section 7.2.6 or as set out in the decision, and the process set out in section 5.2 will apply.

5.4 **Full Consideration**. In making a determination under section 5.2, the Funder will act reasonably and will consider the impact, if any, that a recovery of Funding will have on the Hospital's ability to meet its obligations under this Agreement.

5.5 **Consideration of Weighted Cases**. Where a settlement and recovery is primarily based on volumes of cases performed by the Hospital, the Funder may consider the Hospital's actual total weighted cases.

5.6 **Hospital's Retention of Operating Surplus**. In accordance with the Ministry's 1982 (revised 1999) Business Oriented New Development Policy (BOND), the Hospital will retain any net income or operating surplus of income over expenses earned in a Funding Year, subject to any in-year or year-end adjustments to Funding in accordance with Article 5*.* Any net income or operating surplus retained by the Hospital under the BOND policy must be used in accordance with the BOND policy. If using operating surplus to start or expand the provision of clinical services, the Hospital will comply with section 7.2.1.

5.7 **Funder Discretion Regarding Case Load Volumes**. The Funder may consider, where appropriate, accepting case load volumes that are less than a Service Volume or Performance Standard, and the Funder may decide not to settle and recover from the Hospital if such variations in volumes are: (1) only a small percentage of volumes; or (2) due to a fluctuation in demand for the services.

5.8 **Settlement and Recovery of Funding for Prior Years.**

5.8.1 The Hospital acknowledges that settlement and recovery of Funding can occur up to seven years after the provision of Funding.

5.8.2 The Hospital agrees that if the parties are directed in writing to do so by the Ministry, the Funder will settle and recover funding provided by the Ministry to the Hospital prior to the transition of the funding for the services or program to the Funder, provided that such settlement and recovery occurs within seven years of the provision of the funding by the Ministry. All such settlements and recoveries will be subject to the terms applicable to the original provision of funding.

5.9 **Debt Due**.

5.9.1 If the Funder requires the re-payment by the Hospital of any Funding in accordance with this Agreement, the amount required will be deemed to be a debt owing to the Crown by the Hospital. The Funder may adjust future Funding instalments to recover the amounts owed or may, at its discretion, direct the Hospital to pay the amount owing to the Crown.

The Hospital will comply with any such direction.

5.9.2 All amounts owing to the Crown will be paid by cheque payable to the "Ontario Minister of Finance" and mailed to the Funder at the address provided in section 14.1.

5.9.3 The Funder may charge the Hospital interest on any amount owing by the Hospital at the then current interest rate charged by the Province of Ontario on accounts receivable.

ARTICLE 6. HOSPITAL SERVICES

6.1 **Hospital Services**. The Hospital will:

6.1.1 achieve the Performance Standards described in the Schedules and the HSAA Indicator Technical Specifications;

6.1.2 not reduce, stop, start, expand, cease to provide or transfer the provision of Hospital Services to another hospital or to another site of the Hospital if such action would result in the Hospital being unable to achieve the Performance Standards described in the Schedules and the HSAA Indicator Technical Specifications; and

6.1.3 not restrict or refuse the provision of Hospital Services that are funded by the Funder to an individual, directly or indirectly, based on the geographic area in which the person resides in Ontario, and will establish a policy prohibiting any health care professional providing services at the Hospital, including physicians, from doing the same.

ARTICLE 7. PLANNING AND INTEGRATION

7.1 **Planning for Future Years**.

7.1.1 **Multi-Year Planning.** The Planning Submission will be submitted to the Funder at the time and in the format required by the Funder and may require the Hospital to incorporate:

(a) prudent multi-year financial forecasts;

(b) plans for the achievement of Performance Targets; and

(c) realistic risk management strategies in respect of (a) and (b).

If the Funder has provided multi-year planning targets for the Hospital, the Planning Submissions will reflect the planning targets.

7.1.2 **Multi-Year Planning Targets.** *Schedule A* may reflect an allocation for the first Funding Year of this Agreement as well as planning targets for up to two additional years, consistent with the term of this Agreement. In such an event:

(a) the Hospital acknowledges that if it is provided with planning targets, these targets are:
   A. targets only;
   B. provided solely for the purposes of planning;
   C. subject to confirmation; and
   D. may be changed at the discretion of the Funder in consultation with the Hospital. The Hospital will proactively manage the risks associated with multi-year planning and the potential changes to the planning targets; and

(b) the Funder agrees that it will communicate any material changes to the planning targets as soon as reasonably possible.

7.2 **System Planning**.

"Pre-proposal" means a notice from the Hospital to the Funder that informs the Funder of a potential integration for the health system in sufficient detail to enable the Funder to assess how the integration would impact the Hospital Services, Funding and the health system, including access to, and quality and cost of, services.

The parties acknowledge that sections 8.7, and 8.8 may apply to a confidential pre-proposal.

7.2.1 **General.** As required by the Enabling Legislation, the parties will separately and in conjunction with each other identify opportunities to integrate the services of the health system to provide appropriate, co-ordinated, effective and efficient services. The Hospital acknowledges the importance of advance notice for system planning purposes. If the Hospital is planning to significantly reduce, stop, start, expand or cease to provide clinical services and operational activities that support those clinical services or to transfer any such services to another site of the Hospital, anywhere , and such action does not result in the Hospital being unable to achieve the Performance Standards described in the Schedules and the HSAA Indicator Technical Specification, then the Hospital will inform the Funder of such change with a view to providing the Funder with time to mitigate adverse impacts.

7.2.2 **Pre-proposal.** The Hospital may inform the Funder, by means of a pre-proposal, of integration opportunities in the health system. The Hospital will inform the Funder by means of a pre-proposal if the Hospital is considering an integration of its services with those of another person or entity.

7.2.3 **Further Consideration of Pre-proposal.** Following the Funder's review and evaluation of the pre-proposal and subject to section 7.2.5, the Funder may invite the Hospital to submit a detailed proposal and business case for further analysis. The Funder will provide the Hospital with guidelines for the development of a detailed proposal and business case.

7.2.4 **Funder Evaluation of the Pre-proposal not Consent.** A pre-proposal will not constitute a notice of an integration under the Enabling Legislation. The Funder's assent to develop the concept outlined in a pre-proposal does not: (a) constitute the Funder's approval to proceed with an integration; (b) presume the Funder or the Minister will not issue a decision ordering the Hospital not to proceed with the integration under the Enabling Legislation; or (c) preclude the Funder from exercising its powers under the

Enabling Legislation.

7.2.5 **Act Prevails.** Nothing in this section prevents the Hospital from providing the Funder or the Minister, as applicable, with notice of integration at any time in accordance with the Enabling Legislation.

7.2.6 **Process for System Planning. If:**

(a) the Hospital has identified an opportunity to integrate its Hospital Services with that of one or more other health service providers, or integrated care delivery systems ("Other Providers");

(b) the Other Providers have agreed to the proposed integration with the Hospital;

(c) the Hospital and the Other Providers have agreed on the amount of funds needed to be transferred from the Hospital to one or more of the Other Providers to effect the integration as planned between them and the Hospital has notified the Funder of this amount;

(d) the Hospital has complied with its obligations under the Enabling Legislation, the integration proceeds or will proceed as planned in accordance with the Enabling Legislation;

(e) then the Funder may recover from the Hospital, Funding specified in *Schedule A* and agreed by the Hospital as needed to facilitate the integration.

7.3 **Reviews and Approvals**.

7.3.1 **Timely Response.** Subject to section 7.3.2, and except as expressly provided by the terms of this Agreement, the Funder will respond to Hospital submissions requiring a response from the Funder in a timely manner and in any event, within any time period set out in *Schedule B*. If the Funder has not responded to the Hospital within the time period set out in *Schedule B*, following consultation with the Hospital, the Funder will provide the Hospital with written Notice of the reasons for the delay and a new expected date of response. If a delayed response from the Funder could reasonably be expected to have a prejudicial effect on the Hospital, the Hospital may refer the matter for issue resolution under Article 11.

7.3.2 **Exceptions.** Section 7.3.1 does not apply to: (i) any notice provided to the Funder or Minister under the Enabling Legislation, which will be subject to the timelines of the Enabling Legislation; and (ii) any report required to be submitted to the Ministry by the Funder for which the Ministry response is required before the Funder can respond.

ARTICLE 8. REPORTING

8.1 **Generally**. The Funder's ability to enable the health system to provide appropriate, co-ordinated, effective and efficient services, as contemplated by the Enabling Legislation, is dependent on the timely collection and analysis of accurate information.

8.2 **General Reporting Obligations**. The Hospital will provide to the Funder, or to such other person or entity as the parties may reasonably agree, in the form and within the time specified by the Funder, the Reports, other than personal health information as defined in

the Enabling Legislation, that the Funder requires for the purposes of exercising its powers and duties under this Agreement, the Enabling Legislation or for the purposes that are prescribed under any Applicable Law. For certainty, nothing in this section 8.2 or in this Agreement restricts or otherwise limits the Funder's right to access or to require access to personal health information as defined in the Enabling Legislation, in accordance with Applicable Law.

8.3 **Certain Specific Reporting Obligations**. Without limiting the foregoing, the Hospital will fulfill the specific reporting requirements set out in ***Schedule B***. The Hospital will ensure that all Reports are in a form satisfactory to the Funder, are complete, accurate and signed on behalf of the Hospital by an authorized signing officer, and are provided to the Funder in a timely manner.

8.4 **Additional Reporting Obligations**.

8.4.1 ***French Language Services*.** If the Hospital is required to provide services to the public in French under the provisions of the *French Language Services Act*, the Hospital will submit a French language services report to the Funder annually. If the Hospital is not required to provide services to the public in French under the provisions of the *French Language Service Act*, the Hospital will provide a report to the Funder annually that outlines how the Hospital addresses the needs of its Francophone community.

8.4.2 **Community Engagement and Integration.** The Hospital will report annually on its community engagement and integration activities and at such other times as the Funder may request from time to time, using any templates provided by the Funder.

8.4.3 **Reporting to Certain Third Parties.** The Hospital will submit all such data and information to the Ministry, Canadian Institute for Health Information or to any other third party, as may be required by any health data reporting requirements or standards communicated by the Ministry to the Hospital. To the extent that the Hospital is unable to comply with the foregoing without adversely impacting its ability to perform its other obligations under this Agreement, the Hospital may notify the Funder and the parties will escalate the matter to their respective CEOs and Board Chairs, if so requested by either party.

8.4.4 **CEO Changes.** The Hospital will immediately notify the Funder if it becomes aware that the Hospital's CEO will depart the organization.

8.5 **System Impacts.** Throughout the term of this Agreement, the Hospital will promptly inform the Funder of any matter that the Hospital becomes aware of that materially impacts or is likely to materially impact the health system, or could otherwise be reasonably expected to concern the Funder.

8.6 **Hospital Board Reports**.

8.6.1 **Hospital Board to be Informed.** Periodically throughout the Funding Year and at least quarterly, the Hospital's Board will receive from the Hospital's Board committees, CEO and other appropriate officers, such reports as are necessary to keep the Board, as the governing body of the Hospital, appropriately informed of the performance by the Hospital of its obligations under this Agreement, including the degree to which the Hospital has met, and will continue throughout the Funding Year to meet, its Performance Targets and its obligation to plan for and achieve an Annual Balanced

Operating Budget.

8.6.2 **Hospital Board to Report to Funder.** The Hospital will provide to the Funder, annually, and quarterly upon request of the Funder, a declaration of the Hospital's Board, signed by the Chair, declaring that the Board has received the reports referred to in this Section.

8.7 **Confidential Information**. The receiving party will treat Confidential Information of the disclosing party as confidential and will not disclose Confidential Information except:

8.7.1 with the prior consent of the disclosing party; or

8.7.2 as required by law or by a court or other lawful authority, including the Enabling Legislation and FIPPA.

8.8 **Required Disclosure**. If the receiving party is required, by law or by a court or by other lawful authority, to disclose Confidential Information of the disclosing party, the receiving party will: promptly notify the disclosing party before making any such disclosure, if such notice is not prohibited by law, the court or other lawful authority; cooperate with the disclosing party on the proposed form and nature of the disclosure; and, ensure that any disclosure is made in accordance with the requirements of Applicable Law and within the parameters of the specific requirements of the court or other lawful authority.

8.9 **Document Retention and Record Maintenance**. The Hospital will:

8.9.1 retain all records (as that term is defined in FIPPA) related to the Hospital's performance of its obligations under this Agreement for seven years after this Agreement ceases to be in effect, whether due to expiry or otherwise. The Hospital's obligations under this section will survive if this Agreement ceases to be in effect, whether due to expiry or otherwise;

8.9.2 keep all financial records, invoices and other financially-related documents relating to the Funding or otherwise to the Hospital Services in a manner consistent with international financial reporting standards as advised by the Hospital's auditor; and

8.9.3 keep all non-financial documents and records relating to the Funding or otherwise to the Hospital Services in a manner consistent with all Applicable Law.

8.10 **Final Reports**. If this Agreement ceases to be in effect, whether due to expiry or otherwise, the Hospital will provide to the Funder all such reports as the Funder may reasonably request relating to, or as a result of, this Agreement ceasing to be in effect.

ARTICLE 9. PERFORMANCE MANAGEMENT, IMPROVEMENT AND REMEDIATION

9.1 **General Approach**. The parties will strive to achieve on-going performance improvement. They will follow a proactive, collaborative and responsive approach to performance management and improvement. Either party may request a meeting at any time. The parties will use their best efforts to meet as soon as possible following a request.

9.2 **Notice of a Performance Factor**. Each party will notify the other party, as soon as

reasonably possible, of any Performance Factor. The Notice will:

9.2.1 describe the Performance Factor and its actual or anticipated impact;

9.2.2 include a description of any action the party is undertaking, or plans to undertake, to remedy or mitigate the Performance Factor;

9.2.3 indicate whether the party is requesting a meeting to discuss the Performance Factor; and

9.2.4 address any other issue or matter the party wishes to raise with the other party, including whether the Performance Factor may be a Factor Beyond the Hospital's Control.

9.2.5 The recipient party will acknowledge in writing receipt of the Notice within seven Days of the date on which the Notice was received ("Date of the Notice").

9.3 **Performance Meetings**. Where a meeting has been requested under section 9.2.3, the parties will meet to discuss the Performance Factor within 14 Days of the Date of the Notice. The Funder can require a meeting to discuss the Hospital's performance of its obligations under this Agreement, including a result for a Performance Indicator or a Service Volume that falls outside the applicable Performance Standard.

9.4 **Performance Meeting Purpose**. During a performance meeting, the parties will:

9.4.1 discuss the causes of the Performance Factor;

9.4.2 discuss the impact of the Performance Factor on the health system and the risk resulting from non-performance; and

9.4.3 determine the steps to be taken to remedy or mitigate the impact of the Performance Factor (the "**Performance Improvement Process**").

9.5 **Performance Improvement Process**.

9.5.1 The purpose of the Performance Improvement Process is to remedy or mitigate the impact of a Performance Factor. The Performance Improvement Process may include:

(a) a requirement that the Hospital develop an Improvement Plan; or

(b) an amendment of the Hospital's obligations as mutually agreed by the parties.

9.5.2 Any Performance Improvement Process begun under a prior agreement will continue under this Agreement. Any performance improvement required by a Funder under a prior agreement will be deemed to be a requirement of this Agreement until fulfilled.

9.6 **Factors Beyond the Hospital's Control**. If the Funder, acting reasonably, determines that the Performance Factor is, in whole or in part, a Factor Beyond the Hospital's Control:

9.6.1 the Funder will collaborate with the Hospital to develop and implement a mutually agreed upon joint response plan which may include an amendment of the Hospital's obligations

under this Agreement;

9.6.2 the Funder will not require the Hospital to prepare an Improvement Plan; and

9.6.3 the failure to meet an obligation under this Agreement will not be considered a breach of this Agreement to the extent that failure is caused by a Factor Beyond the Hospital's Control.

9.7 **Hospital Improvement Plan**.

9.7.1 Development of an Improvement Plan. If, as part of a Performance Improvement Process, the Funder requires the Hospital to develop an Improvement Plan, the process for the development and management of the Improvement Plan is as follows:

(a) The Hospital will submit the Improvement Plan to the Funder within 30 Days of receiving the Funder's request. In the Improvement Plan, the Hospital will identify remedial actions and milestones for monitoring performance improvement and the date by which the Hospital expects to meet its obligations.

(b) Within 15 business Days of its receipt of the Improvement Plan, the Funder will advise the Hospital which, if any, remedial actions the Hospital should implement immediately. If the Funder is unable to approve the Improvement Plan as presented by the Hospital, subsequent approvals will be provided as the Improvement Plan is revised to the satisfaction of the Funder.

(c) The Hospital will implement all aspects of the Improvement Plan for which it has received written approval from the Funder, upon receipt of such approval.

(d) The Hospital will report quarterly on progress under the Improvement Plan, unless the Funder advises the Hospital to report on a more frequent basis. If Hospital performance under the Improvement Plan does not improve by the timelines in the Improvement Plan, the Funder may agree to revisions to the Improvement Plan.

The Funder may require, and the Hospital will permit and assist the Funder in conducting, a Review of the Hospital to assist the Funder in its consideration and approval of the Improvement Plan. The Hospital will pay the costs of this Review.

9.7.2 **Peer/Funder Review of Improvement Plan.** If Hospital performance under the Improvement Plan does not improve in accordance with the Improvement Plan, or if the Hospital is unable to develop an Improvement Plan satisfactory to the Funder, the Funder may appoint an independent team to assist the Hospital to develop an Improvement Plan or revise an existing Improvement Plan. The independent team will include a representative from another hospital selected with input from the Ontario Hospital Association. The independent team will work closely with the representatives from the Hospital and the Funder. The Hospital will submit a new Improvement Plan or revisions to an existing Improvement Plan within 60 Days of the appointment of the

independent team or within such other time as may be agreed to by the parties.

ARTICLE 10. REPRESENTATIONS, WARRANTIES AND COVENANTS

10.1 **General.** The Hospital represents, warrants and covenants that:

10.1.1 it is, and will continue for the term of this Agreement to be, a validly existing legal entity with full power to fulfill its obligations under this Agreement;

10.1.2 subject to Applicable Law, it has made reasonable efforts to ensure that the Hospital Services are and will continue to be provided by persons with the experience, expertise, professional qualifications, licensing and skills necessary to complete their respective tasks;

10.1.3 it holds all permits, licences, consents, intellectual property rights and authorities necessary to perform its obligations under this Agreement;

10.1.4 all information (including information relating to any eligibility requirements for Funding) that the Hospital provided to the Funder in support of its request for Funding was true and complete at the time the Hospital provided it, and will, subject to the provision of Notice otherwise, continue to be materially true and complete for the term of this Agreement; and

10.1.5 it does and will continue to operate for the term of this Agreement, in compliance with Applicable Law and Applicable Policy.

10.2 **Execution of Agreement.** The Hospital represents and warrants that:

10.2.1 it has the full power and authority to enter into this Agreement; and

10.2.2 it has taken all necessary actions to authorize the execution of this Agreement.

10.3 **Governance.** The Hospital represents, warrants and covenants that it will follow good governance practices comparable to those set out in the Ontario Hospital Association's Governance Centre of Excellence's "Guide to Good Governance" as it may be amended; will undertake an accreditation process which will include a review of its governance practices; and will promptly remedy any deficiencies that are identified during that accreditation process.

10.4 **Supporting Documentation.** The Hospital acknowledges that the Funder may, pursuant to the Enabling Legislation, require proof of the matters referred to in this Article 10.

ARTICLE 11. ISSUE RESOLUTION

11.1 **Principles to be Applied**. The parties acknowledge that it is desirable to use reasonable efforts to resolve issues and disputes in a collaborative manner. This includes avoiding disputes by clearly articulating expectations, establishing clear lines of communication,

and respecting each party's interests.

11.2 **Informal Resolution**. The parties acknowledge that it is desirable to use reasonable efforts to resolve all issues and disputes through informal discussion and resolution. To facilitate and encourage this informal resolution process, the parties may jointly develop a written issues statement. Such an issues statement may:

11.2.1 describe the facts and events leading to the issue or dispute;

11.2.2 consider:

(a) the severity of the issue or dispute, including risk, likelihood of harm, likelihood of the situation worsening with time, scope and magnitude of the impact, likely impact with and without prompt action taken;

(b) whether the issue or dispute is isolated or part of a pattern;

(c) the likelihood of the issue or dispute recurring and if recurring, the length of time between occurrences;

(d) whether or not the issue or dispute is long-standing; and

(e) whether previous mitigation strategies have been ignored; and

11.2.3 list potential options for its resolution, which may include:

(a) performance management, in accordance with sections 9.4 through 9.7;

(b) a Review of the Hospital or a facilitated resolution, which may involve the assistance of external supports, such a peers, coaches, mentors and facilitators ("**Facilitation**").

11.3 **Escalation**. If the issue or dispute cannot be resolved at the level at which it first arose, either party may refer it to the senior staff member of the Funder who is responsible for this Agreement and to their counterpart in the senior management of the Hospital. If the dispute cannot be resolved at this level of senior management, either party may refer it to its respective CEO. The CEOs may meet within 14 Days of this referral and attempt to resolve the issue or dispute. If the issue or dispute remains unresolved 30 Days after the first meeting of the CEOs, then either party may refer it to their respective Board Chairs (or Board member designate) who may attempt to resolve the issue or dispute.

11.4 **Reviews and Facilitations**. The Hospital will cooperate in every Review and Facilitation. The Hospital acknowledges that for the purposes of any Review, the Funder may exercise its powers under the Enabling Legislation.

11.5 **Funder Resolution**. Nothing in this Agreement prevents the Funder from exercising any statutory or other legal right or power, or from pursuing the appointment of a supervisor of the Hospital with the Ministry, at any time.

ARTICLE 12. INSURANCE AND INDEMNITY

12.1 **Limitation of Liability**. The Indemnified Parties will not be liable to the Hospital or any of the Hospital's Personnel and Volunteers for costs, losses, claims, liabilities and damages

howsoever caused arising out of or in any way related to the Hospital Services or otherwise in connection with this Agreement, unless caused by the negligence or wilful misconduct of the Indemnified Parties.

12.2 **Same**. For greater certainty and without limiting section 12.1, the Funder is not liable for how the Hospital and the Hospital's Personnel and Volunteers carry out the Hospital Services and is therefore not responsible to the Hospital for such Hospital Services; moreover the Funder is not contracting with, or employing, any of the Hospital's Personnel and Volunteers to carry out the terms of this Agreement. As such, the Funder is not liable for contracting with, employing or terminating a contract or the employment of, any of the Hospital's Personnel and Volunteers required to carry out this Agreement, nor for the withholding, collection or payment of any taxes, premiums, contributions or any other remittances due to government for the Hospital's Personnel and Volunteers required by the Hospital to perform its obligations under this Agreement.

12.3 **Indemnification**. The Hospital will indemnify and hold harmless the Indemnified Parties from and against any and all costs, expenses, losses, liabilities, damages and expenses (including legal, expert and consultant fees), causes of action, actions, claims, demands, lawsuits or other proceedings (collectively "**Claims**") by whomever made, sustained, brought or prosecuted (including for third party bodily injury (including death), personal injury and property damage) in any way based upon, occasioned by or attributable to anything done or omitted to be done by the Hospital or the Hospital's Personnel and Volunteers in the course of performance of the Hospital's obligations under, or otherwise in connection with, this Agreement, unless caused by the negligence or wilful misconduct of an Indemnified Party.

12.4 **Insurance**.

12.4.1 **Required Insurance.** The Hospital will put into effect and maintain, for the term of this Agreement, at its own expense, with insurers having a secure A.M. Best rating of B+ or greater, or the equivalent, all the necessary and appropriate insurance that a prudent person in the business of the Hospital would maintain including the following:

(a) **Commercial General Liability Insurance.** Commercial general liability insurance, for third-party bodily injury, personal injury and property damage to an inclusive limit of not less than five million dollars per occurrence and not less than two million dollars for products and completed operations in the aggregate. The policy will include the following clauses:

A. The Indemnified Parties as additional insureds;
B. Contractual Liability;
C. Cross Liability;
D. Products and Completed Operations Liability;
E. Employers Liability and Voluntary Compensation unless the Hospital can provide proof of *Workplace Safety and Insurance Act, 1997* ("**WSIA**") coverage as described in section 12.4.2(b);
F. Non-Owned automobile coverage with blanket contractual and physical damage coverage for hired automobiles, except that such coverage may nevertheless exclude liability assumed by any person insured by the policy voluntarily under any contract or agreement other than

directors, officers, employees and volunteers of the Hospital pertaining only to the liability arising out of the use or operation of their automobiles while on the business of the Hospital; and

G. A thirty-day written notice of cancellation, termination or material change.

(b) **All-Risk Property Insurance.** All-risk property insurance on property of every description providing coverage to a limit of not less than the full replacement cost, including earthquake and flood. Such insurance will be written to include replacement cost value. All reasonable deductibles and/or self-insured retentions are the responsibility of the Hospital.

(c) **Boiler and Machinery Insurance.** Boiler and machinery insurance (including pressure objects, machinery objects and service supply objects) on a comprehensive basis. Such insurance will be written to include repair and replacement value. All reasonable deductibles and/or self-insured retentions are the responsibility of the Hospital.

(d) **Professional Liability Insurance.** Professional liability insurance to an inclusive limit of not less than five million dollars per occurrence for each claim of negligence resulting in bodily injury, death or property damage, arising directly or indirectly from the professional services rendered by the Hospital, its officers, agents or employees.

(e) **Directors and Officers Liability Insurance.** Directors and officers liability insurance to an inclusive limit of not less than two million dollars per claim, with an annual aggregate of not less than four million dollars, responding to claims of wrongful acts of the Hospital's directors, officers and board committee members and of the Hospital's volunteer association and auxiliary in the discharge of their duties on behalf of the Hospital or the volunteer association or auxiliary, as applicable.

12.4.2 **Proof of Insurance.** As requested by the Funder from time to time, the Hospital will provide the Funder with proof of the insurance required by this Agreement in the form of any one or more of:

(a) a valid certificate of insurance that references this Agreement and confirms the required coverage;

(b) a valid WSIA Clearance Certificate or a letter of good standing, as applicable, unless the Hospital has in effect Employers Liability and Voluntary Compensation as described above; and

(c) copy of each insurance policy.

12.4.3 **Subcontractors.** The Hospital will ensure that each of its subcontractors obtains all the necessary and appropriate insurance that a prudent person in the business of the subcontractor would maintain.

ARTICLE 13. REMEDIES FOR NON-COMPLIANCE

13.1 **Planning Cycle**. The success of the planning cycle depends on the timely performance of each party. To ensure delays do not have a material adverse effect on Hospital

Services or Funder operations, the following provisions apply:

13.1.1 If the Funder fails to meet an obligation or due date in *Schedule B*, the Funder may do one or all of the following:

(a) adjust funding for the Funding Year to offset a material adverse effect on Hospital Services resulting from the delay; and/or

(b) work with the Hospital in developing a plan to offset any material adverse effect on Hospital Services resulting from the delay, including providing Funder approvals for any necessary changes in Hospital Services.

13.1.2 At the discretion of the Funder, the Hospital may be subject to a financial reduction if the Hospital's:

(a) Planning Submission is received by the Funder after the due date in *Schedule B* without prior Funder approval of such delay;

(b) Planning Submission is incomplete;

(c) quarterly performance reports are not provided when due; or

(d) financial and/or clinical data requirements are late, incomplete or inaccurate.

If assessed, the financial reduction will be as follows:

A. if received within seven Days after the due date, incomplete or inaccurate, the financial penalty will be the greater of: (i) a reduction of 0.03% of the Hospital's total Funding; or (ii) $2,000; and

B. for every full or partial week of non-compliance thereafter, the rate will be one half of the initial financial reduction.

ARTICLE 14. NOTICE

14.1 **Notice**. A Notice will be in writing; delivered personally, by pre-paid courier, by any form of mail where evidence of receipt is provided by the post office, or by facsimile with confirmation of receipt, or by email where no delivery failure notification has been received. For certainty, delivery failure notification includes an automated 'out of office' notification. A Notice will be addressed to the other party as provided below or as either party will later designate to the other in writing:

To the Funder:

Ontario Health
525 University Avenue, 5th Floor
Toronto ON, M5G 2L3
Attn: Chief Regional Officer, Toronto and East
Email: OH-East_Submissions@ontariohealth.ca

To the Hospital:

Glengarry Memorial Hospital
20260 County Rd 43
Alexandria ON, K0C 1A0
Attn: President and Chief Executive Officer
Email: ralldred-hughes@hgmh.on.ca

14.2 **Notices Effective From**. A Notice will be deemed to have been duly given one business day after delivery if the Notice is delivered personally, by pre-paid courier or by mail. A Notice that is delivered by facsimile with confirmation of receipt or by email where no

delivery failure notification has been received will be deemed to have been duly given one business day after the facsimile or email was sent.

ARTICLE 15. ADDITIONAL PROVISIONS

15.1 **Interpretation**. In the event of a conflict or inconsistency in any provision of this Agreement, the main body of this Agreement will prevail over the Schedules.

15.2 **Amendment of Agreement**. This Agreement may only be amended by a written agreement duly executed by the parties.

15.3 **Invalidity or Unenforceability of Any Provision**. The invalidity or unenforceability of any provision of this Agreement will not affect the validity or enforceability of any other provision of this Agreement and any invalid or unenforceable provision will be deemed to be severed.

15.4 **No Assignment**. The Hospital will not assign this Agreement or the Funding in whole or in part, directly or indirectly, without the prior written consent of the Funder. The Funder may assign this Agreement or any of its rights and obligations under this Agreement to any one or more agencies or ministries of His Majesty the King in right of Ontario and as otherwise directed by the Ministry.

15.5 **Funder is an Agent of the Crown**. The parties acknowledge that the Funder is an agent of the Crown and may only act as an agent of the Crown in accordance with the provisions of the Enabling Legislation. Notwithstanding anything else in this Agreement, any express or implied reference to the Funder providing an indemnity or any other form of indebtedness or contingent liability that would directly or indirectly increase the indebtedness or contingent liabilities of the Funder or Ontario, whether at the time of execution of this Agreement or at any time during the term of this Agreement, will be void and of no legal effect.

15.6 **Insignia and Logo**. Neither party may use any insignia or logo of the other party without the prior written permission of the other party. For the purposes of this section 15.6, the insignia or logo of the Funder includes the insignia and logo of His Majesty the King in right of Ontario.

15.7 **Parties Independent**. The parties are and will at all times remain independent of each other and are not and will not represent themselves to be the agent, joint venturer, partner or employee of the other. No representations will be made or acts taken by either party which could establish or imply any apparent relationship of agency, joint venture, partnership or employment and neither party will be bound in any manner whatsoever by any agreements, warranties or representations made by the other party to any other person or entity, nor with respect to any other action of the other party.

15.8 **Survival**. The provisions in Articles 1 (Definitions and Interpretation) and 5 (Repayment and Recovery of Funding), sections 8.7 (Confidential Information), 8.8 (Required Disclosure), 8.9 (Document Retention and Record Maintenance), 8.10 (Final Reports), and Articles 12 (Insurance and Indemnity), 14 (Notices) and 15 (Additional Provisions) will

continue in full force and effect for a period of seven years from the date this Agreement ceases to be in effect, whether due to expiry or otherwise.

15.9 **Waiver**. A party may only rely on a waiver of the party's failure to comply with any term of this Agreement if the other party has provided a written and signed Notice of waiver. Any waiver must refer to a specific failure to comply and will not have the effect of waiving any subsequent failures to comply.

15.10 **Counterparts**. This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.

15.11 **Further Assurances**. The parties agree to do or cause to be done all acts or things necessary to implement and carry into effect this Agreement to its full extent.

15.12 **Governing Law.** This Agreement and the rights, obligations and relations of the parties hereto will be governed by and construed in accordance with the laws of the Province of Ontario and the federal laws of Canada applicable therein. Any litigation or arbitration arising in connection with this Agreement will be conducted in Ontario unless the parties agree in writing otherwise.

15.13 **Entire Agreement.** This Agreement forms the entire Agreement between the parties and supersedes all prior oral or written representations and agreements, except that where the Funder has provided Funding to the Hospital pursuant to an amendment to a prior hospital service accountability agreement, or amendment thereto, between the Hospital and a local health integration network or the Funder or to this Agreement, whether by funding letter or otherwise, and an amount of Funding for the same purpose is set out in ***Schedule A***, that Funding is subject to all of the terms and conditions on which funding for that purpose was initially provided, unless those terms and conditions have been superseded by any terms or conditions of this Agreement or by the HSAA Indicator Technical Specifications, or unless they conflict with Applicable Law or Applicable Policy.

-SIGNATURE PAGE FOLLOWS -

IN WITNESS WHEREOF the parties have executed this Agreement made effective as of April 1, 2023.

GLENGARRY MEMORIAL HOSPITAL

By:

July 10, 2023

Frank Wetering,
Chair of the Board

Date

I sign as a representative of the Hospital, not in my personal capacity, and I represent that I have authority to bind the Hospital.

And By:

July 10, 2023

Robert Alldred-Hughes,
President and Chief Executive Officer

Date

I sign as a representative of the Hospital, not in my personal capacity, and I represent that I have authority to bind the Hospital.

ONTARIO HEALTH

By:

July 12, 2023

Anna Greenberg,
Chief Regional Officer, Toronto and East

Date

And By:

July 11, 2023

Eric Partington,
Vice President, Performance,
Accountability, and Funding Allocation,
Ontario Health (East)

Date

Hospital Service Accountability Agreements

Facility #: 802

Hospital Name: Glengarry Memorial Hospital

Hospital Legal Name: Glengarry Memorial Hospital

2023-2024 Schedule A: Funding Allocation

Section 1: FUNDING SUMMARY	2023-2024 [1] Estimated Funding Allocation	
Ontario Health Funding	[2] Base	
Ontario Health Global Allocation (Includes Sec. 3)	$15,514,155	
GEM Allocation	$0	
Health System Funding Reform: QBP Funding (Sec. 2)	$0	
Post Construction Operating Plan (PCOP)	$0	[2] Incremental/One-Time
Wait Time Strategy Services ("WTS") (Sec. 3)	$0	$0
Provincial Program Services ("PPS") (Sec. 4)	$0	$0
Other Non-HSFR Funding (Sec. 5)	$0	$757,100
Sub-Total Ontario Health Funding	$15,514,155	$757,100
Non-Ontario Health Funding		
Cancer Care Ontario	$6,324	
Recoveries and Misc. Revenue	$409,300	
Amortization of Grants/Donations Equipment	$200,000	
OHIP Revenue and Patient Revenue from Other Payors	$4,185,871	
Differential & Copayment Revenue	$205,000	
Sub-Total Non-Ontario Health Funding	$5,006,495	

Hospital Service Accountability Agreements

Facility #: 802

Hospital Name: Glengarry Memorial Hospital

Hospital Legal Name: Glengarry Memorial Hospital

2023-2024 Schedule A: Funding Allocation

Section 2: HSFR - Quality-Based Procedures	2023-2024 [1] Estimated Funding Allocation	
	Volume	[4] Allocation
Hip/Knee Replacement (Bilateral)	0	$0
Hip/Knee Replacement (Bilateral - Inpatient Rehab)	0	$0
Non-Cardiac Vascular (Lower Extremity Occlusive Disease)	0	$0
Non-Cardiac Vascular (Aortic Aneurysm)	0	$0
Tonsillectomy	0	$0
Corneal Transplants	0	$0
Spine (Non-Instrumented - Day Surgery)	0	$0
Spine (Non-Instrumented - Inpatient Surgery)	0	$0
Spine (Instrumented - Inpatient Surgery)	0	$0
Shoulder (Arthroplasty)	0	$0
Shoulder (Reverse Arthroplasty)	0	$0
Shoulder (Repairs)	0	$0
Shoulder (Other)	0	$0
Knee Arthroscopy (Degenerative Meniscus and Joint)	0	$0
Knee Arthroscopy (Ligament and Patella)	0	$0
Knee Arthroscopy (Other Meniscus and Joint)	0	$0
Non-Cancer Hysterectomy (Open Abdominal)	0	$0
Non-Cancer Hysterectomy (Laparoscopic via Incision)	0	$0
Non-Cancer Hysterectomy (Laparoscopically Assisted Vaginal)	0	$0
Non-Cancer Hysterectomy (Vaginal)	0	$0
Non-Cancer Hysterectomy (Outpatient)	0	$0
Cataract (Routine Unilateral)	0	$0
Cataract (Routine Bilateral)	0	$0
Cataract (Non-Routine)	0	$0
Chronic Obstructive Pulmonary Disease	0	$0
Congestive Heart Failure	0	$0
Hip Fracture	0	$0
Pneumonia	0	$0
Stroke (Hemorrhage)	0	$0
Stroke (Ischemic Or Unspecified)	0	$0
Stroke (Transient Ischemic Attack)	0	$0
Stroke (Endovascular Treatment)	0	$0
Hip Replacement BUNDLE (Unilateral)	0	$0
Knee Replacement BUNDLE (Unilateral)	0	$0
Hip/Knee Replacement BUNDLE (Bilateral)	0	$0
Shoulder BUNDLE (Arthroplasty)	0	$0
Shoulder BUNDLE (Reverse Arthroplasty)	0	$0
Hip/Knee Replacement (Bilateral - Outpatient Rehab)	0	$0
Hip Replacement BUNDLE (Unilateral - Inpatient Rehab)	0	$0
Hip Replacement BUNDLE (Unilateral - Outpatient Rehab)	0	$0
Knee Replacement BUNDLE (Unilateral - Inpatient Rehab)	0	$0
Knee Replacement BUNDLE (Unilateral - Outpatient Rehab)	0	$0
Shoulder BUNDLE (Arthroplasty - Inpatient Rehab)	0	$0
Shoulder BUNDLE (Arthroplasty - Outpatient Rehab)	0	$0
Shoulder BUNDLE (Reverse Arthroplasty - Inpatient Rehab)	0	$0
Shoulder BUNDLE (Reverse Arthroplasty - Outpatient Rehab)	0	$0

Hospital Service Accountability Agreements

Facility #: 802

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2023-2024 Schedule A: Funding Allocation

Other QBP 1	**0**	**$0**
Other QBP 2	**0**	**$0**
Other QBP 3	**0**	**$0**
Other QBP 4	**0**	**$0**
Other QBP 5	**0**	**$0**
Other QBP 6	**0**	**$0**
Other QBP 7	**0**	**$0**
Other QBP 8	**0**	**$0**
Other QBP 9	**0**	**$0**
Other QBP 10	**0**	**$0**
Sub-Total Quality Based Procedure Funding	**0**	**$0**

Hospital Service Accountability Agreements

Facility #: 802

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2023-2024 Schedule A: Funding Allocation

	2023-2024 [1] Estimated Funding Allocation	
Section 3: Wait Time Strategy Services ("WTS")	**[2] Base**	**[2] Incremental Base**
General Surgery	**$0**	**$0**
Pediatric Surgery	**$0**	**$0**
Hip & Knee Replacement - Revisions	**$0**	**$0**
Magnetic Resonance Imaging (MRI)	**$0**	**$0**
Ontario Breast Screening Magnetic Resonance Imaging (OBSP MRI)	**$0**	**$0**
Computed Tomography (CT)	**$0**	**$0**
Other WTS Funding	**$0**	**$0**
Other WTS Funding	**$0**	**$0**
Other WTS Funding	**$0**	**$0**
Other WTS Funding	**$0**	**$0**
Other WTS Funding	**$0**	**$0**
Other WTS Funding	**$0**	**$0**
Sub-Total Wait Time Strategy Services Funding	**$0**	**$0**
Section 4: Provincial Priority Program Services ("PPS")	**[2] Base**	**[2] Incremental/One-Time**
Cardiac Surgery	**$0**	**$0**
Other Cardiac Services	**$0**	**$0**
Organ Transplantation	**$0**	**$0**
Neurosciences	**$0**	**$0**
Bariatric Services	**$0**	**$0**
Regional Trauma	**$0**	**$0**
Other Provincial Programs (Type details here)	**$0**	**$0**
Other Provincial Programs (Type details here)	**$0**	**$0**
Other Provincial Programs (Type details here)	**$0**	**$0**
Other Provincial Programs (Type details here)	**$0**	**$0**
Other Provincial Programs (Type details here)	**$0**	**$0**
Other Provincial Programs (Type details here)	**$0**	**$0**
Other Provincial Programs (Type details here)	**$0**	**$0**
Sub-Total Provincial Priority Program Services Funding	**$0**	**$0**
Section 5: Other Non-HSFR	**[2] Base**	**[2] Incremental/One-Time**
Ontario Health One-time payments		**$0**
MOH One-time payments		**$757,100**
Ontario Health/MOH Recoveries	**$0**	
Other Revenue from MOHLTC	**$0**	
Paymaster	**$0**	
Sub-Total Other Non-HSFR Funding	**$0**	**$757,100**

Hospital Service Accountability Agreements

Facility #: 802

Hospital Name: Glengarry Memorial Hospital

Hospital Legal Name: Glengarry Memorial Hospital

2023-2024 Schedule A: Funding Allocation

Section 6: Other Funding *(Info. Only. Funding is already included in Sections 1-4 above)*	[2] Base	[2] Incremental/One-Time
Grant in Lieu of Taxes		**$4,350**
[3] Ontario Renal Network Funding (Inc. in Cancer Care Ontario Funding Sec. 4)	**$0**	**$0**
Sub-Total Other Funding	**$0**	**$4,350**

[1] Estimated funding allocations.

[2] Funding allocations are subject to change year over year.

[3] Funding provided by Cancer Care Ontario, not ONTARIO HEALTH.

[4] All QBP Funding is fully recoverable in accordance with Section 5.6 of the H-SAA. QBP Funding is not base funding for the purposes of the BOND policy.

Hospital Service Accountability Agreements

Facility #:	802
Hospital Name:	Glengarry Memorial Hospital
Hospital Legal Name:	Glengarry Memorial Hospital

2023-2024 Schedule B: Reporting Requirements

1. MIS Trial Balance

Q2 – April 01 to September 30	31 October 2023
Q3 – October 01 to December 31	31 January 2024
Q4 – January 01 to March 31	31 May 2024

2. Hospital Quartery SRI Reports and Supplemental Reporting as Necessary

Q2 – April 01 to September 30	07 November 2023
Q3 – October 01 to December 31	07 February 2024
Q4 – January 01 to March 31	07 June 2024
Year End	30 June 2024

3. Audited Financial Statements

Fiscal Year	30 June 2024

4. French Language Services Report

Fiscal Year	30 April 2024

Hospital Service Accountability Agreements

Facility #:	802
Hospital Name:	Glengarry Memorial Hospital
Hospital Legal Name:	Glengarry Memorial Hospital
Site Name:	TOTAL ENTITY

2023-2024 Schedule C1: Performance Indicators

Part I - PATIENT EXPERIENCE: Access, Effective, Safe, Person-Centered

Performance and Monitoring Indicators Mandatory to Report	Measurement Unit	Performance Target 2023-2024	Performance Standard 2023-2024
Percent of Long Waiters Waiting for All Surgical Procedures	Percent	N/A	N/A
90th Percentile Emergency Department (ED) length of stay for Non-Admitted High Acuity (CTAS I-III) Patients	Hours	Indicator focus is to demonstrate maintenance or improvement.	
90th Percentile Emergency Department (ED) length of stay for Non-Admitted Low Acuity (CTAS IV-V) Patients	Hours	Indicator focus is to demonstrate maintenance or improvement.	
Percent of Priority 2, 3 and 4 Cases Completed within Access Targets for MRI	Percent	Indicator focus is to demonstrate maintenance or improvement.	
Percent of Priority 2, 3 and 4 Cases Completed within Access Targets for CT Scans	Percent	Indicator focus is to demonstrate maintenance or improvement.	
Readmissions to Own Facility within 30 days for selected HBAM Inpatient Grouper (HIG) Conditions	Percent	Indicator focus is to demonstrate maintenance or improvement.	
Rate of Hospital Acquired Clostridium Difficile Infections	Rate	Indicator focus is to demonstrate maintenance or improvement.	

Explanatory Indicators To provider discretion to report/at request of region	Measurement Unit
90th Percentile Time to Disposition Decision (Admitted Patients)	Hours
Percent of Stroke/TIA Patients Admitted to a Stroke Unit During Their Inpatient Stay	Percent
Hospital Standardized Mortality Ratio (HSMR)	Ratio
Rate of Ventilator-Associated Pneumonia	Rate
Central Line Infection Rate	Rate
Rate of Hospital Acquired Methicillin Resistant Staphylococcus Aureus Bacteremia	Rate
Percent of Priority 2, 3, and 4 cases completed within Access targets for Cardiac By-Pass Surgery	Percentage
Percent of Priority 2, 3, and 4 cases completed within Access targets for Cancer Surgery	Percentage
Percent of Priority 2, 3 and 4 Cases Completed within Access Targets for Cataract Surgery	Percentage

Hospital Service Accountability Agreements

Facility #:	802
Hospital Name:	Glengarry Memorial Hospital
Hospital Legal Name:	Glengarry Memorial Hospital
Site Name:	TOTAL ENTITY

2023-2024 Schedule C1: Performance Indicators

Part II - ORGANIZATION HEALTH - EFFICIENCY, APPROPRIATELY RESOURCED, EMPLOYEE EXPERIENCE, GOVERNANCE

Performance and Monitoring Indicators	Measurement Unit	Performance Target 2023-2024	Performance Standard 2023-2024
Current Ratio (Consolidated - All Sector Codes and fund types)	Ratio	**0.30**	**>= 0.29**
Total Margin (Consolidated - All Sector Codes and fund types)	Percentage	**2.76%**	**>=2.76%**

Explanatory Indicators	Measurement Unit
Total Margin (Hospital Sector Only)	Percentage
Adjusted Working Funds/ Total Revenue %	Percentage

Part III - SYSTEM PERSPECTIVE: Integration, Community Engagement, eHealth

Performance Indicators	Measurement Unit	Performance Target 2023-2024
Alternate Level of Care (ALC) Throughput	Value	**1.00**

Explanatory Indicators	Measurement Unit
Alternate Level of Care (ALC) Rate	Percentage
Percentage of Acute Alternate Level of Care (ALC) Days (Closed Cases)	Percentage
Repeat Unscheduled Emergency Visits Within 30 Days For Mental Health Conditions	Percentage
Repeat Unscheduled Emergency Visits Within 30 Days For Substance Abuse Conditions	Percentage

Hospital Service Accountability Agreements

Facility #: 802

Hospital Name: Glengarry Memorial Hospital

Hospital Legal Name: Glengarry Memorial Hospital

2023-2024 Schedule C2: Service Volumes

	Measurement Unit	Performance Target 2023-2024	Performance Standard 2023-2024
Clinical Activity and Patient Services			
Ambulatory Care	Visits	**3,000**	**>= 2,250 and <= 3,750**
Complex Continuing Care	Weighted Patient Days	**1,100**	**>= 935 and <= 1,265**
Day Surgery	Weighted Cases	**0**	**-**
Elderly Capital Assistance Program (ELDCAP)	Patient Days	**0**	**-**
Emergency Department	Weighted Cases	**0**	**-**
Emergency Department and Urgent Care	Visits	**17,100**	**>= 12,825 and <= 21,375**
Inpatient Mental Health	Patient Days	**0**	**-**
Inpatient Rehabilitation Days	Patient Days	**3,000**	**>= 2,550 and <= 3,450**
Total Inpatient Acute	Weighted Cases	**820**	**>= 697 and <= 943**

Hospital Service Accountability Agreements

Facility #: 802

Hospital Name: Glengarry Memorial Hospital

Hospital Legal Name: Glengarry Memorial Hospital

2023-2024 Schedule C3: Local Obligations

This schedule sets out provincial goals identified by Ontario Health (OH) and the Local Obligations associated with each of the goals. The provincial goals apply to all HSPs and HSPs must select the most appropriate obligation(s) under each goal for implementation. HSPs must provide a report on the progress of their implementation(s) as per direction provided by OH regional teams.

Goal: Enable Surgical Recovery and Stabilization

Local Obligations related to goal:

- Wait list clean-up and regular data reviews to ensure accuracy of active patient queue
- Onboarding of WTIS and/or SETP if a facility is not already onboarded to both systems. If a facility is already onboarded to WTIS at a basic level of integration, work towards transitioning to a complex level of integration.
- Regular review and revision of facility level procedure mapping to WTIS
- Participate in and contribute to Ontario Health regional strategies to maximize capacity, including but not limited to shifting volumes, as needed, and participating in eReferral and/or central wait list strategies, as appropriate.

Goal: Improve Access and Flow by Reducing Alternate Level of Care (ALC)

Local Obligations related to goal:

- Support improvement through implementation of ALC leading practice playbook
  a. Complete the ALC Leading Practices self-assessment to identify current state
  b. Plan and implement the ALC leading practices to drive ALC process improvements
- Improve ALC coding practices
  a. Review current ALC coding practices and compare against ALC provincial guideline
  b. Plan and implement consistent ALC coding to drive ALC process improvements
- Participate in and contribute to regional plans to support admission diversion, maximize capacity, and support patients transition to community

Goal: Advance Indigenous Health Strategies and Outcomes

Local Obligations related to goal:

- Develop and/or advance First Nations, Inuit, Métis and Urban Indigenous (FNIMUI) FNIMUI Health Workplan:
  a. Partner with your OH team to work through a process of establishing a First Nations, Inuit, Métis and Urban Indigenous Health Workplan, which aligns with provincial guidance, and includes a plan for Indigenous cultural awareness (improving understanding of Indigenous history, perspectives, cultures, and traditions) and cultural safety (improving understanding of anti-racist practice and identifying individual and systemic biases that contribute to racism across the health care system). Ontario Health will provide guidance material to support this process.
  b. Or, if a First Nations, Inuit, Métis and Urban Indigenous Health Workplan (or similar) already exists, demonstrate advancement to implementation of the plan.

- Demonstrate progress (and document in reporting template) on outcomes, access and/or executive training:
  a. Improvement in outcomes regarding First Nations, Inuit, Métis and Urban Indigenous health (note for 23/24 this will give HSPs the opportunity to demonstrate any improvement based on the data currently available to them. In future years, standardized indicators will be developed.)
  b. Progress in increasing culturally safe access to healthcare services, programs to foster Indigenous engagement, and relationship building to improve Indigenous health (note for 23/24 this will give HSPs the opportunity to demonstrate any improvement based on initiatives they have targeted in their First Nations, Inuit, Métis and Urban Indigenous Health Workplan. In future years, standardized indicators will be developed.)
  c. Demonstrate that executive level staff have completed Indigenous Cultural Safety Training

Goal: Advance Equity, Inclusion, Diversity, and Anti-Racism Strategies to Improve Health Outcomes

Local Obligations related to goal:

- Develop and/or advance of an organizational health equity plan
  a. develop an equity plan that aligns with OH equity, inclusion, diversity and anti-racism framework, and existing provincial priorities, where applicable (i.e., French language health services plan; Accessibility for Ontarians with Disabilities Act; the provincial Black Health Plan; High Priority Community Strategy; etc.). Please note that HSPs will be provided with guidance materials to help develop their equity plan and complete a reporting template to submit to the region.
  b. Or, if an equity plan already exists, demonstrate advancement to implementation of the plan, by completing the equity reporting template and submitting to the region.

- Increase understanding and awareness of health equity through education/continuous learning
  a. Continue capacity-building through knowledge transfer, education, and training about health equity within the Region, HSPs will demonstrate that a minimum, executive level staff have completed relevant equity, inclusion, diversity, and anti-racism education (recommended education options to be provided).

☒ Board of Directors ☐ Board Committee - ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: February 22, 2025 Meeting Date Prepared for: March 12, 2025 – Finance
March 27, 2025 - Board

Subject: Capital plan 2025-2026

Prepared by: Linda S. Ramsay

☒ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

The purpose of this briefing note is to share the final Draft of the Capital Plan for 2025-2026

RECOMMENDATION/MOTION

That the Finance, HR and Audit Committee recommend to the Board of Directors that the Capital Plan for 2025-2026 be approved as presented.

That the Finance, HR, and Audit Committee recommend to the Board of Directors the use of the Endowment fund to purchase up to $ 107,621 of capital expenses.

SITUATION & BACKGROUND

November

- Managers received a copy of the 2024-2025 capital plan that included of the projected 3 years. They were to update the identified anticipated purchases of 2025-2026 (items with quotes) and to update the projected requirements for the years 2026 thru 2028.

February

- A first draft of the capital plan was done and presented at the Senior Executive Leadership meeting in February 2025. Based on this initial review and cashflow/funding considerations, the VP were told to reach out to their managers and review their proposals.
- Any known expected funding such as donations/grants were considered to determine the list.
- Following meetings between the managers and VP and final draft of the capital list for 2025-2026 was drafted.

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

- The framework for ethical decision making was used as a tool for the discussion between the VP and managers.

CONSULTED WITH:

- Managers and Senior Executive Leadership

IMPLEMENTATION & COMMUNICATION PLAN

- Once approved by the Board, managers with the help of the Manager of Material Management and Facilities will proceed with the purchases in the new fiscal year.

FUTURE ITEMS TO CONSIDER

- The final capital list will be shared with the Foundation, to help them in their consideration for their proposed contributions for the year 2025-2026

- As we have an unfunded amount of $ 107,621, a motion is being brought to the Board that funds from the Endowment fund are to be used to cover this. We will be monitoring the capital expenses throughout the year to ensure that endowment funds usage is at a minimum.

SUPPORTING DOCUMENTS/ATTACHMENTS

- Capital plan 2025-2026
- Ethical Lens for Decision Making

CAPITAL PLAN

PROJECTIONS (2025-2028)

	2025-2026	2026-2027	2027-2028	2028-2029
INFRASTRUCTURE/MAINTENANCE				
Infrastructure/Building	222,000.00	1,812,000.00	120,000.00	20,000.00
PROJECTS				
Projects	112,710.00	66,500.00	18,000.00	0.00
INFORMATION TECHNOLOGY				
Information Technology and Software	4,360,460.00	2,195,000.00	0.00	0.00
SUPPORT SERVICES				
Support Services	35,000.00	92,000.00	30,000.00	0.00
CLINICAL - NURSING/DIAGNOSTIC SERVICES				
Clinical/Diagnostic Services	407,500.00	2,216,471.60	771,400.00	58,500.00
Contingency - 10 %	104,461.00	98,697.16	93,940.00	7,850.00
GRAND TOTAL:	**5,242,131.00**	**6,480,668.76**	**1,033,340.00**	**86,350.00**
Funding - Depreciation	(591,050.00)			
Funding - HIRF	(50,000.00)			
Funding - ECP (if approved)	(120,000.00)			
Long Term Financing	(4,215,460.00)	(2,195,000.00)		
Funding - Foundation	(125,000.00)	(3,200,000.00)		
Funding - Journee de la Femme	(33,000.00)			
Funding - Endowment	(107,621.00)			
	(5,242,131.00)	**(5,395,000.00)**	**0.00**	**0.00**
UNFUNDED	**0.00**	**1,085,668.76**	**1,033,340.00**	**86,350.00**

ETHICS LENS FOR DECISION MAKING

Questions	Yes	No	N/A	Comments (if yes, how; if no, why not)
1. GATHERING THE COMMUNITY OF CONCERNS				
a. Has the issue been identified?	☒	☐	☐	The initial draft of the capital plan for 2025-2026 was in excess of the available funds.
b. Have the people involved and those who need to be involved been identified?	☒	☐	☐	Managers were tasked to review their individual list and to discuss with their respective VPs.
c. Have the facts of the situation been determined?	☒	☐	☐	
2. CLARIFICATION OF THE FACTS				
a. Have the ethical principles which affect the issue been considered?	☒	☐	☐	Each manager is to consider the risk to patient care, patient safety, visitors and/or staff if a purchase is deferred to another year.
b. Have the professional codes of ethics for all relevant parties, as well as their values been considered?	☒	☐	☐	
c. Have the societal and cultural expectations been identified and explored?	☒	☐	☐	The capital list/request has been shared with the chair of the accessibility committee
d. Have legal requirements been considered to determine compliance with existing laws and policies?	☒	☐	☐	
3. EVALUATIONS OF POSSIBLE OPTIONS/DECISIONS				
a. Have the foreseeable harm/benefits to individual or groups been considered?	☒	☐	☐	At minimum the questions to ask are: Will there be a risk to patient care, patient safety, visitors and/or staff if a purchase is deferred to another year. Will HGMH be vulnerable and/or expose itself to cyber attacks if the investment in IT is not done this year?
b. Is the option selected the one with the best consequences and alignment with the provider's duties and values?	☒	☐	☐	Will any decision of postponement impact our strategic priorities and our operating plan?

ETHICS LENS FOR DECISION MAKING

4. IMPLEMENTATION OF THE DECISION				
a. Has the method of communication, implementation, and documentation of the decision been identified?	☒	☐	☐	Once the capital plan is finalized and approved by the Board, it will be shared with the managers so that purchases can proceed.
b. Have the outcomes been evaluated?	☒	☐	☐	At end of year-end 2025-20265, there should be a review if the postponement of a purchase created an unidentified risk and required any mitigating strategies.

Completed by: Linda S. Ramsay

Date: February 22, 2025

REPORT OF THE GOVERNANCE AND NOMINATING COMMITTEE

March 12, 2025 at 5:00PM MS Teams

Present:	L. Boyling, Chair	G. Peters	Dr. S. Robertson
	G. McDonald	C. Larocque	R. Alldred-Hughes, CEO
Regrets:	None		

Summary of Discussion

Approval of the Agenda
The agenda was reviewed.

Moved By: G. Peters
Seconded By: C. Larocque
THAT the agenda be approved as presented.

CARRIED

Declaration of Conflict of Interest
There were no conflicts declared.

Approval of Previous Meeting Report
The meeting report from January 15, 2025, was shared.

Moved By: Dr. S. Robertson
Seconded By: G. McDonald
THAT the meeting report be approved as presented.

CARRIED

Business Arising from Report
There was no business arising from the report.

Committee Workplan Review
There were no changes to the committee workplan, and things are on track.

Matters for Discussion/Decision

Board Recruitment
Last year, the Corporate Bylaws were amended and now state that the Board shall consist of a minimum of ten (10) and a maximum of twelve (12) directors. With the current Past Chair not returning next Board cycle, there is the opportunity to recruit for one Director as the Past Chair is an ex-officio voting Director.

Moved By: G. Peters
Seconded By: Dr. S. Robertson
THAT the Governance and Nominating Committee commence the recruitment process for the recruitment of one (1) Director for the 2025-2026 Board Cycle.

To increase efforts in recruiting a diverse Director, it was agreed to reach out to the community of Akwesasne since lots of work is being done with them. An application has already been received, and the candidate will be interviewed, however, this person works at a neighbouring hospital which could be perceived a conflict of interest. This will be looked into further should this be the successful candidate. Interviews will aim to be scheduled April 23-25, 2025.

CARRIED

Board and Committee Meeting Schedule
After reviewing the questions from the Governing Body Assessment survey, it was identified that Quality is not on the agenda often enough as the committee only meets four times per Board cycle. Recommendation is being made to change committee meeting frequency so that all committees meet six (6) times per year. This would even out the workload and ensure equal distribution of meeting times as currently the Quality meeting has a heavier workload and Finance often has a shorter workload as they meet eight (8) times per year.

Moved By: C. Larocque
Seconded By: G. McDonald
THAT the Governance & Nominating Committee recommend to the Board of Directors the proposed adjustment to the committee meeting schedule as presented.

The revised workplans were mapped out to list out the even workload for all committees. At the French Language Services meeting in June, the question will be raised as to whether this committee should meet more frequently.

Workplans are discussed and approved at the first committee meeting of the Board cycle, however, it was agreed that the Epic project be added to the Finance, HR and Audit committee work plan. The committees can decide whether anything else should be added at that time.

CARRIED

Governance Accreditation Standard Review
Work is being done on ensuring all Accreditation standards are met for the upcoming Accreditation cycle. As such, it was noted that there was opportunity to amend some of the policies recently reviewed to ensure standards are met.

Moved By: Dr. S. Robertson
Seconded By: C. Larocque
THAT the Governance & Nominating committee recommend to the Board of Directors the approval of the Roles and Responsibilities of the Board Policy, the Nominating and Election Policy, the Responsibilities as a Director and Code of Conduct Policy, and the Responsibilities of the Board Chair, Vice Chair, and Treasurer Policy as amended.

The composition listed in the Nominating and Election Policy will be corrected to reflect the language used in the Corporate Bylaws.

CARRIED

Review Peer-to-Peer Survey Questionnaire
Revisions were made to the Peer-to-Peer survey following discussion from the last meeting.
Moved By: C. Larocque
Seconded By: G. Peters
THAT the Governance & Nominating committee approve the Peer-to-Peer survey questionnaire as amended.

Discussion ensued around the objective of the survey which is to identify whether Directors are good performers or lack thereof. It was agreed that there is no need to have multiple categories in the survey, these should just be Fully Satisfactory, Could Improve and Unknown. The open text box language will be changed to say *Please explain with examples if choosing could improve*. A question will be added at the end of the survey as to whether or not Directors are ready to be considered as Executives of the Board or still need more time.

CARRIED

Documents for Review
Framework for Ethical Decision-Making Policy
This policy was due for regular review.

Moved By: G. Peters
Seconded By: G. McDonald
THAT the Governance & Nominating committee recommend to the Board of Directors the approval of the Framework for Ethical Decision-Making Policy as presented.

A number of changes were required to reflect the requirements of Accreditation and to align with the framework used at the hospital. The policy now outlines the ethical decision-making steps.

A visual was created to help identify the steps for ethical decision-making and will be included at the end of all meeting agendas going forward and will also be displayed in the Boardroom.

CARRIED

Board Mentorship
This policy was due for regular review.

Moved By: G. Peters
Seconded By: G. McDonald
THAT the Governance & Nominating committee recommend to the Board of Directors the approval of the Board Mentorship Policy as presented.

This policy was revised to ensure that both the mentor and the mentee understand what is required of them in Board of Director mentorship. Criteria was included for selecting a mentor for new Board members.

CARRIED

Donor Recognition
This policy was due for regular review.

Moved By: G. Peters
Seconded By: G. McDonald
THAT the Governance & Nominating committee retire the Donor Recognition Policy.

This policy is to be retired as the HGMH Foundation is developing a comprehensive donor recognition policy and all donations should be directed toward the Foundation.

CARRIED

Next meeting: Wednesday, April 9, 2025

K-L. Massia, Recorder

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee - Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: March 3, 2025 Meeting Date Prepared for: March 12, 2025

Subject: Governance Accreditation Standard Feature

Prepared by: R. Alldred-Hughes, President & CEO

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- As part of the hospital's efforts to embrace the new continuous model for Accreditation and embed it into our daily work, committees will feature 1-2 criteria from an Accreditation standard that applies to their committee's work at each meeting
- These features will provide an opportunity for the committee to discuss the standard and how HGMH achieves compliance, identifies opportunities for improvement, while ensuring the committee is well-equipped to make informed decisions and recommendations related to quality

STANDARD / CRITERIA FEATURED

Include the standard name, number(s), statement(s), guideline text, and other information if applicable

2.1.1 The governing body achieves its defined objectives regarding its composition.

Priority: **Normal** | Quality Dimension: **Appropriateness**

Guidelines
To define its objectives regarding its composition, the governing body considers factors such as:

- its roles and responsibilities;
- its areas of decision making;
- the organization's strategic plan, goals, and objectives; and
- relevant laws, regulations, and contractual obligations.

To establish its composition, the governing body defines:

- Its membership size will depend on several factors, including the size of the organization;
- its risks and opportunities;
- the services offered;
- the size of the population served; and
- relevant laws, regulations, and contractual obligations.

The mix of competencies (which may be defined in a competency matrix) required to carry out its governance responsibilities and support the organization's vision, mission, and values. The competency matrix may evolve in response to changes in the organization's environment or its vision, mission, and values. Competencies can include:

- The attributes that members should possess, such as integrity, high ethical standards, sound judgment, empathy, effective interpersonal skills, cultural competency, and a strong commitment to the health of everyone in the community and to the success of the organization in serving the community's short- and long-term needs.

- Subject-specific skills, knowledge, and experience in areas related to governance activities (e.g., quality and safety, law, finance, risk, technology, human resources, sustainability, lived experience and more).

The diverse perspectives it wishes to reflect, including those of the organization's stakeholders (e.g., diverse populations and groups in the community, clients and families who regularly use the organization's services, clinical service providers, and other workforce or volunteer members).

The balance required between adding new members who bring fresh perspectives and retaining experienced members who have the past organizational knowledge to support continuity. Its governing structure, including its mechanism to create committees under its oversight to provide in-depth expertise and advice on specific complex or technical decisions that fall under its governance responsibilities.

The governing body identifies strategies to achieve its composition objectives, even in challenging circumstances. For example, if the governing body membership is full before it achieves the required competencies and diversity, it identifies alternate ways to bring the missing perspectives and expertise to the discussions. This may include recruiting additional members in advisory positions, consulting with stakeholder advisory councils (e.g., one or more advisory councils of members or leaders from different community groups), or diversifying committee memberships.

In some jurisdictions, the composition of the governing body may be determined by government. In this case, the governing body works with government to inform and contribute to the process (e.g., provides input into the required competencies, diversity, perspectives, and structure for governance) and participates to the fullest extent possible.

ACTIONS TAKEN TO MEET STANDARD

Minor amendments were made to the following policies to ensure compliance with the standard:

- Roles and Responsibilities of the Board: added cross-reference to related policies such as the Code of Conduct Policy, CEO and COS Succession Planning, and the Nomination and Election Policy.
- Nomination and Election Policy: wording added to reinforce the process for ensuring that candidates align with the board's competency and diversity requirements.
- Code of Conduct Policy: added cross-reference to related policies and forms and included a section on Exercise of Authority. This policy was revised to now include Responsibilities as a Director and Code of Conduct together.

STANDARD / CRITERIA FEATURED

Include the standard name, number(s), statement(s), guideline text, and other information if applicable

2.2.1 The governing body defines its accountabilities in compliance with its jurisdictional obligations.

Priority: High | Quality Dimension: Appropriateness

Guidelines

The governing body ensures that its accountabilities, including its roles and responsibilities, are defined in compliance with its obligations under relevant laws, regulations, and contractual arrangements as per its jurisdiction. It ensures that its roles, responsibilities, and accountabilities are aligned with the organization's vision, mission, and values, and reflect the organization's role in society.

The governing body's role includes guiding the organization to achieve its vision, mission, and values. The governing body is responsible and accountable for steering and overseeing the functions of the organization, including the quality, safety, legal, financial, technological, marketing, fundraising, and sustainability functions. The governing body must stay informed about the organization and represent the organization's interests. The governing body acts in the

best interests of the organization and its stakeholders, including a commitment to financial and environmental stewardship, organizational health and safety, client outcomes, and the short- and long-term health of the community. The governing body is also responsible for ensuring that relevant information flows in a timely, transparent, and coordinated manner between the governing body, its committees, the organizational leaders, and other stakeholders. Additionally, the governing body is accountable to follow the organization's code of conduct; comply with the organization's confidentiality agreements; participate in orientation and ongoing education; participate in self-evaluation and evaluation of the governing body; and prepare for and attend meetings.

The governing body ensures that it clearly outlines the division of roles, responsibilities, and accountabilities between the governing body and the organizational leaders. It ensures that the information on its roles, responsibilities, and accountabilities is understood by its members, its committees, the organizational leaders, and other stakeholders.

In some jurisdictions, government may be accountable for defining and updating the roles, responsibilities, and accountabilities of the governing body. In this case, the governing body works with government to inform and contribute to the process and participates to the fullest extent possible.

ACTIONS TAKEN TO MEET STANDARD

Minor amendments were made to the following policies to ensure compliance with the standard:

- Roles and Responsibilities of the Board: added cross-reference to related policies such as the Code of Conduct Policy, CEO and COS Succession Planning, and the Nomination and Election Policy.
- Code of Conduct Policy: added cross-reference to related policies and forms and included a section on Exercise of Authority. This policy was revised to now include Responsibilities as a Director and Code of Conduct together.

STANDARD / CRITERIA FEATURED

Include the standard name, number(s), statement(s), guideline text, and other information if applicable

2.2.2 The governing body defines the accountabilities of each of its members, including the chair.

Priority: High | Quality Dimension: Efficiency

Guidelines

The roles, responsibilities, and accountabilities of each member of the governing body include attendance requirements, term lengths, and limits. Term lengths may be determined by regulations; if they are not, they should be established and included in the bylaws.

Governing body members may or may not be financially compensated for their time. When compensation is provided, the governing body ensures it is done transparently and does not create real or perceived conflicts of interest or interfere with the independence of its members.

Each member may fill a different position on the governing body (e.g., chair, vice-chair, secretary, treasurer, committee chair). The governing body documents each position or member's roles, responsibilities, and accountabilities in its operational documents (e.g., in its terms of reference or individual position descriptions). It ensures that the position information is written using neutral language that is not biased in favour of or against a person, group, or attribute (e.g., age, gender identity, race, ethnicity).

In some jurisdictions, government may be accountable for defining, updating the roles, responsibilities, and accountabilities of governing body members, including the chair. In this case, the governing body works with government to inform and contribute to the process and participates to the fullest extent possible.

ACTIONS TAKEN TO MEET STANDARD

Amendments were made to the following policy to ensure compliance with the standard:

- **Roles and Responsibilities of the Board Executives:** included responsibilities of the Vice Chair and the Treasurer.

DISCUSSION QUESTIONS

Choose 1-2 questions from the list below to guide discussion at your meeting, or create your own question(s)

- What does the hospital already do to meet this standard?
- What new things can the hospital implement to meet this standard?
- How would you respond to a surveyor asking you a question about this standard?
- What evidence (i.e.: documentation) can support the hospital's compliance with this standard?

SUPPORTING DOCUMENTS/ATTACHMENTS

- Roles and Responsibilities of the Board Policy
- Nomination and Election Policy
- Code of Conduct Policy
- Roles and Responsibilities of the Board Executives Policy

ROLES AND RESPONSIBILITIES OF THE BOARD

Document Name:	Roles and Responsibilities of the Board	
Document Number:	BOD.01.005.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** N/A
Classification: Board of Directors	**Section:** Governance	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

To ensure that the board has a shared understanding of its governance role, the board has adopted this Sample Statement of the Roles and Responsibilities of the Board.

The board is responsible for the overall governance of the affairs of the hospital.

Each director is responsible to act honestly, in good faith and in the best interests of the hospital and in so doing, to support the hospital in fulfilling its mission and discharging its accountabilities. (Code of Conduct BOD.01.017.X.XX)

PROCEDURE

1. Strategic Planning and Mission, Vision and Values

a) The board participates in the formulation and adoption of the hospital's mission, vision and values.
b) The board ensures that the hospital develops and adopts a strategic plan that is consistent with the hospital's mission and values, which will enable the hospital to realize its vision. The board participates in the development of and ultimately approves the strategic plan.
c) The board oversees hospital operations for consistency with the strategic plan and strategic directions.
d) The board receives regular briefings or progress reports on implementation of strategic directions and initiatives.
e) The board ensures that its decisions are consistent with the strategic plan and the hospital's mission, vision and values unless there is a sound rationale to do otherwise.
f) The board annually conducts a review of the strategic plan as part of a regular annual planning cycle.

2. Quality and Performance Measurement and Monitoring

a) The board is responsible for establishing a process and a schedule for monitoring and assessing performance in areas of board responsibility including:
   - Fulfillment of the strategic directions in a manner consistent with the mission, vision and values
   - Oversight of management performance

- Quality of patient care and hospital services
- Financial conditions and risks
- Stakeholder relations
- Board's own effectiveness

b) The board ensures that management has identified appropriate measures of performance.
c) The board is responsible for establishing policies and plans related to the quality improvement plan.
d) The board ensures that policies and improvement plans are in place related to quality of care, patient safety, consumer experience, and access.
e) The board monitors quality performance against the board-approved quality improvement plan, performance standards, and indicators.
f) The board ensures that management has plans in place to address variances from performance standards indicators, and the board oversees implementation of remediation plans.

3. Financial and Resources Oversight

a) The board acts in the best interest of the hospital and its stakeholders.
b) The board is responsible for stewardship of financial resources including ensuring availability of, and overseeing allocation of, financial resources.
c) The board approves policies for financial planning and approves the annual operating and capital budget.
d) The board monitors financial performance against budget.
e) The board approves investment policies and monitors compliance.
f) The board ensures the accuracy of financial information through oversight of management and approval of annual audited financial statements.
g) The board ensures management has put measures in place to ensure the integrity of internal controls.
h) The board oversees asset management.

4. Oversight of Management Including Selection, Supervision and Succession Planning for the CEO and Chief of Staff
(CEO and COS Succession Planning BOD.01.004.X.XX)

a) The board recruits and supervises the CEO and COS by:
- Developing and approving the CEO and COS job descriptions
- Undertaking a recruitment and selection process for the CEO and COS
- Reviewing and approving the CEO and COS annual performance goals
- Reviewing the performance of the CEO and COS and determining compensation

b) The board ensures succession planning is in place for the CEO and COS.
c) The board exercises oversight of the CEO's supervision of senior management as part of the CEO's annual review.
d) The board develops, implements and maintains a process for the selection of department chiefs and other medical leadership positions as required under the

hospital's by-laws or the *Public Hospitals Act*.

5. Enterprise Risk Management Oversight

a) The board is responsible to be knowledgeable about risks inherent in hospital operations and ensure that appropriate risk analysis is performed as part of board decision-making.
b) The board oversees management's risk management program including an assessment of risks relative to their probability and potential impact.
c) The board ensures that appropriate programs and processes are in place to protect against risk.
d) The board is responsible for identifying unusual risks to the organization for ensuring that there are plans in place to prevent and manage such risks.

6. Stakeholder Communication and Accountability

a) The board identifies hospital stakeholders and understands stakeholder accountability.
b) The board ensures the organization appropriately communicates with stakeholders in a manner consistent with accountability to stakeholders and to promote engagement.
c) The board contributes to the maintenance of strong stakeholder relationships.
d) The board performs advocacy on behalf of the hospital with stakeholders where required in support of the mission, vision and values and strategic directions of the hospital.

7. Governance

a) The board is responsible for the quality of its own governance.
b) The board establishes governance structures to facilitate the performance of the board's role and enhance individual director performance.
c) The board is responsible for the recruitment of a skilled, experienced and qualified board.
d) The board ensures ongoing board training and education.
e) The board assesses and reviews its governance by periodically evaluating board structures including board recruitment processes and board composition and size, number of committees and their Terms of Reference, processes for appointment of committee chairs, processes for appointment of board officers and other governance processes and structures. (Nomination and Election Policy BOD.01.016.X.XX)

8. Legal Compliance

a) The board ensures that appropriate processes are in place to ensure compliance with legal requirements.

***9.* Amendment**

a) This statement may be amended by the board.

DEFINITIONS:

Hospital stakeholder: individuals or groups who are greatly influenced by the hospital and have a vested interest in its success. Examples of hospital stakeholders are patients, physicians, employees, the broader community, and legislative and regulatory bodies.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
BOD.01.017.X.XX	Code of Conduct
BOD.01.004.X.XX	CEO and COS Succession Planning
BOD.01.016.X.XX	Nomination and Election

ASSOCIATED FORMS:

Form Number	Form Name
51-A-215-XX	Annual Declaration and Consent Form

Document Name:	Nomination and Election	
Document Number:	BOD.01.016.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Board Orientation
Classification: Board of Directors	**Section:** Governance	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

Hôpital Glengarry Memorial Hospital is committed to a fair and equitable process for nominating and electing members to the Board of Directors such that the Board will continue to comprise members' representative of the diversity of the community we serve.

The purpose of this policy is to ensure that the Board is comprised of individuals who possess the skills, qualities, and experience to collectively contribute to effective Board governance and to assist the Board in identifying qualified individuals to become Board members.

PROCEDURE:

Composition of the Board

The composition of the Board will consist of ~~up to 15 directors, 11 elected, and have up to five *ex-officio* non-voting directors~~10 to 12 Directors, the Past Chair as an ex-officio voting Director and the ~~. The~~following four *ex-officio* non-voting directors~~: shall be the~~

i) President and CEO,
ii) Chief of Staff,
iii) ~~VP of Clinical Services &~~ Chief Nursing Executive, and ~~the~~
iv) President of the Medical Staff (if one exists).

In alignment with the hospital's commitment to equity, diversity, and inclusion, the Board shall strive to reflect the diverse perspectives, backgrounds, and experiences of the community it serves. This includes, but is not limited to, consideration of gender, race, ethnicity, age, professional expertise, and lived experience. A broad range of viewpoints enhances decision-making, fosters innovation, and strengthens governance effectiveness.

Term of Office

An elected director is elected to the Board in accordance with the terms described in the HGMH Corporate By-Laws.

Ex-officio directors are members of the Board by virtue of their position within the organization and will serve on the Board according to the applicable terms of the particular office.

In order to adhere to the requirements of the *Public Hospitals Act*, in which four directors must retire (subject to re-election) each year, appointments to the Board will be staggered and any mid-term vacancy will be filled by the Board until the next annual general meeting.

Process for Nominations

a) Nominations Committee

The Board shall establish a Nominations Committee which shall be charged with the responsibility of identifying and recommending individuals to become Board members.

The size and composition of the Nominations Committee shall be determined by the Board from time to time and may include non-board members. The Board shall appoint the Chair of the Nominations Committee, who shall be a member of the Board.

The Nominations Committee will follow the Guidelines for Director Selection (see Appendix A).

b) Nomination Process

The *Public Hospitals Act* requires that four Board members retire each year. This means that four positions on the Board must be up for election or re-election each year. If a director has not yet completed his/her maximum number of terms, he or she may stand for re-election.

The Board shall identify qualified candidates through the following process:

- The number of vacancies will be determined each year and the necessary criteria to fill those vacancies will be identified by conducting a skill-set analysis. Directors will be evaluated based on their performance and renewal will not be automatic;
- A call for nominations will be made and interested parties will be encouraged to submit applications
- Vacancies will be advertised in the local newspapers, as well as on the hospital website;
- Applications will be submitted to the Chair of the Nominations Committee and reviewed by the Nominations Committee;
- A short-list of candidates will be developed by the Nominations Committee of those individuals who meet all of the criteria identified by the Board;
- Reference checks will be initiated before the annual general meeting at the call of the Chair of the Nominations Committee.

c) Election Process

The voting members of the corporation have the ultimate responsibility of approving the recommendation of the Nominations Committee; however only

nominees approved by the Nominations Committee through the nomination process set out in this policy shall be eligible for election.

Election of Board members is completed each year as part of the annual general meeting.

The Nominations Committee shall identify candidates to be brought forward to the voting membership for consideration.

Candidates recommended by the Nominations Committee will be presented to the voting members for election and approval.

The Nominations Committee may recommend more candidates than vacancies.

In the event that the number of candidates equals the number of vacancies, the voting members may be asked to vote for or against the slate and, if such a vote does not carry, the vote shall take place for or against each nominee individually.

In the event that one or more recommended candidates are not elected, the Board shall determine an appropriate process to bring new candidates forward for election.

In the event of a tie, the deciding vote will be cast by the Chair of the Board.

ASSOCIATED FORMS:

Form Number	Form Name
51-A-175-XX	Board Skills Matrix

REFERENCES:

1. Public Hospitals Act
2. Guide to Good Governance

Appendix A: Guidelines for Director Selection

Through the nomination and election process, the board selects directors according to their skills, experience, and personal qualities.

The board should seek a balance within the board concerning the skills and experience of directors, while considering any unique or special requirements of the corporation at the current time.

The board should ensure all directors possess the personal qualities necessary to perform their role as board members. The board should have the capacity to understand the diversity of the community served, including demographic, linguistic, cultural, economic, geographic, gender, ethnic and social characteristics of the communities served by the organization.

The skills, experience, knowledge, and personal qualities that the board will use to select potential directors are set out below.

Skills, Experience and Knowledge
The board is to reflect a complementary mixture of skills, experience and knowledge. The skills, experience and knowledge the board will consider in selecting members include the following:

- Accounting designation/financial expertise;
- Board and governance expertise;
- Business management;
- Clinical experience;
- Construction and project management;
- Education;
- Ethics;
- Government and government relations;
- Health care administration and policy and health system needs, issues and trends;
- Human resources management and labour relations;
- Information technology;
- Knowledge and experience in research;
- Legal expertise;
- Patient and health care advocacy;
- Performance management;
- Political acumen;

- Public affairs and communications;
- Quality and patient safety;
- Risk management;
- Diversity, Equity, & Inclusion
- Strategic planning; and
- Understanding of community/catchment area.

Personal Qualities

The board requires all of its board members to:

- Commit to adhere to the mission, vision and core values of the organization;
- Act with honesty and integrity;
- Understand a director's role and fiduciary duties, and the role of the board;
- Think strategically;
- Work as part of a team;
- Communicate effectively;
- Have, or commit to acquire, financial literacy appropriate for the organization's scope of activities;
- Be willing to devote the time and effort required to be an effective board member, including attendance at board orientation, board retreats, board meetings, committee meetings, and organization events;
- Be free of conflicts that would impede a director's ability to fulfill his or her fiduciary duties; and
- Demonstrate ability to recognize and manage specific conflicts of interest that arise from time to time.

Document Name:	Responsibilities as a Director and Code of Conduct	
Document Number:	BOD.01.017.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Board Orientation
Classification: Board of Directors	**Section:** Governance	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The hospital is committed to ensuring that it achieves standards of excellence in the quality of its governance and has adopted this policy describing the duties and expectations of directors.

A director who wishes to serve on the board must confirm in writing that ~~he or she~~they will abide by this policy by signing the Annual Declaration and Consent Form (51-A-215-XX) and must accept to have a criminal reference check.

This Code of Conduct applies to all directors, including *ex-officio* directors and non board members of board committees. Directors are also required to comply with the hospital's policy on Ethics and Standards of Business Conduct, which applies to employees and professional staff.

PROCEDURE:

The Hospital is committed to ensuring that, in all aspects of its affairs, it maintains the highest standards of public trust and integrity.

Directors' Duties

All directors of the hospital stand in a fiduciary relationship to the hospital corporation. As fiduciaries, directors must act honestly, in good faith, and in the best interests of the hospital corporation.

Directors will be held to strict standards of honesty, integrity, and loyalty. A director shall not put personal interests ahead of the best interests of the corporation.

Directors must avoid situations where their personal interests will conflict with their duties to the corporation. Directors must also avoid situations where their duties to the corporation may conflict with duties owed elsewhere as per the Conflict of Interest Policy (BOD.01.013.X.XX).

In addition, all directors must respect the confidentiality of information about the corporation.

Exercise of Authority

A Director carries out the powers of office only when acting as a member during a duty constituted meeting of the Board or one of its committees. A director respects the responsibilities delegated by the Board to the Chief Executive Officer (CEO) and Chief of Staff (COS), avoiding interference with their duties but insisting upon accountability to the Board and reporting mechanisms for assessing organizational performance.

Time and Commitment

A director is expected to commit the time required to perform board and committee duties including preparation for an attendance at Board meetings, assigned committee meetings and events.

The board meets approximately nine times a year and a director is expected to adhere to the ~~b~~Board's ~~a~~Attendance policy (BOD.01.014.X.XX) that requires attending at least 75 percent of board meetings.

A director is expected to serve on at least one standing committee.

Participation

A Director expects to receive relevant information in advance of the meetings and reviews pre-circulated material and comes prepared to Board and committee meetings and educational events, asks informed questions, and makes constructive contribution to discussions.

Education

A director shall be knowledgeable about:

- The operations of the hospital;
- The health care needs of the community served;
- The health care environment generally;
- The duties and expectations of a director;
- The board's governance role;
- Board's governance structure and processes;
- Board adopted governance policies; and,
- Hospital policies applicable to board members.

A director will participate in a board orientation session, orientation to committees, board retreats and board education sessions. A director should attend additional appropriate educational conferences in accordance with board approved policies.

Best Interests of the Corporation

Directors must act solely in the best interests of the corporation. All directors, including *ex-officio* directors, are held to the same duties and standard of care. Directors who are

appointed by a particular group must act in the best interests of the corporation, even if this conflicts with the interests of the nominating party.

Teamwork
A Director maintains effective relationships with Directors, management, and stakeholders by working positively, cooperatively, and respectfully with others in the performance of their duties while exercising independence in decision making.

Confidentiality
Directors and committee members owe a duty to the corporation to respect the confidentiality of information about the corporation whether that information is received in a meeting of the Board or of a committee or is otherwise provided to or obtained by the director or committee member as per the Confidentiality for Board and Committee Members Policy (BOD.01.015.X.XX). Directors and committee members shall not disclose or use for their own purpose confidential information concerning the business and affairs of the corporation unless otherwise authorized by the Board.

It is recognized that the role of director may include representing the hospital in the community. However, such representations must be respectful of and consistent with the director's duty of confidentiality. In addition, the chair is the only official spokesperson for the board. Every director, officer and employee of the corporation shall respect the confidentiality of information about the hospital whether that information is received in a meeting of the board or of a committee or is otherwise provided to or obtained by the director.

A director is in breach of his or her duties with respect to confidentiality when information is used or disclosed for other than the purposes of the hospital corporation.

Board Spokesperson
The board has adopted a policy with respect to designating a spokesperson on behalf of the board. Only the chair or designate may speak on behalf of the board. The CEO, or the Chief of Staff or their designates may speak on behalf of the organization as per the Communications and Hospital Spokesperson Policy (BOD.01.001.X.XX).

No director shall speak or make representations on behalf of the board unless authorized by the chair or the board. When so authorized, the board member's representations must be consistent with accepted positions and policies of the board.

Media Contact and Public Discussion
News media contact and responses and public discussion of the hospital corporation's affairs should only be made through the board's authorized spokespersons. Any director

who is questioned by news reporters or other media representatives should refer such individuals to the appropriate representatives of the corporation.

Respectful Conduct
It is recognized that directors bring to the board diverse background, skills and experience. Directors will not always agree with one another on all issues. All debates shall take place in an atmosphere of mutual respect and courtesy.

The authority of the chair must be respected by all directors.

Community Representation and Support
A director shall represent the board and the hospital in the community when asked to do so by the board chair.

Board members shall support the hospital and the foundation through attendance at hospital and foundation sponsored events.

Corporate Obedience – Board Solidarity
Directors acknowledge that properly authorized board actions must be supported by all directors. The board speaks with one voice. Those directors who have abstained or voted against a motion must adhere to and support the decision of a majority of the directors.

Obtaining Advice of Counsel
Request to obtain outside opinions or advice regarding matters before the board may be made through the chair.

Evaluation and Continuous Improvement
A Director is committed to a process of continuous self-improvement as a Director. All Directors participate in the evaluation of the Board, and elected Directors participate in individual Director peer assessment and act upon results in a positive and constructive manner.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
BOD.01.013.X.XX	Conflict of Interest
BOD.01.014.X.XX	Board Attendance
BOD.01.015.X.XX	Confidentiality for Board and Committee Members
BOD.01.001.X.XX	Communications & Hospital Spokesperson

ASSOCIATED FORMS:

Form Number	Form Name
51-A-172-24	Board Member Pledge of Confidentiality
51-A-215-XX	Annual Declaration and Consent Form

REFERENCES:

1. Guide to Good Governance
~~1.~~2. Trillium Health Partners – Board Effectiveness Governance Policy Framework, Responsibilities as an Elected and Ex-Officio Director Policy.

Document Name:	Roles and Responsibilities of the Board Chair, Vice Chair and Treasurer	
Document Number:	BOD.01.XXX.X.XX	
Review Period:	☒3 years ☐1 year	**Manual:** Board Orientation
Classification: Board of Directors	**Section:** Governance	
Owner: Chief Executive Officer	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

This policy defines the roles and responsibilities of the Board Chair, Vice Chair, and Treasurer to ensure effective governance and leadership of the hospital's Board of Directors.

The Board of Directors is responsible for the strategic oversight and governance of the hospital. The Board Chair, Vice Chair, and Treasurer play key leadership roles in fulfilling the Board's mandate.

PROCEDURE:

1. Role of the Chair

The Board Chair is the leader of the board and is responsible for:

- Ensuring the integrity and effectiveness of the board's governance role and processes;
- Presiding at meetings of the board and members;
- Representing the board within the organization and the organization to its stakeholders; and
- Maintaining effective relationships with board members, management and stakeholders.

2. Responsibilities of the Chair

Board Governance

The Board Chair ensures the Board meets its obligations and fulfills its governance responsibilities. The Board Chair oversees the quality of the Board's governance processes including:

- Ensuring that the board performs a governance role that respects and understands the role of management;
- Ensuring that the board adopts an annual work plan that is consistent with the organization's strategic directions, mission and vision;
- Ensuring that the work of the board committees is aligned with the board's role and annual work plan and that the board respects and understands the role of board committees and does not redo committee work at the board level;

- Ensuring board succession by ensuring that there are processes in place to recruit, select and train directors with the skills, experience, background and personal qualities required for effective board governance;
- Ensuring that the board and individual directors have access to appropriate education;
- Overseeing the board's evaluation processes and providing constructive feedback to individual committee chairs and board members as required; and
- Ensuring that the board's governance structures and processes are reviewed, evaluated, and revised from time to time.

Presiding Officer

The Cchair is the presiding officer at board and members' meetings. As the presiding officer at board and members' meetings, the Cchair is responsible for:

- Setting agendas for board meetings and ensuring matters dealt with at board meetings appropriately reflect the board's role and annual work plan;
- Ensuring that meetings are conducted according to applicable legislation, by-laws and the board's governance policies and rules of order;
- Facilitating and forwarding the business of the board, including preserving order at board meetings;
- Encouraging input and ensuring that the board hears all sides of a debate or discussion;
- Encouraging all directors to participate and controlling dominant members;
- Facilitating the board in reaching consensus;
- Ensuring relevant information is made available to the board in a timely manner and that external advisors are available to assist the board as required; and
- Ruling on procedural matters during meetings.

Representation

- The Cchair is the official spokesperson for the board;
- The Cchair represents the organization in the community and to its various stakeholders;
- The Cchair reports on behalf of the board to members at each annual meeting of members;
- The Cchair represents the board within the organization, attending and participating in events as required; and
- The Cchair represents the board in dealings with key stakeholders, as required.

Relationships

- The Bboard Cchair facilitates relationships with, and communication among board members and between board members and senior management;
- The Cchair establishes a relationship with individual directors, meeting with each director at least once a year to ensure that each director contributes his/her special skills and expertise effectively;

- The Cchair provides assistance and advice to committee chairs to ensure that they understand board expectations and have the resources that are required for performance of their terms of reference; and
- The Cchair maintains a constructive working relationship with the chief executive officer and chief of staff providing advice and counsel as required. In particular:
    - The Cchair works with the cChief eExecutive oOfficer and Cchief of sStaff to ensure he or she understands board expectations; and
    - The Cchair ensures that cChief eExecutive oOfficer and Cchief of Sstaff annual performance objectives are established, and that an annual evaluation of the Cchief eExecutive oOfficer and Cchief of Sstaff is performed.

Other Duties

The cChair performs such other duties as the board determines from time to time.

Skills and Qualifications

The bBoard cChair will possess the following qualities, skills, and experience:

- Proven leadership skills;
- Good strategic and facilitation skills, ability to influence and achieve consensus;
- Ability to act impartially and without bias and display tact and diplomacy;
- Effective communicator;
- Political acuity;
- Must have the time to continue the legacy of building strong relationships between the organization and stakeholders;
- Ability to establish trusted advisor relationships with chief executive officer and chief of staff and other board members;
- Governance and board-level experience in the health sector;
- Understanding and appreciation of quality improvement and patient safety; and
- Outstanding record of achievement in one or several areas of skills and experience used to select board members.

Term

The Board Chair will serve an initial term of two years, renewable for an additional term of one year at the discretion of the board.

3. Roles and Responsibilities of the Vice-Chair

The responsibilities of the Vice Chair include:

- **Assisting the Chair in executing their duties as required**
- **Assuming the role of Board Chair in their absence or incapacity**
- **Serving on the Executive Committee of the Board**
- **Supporting governance and strategic planning initiatives**
- **Participating in Board member development and succession planning**

4. Roles and Responsibilities of the Treasurer

The responsibilities of the Treasurer include:

- **The Treasurer provides oversight of the hospital's financial matters and ensures financial accountability with Executive Support**
- **Chairing the Finance, HR and Audit Committee**
- **Providing summary reports on financial matters to the Board of Directors**
- **Overseeing the annual audit of the hospital ensuring compliance with accepted accounting principles**
- **Presenting annual budget to the Board for approval**
- **Serving on the Executive Committee of the Board**
- **Overseeing matters related to Human Resources and labour relations of the hospital**

REFERENCES:

1. Guide to good Governance

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: March 4, 2025 Meeting Date Prepared for: March 12, 2025

Subject: Policy Reviews

Prepared by: Robert Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

The purpose of this briefing note is to provide an overview of the three policies up for review and highlight any material changes to each policy.

RECOMMENDATION / MOTION

That the Governance and Nominating Committee recommend to the Board of Directors to formally adopt the Accountability for Reasonableness Ethical Decision-Making Framework for organizational ethical decision making.

That the Governance and Nominating Committee recommend to the Board of Directors the approval of the following policies as amended: Framework for Ethical Decision-Making, and Board Mentorship Program.

That the Governance and Nominating Committee recommend to the Board of Directors the retirement of the Donor Recognition policy.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

Summary of amendments:

Framework for Ethical Decision Making

- A review of the Framework for Ethical Decision Making Policy was conducted, and it required a number of changes to reflect the requirements of Accreditation Canada and the Framework that is used by HGMH.
- The policy now outlines the ethical decision making frameworks steps, and graphic that the hospital uses to support the communication of our ethical decision making framework.
- This solidifies the hospitals commitment to ethical decision making, and codifies our specific ethical decision making framework used by HGMH.

Board Mentorship

- To ensure that both the mentor and the mentee understand what is required of them in Board of Director mentorship, each have been provided additional information with respect to their role in the time limited relationship.
- In addition, when selecting a mentor for new board members there has been criteria added to select appropriate mentors for new Board members.

Donor Recognition

- This policy should be retired as the HGMH foundation has developed a comprehensive donor recognition policy (to be finalized) and HGMH should be directing all donations toward the HGMH Foundation.

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

- Obtain Board Approval – March 27, 2025
- Update Board Policy Online
- Include updates in Board Orientation Material

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- *Framework for Ethical Decision Making*
- *Board Mentorship Program*
- *Donor Recognition*

POLICY NUMBER: GO.01.021.2.22

POLICY TYPE: GOVERNANCE

SUBJECT: FRAMEWORK FOR ETHICAL DECISION-MAKING

POLICY: Hôpital Glengarry Memorial hospital is committed to conducting all of the hospital's administrative and governance affairs, activities, patient care, and treatments with the highest level of ethical conduct, simultaneously supporting a culture of trust, integrity, and openness.

~~To further this commitment, the Board will use the "Ethical Lens Guidelines" (Appendix A) document when developing policies and procedures.~~The purpose of this policy is to outline the Accountability for Reasonableness (A4R) ethical decision making framework that is used to inform decision making within the Corporation to support organizational ethical decision making.

In addition to abiding by a number of other existing policies which pertain to the promotion of Board ethical conduct: Governance and Accountability, Code of Conduct, Confidentiality, Conflict of Interest, and others pertaining to compliance with Federal and Provincial Law, to name a few.

PREAMBLE:
The purpose of this policy is to promote a culture of trust, integrity, and openness. HGMH's reputation for integrity and honesty is important; hence, our commitment to the realization of our vision, mission, through honesty, fairness, and respect of the individual and the community we serve is paramount. To achieve this goal, at all times we must be asking ourselves "Am I doing the right thing, or making the decision for the right reason?"

The framework incorporates the organization's mission, vision, and values as well as additional values/principles that are agreed upon by relevant stakeholders.

Definition:
What is ethics?
Ethics is about making "right" or "good" choices and the reasons that we give for our choices and actions. Ethics promotes reflective practice in the delivery of health care. Ethics can be described as a way of critically looking at issues in health care that encompasses:

References: Definition of Ethics adapted from Dr. Barbara Secker, Joint Centre for Bioethics, University of Toronto; Winnipeg Regional Health Authority, "Ethical Decision-Making Framework", 2015; Hotel-Dieu Grace Healthcare, Centre for Clinical Ethics, "A Principle Based Framework for Ethical Decision Making", 2004.
Approved by: Board of Directors Effective Date: Nov 2015

Revised: Oct 2019 Reviewed: April 2022

- Deciding what we should do - what decisions are morally right or acceptable based on the values and principles we agree are relevant.
- Explaining why we should do it; justify our decision using language of values and principles to explain why
- Describing how we should do it - outlining an appropriate process of enacting the decision.

PROCEDURE:

1. ~~To follow a framework which is deemed appropriate by those involved for each situation.~~The A4R Framework provides a step-by-step, fair process to help guide healthcare providers and administrators in working through ethical issues encountered in the delivery of healthcare.

2. The ~~chosen framework must minimally involve~~A4R Framework incorporates the following steps:

- ~~Identification of the problem;~~
- ~~A fact-finding component~~
- ~~Consideration of alternatives;~~
- ~~Examination of values;~~
- ~~Evaluation of alternatives / solutions;~~
- ~~Decision;~~
- ~~Implementation plan / evaluation.~~
- **Determine** your mandate and the question you are trying to answer as this will establish the type and scope of the answer you get. The goal is to ensure that the group is working on the same problem and asking the right question to solve it.
- **Identify** your stakeholders (those who will be impacted by the decision) and **include** them in decision-making. Stakeholders may be involved as decision-makers or as consultants in decision-making. The aim is to ensure that decision-making includes a broad range of ideas and stakeholder perspectives. Consider who else needs to be consulted for their perspective after a draft decision is reached.
- **Clarify** your decision-making procedure upfront (e.g., identify organizational values and strategic priorities, develop criteria from those values, prioritize the criteria, generate options, judge quality of your different options against those criteria, and select option).Decision-makers and stakeholders alike need to know and understand a) how decisions will be made and b) how and on what basis they can revisit decisions.
- **Provide** a statement of rationale for each decision. It is not enough that a decision is made. Ethical decision-making requires that reasons be given to justify each decision utilizing value-based criteria.
- **Communicate** the decision and its rationale to stakeholders. The key is access to information and this means *effective communication*. Knowing who your stakeholders are will help to identify who best to communicate with them and

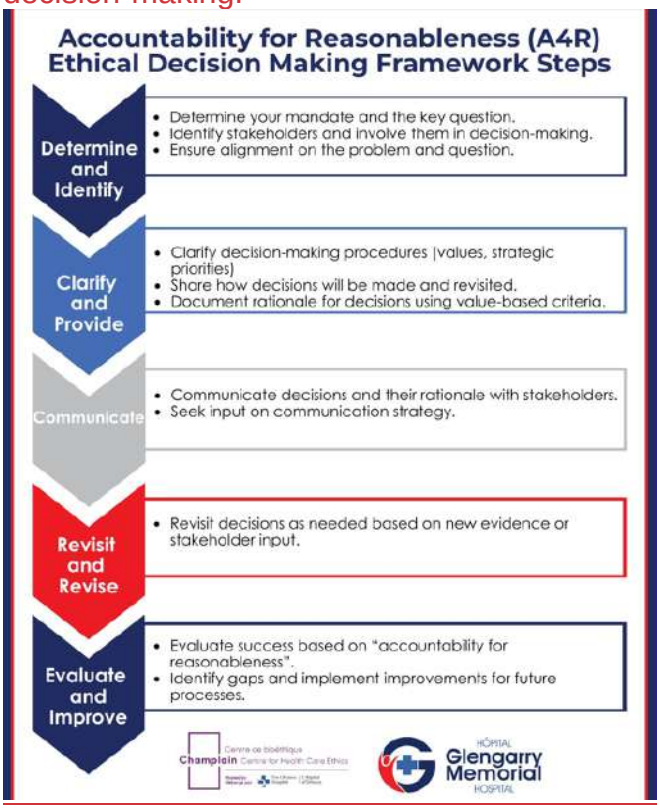
how (e.g., websites, email, forums, newsletters). Better yet, ask their input on how to develop an effective communication strategy.

- **Revisit and revise** decisions on the basis of new evidence or argument brought forward either through a formal appeals mechanism or through consultation with stakeholders.
- **Evaluate** how successfully the decision-making process met the conditions of 'accountability for reasonableness'. There may be gaps between *what you do* and *what you should be doing*. To close this gap, you need to be able to evaluate your success.
- **Improve** the decision-making process to make it more ethical. The gaps you identify are areas of improvement for subsequent iterations of decision-making. Learning from experience demonstrates that you take seriously our corporate commitment to being publicly accountable and to seeking excellence in how we do business as a health care institution.

3. To further facilitate the process, the Regional Ethicist Program may be approached for input / leadership in the process.

4. In addition to Appendix A, HGMH uses the following graphic to depict the A4R ethical decision making framework process.

~~The frameworks mentioned in the references section of this policy may also be used to for support in ethical decision-making.~~



~~APPENDIX A~~

~~ETHICAL LENS GUIDELINES~~

~~**What is a "Lens":** It is a template or method to guide policy authors in ensuring that the HGMH ethical principles and values are reflected in the policy or procedure being developed.~~

~~**Directions for Use:**~~

1. ~~During the process of policy development, or upon completion of the first draft of the policy, ask the 10 questions in the Lens.~~

2. ~~Check "YES" or "NO" on the template and complete the COMMENTS section.~~

3. ~~In the COMMENTS section:~~

   a) ~~If "YES", indicate "how" the values and principles are maintained.~~
   b) ~~If "NO", indicate "why" the values and principles are not maintained.~~

4. ~~If the question doesn't apply, indicate N/A.~~

~~The completed "LENS" should accompany the policy during the approval process. The Governance Committee is available for consultation at the discretion of the policy author.~~

~~ETHICS LENS FOR POLICY DEVELOPMENT~~

~~Questions~~	~~Yes~~	~~No~~	~~N/A~~	~~Comments (if yes, how; if no, why not)~~
~~1. Does the policy reflect honesty, respect, and truthfulness in its content and intent?~~				
~~2. Does the policy promote free and informed choices on the part of our clients?~~				
~~3. Does the policy reflect unique or specific cultural considerations?~~				
~~4. Does the policy protect the right and need for confidentiality?~~				
~~5. Does the policy consider the unique needs of individuals, agencies, and communities in its content and/or intent?~~				
~~6. Does the policy reflect innovation, cost-effectiveness, and evidence-based best practices citing relevant references?~~				
~~7. Does the policy address the needs and contributions of all stakeholders?~~				
~~8. Does the policy address the legal requirements associated with the content and / or its intent?~~				
~~9. Does the policy clearly outline proper accountability and prudent expenditure of public funds?~~				
~~10. Is the policy consistent with, and supportive of, professional codes of ethics?~~				

POLICY NUMBER: GO.01.020.1.22

POLICY TYPE: **GOVERNANCE (Administration)**

SUBJECT: **BOARD MENTORSHIP PROGRAM**

POLICY: The Board will provide governance development services for newly elected Board members through mentorship by existing Board members.

PROCEDURE:

1. A mentor for each new Board member will be named by the Governance Committee to become a resource for these new Board members for their first year, through peer-to-peer learning and to encourage the sharing of knowledge, experience, and productive involvement in Board matters.

~~2. Duties of the Mentor are:~~
~~a) To be reasonably available to be consulted by the new member, as required;~~
~~b) To be available to discuss items on the agenda with the new member before the Board and Committee meetings;~~
~~c) To sit with the new member at Board and Committee meetings; and~~
~~d) To advise the new member regarding continuing education.~~

2. Mentor assignments will be communicated to the new member at the time of their Committee assignments.

Role of the Mentor

A mentor is a trusted and experienced advisor who has direct interest in the development and education of a mentee. The mentor is guided by the following:

- Meet face-to-face, or, virtually with your mentee within the first month of assignment
- Discuss your goals and objectives as a mentor with your mentee within the first month of the relationship
- Be accessible to your mentee (in person, phone and email)
- Support and encourage the mentee's development
- Acts as a role model, assisting in learning, accessing resources
- Provides opportunities for discussion
- Provides solid guidance and leadership to Director
- Shares learning from own experiences with Director
- Contact the Governance Committee Chair with any questions or concerns, or if you are unable to continue your commitment to your mentee for any reason

- Plans the mentoring experience in conjunction with the Director based on their needs and goals
- Maintains confidentiality
- Communicates regularly with the Director regarding specific needs
- Meets with the Director and the Board Chair when appropriate throughout the mentorship relationship

Role of the Mentee

A mentee is defined as someone who has a mentor, with the objective of developing their knowledge base to be an effective hospital board member. A mentee agrees to the following:

- Meet face-to-face, or, virtually with your mentor within the first month of assignment
- Define your mentorship goals. Share these with your mentor within the first month.
- Be accessible to your mentor (in person, phone and email)
- Be prepared for meetings with your mentor, to discuss questions that you may have
- Remain open to advice
- Owns the mentoring process and responsibility for its success
- Contact the Governance Committee Chair with any questions or concerns, or if you are unable to continue your commitment to your mentor for any reason
- Plans the mentoring experience in conjunction with the mentor based on their needs and goals
- Maintains confidentiality
- Communicates regularly with the mentor regarding specific needs
- Meets with the mentor and the Board Chair when appropriate throughout the mentorship relationship

Selection of a Mentor

The following skills and experiences will be considered when selecting experienced board members to become mentors:

- Minimum 1 year on the Board
- Good knowledge of the strategic priorities of HGMH
- Good knowledge and understanding of Governance
- Experience in leadership role on the board or board committees
- Ability to satisfy the necessary time commitment
- Understanding the challenges faced by new Directors
- Active participation in the Board activities
- Effective communication skills
- Critical thinking and problem solving skills
- Willingness and ability to share knowledge and skills
- Demonstrated commitment to the mission, vision and values of HGMH

REPORT OF THE MEETING OF THE FINANCE, HR, AND AUDIT COMMITTEE

March 12, 2025 at 6:00PM Boardroom/MS Teams

Present:	C. Nagy, Chair	L. Boyling	Dr. S. Robertson
	F. Desjardins	Dr. G. Raby	R. Alldred-Hughes, CEO
	K. MacGillivray, CHRO	S. Bussiere	

Regrets: L. Ramsay

Summary of Discussion

1.0 Approval of Agenda

Agenda: The agenda was reviewed.

Moved By: F. Desjardins
Seconded By: Dr. S. Robertson
THAT the agenda be approved as presented.

CARRIED

Declaration of Conflict of Interest: there were no conflicts declared.

2.0 Minutes

Report from the Previous Meeting: The report of the meeting of February 12, 2025, was shared.

Moved By: Dr. S. Robertson
Seconded By: F. Desjardins
THAT the report of the meeting of February 12, 2025, be approved as presented.

CARRIED

Business Arising:
There was no business arising from the minutes.

3.0 Matters for Discussion/Decisions

3.1 Audit Plan Presentation
A meeting will be scheduled on April 9th, 2025 to review the audit plan with the auditor.

3.2 Financial Statements – January 2025
The financial statement ending January 2025 were discussed.

Moved By: Dr. S. Robertson
Seconded By: F. Desjardins
That the Finance, HR, and Audit Committee recommend to the Board of Directors the January 2025 financial statements as presented.

The Hospital received $ 469,833 of global funding in January, which was 10 months of the remaining total of the Bill 124 current year funding which was announced in late December. Out of province revenues were significantly lower which explains the decrease in out of province revenues. Employer portion of CPP and EI is higher as it's the beginning of the new year.

Moved By: Dr. S. Robertson
Seconded By: F. Desjardins
That the Finance, HR, and Audit Committee recommend to the Board of Directors to transfer up to $ 125,000 of parking income into capital reserves should the Hospital finish in a surplus of more than $ 150,000.

With multiple costly projects upcoming, it was agreed to transfer up to $ 125,000 to capital reserves from parking revenues for future use.

CARRIED

3.3 HSAA Extending Agreement
Ontario Health is looking to extend the Hospital Service Accountability Agreement (HSAA) which means that a recovery strategy is not needed at this time.

Moved By: Dr. S. Robertson
Seconded By: F. Desjardins
THAT the Finance, HR, and Audit Committee recommend to the Board of Directors the signing of the HSAA Extending Agreement as presented.

Once funding is known, the HSAA will be updated by Ontario Health.

CARRIED

3.4 Capital Plan 2025-2026
The proposed Capital Plan for 2025-2026 was shared.

Moved By: Dr. G. Raby
Seconded By: L. Boyling
THAT the Finance, HR and Audit Committee recommend to the Board of Directors the Capital Plan for 2025-2026 as presented.

A first draft of the capital plan was shared with Senior Leadership in February and had an unfunded amount of $800,000. Using the framework for ethical decision-making VPs worked with their managers to identify purchases that could be deferred as were not critical to the quality and safety of patients at this time. The capital plan now has an unfunded amount of $107,621.

Moved By: Dr. G. Raby
Seconded By: L. Boyling
That the Finance, HR, and Audit Committee recommend to the Board of Directors the use of the Endowment fund to purchase up to $ 107,621 of capital expenses.

It was agreed that the endowment fund be used to cover the unfunded portion of the capital plan. Monitoring of capital expenses throughout the year will be done to ensure that endowment funds usage is at a minimum.

CARRIED

4.0 Matters for Information

4.1 Declaration of Compliance – January 2025
The declaration of compliance for January 2025 was included in the package.

5.0 Matters for Information – People/Partnerships

5.1 Employee Engagement Survey Results

Because this survey was done through Accreditation, we had to wait to get the results. The results have now been received, and action plans are being worked on to then be presented to the committee.

5.2 Board Award of Excellence Call for Nominations

The communication plan was shared for the Board Award of Excellence Call for Nominations.

6.0 Date of Next Meeting

Next meeting: May 14th, 2025

K-L. Massia, Recorder

Correspondence

February 26, 2025 – Standard Freeholder – Vote SDSG: Is the well of support for rural Ontario hospitals dry?

March 4, 2025 – The Review – Outpatient lab hours changing at Glengarry hospital

March 4, 2025 – Seaway News – HGMH reduces lab hours

March 19, 2025 – Seaway News – Hospital uses money, “perfect place” pitch to recruit more physicians