

## Board of Directors In Camera Meeting Agenda

Date: Thursday, October 22, 2026  
Time: Following the Board meeting  
Location: Boardroom / Microsoft Teams

| Agenda Item                                                                                                                                                            | Attachment |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| <b>1. Call to Order (L. Boyling)</b>                                                                                                                                   |            |
| 1.1 Confirmation of Quorum                                                                                                                                             |            |
| 1.2 Adoption of the agenda                                                                                                                                             | P. 1-2     |
| 1.3 Declaration of Conflict of Interest ( <a href="#">Policy BOD.05.003.X.XX</a> )                                                                                     |            |
| <b>2. Minutes (L. Boyling)</b>                                                                                                                                         |            |
| 2.1 Approval of previous meeting minutes - September 24, 2026                                                                                                          | P. 3-5     |
| 2.2 Business arising from minutes                                                                                                                                      |            |
| <b>3. Matters for Discussion/Decision</b>                                                                                                                              |            |
| 3.1 Report of the Chief of Staff (Dr. L. MacKinnon)                                                                                                                    | P. 6-7     |
| 3.2 Physician Leave of Absence - Dr. C. Seid (Dr. L. MacKinnon)<br><b>THAT the Board of Directors approve the leave of absence for Dr. Cherinet Seid as presented.</b> | P. 8       |
| 3.3 Foundation Updates (D. Elie)                                                                                                                                       |            |
| 3.4 Hospital Efficiency and Workforce Optimization Measures (R. Alldred-Hughes)                                                                                        | P. 9-11    |
| 3.5 Letter to MOLTC - Relocation of Long-Term Care Beds (R. Alldred-Hughes)                                                                                            | P. 12-17   |
| 3.6 Future Planning - Continued Discussion from Board Retreat (L. Boyling)                                                                                             | P. 18-37   |
| <b>4. Consent Agenda</b>                                                                                                                                               |            |
| 4.1 Report of the Medical Advisory Committee                                                                                                                           | P. 38-42   |
| 4.2 Draft Executive Committee Report                                                                                                                                   | P. 43-44   |
| <b>THAT the Board of Directors approve and receive all documents as presented in the consent agenda.</b>                                                               |            |
| <b>4. Adjournment (L. Boyling)</b>                                                                                                                                     |            |

\*Meeting moves to Meeting of Directors Without Management (BOD.05.019)

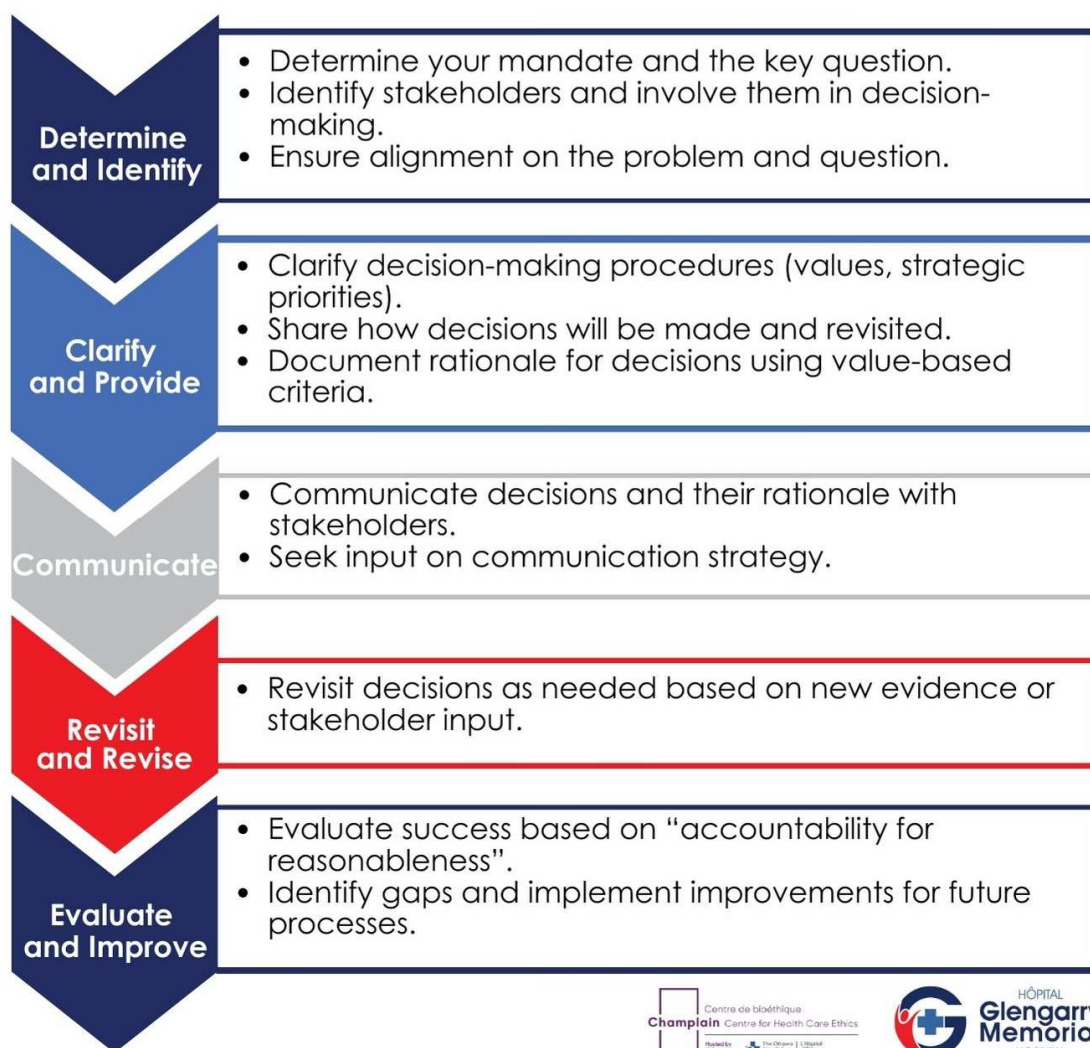


## Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

### Values that Optimize Fairness in the Process of Decision-Making



### A4R Action Steps



## MINUTES OF IN CAMERA MEETING OF THE BOARD OF DIRECTORS

|          |                              |                         |                       |
|----------|------------------------------|-------------------------|-----------------------|
| Date     | Thursday, September 24, 2026 |                         |                       |
| Time     | Following the Board Meeting  |                         |                       |
| Location | Boardroom/Microsoft Teams    |                         |                       |
| Present: | L. Boyling, Chair            | C. Larocque, Vice-Chair | C. Nagy, Treasurer    |
|          | B. Pulice                    | D. Elie (v)             | G. McDonald (v)       |
|          | G. Peters                    | K. McTaggart            | M. Nichols            |
|          | R. Cardinal                  | R. Alldred-Hughes, CEO  | R. Romany, CNE        |
|          | K. MacGillivray, CHRO        | L. Ramsay, CFO          | Dr. L. MacKinnon, COS |
| Regrets: | F. Desjardins                | H. Salib                |                       |

### 1. Call to Order

L. Boyling, Chair, called the meeting to order at 6:26pm.

#### 1.1. Quorum

A quorum was present.

#### 1.2. Adoption of the Agenda

The agenda was reviewed.

Moved By: B. Pulice

Seconded By: C. Nagy

THAT the agenda be adopted as presented.

**CARRIED**

#### 1.3. Declaration of Conflict of Interest

There were no conflicts of interest declared at this time.

### 2. Minutes

#### 2.1 Approval of previous meeting minutes

The previous meeting minutes were reviewed.

Moved By: K. McTaggart

Seconded By: D. Elie

THAT the previous meeting minutes of June 18, 2026, be approved as presented.

**CARRIED**

### 3. Matters for Discussion/Decision

#### 3.1 Report of the President & CEO

The report of the President & CEO was shared in which it was discussed that the CT project received Ministry approval to proceed through construction, with go live planned for October 2027. New provincial expectations for cost efficiency and patient flow were reviewed, including challenges for small rural hospitals and planned improvement measures.

Rehabilitation planning considered retaining the existing 15 beds within the redevelopment

plan, with future expansion subject to regional planning. No decisions have been made regarding changes to the rehabilitation program.

### 3.2 Capital Redevelopment Update

R. Alldred-Hughes provided an update on capital redevelopment planning and discussions with Ontario Health, in which there was expressed support for the Community Health Hub. A revised pre-capital submission is being prepared with continued support from the consulting firm and additional evidence supporting future service demand and inpatient bed capacity. Stroke rehabilitation planning will be addressed separately through regional discussions. The revised submission will return to the Board for review and endorsement before resubmission.

### 3.3 Foundation Updates

An update from the August Foundation meeting noted that \$2.5 million had been raised, with a further \$2.2 million in net revenue anticipated by year-end. Upcoming activities included a donation from the Community Run, Harvest Tastings on October 21 at The North Mulligan, and the Glengarry Encore event. Discussion ensued around whether there was a set financial contribution expected from Directors to which it was acknowledged that there is no donation expectation however, members are encouraged to support events through attendance and promotion.

### 3.4 Q1 HR Metrics

The Q1 HR Metrics Report was reviewed which highlighted improved workforce stability, retention, and vacancy rates. Training activity was affected by resources dedicated to the Epic project. However, equity and inclusion training exceeded its annual target. Workplace safety, disability trends, and labour relations continue to be monitored, with no grievances advancing to arbitration during the quarter.

With Epic implementation one month away, recruitment has been temporarily paused to avoid training new staff on two systems. Offers continue to be made to candidates with start dates after implementation.

### 3.5 Whistleblowing Report

The annual Whistleblowing Report was reviewed. One report was received, investigated, and determined to be unfounded. There are no outstanding whistleblowing investigations.

### 3.6 Report of the Chief of Staff

Strong emergency department performance was highlighted as well as the ongoing work on CT planning, and physician readiness for Epic. Regional physician recruitment efforts and medical student mentorship continue. Physician coverage remains strong in both the inpatient and emergency departments, with schedules secured several months in advance.

### 3.7 Chief Renewals

Both department Chiefs wish to renew their contracts. These are for two-year periods.

Moved By: B. Pulice

Seconded By: C. Larocque

That the contracts for the Chief of Inpatient and Ambulatory Care and the Chief of Emergency Department be renewed.

**CARRIED**

### 3.8 Professional Staff Appointment

Two physicians have submitted their applications to join the Professional Staff.

Dr. Alexa Schryver is currently practicing at the hospital with temporary privileges in the Emergency Department and on the inpatient unit and things are going very well.

Moved By: R. Cardinal

Seconded By: M. Nichols

That the Board of Directors approve that Dr. Alexa Schryver be credentialed with Associate privileges in General Medicine and Emergency following the recommendation of the Medical Advisory Committee.

**CARRIED**

Dr. Mohammad Ameen is also currently practicing at the hospital with temporary privileges on the inpatient unit. He is looking to relocate to the area and enjoys rural medicine.

Moved By: C. Larocque

Seconded By: M. Nichols

That the Board of Directors approve that Dr. Mohammad Ameen be credentialed with Locum Tenens privileges in General Medicine following the recommendation of the Medical Advisory Committee.

**CARRIED**

### 4. Consent Agenda

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

4.1 Report of the Medical Advisory Committee

4.2 Privacy and Confidentiality Report

Moved By: G. Peters

Seconded By: R. Cardinal

THAT the Board of Directors approve and receive all documents as presented in the consent agenda.

**CARRIED**

### Adjournment

The meeting adjourned at 7:07pm.

K-L Massia, Recording Secretary

## **Report of the Chief of Staff**

### **October 2026**

#### **Chief of Emergency**

Dr. Sara Farmer has submitted her resignation as Chief of Emergency, effective at the end of December. The position has been posted and circulated to the physician group, with October 23, 2026, set as the deadline for expressions of interest. To date, one expression of interest has been received.

#### **Epic Physician Training**

Epic physician training is progressing as planned, with final preparations underway to ensure readiness and alignment with established workflows.

#### **Physician Recruitment Taskforce**

The Workforce Attraction & Recruitment and Community Promotion & Welcome working groups have merged, and Suzanne and I will continue to participate moving forward.

At the October 2 FMRQ Career Day in Montreal, Suzanne engaged with Quebec medical residents interested in practicing in Ontario. Nine residents expressed interest in learning more about opportunities at HGMH, with the majority interested in inpatient work and a few exploring opportunities in emergency medicine and family medicine. Their contact information was collected, and follow-up information has since been shared by email.

Upcoming Physician Recruitment Events:

- October 30 – University of Ottawa Department of Family Medicine (DFM) Job Fair
- November 11–13 – Family Medicine Forum (FMF), Toronto

#### **Medical Students/Residents**

ED physicians mentored a third-year medical student during their two-week emergency medicine rotation from September 28 to October 11. The student is completing a 14-week family medicine placement in Akwesasne.

A four-week pause in student education is planned to allow teams to focus on adapting to the new Epic system.

#### **Inpatient and Emergency Department Schedules**

Staffing remains stable across both the Inpatient and Emergency Departments. The Inpatient schedule for January through June is currently being finalized. The Emergency Department schedule is complete through the end of January 2027, with a few second-physician shifts remaining to be filled and the On-Call schedule expected to be finalized shortly.

#### **Physician Leaves**

Physician leave updates are being monitored, with coverage arrangements coordinated as needed to support continued service delivery and maintain staffing across the Inpatient and Emergency Departments.



- Dr. Cherinet Seid (Emergency Medicine) has requested a Personal Leave of Absence from September 9<sup>th</sup> to mid-December 2026; Awaiting Board Approval.
- Dr. Eric Bilodeau's (Emergency, and General Medicine) request for a Medical Leave of Absence has been approved by the Medical Advisory Committee from December 2, 2026, to March 1, 2027, gradual return to work.

October 9, 2026

Board of Directors  
Hôpital Glengarry Memorial Hospital

Re: Recommendation for Approval of Personal Leave of Absence – Dr. Cherinet Seid

Dear Board Members,

At the Medical Advisory Committee meeting October 6, 2026.

Motioned by: Dr. L. MacKinnon

Seconded by: Dr. D. Read

THAT the Medical Advisory Committee recommend to the Board of Directors to approve personal leave of absence for Dr. C. Seid from September 9 – mid-December 2026.

**CARRIED**

Should you have any questions, please do not hesitate to contact me.

Sincerely,



Dr. Lisa MacKinnon, Chief of Staff

## DECISION SUPPORT DOCUMENT FOR

☒ Board of Directors

☐ Board Committee -

☐ Senior Leadership Team

☐ Other (please specify):

Date Prepared: September 30, 2026

Meeting Date Prepared for: October 8, 2026 – Executive  
October 22, 2026 - Board

Subject: Hospital Efficiency and Workforce Optimization Measures

Prepared by: Robert Aldred-Hughes, President & CEO

☐ DECISION SOUGHT\*

☒ FOR DISCUSSION/INPUT

☐ FOR INFORMATION ONLY

### PURPOSE

The purpose of this briefing note is to provide the Board of Directors with an update on management's ongoing review of hospital operating efficiencies and to seek support for targeted workforce measures intended to reduce operating costs while maintaining current patient services, programs and access to care.

Following a review of staffing utilization, overtime and premium pay, peer benchmarking and current operating requirements, management is planning the following:

- A reduction of 2.8 FTE Personal Support Worker (PSW) positions; and
- An annualized reduction target of \$75,000 in overtime and premium pay.

These measures do not reduce the hospital's current service offerings, programs, beds or hours of operation, and achieve a targeted savings of \$218,000.

### 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.*

- HGMH continues to review its operations to identify opportunities to improve efficiency while protecting patient care and maintaining the programs and services relied upon by our communities.
- Management's approach has been to prioritize opportunities within the hospital's existing cost structure before considering measures that could affect service delivery. This is consistent with the broader sector direction toward the use of benchmarking, workforce optimization and other internal efficiencies. Ontario Health has specifically identified workforce optimization, staffing mix and reductions in overtime as examples of efficiency opportunities being pursued across hospitals.
- The review has included consideration of peer hospital staffing information, HGMH's current staffing models, utilization of available staffing resources, overtime and premium pay, operational requirements, and opportunities to better align staffing with organizations of similar size and scope.
- This work has identified an opportunity to reduce PSW staffing by 2.8 FTE while continuing to support the current clinical model and maintaining existing hospital services. The proposed change better aligns staffing resources with comparable organizations and represents an opportunity to reduce base operating costs without reducing clinical programs or patient access.

- Management has also identified overtime and premium pay as an area requiring greater discipline. Additional staffing resources and scheduling flexibility should, where possible, reduce reliance on overtime, call ins and other premium costs. A reduction target of \$75,000 has therefore been established, with ongoing monitoring of utilization and staffing practices to support achievement of this goal.
- The proposed measures reflect management's intention to focus first on efficiencies within existing operations rather than reductions to patient services.

## IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

*Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.*

- The proposed measures have been developed with the objective of achieving sustainable savings while minimizing impact on patients and frontline service delivery.
- The 2.8 FTE PSW reduction represents a permanent reduction in the hospital's base cost structure of approximately \$143,000. Importantly, the change does not involve the closure of beds, reduction of clinical programs, change in operating hours or elimination of a service. Staffing levels will continue to be managed according to patient needs, acuity and operational requirements.
- The \$75,000 overtime and premium pay target is intended to improve how existing staffing resources are utilized rather than establish a fixed reduction in necessary patient care. Management will continue to monitor overtime, call ins, staffing patterns and use of resource coverage to ensure available resources are being used effectively before additional premium costs are incurred.
- There are workforce and operational risks associated with any staffing change. These include the potential for increased workload, unanticipated changes in patient acuity, sick calls and short notice vacancies. These risks will require active management through scheduling, appropriate use of available resources and ongoing monitoring of quality and staffing indicators.
- The approach also reflects an important distinction in HGMH's efficiency work. Rather than reducing services to achieve savings, management is seeking to ensure that the resources supporting those services are appropriately aligned with operational requirements and comparable hospitals. Ontario Health's regional planning direction similarly distinguishes internal staffing mix initiatives that do not reduce services from initiatives that affect service volumes or access.
- Management believes these measures represent a reasonable balance between financial stewardship and the hospital's responsibility to maintain safe, accessible patient care.
- The objective is not simply to reduce staffing costs, but to ensure that staffing resources are being used effectively and are appropriate for the size, scope and activity of the organization. Continued monitoring will be important to confirm that the anticipated savings are realized and that the measures do not create unintended impacts on quality, patient access or workforce sustainability.

## FINANCIAL IMPACT

The proposed changes will generate recurring operating savings through two mechanisms:

- PSW staffing: recurring salary and benefit savings associated with the reduction of 2.8 FTE, approximately \$143,000.
- Overtime and premium pay: targeted annualized savings of \$75,000 through improved scheduling, utilization of existing staffing resources and greater management of premium costs through scheduling considerations.
- As staff reductions have the potential to require exit costs, they could be as high as \$28,500. Which has the potential to impact our balanced position in this fiscal year as one time exit cost payments are required.

These measures contribute to HGMH's broader financial sustainability work and demonstrate that the organization continues to pursue internal efficiencies while maintaining its current scope of patient services.

#### **CONSULTED WITH:**

*Indicate those bodies and individuals who have been consulted with in the development of this decision support document*

- Senior Leadership Team
- Vice President Clinical Services, Quality & Chief Nursing Executive
- Chief Human Resources Officer
- Vice President Corporate Services & Chief Financial Officer
- Managers of Clinical Programs

#### **IMPLEMENTATION & COMMUNICATION PLAN**

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

- A Human Resources Plan is being developed, with appropriate notices to unions and staff to occur in line with the applicable Collective Agreement.

## DECISION SUPPORT DOCUMENT FOR

☒ Board of Directors

☐ Board Committee -

☐ Senior Leadership Team

☐ Other (please specify):

Date Prepared: October 9, 2026

Meeting Date Prepared for: October 8, 2026 - Executive  
October 22, 2026 - Board

Subject: Long Term Care Consultation & Impact on potential 'Palace' closure

Prepared by: Robert Aldred-Hughes, President & CEO

☐ DECISION SOUGHT\*

☒ FOR DISCUSSION/INPUT

☐ FOR INFORMATION ONLY

### PURPOSE

- To seek the Board's considerations on the potential closure of the Palace long term care home and relocation of capacity outside North Glengarry, and determine whether there is general support for HGMH's continued dialogue and participation.

### 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 Palace is a 70 bed long term care home located in Alexandria and operated by Southbridge Care Homes. The Ministry of Long Term Care is reviewing a proposal for a new 320 bed home in Cornwall, known as Southbridge Cornwall 2, under Project 26 017. The proposal would bring together beds from The Palace, Heartwood in Cornwall and Pinecrest in Plantagenet, along with additional approved beds. The existing homes would close when the new development is completed.
- For North Glengarry, the proposal would mean moving the 70 beds currently located at The Palace outside the municipality. The central concern is the loss of local access to long term care. Residents requiring this care could have fewer opportunities to remain in their community, and families and friends could face greater travel demands to maintain regular contact and support.
- The Province is seeking public comments until October 16, 2026. North Glengarry issued a public notice on October 1 encouraging residents and interested parties to participate. The municipality has also indicated that Council will consider a formal resolution at its October 13 meeting. The proposal remains under review, and a final outcome and implementation timeline have not been confirmed in this briefing note.
- HGMH has prepared a response to the request for consultation. From the hospital's perspective, preserving local long term care capacity is relevant to access across the continuum of care and timely discharge for patients who can no longer return home. A reduction in local placement options could contribute to longer hospital stays and pressure on bed availability. The extent of these impacts requires further assessment. (Response attached)
- At their request, I met with the Mayor, Deputy Mayor and Chief Administrative Officer of North Glengarry to discuss the matter and HGMH's potential involvement. A further meeting has been scheduled by the Township of North Glengarry for October 16, 2026, with MPP Stéphane Sarrazin, our Board Chair and I will have been invited to attend. I am seeking the Board's considerations to help guide these discussions and establish whether there is general support for our continued dialogue and participation.

## OPTIONS CONSIDERED & ANALYSIS

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

- Continued participation would allow HGMH to bring the hospital and patient care perspective to discussions, help clarify the implications of losing local capacity and explore possible responses with partners. This is my recommended approach.
- A limited role focused on providing information would require less management time, but offer less opportunity to influence discussions. A more active role in developing a solution could be considered as options become clearer and the Board assesses their fit with HGMH's mandate and resources.

## IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

*Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.*

- The potential closure or relocation of the Palace Long Term Care Home presents implications for local healthcare access, hospital operations, and broader community planning. The loss of long term care capacity within North Glengarry could limit residents' ability to remain close to family and community supports, while potentially increasing pressures on HGMH related to alternate level of care (ALC), patient flow, and inpatient bed availability.
- From a strategic perspective, HGMH has an interest in supporting efforts to preserve local healthcare capacity and ensuring that the needs of our communities are considered in future planning. Participation in discussions with municipal and provincial representatives is consistent with the Hospital's mission and strategic priorities, particularly equitable access to care, system integration, and future planning. As discussions evolve, there may also be opportunities to consider how local healthcare organizations can contribute to sustainable models of care that better meet the needs of an aging population.
- Any future opportunities for greater involvement would require careful consideration of financial sustainability, operational capacity, governance responsibilities, and alignment with the Hospital's strategic direction.

In considering HGMH's continued involvement, the Board is asked to consider:

- *The importance of maintaining local long term care capacity and its relationship to the Hospital's mandate and strategic priorities.*
- *The potential impact on patients, families, hospital operations, and the broader healthcare system.*
- *The appropriate scope of HGMH's involvement in advocacy, consultation, and collaborative planning, while remaining open to opportunities that may emerge through these discussions.*
- *The importance of evaluating any future proposals against organizational capacity, financial sustainability, community benefit, and long term strategic alignment.*
- Management is seeking the Board's perspectives on the potential implications of the Palace Long Term Care Home closure and its general support for HGMH to remain actively engaged in discussions regarding the future of local long term care capacity. This engagement would allow HGMH to contribute to community planning, explore potential partnerships, and assess opportunities that may align with the Hospital's long term strategic direction. As discussions progress and potential options become clearer, management would return to the Board with any proposals requiring further consideration or formal approval.

## SUPPORTING DOCUMENTS/ATTACHMENTS

*List any supporting documents or attachments*

- *October 1 Letter To MOLTC Consultation Process*

October 1, 2026

**Submitted by:** Robert Alldred-Hughes, President & CEO  
Hôpital Glengarry Memorial Hospital  
Alexandria, Ontario

**Sent via e-mail:** *LTCHomes.Licensing@bursonglobal.com*

**Project #26-017: Submission to the Ministry of Long Term Care License Consultations -  
Southbridge Cornwall 2 Long Term Care Development Proposal - Regarding the Proposed  
Relocation of 70 Long Term Care Beds from The Palace, Alexandria**

To whom it may concern:

Hôpital Glengarry Memorial Hospital appreciates the opportunity to provide comments regarding the proposed Southbridge Cornwall 2 long term care development.

HGMH supports the modernization and redevelopment of long term care infrastructure in Eastern Ontario and recognizes the importance of ensuring residents have access to modern, safe and appropriate environments in which to receive care.

We are, however, concerned about the proposal to relocate all 70 licensed long term care beds currently operated at The Palace in Alexandria to the proposed development in Cornwall.

The Palace is currently a 70 bed long term care home located in the heart of Alexandria. Yorkville Development LP and Southbridge Care Home's proposal indicates that these beds would be incorporated into the new 320 bed Southbridge Cornwall 2 development and that The Palace would close following completion of the new home.

HGMH respectfully requests that the Ministry undertake further consideration of the health system and community impacts associated with removing this long term care capacity from North Glengarry before making a final decision regarding the relocation of these beds.

**Maintaining health care capacity in rural communities**

HGMH is a rural hospital serving North Glengarry and surrounding communities. Our experience demonstrates the importance of maintaining an appropriate continuum of care close to home, including hospital, rehabilitation, primary care, home and community care, and long term care. The removal of 70 long term care beds from Alexandria would represent a significant reduction in local health care capacity.

Ontario's long term care legislation recognizes the importance of geography in determining long term care need. The Fixing Long Term Care Act requires consideration of existing long term care

bed capacity, other available health services, and current and predictable continuing demand when determining the appropriate number of long term care beds in an area.

We believe these considerations warrant a specific assessment of North Glengarry before existing beds are permanently relocated to another community.

### **An aging rural population**

North Glengarry and the broader communities served by HGMH have an aging population. HGMH's own long range planning anticipates substantial growth in the number of older adults requiring health services over the coming decades.

Long-term care infrastructure decisions being made today will therefore have implications well beyond the immediate redevelopment of an individual home.

Waiting lists represent only one measure of future need and can change over time. A long-term planning decision should also consider population aging, future demand, rural geography and the availability of other health and community services.

### **Impact on hospital capacity and patient flow**

Access to long-term care is directly connected to hospital capacity.

HGMH operates acute medical and regional rehabilitation beds and regularly cares for patients who require additional support before they can safely return to the community or transition to another care environment.

A reduction in long term care capacity within the community has the potential to affect hospital discharge options, alternate level of care pressures, caregiver burden and the ability of residents to remain close to their families and existing supports.

Before the relocation is finalized, HGMH recommends that the Ministry, in collaboration with Ontario Health, assess the potential impact on hospital flow, alternate level of care, home and community care services and future long term care demand within North Glengarry.

### **Rural, linguistic and community access**

HGMH is a designated bilingual hospital serving a community with a significant Francophone population. Maintaining access to health services within rural communities is particularly important for older adults, whose ability to travel may be limited and whose family and social supports are often closely connected to their home community.

Relocating long term care capacity approximately 40 kilometers away to Cornwall changes more than the location of a building. It can affect family involvement, continuity with local health providers, community connections and access to services in the resident's language of choice.

These impacts should form part of the Ministry's consideration of the proposal.

**An opportunity to explore a local redevelopment solution**

HGMH is not suggesting that an aging long-term care facility should be maintained indefinitely if it no longer represents an appropriate environment for residents.

Rather, we respectfully suggest that redevelopment of long-term care capacity and relocation of that capacity are two separate questions.

Before Alexandria's 70 long term care beds are permanently relocated, HGMH recommends that the Ministry, Southbridge Care Homes, Ontario Health, the Township of North Glengarry and local health system partners explore whether there is a viable option to retain long term care capacity within North Glengarry.

HGMH would be pleased to participate in those discussions.

The hospital is currently undertaking long range planning regarding the future of its campus and the integration of health and community services. This creates an opportunity to consider whether long term care could form part of a broader local health services strategy, either through redevelopment by the existing operator or through another partnership model.

HGMH is not proposing through this submission that the hospital become a long term care operator. We are, however, prepared to explore how our hospital, our campus, our clinical services and our community partnerships could contribute to a sustainable local solution.

**Our request**

HGMH respectfully requests that the Ministry:

1. Consider the impact of removing 70 existing long term care beds from North Glengarry as a distinct component of its review of the Southbridge Cornwall 2 proposal.
2. Assess current and projected long term care requirements for North Glengarry, including population aging, rural geography, Francophone access, hospital utilization, alternate level of care pressures and availability of community services.
3. Engage HGMH, the Township of North Glengarry, Ontario Health, Southbridge Care Homes and other appropriate community partners in discussions regarding opportunities to retain long term care capacity in North Glengarry.
4. Explore whether all or a portion of the existing 70 licensed beds could be redeveloped within North Glengarry rather than permanently relocated to Cornwall.

HGMH recognizes the need to modernize Ontario's long term care infrastructure and supports investments that improve the quality of care and living environments for residents.

At the same time, modernization should not unintentionally result in the erosion of essential health care capacity in rural communities.

The proposed relocation of 70 long term care beds represents a significant health system planning decision for North Glengarry. We believe there is an opportunity to work collaboratively with the Ministry, Southbridge, Ontario Health and our municipal and community partners to find a solution that supports redevelopment while preserving access to long term care for the residents of North Glengarry.

We would welcome the opportunity to participate in those discussions.

Sincerely,



Robert Alldred-Hughes  
President and Chief Executive Officer

Cc.

*Ryan Bell, CEO of Southbridge Care*

*Vicky Simanovski, Interim Chief Regional Officer, Ontario Health East*

*Carl Bonura, Director, Capacity, Access & Flow, Ontario Health East*

*Stéphane Sarrazin, MPP, Glengarry-Prescott-Russell*

*Mayor Jamie MacDonald, Township of North Glengarry*

*Louise Boyling, HGMH Board of Directors Chair*

*Rachel Romany, Vice President of Clinical Services, Quality, & Chief Nursing Executive*



# HGMH Board Retreat Discussion Notes and Takeaways

These notes from HGMH's Board Retreat on October 3, 2026 provide an overview of the presentations and discussion to guide the organization's next steps in becoming an integrated health hub.

## Participants

Louise Boyling, Board Chair  
Charlotte Nagy, Board Treasurer  
Brigitte Pulice, Board Director  
Francois Desjardins, Board Director  
Gordon Peters, Board Director  
Raynald Cardinal, Board Director

Robert Alldred-Hughes, President & CEO  
Rachel Romany, VP Clinical Services, Quality & CNE  
Linda Ramsay, VP Corporate Services & CFO  
Kayla MacGillivray, Chief Human Resources Officer  
Dr. Lisa MacKinnon, Chief of Staff  
Dr. Dale Pepper, President of Professional Staff Association

## Focus and Next Steps

HGMH Board members and senior leaders gathered to generate fresh thinking about the organization's broader role in working with partners to become an integrated health hub that offers people in north Glengarry greater access to the services they need. This evolution must be done with awareness of the community's rural nature, age and demographic trends, and related needs such as transportation that affect access to care and support.

Coming out of the session, participants identified the following as important next steps for HGMH:

1. Develop an initial vision of community health that can evolve as HGMH engages with community members.
2. Develop a shared understanding of community needs, existing services, gaps in care and support and possible overlaps — grounded in data and stories.
3. Identify opportunities for change to address gaps, leverage existing resources across partners, and attract new investment where possible.

# Recapping the Day

## Welcome, Introduction and Process

Chair Louise Boyling offered a land acknowledgement and reflections on the opportunity of the day as HGMH moves toward becoming an integrated health hub. The intent of the retreat was clarified:

- Learn about health system trends and the experiences of other communities that are working toward integrated health hub models, including Deep River.
- Develop a shared vision for, and understanding of, the next best steps for HGMH.

Facilitator Pamela Smit of Veradus Consulting reviewed the overall process and flow for the day. Each participant introduced themselves.

## Future of Rural Health and What it Means for HGMH

Deloitte Partner and Chief Medical Officer Dr. Tom Stewart spoke about emerging health system trends and what to consider when advancing toward becoming an integrated health hub, supported by examples of what is happening in different communities. Societal shifts, technological change, fiscal challenges, and new modes of care focused on promoting wellness are converging to place new demands on — and create new opportunities for — healthcare organizations including HGMH. (The slide deck prepared in advance is attached for information.)

### Key takeaways

#### *Work across the system*

- Work as one team across the system to provide care and support in an integrated way
- Establish a shared value proposition that articulates what we are here to do for the community
- Create energy around “this is the right thing to do”
- Focus on growing together

#### *Focus on equity and wellness*

- Recognize that rural Canadians face equity challenges and a higher burden of chronic illness
- Focus on upstream wellness and work to prevent chronic conditions (e.g., eight risk factors result in 15 chronic conditions that represent 80% of the cost of healthcare)
- Embrace a broad understanding of what contributes to good health, including housing, social connection, navigation support and supports for people to live longer at home
- Invest in infrastructure to enhance access to community supports that are less costly than acute and long-term care

#### *Understand gaps and harness assets*

- Recognize that every community is different with unique needs, capacity, and access to services
- Conduct a gap analysis and collect shared community health data to map current state and envision an ideal future state
- Engage partners to harness a range of assets including public, private and volunteer resources
- Consider different partners that may currently be underutilized (pharmacists, paramedics)

#### *Get things done — rather than getting them ‘perfect’*

- Lead with a focus on what residents need, not governance

- Start with simple partnerships
- Develop simple fixes that can make a big difference, e.g.:
  - Leverage digital connectivity to understand the whole person and their needs
  - Avoid too many handoffs across partners, which create angst and waste resources
  - Identify high-intensity service users and establish one team, one medical record, one number to call for all their needs

*Develop a resilient workforce*

- Adopt measures to recruit, retain and grow local
- Recognize that retention improves when staff are happy and can get things done
- Invest in helping people stay at work or get back to work faster
- Consider offering supports for employees such as navigation for elder care, prevention of chronic illness, support for mental health and substance use issues

*Highlight economic impacts*

- Make the case for return on investment to the government and the community when access to services is enhanced
- Identify economies of scale across partners
- Showcase the contribution of health services to the local economy

## Building an Integrated Health Hub: The Deep River Experience

Deep River and District Health CEO Janna Hotson spoke about her organization's journey toward becoming an integrated health hub, including how the model evolved, partnerships and integration, lessons learned, challenges encountered and considerations that may be relevant to HGMH. (Presentation slides are attached for more information.)

### Key takeaways

*Understand your starting point*

- Respect that each community and path forward is unique given different stages of integration
- Appreciate that change is not an overnight process

*Adopt an integrated population and community health approach*

- Engage broadly to develop a clear understanding of current and future needs
- Engage effectively to understand community priorities for action that can guide service development
- Let community need shape organizational direction

*Be deliberate about the role of your organization*

- Adopt a philosophy of helping people find the *right* support — not just or not necessarily *our* support
- Be clear and transparent that being a hub is not about what the organization develops, owns or delivers
- Respect and acknowledge sector differences and identities including culture, practice, skills and boundaries

*Enhance workforce opportunities and impact*

- Share expertise and capacity to strengthen support for smaller programs
- Be more flexible with recruitment and employment opportunities
- Build skills and grow local capacity

*Match ambition with capacity*

- Consider the risks of not acting to preserve the long-term sustainability of local services in rural communities
- Plan for growth and sustainability
- Monitor developments and combined demands on leadership and staff involved in advancing the work

## HGMH's Future: Clear Vision, Defined Direction

Building on the learnings from the speakers and discussion, participants explored the future role for HGMH and identified the next best steps to evolve as an integrated health hub. As summarized on page 1, those steps are to:

1. Develop an initial vision of community health that can evolve as HGMH engages with community members.
2. Develop a shared understanding of community needs, existing services, gaps in care and support and possible overlaps — grounded in data and stories.
3. Identify opportunities for change to address gaps, leverage existing resources across partners, and attract new investment where possible.

The HGMH senior leadership team will engage in strategic action planning to advance this work with governance oversight from the Board. As the work unfolds it will be important to:

- Embrace a broad understanding of community and population health as seen through and guided by an equity lens (e.g., aware of rural living conditions, francophone language needs, impacts of aging, Indigenous heritage, income level, etc.), with a 'whole person' wellness focus.
- Lead with a focus on meeting community needs and developing a shared vision that builds relationships and trust with partners.
- Engage broadly with community members, partner organizations and employees.
- Be open that HGMH's role could evolve as an anchor organization, and advocate for community health alongside a physical hub for co-located services — remembering this is not just about HGMH's building and services.
- Be nimble and focus on action, seizing opportunities to get traction to meet community needs in an integrated way with partners.
- Make the case for change to save and reinvest funds as HGMH addresses pain points and inefficiencies while growing and sustaining services to better meet community needs.

## Reflections and Closing

Feedback on the day was positive. Directors and senior leaders are keen to evolve HGMH toward becoming more of an integrated health hub. Participants reiterated the importance of grounding the work in a clear understanding of community need while being open to working through biases and differences in perspective. It was acknowledged this is a long-term process that will require focused time and resources to advance and sustain the work.



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Dr. Tom Stewart, Partner and Chief Medical Officer at  
Deloitte, presents the

# The Future of Rural Health: What Does it Mean for HGMH?

October 3<sup>rd</sup>, 2026

1



HGMH BOARD PRESENTATION | DRIVING IMPACT AS AN ONTARIO RURAL HEALTH SYSTEM

## Agenda

*Joining you today*



**Dr. Tom Stewart**

1. Our Activity in Rural Health
2. Future of Health
3. Health-Productivity Gap
4. Closing and Q&A

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2

HGMH BOARD PRESENTATION | DRIVING IMPACT AS AN ONTARIO RURAL HEALTH SYSTEM

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## Trends Reshaping Healthcare and What They Mean for HGMH

Public healthcare in Canada is increasingly shifting toward partnership, equity, prevention, and innovative models.

### One team, one goal

Work as one team with primary care, EMS, long-term care and community agencies through the OHT.

### A shared value proposition

Commit to transparent, timely reporting on what shared investments deliver for the community.

### Equity by design

Rural access is an equity issue: distance, transportation, Francophone patients, seniors living alone.

### Shared data, earlier action

Connected records and shared community health data, so we see the whole patient, not just the visit, and can act on root causes.

### A resilient workforce

Recruiting and retaining in a rural market means developing local pipelines and broader skill mixes that flex across roles.

### Funding for wellness

Diversify beyond base funding and volume, instead align incentives with wellness and health promotion.

Source: Deloitte Strategy Engagement

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## How to Mobilize A Connected Rural Health System

An empowered local ambassador converts public-sector authority into a partner network, with a community navigator guiding residents across it.

1

### Empowered ambassador

A trusted local figure receives authority from the Mayor or Ministry of Health

2

### Needs assessment

Assess what residents actually need to define the ideal future state

3

### Gather partners

Recruit the organizations that can fill each identified gap

4

### Community navigator

One guide helps residents move across every service

Authority granted by the Mayor / Ministry of Health

One navigator connects residents to every partner

Primary care
Hospital & ED
Transportation

Community Navigator

Long-term care
Housing & social supports
Mental health & addictions

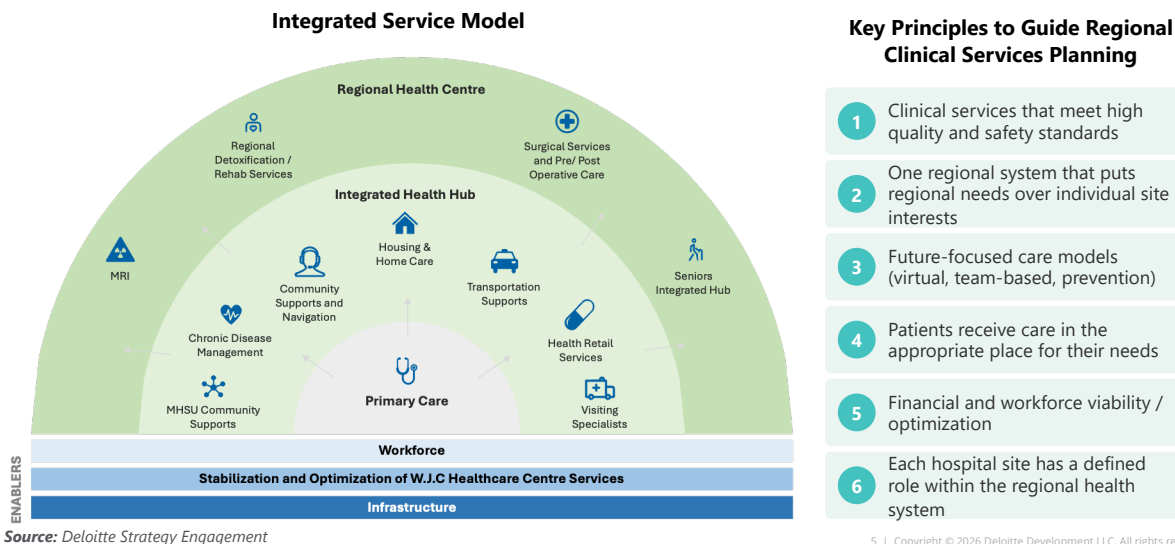
Source: Deloitte Strategy Engagement

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## How to Anchor Your Future State Model in the Community's Needs

Shared principles can align multiple individual sites around one regional system while preserving local demand and delivery.



5

## Example: Stelmach Community Wellness Centre

Alberta's first community-based, one-stop wellness destination, operated by Covenant Health.



- Opened in June 2026 in southeast Edmonton (Mill Woods), as the **first phase of the Covenant Wellness Community**
- **One community location** for outpatient clinics, primary care and diagnostics
- **Clinics moved out of Grey Nuns Community Hospital**, easing acute-care pressure, with urgent care planned in the next phase

Source: Covenant Wellness Community

### Services under one roof

|                        |                       |
|------------------------|-----------------------|
| Primary care clinic    | Seniors' clinic       |
| Diabetes clinic        | Heart function clinic |
| Cardiac rehabilitation | Stroke prevention     |
| Neurology clinic       | ENT clinic            |
| Orthopedics            | Plastic surgery       |
| Nutrition counselling  | Geriatric psychiatry  |
| Pre-admission surgery  | Diagnostic imaging    |

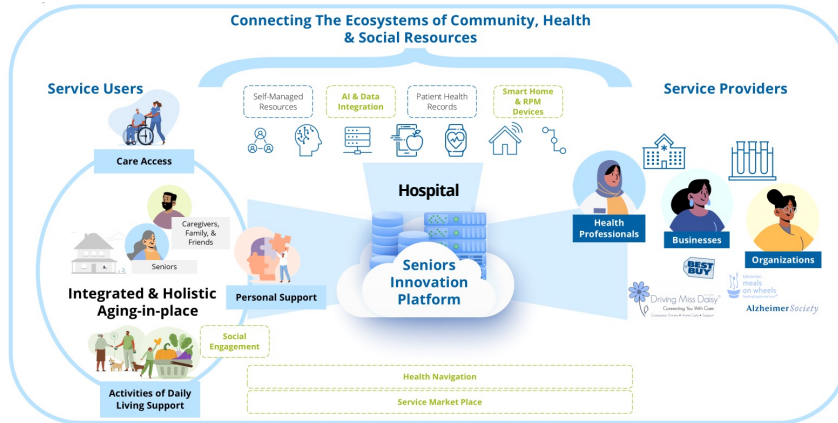
Plus a women's health clinic, vision and hearing clinics, pathology, nutrition and day programs, retail health tenants (dental, sleep clinic) and a planned urgent care centre.

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## One Digital Layer to Enable One Rural System

The digital layer should make the rural network function as one system by connecting information, teams, and navigation across settings.



### Outcomes

- Provide alternative models that support primary care
- Streamline service & care processes to reduce expenditures
- Enable data-driven decision-making and support to promote health
- Improve experiences of patients and families
- Improve accessibility & inclusivity for older adults
- Generate lasting benefits for providers and practitioners

Source: Deloitte Strategy Engagement

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## What the Push to Integrated Care Looks Like in Rural Communities

The question shifts from "What should the hospital own?" to "How should the community's services work as one system?" which is a gradual process with many steps along the way.

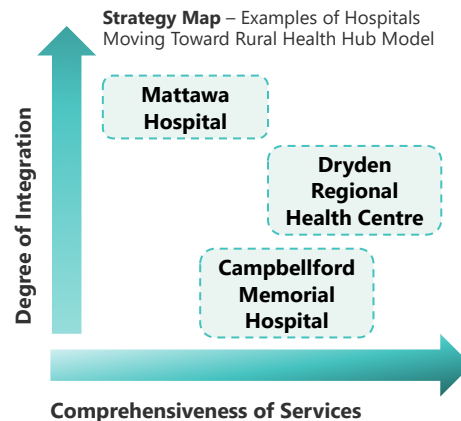
**Degree of Integration** – how formalized the clinical, management and governance linkages between health service providers are



**Degree of Comprehensiveness** – the range of services that are locally available and co-located



**Strategy Map** – Examples of Hospitals Moving Toward Rural Health Hub Model



Source: Ontario Hospital Association ("Local Health Hubs for Rural and Northern Communities"; "Enhancing Access Through Integration")

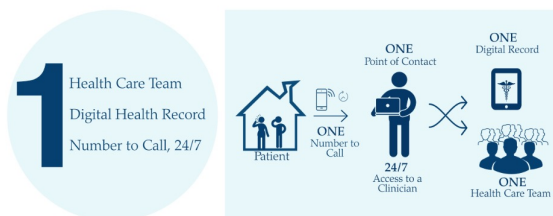
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## Integrated Care Example: St. Joseph's Health Systems

One team, one record, one number and one fund create continuity from hospital to home and align accountability around the full patient journey.

### Integrated Comprehensive Care (ICC) Model



### Impact

**\$4,000**

Capacity savings per patient

**30%**

Reduction in ED visits

**30%**

Reduction in re-admissions

**98%**

Patient satisfaction rating

### Keys to Success

- Integrated organizational / leadership structure creates strategic alignment
- Shared resources and best practices across individual sites
- Integrated model promotes efficiency and mobility

### Other strong examples of system integration

**Humber Meadows:** CEO of HRH sits on the Board of this LTC home

**Renfrew Victoria & St. Francis Memorial:** Shared CEO across two rural hospitals

Sources: St. Joseph's Health System; Humber Meadows; Renfrew Victoria; St. Francis Memorial

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## Implications and Next Steps for HGMH

HGMH's strategic opportunity is to become the trusted local integrator of care with clearer integration, governance, and digital enablement.

### The Building Blocks for HGMH's Future Model

- 1 Follow a structured, **needs-first** planning sequence, designed for HGMH's specific population
- 2 Create **shared principles** across organizations to achieve "one regional system"
- 3 Develop a **technology / data layer** that connects health records and community data in one system that simplifies access to necessary supports for vulnerable populations (e.g., seniors)
- 4 **Shared leadership roles** across sites / from hospital to LTC and other community supports can drive integrated care
- 5 Pursue a blended, **sustainable funding approach**, combining government investment with recurring operational revenue

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# Future of Health

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## Several forces are propelling us to the Future of Health™

Recent external pressures and key forces have accelerated the time horizon towards Future of Health™.

### MACRO FORCES

#### Environmental, Social Governance (ESG)

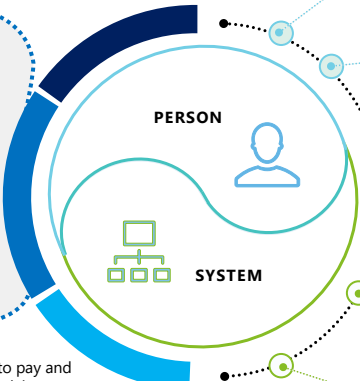
**Climate Change** - The complex relationship between climate change and health has become increasingly pronounced

**Health Equity** - Increased focus on helping individuals achieve their full health & wellbeing regardless of race, income, gender, etc.

**Stakeholder Alignment** - Growing alignment between C-Suite, consumers, and employees around ESG elements

#### FISCAL CHALLENGES

Driven by constraints on ability to pay and continuous demand growth—implying ongoing need for action across the ecosystem



### FUTURE OF HEALTH™ FORCES

Enhanced roles of consumers and patients in health care journey

Proliferation of digital, data and AI to enable smart health care

Technology & data ubiquity

Formation of local ecosystems for breakthrough health care innovation and industrialization

Diversification of health care funding models and integration with care

Sick care to health care

Source: Deloitte Future of Health

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## The Next Waves of Healthcare

Driven by technology, data and AI advancements, three waves of innovation are going to catalyze industry change and move towards new networks and eco-systems focused on a holistic view of health.

### Wave 0 Legacy Incumbents & Silos

- Separate entities / assets serve a given need
- Siloed orgs with misaligned macro-level incentives
- Business model: Reimbursement-based sick care, fee for service

### Wave 1 Fragmentation

- Proliferation of new tools, care models, data and consumerism fracture the rigid incumbent system
- Other macro dynamics accelerated this fragmentation e.g., long wait times due to lack of \$, workers, or both
- Business model: More towards evidence-based sick care, still dominantly fee for service

WHERE WE ARE NOW

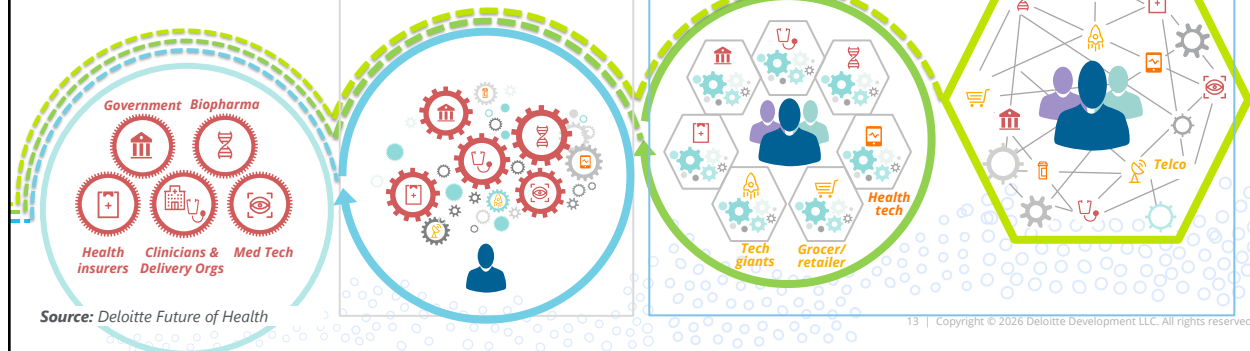
### Wave 2 Re-Assembly

- Reconstruction around the empowered person or patient, leveraging data & new care experiences
- Data is connected, and key players converge
- Business model: Intelligence-based sick care, fee for health emerges

### Wave 3 Flow

- Networks and ecosystems become increasingly sophisticated
- Value from the system comes from wellness rather than only sick care
- Business model: intelligence-based health care and wellness

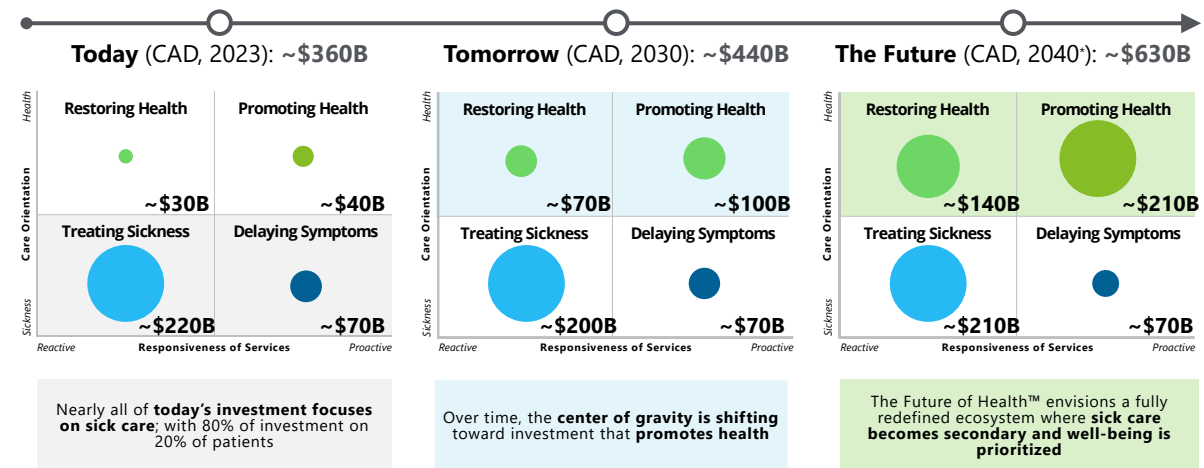
FUTURE OF HEALTH™



13

## Funding Models Are Shifting Toward Health and Wellness Outcomes

In line with these focus areas, spend will shift upstream, as the human, societal and financial returns for promoting health and well-being are shown to outweigh those related to treating symptoms and disease.



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# Health-Productivity Gap

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## Canada's Productivity & Health Gap

The Health Productivity Gap aims to answer two key questions: "How much productive capacity does Canada forgo when illness prevents full participation in the workforce?" and "How much of that capacity could be recovered by those workers?"

Productivity determines how much value workers create, and ultimately supports better wages, jobs, and living standards.

\$100B

▶

Canada's estimated 2025 loss in economic output comprised of caregiving, morbidity, and mortality costs

Economic loss  
\$79 billion



Recoverable  
\$25 billion

Targeted improvements to health care could add **over \$25 billion** to the Canadian economy.

"Get this right, and we don't just fix healthcare. We redefine what the economy is capable of, shaping how Canadians live and work, organizations perform, and Canada competes."

Scan here for Full Report

ENGLISH



FRENCH



Source: Deloitte Report ("The Health Productivity Gap (HPG)")

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### Seven action to narrow the Health Productivity Gap

**ACTION 1:**  
Enroll every Canadian in a Health Home

**ACTION 2:**  
Make prevention proactive & personalized

**ACTION 3:**  
Remove barriers to participation

**ACTION 4:**  
Give individuals financial tools for prevention

**ACTION 5:**  
Create capacity from what we already have

**ACTION 6:**  
Meaningfully digitize health infrastructure

**ACTION 7:**  
Redesign financing & incentives

Scan here for Full Report

ENGLISH

FRENCH

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## Move Upstream

**8 risks and behaviors**

drive **15** chronic conditions

1. Diabetes
2. Coronary Artery Disease
3. Hypertension
4. Back Pain
5. Obesity
6. Cancer
7. Asthma
8. Arthritis
9. Allergies
10. Sinusitis
11. Depression
12. Congestive Heart Failure
13. Lung Disease (COPD)
14. Kidney Disease
15. High Cholesterol

accounting for **80%** of total costs for all chronic illnesses worldwide

**AON Hewitt 2012 Health Care Survey**

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**DEEP RIVER &  
DISTRICT HEALTH**

## Building an Integrated Health Hub: *The Deep River Experience*

Janna Hotson  
President, Chief Executive Officer & LTC Administrator  
Deep River and District Health

Hôpital Glengarry Memorial Hospital (HGMH) Board Retreat | October 3, 2026

1

### About your Presenter



**Janna Hotson MHA, RN, CHE**  
President and Chief Executive Officer,  
Deep River and District Health

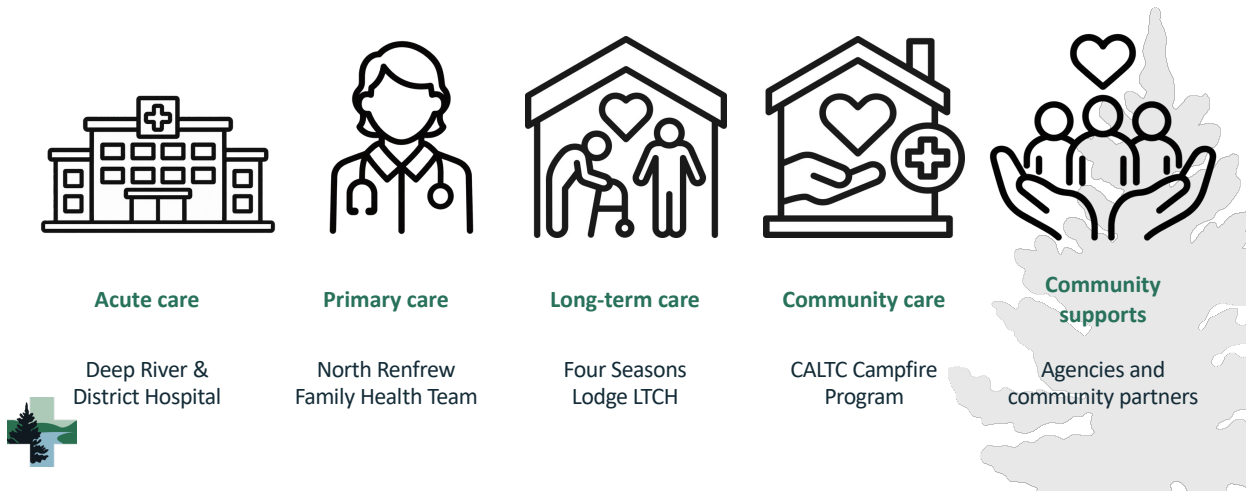
- Registered Nurse
- Masters in Healthcare Administration
- Certified Healthcare Executive with the Canadian College of Health Leaders
  - *Recipient of CCHL Eastern Chapter 2026 Distinguished Service Award*
- Administrator, Four Seasons Lodge Long-Term Care Home
- Surveyor with Accreditation Canada
- Professor in Business, Technology and Outdoor Training at Algonquin College
- Peer Assessor, Quality Assurance, College of Nurses of Ontario
- 20+ years of experience across healthcare sectors and settings



2

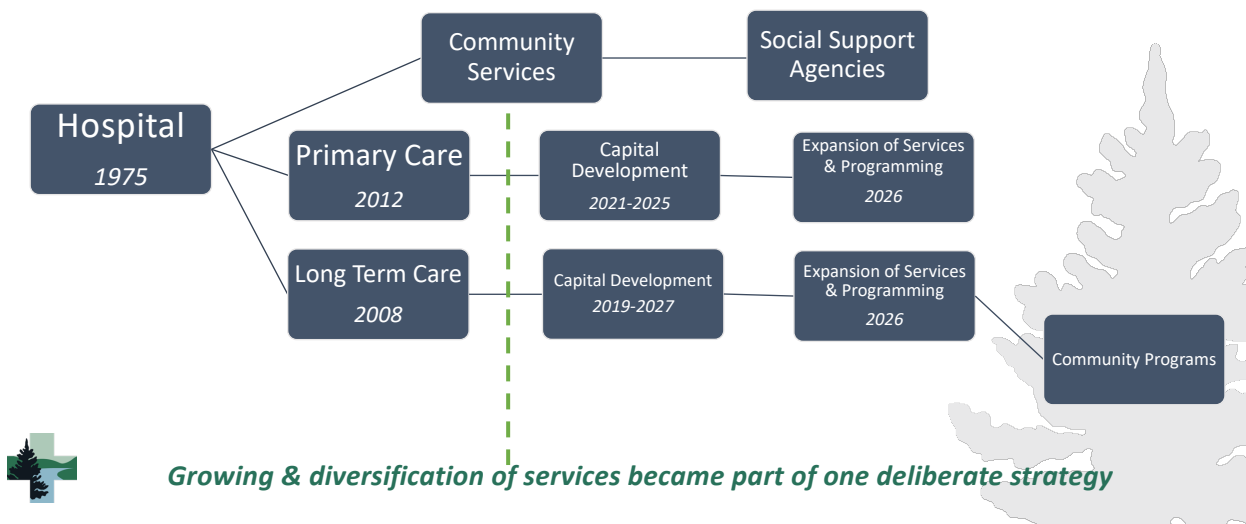
## Who We are – Deep River and District Health Campus

### One integrated Campus of Care



3

## From Rural Hospital to Rural Health Hub



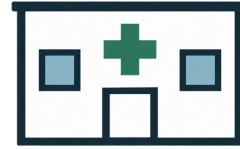
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## — The Strategic Shift: From Institution to Population Health

*How do we sustain our hospital?*



*How do we sustain the health of our community?*



5

## — The Strategic Shift – The Path

*A conscious decision to look broadly at current and future need*



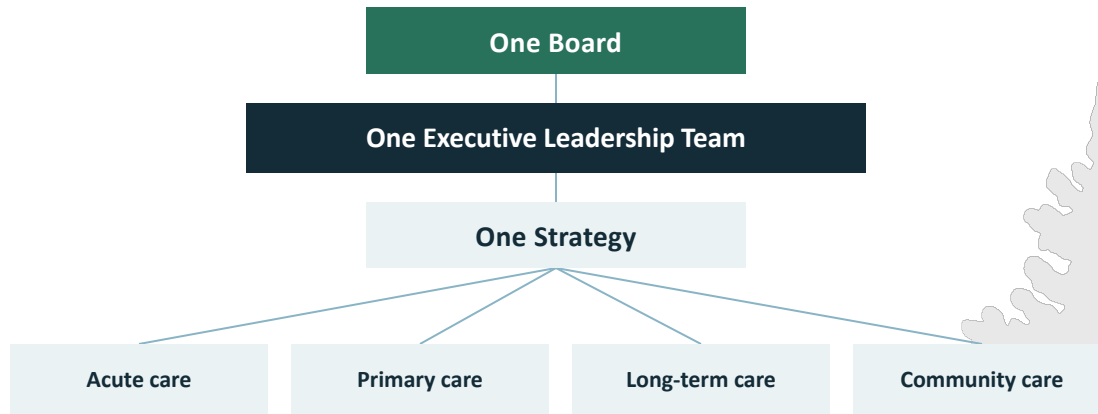
**DRDH as an anchor and facilitator**

Connect partners and support development around need



6

## The Foundation: One Governance and Leadership Structure



Campus & Community priorities guide decisions across sectors

7

## A coordinated platform for investment

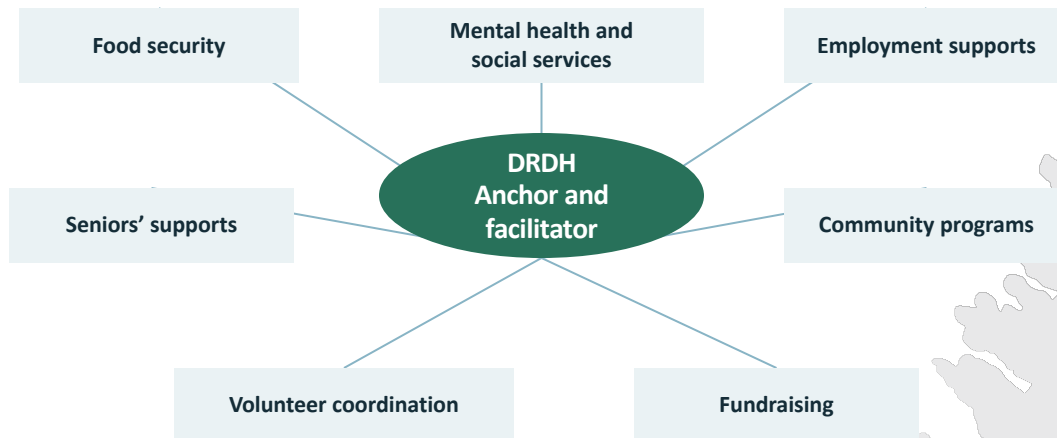
|             |                |                                           |
|-------------|----------------|-------------------------------------------|
| 2021 - 2025 | Primary care   | Purpose-built Family Health Team facility |
| 2023 - 2026 | Hospital       | ED registration, triage and waiting area  |
| 2018 - 2027 | Long-term care | Replacement and expansion to 96 beds      |
| 2024 - 2028 | Hospice        | Residential palliative care on campus     |
| 2026        | Community      | Community programming and care on campus  |



*Shared planning connects each project to the continuum*

8

## DRDH Shifts to an Anchor and Community Facilitator



9

## What integration changes



### Patients and community

- More care close to home
- Easier transitions in care
- Earlier support as needs change
- Community priorities shape services

### Organization

- Community needs guide plans
- Shared expertise and infrastructure
- Aligned investment and programs
- Capacity for new services

### Staff and physicians

- Broader career pathways
- Learning across sectors
- Flexible roles and recruitment
- Shared expertise and leadership support

*Shared capacity brings greater complexity and sector accountability*

10

## Workforce Opportunities and Local Impact

### Shared expertise and capacity

- Shared leadership and corporate expertise give smaller programs access to stronger support.

### Careers that grow locally

- Build skills and move across programs without leaving the community.

### More flexible recruitment

- Combine physician work across settings and offer a wider range of clinical roles.

~\$8M

Estimated annual wages  
from LTC & Program expansion  
at full operation

Local jobs and wages support  
community sustainability



11

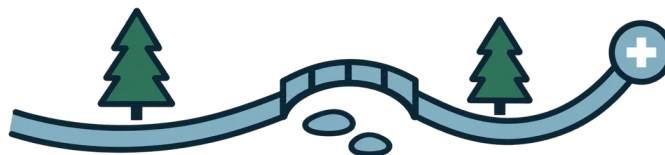
## Enablers and challenges along the way

### What helps integration

- Knowledge across sectors
- Respect for practice and culture
- Strongest applicable practices
- Shared organizational expertise
- Transparent decisions

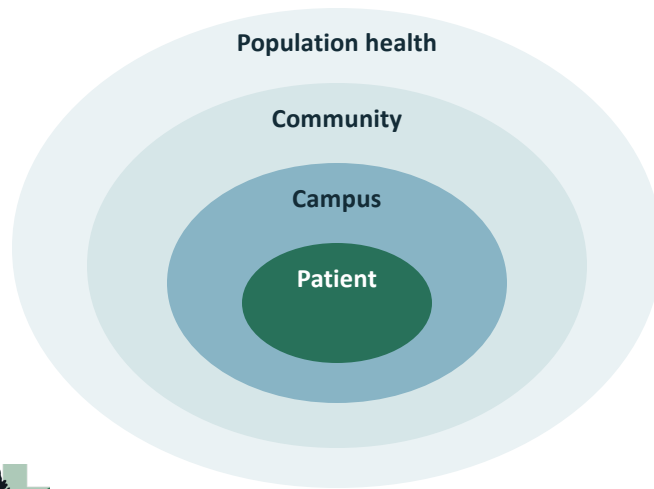
### What needs attention

- Hospital assumptions
- Wages and funding
- Leadership equity
- Capacity and pace
- Sector boundaries
- Ministry & Partner Barriers
- Governance Expectations



12

## The next stage of our health hub



### Community Care

Campfire bridges home and LTC  
Transportation & Access

### Residential hospice

Key piece of care continuum & access

### Social & Health Supports

Building relationships to welcome  
partners & agencies on site

### Healthy environments

Naturalized campus and  
environmental initiatives

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## Three Lessons for Board Looking Ahead

### 01 Let community need shape organizational direction

Use population data and community experience to guide priorities, investment and the organization's evolving role.

### 02 Be deliberate about the role your organization should play

Decide where to deliver, partner or facilitate. Build governance that understands and represents each sector.

### 03 Match ambition with capacity and accountability

Assess operating funding, workforce, leadership capacity and sector requirements alongside every growth opportunity.



*What does your community need from you, and what would make that sustainable?*

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## MAC Minutes



### MINUTES OF THE MEDICAL ADVISORY COMMITTEE MEETING

*October 6, 2026, at 12:00pm*

**Boardroom / MS TEAMS**

Present: Dr. L. MacKinnon Dr. D. Read  
R. Alldred-Hughes, CEO Dr. C. McCudden

Absent: Dr. D. Pfeffer R. Romany, CNE Dr. S. Farmer

#### **CALL TO ORDER**

The meeting was called to order at 12:04 p.m.

#### **Quorum**

A quorum was attained.

#### **Adoption of Agenda**

The agenda was adopted as presented.

Add 3.0: presentation for hs-Troponin

Motioned by: Dr. D. Read

Seconded by: Dr. L. MacKinnon

THAT the Medical Advisory Committee approve the agenda as presented.

**CARRIED**

#### **Declaration of Conflict**

No declaration of conflict of interest noted.

#### **REPORT OF THE LAST MEETING**

##### **Approval of the Minutes**

The minutes of the last meeting held on September 1, 2026, were included in the package and approved with correction that Dr. Farmer is taking a step back from her Chief of Emergency role.

Motioned by: Dr. L. MacKinnon

Seconded by: Dr. D. Read

THAT the Medical Advisory Committee approve the previous meeting minutes as presented with corrections.

**CARRIED**

#### **STANDING ITEMS**

##### **Presentation hs-Troponin**

Dr. McCudden provided an update on the implementation of high-sensitivity troponin testing, which will go live with Epic on October 24, 2026. Dr. McCudden plans to be on-site the morning

## MAC Minutes

of go-live to assist with questions and provide support. A memo and the presentation will also be circulated to the ED teams this week.

### Attendance Summary

Deferred.

### Physician HR Plan

#### HR Plan Discussion:

Dr. MacKinnon led the discussion regarding the HR Plan included in the meeting package noting that Dr. Ameen and Dr. Schryver seem to be doing well, and we are hopeful that Dr. Benoit enjoys her first week (in November) and wants to stay.

### ED P4R Patient Flow Update

The P4R metrics were included in the package.

### Quality/Patient Experience (Quarterly)

Deferred.

### Quality Updates: Critical Incidents & Quality of Care Review (May/Nov)

None to bring forward.

### Epic Update

The training went well although we are unsure who has successfully completed their login labs. S. Laframboise will follow up with D. Lorimer regarding the physician group statistics.

## **BUSINESS ARISING**

### BBOC Update

Dr. Read advised that an email was circulated to the Inpatient physician group regarding BBOC payments; however, no responses have been received to date. There are no changes to the current process for Emergency physicians. A discussion also took place regarding the admissions process.

### Physician Satisfaction Survey

Deferred.

## **ITEMS FOR DISCUSSION/DECISION**

### Pharmacy & Therapeutics

#### Formulary Change Request Levofloxacin

**Recommendation:** to approve the formulary change request: addition of Levofloxacin as presented.

Motioned by: Dr. L. MacKinnon

Seconded by: Dr. D. Read

## MAC Minutes

THAT the Medical Advisory Committee approve the formulary change request: addition of Levofloxacin as presented.

**CARRIED**

Formulary Change Request: addition of Ondansetron ODT 4mg

**Recommendation:** to approve the formulary change request: addition of Ondansetron as presented.

Motioned by: Dr. L. MacKinnon

Seconded by: Dr. D. Read

THAT the Medical Advisory Committee approve the formulary change request: addition of Ondansetron as presented.

**CARRIED**

Formulary Change Request: removal of Sumatriptan-DHE

**Recommendation:** to approve the formulary change request: removal of Sumatriptan-DHE as presented.

Motioned by: Dr. L. MacKinnon

Seconded by: Dr. D. Read

THAT the Medical Advisory Committee approve the formulary change request: removal of Sumatriptan-DHE as presented.

**CARRIED**

Formulary Change Request: addition of Enoxaparin – Elonox and removal of Redesca

**Recommendation:** to approve the formulary change request: addition of Enoxaparin – Elonox and removal of Redesca.

Motioned by: Dr. L. MacKinnon

Seconded by: Dr. D. Read

THAT the Medical Advisory Committee approve the formulary change request: addition of Enoxaparin – Elonox and removal of Redesca.

**CARRIED**

Formulary Change Request: removal of Triacomb 0.1% Cream

**Recommendation:** to approve the formulary change request: removal of Triacomb 0.1% Cream.

Motioned by: Dr. L. MacKinnon

Seconded by: Dr. D. Read

THAT the Medical Advisory Committee approve the formulary change request: removal of Triacomb 0.1% Cream.

**CARRIED**

## CREDENTIALS

### Evaluations

## MAC Minutes

Dr. Dr. Jacqueline Cochrane 12-month evaluation was completed by Dr. Read noting a good fit for this hospital. Dr. Cochrane is enjoying practicing here and staff and patient love her.

### REPORTS

#### Chief of Staff

Dr. MacKinnon shared the following key points:

- Discussions have taken place regarding primary care models and potential funding opportunities that may support local initiatives. We are contemplating submitting an application for a Family Health Team (FHT), including consideration of potential IPCT funding to establish an FHT administered by the hospital.
- Dr. Eric Bilodeau has requested a medical leave of absence (LOA) from December 2, 2026, to a gradual return to clinical duties at HGMH March 1, 2027.

Motioned by: Dr. L. MacKinnon

Seconded by: Dr. D. Read

THAT the Medical Advisory Committee approve medical leave of absence for Dr. E. Bilodeau from December 2, 2026 to a gradual return to clinical duties at HGMH March 1, 2027.

**CARRIED**

This approval is in accordance with the Professional Staff By-Laws section 3.10.

- Dr. Cherinet Seid had requested a personal leave of absence due to a change in personal circumstances. The requested leave was September 9 – mid-December 2026.

Motioned by: Dr. L. MacKinnon

Seconded by: Dr. D. Read

THAT the Medical Advisory Committee recommend to the Board of Directors to approve personal leave of absence for Dr. C. Seid from September 9 – mid-December 2026.

**CARRIED**

- Dr. MacKinnon is away for vacation November 16-30, 2026 inclusive. She will find suitable replacement coverage for this time period.

#### Chief of Emergency

Deferred.

#### Chief of Inpatient and Ambulatory Care

Upcoming meetings planned with Rehab Lead Physician and the Manager of Inpatient Unit and Patient Flow.

#### Professional Staff Association

Deferred.

## MAC Minutes

### Chief Executive Officer

R. Alldred-Hughes shared that our CT planning is moving forward and he is expecting to sign off on a purchase order soon that will be a turnkey model. Dr. Scharf's support in navigating discussions on future pathways has been beneficial.

### Chief Nursing Executive

Deferred.

### Consent Agenda

The minutes and reports include in the package were received and acknowledged.

### Date and Time of Next Meeting

The next meeting is scheduled for November 3, 2026, at 12:00 PM.

### Adjournment

The meeting was adjourned at 13:34 pm.

S. Laframboise, Recorder

## MINUTES OF THE MEETING OF THE EXECUTIVE COMMITTEE

Date Thursday, October 8, 2026  
Time 3:00PM  
Location Boardroom/Microsoft Teams  
Present: L. Boyling, Chair C. Nagy C. Larocque  
R. Alldred-Hughes, CEO Dr. L. MacKinnon, COS  
  
Regrets: None

### 1. Call to Order

L. Boyling, called the meeting to order at 3:00pm.

#### 1.1. Quorum

1.2. A quorum was present.

#### 1.3. Adoption of the Agenda

The agenda was reviewed and approved.

Moved By: C. Nagy

Seconded By: C. Larocque

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

#### 2.1. Approval of the Minutes

The minutes from the meeting held on April 16, 2026, were reviewed.

Moved By: C. Larocque

Seconded By: C. Nagy

THAT the minutes of the meeting of April 16, 2026, be approved as presented.

**CARRIED**

### 3. Matters for Discussion/Decision

#### 3.1 Review Personal Business Commitments Progress

##### 3.1.1 Personal Business Commitments of the CEO

The progress on the personal business commitments of the CEO were reviewed in which things are going well with no concerns.

##### 3.1.2 Personal Business Commitments of the COS

The progress on the personal business commitments of the COS were reviewed with the only item not yet started being the NVCI training as the focus at the moment is on Epic training.

### 4. Matters for Information

#### 4.1 Hospital Efficiency and Workforce Optimization Measures

Discussion ensued on efficiency measures to support the balanced-budget plan required by Ontario Health. Peer benchmarking identified higher PSW hours, prompting a planned reduction of 2.8 FTE for approximately \$143,000 in annual savings, alongside efforts to reduce overtime and premium pay. Other options were excluded due to safety concerns. The measures maintain current services, and no external communication is planned. The update was shared for information.

#### **4.2 Letter to MOLTC - Relocation of Long-Term Care Beds**

Discussion ensued around Southbridge's proposal to close The Palace and relocate long-term care beds from Alexandria and Plantagenet to a larger facility in Cornwall, noting potential impacts on inpatient capacity, discharge planning, and patient flow. HGMH submitted a letter to the Ministry of Long-Term Care outlining its concerns.

Since then, a meeting has taken place with the Mayor, Deputy Mayor, and CAO to discuss community and hospital implications. HGMH will also support the Township in a proposed meeting with the MPP.

#### **5. Date of Next Meeting**

April 8, 2027