2025-2026 Board Member Orientation
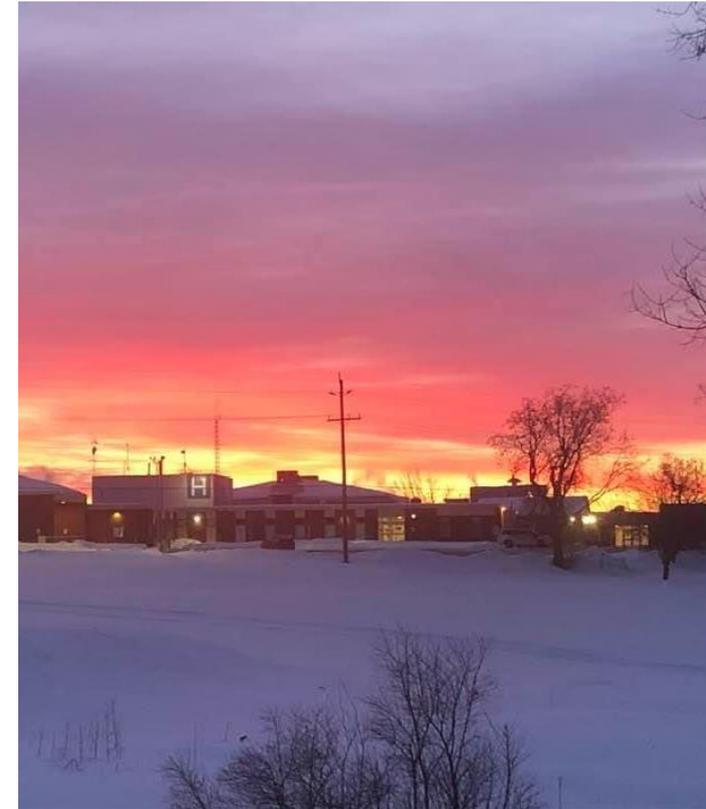
Welcome

This orientation was prepared to help new directors feel as comfortable as possible with HGMH Board roles, policies, processes, procedures, services and programs early in their mandate.

Introductions

Hôpital Glengarry Memorial Hospital Overview

Established in 1965, the hospital has grown to provide vital services to the community, including acute care, emergency services, stroke and geriatric rehabilitation, specialist clinics, and more.

Hôpital Glengarry Memorial Hospital Overview

Services

Emergency Department (between 15,000 and 24,000 annual visits)
• 24/7 service

Inpatient Care (37 beds)
• Acute Medicine………………………………………..……22 beds
• Rehabilitation (Stroke & Geriatric)……………15 beds

This represents a comprehensive list of the clinical services offered by HGMH as a Small Rural Hospital.

Outpatient Clinics (15,600 annual visits)
• Outpatient Stroke Rehabilitation
• Cardiac Rehabilitation
• Physiotherapy
• Ontario Telemedicine Clinic
• Pain Clinic
• Urology Clinic
• Endoscopy
• Gynecology Clinic
• Respirology Clinic
• Outpatient Diagnostic Imaging
   (general x-ray, BMD & ultrasound)
• ECG, Phlebotomy and Holter Monitor
• Minor Surgery
• Hematology
• Pool Rehabilitation Program

HGMH
Board of Directors

Roles & Responsibilities of the Board Chair, Vice Chair and Treasurer

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.

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

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

Key policies for review:

- Roles and Responsibilities of the Board Chair, Vice-Chair, and Treasurer (BOD.05.008)

Roles and Responsibilities of the Board

The fundamental role of the Board is to govern the Corporation. **Boards govern, they do not manage.** The *Excellent Care For All Act* strengthens the responsibility of a Hospital Board regarding oversight for the *quality* of care delivered within hospitals. This is one of the primary roles of the Quality Committee.

Key policies for review:
- Roles and Responsibilities of the Board(BOD.05.009)

- Conflict of Interest (BOD.05.003)

- Confidentiality for Board and Committee Members (BOD.05.005)

Roles & Responsibilities of the Board

A broader list of the Board's roles and responsibilities include policy-making, decision-making, oversight, strategic planning, quality of care, financial oversight, Board effectiveness, Chief Executive Officer (CEO), Chief of Staff (COS), management performance and evaluation.

The Ontario Hospital Association (OHA) is an excellent resource for Board Governance, as well as the OHA's Guide to Good Governance.

Responsibilities as a Director and Code of Conduct

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.

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

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.

Key Policies for Review:
- Responsibilities as a Director and Code of Conduct (BOD.05.007)

Board Structure & Accountability
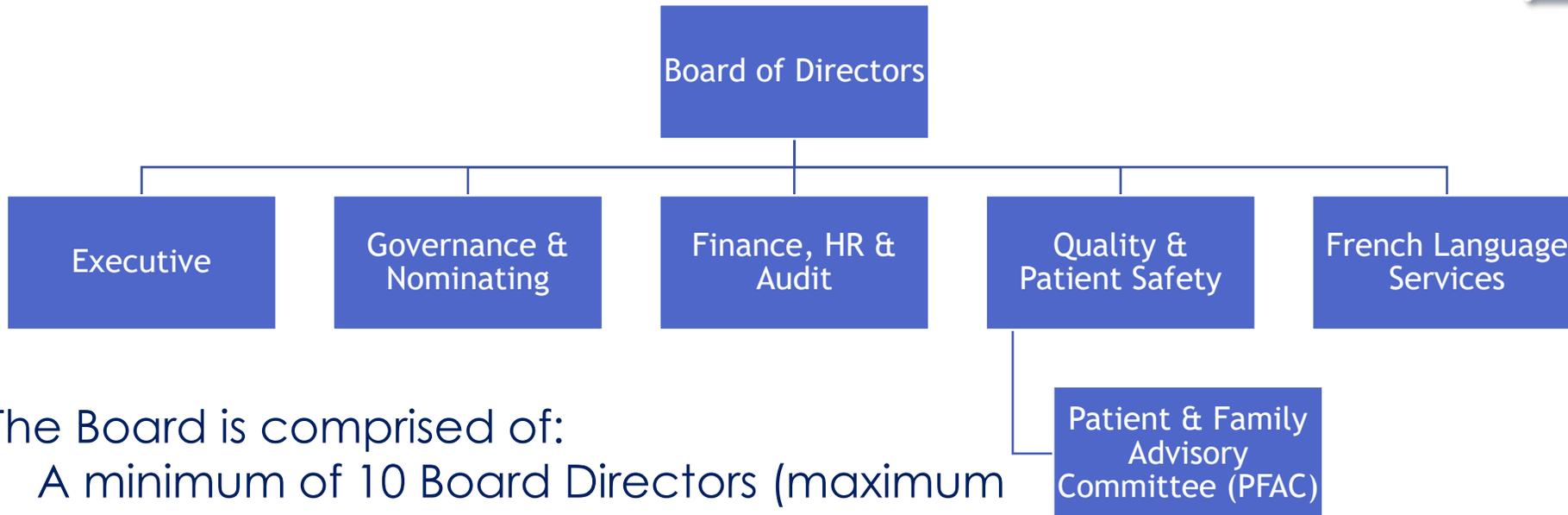
The Board is comprised of:
- A minimum of 10 Board Directors (maximum of 12)
- 3 ex-officio members
  - CEO
  - CNE
  - COS

Board Structure & Accountability

Hospital corporations are non-share capital corporations, incorporated by letters patent under the corporation's act (Ontario).

Other significant legislation is as follows:
- Public Hospitals Act
- Local Health System Integration Act
- Excellent Care for All Act
- Broader Public Sector Accountability Act
- Broader Public Sector Executive Compensation Act

Board Committee Terms of Reference:
- Governance & Nominating Committee
- Finance, HR & Audit Committee
- Quality & Patient Safety Committee
- French Language Services Committee
- Executive Committee

Board Meeting Structure

- Meeting dates and times are posted on the Board Portal and determined by the Board prior to the start of the new Board cycle
- The Chair, in consultation with the President & CEO, is responsible for developing an agenda for each Board meeting in line with the work plans
- Agendas are divided into sections including Matters for Discussion and Consent Agenda. The Board shall use the consent agenda for the passage of non-controversial and/or routine matters. Consent agenda items may include, without limitations:
  - -approval of previous minutes
  - -routine Committee and/or other informational reports
  - -correspondence requiring no action; and
  - -actions that do not require a Director to disclose a potential conflict or otherwise abstain from voting

Key Policies for Review
- Regular Meetings of the Board and Notice (BOD.05.013)

Board Mentorship

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.

Roles of the Mentor are:
- 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
- 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

Key policies for review:
- Board Mentorship (BOD.05.002)

Board Portal and Email

The Board Portal is a secure digital platform used by Board members to view materials such as board meeting packages, board policies, board meeting dates, committee membership and member contact information, and other board materials.

A username and password will be assigned to all new Board members and a tip sheet will be provided with how to access the portal.

Since communication to the Board is done through email, all Board members will be provided with an HGMH email address that is to be used for hospital communications.

Key Policies for Review:
- Hospital Email Usage for Board Directors (BOD.05.011)

Board Portal   Account   Log out   FR

HÔPITAL
Glengarry Memorial
HOSPITAL

Find what you're looking for:

Meeting Dates & Members

Meeting Packages

Board Policies

Contact List

Accreditation

Resources

Capital Redevelopment

By-Laws

Other Key Documents

Meetings for 2025-2026 & Member List

Board of Directors

Governance & Nominating Committee

Finance, HR, and Audit Committee

Quality & Patient Safety Committee

French Language Services

Executive Committee

Attendance Requirement

It is recognized that Board members may be unable to attend some meetings due to conflicts with other commitments or other unforeseen circumstances. An attendance rate of at least 75% is expected of all Board members and is tracked for board meetings as well as board committee meetings.

The Governance Committee reviews attendance twice per board cycle and reports attendance to the Board.

Where a director fails to attend 75% of meetings of the Board or of a committee during a board cycle, or is absent for three consecutive meetings, the Board Chair will discuss the reasons for the absences with the director and may ask them to resign.

Key Policies for Review
- Board Attendance (BOD.05.004)

Board Surveys

- The **Board Peer Assessment Survey** is an anonymous survey completed yearly to evaluate the effectiveness and performance of our esteemed board members.

- The **Board Committee Effectiveness Survey** is completed yearly and aims to ensure that Board committees are operating at their optimal level to fulfill their respective mandates and support strategic objectives of the hospital. This survey serves as a valuable tool to evaluate the strengths and weaknesses within each committee.

- A third survey is also sent out throughout the year from the Ontario Hospital Association (OHA) which allows us to identify areas in which we are performing well, and where we can improve in comparison to our peer hospital boards.

Key Documents for Review:
- Board Peer Assessment Survey
- Board Committee Evaluation Survey

Strategic Direction

Governance & Nominating Committee

Role:

- The role of the Governance & Nominating Committee is to advise the Board on matters relating to the Board's governance structure and processes, evaluation of the Board's effectiveness, recruitment, and education, and evaluation of Board members.

Overview of Responsibilities:

1. Oversee board recruitment

2. Oversee board education and board retreats

3. Ensure succession planning for the office of the board as well as the CEO and COS

4. Make recommendations to the board of nominees

5. Ensure periodic review and evaluation of board committee performance

6. Review and make recommendations to the Board on composition, size, structure, board policies and procedures, by-law amendments, board attendance and strategic planning

7. Ensure Diversity, Equity, and Inclusion is integrated in all aspects

Strategic Plan 2023-2028

- Strategic planning commenced in November 2022

Input was received from:

- Board of Directors
- Management Team
- Staff
- Physicians
- Volunteers
- Hospital Foundation
- Partner Hospitals
- Ontario Health Team Partners
- Patients & Families
- Township of North and South Glengarry
- Community
- Grand Chief of Akwesasne
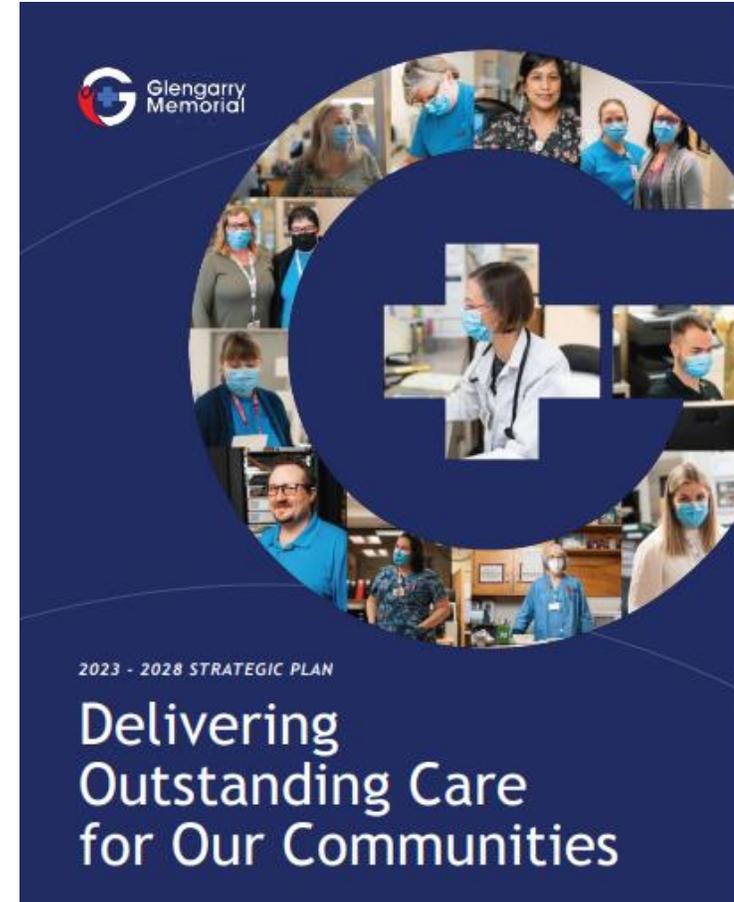
Mission, Vision & Values

Our mission

- Delivering outstanding care for our communities.

Our vision

- Providing you care, your way, with seamless integration, innovation, and equitable access for our communities.

Our values

- Our '**PACT**' is our promise to have **P**assion, **A**ccountability, **C**ompassion & **T**eamwork at the heart of all we do, everyday.

Strategic Priorities

Strategic Plan Monitoring

Reports on strategic initiatives are provided to Board Members quarterly using a simple and easy tool for Board Members to review progress on initiatives that advance our strategic direction.

Status is indicated as follows:

- Black once fully complete

- Green when on track with no barriers for completion

- Yellow when not on track with mitigation plans in place

- Red when not on track and the initiative is at risk

Strategic Action Report Q4

Strategic Dimension	Strategic Direction	Executive Lead	Action	Progress	Status
Quality & Safety	Enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.	K. MacGillivray	Implement at least two actions from the Inclusion, Diversity, Equity, and Anti-Racism framework that support equitable access and/or culturally safe care.	•	Complete
		R. Romany	Implement at least two Best Practice Guidelines (BPG) aligned with the Registered Nurses Association of Ontario, Best Practice Spotlight Organization.	•	Complete
		R. Romany	Develop a business case for Surgical Services at HGMH to support care close to home and wait time reduction in the region.	•	Complete
		R. Alldred-Hughes	The Patient & Family Advisory Committee (PFAC) will develop and implement two initiatives to continue advancing person and family centred care.	•	Complete
People & Culture	Improve engagement by investing in the organizations people and empower a caring and positive culture for all.	K. MacGillivray	Develop a creative recruitment brand that markets the hospital to prospective talent in a meaningful way.	•	Complete
		K. MacGillivray	Redesign and validate adjustments to the onboarding process for new hires, to ensure the new employee experience is seamless and positive.	•	Complete
		K. MacGillivray	Develop and implement a standardized retirement recognition program that celebrates staff members who are retiring from the hospital in a meaningful way.	•	Complete

	Fully complete		On track – no barriers for completion		Not on track – mitigation plans in place		Not on track – initiative at risk

IDEA Committee (Established 2024)

Purpose & Role

- Promotes a culture of inclusion, diversity, equity, and accessibility within the hospital.
- Advises and supports initiatives that foster respectful, culturally safe, and welcoming environments for all patients, families, staff, and community members.
- Aligns hospital policies, programs, and services with best practices in IDEA principles.

Key Initiatives

- Development of a Land Acknowledgement Policy.
- Hosting educational and cultural events to increase awareness and engagement.
- Supporting Truth and Reconciliation efforts, including recognition of Indigenous history and traditions.

Key Policies for Review
- Land Acknowledgment (COR.03.024)

Inclusion, Diversity, Equity & Anti-Racism

Board Meeting Practice
- At the start of every Board meeting, the Land Acknowledgement is read aloud by the Board Chair or their delegate.

Board of Directors – Role in IDEA
- Ensure HGMH has a comprehensive Inclusion, Diversity, Equity & Anti-Racism Framework that addresses systemic and structural racism, and supports education in racism and cultural safety.
- Oversee clear reporting and follow-up procedures for discrimination or harassment.
- Review periodic reports on IDEA activities through the Governance Committee.
- Champion an inclusive and culturally safe environment for diverse, racialized, and marginalized individuals.
- Reflect the diversity of the community in governance, leadership, and workforce.

Key Policies for Review
- Inclusion, Diversity, Equity and Anti-Racism (BOD.01.001)

Ethical Decision-Making Framework

Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

Values that Optimize Fairness in the Process of Decision-Making

Relevance | Publicity/Transparency | Revision/Appeals | Enforcement | Empowerment

A4R Action 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.

The Board adopted the Accountability for Reasonableness (A4R) Ethical Decision-Making Framework, used to inform decision making within the Corporation to support organizational ethical decision making.

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.

Key Policies for Review
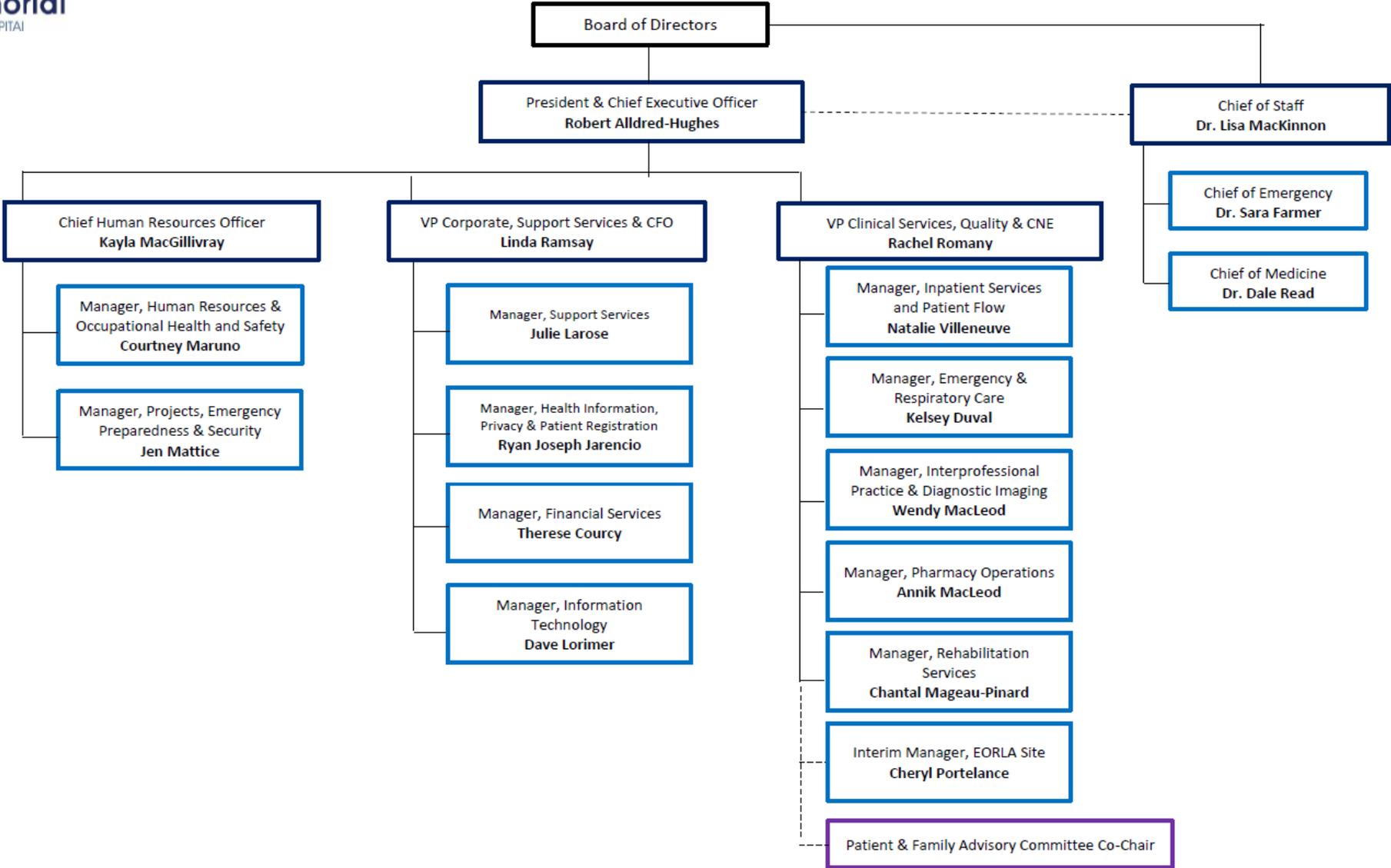- Framework for Ethical Decision-Making (BOD.03.003)

Leadership

Leadership Structure

ORGANIZATIONAL CHART

August 5, 2025

Board of Directors

President & Chief Executive Officer
Robert Alldred-Hughes

Chief of Staff
Dr. Lisa MacKinnon

Chief of Emergency
Dr. Sara Farmer

Chief of Medicine
Dr. Dale Read

Chief Human Resources Officer
Kayla MacGillivray

- Manager, Human Resources & Occupational Health and Safety
Courtney Maruno
- Manager, Projects, Emergency Preparedness & Security
Jen Mattice

VP Corporate, Support Services & CFO
Linda Ramsay

- Manager, Support Services
Julie Larose
- Manager, Health Information, Privacy & Patient Registration
Ryan Joseph Jarencio
- Manager, Financial Services
Therese Courcy
- Manager, Information Technology
Dave Lorimer

VP Clinical Services, Quality & CNE
Rachel Romany

- Manager, Inpatient Services and Patient Flow
Natalie Villeneuve
- Manager, Emergency & Respiratory Care
Kelsey Duval
- Manager, Interprofessional Practice & Diagnostic Imaging
Wendy MacLeod
- Manager, Pharmacy Operations
Annik MacLeod
- Manager, Rehabilitation Services
Chantal Mageau-Pinard
- Interim Manager, EORLA Site
Cheryl Portelance
- Patient & Family Advisory Committee Co-Chair

People Overview

Leadership Demographics

- *Average Age of the Leadership Team is 47*
- *Median Age of the Leadership Team is 47*
- *12.5% of the Leadership Team is eligible for retirement now, and 31.25% within the next 5 years.*

Leadership Years of Service

40% - 0-5 Years of Service

20% - 5-10 Years of Service

7% - 10-15 Years of Service

20% - 15-20 Years of Service

7% - 20-25 Years of Service

7% - 25-29 Years of Service

People Overview

- **189 Staff Members**
  - Average age of staff members is 42

- **55 Physicians** (Emergency Physicians, Inpatient Physicians, and Consultants)
  - Average age of physicians is 51

- **Over 100 volunteers**

- Two bargaining agents; ONA and CUPE

Succession Planning

To develop the leadership pipeline at HGMH, we have focused on a four-step process to identify "high potential" or "fully competent" individuals to assume key positions immediately or as the need arises.

The four-step process to succession planning at HGMH is as follows:
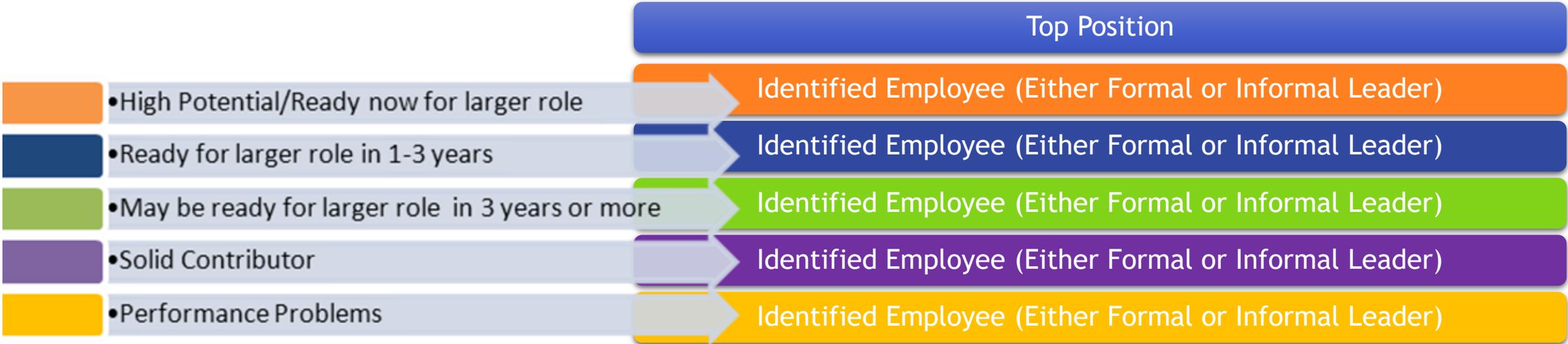
Key policy for review:
- CEO and COS Succession Planning (BOD.02.001)

| Identify Key Positions | Identify Competencies | Assess People | Develop Plan |

Succession Planning

All Senior Leadership and Middle Management Positions have been identified as key positions for the purposes of HGMH's Succession Plan.

Top Position
Identified Employee (Either Formal or Informal Leader)
Identified Employee (Either Formal or Informal Leader)
Identified Employee (Either Formal or Informal Leader)
Identified Employee (Either Formal or Informal Leader)
Identified Employee (Either Formal or Informal Leader)

- High Potential/Ready now for larger role
- Ready for larger role in 1-3 years
- May be ready for larger role in 3 years or more
- Solid Contributor
- Performance Problems

Succession Planning

Role	Current Incumbent	Emergency Cover	Ready Now	Ready in 12-18 Months	Ready in 3-5 Years
CEO	Sarah	Fred	Gap	Gap	Fred

Upon identification of the High Potential and Ready candidates, the senior manager will prepare a development plan using some of the following methods:

1. Guiding Education & Professional Development
2. Providing experience in required areas of development (special projects/assignments)
3. Formalizing a mentorship arrangement
4. Continuous coaching

Where there are gaps – plans to recruit externally will be identified if no internal candidates will meet the requirements of the positions.

Talent Management

The HGMH Talent Management Program has 7 phases:

1. Workforce planning and talent acquisition
2. Performance management
3. Employee development
4. Succession planning
5. Compensation and rewards
6. Engagement and retention
7. Employee transition

Key Policies for Review:
- Talent Management Program (COR.08.006)

Financial Viability

Finance, HR & Audit Committee Committee

Role:
- To provide oversight over the financial operations of the Hospital, the annual external audit, and the planning of construction, renovation and maintenance of infrastructure and associated equipment. It will assist the Board in fulfilling its obligations relating to human resources and compensation matters.

Responsibilities:
- Budget Planning and Oversight
- Long Term Planning
- Asset Management
- Financial Transactions
- Donations and Bequests
- Investments
- Internal Controls, Risk Management, and Oversight of Internal Audit
- External Audit
- Human resources
- Building and property
- Compliance with Applicable Law
- Other such duties as may be requested by the Board from time to time

Finances – Operating & Capital

- Internal financial statements presented show the revenues and expenses of the hospital's operations.

- HGMH receives a global budget from the Ministry, and it is up to the hospital to determine where and how that money will be spent since funds are unrestricted.

- Capital expenses are acquisitions made that have a useful life longer than a year and they are to be used for the regular operations of the hospital. The Ministry of Health does not provide funding for capital equipment.

Donations

- HGMH Foundation
- Journée de la Femme Alexandria
- HGMH Auxiliary
- HGMH Endowment Fund:
  - The Hospital's Endowment fund is to be administered in accordance with guidelines as set by the Board of Directors in accordance with the Corporate Bylaw.
  - Donations to the Endowment Fund shall be considered unrestricted as to their end use, unless given with a purpose or time restriction by the donors. The Finance Committee shall ensure proper records and controls are maintained to comply with donors' specific conditions, and also that proper records are maintained.
  - The basic concept of endowments is to provide funding for long-term needs, whereby the fund contributed by donors are not spent immediately but are invested to provide a stream of earnings which can then be used. The Board shall, at its discretion, recommend the amount to be transferred from the Endowment Fund for general corporate purposes. The Board shall make decisions on spending from restricted gifts and funds to the extent that donors' restrictions are met.

Key Policies for Review:
- Management of Endowment Funds (BOD.04.003)
- Investments (BOD.04.002)

Hospital Services Accountability Agreement (HSAA)

What is the HSAA?
- A legal agreement between Hôpital Glengarry Memorial Hospital (HGMH) and Ontario Health.
- Outlines the funding, services, performance targets, and reporting requirements for the hospital.
- Ensures alignment with provincial health system priorities and accountability for the use of public funds.

Key Elements
- Service Volumes – specifies the types and volumes of hospital services to be delivered.
- Performance Indicators – includes targets for quality, access, efficiency, and patient safety.
- Funding Commitments – outlines base and targeted funding allocations.
- Reporting Obligations – requires submission of data and performance reports to Ontario Health.
- Compliance Requirements – adherence to applicable laws, standards, and policies.

Board's Role
- Approve the HSAA before execution.
- Monitor performance against HSAA indicators and targets.
- Oversee compliance with funding and reporting requirements.
- Engage in discussions with Ontario Health on performance and system integration opportunities.

Enterprise Risk Management

Accreditation Canada Standard: Governance
The governing body ensures that an integrated risk management approach and contingency plans are in place.

Key Policies for Review:
- Enterprise Risk Management(BOD.03.004)

Assessing Risk at HGMH Using a Risk Map

Likelihood		Minor (1)	Moderate (2)	Significant (3)	Severe (4)
	Very Likely (4)	4	8	12	16
	Likely (3)	3	6	9	12
	Possible (2)	2	4	6	8
	Unlikely (1)	1	2	3	4
		Minor (1)	Moderate (2)	Significant (3)	Severe (4)
		Impact			

Enterprise Risk Management

Enterprise Risk Management

Item #	Risk Score	Risk	Description	Impact	Likelihood	Plan
3	16	Cap on management salary	Ability to recruit externally is hampered for executive and selected leadership positions	4	4	While lobbying efforts are unlikely to succeed (and even potentially negatively impact us reputationally), continue to advocate via the OHA. In terms of local efforts, continue to focus on internal succession planning and performance excellence to ensure we maximize potential to develop talent from within.
4	16	Recruitment and Retention of Front-Line Staff	Current Pandemic and shortage of front line staff pose industry wide challenges.	4	4	Exploit new graduate initiative and engage management and staff in developing new master rotations. Investigate and potentially prioritize scheduling software to modernize staffing processes and facilitation better staff engagement.
6	16	Revenue Certainty	Hospitals are experience significant revenue reductions due to low interprovincial activity. Policy direction from the Ministry of Health in the short and long term is not known.	4	4	Focus efforts on lobbying as part of the Champlain group of hospitals who are all negatively impacted. Engage with local politicians and work with the Ontario Health East Region on mitigation strategies (eg. budget waivers, funding for working capital deficits).
5	12	Physical Infrastructure	The original hospital design poses structural impediments to optimal care in selected areas, such as accessibility, bariatrics and administrative space.	3	4	Our medium range planning aims to gain additional space through our project with IHA. In the short term, the hospital should explore temporary space (eg. admin trailer) as possible options.
18	12	Viability of Core Programs	It is important for a small hospital to maintain all it's clinical offerings in a robust high quality manner. The pandemic has impacted the clinical activity in key areas (eg. Emergency Department, Orthopedic clinic).	3	4	Our primary concerns are centred around our Emergency volume which is significantly depleted due to the pandemic.
9	8	Capacity Challenges	Hospitals do not run optimally at 100% and issues with access to Long Term Care persist.	2	4	Our strategy is to apply for, and via IHA, build a long term care home to do our part to alleviate backlogs in getting patients out to Long Term Care.
10	8	Ability to fund Capital Projects & Equipment	Potential challenges with operating deficits due to revenue loss deplete the hospitals funds available for capital. This will increase our dependency on the Foundation as a source of funding for capital projects.	2	4	With revenues depleted we are preparing the temporarily hold discretionary capital purchases for FY 21/22. For emergency replacement of critical clinical equipment, work with the Foundation and Endowment funds to prepare for dispersement for potential contingency items.
12	6	Future Cost Escalation	Cost pressures continue to rise each year. This poses operational challenges especially in ligh of shrinking revneues and unknown policy approach to hospital funding for the upcoming fiscal year.	2	3	Proactively plan our budget to bend the curve on cost escalation through efficiencies, process redesign and elimination of waste.
14	6	Culture/Morale at the Hospital	The pandemic has put serious stress on the health system and the workers that make it function. Combined with staffing shortages of selected workers, morale has been depleted. This hampers the ability of the hospital to effectively move forward to advance care delivery and processes.	2	3	focus efforts on recruitment to alleviate staffing pressures and invest in creative ways to engage staff while respecting public health guidance eg. virtual town-hall meetings, new news letters "You Ask We Answer".
13	4	Supply Chain	The pandemic exposed weaknesses in supply chain for the health sector. Distruption to supply chain can pose serious risks to the delivery of patient care.	2	2	
1	4	Leadership Succession/Development	Succession Planning and Leadership Development are critical for HGMH especially with caps on management Salaries.	2	2	
7	4	Cyber Attacks/Business Continuity	Electronic threats and attacks are a reality of our electronic world.	2	2	
8	4	Physician Recruitment and Rention	Ability to recruit and attract top talent can be challenging for small hospitals that do not have full service lines.	2	2	
11	4	Legilsative Compliance	Restraints?	2	2	
15	3	Organizational Depth/Overlap/Redundancy	As a small organization, creating redundancy for key processes posing risks to operations should unexpected absences occur.	1	3	
16	3	Information Management Capabilities	While the hospital has advanced into the electronic age in our clinical systems, our business systems remain highly manual and or antiquated. Decision making is often slowed by the manual collection of data, or is not supported by data in selected areas.	1	3	
17	2	French Language Designation	French language designation is important given our geography, patient population and commitment to our community.	2	1	

Top Identified Risks at HGMH for 2024/2025

- Health System Funding
- Physical Infrastructure
- Information Technology
- Capital Funding

Health Information Systems

- A health information system (HIS) refers to a system designed to manage healthcare data.

- This system collects, stores, manages and transmits our patient's electronic medica record.

Health Information Systems

- The CHAMP partnership is a collaborative of the Champlain regional hospitals that use the Meditech Healthcare Information System.

- Partner organizations include Arnprior & District Memorial Hospital, Hôpital Montfort, Bruyère Continuing Care, and Hôpital Glengarry Memorial Hospital.

- A CHAMP Value Analysis has been conducted to determine the future state, including the analysis of the Health Information System (HIS), and different governance models and partnerships.
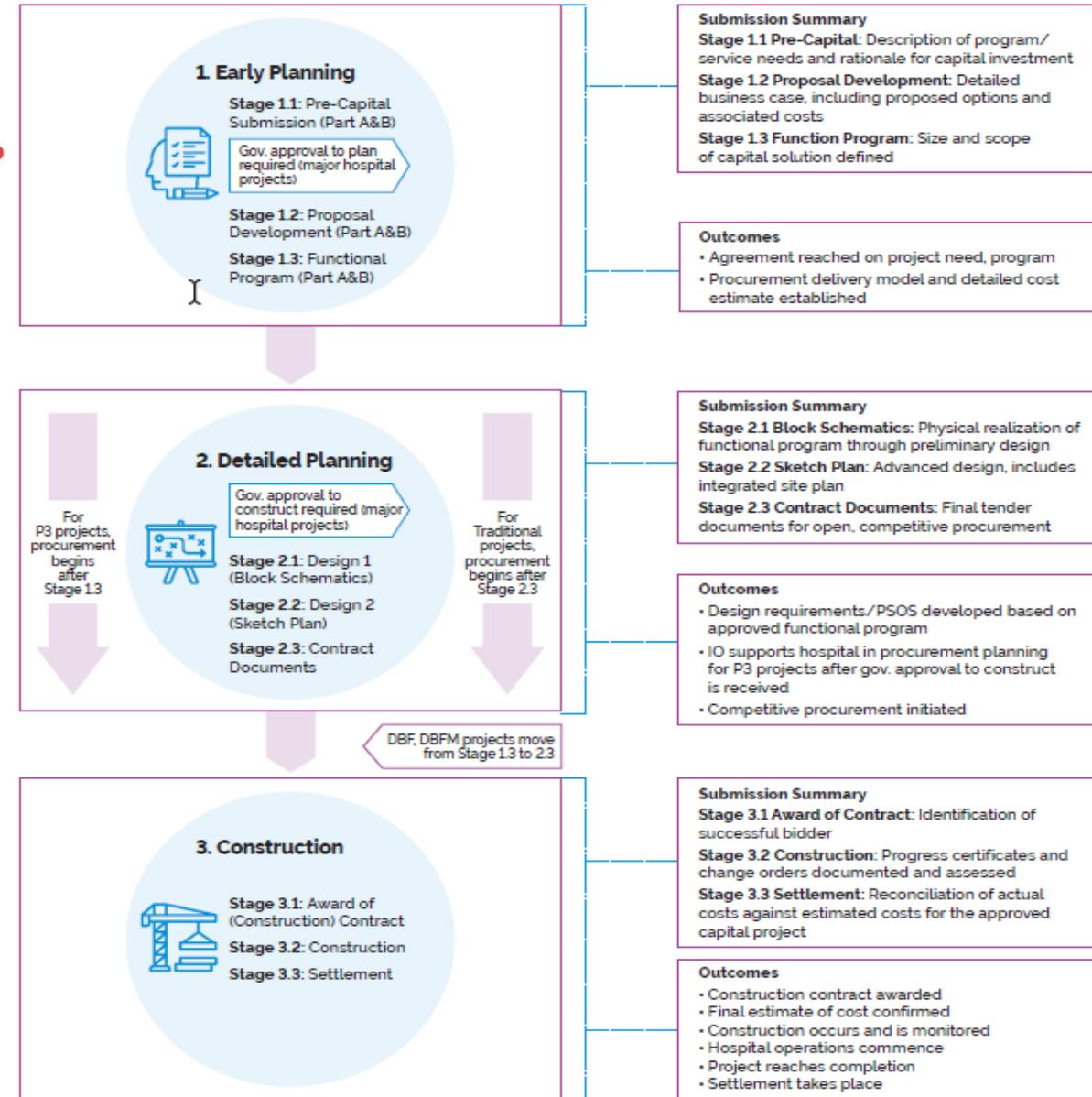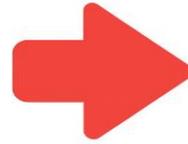
Health Information Systems

- As a result, HGMH will be joining the Atlas Alliance, lead by The Ottawa Hospital and our HIS will be EPIC. Planned Implementation is October 2026.

- Atlas Alliance will then consist of 16 other hospitals and healthcare organizations in the region.

Capital Redevelopment Planning

A hospital "Capital Project" can be defined as alteration(s) to a hospital building through demolishing, building, modifying, renovating or adding to a physical space which enables that space to support clinical functions; or a project that provides or replaces essential equipment to perform a defined function for building operations (infrastructure project). It can either be self-funded (own funds) or cost-shared by the ministry.

WE ARE HERE

1. Early Planning

Stage 1.1: Pre-Capital Submission (Part A&B)

Gov. approval to plan required (major hospital projects)

Stage 1.2: Proposal Development (Part A&B)

Stage 1.3: Functional Program (Part A&B)

Submission Summary
Stage 1.1 Pre-Capital: Description of program/service needs and rationale for capital investment
Stage 1.2 Proposal Development: Detailed business case, including proposed options and associated costs
Stage 1.3 Function Program: Size and scope of capital solution defined

Outcomes
- Agreement reached on project need, program
- Procurement delivery model and detailed cost estimate established

2. Detailed Planning

Gov. approval to construct required (major hospital projects)

Stage 2.1: Design 1 (Block Schematics)

Stage 2.2: Design 2 (Sketch Plan)

Stage 2.3: Contract Documents

For P3 projects, procurement begins after Stage 1.3

For Traditional projects, procurement begins after Stage 2.3

DBF, DBFM projects move from Stage 1.3 to 2.3

Submission Summary
Stage 2.1 Block Schematics: Physical realization of functional program through preliminary design
Stage 2.2 Sketch Plan: Advanced design, includes integrated site plan
Stage 2.3 Contract Documents: Final tender documents for open, competitive procurement

Outcomes
- Design requirements/PSOS developed based on approved functional program
- IO supports hospital in procurement planning for P3 projects after gov. approval to construct is received
- Competitive procurement initiated

3. Construction

Stage 3.1: Award of (Construction) Contract

Stage 3.2: Construction

Stage 3.3: Settlement

Submission Summary
Stage 3.1 Award of Contract: Identification of successful bidder
Stage 3.2 Construction: Progress certificates and change orders documented and assessed
Stage 3.3 Settlement: Reconciliation of actual costs against estimated costs for the approved capital project

Outcomes
- Construction contract awarded
- Final estimate of cost confirmed
- Construction occurs and is monitored
- Hospital operations commence
- Project reaches completion
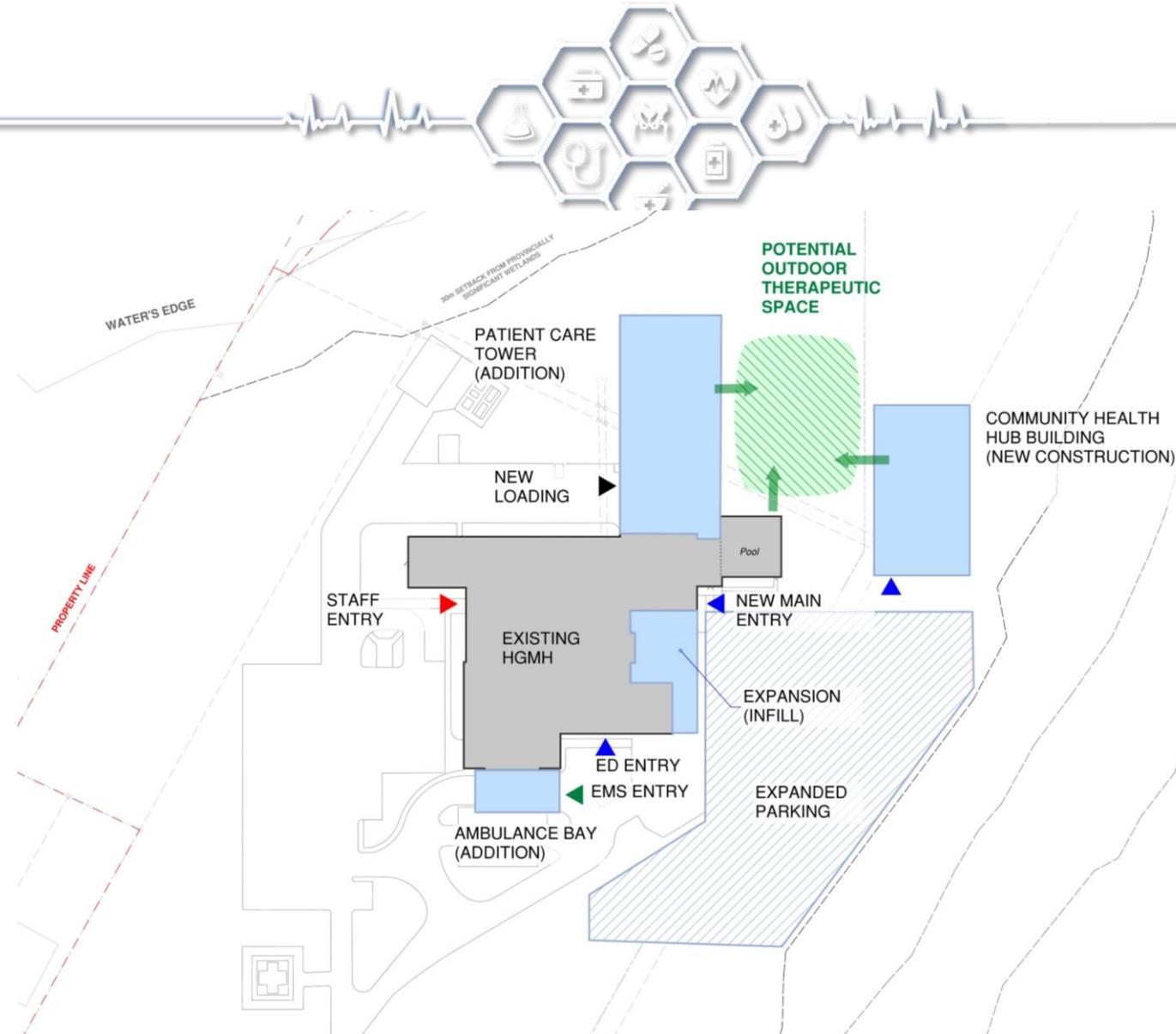- Settlement takes place

Capital Redevelopment Planning

On July 3, 2025 HGMH submitted a Pre-Capital plan to the Ministry of Health, seeking approval to move to stage 1.2 of the capital planning process.

Plan Highlights - Built in three phases

Phase 1: Community Health Hub
Phase 2: Patient Care Tower &
                Ambulance Bay
Phase 3: Infill and renovate existing
                building

BREAK/
HOSPITAL TOUR

Relationships

Ontario Health Team
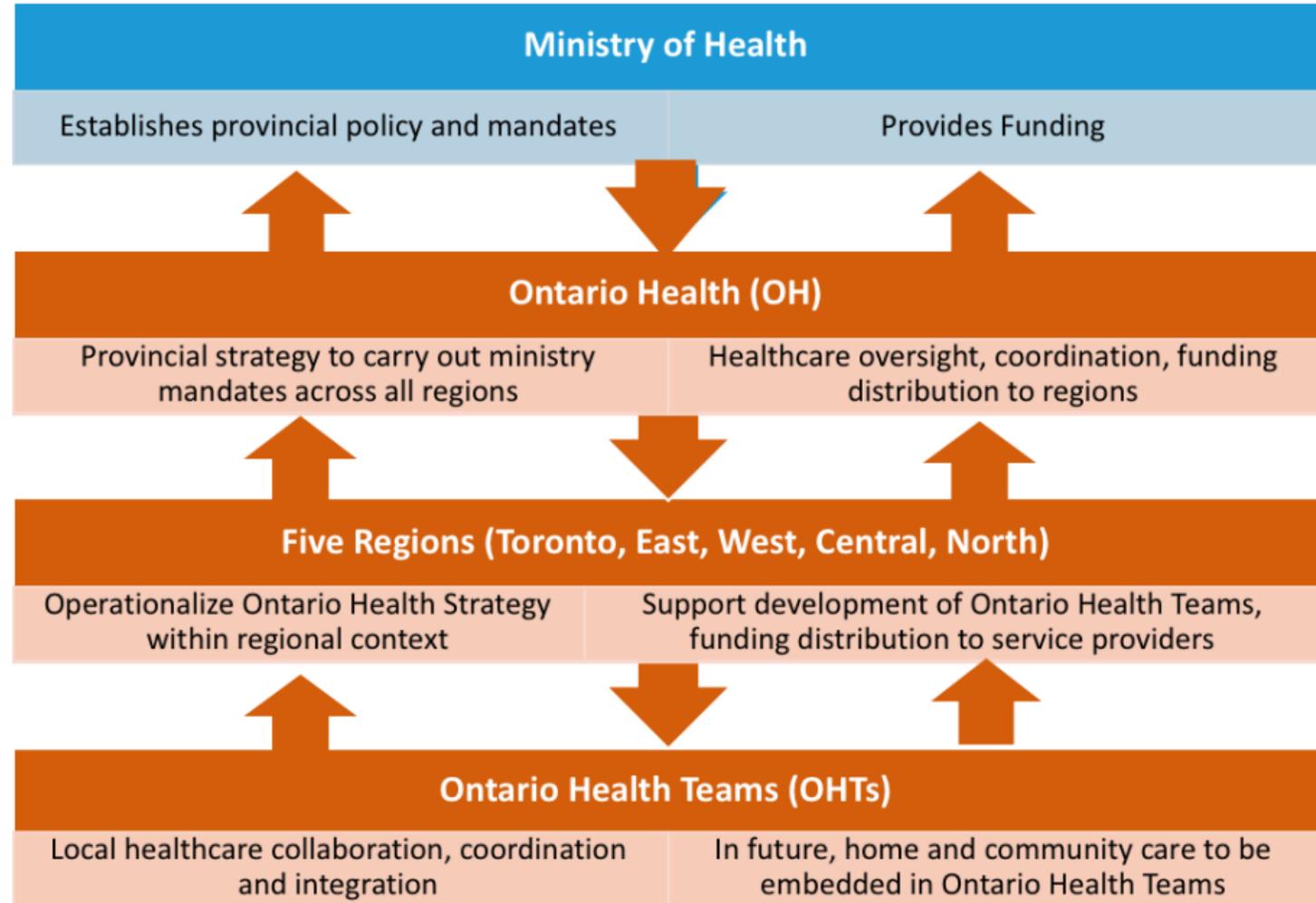
Ontario Health Team

- GROHT is one of 58 OHTs in Ontario.

- Currently, GROHT OHT has 42 partners from across all health sectors, including hospitals, primary care, home and community care, mental health and addictions, long term care, public health, emergency services.

- OHTs will, at maturity, be responsible for all programs, services and outcomes for their attributed population.

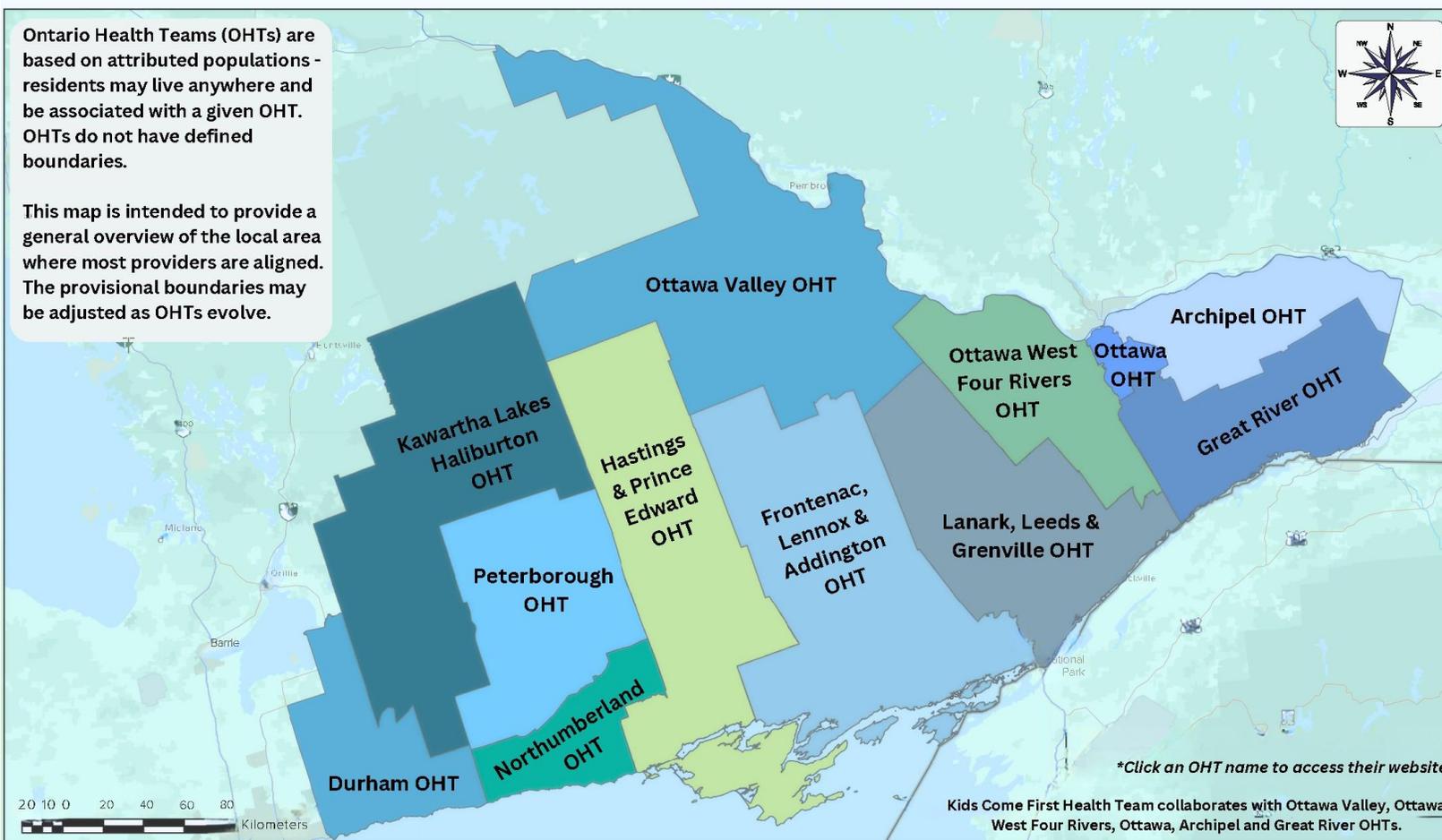- The attributed population of GROHT is 133,023

Ontario Health Team

Ontario Health Teams (OHT) within Ontario Health East

Ontario Health Teams (OHTs) are based on attributed populations - residents may live anywhere and be associated with a given OHT. OHTs do not have defined boundaries.
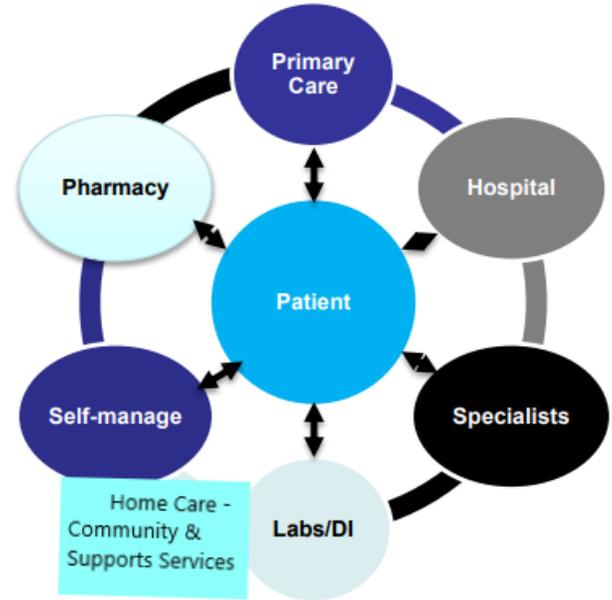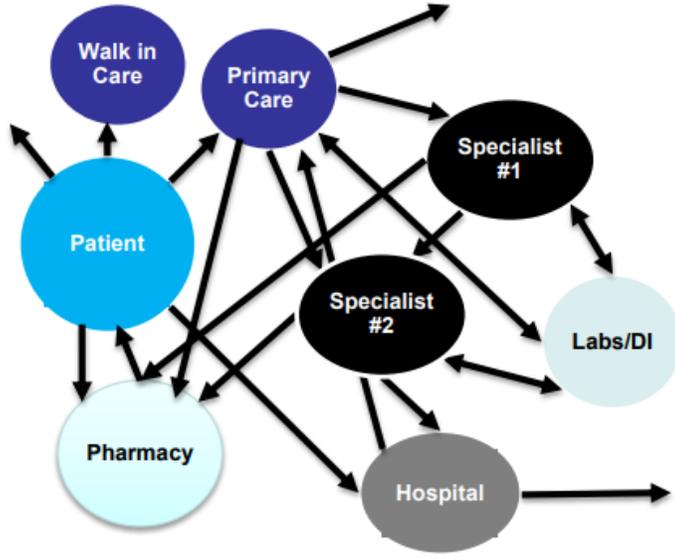
This map is intended to provide a general overview of the local area where most providers are aligned. The provisional boundaries may be adjusted as OHTs evolve.

Ottawa Valley OHT

Archipel OHT

Ottawa West Four Rivers OHT

Ottawa OHT

Great River OHT

Kawartha Lakes Haliburton OHT

Hastings & Prince Edward OHT

Frontenac, Lennox & Addington OHT

Lanark, Leeds & Grenville OHT

Peterborough OHT

Northumberland OHT

Durham OHT

Click an OHT name to access their website.

Kids Come First Health Team collaborates with Ottawa Valley, Ottawa West Four Rivers, Ottawa, Archipel and Great River OHTs.

Ontario Health Team

OHT Transformation: Introduction to Integrated, Accountable Local Care Systems

Ontario Health Team

GR OHT éso GF Collaborative Structure

Collaboration Council

System Transformation Support Tables
- Digital Health
- Quality, Evaluation and Education
- Equity, Diversity and Inclusion
- HR, Finance and Legal
- Communication and Community Engagement

Steering Committee

System Transformation/Project Teams
- Project A: Building Capacity with Primary Care Providers/Practices
- Project B: Mental Health and Addictions
- Project C: Frail Older Adults and Complex Care Needs

Co-Design Expert Tables
- Lived Experience Partners
- French Language Services
- Primary Health Care Clinicians
- Indigenous Community – TBD
- Others – TBD (e.g. Sector Specific)

Backbone Support Team

External Resources/Networks
- Regional Networks
- Physician and Primary Care Association

Partnerships

Some examples of partnerships are:

- EORLA (Eastern Ontario Regional Laboratory Association)
- CHAMP (Champlain Association of Meditech Partners)
- Atlas Alliance
- Great River Ontario Health Team
- Mohawk Council of Akwesasne Department of Health
- Cornwall Community Hospital (Radiologist coverage)
- Queensway Carleton
- Community Wide Scheduling (CWS)
- Dynacare - Outpatient lab collection station
- Glengarry Community Living (IT support)
- Northwest (Pharmacist coverage)
- Township of North Glengarry (Pool)
- Ontario Health at Home (Discharge Planning)

Communications

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.

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.

At HGMH, we strive to communicate information about our organization, programs, and services in an effective and efficient way. To do so, we have a comprehensive communications plan to support this focus.

Key Policies and Documents for Review:
- Communications & Hospital Spokesperson (BOD.05.018)
- Communication and Community Engagement Plan

Quality, Safety & Effectiveness

Quality & Patient Safety Committee

Role:

- The role of the Quality & Patient Safety Committee is to make recommendations to the Board of Directors on matters relating to the overall quality of patient care and the safety of the patients, staff, volunteers and visitors to the hospital.

Responsibilities:

1. Monitor and report to the Board (quarterly) on the quality of care provided by the hospital and ensure that internal systems for continuous quality improvement incorporates innovation, evidence , and patient and family centered care.

2. Make recommendations to the Board about quality improvement policies.

3. Ensure update of the Annual Quality Improvement Plan supporting the requirements of the Excellent Quality Care for All Act.

4. Ensue that the Annual Quality Improvement Plan engages both patients and caregivers.

Quality & Patient Safety Committee

Responsibilities (continued):

5. Review critical incident reports and investigate to mitigate the likelihood of reoccurrence.

6. Ensure compliance with Accreditation Canada standards.

7. To review the Terms of Reference annually.

Quality & Patient Safety Committee

Reports:

- Quality Improvement Plan

- Quality Dashboard

- Patient Safety Reports

- Patient and Family Satisfaction Surveys

- Occupational Health & Safety Reports

- Accreditation Compliance Report

Medical Advisory Committee (MAC)

Composition of Medical Advisory Committee

- Chief of Staff

- Chief of Departments

- President and Secretary of the Professional Staff

- The Lab Director, CEO and CNE also attend MAC as non-voting members

Medical Advisory Committee (MAC)

Duties and responsibilities

a) make recommendations to the Board concerning the following matters:
- Appointment and reappointment to the Professional Staff and any requests for change in privileges,
- The Bylaws and Rules and Regulations respecting the Professional Staff,
- Revocation, suspension and restriction of privileges of any member of the Professional Staff,
- The quality of care provided in the Hospital by the Professional Staff

b) supervise the clinical practice of medicine, dentistry, midwifery, and extended class nursing in the Hospital;

c) appoint the Medical Staff members of all committees established under section 9.4;

d) receive reports of the committees of the Medical Advisory Committee;

e) advise the Board on any matters referred to the Medical Advisory Committee by the Board;

Board Role in Credentialing and Re-credentialing

- Credentialing is a process in which applications for initial appointment to the hospital is reviewed, qualifications verified, and privileges granted to Professional Staff at HGMH.

- Professional Staff includes Physicians, Nurse Practitioners, Dentists, Optometrists and Midwives.

Key Documents for Review:
- Professional Staff Bylaws
- Professional Staff Rules & Regulations
- Credentialing Presentation

Quality Improvement Plan (QIP)

The QIP is based on priorities identified by the Internal Quality Committee in collaboration with the Hospital's Board, Senior Management, Leadership Teams and our Patient and Family Advisory Committee. The plan is aligned with best practices and the Excellent Care for All Act. This balanced approach ensures key improvement initiatives in the areas of Timely and Efficient Transitions, Service Excellence, Safe and Effective Care, and Equity.

2024-25 QUALITY IMPROVEMENT PLAN (QIP) [Org ID 802]

AIM		MEASURE						
THEME	QUALITY DIMENSION	MEASURE/INDICATOR	TYPE	UNIT/POPULATION	SOURCE/PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE	LEADER
Equity	Equitable	Percentage of executive and management staff who have completed relevant inclusion, diversity, equity and accesibility (IDEA) education.	O	%/applicable Staff	Local data collection/most recent consecutive 12-month period	N/A	100%	Chief, Human Resources
Experience	Patient-Centred	Percentage of respondents who respond positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	%/Survey respondents	Local data collection/2023-24 Q1	84%	86%	VP Clinical Services, Quality & CNE
Safety	Safe	Rate of workplance physical violence incidents resulting in lost time injury	O	%/Staff	Local data collection/most recent consecutive 12-month period	0.6%	0.5%	Chief, Human Resources
Safety	Safe	Number of reported near misses related to controlled substances within the organization.	C	Number	Hospital Collected Data April 1 - December 30, 2023 (Q1, Q2, Q3)	19.7	12.0	Manager, Pharmacy Operations

Accreditation

- Founded in 1958

- Not-for-profit, independent organizations

- Over 1000 clients in all areas of health care

- Peer review process based on evidence-based standards of excellence

- The theme for HGMH's 2022-2026 Accreditation Cycle is the Wizarding World.

Glossary of Terms

Quality Performance Roadmap

o *Self-assessment results*

Required Organizational Practice (ROPs)

o *Essential practice that must be in place*

Priority Process

o *Significant impact on safety, quality of care, and service*

Tracer

o *Interactive process/direct observation to gather evidence*

Governance Preparation

ACCREDITATION AGRÉMENT CANADA
Qmentum

STANDARDS

Governance

For Surveys Starting After:
January 1, 2018

Date Generated: January 27, 2017
Ver. 12

ACCREDITATION AGRÉMENT CANADA
Qmentum

Governance Functioning Tool

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not Applicable
1. We regularly review and ensure compliance with applicable laws, legislation, and regulations.	O	O	O	O	O	O
2. Governance policies and procedures that define our role and responsibilities are well documented and consistently followed.	O	O	O	O	O	O
3. Subcommittees need better defined roles and responsibilities.	O	O	O	O	O	O
4. As a governing body, we do not become directly involved in management issues.	O	O	O	O	O	O
5. Disagreements are viewed as a search for solutions rather than a "win/lose".	O	O	O	O	O	O
6. Our meetings are held frequently enough to make sure we are able to make timely decisions.	O	O	O	O	O	O
7. Individual members understand and carry out their legal duties, roles, and responsibilities, including subcommittee work (as applicable).	O	O	O	O	O	O

Governance Functioning Tool

- Membership and structure
- Roles and responsibilities
- Meetings and decision-making processes
- Process of evaluation

Trillium Gift of Life Network (TGLN)

- In November 2024, the hospital joined the TGLN, Ontario's organ and tissue donation and transplantation agency ensuring that organ and tissue donation is supported in alignment with patient wishes

- Participating in TGLN is not a mandatory requirement for small hospital which meant that the hospital could not act on donor wished even if a deceased patient had pre-registered as a donor.

- The implementation of TGLN reflect our ongoing commitment to delivering outstanding care

Whistleblowing

- Any person who becomes aware of a breach of professional, ethical, financial, or legal behaviour, non-compliance with applicable laws and regulations, or contravention of any policy governing the conduct of persons associated with HGMH and attempts to conceal any such breach or contravention, is responsible for reporting this immediately.

- A Compliance Officer will be designated to address whistleblowing reports and these will be reported to the Finance. HR and Audit Committee through the compliance report.

Key Policy for Review:
- Whistleblowing (BOD.03.002)

Other Board Committees

Executive Committee

Role:

- The role of the Executive Committee is to exercise the full powers of the Board in all matters of administrative urgency, reporting every action at the next meeting of the Board.

Overview of Responsibilities:

- Make decisions binding on the Board in situations where it is not possible or practical to call a meeting of the Board

- Review annual performance goals of the CEO and COS and execute yearly performance evaluations for the CEO and COS

- Review succession planning for the CEO and COS

Executive Pay for Performance

HGMH is committed to rewarding the strategic accountabilities of the CEO, COS and the Executive Team by providing an incentive plan that:

1. Engages the CEO, COS and Executive Team in the business of the organization;
2. Encourages long term and short term "results orientation";
3. Maximizes the commitment to achieve key strategic and operational objectives;
4. Ensures individual performance is quality focused; and
5. Creates a team focused approach to corporate goals.

Key Documents for Review:
- Executive Compensation Framework

Performance check-ins will occur on the following schedule:

- CEO/COS performance related to annual personal business commitments will be reviewed on a six-month basis by The Executive Committee.
- The Executive Team performance related to annual personal business commitment indicators will be reviewed by the CEO on a six-month basis or more often as determined by the CEO.

Performance Assessment Category	Does Not Meet	Almost Fully Achieved	Fully Achieved
Weighted Payment of 3% At Risk	0	50%	100%
Goal #1 Quality (50% weighting)	0	0.75%	1.5%
Goal #2 Financial (30% weighting)	0	0.45%	0.9%
Goal #3 Strategic/Significant Initiative (20% weighting)	0	0.30%	0.6%

French Language Services Committee

Role:

- The role of the French Language Services Committee is to establish and maintain French language services to ensure continued availability, quality of service, as well as permanence of services.

Overview of Responsibilities:

- Develop and implement policies and procedures to facilitate the provision of French language services

- Ensure that French language training is available

- Monitor patient satisfaction for French language services received

- Inform the Board annually as to the status of French language services

- Inform the Board Quality Committee with indicators on French language services on a regular basis

Patient & Family Advisory Committee

Role:
- The Patient and Family Advisory Committee (PFAC) serves in an advisory capacity, making recommendations on matters that impact the experience of patients and their families at HGMH.

Overview of Responsibilities:

- Serve as liaison between patients and families and the hospital, conveying concerns, ideas and suggestions

- Participate in the annual development of the hospitals Quality Improvement Plan

- Participate in strategic planning process

- Provide advice to the hospital Leadership team on practices and initiatives related to patient and family centered care

- Assist in reviewing and providing feedback on patient satisfaction

- Participate in the Accreditation preparation and on-site survey

- Lead and support initiatives and actions that help further the hospitals strategic and operating plans related to patient and family centred care

- *A designated PFAC member attends the open session of the Board of Directors to ensure the patient and family voice is heard in all of the Board's decision making.*

Dates of Importance

September 11th, 2pm
- Special In Camera Board Meeting
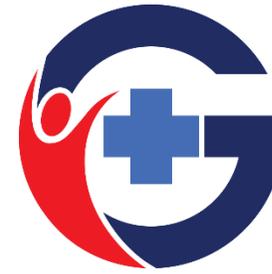- Staff and family BBQ – 3pm

October 4th, 2025, 10am
- Board Retreat

Questions?

HÔPITAL
Glengarry Memorial
HOSPITAL