MUSKOKA ALGONQUIN HEALTHCARE

"Proudly Serving our Communities - Delivering Best Patient Outcomes with High Standards & Compassion"

MASTER PROGRAM

Revised 2016 FEBRUARY

rpg

Resource Planning Group Inc.
502-703 Evans Ave.
Toronto ON M9C 5E9
T 416-498-5205 **F** 416-498-7907
E toronto@rpg.ca

208-1525 West 8th Ave.
Vancouver BC V6J 1T5
T 604-736-6426 **F** 604-736-4079
E vancouver@rpg.ca

www.rpg.ca

The content of this document is the product of a collaborative effort of Resource Planning Group Inc. and Muskoka Algonquin Healthcare and requires the formal approval of these parties prior to its use. The specifications herein do not absolve the parties providing subsequent design services from their own responsibility to provide fully functional and complete facilities and to satisfy applicable building code requirements.

This document is to be used solely by the Muskoka Algonquin Healthcare for the development and use of the project facilities. It is not to be reproduced or copied in any form for use on projects other than that for which the document was prepared.

Table of Contents **Page**

Executive Summary

EXECUTIVE SUMMARY

Introduction

Community hospitals have a key role to play as part of an integrated collaborative and sustainable system of care. Muskoka Algonquin Healthcare (MAHC) provides residents of the local community with equitable and reasonable access to quality health care services close to home. MAHC will continue in its role of improving access to care and of supporting and enhancing a "healthy community". It will continue to maintain effective linkages with larger centres and with community and primary care providers thereby not duplicating health care services at the community hospital level.

Special challenges being faced by community hospitals that may make the provision of some services difficult to sustain include:

- lower visit volumes
- lower access to health care professionals
- struggle to provide services to fluctuating population while maintaining our quality commitment
- shrinking funding
- small volumes/lack of critical mass
- duplication of many capital costs in 2-site acute care model
- duplication of many operating costs
- recruitment and retention of doctors and skilled staff
- aging facilities.

In addition to the above, MAHC acknowledges current changes occurring in the healthcare landscape that include:

- technology advancements/changing demographics
- aging populations have more complex needs
- provincial spending on hospitals will not grow; funding will flow to innovative strategies and to care provided in the community
- Ministry of Health & Long-Term Care focusing on primary health care in community:
  - major investments in Family Health Teams/Health Hubs/HealthLinks/Nurse Practitioners/Nursing Stations (e.g., Rosseau)/care in the home via CCAC
  - recently announced: Dorset, Port Carling, Wahta, and mobile hub for outreach.
- hospitals must be resourceful and continue to collaborate with community service providers

- diagnostic and treatment technology is changing rapidly, but at a cost
- hospitals are focusing on high-need, specialized care that can't be provided elsewhere.

MAHC is working with the North Simcoe Muskoka (NSM) LHIN, Orillia Soldiers Memorial Hospital (OSMH), Collingwood General and Marine Hospital (CGMH), Royal Victoria Regional Health Centre (RVRHC), Georgian Bay General Hospital (GBGH), Waypoint, and other health care partners, to develop innovative ways of delivering health care services to their communities in the future. These services will meet the future health care needs of Muskoka residents and align with the NSM LHIN's Integrated Health Services Plan (IHSP) and Ontario's Action Plan to Transform Health Care.

This Master Program for the MAHC Capital Development Project is built on previous planning work completed by the organization over the past three years. It has been advanced by the more recent extensive and ongoing exploration by MAHC to define its future role within an evolving health care system. The health care system as a whole is moving toward increased community resources better integration of community services and primary health care with MAHC and other hospitals in the NSM LHIN better coordination of care and a more appropriate use of hospital care. This Master Program therefore aims to respond to both internal and external forces in the short and long-term.

In consideration of the health system priorities and future directions MAHC established the following key objectives that were fundamental to the development of the Master Program:

- To create partnerships in the provision of care in support of a sustainable, accessible system of care.
- To reduce inappropriate admissions to hospital through innovative programs.
- To plan flexibility and capacity into the organization - thereby the hospitals will support future changes in the scope of service provision and service volumes without undue capital investment.
- To plan options for delivering changes to health care, which are sustainable and efficient, while considering providing care close to home.

It is assumed that changes in the scope of service provision, service volumes, and locations of service delivery, will occur as MAHC continues to work on the consolidation and integration of health services.

Background

In 2011/12 MAHC began a capital planning process in response to the organization's need to update current facilities to address significant deficiencies in space, service/department locational adjacencies, and mechanical ventilation (HVAC) systems, which are challenging the organization on a daily basis to provide safe, efficient, and quality health care now, and in the future for Muskoka residents.

In 2012, MAHC submitted a Pre-Capital Submission to the Ministry of Health and Long-Term Care (MOHLTC) and the North Simcoe Muskoka Local Health Integration Network (NSM LHIN). Subsequently the MOHLTC requested that MAHC develop a Master Program and Master Plan to more fully inform future decision making on use of sites and facilities. The 2012 Pre-Capital Submission will be updated based on the outcomes of the master programming and planning process and the document will be re-submitted to the MOHLTC and the NSM LHIN for approval to proceed to more detailed planning stages.

Purpose of the Master Program

The Master Program represents the first stage of the capital planning process. The purpose of this high level, pre-design document is to explore the future roles, strategies for service delivery, and strategies for collaboration and partnerships in order to develop an overall understanding of the type, amount and configuration of space needed to properly support patients and staff in the future. This information allows informed judgments to be made about the future facilities and their related sites. In addition information that is documented in the Master Program will inform the subsequent stages of planning, including the development of the Master Plan, as well as, the more detailed Functional Program.

The development of a Master Program requires extensive planning expertise and the contributions of both internal and external Health Service Provider (HSP) stakeholders. It considers the interplay between program/service elements and physical/cost elements, conducts analyses of multiple development options, and identifies a preferred physical solution in a Facility Development Plan. The Master Program is an early step in the planning and design process. More detailed material and continued/increased involvement of staff is part of the subsequent planning stages of functional programming and architectural design.

This Master Program builds on earlier MAHC planning initiatives including:

- The 2012-2014 Strategic Plan and subsequent refreshed 2015-2018 Strategic Plan.
- Pre-Capital Submission October 2012.

The MAHC Master Program will be divided into two sections - Service Delivery Model (scope of service descriptions and options for future service delivery) and the Spatial Requirements (design criteria and space projections).

Service Delivery Model

The objectives of the Service Delivery Model include:

- studying/developing a model of integrated care
- defining a facility that supports and enhances key partnerships to best meet the health care needs of residents of the Muskoka Census Division and East Parry Sound communities situated in a rural location
- contributing to local health system integration and a unified patient-centered and family-centered system of care
- providing services to accommodate projected needs-based demographic change
- defining health services and model(s) of service delivery that support the NSM Local Health Integration Network's (NSM LHIN) Integrated Health Services Plan (IHSP) and Care Connections plan and MOHLTC initiatives
- being consistent with Provincial Agencies requirements such as Cancer Care Ontario and Ontario Renal Network.

The Service Delivery Model section is comprised of three sub-sections:

A) Program Parameters
B) Master Program Components
C) Options for Service Delivery

In combination these three sections describe the current and future state of programs/services for MAHC and the potential scenarios by which these services may be provided - in the built environment(s).

Section A) Program Parameters provides background and overarching principles and assumptions for the project to serve as a foundation for the subsequent planning work.

Section B) Master Program Components details the current and future service provision (programmatic and workload) under the scenario by which acute and ambulatory services continue to be provided across both sites (and therefore not consolidated). It therefore describes a future scenario closest to the existing state of MAHC.

Section C) Options for Service Delivery details the advantages and disadvantages of the various models of future service provision considered (i.e., one site vs. two sites). The space implications for each scenario are then tested in the *Spatial Requirements* section.

Spatial Requirements

The objectives of the Spatial Requirements section include:

- providing high-level space requirements to align with the proposed service delivery model
- studying the long-term implications of future changes in service provision and related space requirements
- providing a framework to address short- and long-term space and facility issues
- providing facilities that meet infection prevention and control standards and reflect best practice and evidence-based design.

Note: for this study, space requirements have been developed for the following three options:

1. Two Full Service Acute Sites - attempting to maintain current services across both sites.
2. Centres of Focus (Hybrid) - distributing workload across both sites in a rationalized approach.
3. One Hospital (Centrally Located).

Planning Context

The Master Program describes the current and future role and scope of clinical support, administrative, and general support services for MAHC. It also includes projected activity resource requirements and facilities implications for the future provision of programs and services at MAHC.

Staffing models to align with the future clinical services delivery models will be developed in the subsequent Human Resources Plan as part of the next stage of planning.

Planning Horizons

The planning horizons are based on needs anticipated in the years 2019/20, 2024/25 and 2034/35.

Notes & Assumptions on the Future Provision of MAHC Health Services

In the future MAHC will continue to provide a full complement of acute care hospital-based clinical services, as discussed in the following pages for their catchment area, as well as for the seasonal residents, and significant tourist population that vacations in Muskoka each summer.

MAHC will continue to identify and implement consolidation of clinical and other services, to achieve clinical best practices and program critical mass integration of clinical disciplines to provide seamless care coordination with primary care services to reduce admissions and techniques to reduce length of stay. *Note:* ensuring sufficient human resource capacity within the LHIN to support these transitions will be fundamental.

Strategies for future delivery of MAHC's acute care hospital-based services that align with evidenced based practices include:

- patient and family-centered care/patient experience
- care provided close to home
- reduced wait times
- reduced numbers of Alternate Level of Care (ALC) patients
- integration/collaboration of health care services across hospital/community organizations providing continuity of care
- services moving into the community
- campus of care models
- step-up/step-down medical/surgical care beds
- more services for less
- management of chronic disease
- health promotion and disease prevention.

Assumptions For Planning MAHC's Future Clinical Services

Key assumptions used for planning the future ***Ambulatory Care Services*** at MAHC include:

- Reduction in some hospital-based ambulatory clinics assuming that some outpatient care will increasingly be provided by primary care and community services.
- MAHC will continue to develop and offer ambulatory services in the acute-care setting focusing on high-risk complex patients. These programs will compliment - not duplicate - services provided in the community.
- Provide enhanced ambulatory clinics focused on the community's needs (e.g., chronic disease management and prevention, dementia and mental health) and continued coordination with community partners.
- Chemotherapy Services will remain on one site.
- Dialysis Services will remain on one site.
- Surgical Follow-up Clinics at HDMH and Pediatric Clinics at both sites will continue to be offered in flexible clinic space but at a reduced level of activity.

- Effectively use human resources through appropriate team-based care and skill mix, and flexibly use available treatment space resources.

Assumptions used for planning future ***Emergency Services*** at MAHC include:

- Reduce low acuity Emergency Department (ED) visits (CTAS Level 4/5). The impact of this planned change will likely translate to a higher overall acuity of patients presenting at the Emergency Department.
- Assume that the increasing number of initiatives in the community by family physician offices, nurse practitioner clinics, CCAC, etc., will continue to enhance support for patients in the community and at home.
- Reduce wait times in the ED to improve wait times for less urgent CTAS 4 and non-urgent CTAS 5 patients the ED will continue to incorporate a fast track ("See and Treat") area.
- Assumed these and other initiatives being developed will further reduce hospital workload.

Assumptions used for planning future ***Inpatient Services*** (refer to Table 1 on the next page) at MAHC include:

- Generally continue to support the health care strategies of reducing admission and readmission rates to hospital and reducing lengths of hospital stays for admitted patients.
- Provide a service delivery model that maximizes patient and family-centered care/experience and clinical efficiencies where nursing staff are decentralized to smaller clusters of inpatient beds.
- Reduce low acuity ICU beds use by improving the occupancy capabilities of the future general medical and surgical beds so that ICU beds are no longer needed/used for surge capacity.
- Develop step-down/-up services supported by bed allocation to provide the appropriate 'right care' in the ICU.
- Reduce ALC days in hospital.
- Maintain the flexible assignment of the Medical/Surgical inpatient beds.
- Continue to decrease the number of inpatient surgical cases as appropriate.
- Focus medical/surgical inpatient care on community needs including increased care of older patients.
- Align the Maternal/Child model of care across the two sites. Develop a labour delivery recovery post partum (LDRP) care model.

- Increase CCC services to support demographic growth demand, factoring current utilization rates.

Table 1: Inpatient Services Bed Summary

			Total	MAHC Site		MAHC Single Site		
Program Inpatient Beds	2012-13	2013-14	2014-15	SMMH	HDMH	**2019-20**	**2024-25**	**2034-35**
Total	**111**	**99**	**96**	59	37	**108**	**115**	**139**
Medicine [1] [2]	**69**	**61**	**66**	37	29	**67**	**69**	**86**
Surgical [3]	**-**	**-**	**-**	-	-	**13**	**15**	**18**
Critical Care	**9**	**9**	**9**	4	5	**7**	**8**	**10**
Obstetrics	**5**	**5**	**5**	2	3	**3**	**3**	**3**
Complex Continuing Care	**28**	**24**	**16**	16	0	**18**	**20**	**22**
Nursery (not in total)	**3**	**3**	**3**	1	2	**2**	**2**	**2**

Notes:

(1) In 2014-15 medicine beds consisted of 61 beds plus 5 overflow beds staffed and operated

(2) Reflects equivalent beds currently housed in the Medicine Inpatient Units

(3) Surgical beds are not formally designated in current and historical workload

Assumptions used for planning future ***Surgical Services and Endoscopy*** at MAHC include:

- Reduce the rate of screening endoscopies due to the adoption of best practice guidelines.
- Continue to perform cataract surgery and endoscopy procedures at MAHC not by independent clinics in community locations.
- Use the main ORs for more major surgical cases, assume minor surgical procedures (lumps and bumps) and cataracts will be performed in an ambulatory surgical centre at MAHC.

Options for Service Delivery

Overview

MAHC is close to its limit in improving efficiencies in service delivery as a result of its creative endeavours over the past few years and as indicated earlier in the Pre-Capital Submission its physical resources continue to be a serious impediment in providing a contemporary health care environment that will support the:

- changes required for improved service delivery models
- patient needs for privacy/confidentiality
- staff needs for a supportive work environment
- efficiencies in service delivery
- infection prevention and control
- provision of a safe patient and family-centered environment.

Several options were explored for providing MAHC's future clinical services model. All options considered balancing the clinical benefits with the patients' needs aligned with operational efficiencies and the organization's strategic directions. At the beginning of the planning exercise nine potential options were explored, which eventually were distilled to three viable options:

1. Two Full Service Acute Sites - attempting to maintain current services across both sites.
2. Centres of Focus (Hybrid) - distributing workload across both sites in a rationalized approach.
3. One Hospital (Centrally Located).

Throughout the entire planning process it was evident that maintaining the current service model across two sites would not be sustainable in the long-term, both operationally and from a capital investment perspective. As a result, variations to the two-site service delivery model were explored extensively with the intent of ensuring appropriate services in each of the communities and, at the same time, offering access to services that have sufficient volumes to maintain clinical expertise that can also be operated efficiently. As much as possible service integration with other providers was explored and factored into the workload projections. Service redesign in terms of reducing ALC patients, lower admission rates, and shifting to community and outpatient care were all factored into the future service models.

A series of criteria and guiding principles were established to assist the decision makers with the options selection process. The principles addressed operational benefits, access to care, community and government support, sustainability, capital cost, growth potential and opportunities to develop a campus of care service model.

Workshop Outcomes

In all workshop sessions, care close to home, the communities' strong connections to their local hospitals and the related fundraising opportunities within the local communities, the travel distances to care, and current lack of convenient public transportation were discussed as key advantages of retaining the current model of two acute care hospital sites (see Appendix A).

A compelling benefit of deviating from the current model to either a two-site model (acute hospital/ambulatory care) or a single site model include: decreases in duplication of services, enhanced efficiencies in service delivery and staffing models, opportunities to develop new models within services due to the increased critical mass and overall decreased operating costs.

The Ad-Hoc Steering Committee who oversaw the process outlined the advantages/opportunities, disadvantages/challenges as well as key considerations for each of the final options and shared this overview with internal and external stakeholders during the final engagement sessions in March 2015. All stakeholders were encouraged to provide MAHC with feedback and suggestions as to any further considerations with respect to these final three options. Several issues for further consideration emerged as the models were presented, specifically, access to emergency services and ensuring reasonable drive times and access by the majority of the population served.

The final three options were rated by the Steering Committee based on a series of guiding principles and criteria developed. Option 3, One Hospital (centrally located) was selected as the preferred option as this model would best provide accessible, safe, high quality, cost efficient and sustainable health care in the year 2030 and beyond. An analysis of drive times and access to an Emergency Department determined that a central location between the Towns of Huntsville and Bracebridge would best serve the entire service population.

Workload Summary

Following is the summary table of the current and projected workload for MAHC's clinical and diagnostic services:

Table 2: Current & Projected Workload

Activity Centre	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
Ambulatory Care						
Cataracts procedures	704	675	696	803	913	1,127
Diabetes visits	5,035	3,542	3,058	3,325	3,885	4,422
Dialysis treatments	2,689	3,370	3,405	3,653	3,900	4,400
Fracture Clinic visits	3,108	n/a	n/a	2,713	2,876	3,198
Medical Day Care visits	1,838	1,834	1,816	2,034	2,538	3,077
Minor Surgical procedures	2,919	2,326	2,034	2,184	2,477	2,703
Oncology Clinic visits	1,837	1,874	1,798	2,063	2,703	3,299
Systemic Therapy treatments	954	1,029	1,349	1,548	2,028	2,489

Activity Centre	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
Emergency Services						
Unscheduled visits	42,764	42,855	43,504	39,318	41,378	46,026
Maternal/Child						
Births:	322	266	275	266	263	267
- Vaginal	*179*	*172*	*193*	*187*	*185*	*188*
- C-section	*143*	*94*	*82*	*79*	*78*	*79*
Surgical Services						
Surgical Suite:	4,096	4,226	3,827	4,153	4,481	5,134
- Inpatient cases	*804*	*855*	*812*	*876*	*941*	*1,074*
- Outpatient cases	*3,292*	*3,371*	*3,015*	*3,277*	*3,540*	*4,060*
Endoscopy:	4,263	4,367	4,314	4,007	4,229	3,875
- Inpatient cases	*217*	*206*	*231*	*292*	*326*	*330*
- Outpatient cases	*4,046*	*4,161*	*4,083*	*3,715*	*3,903*	*3,545*
Cardiorespiratory Services						
Cardiology procedures	13,294	14,014	13,474	13,015	14,416	16,742
Respiratory Therapy procedures	83,819	76,472	37,771	38,409	42,022	48,208
Diagnostic Imaging Services						
General Radiography exams	38,489	40,438	41,238	41,581	44,284	49,800
Interventional exams	405	410	441	460	521	608
Mammography exams	4,061	4,280	4,315	4,651	4,946	5,447
CT Scanning exams	16,479	16,795	19,614	20,717	22,092	24,643
Ultrasound / ECHO exams	17,084	19,918	24,820	26,256	28,045	31,425
Nuclear Medicine exams	3,254	2,715	2,829	2,571	2,709	3,024
Bone Mineral Densitometry exams	2,138	2,086	1,987	2,146	2,275	2,502
MRI exams	---	---	---	---	1,200	1,200
Clinical Laboratory Services						
Anatomic Pathology procedures	70,155	13,741	18,013	19,451	20,770	23,196
Clinical Chemistry procedures	422,486	249,305	262,709	283,675	302,918	338,294
Clinical Hematology procedures	116,335	60,087	72,576	78,368	83,684	93,457
Clinical Microbiology procedures	81,003	29,798	29,481	31,834	33,993	37,963
Cytopathology procedures	4,541	1,104	1,218	1,315	1,404	1,568
Pre & Post Analysis procedures	95,306	99,219	105,503	113,923	121,651	135,857
Transfusion Medicine procedures	15,842	7,046	6,110	6,598	7,045	7,868

Note: Please see the respective Master Program Component sections for further detail.

SERVICE DELIVERY MODEL

A) Program Parameters

A) PROGRAM PARAMETERS

Introduction

The purpose of this section is to describe factors expected to influence development of future facilities for MAHC. Program Parameters are used primarily in the preparation of Master Program and Functional Program information. The Hospital's intended functional content and major operating systems affecting the manner in which these functions are conducted must be fully understood before they can be sized as individual blocks of space. RPG refers to these blocks of space as "functional components" and these represent the major building blocks that will be used to construct models of future facilities in the physical planning tasks that occur later.

Collectively the Program Parameters assist subsequent planning initiatives by describing/identifying among other matters:

- the mission, vision, and values
- the geographical setting and catchment area
- the major clinical services and their roles
- the key facility-wide operating systems and support services
- best practice principles
- key partnerships and alliances and how they affect service planning and delivery.

In particular the Program Parameters describes how MAHC will function within the North Simcoe Muskoka LHIN's (NSM LHIN) third Integrated Health Service Plan (IHSP) 2013-2016 *Healthy People Excellent Care One System*. The NSM LHIN IHSP 2013-2016 is drafted to include the following three strategic priorities which align with the provincial priorities outlined in Ontario's Action Plan for Health Care. They include:

1. Healthy People - Keeping Ontario healthy and providing support to become healthier.
2. Excellent Care - Faster access and a stronger link to family health care.
3. One System - The right care at the right time in the right place.

Planning Horizons

The planning horizons are based on needs anticipated in the years 2019/20 2024/25 and 2034/35.

Muskoka Algonquin Healthcare

Mission: *Proudly Serving our Communities - Delivering Best Patient Outcomes with High Standards and Compassion.*

Vision: *Outstanding Care - Patient & Family Centered.*

Values:

Accountability: Accepting personal responsibility for achieving our goals.

Respect: Respecting those we serve each other and ensuring we maintain the highest level of privacy protection.

Optimism: Believing in our ability to make a difference in our community.

Leadership: Communicating clear direction and inspiring people to make a difference.

Engagement: Working together with commitment, honesty and integrity.

**The principle behind the Values is that everyone has 'A ROLE' to play in providing outstanding patient-focused care.*

Located within the North Simcoe Muskoka Local Health Integrated Network (NSM LHIN) Muskoka Algonquin Healthcare (MAHC) is a multi-site health care organization providing acute care services at the Huntsville District Memorial Hospital in Huntsville and the South Muskoka Memorial Hospital in Bracebridge. MAHC provides ambulatory care, 24-hour emergency services, surgical services, and inpatient and outpatient care at both hospital sites. In addition the organization delivers outpatient services at the Almaguin Highlands Health Centre in Burk's Falls. These services include general x-ray, physiotherapy, diabetes education, and blood collection through Gamma Dynacare.

MAHC has a $75 million operating budget and employs close to 700 people, over 350 volunteers, and approximately 85 active physicians. The population served by MAHC is estimated at close to 70,000 people with a permanent population of 60,000 in Muskoka and a permanent population of 8,600 in East Parry Sound. During peak cottage season, the served population rises by an additional 80,000+ people (source: 2013 data, District of Muskoka). Over two thirds of MAHC inpatients reside in Huntsville, Bracebridge, or Gravenhurst. Approximately 8% of MAHC inpatients reside outside of the NSM and NE LHINs. *Huntsville District Memorial Hospital (HDMH)* site, located in Huntsville Ontario, supports a full range of inpatient and outpatient services including: emergency care, surgical services, diagnostic imaging, and ambulatory, chemotherapy, and dialysis services.

South Muskoka Memorial Hospital (SMMH) site, located in Bracebridge Ontario, supports a full range of inpatient and outpatient services including: emergency care, diagnostic imaging, surgical services, and complex continuing care.

MAHC's Strategic Action Plan 2015-2018

In January 2015 the Board of Directors approved a refreshed. *"The 2015-2018 Strategic Plan is a solid meaningful and forward-looking plan of action that supports future growth and enhances the services and care provided to MAHC's communities." This strategic plan builds on the previous 2012-2014 plan that was developed* after discussions with over 150 stakeholders both internally and externally along with a detailed environmental scan the plan outlines five strategic areas for the organization to focus on:

1. Quality Care & Safety.
2. Partnerships & Collaboration.
3. Education & Innovation.
4. People.
5. Sustainable Future.

The MAHC Master Program and Master Plan were developed within the context of MAHC's Strategic Plan 2012-2014 and 2015-2018.

Provincial & Regional Planning Priorities

In developing the Master Program MAHC has aligned the clinical service delivery and strategies for future service delivery with provincial and local planning priorities and frameworks and community needs including key priorities outlined in:

- Ontario's Action Plan for Health Care (MOHLTC).
- Ontario's Priority Programs.
- NSM LHIN's Integrated Health Service Plan.
- NSM LHIN's Care Connections.
- Rural and Northern Health Care Report.
- MAHC 2012-2014 Strategic Plan.

These priorities were central to the programming process and form the basis for moving forward with planning development.

Ontario's Action Plan to Transform Health Care

The Ministry's Action Plan for Ontario will transform health care to ensure families get the best care where and when they need it while ensuring all Ontarians get better value for their health care dollars. MAHC's redevelopment goals are consistent with these directions and the Ministry's Action Plan top priorities of:

1. Keeping Ontarians Healthy.
2. Faster Access to Stronger Family Health Care.
3. Access to the Right Care at the Right Time in the Right Place.

The Action Plan is patient-centered. Patients should have:

- Support to become healthier with initiatives such as:
  - Childhood Obesity Strategy
  - a Smoke-Free Ontario
  - online cancer risk profile and expanded screening.
- Faster access and a stronger link to family health care through initiatives such as:
  - family health care at the centre of the system
  - faster and more convenient access
  - house calls
  - local integration of family health care
  - a focus on quality in family health care.

- The right care at the right time in the right place utilizing:
  - best evidence and clinical guidelines
  - strengthening Ontario's Telemedicine Network
  - timely preventative care
  - early intervention
  - providing care as close to home as possible
  - Seniors Strategy focusing on supporting seniors to stay healthy and live at home longer
  - local integration reform
  - moving routine procedures from the hospital into the community
  - funding reform.

MOHLTC Provincial Priority Programs

Current Ministry of Health Priority Programs include:

- Ontario Bone and Joint Network: MAHC is part of the Ortho Bed Registry and uses the registry to collect data improve networking and improve access for hip fractures in the NSM LHIN.
- Ontario Cancer Plan: MAHC's South Muskoka Memorial Hospital site is a designated Ontario Breast Screening Program (OBSP) site. MAHC's Oncology services are a satellite of the Northeast Cancer Centre in Sudbury and the Royal Victoria Regional Health Centre's Simcoe Muskoka Regional Cancer Centre in Barrie.
- Ontario Renal Network: MAHC's Dialysis Unit is a satellite of the Regional Dialysis Program at Orillia Soldiers' Memorial Hospital (OSMH). MAHC works with OSMH to access transplantation and other tertiary and quaternary nephrology services and adheres to best practices and mandates of the Regional Dialysis Program as directed by the Ontario Renal Network.
- Ontario Stroke Strategy.
- Ontario Telemedicine Network to support clinics and access to specialists.
- Cardiac Care Network of Ontario: MAHC has representatives on the Critical Care Steering Committee of the NSM LHIN. In addition, MAHC observes the policies, procedures, and protocols pertaining to the Regional Cardiac Care Program of Southlake Regional Health Centre. MAHC also uses the Critical Care Information System for access to data.

- Ontario Perinatal Network Midwifery Plan: MAHC receives guidance from the Ontario Perinatal Network and through the local public health services that provide access to pre- and post-partum visits and other education programs.
- GTA-West Diagnostic Imaging Repository.

NSM LHIN Integrated Health Service Plan

As previously mentioned MAHC's high-level goals for redevelopment are consistent with the NSM LHIN's three strategic priorities.

The North Simcoe Muskoka LHIN's (NSM LHIN) third Integrated Health Service Plan (IHSP) 2013-2016 *Healthy People Excellent Care One System* outlines a comprehensive plan to support the MOHLTC's priorities to achieve an integrated health system, improve access to care, and promote equitable access to health and health care for all Ontarians.

1. Healthy People - Keeping Ontario healthy and providing support to become healthier.
2. Excellent Care - Faster access and a stronger link to family health care.
3. One System - The right care at the right time in the right place.

MAHC's Priority Partnerships

Over the past number of years MAHC has continued to establish partnerships with other hospitals and community services in their region. These partnerships align with NSM LHIN's priorities in providing a system of hospital and community-based health care. The system currently provides patients with the best care in the most appropriate setting and has decreased the need for some hospital admissions and designated beds continuing to build on and strengthen system efficiencies.

Linkages & Partnerships with Community Services

During the master programming process MAHC met with a group representing key Community Services (listed on the next page in Table 3). These services among others support MAHC in ongoing improvements to services and service delivery, which enables patients to flow from the emergency department and inpatient units to the community, thereby reducing the average length of stay and readmission rates to hospital, and providing patient care in the most appropriate location. MAHC operates the Seniors Assessment and Support Outreach Team (SASOT) and accommodates this service on one hospital site. In addition the NSM CCAC community service is accommodated on both hospital sites.

Table 3: Community Services Consulted

1.	CMHA - Addiction Outreach Services
2.	District of Muskoka
3.	Family Health Teams
	- Algonquin Family Health Team (FHT)
	- Burk's Falls FHT
	- Cottage Country FHT
4.	Hospice:
	- Hospice Huntsville Algonquin Grace
	- Hospice Muskoka
5.	Midwives of Muskoka
6.	Muskoka EMS
7.	Muskoka Parry Sound Commnity Mental Health
8.	Muskoka Parry Sound Community Rehabilitation partner
9.	Muskoka Victim Services
10.	Nurse Practitioner Clinics
11.	Nursing Stations
12.	NSM CCAC
13.	SASOT
14.	Simcoe Muskoka District Health Unit
15.	SMMH/HDMH Auxillary
16.	SMMH/HDMH Foundations

These Community Services (as well as others) provide a wide variety of health care focusing on supporting individuals in their homes and other community locations and providing quality of care. The goal is to facilitate successful discharges, reduce emergency department and repeat visits, and avoid unnecessary hospital admissions.

Currently and into the future the local Community Services will support the continuum of health care and work with MAHC to:

- increase primary care access
- improve patient satisfaction
- increase physician follow-up within seven days of hospital discharge
- reduce the number of unattached patients
- provide programming for and management of chronic disease
- contribute to prenatal and postnatal programming

- enhance health promotion disease prevention and chronic disease management
- improve care co-ordination and navigation of the health care system at the local level
- provide house calls children's services access to specialist services
- provide intensive case management for geriatric and palliative clients
- provide compassionate end-of-life care at home in hospital and in the community
- participate in hospital-to-home initiatives to improve coordination of post-discharge primary care
- among many other services.

Service Delivery Area Demographics & Health Status

Situated in rural cottage country, MAHC's services anchor and support the health service system for the Muskoka Census Division and East Parry Sound communities as follows:

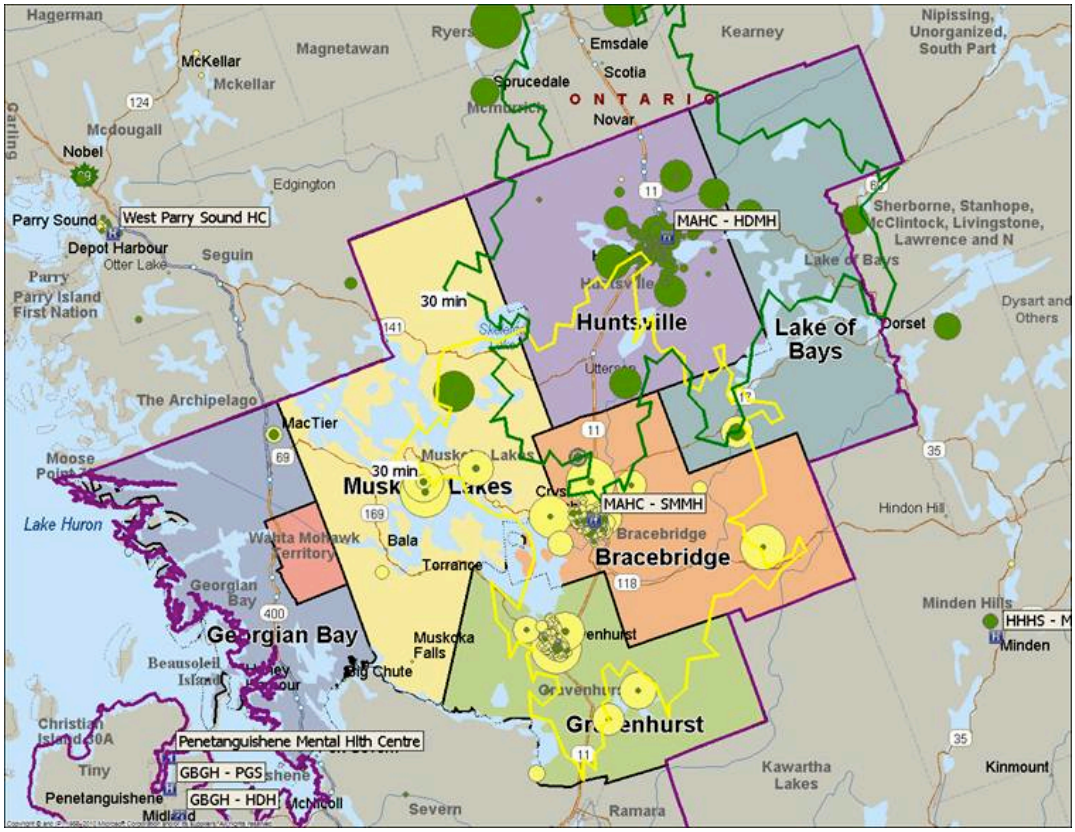
- Muskoka - six municipalities (the Towns of Bracebridge, Gravenhurst, and Huntsville; and the Townships of Georgian Bay, Lake of Bays, and Muskoka Lakes)
- Wahta Mohawk First Nation
- Moose Deer Point First Nation
- patients from municipalities within the Parry Sound district – providing significant patient origin from the North East LHIN:
  - East Parry Sound 1 - Burk's Falls/Perry/McMurrich/ Monteith/Kearney/Armour/Ryerson
  - East Parry Sound 2 - Sundridge/Jolly/Strong/South River/ Magnetawan/Machar.
- a large influx of summer tourists (80,000+ seasonally and 2,100,000 annually)
- prisoner population from two federal institutions.

Figure 1: Map of the Service Delivery Area

Size of the circle is dependent on the # of cases per postal code larger circles reflect rural postal codes

Legend:

- *MAHC-SMMH*
- *MAHC-HDMH*



The service delivery area information is from the Drive Time Analysis October 18 2012 developed by the HCM Group.

Drive Time Analysis

Service delivery in MAHC communities requires the orchestration of services across a large land area and the greatest commitment of regional district and local health providers to work together. Therefore the rural status and related travel times of the MAHC community are important considerations for service offerings. In this regard the percentage of the Muskoka population that resides within a 30-45 or 60 minute drive time to either of MAHC's two hospital sites was analyzed (refer to Table 4 on page 21). As a proxy for total Muskoka residents, the MAHC emergency department visits were used to analyze the driving times with the following results:

1. Percent of Muskoka SubLHIN patients covered within drive time polygons include:
   - HDMH 30 Minutes: 41%
   - HDMH 45 Minutes: 85%
   - HDMH 60 Minutes: 98%

- SMMH 30 Minutes: 50%
- SMMH 45 Minutes: 85%
- SMMH 60 Minutes: 100%
- HDMH & SMMH 30 Minutes: 76%
- HDMH & SMMH 45 Minutes: 93%
- HDMH & SMMH 60 Minutes: 100%

2. Percent of East Parry Sound (Area 1) patients covered within drive time polygons include:
   - HDMH & SMMH 30 Minutes: 26%
   - HDMH & SMMH 45 Minutes: 80%
   - HDMH & SMMH 60 Minutes: 88%

3. Percent of East Parry Sound (Area 2) patients covered within drive time polygons include:
   - HDMH & SMMH 30 Minutes: 0%
   - HDMH & SMMH 45 Minutes: 23%
   - HDMH & SMMH 60 Minutes: 95%

The Master Program and Master Plan assumes that any new site(s) being considered for future redevelopment would need to consider the drive times, driving conditions, and driving distances. In this regard in relation to future sites and location of services:

- all scenarios fulfill or nearly fulfill the 'guidelines' in the Rural and Northern Health Care Framework except single siting services at either the Huntsville or Bracebridge locations
- average travel time would not increase significantly if MAHC was located at one acute care site, for example, at Hwy 11 and Hwy 141.

Table 4, on the next page, outlines access to hospital services under various planning scenarios used in the analysis of siting options.

Table 4: Drive Time Analysis

Percent of region's residents that can reach any hospital within:

	60 minutes			45 minutes			30 minutes		
Single siting scenarios	*Muskoka SubLHIN*	*East Parry Sound 1*	*East Parry Sound 2*	*Muskoka SubLHIN*	*East Parry Sound 1*	*East Parry Sound 2*	*Muskoka SubLHIN*	*East Parry Sound 1*	*East Parry Sound 2*
Current State: HDMH and SMMH	**100%**	**88%**	**95%**	**93%**	**80%**	**23%**	**76%**	**26%**	**0%**
Hwy 11 & Hwy 60	98%	100%	95%	88%	88%	32%	55%	52%	0%
Hwy 11 & Taylor Rd.	100%	88%	95%	92%	7%	23%	65%	0%	0%
Hwy 11 & Hwy 141	100%	88%	95%	93%	71%	23%	73%	0%	0%
Hwy 11 & Hwy 117	100%	88%	95%	93%	33%	23%	72%	0%	0%
Huntsville District Memorial only	98%	88%	95%	85%	80%	23%	41%	26%	0%
South Muskoka Memorial only	100%	79%	95%	85%	0%	23%	50%	0%	0%

Population Growth Related Workload Projections and Demographic Information

MAHC primarily serves the population residing in the Muskoka District of the NSM LHIN and to some extent residents residing in East Parry Sound. Table 5 below illustrates projected growth rates for both weighted and unweighted catchment populations over the 20-year planning horizon.

Table 5: Age Weighted Population Growth

	Region	2014	2019	2024	2034	20 Year Change
Unweighted	Muskoka SubLHIN	62,126	63,901	65,986	70,159	13%
	Parry Sound	43,093	43,333	43,556	43,546	1%
	NSM LHIN	471,331	498,249	527,377	585,733	24%
	Province	13,672,718	14,392,871	15,181,617	16,755,443	23%
Weighted[1]	Muskoka SubLHIN[2]	79,948	88,418	98,549	120,591	51%
	Parry Sound	56,489	61,642	67,339	77,310	37%
	NSM LHIN	525,604	591,920	674,386	860,928	64%
	Province	14,135,390	15,707,579	17,715,987	22,138,586	57%

Source: Ministry of Finance Population Projections (Fall 2014), Discharge Abstract Database (DAD) 2011/12

Notes:

1. Since use of hospital services is strongly associated with age the weighted growth rate is provided. Weighted growth rates (51% for the Muskoka SubLHIN) take into account for example, that seniors on average use more hospital services than younger people. This increased population will bring a higher prevalence of age-related conditions such as circulatory disease, diabetes, arthritis, and dementia.
2. Weighted growth in the Muskoka sub-LHIN is somewhat less than that in the NSM LHIN and slightly less than the provincial average.

The following observations are noted:

A. Population projections indicate steady population growth for Muskoka District. Minimal growth is projected for Parry Sound including East Parry Sound 1 and 2 geographic areas.

B. Muskoka District projected growth is less than the NSM LHIN or Ontario.

C. Current or shorter-term growth (2014-2019) demonstrates varying growth by age cohort and by relative versus absolute change.

D. The seasonal population, which substantially increases MAHC's workload volumes in the summer months, is included in all workload projections through the analysis of market share since MAHC is a provincial resource.

Workload Projections

Factors Considered: In addition to population growth and aging the following factors were considered in the analysis of MAHC's current and future bed numbers as well as other workload:

- population growth and aging
- market share and opportunities for repatriation
- occupancy rates
- opportunities to reduce use of hospital resources including:
  - ALC use of acute resources
  - Ambulatory care sensitive conditions
  - avoidable Emergency Department (ED) visits
  - the mix of inpatient and day surgery
  - rates of interventions.
- the implications of access to care based on siting options.

Important Findings: the following were found to be of significance during the workload analysis process:

1. Expected growth in hospital services in Muskoka sub-LHIN is less than the NSM LHIN and provincial averages
2. MAHC performs well on important measures of clinical performance:
   - about the expected number of readmissions within 90 days
   - slightly fewer post-surgical complications than expected
   - few opportunities to substitute day surgery for inpatient surgery
   - shorter inpatient lengths of stay for obstetrics than expected.
3. MAHC's ED is a provincial resource: only 57% of MAHC's ED visits by residents of Huntsville, Bracebridge or Gravenhurst
4. MAHC has few opportunities to repatriate surgical patients from the Muskoka region

5. Siting options:
    - average travel time would not increase significantly if MAHC was located at one acute care site at Hwy 11 and Hwy 141
    - average travel time would increase if MAHC were single sited at either Huntsville or Bracebridge
    - all scenarios fulfill or nearly fulfill the 'guidelines' in the Rural and Northern Health Care Framework except single siting Emergency Services at Huntsville or Bracebridge.
6. MAHC's medical/surgical beds are over occupied.

The following opportunities to reduce use of MAHC resources have been considered and/or addressed in the Master Program:

- 28% of MAHC's total inpatient days are ALC the NSM LHIN's ALC target is 9.5%
- MAHC has a high propensity to admit inpatients to the ICU
- 49% of MAHC's ED visits are CTAS Level 4 and 5
- Muskoka residents have very high rates of endoscopic procedures including colonoscopies and gastroscopies
- MAHC has Ontario's fourth highest proportion of deliveries by Caesarean Section

Health Status of the Muskoka Residents

The NSM LHIN and Muskoka Census Division have unique communities. This area has a higher population of older people compared to the Province of Ontario and will continue to grow with a very significant increase becoming apparent in 2012 and continuing to expand to 2035. This increased senior population will bring a higher prevalence of age-related conditions such as circulatory disease, diabetes, arthritis, and dementia. In addition the NSM LHIN and Muskoka Census Division have significantly larger aboriginal communities compared with the provincial average. Based on current health trends planning will require a focus on diabetes and the complications arising from late stage diabetes, including ongoing complex care and rehabilitation.

Being able to meet and sustain the needs of these populations in particular will require appropriate facilities to respond to the growing demand for health care and models of care that are effective and operationally efficient.

Current & Proposed Model of Care

Currently MAHC provides the following **Clinical Services:**

- Ambulatory Care Services
- Emergency Services
- Critical Care Services
- Medical/Surgical Inpatient Services
- Maternal/Child Services
- Complex Continuing Care Services
- Surgical Services.

These are supported by a complement of Clinical Support Services (Allied Health, Diagnostic Imaging, Laboratory, Pharmacy) Education and Training Services, Corporate and Administrative Services, Foundations/Auxiliaries, Facilities and General Support Services at each site. As well various Community Services partner in the on-site provision and support of hospital care.

Some of MAHC's more recent changes in service delivery, which have benefitted patients and staff either directly or indirectly include the following:

- implemented a Seniors Assessment and Support Outreach Team (SASOT) which provides outreach geriatrics assessment and management in the patient's home with a focus on supporting - earlier successful discharge to home or next care destination, a reduction in emergency department visits, and admission avoidance
- adopted the Home First philosophy with a goal to reduce MAHC's ALC days
- is a member of the NSM LHIN's Senior Friendly Hospital Task Force and working to develop an Accessibility and Senior Friendly hospital plan in support of a more senior friendly hospital
- is committed to optimizing surgical services by providing access to right care has integrated RN First Assist into the surgical team to use the fullest scope of inter-professional practice
- identified falls prevention as a priority in its Quality Improvement Plan Year II (2012/13) and Year V (2015/2016)
- partnered with BIRT Community Care – Wynedale Community Mental Health (the Behavioural Support System's Mobile Support Team) for mental health services in the Emergency Departments
- as a member of the Ortho Bed Registry MAHC uses the registry to collect data, improve networking, and improve access for hip fractures in the NSM LHIN

- hosted a Diabetes Program through Northern Diabetes Network (NDN) beginning in 1993. NDN program funding transferred to NSM-LHIN 2012. MAHC operates two satellites of program – one servicing the Huntsville catchment area, one servicing the Bracebridge catchment area
- implemented Chemotherapy Service in 1991 at HDMH and in 2005 at SMMH bringing service to the patient closer to home. Service was single sited to HDMH site in 2014/15
- implemented a Colonoscopy Screening Program in association with Cancer Care Ontario improving clinical outcomes (cancer prevention) and bringing service closer to home
- CT Scanning technology was upgraded at HDMH in 2014. improving diagnostic technology closer to home. Planned CT Scanning technology upgrade at SMMH in 2015
- implemented PACS and other IT initiatives resulting in overall improvement in care and efficiency
- developed a partnership with NSM CCAC which includes in-hospital discharge planning
- MAHC has had a formal affiliation with the Northern Ontario School of Medicine since 2007, as teaching site for 3rd year clerkship students, along with a variety of 4th year medical students, and residents from various disciplines at all levels of learning
- developed academic linkages improving physician coverage, increasing awareness of MAHC, and improving overall quality of care resulting in recruitment benefits
- implemented the Ottawa Model Smoking Cessation Program
- implemented a number of enhancements to the clinical care model such as:
  - bedside transition of care reporting
  - quality based practices
  - regional falls prevention program
  - nursing directives
  - fracture clinic
  - Patient Experience & Flow Navigator for each site to facilitate patient flow
  - vascular and tele-trauma using Ontario Telehealth Network
  - wait time improvement strategies in keeping with the MOHLTC strategies

- introduced Physician Assistants and Nurse Practitioner positions to assist with patient care and enhance flow
- introduced bullet rounds on the medical and surgical patient care areas
- improved communications between healthcare providers by implementing the Situation Background Assessment Recommendation (SBAR) tool
- developed and implemented an ethics framework
- developed a bed registry for complex continuing care (CCC) patients
- implemented an antibiotic stewardship model
- implemented a process for the 'best possible medication history' (BPMH) for admitted patients
- implemented orders sets, which standardize the delivery of care
- actively participated in the LHIN Collaborative Care Connection strategy
- implemented LEAN quality improvement methodology, which is a customer-centric methodology focused on continuously identifying improvement opportunities by eliminating "non-value added" (or wasteful) activities and creating value.

In the future MAHC will continue to provide a full complement of acute care hospital-based clinical services as discussed below to serve the catchment area as well as for the significant tourist population that vacations in Muskoka each summer.

Recently MAHC has made progress in expanding its clinical delivery system to respond to changing demographics, technological advances and new demands on the health care system, including consolidation and integration of services requiring new and different service delivery models in the future.

MAHC will continue to identify and implement consolidation of clinical and other services to achieve clinical best practices and program critical mass integration of clinical disciplines to provide seamless care coordination with primary care services to reduce admissions and techniques to reduce length of stay. *Note:* ensuring sufficient human resource capacity within the LHIN to support these transitions will be fundamental.

Health System Integration

MAHC's commitment to integration is reflected in MAHC's third strategic priority: Partnerships & Collaboration.

In the past year 17 different members of the MAHC leadership team have participated in 32 different Care Connections programs, committees, and coordinating councils.

In the past MAHC has taken an active role in providing leadership with respect to health system integration as part of the NSM LHIN Care Connections philosophy.

MAHC understands that a unified system of care is a single integrated system of care, which allows patients and families to seamlessly access and receive health services. Key elements of a unified system include:

- patients and families and their information move smoothly across care settings/environments
- system navigation is clear to patients/families and assistance is provided to ease transitions
- providers have clearly defined roles and responsibilities and a clear understanding of how to work together
- the system has sufficient capacity appropriately distributed.

Assumptions For Planning MAHC's Future Clinical Services Within a Single Integrated System of Care

General Assumptions

Within the next couple of decades sustainable health services will require a mix of funding and capacity increases alongside improvements in the use of existing resources. MAHC will:

- pursue opportunities for optimizing resource use for ALC and End of Life patients
- improve practices for high impact medical conditions - this involves the continuum of care including primary and secondary management
- will continue to work with the NSM LHIN and Community Services to organize the post-acute care required to reduce future re-hospitalization since admission to hospital is an important marker for future hospital use.

An overall general assumption that impacts the access to services and future service locations is the lack of a dependable transportation system in Muskoka to assist in transporting patients/families/public to the hospital sites. Future planning assumes that a transportation system will be implemented.

Ambulatory Care Services Assumptions

Assumptions used for planning the future Ambulatory Care Services at MAHC include:

- Though the local Family Health Teams (FHTs) and Nurse Practitioner Clinics offer many ambulatory programs for individuals with a chronic disease including Chronic Obstructive Pulmonary Disease and Coronary Artery Disease, among others, recent innovative care delivery models built on chronic disease management principles and focused on the most costly highest risk and multi morbid patients have recognized the importance of the hospital in chronic illness management and the fact that attending to acute illness episodes is integral to the delivery of chronic illness care.[1]

  There is a role for MAHC to play in the care of individuals with diabetes and other chronic diseases. This role is intensified if chronic disease management services become unavailable in the community.

  Consequently in its role as a provider of hospital-based ambulatory care, MAHC will continue to develop and offer ambulatory services in the acute care setting focusing on high-risk complex patients.

- Provide enhanced ambulatory clinics focused on the community's needs including chronic disease management for diabetes, cardiac care, dementia and mental health, and continue MAHC's geriatric assessment program (SASOT) for older health care needs clinics will support individuals in the community identified at risk.
- Chemotherapy Services will remain on one site in future planning.
- Dialysis Services will remain on one site in future planning.
- Prenatal Obstetrics Clinic at SMMH Surgical Follow-up Clinics at HDMH and Pediatric Clinics at both sites will move to the community.
- Further research and trial/test applications that may help to support patients who currently have repeated hospital admissions to remain in their homes.
- Effectively use human resources through appropriate team-based care and skill mix and flexibly use available treatment space resources.

[1] Julie A. Schmittdiel PhD Stephen M. Shortell PhD Thomas G. Rundall PhD Thomas Bodenheimer MD and Joe V. Selby MD MPH Effect of Primary Health Care Orientation on Chronic Care Management (Family Service website Mar 2006).

Emergency Services Assumptions

Assumptions used for planning future Emergency Services at MAHC include:

- Reduce low acuity ED visits based on the assumption that acceptable alternatives to the ED will be made available to MAHC's patient population.
- Assume that the increasing number of initiatives in the community by family physician offices, nurse practitioner clinics, CCAC, etc. will continue to enhance support for patients in the community and at home. These initiatives are helping to avert inpatient admissions from the ED reduce patients' lengths of stay in hospital and reduce the number of patients revisiting the ED while providing patient care in the most appropriate place. The initiatives include the current use of CCAC Case Managers working in the hospitals.
- Reduce wait times in the ED to improve wait times for less urgent triage 4 and non-urgent triage 5 patients. The ED will continue to incorporate a fast track "See and Treat" area.
- In the future these and other initiatives being developed in response to the ER/ALC Wait List Strategy, the Aging at Home Strategy, and the NSM LHIN priorities to improve access to Emergency Services, will further reduce hospital workload.

Inpatient Services Assumptions

Assumptions used for planning future Inpatient Services at MAHC include:

- Generally continue to support the health care strategies of reducing admission and readmission rates to hospital and reducing lengths of hospital stays for admitted patients.
- Provide a service delivery model that maximizes patient-centered and family-focused care/experience and clinical efficiencies where nursing staff are decentralized to smaller clusters of inpatient beds.
- Reduce low acuity ICU bed use by improving the occupancy capabilities of the future general medical and surgical beds so that ICU beds are no longer needed/used for surge capacity. MAHC has a high propensity to admit inpatients to the ICU. At the Provincial average rate of ICU admissions per general medical/surgical inpatient MAHC would require three fewer ICU beds in 2014/15. *Note: operating an ICU with fewer than four beds may be unrealistic due mainly to staffing inefficiencies.*
- Develop Step-down/-up services supported by bed allocation to provide the appropriate 'right care' in the ICU.
- Reduce ALC days in hospital.

- Maintain the flexible assignment of the Medical/Surgical inpatient beds in the support of either medical or surgical patients as needed.
- Continue to decrease the number of inpatient surgical cases as appropriate.
- Focus medical/surgical inpatient care on community needs including an increased care of older patients.
- Align the Maternal/Child model of care across the two sites. Develop a labour delivery recovery post partum (LDRP) care model this may be implemented based on future critical mass and the site(s) on which the service(s) will be located.
- Pursue designated Stroke Rehabilitation beds as part of the Regional Integrated Stroke Program, which *may* be provided by MAHC in the near future.

Surgical Services & Endoscopy Assumptions

Assumptions used for planning future Surgical Services and Endoscopy at MAHC include:

- Reduce the rate of screening endoscopies due to the adoption of best practice guidelines.
- Increase substitution of non-invasive diagnostics including CT Scan and new technologies such as ingestible cameras for diagnostic endoscopies.
- Continue to perform cataract surgery and endoscopy procedures at MAHC not by independent clinics in community locations.
- Use the main ORs for more major surgical cases assume minor surgical procedures (lumps and bumps) and cataracts will be performed in an ambulatory/surgical centre at MAHC.

Campus of Care

Currently a number of organizations are located on the MAHC hospital sites. These include a Family Health Team, Hospice, and a satellite location of One Kids Place, among others. Though these organizations are not formally part of MAHC's development of this Master Program, it does not preclude the continued locating of services close to the hospitals that provide a one-stop approach to patient service provision.

Integration of Fairvern Nursing Home

MAHC has been working closely with Fairvern Nursing Home, the District of Muskoka, and NSM LHIN to explore options to relocate Fairvern to the HDMH Site as part of the nursing home's redevelopment plan and in support of a Campus of Care delivery model. The Nursing Home provides long-term care assisted living and convalescent care.

Existing Facilities Issues

The existing Hospitals are severely challenged to meet the treatment needs of the community or the needs of the staff delivering and supporting care. Either there is not enough space, or current space is not functional and able to support changing treatment practices and new technology. The Hospital has had a number of renovations, which have improved and updated some areas, however a number of issues still need to be addressed.

The following are some of the major existing space/functionality issues within the facility:

- There is inadequate space for delivery of service many areas are undersized, including but not limited to: the Inpatient Units, Emergency Department, Ambulatory Services, Allied Health Services, Surgical Services, Diagnostic Imaging Services, and Pharmacy.
- There are an insufficient number of single patient rooms.
- There are inappropriate washroom facilities (for example patient rooms do not have washrooms or showers). Washrooms do not meet accessibility standards.
- There are numerous infection control issues, for example: lack of places to isolate patients; poor separation of in/outpatient services, which in an “outbreak” situation would result in a significant disruption of outpatient services; poor separation for the transport of clean and soiled supplies etc.; a significant lack of hand-washing sinks; and limited negative air pressure capabilities for the management of patients with an airborne infection.
- The physical relationships of departments to departments are poor resulting in wasted staff time in moving between departments and causing patients confusion.
- Patient privacy/confidentiality is seriously compromised. For example, many of the inpatient and outpatient areas do not provide appropriate areas for private conversations, patient confidentiality, patient assessments, and changing facilities.
- There is inadequate space for inter-professional teams to work in. For example the inpatient units do not provide enough space for clinical supports to provide services on the Units.
- There are inadequate storage areas.
- Accessibility issues exist throughout both of the Hospitals.
- There is inadequate infrastructure for organized long-term growth and change.
- The current facilities do not have appropriate on-call, study, teaching, and resource spaces for medical students.
- The air handling systems are inadequate.
- Facilities have asbestos.

MAHC's Guiding Principles

To assist the Master Program/Master Plan Ad Hoc Steering Committee to explore in detail and articulate Muskoka Algonquin Healthcare's future program and service planning and the related future physical infrastructure planning in an approach that was thoughtful and that would best provide safe, quality, sustainable health care in the year 2030 and beyond, the following guiding principles were adopted early in the planning process:

- appropriate space
- evidence-based (best practice)
- patient and family-centered care
- improved environmental quality
- elder-friendly (accessible/barrier-free)
- reduced wait times
- efficient
- amenities
- compliant with infection Prevention and Control Practices
- collaborate with external care providers (campus of care)
- use of technology
- create an environment of wellness
- establish strong community connections
- design for flexibility and future change
- operational efficiency
- creating a positive work environment.

Guiding Principles for the Master Program

MAHC's guiding principles were used as a framework to identify key criteria that must be met as part of the Master Program in the future redevelopment of the MAHC Hospital(s). These principles are guided by the belief that patient safety is a fundamental right and a key direction from the MOHLTC and the NSM LHIN.

MAHC's guiding principles have been interpreted for the Master Program as follows:

- Plan the appropriate space necessary to:
  - correct current deficiencies
  - meet the community's need for expanded and enhanced services available closer to home.
- Improve the quality of the environment for patients and families:
  - privacy and confidentiality
  - safety and infection prevention and control
  - comfort and quiet.
- Ensure that accessibility standards are met throughout the facility.
- Ensure that the building(s) is "senior friendly".
- Make provisions to ensure that the use of technology is

maximized.

- Reduce time and effort for patients and families by improving accessibility circulation and functionality.
- Ensure patient privacy in patient care areas by eliminating or minimizing thru traffic.
- Increase overall efficiency through:
  - a more functional organization and layout
  - the consolidation of related services
  - the sharing of common functions.
- Provide physicians, staff, students/learners, and volunteers with better amenities and more functional work environments.
- Provide a framework to address short and medium-term issues.
- Satisfy government and regulatory agency requirements.
- Meet infection prevention and control requirements.
- Consider approaches that will provide long-term flexibility to accommodate changing needs.
- Maintain collaboration and integration with external care providers and allow flexibility to allow for future collaborative opportunities.
- Ensure user input throughout the planning process.

B) Master Program Components

B) MASTER PROGRAM COMPONENTS

The following components comprise the Master Program for MAHC's new and/or renovated future facilities and sites development. Descriptions of the role and scope of current programs/services and future approaches to care have been provided grouped by the subheadings as shown below.

Clinical Services

- Ambulatory Care Services
- Emergency Services
- Inpatient Services
- Medical/Surgical Inpatient Services
- Critical Care Services
- Maternal/Child Services
- Complex Continuing Care
- Integrated Stroke Program
- Surgical Services
- Community Services On-Site
- Education & Training Services

Clinical Support Services

- Allied Health Services
- Cardiorespiratory Services
- Diagnostic Imaging Services
- Clinical Laboratory Services
- Pharmacy Services
- Administration & Support Services

General Support Services

- Facility Services
- Medical Device Reprocessing Department
- Physician & Staff Amenities
- Main Lobby Services

ROLE & SCOPE OF CURRENT & FUTURE CLINICAL SERVICES

The following are descriptions of the role and scope of current MAHC Clinical Support Services, irrespective of their current site locations. The future siting is addressed under Section C) Options for Service Delivery.

Clinical Services include:

- Ambulatory Care Services
- Emergency Services
- Inpatient Services
- Medical/Surgical Inpatient Services
- Critical Care Services
- Maternal/Child Services
- Complex Continuing Care
- Integrated Stroke Program
- Surgical Services
- Community Services On-Site
- Education & Training Services

Ambulatory Care Services

Scope of Service Assumptions

Currently Muskoka Algonquin Healthcare provides Ambulatory Care Services at the two hospital sites - HDMH and SMMH. MAHC also provides outpatient clinics at the Almaguin Highlands Health Centre (AHHC) located in Burk's Falls.

Current Status: Ambulatory Care Services provide access to quality outpatient care close to home for residents of Muskoka and the surrounding area. Regularly scheduled clinics as well as specialty physician consult clinics are provided. Access to these services occurs in a timely accessible manner in order to:

- prevent unnecessary admissions to MAHC hospitals
- reduce the length of an inpatient stay post-admission following inpatient care a patient's recovery continues through attendance at many outpatient services and clinics
- contribute to the ongoing health and well-being of the community through education about health prevention and disease management.

During the development of the 2012 Pre-Capital Submission MAHC identified the need for better coordination of Chronic Disease Management (CDM). Currently there are increasing numbers of individuals with chronic conditions including: increasing obesity, diabetes, substance abuse, and mental health problems; and other chronic conditions of arthritis, congestive heart failure, Chronic Obstructive Pulmonary Disease (COPD), renal failure, cancer, stroke, osteoporosis, and hypertension, among others.

Though the local Family Health Teams (FHTs) and Nurse Practitioner Clinics offer many ambulatory programs for individuals with a chronic disease including COPD and Coronary Artery Disease, among others, recent innovative care delivery models built on CDM principles and focused on the most costly highest risk and multi morbid patients have recognized the importance of the hospital in chronic illness management and the fact that attending to acute illness episodes is integral to the delivery of chronic illness care.[2]

There is a role for MAHC to play in the care of individuals with diabetes and other chronic diseases. *Note:* this role is intensified if chronic disease management services become unavailable in the community.

[2] Julie A. Schmittdiel PhD Stephen M. Shortell PhD Thomas G. Rundall PhD Thomas Bodenheimer MD and Joe V. Selby MD MPH Effect of Primary Health Care Orientation on Chronic Care Management (Family Service website Mar 2006).

Future Planning Assumptions: In its role as a provider of hospital-based ambulatory care, MAHC will continue to develop and offer ambulatory services in the acute care setting focusing on high-risk complex patients. These would include treatment to patients who are accessing regional programs such as: dialysis, chemotherapy, diabetes, and stroke, as well as patients with chronic diseases and complex hard-to-treat refractory medical conditions, i.e., wound care. As part of the continuum of care MAHC's ambulatory services will improve practices for patients with high-risk medical conditions including integrating services with primary care providers.

To ensure the right mix and type of ambulatory care services will be provided in the future during master programming, MAHC evaluated the current ambulatory services in consideration of the following questions:

1. Why is MAHC operating this clinic/offering this service?
2. What value does it bring to the hospital?
3. Can it be offered at just one site rather than both to decrease overall cost to the hospital?
4. Can it be offered off-site by another provider?
5. Does it support the focus on high-risk complex patient needs?
6. Does it provide an alternative to inpatient care support reduced lengths of inpatient stays and offer alternative referral options from the emergency department?

The evaluation resulted in the decision to move some of the ambulatory services out of the hospital including: prenatal and antenatal clinics, surgical clinics, and specialist pediatrician clinics, and the Seniors Assessment and Support Outreach Team (SASOT) as indicated in the table on the next page. These will move into community settings.

Ambulatory Care Services remaining in a hospital setting will consist of a number of clinics whose main objectives will be to support consultations, interventions, diagnostic exams, and follow-up. In order to provide efficiency in service delivery and appropriate care ambulatory care services will be consolidated into facilities located in one central location in the hospital.

Table 6: Current & Future Ambulatory Care Clinics & Services Visits by Site:

Note: though the table designates future clinics across the two existing sites, the following section on *Section C Options for Service Delivery* more clearly indicates that ambulatory services may be delivered across two sites or combined on a single site.

		CURRENT		FUTURE	
		HDMH	SMMH	HDMH	SMMH
1.	Chemotherapy Services				
	- Systemic Chemotherapy	✓	-	✓	-
	- Oncology Clinic	✓	✓	✓	✓
	- Biologic Anti-inflam Infusion Clinic	✓	-	✓	-
2.	Dialysis Unit	✓	-	✓	-
3.	Clozaril Clinic	✓	✓	✓	✓
4.	Diabetes Care	✓	✓	✓	✓
5.	Fracture Clinic	✓	✓	✓	✓
6.	Medical Day Care	-	-	✓	✓
7.	Nutrition Services	✓	✓	✓	✓
8.	Obstetrics Clinics:	✓	✓	-	-
	- Prenatal Clinic	-	✓	-	-
	- Antenatal Clinic	-	✓	-	-
	- Obs Breast Feeding	✓	✓	✓	✓
	- Obs Non-stress Test	✓	✓	✓	✓
	- Newborn Clinic	-	✓	✓	✓
9.	OTN Service	✓	✓	✓	✓
10.	Pediatric Outreach Clinics	✓	✓	-	-
11.	Seniors Assess (SASOT)	-	-	-	-
12.	Surgical Clinics:				
	- Lumps and Bumps	✓	✓	✓	✓
	- Surgical Clinics	✓	✓	-	-
	- ER Offload Clinic	✓	-	-	-
	- Pre-surgical Assessment	✓	✓	✓	✓

Notes for Table 6:

A. Medical Day Care Services currently are provided in the chemotherapy area and the ER Off-load Clinic (EROC). In future a Medical Day Care (MDC) area will be planned. The Biologic Anti-inflammatory Infusion Clinic will operate from the MDC as will the EROC.

B. The Clozaril Clinic will operate from the Pharmacy.

C. Some surgical outpatient visits occur on the hospital sites in the ED and EROC. These will be eliminated in the future. Some Surgical Pre-Surgical Assessmen Clinic visits occur on the site in future the clinic services will be more formalized.

Chemotherapy Services

Current Status: Currently outpatient oncology services are provided at each of the two hospital sites (weekdays 0730-1600). The Chemotherapy Supportive Care & Infusion Clinic at the HDMH site provides systemic chemotherapy and supportive care such as blood work for chemotherapy, transfusion of blood and blood products, pump disconnections, intravenous iron, and infusion of drugs used to manage side effects of chemotherapy. Biologic anti-inflammatory infusions currently are only provided at the HDMH site. *Note:* the Biologic Anti-inflammatory Clinic is revenue generating.

The Infusion Clinic at the SMMH site provides supportive care such as blood work for chemotherapy, transfusion of blood and blood products, pump disconnections, intravenous iron, and infusion of drugs used to manage side effects of chemotherapy.

Each clinic is supported by an on-site Clinical Laboratory and Pharmacy.

MAHC partners in oncology care with the Northeast Cancer Centre in Sudbury, and the Simcoe Muskoka Regional Cancer Centre in Barrie. Care is provided as close to home as possible.

Future Planning Assumptions: In 2014 Chemotherapy Services were sited on the HDMH site only. More robust chemotherapy services are being reintroduced at the neighbouring Orillia Soldiers' Memorial Hospital. By locating systemic chemotherapy at one site MAHC has achieved safety standards and improved outcomes through focused specialization positively impacted critical volume and clinical competency in delivering this complex high-risk treatment eliminated the duplication of costly services and aligned with regional and provincial priorities. In future, Medical Day Care (MDC) services will be provided from a designated MDC clinic space.

Chemotherapy hours of operation will be extended as an additional service for patients.

Dialysis Clinic

Current Status: The Dialysis Unit is currently located at the HDMH Site. The unit has six treatment stations and administers 12 dialysis treatments per day, six days a week, and 3,405 treatments on an annual basis including treatment to vacationers and cottagers visiting the area on a shorter-term/seasonal basis. The unit can care for six stable patients at any one time and offers a morning and afternoon shift from 6:30 a.m. to 6:30 p.m.

It has operated as a satellite clinic since 1996 presently under the Regional Kidney Care Program of Orillia Soldiers' Memorial Hospital (OSMH). The service is delivered using a hub and spoke model with the OSMH being the hub. Patients are referred to hemodialysis through the Regional Kidney Care Program at OSMH. Vacationers and cottagers visiting the area will also access dialysis treatment

Home Dialysis is available in the area the services are coordinated by OSMH. Currently there are approximately four to five patients that receive home dialysis. Typically the patients receiving dialysis at MAHC are elderly and have co-morbidities.

Future Planning Assumptions: MAHC will continue to provide dialysis services in the future as described above.

Outpatient Rehabilitation Services

(Refer to the section on Allied Health for further information on Rehabilitation Services)

Diabetes Education Programs

Expert education and support is essential to help prevent and manage diabetes. The Diabetes Education Team of nurses and dietitians help patients learn as much as possible about living with diabetes.

Current Status: Currently diabetes services include group education and individual visits for:

- adults new to diabetes
- refresher programs
- starting insulin
- insulin pumps
- pregnancy and diabetes
- education awareness events

- education and training for health care professionals and community service groups
- gestational/juvenile diabetes
- type 2 diabetes.

Future Planning Assumptions: In the future it is assumed that Diabetes Education will be delivered as a shared care model between MAHC and community services. Along the continuum MAHC would care for patients with more complex medical issues and co-morbidities.

Note: the NSM LHIN currently is conducting a value stream mapping exercise on the management of diabetes care across the Region.

Clozaril Clinic

(Refer to the section on Pharmacy Services for further information)

Medical Day Care

Current Status: Currently Medical Day Care services are provided on each of the hospital sites from the Chemotherapy area. As well the ER Off-Load Clinic on the HDMH site provides IV infusions and suturing, among other procedures typically performed in a surgical/medial day care.

Future Planning Assumptions: MAHC will continue to provide surgical/medical day care services in the future. A medical day care unit will be planned for patients requiring prolonged assessment/treatment/procedures of up to 8 hours. These will include transfusion of blood and blood products, pump disconnections, intravenous iron, and biologic anti-inflammatory infusions, bladder instillations, and infusion of medications, among others. Due to the low visit volumes the MDC has been programmed to operate scheduled clinics from shared ambulatory clinic space.

Nutrition Services

(Refer to the section on Allied Health for further information)

Current Status: Currently Registered Dieticians provide nutritional counseling to outpatients by appointment.

Future Planning Assumptions: MAHC will continue to provide outpatient nutritional counseling in the future as described above. In addition gaps in service provision to chemotherapy patients will be addressed.

Fracture Clinic

Current Status: Currently patients diagnosed with fractures in the Emergency Department are often referred by the Emergency physician to the Fracture Clinic (offered once per week at HDMH varying days/times at SMMH). The appointment is usually made for the patient before they leave the ED. The clinics are held one morning each week in the Emergency Department at both Hospitals. Fracture care assessment and further referrals are provided as needed and appropriate.

It is possible that more complicated fractures may be referred to the Royal Victoria Regional Health Centre in Barrie or the West Parry Sound Health Centre.

Future Planning Assumptions: MAHC will continue to provide Fracture Clinic services as described above.

Obstetrics Clinics

(Refer to the section on Maternal/Child Inpatient Services for further information)

Ontario Telemedicine Network Service

The Ontario Telemedicine Network (OTN) service is available at both hospital sites Monday to Friday. OTN utilizes two-way videoconference technology allowing patients to access a specialist anywhere in Ontario in a timely manner. Other benefits include reduced travelling time and costs and avoiding risky weather conditions.

Current Status: Currently the organization embraces the use of telemedicine technology where possible to support clinical (including teletrauma vascular telederm), administrative, and education programs. All sites have telehealth capabilities through the use of the Ontario Telemedicine Network. Specific sites have enhanced capabilities allowing for telemedicine services to be provided.

Future Planning Assumptions: It is expected that the use of telemedicine technology will expand significantly in the future enabling home to hospital connections for diagnosis and treatment. This will include telemental health e-clinic visits, virtual medicine, home dialysis, among others.

Pediatric Outreach Clinics

Current Status: Currently pediatricians from Orillia provide pediatric outreach clinics at each of the two MAHC hospital sites:

- HDMH - an outreach clinic in the surgical suite once per month.
- SMMH - an outreach clinic in the cardio-respiratory department once per month.

Future Planning Assumptions: In the future the clinics will be offered in the community at a family health team or other offices.

Seniors Assessment and Support Outreach Team (SASOT)

(Refer to the section on Community Services - On-Site for further information).

Stroke Prevention Clinic

Current Status: not applicable.

Future Planning Assumptions: A Stroke Prevention Clinic may be added to the service provision if the Integrated Stroke Program is delivered by MAHC in the future.

Surgical Clinics

Current Status: MAHC currently provides the following ambulatory surgical services in the hospitals:

- lumps and bumps
- Emergency Room Off-load Clinic (EROC) manages CTAS Levels 4 and 5 patients who arrive at the ED and require IV medications, suturing, etc. The clinic currently is used as a medical/surgical day care
- Surgical Clinics including follow-up acupuncture and laser procedures
- Pre-surgical Assessment Clinic currently patients receive pre-surgical assessments on an as-required basis.

Future Planning Assumptions: MAHC will continue to provide ambulatory surgical services. In future some services will be moved off-site while others will be added:

- lumps and bumps and minor surgical procedures
- a new Medical Day Care unit will support the reduction of Level 4 and 5 patient visits to the ED as well as help to manage Level 4 and 5 patients arriving at the ED who require medical day procedures (services currently provided by the EROC clinic on the HDMH site)

- the Surgical Day Care (adjacent to the Surgical Suite) will support non OR-type procedures including scheduled liver biopsies and bone marrow among others
- cataracts will be moved from the main ORs to an ambulatory minor procedure service area
- surgical follow-up clinics will be offered in the community in surgeons' offices
- Pre-surgical Assessment Clinic in the future to reduce the risk of complications all patients having elective procedures at MAHC will receive a scheduled pre-surgical screening and assessment. It is expected that approximately 70% to 75% of all clinic contacts will be by telephone, the remainder will be on-site visits.

Workload

Table 7: Current & Projected Ambulatory Care Workload

	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC Ambulatory Care						
Surgical Clinic:						
- Surgical Clinic Visits	2,919	2,326	2,034	2,184	2,477	2,703
- Cataracts	704	675	696	803	913	1,127
- Off-load Clinic Visits/Procedures	1,422	503	254	273	309	331
Fracture Clinic Visits (in ED)	3,108	n/a	n/a	2,713	2,876	3,198
Nutrition Consults	38	38	30	34	42	51
Diabetes Visits	5,035	3,452	3,058	3,325	3,885	4,422
Dialysis:						
- # of Patients	24	21	24	28	38	67
- # of Treatments annually	2,689	3,370	3,405	3,653	3,900	4,440
Chemotherapy:						
- Systemic Therapy Treatments	954	1,029	1,349	1,548	2,028	2,489
- Oncology Clinic Visits	1,837	1,874	1,798	2,063	2,703	3,299
Medical Day Care from Off-load	1,838	1,834	1,816	2,034	2,538	3,802
HDMH Ambulatory Care						
Surgical Clinic:						
- Surgical Clinic Visits	2,028	2,326	1,422	1,527	1,732	1,890
- Cataracts	365	530	696	747	848	1,027
- Off-load Clinic Visits/Procedures	414	503	254	273	309	331

	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
Fracture Clinic Visits (in ED)	n/a	n/a	n/a			
Nutrition Consult	27	32	25	28	35	42
Diabetes Visits	3,534	2,616	2,250	2,447	2,858	3,253
Dialysis:						
- # of Patients	18	21	24	28	38	67
- # of Treatments annually	2,689	3,370	3,405	3,653	3,900	4,440
Chemotherapy:						
- Systemic Therapy Treatment	666	737	1,285	1,475	1,932	2,371
- Oncology Clinic Visits	805	951	1,033	1,185	1,553	1,895
MDC visits[1]	830	985	959	1,074	1,341	2,008
SMMH Ambulatory Care						
Surgical Clinic:						
- Surgical Clinic Visits	891	n/a	612	657	745	813
- Cataracts	339	145	n/a	0	0	0
- Off-load Clinic Visits/Procedures	---	---	---	---	---	---
Fracture Clinic Visits	n/a	n/a	n/a			
Diabetes Visits	1,501	836	808	879	1,026	1,169
Nutrition Consult	11	6	5	6	7	9
Chemotherapy:						
- Systemic Therapy Treatment	288	292	64	73	96	118
- Oncology Clinic Visits	1,032	923	765	878	1,150	1,404
MDC Visits	1,008	849	857	960	1,198	1,794

Note:

A. Medical Day Care visits include therapy phlebotomies biologic anti-inflammatory clinic and nursing clinic. The service is provided from the Chemotherapy Clinic because of the available nursing resources.

Location Priorities

In order of priority:

1. Main Hospital Entrance - patient parking and entry to ambulatory care area.
2. Emergency Services - for use of the ambulatory area at times of increased patient volumes.
3. Diagnostic Imaging.

Emergency Services

Scope of Service Assumptions

Current Status: Currently an interprofessional team comprised of emergency physicians, general practitioners, registered nurses, registered practical nurses, nurse practitioners, and physician assistants, provide 24/7 emergency services at both of the MAHC hospital sites. The services are provided according to the 5-level Canadian Triage Assessment Scale (CTAS) for unscheduled care of patients of all age groups. The 5 CTAS categories include: trauma/resuscitation, emergent, urgent, less urgent, and non-urgent care.

Patients who are critically ill or need specialized services (cardiac, trauma, mental health, etc.) may be transferred to another hospital once they are stable. Each of MAHC's sites is equipped with a helipad. Transfers may be managed by the ED or CritiCall Ontario and depend on the patient's needs and availability of a bed at another hospital.

Currently patients may return to the ED or contact their family care provider for a follow-up visit after being in the ED.

Services currently provided from the ED include:

- triage (providing a single point of entry and access to all emergency services), assessment and treatment of emergent, urgent, and non-urgent medical conditions, patient instruction and discharge, home transfer, or admission
- resuscitation and stabilization of adult and pediatric patients with life-threatening illness, including multiple trauma patients to be transferred to a tertiary care centre
- emergent care for adult and pediatric patients requiring immediate medical attention
- urgent care of patients requiring medical attention for non-life threatening conditions
- minor care of less urgent and non-urgent patients in a fast track 'See and Treat' area. This area supports the timely flow of patients through the ED, operates 24-7, and employs dedicated staff (coverage by 1 physician) for 12 hours of each day. *Note*: in future the model for See and Treat either will be integrated within the ED or located adjacent to the ED in a separate area
- monitoring and treatment of patients whose disposition is unclear for no more than 24 hours
- provision of mental health emergency services for patients with psychogeriatric behavioural and/or alcohol/addictions issues. Services include secure receiving and stabilization of patients in psychiatric distress, some of whom will be held and then transferred to regional partners with mental health beds and the resources to look after these patients

- splinting and casting services including setting and applying casts to fractured bones and dislocated joints for emergency patients, patient referral to the fracture clinic, splinting and casting services also are provided on the inpatient units
- emergency response preparedness including Chemical Biological Radiological Nuclear Environmental (CBRNE) accident decontamination
- scheduled follow-up visits.

Emergency Services are supported by the following:

- District Stroke Centre (see below)
- Emergency Off-load Clinic (HDMH site only) provides clinic space and supplies for scheduled medical and surgical minor interventions/procedures for CTAS Level 4 and 5 patients
- Fracture Clinic currently located adjacent to each ED
- CCAC staff in the ED support discharge planning and link patients to community services.

District Stroke Centre

Currently the District Stroke Centre is part of the Central East Stroke Network. The Centre offers specific expertise in assessing and treating anyone who shows the signs or symptoms of stroke. Services include: district responsibilities, patient support at home, crisis response to the Emergency Room, including the provision of t-PA medications and primary care support. Ambulatory care activities include visits to district partners including FHTs and NPs the provision of in-services training and education sessions among others. Currently the District Stroke Centre is accommodated in ambulatory care at the HDMH site and the team responds to calls from the HDMH ED. Access to rehabilitation services are provided on both sitess from 0830-1600 weekdays.

Future Planning Assumptions: MAHC will continue to provide 24/7 unscheduled Emergency care for patients of all age groups as described above.

Future service provision assumes that:

- The ED will not accommodate scheduled patient visits
- CTAS Level 4 and 5 visits will be reduced
- The ED(s) will cotinue to have access to stroke services.

Table 8: Current & Future Emergency Services By Site

Note: though the table designates future emergency services across the two existing sites the section titled *Section C Options for Service Delivery* more clearly indicates that services may be combined on a single site, two full service EDs, or delivered across two sites by distributing the workload in a rationalized approach with each site having an ED.

		CURRENT		FUTURE	
		HDMH	SMMH	HDMH	SMMH
	Emergency Services	*visits*	*visits*	*visits*	*visits*
1.	- CTAS 1	✓	✓	✓	✓
	- CTAS 2	✓	✓	✓	✓
	- CTAS 3	✓	✓	✓	✓
	- CTAS 4	✓	✓	✓	✓
	- CTAS 5	✓	✓	✓	✓
2.	District Stroke Centre	✓	-	✓	-
3.	Scheduled Ambulatory	✓	✓	-	-

Notes:

A. Fracture clinic visits included in ED total visit volumes.

B. Some surgical outpatient visits occur on the hospital sites in the ED and EROC. These will be eliminated in the future.

C. MAHC will continue to have helipad access.

Workload

Table 9: Current & Projected Workload

Visits	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
Total Unscheduled	**42,764**	**42,855**	**43,505**	**39,318**	**41,378**	**46,026**
Total Other[1]	3,108	n/a	n/a	---	---	---
HDMH						
Total Unscheduled	**22,808**	**22,252**	**23,428**	**20,841**	**21,810**	**23,954**
CTAS 1+2	1,008	2,268	2,313	2,441	2,576	2,868
CTAS 3	9,157	9,260	9,839	10,247	10,747	11,903
CTAS 4+5	12,630	10,724	11,276	8,153	8,487	9,183
Other[1]	13	n/a	n/a	---	---	---

Visits	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
SMMH						
Total Unscheduled	**19,956**	**20,603**	**20,077**	**18,477**	**19,568**	**22,072**
CTAS 1+2	1,465	1,811	1,721	1,827	1,942	2,202
CTAS 3	7,921	8,944	8,478	8,889	9,397	10,594
CTAS 4+5	10,551	9,848	9,878	7,761	8,229	9,276
Other[1]	19	n/a	n/a	---	---	---
Scheduled visits[1]	1,552	n/a	n/a	---	---	---

Notes:

1. For the most part the actual scheduled visits to the ED include Fracture Clinic visits and visits by patients requiring daily IV medications.

Important factors that were used in the data analysis and the development of the services projections include:

A. Population growth and aging:
   - The forecast incorporates growth rates specific to each region and 5 year age group. Weighted to accommodate the increasing population of older adults.
   - It is assumed that the rate of CTAS 1, 2, and 3 ED visits per capita will remain at the current level and the number of ED visits in the future will increase with demographic growth.

B. Market share and opportunities for repatriation:
   - 57% of MAHC ED visits are for residents of Huntsville, Bracebridge, or Gravenhurst.
   - 17% of MAHC ED visits are for patients who reside outside of the NSM and NE LHIN.

C. Opportunities to reduce use of hospital resources include:
   - Move scheduled visits out of the ED to a hospital-based ambulatory care clinic or to a community health service provider.
   - Avoidable ED visits: 49% of MAHC's ED visits are for triage Level 4 and 5 care. It is assumed that ED visits for CTAS Level 4 and 5 patients in MAHC's catchment area will be decreased to at least the 75th percentile rate in the future.

D. Workload includes visits to the ED by the significant summer tourist population.

E. Future projections exclude any scheduled or follow-up visits to Emergency Services. These services will be provided either in ambulatory care or physician offices.

F. Wait times at each of MAHC's EDs are shorter than the provincial average. Currently the average wait times at the HDMH Site are 3.7 hours for complex conditions and 1.5 hours for uncomplicated conditions compared to the provincial average of 5.7 and 2.2 respectively. The average wait times at the SMMH Site are 4.1 hours for complex conditions and 1.9 hours for minor conditions.

   'Our goal is to minimize waiting times The Ministry through the North Simcoe Muskoka LHIN is building on the success of its ER performance improvement program and is investing $926,500 in one-time funding in MAHC's hospital sites through the Pay for Results program. While the HDMH Site has been part of this program for some time this is the first time that Pay for Results funding will include the South Muskoka Memorial Hospital (SMMH) Sites.' (Per the MAHC web site).

Location Priorities

In order of priority:

1. Ambulatory Care (depending on site option) - for sharing of space resources in peak times.
2. Diagnostic Services for access to CT Scan.
3. Clinical Laboratory.
4. Intensive Care Unit (depending on future need to share staffing).
5. Surgical Services.

Note: the ED requires a separate dedicated walk-in entry and ambulance entry.

Inpatient Services

Scope of Service Assumptions

Current Status: MAHC provides inpatient care at both the HDMH and SMMH sites. The inpatient services provides care for patients experiencing critical, acute, and complex medical and surgical conditions, and low risk obstetrical care for pregnant women.

Future Planning Assumptions: In future MAHC Inpatient Services will work to improve flow through the hospital from inpatient care to alternate levels of care in the community (e.g., home care). This will include addressing the factors that contribute to longer lengths of in-hospital stay and increased readmission rates of patients back into hospital care as well as developing sustainable solutions that generate better patient experience and health outcomes, improve bed utilization and access to specialized services, rehabilitation, senior friendly practices, and other transitional services to reduce ALC rates in hospital.

Improved flow through the hospital will be reliant on the availability of appropriate (type, quality, and quantity) of community services.

Table 10: Current & Future Inpatient Services Beds By Site

Note: though the table designates future bedded services across the two existing sites the section titled *Section C Options for Service Delivery* more clearly indicates that bedded services may be delivered across two sites or combined on a single site.

		CURRENT		FUTURE	
		HDMH	SMMH	HDMH	SMMH
1.	Medical /Surgical	✓	✓	✓	✓
2.	Critical Care	✓	✓	✓	✓
	- Step-Down/-Up	-	-	✓	✓
3.	Maternal/Child	✓	✓	✓	✓
4.	Complex Cont. Care	-	✓	-	✓

Notes:

A. Currently MAHC operates 96 inpatient beds across the two hospital sites.

B. Bed utilization flows between the medical/surgical bed compliment and the maternal beds at both sites.

C. With approval from the Ministry of Health and Long-Term Care, MAHC closed 12 Interim Long-Term Care Beds at the HDMH Site on March 31, 2013.

Medical/Surgical Inpatient Services

Scope of Service Assumptions

Current Status: An inter-professional team provides a broad range of medical and surgical inpatient services for patients requiring admission to hospital for diagnosis, observation, and treatment.

Care delivery is patient and family centered. The team's goal is to provide safe and excellent health care to assist in recovery and a smooth transition to home or the community.

Medical/surgical inpatient services mainly are provided to adults however occasionally adolescent patients are admitted for a short length of stay.

The more common medical diagnoses include acute stroke and chronic disease including respiratory, arterial disease, cardiac, sepsis, dementia, alcohol-related and mental health.

The more common most responsible diagnosis that require inpatient care include: digestive system malignancy, hepatobilliary system and pancreas injuries/poisoning, and toxic drug effects, kidney and urinary system, respiratory system, and arthritis and musculoskeletal system.

Future Planning Assumptions: In the future medical and surgical inpatient services will continue to be provided as described above and to an increasingly elderly population within 80 beds (2019), 84 beds (2024) and 104 beds (2034).

Workload

Table 11: Current & Projected Workload

Beds	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
Medical/Surgical Beds	69	61	66	80	84	104
Occupancy	102%	n/a	n/a	90%	90%	90%
Patient Days	25,843	17,843	18,503	21,919	24,615	30,945
ALOS	6.4	4.2	4.2	4.3	4.3	4.5
Separations	4,018	4,248	4,405	5,097	5,724	6,877
ALC Days	7,208	7,213	5,816	4,361	2,979	3,219
ALC Rate	22%	29%	24%	18%	11%	9.5%

Beds	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
HDMH						
Medical/Surgical Beds	28	n/a	29	32	34	42
Occupancy	102%	n/a	n/a	90%	90%	90%
Patient Days	10,576	6,925	8,203	8,660	9,804	12,487
ALOS	5.7	3.6	3.9	3.99	4.04	4.14
Separations	1,861	1,908	2,088	2,170	2,426	3,016
ALC Days	3,210	3,899	3,056	1,852	1,365	1,310
ALC Rate	23%	36%	27%	18%	11%	9.5%
SMMH						
Medical/Surgical Beds	41	n/a	37	48	50	62
Occupancy	102%	n/a	n/a	90%	90%	90%
Patient Days	15,268	10,918	10,300	12,930	14,619	18,432
ALOS	7.1	n/a	4.69	4.78	4.86	5.02
Separations	2,157	2,200	2,196	2,705	3,008	3,671
ALC Days	3,998	2,954	2,356	2,838	1,806	1,935
ALC Rate	21%	21%	19%	18%	11%	9.5%

Notes:

Important factors that were used in the data analysis and the development of the Inpatient services bed projections include:

A. Population growth and aging:

- The forecast incorporates growth rates specific to each region and five year age group. Since use of hospital services is strongly associated with age the weighted growth rate was used for the projections.

B. Market share and opportunities for repatriation:

- two thirds of MAHC inpatients reside in Huntsville, Bracebridge, or Gravenhurst.
- 8% of MAHC inpatients reside outside of the NSM and NE LHINs.

C. Occupancy rates:

- Current occupancy rates for medical and surgical inpatient beds are higher (102%) than the NSM LHIN recommended target occupancy for planning purposes (85/90%). The current occupancy rates were adjusted to the LHIN recommended % to support bed projections.

D. Opportunities to reduce use of hospital resources including:

- ALC use of acute resources - 27% of MAHC's total inpatient days are ALC, the NSM LHIN's ALC target is 9.5% projections assume a gradual decrease in ALC occupancy over the 20 year planning horizon to the 9.5% target.
- If MAHC were to reduce its ALC rate from the current 27% of total days to the LHIN target 9.5% the hospital would need six beds now and 10 beds in 20 years. Achieving this assumes investment in non-hospital community-based services.

E. Reducing Ambulatory Care Sensitive Condition acute inpatient days to the Provincial average did not have a significant effect on bed volume.

Location Priorities

In order of priority:

1. Intensive Care Unit (telemetry).
2. Surgical Services.
3. Emergency Services.
4. Diagnostic Imaging.
5. Discharge Lounge.
6. Staff education areas including the simulation room.

Critical Care

Scope of Service Assumptions

MAHC's Intensive Care Unit (ICU) will provide Level 3 Critical Care Services and Step-Down/-Up care with specialized intensive nursing care assessments and interventions/invasive diagnostic work not available on the medical/surgical inpatient unit.

Current Status: Currently MAHC's Critical Care Services are provided at each site – HDMH (5 beds) and SMMH (4 beds).

Each of the existing ICUs provide Level 3 close observation and treatment of critically ill or injured surgical and cardiac patients who require a high level of care. These patients have life-threatening conditions and need comprehensive critical care and constant monitoring. Patients may be admitted to the ICU after complex surgery as a result of overwhelming infection or after trauma.

Note: Critical Care Services are part of the Trillium Gift of Life Network. As such the service is required to be a Level 3 ICU.

Care is provided for patients requiring:

- support for a single and multi-system organ failure
- short-term ventilation (<48 hours) and longer term ventilation (>48 hours)
- post-operative care
- overdose management
- 'step-up care' from a lower level of care
- monitoring haemodynamically
- telemetry monitoring of patients on the acute care medical/surgical inpatient units who are of significant risk of cardiac arrest and
- cardiac monitoring of patients in the ICU.

Each nurse cares for one, two, or a maximum of three patients. The ratio depends on the complexity and acuity of the illness. Each unit is staffed with two qualified RNs at all times.

Currently with the high occupancy rate in the medical/surgical beds MAHC has a high propensity to admit patients to the ICU. Not many of the patients in ICU require this level of critical care.

Future Planning Assumptions: The ICUs will continue to be a Level 3 critical care service provider and integral within the Hospital's spectrum of care as noted above. In the future only critical care patients will be supported in the ICU and intermediate care Step-down/Step-up services will be developed for high dependency patients and cardiac care patients.

Workload

Table 12: Current & Projected Workload

Beds	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
Beds ICU	9	9	9	6	7	8
Beds SDU	n/a	n/a	n/a	1	1	2
Occupancy	70%	63%	57%	80%	80%	80%
Patient Days ICU	2,303	2,083	1,887	1,752	2,044	2,336
Patient Days SDU	n/a	n/a	n/a	292	292	584
ALOS	2.8	2.8	2.6	2.9	2.9	2.9
Separations	829	745	740	704	805	1,007
HDMH						
Beds ICU	5	5	5	3	3	4
Beds SDU	n/a	n/a	n/a	1	1	1
Occupancy	73%	67%	68%	80%	80%	80%
Patient Days ICU	1,325	1,225	1,233	876	876	1,168
Patient Days SDU	n/a	n/a	n/a	292	292	292
ALOS	2.50	2.50	2.44	2.9	2.9	2.9
Separations	529	490	505	403	403	503
SMMH						
Beds ICU	4	4	4	3	4	5
Beds SDU	n/a	n/a	n/a	1	1	1
Occupancy	67%	62%	59%	80%	80%	80%
Patient Days ICU	978	858	654	876	1,168	1,277
Patient Days SDU	n/a	n/a	n/a	292	292	292
ALOS	3.26	3.36	2.78	2.9	2.9	2.9
Separations	300	255	235	403	503	541

Notes:

Important factors that were used in the data analysis and the development of the Inpatient services bed projections include:

A. Population growth and aging:

- The forecast incorporates growth rates specific to each region and five year age group. Since use of hospital services is strongly associated with age the weighted growth rate was used for the projections.

B. Market share and opportunities for repatriation:

- Two thirds of MAHC inpatients reside in Huntsville, Bracebridge, or Gravenhurst.
- Eight percent of MAHC inpatients reside outside of the NSM and NE LHINs.

C. Occupancy rates:

- Current occupancy rates in the ICUs are low and have been adjusted to NSM LHIN acceptable rates for projected beds.

D. Opportunities to reduce use of hospital resources including:
   - MAHC has a high propensity to admit inpatients to the ICU projections assume a decrease in ICU bed requirements over the 20-year planning horizon and the development of Medical/Surgical Step-Down/-Up beds to support more appropriate levels of care.
   - Single-siting ICU beds will result in fewer beds.

Location Priorities

In order of priority:

1. ICU and Step-down to Surgical Day Care (SDC).
2. ICU to ED.
3. Medical/Surgical Inpatient Services.

Note: Respiratory Therapy requires close adjacency to ICU, Surgical Services, and the ED.

Maternal/Child Services

Scope of Service Assumptions

Maternal/Child Services will provide comprehensive patient and family-centered antepartum, intrapartum, and post-partum care to mothers and newborns. Care will be delivered in a multidisciplinary model that includes obstetricians, family physicians, registered nurses, and midwives.

Current Status: Currently inpatient obstetrical services are provided at each of MAHC's two sites - HDMH (3 beds) and SMMH (2 beds) post-partum care is provided on the medical/surgical inpatient units at each site. In addition, care at the SMMH site is supported by an outpatient prenatal and antenatal clinic.

The Midwives of Muskoka and the Midwives of Haliburton use MAHC birthing facilities for their clients who wish to have their newborns delivered in hospital.

Other obstetrical services provided at MAHC include:

- on-unit lactation/breastfeeding support (post-partum) at both the HDMH and SMMH sites
- on-unit non-stress testing at both the HDMH and SMMH sites
- Physicians provide a prenatal and antenatal clinic at the SMMH site offering complete prenatal care for women with low-risk pregnancies from the early onset of pregnancy to birth and afterwards. *Note:* beginning in 1999 in response to a shortage of family physicians the clinic currently is operated by a group of four family physicians
- prenatal classes including a tour of the Maternal/Child unit at the SMMH site
- pre-admission group including a tour of the Maternal/Child unit at the HDMH site
- antenatal visits at the SMMH site prenatal and antenatal clinic
- antenatal visits at the HDMH site over 20 weeks and
- newborn follow-up at both sites.

Pregnant women requiring tertiary care are transferred to Orillia Soldiers' Memorial Hospital (OSMH), Mount Sinai, or London Health Sciences. Newborn babies who require tertiary care and are less than 32 weeks are transferred to OSMH for Level 2 care or to an available bed in a tertiary care centre.

Family physicians provide some prenatal and intrapartum care for expectant mothers. Local Family Health Teams provide newborn care.

The maternal/child services are supported by a variety of community partnerships and resources including: Public Health, Great Beginnings, Early Years, Infant Hearing Screening, Smokers' Helpline, and Helping Hands Program.

Future Planning Assumptions: MAHC will continue to provide comprehensive patient and family-centered antepartum intrapartum and post-partum care to mothers and newborns. It is assumed that in the future the model of care will encompass labor delivery, recovery, and post partum care (LDRP) in one patient bedroom for mothers having normal vaginal deliveries. Mothers having c-sections will be transferred into a single-bedded room for post-partum care. In addition the antepartum/post-partum rooms will be utilized for antenatal admissions, post-partum stays for c-section patients, post-partum readmissions, post-partum aborted outcomes, and excessive post-partum stays.

A single room maternity care model will support patient and family-centered care by keeping the infant in a single room with the mother as much as possible. The same nursing staff will care for the mother and baby during each phase of their hospital stay. The service will provide expectant mothers with an option for a water birth supported by a birthing tub room.

Lactation/breastfeeding, non-stress testing, prenatal/pre-admission, classes/groups, antenatal visits, and newborn follow-up visits will continue to be supported on the units. The current prenatal and antenatal clinic at the SMMH site will be provided from the community in the future.

Inpatient women's health services will be provided solely in the Medical/Surgical Inpatient Units.

Care will be patient and family-centered.

The units will be secured with controlled access.

Workload

Table 13: Current & Projected Workload

Beds/Visits	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 20179/20	Projected 2024/25	Projected 2034/35
MAHC						
Beds	5	5	5	3	3	3
Births:	322	266	275	266	263	267
- Vaginal	179	172	193	187	185	188
- C-section	143	94	82	79	78	79
Occupancy	43%	n/a	n/a	75%	75%	75%
Patient Days	1,090	608	581	820	820	820
ALOS (days)	1.87	2.05	1.96	1.99	2.02	2.08
Separations	583	297	297	289	288	296

Beds/Visits	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 20179/20	Projected 2024/25	Projected 2034/35
HDMH						
Beds	3	3	3	2	2	2
Births:	204	156	162	156	153	154
- Vaginal	106	109	118	114	112	113
- C-section	98	47	44	42	41	41
Occupancy	29%	n/a	n/a	75%	75%	75%
Patient Days	322	330	303	547	547	547
ALOS (days)	n/a	1.89	1.71	1.71	1.72	1.72
SMMH						
Beds	2	2	2	2	2	2
Births:	118	110	113	110	110	112
- Vaginal	73	63	75	73	73	74
- C-section	45	47	38	37	37	38
Occupancy	37%	n/a	n/a	75%	75%	75%
Patient Days	273	278	278	547	547	547
ALOS (days)	n/a	2.28	2.32	2.39	2.47	2.60

Notes :

Important factors that were used in the data analysis and the development of the Inpatient services bed projections include:

A. Population growth and aging:

- The forecast incorporates growth rates specific to each region and five year age group.

B. Market share and opportunities for repatriation:

- Two thirds of MAHC inpatients reside in Huntsville, Bracebridge, or Gravenhurst.
- 8% of MAHC inpatients reside outside of the NSM and NE LHINs.

C. Occupancy rates:

- Current occupancy rates for Maternal/Child inpatient beds are lower (33%) than the NSM LHIN recommended target occupancy for planning purposes (75%). The current occupancy rates were adjusted to the LHIN recommended % to support bed projections.

D. Opportunities to reduce use of hospital resources including:

- If Maternal/Child Services remains on two sites the projections assume two beds per site. However to support peak times on the units three beds would be required at each site – two LDRP with access to a shared water birthing room and 1 post partum room. All rooms will include the mother, newborn, and family.
- If Maternal/Child Services are provided from one site the projections assume three total beds – two LDRP with access to a shared water birthing room and one post partum room. All rooms will include the mother, newborn, and family.
- While the 1 site provision of Maternal/Child services supports a more efficient model of care the 2-site provision of services supports care close to home. Further discussion on a one site versus a 2-site model is discussed under Section C Options for Service Delivery.

E. MAHC had Ontario's fourth highest proportion of deliveries by Caesarean Section. MAHC developed a strategy paper *"Strategies for Caesarean Section Reduction SMMH Site May 29 2012" an*d is in the process of reviewing the high % of c-sections and will set a target rate for primary and repeat c-sections and strategies for achieving the target rate.

F. Currently approximately 70% of deliveries by midwives are performed in hospital and 30% at home. In the current year 45 to 50 births occurred at home. Projections assume that deliveries at home will not increase deliveries by midwives in hospital will increase but not significantly.

G. Staffing models will be developed in the Human Resources Plan, which will form part of a subsequent project.

Location Priorities

In order of priority:

1. Surgical Services (for c-sections 24-hour epidural coverage - anesthesia).
2. Respiratory Therapy.
3. Diagnostic Services.
4. Emergency Services.

Complex Continuing Care (CCC)

Scope of Service Assumptions

MAHC's Complex Continuing Care Service will provide time-limited in-hospital care for patients with complex medical conditions and those requiring restorative slow-stream rehab and end-of-life care.

Current Status: MAHC currently delivers Complex Continuing Care services to inpatients over 18 years of age. *Note:* as of April 2015 all of the CCC beds are housed on the SMMH site in a 16-bed unit.

Individuals access service is through the centralized CCC bed registry. MAHC is part of the Regional Complex Continuing Care Program. Patients are referred to this program before admission and may be admitted to one of three locations within the region.

Individuals admitted to Complex Continuing Care are medically stable (diagnosis and acute phase complete) but have multiple complex chronic conditions requiring daily skilled assessment and active care by an inter-professional team. On admission patients have discharge planning goals and standardized admission and discharge criteria in place. An interdisciplinary intervention approach is utilized to assist the patient in achieving the determined outcome.

Care is specialized time-limited and transitional in nature and patients move to the most appropriate care environment for their needs. "Home First" is the primary focus for discharge however admission to an acute rehabilitation facility or other community settings also may be identified as the best means of improving a patient's function. ALC patients are admitted to a long-term care facility(s) or retirement homes.

In addition MAHC works closely with their local CCAC representative(s) whose role is enhanced to include centralized wait list management and standardized assessment referral and placement processes.

End-of-life care is provided within the CCC bed complement when required to maintain or improve the life of a dying person. It is not focused on curative care but rather on achieving comfort and ensuring respect for the person nearing death and maximizing quality of life for the patient family and loved ones.[3]

End-of-life care is supported by Hospice Muskoka in Bracebridge and Hospice Huntsville/Algonquin Grace in Huntsville.

Transportation remains a major issue for CCC patients requiring follow-up appointments and referrals to outside specialists for emerging problems. Current transportation is either unreliable or costly.

[3] As defined by Health Canada: http://www.hc-sc.gc.ca/hcs-sss/palliat/index-eng.php

Future Planning Assumptions: In the future MAHC will continue to deliver Complex Continuing Care services to inpatients over 18 years of age as part of the NSM LHIN's Complex Continuing Care Regional Program. CCC services will continue to care for patients with complex medical conditions and those requiring restorative slow-stream rehab and end-of-life care.

CCC will address the following service improvements for their patient population:

- Transitional care needs between the hospital and community providers CCC will improve access to social work services for patients who are under 65 years of age. This will increase CCC's ability to discharge and transfer patients from the unit at the appropriate time and thereby decrease the patient's length of stay. *Note:* SASOT currently provides social work services for patients 65 and over.
- Improved access to Rehab Services in CCC moving from a six-day-a-week model to a potentially seven-day-a-week model for rehabilitation services.
- Increased access to ambulatory care and specialist services In future MAHC will explore a less costly and disruptive solution to the provision of transportation between hospital sites as a whole and in particular for CCC patients requiring follow-up appointments and referrals to outside specialists for emerging problems.

CCC will address the following programming improvements for their patient population:

- Foot care services to improve mobility/reduce falls and reduce incidence and severity of diabetic foot ulcers and amputation rates.
- Bladder Scanner to identify bladder problems promote continence (and a home discharge) and reduce UTI rates from catheterizations.
- Portable Doppler (Ultrasound) for ABIs (Ankle Brachial Indexes): to assess arterial circulation to appropriately treat arterial and venous leg ulcers via compression therapy.
- Access to advanced wound care supplies and equipment to manage the increased complexity of wounds that often accompany medically complex patients.

Workload

Table 14: Current & Projected Workload

Beds	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
Beds	28	24	24(16)	18	20	22
Occupancy	84%	n/a	n/a	95%	95%	95%
Patient Days	8,548	7,773	6,228	6,241	6,935	7,628
ALOS	63.3	56.7	52.8	45.2	44.9	44.3
Separations	135	137	137	138	154	172
HDMH						
Beds	10	10	24 (16)	18	20	22
Occupancy	85.3%	60.4%	71.1%	95%	95%	95%
Patient Days	3,113	2,205	6,228	6,241	6,935	7,628
ALOS	59.5	61.2	52.8	45.2	44.9	44.3
Separations	54	50	137	138	154	172
SMMH						
Beds	18	19	0	---	---	---
Occupancy	82.7%	80.3%	0	---	---	---
Patient Days	5,435	5,569	0	---	---	---
ALOS days	81.8	63.1	0	---	---	---
Separations	81	87	0	---	---	---

Notes:

Important factors that were used in the data analysis and the development of the Inpatient services bed projections include:

A. As of January 2014 all of the CCC beds were located on the SMMH site. On April 01 2015, the beds numbers were reduced from 24 to 16 beds.

B. Population growth and aging:

- The forecast incorporates growth rates specific to each region and five year age group. Since use of hospital CCC services is strongly associated with age the weighted growth rate was used for the projections.

C. Market share and opportunities for repatriation:

- Two thirds of MAHC inpatients reside in Huntsville, Bracebridge, or Gravenhurst.
- 8% of MAHC inpatients reside outside of the NSM and NE LHINs.

D. Occupancy rates:

- Current occupancy rates for CCC inpatient beds are lower (84%) than the NSM LHIN recommended target occupancy for planning purposes (95%). The current occupancy rates were adjusted to the LHIN recommended % to support bed projections.

E. CCC bed utilization:

- Muskoka residents are using less than the provincial average level of access to CCC services projections. Increases in CCC bed requirements over the 20-year planning horizon reflect the demographics of the population balanced with current utilization rates

Location Priorities

In order of priority:

1. Outdoor therapeutic courtyard(s).
2. Rehabilitation Services (OT and PT).
3. Medical/Surgical Inpatient Services – for future flexibility in bed use.
4. Diagnostic Imaging.
5. Staff education areas including the simulation room.

Integrated Stroke Program

Scope of Service Assumption

Current Status: Not applicable though MAHC provides care for patients who have experienced a Stroke and have the services of the District Stroke Program in the HDMH emergency department. The organization does not currently have a formal Integrated Acute Stroke Rehab Program. Currently, it is estimated that approximately three equivalent beds in the Medical/Surgical are used on a daily basis for stroke patients.

Future Planning Assumptions: MAHC will continue to work with the NSM LHIN on the development of a regional stroke rehab program in which initial planning allocates up to 10 beds to MAHC. However, as the planning is still on going, these beds have not been included in MAHC's bed projections.

Surgical Services

Scope of Service Assumptions

Surgical Services/Endoscopy will provide a broad range of surgical care in support of residents of MAHC's catchment area.

Current Status: Currently Surgical Services provide a broad range of surgical care at each MAHC hospital site – HDMH (two ORs and two endoscopy suites) and SMMH (two ORs, one endoscopy suite and one urology suite) in support of residents of the Muskoka catchment area.

Surgeries and procedures are scheduled at both hospital sites Monday to Friday from 0700 hours to 1600 hours. The Service also provides 24/7 support to the two Emergency Departments.

Each site provides elective and non-elective inpatient and outpatient surgery in the following specialties:

- general surgery (both hospital sites)
- obstetrics elective and urgent c-section (both hospital sites)
- ophthalmology (eye at HDMH and laser at SMMH)
- emergency eye surgery (SMMH)
- cataract surgery (HDMH)
- urology (SMMH)
- gynaecology (SMMH)
- endoscopy (both hospital sites).

The new gynaecology surgical service (SMMH site) will include minor intermediate and major procedures and will be available once per week on an ongoing basis. The service is being established by the Chief of Obstetrics at Orillia Soldiers' Memorial Hospital (OSMH).

Minor Surgical Procedures (lumps and bumps) are performed at both hospital sites – in the surgical clinics at HDMH and in the ORs and surgical day care unit at SMMH.

Pre-surgical assessments are provided on a case-by-case basis. There is no formal process established and patients are referred to an anesthesia consult for pre-surgical evaluation as required.

The existing surgical services at each site are supported by a Surgical Day Care (SDC), Post-Anaesthetic Care Unit (PACU), an in-house Medical Device Reprocessing Department (MDRD), and Infection Prevention and Control.

Advanced and sophisticated equipment aids in the process and includes:

- three endoscopy suites for minimally invasive diagnoses using an endoscope (two at HDMH and one at SMMH)

- a urology suite which includes a state-of-the-art imaging table for urological procedures and cystoscopies (SMMH).

Approximately 90% of patients receive surgery through the SDC Unit. Patients are admitted into day surgery in the morning, undergo surgery, are monitored during recovery, and return home – all on the same day.

Endoscopy Services operate a mainly ambulatory basis designed to meet the needs for colorectal cancer screening, benign colon esophageal disease, and local cystoscopy. Endoscopy procedures are achieved via IV monitored sedation with anaesthesia support as available.

Endoscopy/cystoscopy cases include but are not limited to the following services:

- gastroscopy
- cystoscopy
- colonoscopy
- sigmoidoscopy.

Endoscopic Retrograde Cholangiopancreatogram is performed at both sites.

Currently patients having endoscopies are prepared and recovered in the surgical day care at each site.

Future Planning Assumptions: MAHC will continue to provide Surgical Services as described above. Efficiencies will be gained through the future mix of surgical services provided on each of the two sites or the provision of a single site service.

Table 16: Current & Future Surgical Services Cases By Site

Note: though the table designates future services across the two existing sites the section titled *Section C Options for Service Delivery* more clearly indicates that surgical services may be delivered across two sites or combined on a single site.

		CURRENT		FUTURE	
		HDMH	SMMH	HDMH	SMMH
1.	Surgical Procedures	√	√	√	√
2.	Minor Surgical Procedure	√	√	-	-
3.	Cataracts	√	√	-	-
4.	Endoscopy	√	√	√	√

Notes for Table 16:

A. In the future it is assumed that MAHC will continue to provide Surgical and Endoscopy Services at MAHC for Muskoka residents. The future services may continue to be provided on/across two hospital sites, on one amalgamated hospital site, or on one hospital site and an ambulatory care site. *Refer to the section on Options for Service Delivery.*

B. Ambulatory surgical services including the ER Off-load Clinic (EROC at HDMH) and Pre-surgical Assessment Clinic are described in the Ambulatory Care section of the Master Program.

Workload

Table 17: Current & Projected Workload

	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
Surgical Suite:	*4,096*	*4,226*	*3,827*	*4,153*	*4,481*	*5,134*
- Inpatient cases	804	855	812	876	941	1,074
- Outpatient cases/SDC	3,292	3,371	3,015	3,277	3,540	4,060
Cataract surgical cases	555	673	698	(803)[1]	(913)[1]	(1,127)[1]
Endoscopy:	*4,263*	*4,367*	*4,314*	*4,007*	*4,229*	*3,875*
- Inpatient cases	217	206	231	292	326	330
- Outpatient cases	4,046	4,161	4,083	3,715	3,903	3,545
HDMH						
Surgical Suite:	*1,610*	*1,727*	*1,746*	*1,891*	*2,033*	*2,314*
- Inpatient cases	362	364	278	298	317	356
- Outpatient cases/SDC	1,248	1,363	1,468	1,593	1,716	1,958
Cataract surgical cases	309	528	698	(803)[2]	(913)[2]	(1,127)[2]
Endoscopy:	*2,232*	*2,410*	*2,318*	*2,185*	*2,296*	*1,963*
- Inpatient cases	119	92	125	121	135	135
- Outpatient cases	2,113	2,318	2,193	2,064	2,161	1,948
SMMH						
Surgical Suite:	*2,486*	*2,499*	*2,081*	*2,262*	*2,448*	*2,821*
- Inpatient case	442	491	534	578	624	718
- Outpatient case/SDC	2,044	2,008	1,547	1,684	1,824	2,103
Cataract cases	246	145	n/a	---	---	---
Endoscopy:	*2,031*	*1,957*	*1,996*	*1,822*	*1,933*	*1,791*
- Inpatient cases	98	114	106	171	191	194
- Outpatient cases	1,933	1,843	1,890	1,651	1,742	1,597

Notes to Table 17:

1. In future cataract procedures will be performed in ambulatory care.

Important factors that were used in the data analysis and the development of the Inpatient services include:

A. Approximately 90% of patients receive surgery through the Surgical Day Care Unit (SDC) as same day admit or outpatients. It is assumed that this percentage will continue in the future.

B. Population growth and aging:
   - The forecast incorporates growth rates specific to each region and five year age group.

C. Market share and opportunities for repatriation:
   - MAHC has few opportunities to repatriate surgical patients from the Muskoka region.

D. Opportunities to reduce use of hospital resources including:
   - the mix of inpatient and day surgery cases
   - reduction over time in the rate of caesarean section
   - reduction over time in colonoscopies and gastroscopies to provincial averages.

Location Priorities

In order of priority (assumes Surgical Services includes pre- and post-surgical spaces staff room on-call room waiting room):

1. MDRD.
2. ICU.
3. Emergency Department.
4. Maternal Services.
5. Pathology.
6. Respiratory Therapy.
7. Diagnostic Imaging including x-ray and CT Scan.
8. Clinical Laboratory.
9. Teaching space.
10. Pre-Surgical Assessment Clinic.

Community Services – On-Site

Scope of Services Assumptions

NSM Community Care Access Centre (CCAC)

Current Status: Currently the CCAC provides a 'one-stop' access to health and personal support services to help people of all ages live independently in their home and their communities. Case coordinators work within the hospital setting to assess and determine the extent of home and community services required for patient discharge.

CCAC staff work with individuals and their families to assess specific needs and develop a plan of service. When living independently is no longer possible staff help to investigate alternatives such as supportive residential options, retirement homes, long-term care homes, convalescent and respite care. Staff are also responsible for:

- providing the access point to a long-term care home admission
- connecting all residents in the community with needed health and social services through their information and referral service
- through 'Health Care Connect' helping people without family physicians to find a family health care provider.

Future Planning Assumptions: The NSM CCAC will continue to provide services to MAHC patients on both of the Hospital sites.

Seniors Assessment & Support Outreach Services (SASOT)

Current Status: Currently the SMMH site accommodates the Seniors Assessment and Support Outreach Team (SASOT).

SASOT's role is to provide assessment and support to patients 65 years of age and older residing in the South Muskoka catchment area. Patients may be seen in their own home, a retirement residence, or in the emergency department. In addition the team assesses patients in the hospital who are designated ALC and support them through the discharge process.

SASOT is an interprofessional care team consisting of two Social Workers an Occupational Therapist and a Nurse and Medical Advisor. The team's intervention is short-term: assess, liaise, link and refer. The goal of the team is to facilitate successful discharges reduce emergency department and repeat visits and avoid unnecessary hospital admissions.

Future Planning Assumptions: MAHC will continue to accommodate the SASOT team on the hospital site.

Table 18: Current & Future Community Services Cases By Site

Note: though the table designates future services across the two existing sites the section titled *Section C Options for Service Delivery* more clearly indicates that community services may be delivered across two sites or combined on a single site.

		CURRENT		FUTURE	
		HDMH	SMMH	HDMH	SMMH
1.	NSM CCAC	✓	✓	✓	✓
2.	SASOT	-	✓	-	✓
3.	Midwives	✓	✓	✓	✓

Note:

A. Midwives provide obstetrical care on the Maternal/Child Inpatient Unit. *(refer to the Maternal/Child services section)*.

Workload

n/a

Location Priorities

In order of priority:

1. Emergency Department.
2. Medical/Surgical Inpatient Services.

Education & Training Services

Scope of Service Assumptions

Current Status: At present MAHC participates in training programs for medical students through the Northern School of Medicine (NOSM). Additionally MAHC provides clinical placements for nursing and other allied health professional students, education and training sessions for staff, and patient education programming.

Patient Education

In MAHC's clinical service provision there is a strong focus on patient education particularly with respect to diabetes and nutrition.

In future patient education programming will be further developed in partnership with the other care providers in the hospital.

Staff Medical Learner & Health Professional Learners

In addition to the ongoing education and training that is provided to patients and their families as part of clinical and therapy services MAHC will continue to provide high quality learning opportunities for staff medical learners and health professional learners that will facilitate the essential ongoing development of a qualified skilled and dedicated health care workforce including:

- MAHC staff including large staff education and training events
- medical learners the Northern Ontario School of Medicine coordinates and facilitates medical student placement at MAHC currently there are three to five (per site) medical learners in the program in the future it is expected that this number will increase
- health professional learners (including nursing, OT, SLP, respiratory therapy, laboratory tech, x-ray tech, ultrasound tech students, among others) currently there are 50 student placements in a year and five to six students in each hospital at any one time
- external health professionals and agencies located in the service delivery area
- members of the community.

Staff education will be coordinated by a clinical educator.

Education will occur in various forms as noted below:

- orientation sessions
- computer training
- meetings

- conferences
- workshops
- training sessions (CPR, triage, first aid training (25 people), etc.)
- simulations
- webinars
- both small and large education events
- inter-professional rounds.

Facilities for Medical Learner Education

In future MAHC will require appropriate on-call, study, teaching and resource space for medical student education. The space will be planned according to parameters articulated by PAIRO (Professional Association of Interns & Residents of Ontario and include (at each site):

- lockers and washroom facilities
- one dedicated on-call room
- work space located away from the clinical areas – one workroom per floor in the hospital
- 1 dedicated classroom/learning space for large group sessions
- one to two dedicated exam rooms
- a lecture theatre to accommodate 70 individuals.

Ontario Telemedicine Network (OTN)

At present, MAHC's two sites are part of the OTN and have videoconferencing capabilities for meetings and education as well as for clinical consultation. *In future* telemedicine services will continue to expand.

Workload

n/a

Location Priorities

In order of priority:

1. Front Entry.
2. Centrally located for easy access by staff and medical learners and students.

ROLE & SCOPE OF CLINICAL SUPPORT SERVICES

The following are descriptions of the role and scope of current MAHC Clinical Support Services.

Clinical Support Services include:

- Allied Health Services
- Cardiorespiratory Services
- Diagnostic Imaging Services
- Clinical Laboratory Services
- Pharmacy Services
- Administration & Support Services

Allied Health Services

Scope of Service Assumptions

Allied Health will provide a broad range of care in support of residents of the MAHC's catchment area.

Current Status: Allied Health professionals provide services as directed by physicians both as part of multi-disciplinary teams and on an individual basis. Services may be provided in hospital for inpatients and outpatients or as outreach services to patients in Burk's Falls.

Note: Burk's Falls Ambulatory Clinic is not part of the scope of this Master Program.

Inpatient rehabilitation services including PT, OT, SLP, and Activation Recreation therapies are provided for patients on the Complex Continuing Care and acute Medical/Surgical inpatient units - the inpatient services are provided by MAHC staff. Currently the inpatient rehabilitation services are limited due to space constraints on the units.

Outpatient rehabilitation services including OT, PT, and Videofluoroscopy are provided by MAHC staff. Private physiotherapy services are offered in shared space by Allied Health professionals from the local community. These providers rent space from MAHC on a contract basis.

Future Planning Assumptions: Allied Health will continue to provide and enhance consultation, assessment, treatment, and discharge planning services to inpatients and outpatients. Rehab therapies will assist patients to maintain their sense of dignity and independence through improved health and quality of life by offering an intensive integrated interdisciplinary and individualized program to each patient.

As CCC inpatient services shift to the provision of complex medical care, restorative slow-stream rehab care, and end-of-life care, rehabilitation services will be increased on this unit.

Table 19: Current & Future Allied Health Services Cases By Site

Note: though the table designates future services across the two existing sites the section titled *Section C Options for Service Delivery* more clearly indicates that allied health services may be delivered across two sites or combined on a single site.

		CURRENT		FUTURE	
		HDMH	SMMH	HDMH	SMMH
1.	Social Work	✓	✓	✓	✓
2.	Physiotherapy	✓	✓	✓	✓
3.	Occupational Therapy	✓	✓	✓	✓
4.	Speech Language Pathology	✓	✓	✓	✓
5.	Activation/Rec Therapy	✓	✓	✓	✓
6.	Dietician	✓	✓	✓	✓

Notes:

A. Social Work supports the Dialysis Program at the HDMH Site.

B. Physiotherapy services are provided as part of an ambulatory clinic at the Almaguin Highlands Health Centre in Burk's Falls.

C. Occupational Therapy supports only outpatient visits at SMMH.

D. Dietician supports inpatients and a small percentage of outpatient visits at SMMH.

E. Activation/Recreation Therapy supports inpatient care at both sites.

Workload

Table 20: Current & Projected Workload

	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
Attendance Days:						
Social Work	n/a	n/a	n/a	n/a	n/a	n/a
Activation/Recreation	5,659	5,927	5,232	5,640	5,997	6,605
Physiotherapy:						
- Inpatient	11,129	11,028	9,550	10,785	12,099	15,255
- Outpatient	4,300	3,567	5,545	5,977	6,356	7,000
Occupational Therapy:						
- Inpatient	1,219	3,418	3,035	3,427	3,845	4,848
- Outpatient	183	281	467	503	535	590
Speech Language Pathology:						
- Inpatient	754	657	672	759	851	1,073
- Outpatient	87	91	121	130	139	153
Dietician:						
- Inpatient	1,275	1,220	971	1,097	1,230	1,551
- Outpatient	100	71	83	89	95	105

Location Priorities

In order of priority:

1. Inpatient Units – CCC and Medical/Surgical Inpatient units.
2. Ambulatory Care.

Cardiorespiratory Services

Scope of Service Assumptions

Cardiorespiratory Services will provide a broad range of care in support of residents of the MAHC's catchment area.

Current Services: MAHC provides comprehensive inpatient and outpatient programs and services for people with heart and lung disease from both sites. A team of clinical experts provide consultation, testing, education and support for cardio, and respiratory conditions.

Service provided include:

- cardiac Holter monitoring
- 24-hour blood pressure monitoring
- Echocardiograms (performed in DI)
- Electrocardiograms
- Pulmonary Function Testing including Body Box
- home oxygen assessments including walk tests and arterial blood gas collection and analysis
- cardiac stress testing and pharmacological stress testing
- Nuclear heart scans following cardiac stress testing
- Echo stress testing
- pacemaker clinic (follow-up care at HDMH only)
- Asthma and Chronic Obstructive Pulmonary Disease (COPD) education
- inpatient tobacco cessation program.

Future Planning Assumptions: MAHC will continue to provide cardio-respiratory services for inpatients and outpatient as described above.

Table 21: Current & Future Cardiorespiratory Services Cases By Site

Note: though the table designates future services across the two existing sites the section titled *Section C Options for Service Delivery* more clearly indicates that cardio-respiratory services may be delivered across two sites or combined on a single site.

		CURRENT		FUTURE	
		HDMH	SMMH	HDMH	SMMH
1.	Holter Monitoring	√	√	√	√
2.	Blood Pressure Monito	√	√	√	√
3.	Electrocardiograms	√	√	√	√
4.	Pulmonary Function	√	√	√	√
5.	Cardiac Stress Testing	√	√	√	√

		CURRENT		FUTURE	
		HDMH	SMMH	HDMH	SMMH
6.	ECHO Stress Test	-	-	✓	✓
7.	Pacemaker Clinic	✓	-	✓	-
8.	COPD Education	✓	✓	✓	✓
9.	Respiratory Therapy	✓	✓	✓	✓

Workload

Table 22: Current & Projected Workload

	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
Cardiology I/P	3,127	3,085	2,682	3,057	3,932	5,106
Cardiology ED	9,334	8,700	9,574	8,645	9,089	10,098
Cardiology O/P	833	2,229	1,218	1,313	1,396	1,538
Resp. Procedure I/P	40,859	34,431	22,008	25,236	28,658	37,478
Resp. Procedure O/P	42,960	42,041	15,763	16,991	18,067	19,899
HDMH						
Cardiology I/P	1,094	n/a	1,176	1,340	1,724	2,239
Cardiology ED	4,574	n/a	4,897	4,422	4,649	5,165
Cardiology O/P	483	n/a	881	950	1,010	1,112
Resp. Procedure I/P	15,935	n/a	9,741	11,169	12,684	16,588
Resp. Procedure O/P	19,332	n/a	14,075	15,171	16,132	17,767
SMMH						
Cardiology I/P	2,033	n/a	1,506	1,717	2,208	2,867
Cardiology ED	4,760	n/a	4,677	4,223	4,440	4,933
Cardiology O/P	350	n/a	337	363	386	425
Resp. Procedure I/P	24,924	n/a	12,267	14,066	15,974	20,890
Resp. Procedure O/P	23,628	n/a	1,688	1,820	1,935	2,131

Location Priorities

In order of priority:

1. Diagnostic Imaging.
2. Ambulatory Care areas.
3. RRT satellite workshop and equipment storage to Surgical Suite and ICU.

Diagnostic Imaging Services

Scope of Service Assumptions

Diagnostic Imaging Services will provide a broad range of diagnostics in support of residents of the MAHC's catchment area.

Current Status: The Diagnostic Imaging Department provides a full range of imaging and therapeutic services to hospital patients, community residents, and people vacationing in the region. These services help to identify medical conditions and disease and assist in developing the best course of treatment. Over 90,000 exams are performed each year. *Note:* the imaging departments at MAHC work closely with educational institutions to provide clinical placements that train the next generation of Medical Radiation Technology students and other imaging professionals.

The Diagnostic Imaging Department uses PACS (Picture Archiving and Communication System) technology. This digital system allows health care providers to access digital images and reports 24/7. Information can be shared across locations. Patients benefit from more accurate and timely diagnosis, faster treatments and reduced wait times.

Future Planning Assumptions: MAHC will continue to provide Diagnostic Imaging Services at each site as noted above.

Table 23: Current & Future Diagnostic Services Cases By Site

Note: though the table designates future services across the two existing sites the section titled *Section C Options for Service Delivery* more clearly indicates that diagnostic services may be delivered across two sites or combined on a single site.

		CURRENT		FUTURE	
		HDMH	SMMH	HDMH	SMMH
1.	X-ray/Gen Radiography	√	√	√	√
2.	Fluoroscopy	√	-	√	-
3.	CT-Scan	√	√	√	√
4.	MRI	-	-	-	√
5.	Mammography	√	√	√	√
6.	Stereotactic Mammo	-	-	√	√
7.	Ont. Breast Screening	-	√	-	√
8.	Bone Densitometry	√	√	-	-
9.	Ultrasound	√	√	√	√
10.	Echocardiography	√	√	√	√
11.	Nuclear Medicine	√	-	√	-
12.	Interventional Rad	√	√	√	√

Notes for Table 23:

A. In addition there is one c-arm and one mobile x-ray in each surgical suite. A Urology Suite in the SMMH surgical suite.

B. In future models mammography OBSP could be located on one site; nuclear medicine should be on the same site as the ORs and cardio-resp and stereotactic mammography same site as the ORs.

Workload

Table 24: Current & Projected Workload

	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
X-ray I/P	4,836	4,420	4,444	5,019	5,630	7,099
X-ray ED	17,346	17,233	17,796	16,069	16,894	18,770
X-ray O/P Surg	1	3	n/a	0	0	0
X-ray O/P	17,741	19,192	19,439	20,953	22,281	24,539
Mammo O/P	4,061	4,280	4,315	4,651	4,946	5,447
CT Scan I/P	1,365	1,468	1,416	1,599	1,794	2,262
CT Scan ED	2,493	2,635	2,849	2,573	2,705	3,005
CT Scan O/P Surg	177	78	n/a	0	0	0
CT Scan O/P	12,444	12,614	15,349	16,545	17,593	19,376
Ultrasound I/P	1,356	1,558	2,496	2,819	3,162	3,987
Ultrasound ED	2,259	3,113	3,579	3,232	3,398	3,775
Ultrasound O/P	13,469	15,247	18,745	20,205	21,485	23,663
Nuclear Medicine I/P	92	53	73	82	92	117
Nuclear Medicine ED	4	n/a	3	3	3	3
Nuclear Medicine OP	5,296	2,662	2,753	2,486	2,614	2,904
BMD	2,138	2,087	1,987	2,146	2,275	2,502
MRI (Future)	-	-	-	-	1,200	1,200
HDMH						
X-ray I/P	1,934	n/a	n/a	2,007	2,252	2,840
X-ray ED	8,673	n/a	n/a	8,034	8,447	9,385
X-ray O/P Surg	0	n/a	n/a	0	0	0
X-ray O/P	6,517	n/a	n/a	8,172	8,690	9,570
Mammo O/P	1,572	n/a	n/a	1,814	1,929	2,124
CT Scan I/P	546	n/a	n/a	640	718	905
CT Scan ED	1,247	n/a	n/a	1,286	1,352	1,502
CT Scan O/P Surg	69	n/a	n/a	0	0	0
CT Scan O/P	4,853	n/a	n/a	6,452	6,861	7,557
Ultrasound I/P	542	n/a	n/a	1,127	1,265	1,595
Ultrasound ED	1,130	n/a	n/a	1,616	1,699	1,887
Ultrasound O/P	5,219	n/a	n/a	7,880	8,379	9,229
Nuclear Medicine I/P	37	n/a	n/a	33	37	47
Nuclear Medicine ED	2	n/a	n/a	1	1	2
Nuclear Medicine OP	2,648	n/a	n/a	1,243	1,307	1,452
BMD	n/a	1,120	1,040	2,146	2,275	2,502

	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
SMMH						
X-ray I/P	2,902	n/a	n/a	3,011	3,378	4,259
X-ray ED	8,673	n/a	n/a	8,034	8,447	9,385
X-ray O/P Surg	n/a	n/a	n/a	0	0	0
X-ray O/P	10,193	n/a	n/a	12,781	13,591	14,969
Mammo O/P	2,459	n/a	n/a	2,837	3,017	3,323
CT Scan I/P	819	n/a	n/a	959	1,076	1,357
CT Scan ED	1247	n/a	n/a	1,286	1,352	1,502
CT Scan O/P Surg	107	n/a	n/a	0	0	0
CT Scan O/P	7,590	n/a	n/a	10,092	10,732	11,819
Ultrasound I/P	814	n/a	n/a	1,691	1,897	2,392
Ultrasound ED	1,130	n/a	n/a	1,616	1,699	1,887
Ultrasound O/P	8,163	n/a	n/a	12,325	13,106	14,434
Nuclear Medicine I/P	55	n/a	n/a	49	55	70
Nuclear Medicine ED	2	n/a	n/a	1	1	2
Nuclear Medicine ED	2,648	n/a	n/a	1,243	1,307	1,452
BMD	n/a	966	947	-	-	-
MRI (Future)	-	-	-	-	1,200	1,200

Location Priorities

In order of priority:

1. Emergency Department.
2. Medical/Surgical Inpatient Services.
3. Ambulatory Care.
4. Hospital's Main Entrance.

Note: locate DI on an outside wall for future expansion.

Clinical Laboratory Services

Scope of Service Assumptions

Current Status: Laboratory Services at MAHC provide consultative services and testing to investigate and/or monitor illness and to help promote well-being. The main purpose of MAHC's laboratories is to provide services for patients in the Emergency Department and on the inpatient units at the two hospital sites. Lab Services also supports outpatient dialysis and chemotherapy. Limited outpatient testing is provided through coordinated appointments by physician office referrals.

Referral testing sites include Gamma Dynacare and/or Orillia Soldiers' Memorial Hospital, Royal Victoria Regional Health Centre, and the Public Health Laboratory.

Future Planning Assumptions: MAHC will continue to provide the Clinical Laboratory Services noted above.

Table 25: Current & Future Laboratory Services Cases By Site:

Note: though the table designates future services across the two existing sites the section titled *Section C Options for Service Delivery* more clearly indicates that laboratory services may be delivered across two sites or combined on a single site.

		CURRENT		FUTURE	
		HDMH	SMMH	HDMH	SMMH
1.	Phlebotomy	✓	✓	✓	✓
	- therapeutic phlebotomy	✓	✓	✓	-
2.	ECG	✓	✓	✓	✓
3.	Hematology	✓	✓	✓	✓
4.	Chemistry	✓	✓	✓	✓
5.	Microbiology	✓	-	✓	-
6.	Cytology	✓	-	✓	-
7.	Pathology	-	✓	-	✓
8.	Autopsy	-	✓	-	✓
9.	Transfusion Medicine	✓	✓	✓	✓
10.	Point of Care (POCT)	✓	✓	✓	✓

Notes:

A. Lab services provided at each of the two hospital sites include: Phlebotomy and ECG, Therapeutic Phlebotomies, Hematology, Chemistry, Transfusion Medicine, and POCT.

B. Services provided only at the HDMH Site include: Microbiology and Cytology.

C. Services provided only at the SMMH Site include Pathology and Autopsy.

Workload

Table 26: Current & Projected Workload

	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
Procedures:						
Anatomical Pathology	70,155	13,471	18,013	19,451	20,770	23,196
Clinical Chemistry	422,486	249,305	262,709	283,675	302,918	338,294
Clinical Hematology	116,335	60,087	72,576	78,368	83,684	93,457
Clinical Microbiology	81,003	29,798	29,481	31,834	33,993	37,963
Cytopathology	4,541	1,104	1,218	1,315	1,404	1,568
Pre & Post Analysis	95,308	99,219	105,503	113,923	121,651	135,857
Transfusion Medicine	15,842	7,046	6,110	6,598	7,045	7,868
HDMH						
Anatomical Pathology	42,093	n/a	7,565	11,670	12,465	13,917
Clinical Chemistry	253,492	n/a	110,338	170,205	181,751	202,976
Clinical Hematology	69,801	n/a	30,482	47,021	50,211	56,074
Clinical Microbiology	48,602	n/a	12,382	19,100	20,396	22,778
Cytopathology	2,725	n/a	512	789	843	941
Pre & Post Analysis	57,185	n/a	44,311	68,354	72,991	81,514
Transfusion Medicine	9,505	n/a	2,566	3,959	4,227	4,721
SMMH						
Anatomical Pathology	28,062	n/a	10,448	7,780	8,308	9,278
Clinical Chemistry	168,994	n/a	152,371	113,470	121,167	135,317
Clinical Hematology	46,534	n/a	42,094	31,347	33,474	37,383
Clinical Microbiology	32,401	n/a	17,099	12,734	13,597	15,185
Cytopathology	1,816	n/a	706	526	562	627
Pre & Post Analysis	38,123	n/a	61,192	45,569	48,660	54,343
Transfusion Medicine	6,337	n/a	3,544	2,639	2,818	3,147

Location Priorities

In order of priority:

1. Emergency Services.
2. Ambulatory Care.
3. Hospital's Main Entrance.
4. All Care Areas.

Pharmacy Services

Scope of Service Assumptions

Pharmacy Services primarily supports inpatient services, outpatient dialysis, and chemotherapy.

Current Status: Pharmacy Services primarily supports inpatient clinical services, outpatient dialysis, and chemotherapy. The pharmacy model used is a traditional model of medication dispensing by prescription (50%), ward stock (40%-50%), IV chemo, non sterile IV prep, 24-hour fills, first dose dispensing, narcotics dispensing, and a pharmaceutical care model to enhance the patient services. In addition the service prepares and provides manual unit dose medications for the HDMH Emergency Department.

In support of the pharmaceutical care model Pharmacy Services is patient-centered and semi-decentralized to the program areas. With the current 3.8 FTE Pharmacists it is difficult for the Pharmacy to provide clinical pharmacist support to the clinical services. Support is limited to the Chemotherapy and Dialysis Programs operated by MAHC in association with the Health Sciences North and the Royal Victoria Regional Health Centre (for chemotherapy) and the Orillia Soldiers' Memorial Hospital (for dialysis).

Future Planning Assumptions: MAHC will continue to provide Pharmacy Services across the hospital site(s). In the future it is assumed that:

- a unit dose medication dispensing system will be implemented throughout the hospital to support safe delivery of medications - dispensing may be performed at the bed side to reduce risk
- clinical pharmacists on multidisciplinary patient care teams
- medication reconciliation completed by pharmacy/pharmacy techs.

In the future the goal would be to fully integrate clinical pharmacists with the multidisciplinary patient care teams to provide enhanced medication system safety, medication reconciliation, and counseling for patients on a one-to-one basis to promote patient-centered care and produce positive health outcomes.

Clozaril Clinic

Current Status: Currently the Pharmacies at each of MAHC's sites are mandated to dispense Clozaril. There are approximately 20 outpatients in the program who are covered by OHIP. The clinic runs one half day per week at both sites.

Future Planning Assumptions: MAHC will continue to provide a Clozaril Clinic as described above.

Table 27: Current & Future Pharmacy Services By Site:

Note: though the table designates future services across the two existing sites the section titled *Section C Options for Service Delivery* more clearly indicates that pharmacy services may be delivered across two sites or combined on a single site.

		CURRENT		FUTURE	
		HDMH	SMMH	HDMH	SMMH
1.	Medication Dispensing	✓	✓	✓	✓
2.	Chemo Admixture	✓	-	✓	-
3.	Epidural Admixture	✓	✓	✓	-
4.	Intravenous IV Admixture	✓	✓	✓	-
5.	Infusion Clinic	✓	-	✓	✓
6.	Dialysis Clinic	✓	-	✓	-
7.	Clozaril dispensing	✓	✓	✓	✓
8.	Total Parenteral Nutrition (TPN) preparation	-	✓	-	✓

Notes:

A. Ideally a main Pharmacy would be located adjacent to the Chemotherapy unit in either a single-site option or two-site option. In this configuration a satellite IV prep area would not be required. If this configuration is not achievable a satellite Pharmacy would be required adjacent to Chemotherapy.

B. In a two-site option, with an ambulatory site and an acute care site, a main Pharmacy would be located on the acute care site and a satellite pharmacy/sterile IV prep on the ambulatory site adjacent to Chemotherapy.

C. In a two-site option, with two acute care hospitals, two main pharmacies would be required. Efficiencies may be gained by centralizing the shipping/ receiving bulk stores and future unit dose packaging on one site. IV prep would be on one site.

Workload

Table 28: Current & Projected Workload

	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
Workload Units:						
Inpatient Med / Surg	543,404	530,083	532,318	601,519	676,044	851,709
Inpatient CCC	46,338	50,906	37,890	44,265	51,299	69,869
Emergency	21,321	26,623	25,075	22,642	23,804	26,447
OP Surgery	39	4,864	4,864	5,243	5,575	6,140
Oncology	27,558	95,298	96,124	112,004	129,110	171,182
Outpatient / Other	48,912	15,273	15,275	16,465	17,508	19,282
HDMH						
Inpatient Med / Surg	217,362	n/a	227,783	257,395	289,284	364,453
Inpatient CCC	46,338	n/a	37,890	44,265	51,299	69,869
Emergency	10,661	n/a	13,503	12,193	12,819	14,242
OP Surgery	15	n/a	2,426	2,615	2,781	3,063
Oncology	15,157	n/a	47,385	55,213	63,464	84,395
Outpatient / Other	24,456	n/a	7,619	8,213	8,733	9,618
SMMH						
Inpatient Med/Surg	326,042	n/a	286,031	323,215	363,260	457,650
Inpatient CCC	n/a	n/a	n/a	n/a	n/a	n/a
Emergency	10,661	n/a	11,572	10,449	10,986	12,205
OP Surgery	24	n/a	2,438	2,628	2,794	3,077
Oncology	12,401	n/a	48,739	56,791	65,464	86,796
Outpatient / Other	24,456	n/a	7,656	8,252	8,775	9,664

Location Priorities

In order of priority:

1. Vertical and horizontal transportation routes that access all inpatient units.
2. Shipping/Receiving area.
3. From the Pharmacy night cupboard to Emergency Services.

Administration & Support Services

Scope of Service Assumptions

Current Status: Administrative Services at MAHC support all clinical and non-clinical services/programs, and are comprised of the Board of Directors, General Administration, Finance (Business Office), Human Resource, Occupational Health & Safety, and Infection Control. Administrative Service senior leaders include:

- Chief Executive Officer (CEO)
- Chief of Medical Staff (COS)
- Chief Financial Officer Corporate Services and Risk
- Chief Executive Diagnostics Ambulatory and Planning
- Chief Executive Clinical Services & System Transformation
- Chief Quality & Nursing Executive
- Chief Executive Human Resources & Support Service.

Currently Administrative Support Services include:

- Health Information
- Communications/Executive Assistants
- Central Registry including Admitting
- Information Services and Telecommunications
- Communications
- Foundations
- Auxiliaries
- Spiritual Care.

Future Planning Assumptions: Administrative and Support Services are expected to provide similar services in the future.

General Administration will continue to provide overall direction and management of the organization, including communications, in accordance with the strategic directions, mission, and vision.

Finance will be responsible for the management of financial operations and control of the operating budget including payroll, accounts payable/receivable statistics, capital inventory reporting, and MIS.

Human Resources will be responsible for screening and recruitment of new employees, counseling, and union negotiations, among others.

Occupational Health & Safety and Infection Control will include counseling services, medical examinations, and work injury assessments. OH&S and Infection Control will be linked with the LHIN Infection Control Network.

Health Records will be responsible for maintaining patient records and ensuring confidentiality as well as maintaining records and statistical information for research and legal investigations. The electronic health record will be implemented in the foreseeable future. Health Records will also be responsible for transcription of medical records.

Patient Registration will be responsible for maintaining bed status information and the registration of all inpatient and outpatient visits. All outpatients will register/check-in at the Central Registration Desk before appointments. Patient Registration will be patient-centered and Lean methodologies will be implemented to ensure that the most efficient and comfortable registration experiences occur for patients.

Information Services will provide the following services:

- maintenance of a Hospital-wide integrated information system
- maintenance of a Hospital-wide integrated booking/scheduling system
- support of the electronic health record system
- support of the electronic imaging management system
- support of the use of wireless technology systems throughout the organization
- support of the point-of-care documentation technology to allow for bedside charting
- implementation support and maintenance of information systems
- provision of user training and technical support.

Wireless technology will be maximized in the new facilities.

Switchboard & Reception Services will be responsible for answering phones, paging staff, managing codes, and monitoring alarms, among other tasks. Switchboard and reception functions will be centralized.

As a result of the merging of two separate Hospitals, MAHC has maintained two distinct **Foundations**. These include the South Muskoka Hospital Foundation and the Huntsville Hospital Foundation. It is assumed that the two organizations will remain as separate entities as long as two acute care hospital sites exist.

South Muskoka Hospital Foundation: The South Muskoka Hospital Foundation was established in 1980 to support the compassionate care of patients at South Muskoka Memorial Hospital. At the heart of the Foundation is our commitment to three central priorities.

- improving the physical campus to provide the best possible patient care environment
- developing and furthering core programs and services
- preparing for unexpected and urgent circumstances by bolstering unrestricted funds.

Huntsville Hospital Foundation: The Huntsville Hospital Foundation is a fundraising organization dedicated to improving health care services for the residents of Muskoka and East Parry Sound. The Foundation's mandate is to provide ongoing capital and education resources for Huntsville District Memorial Hospital.

The Foundation was established as a registered charity in 1984 to receive maintain and distribute funds raised by personal donations, grants, capital projects, special event fundraising, and special programs not covered by government grants. All funds received by the Huntsville Hospital Foundation are used to enhance patient care either through staff training or capital equipment purchases at HDMH.

Future Planning Assumptions: The South Muskoka Memorial Hospital Foundation and the Huntsville Hospital Foundation will continue to be responsible for stewardship, donor relations, annual giving programs, legacy giving, capital campaign, and management of the donor database among others to improve health care services for the residents of MAHC's catchment area (SMMH – 4 staff, HDMH – 3 staff).

As a result of the merging of two separate Hospitals MAHC has maintained two distinct **Auxiliaries**. These include the South Muskoka Memorial Hospital Auxiliary and the Huntsville Hospital Auxiliary. It is assumed that the two organizations will remain as separate entities as long as two acute care hospital sites exist.

South Muskoka Memorial Hospital Auxiliary: Formed in 1949 the South Muskoka Memorial Hospital Auxiliary facilitates volunteer placement in clinical and non-clinical programs/services throughout SMMH including: Day Surgery, Breast Screening, Emergency Department, and Ambulatory Clinics, among other services.

In addition the auxiliary will:

- operate the gift shop
- operate the Coffee Bar (Muskoka Mocha)
- sell H.E.L.P.P. (Nevada Tickets)
- provide portering services (Care In Action)
- hold annual fundraising and special events.

Huntsville Hospital Auxiliary: The Auxiliary facilitates volunteer placement in clinical and non-clinical programs/services throughout the HDMH site including: Blood Donor Clinic, Chemotherapy Clinic, Day Surgery, and Diagnostic Imaging, among other services.

In addition the auxiliary:

- operates the gift shop
- provides hair care for patients
- operates the vending machines
- provides portering services
- holds annual fundraising and special events including: Annual Golf Classic and the Variety Show.

Future Planning Assumptions: In the future the SMMH Auxiliary and the Huntsville Hospital Auxiliary will continue to facilitate volunteer placement in clinical and non-clinical programs/ services *(SMMH – 2 staff, HDMH – 1 staff).*

Spiritual Care: The Muskoka Chaplaincy Association (MCA), in partnership with MAHC, provides a part-time chaplain two days per week at both hospital sites. MCA is working with MAHC to expand in-hospital spiritual care programming in the future through a roster of special-trained and supervised Volunteer Chaplains.

Workload

n/a

Location Priorities

In order of priority:

1. Administration, Finance, Human Resources, Communications, OH&S and Infection Control be located on main circulation routes with equitably accessible to all staff.
2. Administration/Communications and Human Resources will be located so as to be readily accessible to the public as well.

3. Health Information Services (Health Records) will be located in close proximity to the Physicians' Lounge(s) for easy access for chart completion *until a full electronic health record is functional.*
4. Patient Registration and Switchboard & Reception Services shall be located at the main entrance to the facility. The Emergency Department and Ambulatory Care Centre shall be close by.
5. Telecommunications can be located in a service area of the building.
6. The server room (Information Services) must be in a secured location.
7. The Foundation will be located near the main entrance in a highly visible position.
8. Spiritual Care will be located on a main public circulation route. Proximity to the Emergency Department will be an advantage.

ROLE & SCOPE OF GENERAL SUPPORT SERVICES

The following are descriptions of the role and scope of current MAHC General Support Services.

General Support Services include:

- Facility Services:
  - Environmental Services
  - Plant Operations and Maintenance
  - Materials Management
  - Food and Nutrition Services
- Medical Device Reprocessing Department
- Physician and Staff Support Services
- Main Lobby Services

Facility Services

Scope of Service Assumptions

Facility Services encompasses:

- Environmental Services
- Plant Operations and Maintenance
- Materials Management
- Food and Nutrition Services.

Environmental Services

Current Status: Environmental Services includes the following:

- Housekeeping Services including:
  - general and special cleaning tasks
  - waste management including:
    - removal of general waste, recyclables, and confidential documents (as appropriate by a shredding contract service)
    - proper disposal of biohazardous materials by approved transport
  - managing the supply of cleaning products throughout the Hospital
  - on-site washing of specialty items (such as but not limited to mop heads and special mattress/pressure pads)
  - room set-ups
  - patient equipment cleaning (not Dialysis Machines or CT Scanner)
  - window washing/carpet cleaning
- Linen/Laundry Services are outsourced to Booth Centennial and delivered directly to each site each weekday MAHC provides:
  - purchasing and inventory of linen
  - delivery and pick-up of linens from patient care areas through a cart exchange system
  - holding/shipping of soiled linens
  - limited on site laundering services.

Future Planning Assumptions: In the future Environmental Services will continue to provide the services as described above.

Plant Operations & Maintenance

Current Status: Plant Operations & Maintenance includes the following services and/or management of the service contracts:

- operation and maintenance of building systems
- renovation and capital projects
- receiving of heavy equipment
- maintenance of equipment asset database
- moving/setting-up furniture (heavy items)
- delivery of cylinder gases to patient care areas
- pick-up/delivery of building supplies
- disposal of flammable and hazardous waste
- preventative maintenance programs
- painting and repairs to the building and general equipment
- responsibility for WHMIS and fire safety
- grounds keeping services to the sites including but not limited to:
  - general upkeep
  - grass cutting
  - snow removal (contract)
  - flower beds
  - painting.
- Security Services including general security of the Hospitals with 24/7 coverage
- parking systems and control
- pest control
- morgue.

Future Planning Assumptions: In the future Plant Operations and Maintenance will continue to provide the services as described above.

Materials Management

Current Status: Materials Management at MAHC includes the following:

- shipping and receiving including:
  - shipping/receiving all goods to/from the hospital sites including medical supplies, pharmaceutical and laboratory supplies, mail equipment, furnishings, building materials, and others as appropriate

  - providing holding/marshaling areas for goods in and out of the hospital sites
  - providing refrigeration for hazardous materials
- maintaining a stores warehouse at each site some stores are shared across sites
- distribution of all medical supplies utilizing a re-stock system
- managing all special equipment and supplies order as well as capital purchases
- internal mail delivery
- storage of equipment and furniture.

MAHC and OSMH share a Director of Materials Management and have a purchasing partnership and mutual contracts with suppliers.

Biomedical Engineering is outsourced. The contract is held with Materials Management. Currently the service is at each of the two hospital sites for 1 day a week and at that time uses the facilities' workshops.

Future Planning Assumptions: In the future Materials Management will continue to maintain a stores warehouse on each hospital site. MAHC has reviewed the potential for a just-in-time (JIT) material delivery system, which would significantly reduce the need to store quantities of materials on the sites. However MAHC has not implemented a JIT system due to the difficulties presented by the travel distances transportation systems and winter weather.

Note: if in the future a JIT system is put into place MAHC will only need to maintain emergency stat inventory and stat stores for all departments of the Hospital except some products for Dietary Services and Maintenance.

Food Services & Nutrition Services

Current Status: Food Services & Nutrition Services provides nutritious meals to inpatients, ambulatory care patients, staff, and visitors. Services include:

- purchasing receiving and storage of food products
- inpatient meal services
- cafeteria services (only available if in the future all hospital services were located on one site)
- warewashing and
- catering services.

The basic tenet of the meal service model is patient choice. Patients select meals in the morning from a menu. The kitchen purchases their own supplies from Sysco and local providers and produces 80% of the meals from scratch on site. At meal times dietary-staff deliver meals to the patient and nursing staff return the trays to the carts. The model is designed to improve the quality of food and the level of service for the patient. It has been shown that food made in the hospital kitchens has lower sodium and fat content.

Previously MAHC operated a cafeteria on each of the hospital sites. Due to high costs and low utilization the cafeterias were closed and lunchrooms were put in their place. The Auxiliary on each site provides a coffee and wrapped sandwich service in the front entry. In the future in the single site option (only) where all MAHC services are located on one site the master program provides space for a cafeteria/cafe. The cafe would focus on health and wellness products and provide hot meals and beverages.

Future Planning Assumptions: Food Services and Nutrition Services will continue to provide the services noted above.

The Fairvern Nursing Home may be located on the hospital site. If this co-location occurs it is assumed that MAHC's Food Services would support the nursing home's resident population.

Facility Services Future Planning Assumptions

In reviewing the advantages and disadvantages of a single hospital site versus a two-hospital site model Facility Services identified several efficiencies for the single-site model:

- a cafeteria could be re-introduced
- there is more potential for other retail opportunities
- purchasing and distribution roles and shipping and receiving functions could be consolidated
- only one kitchen would be required instead of two (saving on capital costs for equipment purchase)
- only one Materials Management warehouse would be required.

Workload

Table 29: Current & Projected Workload

	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
Beds	111	99	96	108	115	139

Location Priorities

In order of priority:

1. Shipping/Receiving to Stores.
2. Shipping/Receiving to Housekeeping Stores.
3. Shipping/Receiving to Maintenance Workshops.
4. Shipping/Receiving to Kitchen.
5. Kitchen to inpatient units.
6. Shipping to recycling and waste paper storage.
7. Morgue to Shipping or alternative funeral home entry.
8. Security adjacent to or internal to the Emergency Department and ideally also close to the main entrance of the facility.

Note: the Cafeteria in the single site option (only) would need to be located with a public face to encourage use by both staff and visitors. Access from the cafeteria to an outdoor area for summer functions including seating and barbecues is highly desirable.

Medical Device Reprocessing Department

Scope of Service Assumptions

The Medical Device Reprocessing Department (MDRD) is located on each of MAHC's two hospital sites. The MDRD works closely with surgical and inpatient services to provide quality and safe patient care.

Current Status: Currently a main MDRD is located at each of the SMMH and HDMH Sites. Both departments provide full reprocessing services including:

- decontamination
- reprocessing
- sterilization
- storage of reusable medical devices
- storage and management of trial pieces of medical equipment
- picking of instrumentation for the ORs
- scope reprocessing:
  - at the HDMH site endoscope cleaning and sterilization is performed in a room located adjacent to the endoscopy suite and separate from the surgical area
  - at the SMMH site endoscope cleaning and sterilization is performed in a room that is located within the operating room area.
- respiratory equipment reprocessing
- reusable patient utensils reprocessing.

Ultrasound probes are reprocessed in Diagnostic Imaging in state of the art hydrogen peroxide reprocessors.

Neither MDRD provides reprocessing services for off-site services (physician clinics, EMS, etc.).

Recently both MDRD sites were renovated to meet Canadian Safety Association (CSA) standards. The SMMH renovation was completed in August 2013 and the HDMH renovation was completed in February 2014. Both renovated areas remained within the existing space allocated to MDRD. Though they meet all infection prevention and control and CSA standards and provide adequate capacity to meet current and future workload the newly renovated facilities in the restricted existing building footprints continue to be challenged to:

- separate clean and dirty transportation routes to and from the ORs
- provide cart washers in the MDRDs
- accommodate storage facilities for surgical supplies
- meet future standards for the mechanical ventilation/ exchanges and plumbing/steam systems.

Current Equipment: following is a list of the current major pieces of reprocessing equipment located on each site and notes on future requirements:

MDRD Equipment	HDMH	SMMH
washer/dryer	1	1
Pasteurmatic pass/through	1	1
autoclave[1]	1	1
dryer for respiratory equipment	1	1
Steris	2	3
scope reprocessors	2	3
scope storage cabinets	2	2
dedicated RO water	1	1
cart washer[2]	n/a	n/a

Notes:

1. In future 1 autoclave is required to be added to the MDRD at each site. This would provide a total of 4 autoclaves shared between two sites. Three autoclaves would be required for a single site hospital.
2. There currently are portable cart washers located on the patient care areas to wash wheelchairs and commodes.

Future Planning Assumptions: It is assumed that MDRD will continue to reprocess a majority of non-disposable surgical instruments scopes and patient care items on-site in the future. The most significant services supported by the MDRD will include Operating Room (OR), Endoscopy Suite Birthplace, Emergency Services (ED), and Diagnostic Imaging (DI).

The future MDRD assumes the following will be in place:

- dedicated clean and soiled circulation routes/elevators to the surgical suite sterile core/holding area
- storage for surgical supplies in the MDRD, not in the surgical suit, to facilitate case cart preparation by MDRD staff
- (satellite) endoscope cleaning services located adjacent to the endoscopy suite
- provision of a second back-up autoclave (located at each site as required) in the event the current unit is out of service and/or to handle additional volume within the appropriate turnaround time
- full use of a case cart system for the surgical suite.

The future location(s) for MDRD services will depend on the clinical services being provided and model of service provision. If MAHC continues to provide clinical services across two sites there may be some opportunities for some of the MDRD services to be single sited and for soiled and clean/sterile instrumentation/ equipment to be transported between sites. That said the current transportation issues and challenges would need to be addressed and resolved before a single site MDRD service would be viable.

Note: as far as the MAHC MDRD Planning Team is aware there are no plans current or future to regionalize/centralize MDRD services or to provide them from a third party source.

Workload

Table 30: Current & Projected Workload

	Actual 2012/13	Actual 2013/14	Actual 2014/15	Projected 2019/20	Projected 2024/25	Projected 2034/35
MAHC						
Beds	111	99	96	108	115	139

Location Priorities

In order of priority:

1. Surgical Suite (via dedicated clean and soiled elevators or circulation routes).
2. Endoscopy Suite (via direct connection to scope reprocessing) this may be a satellite scope reprocessing room.
3. Main hospital service corridors.
4. Shipping and Receiving.

Physician & Staff Amenities

Scope of Service Assumptions

Current Status: Currently each of the MAHC hospital sites accommodates centralized staff locker rooms a physician lounge and on-call rooms. The locker rooms are located close to the staff entry to the facilities adjacent to the staff parking lots.

Note: the cafeterias on each site recently were closed.

Future Planning Assumptions: In the future staff amenities will include:

- centralized male and female staff locker facilities for all staff including physicians and students:
  - central lockers
  - washrooms/showers.
- a staff lunchroom (if in the future all MAHC services were located on a single site the critical mass would support the re-opening of the cafeteria a two-site model would include staff lunchrooms on each site)

  In addition the service delivery areas will accommodate small lockers.
- physician consult/lounge:
  - mail boxes
  - dictation/computer cubicles
  - casual meeting space (4) and lounge seating (4) and
  - washrooms.

  Though a small physician lounge will be planned to provide a place for physicians to pick-up reports, etc. currently and increasingly in the future the physicians expect to spend most of their time in the service delivery areas. Consequently physician support spaces will be provided on the inpatient units in the ED and surgical suite to accommodate private conversations and staff meetings.
- on-call rooms
- Medical Student Amenities.

Education/conference rooms will be available for physicians residents staff and students as required. *(Refer to the Education & Training section).*

Workload

n/a

Location Priorities

In order of priority:

1. Staff Facilities will be located in a non-public area of the Hospital equitably accessible to all staff and in proximity to the staff entrance and parking lot.
2. The Physician Lounge will be located with convenient access to the Emergency Department, Surgical Suite and Obstetrics Unit. A location close to Health Records is also desirable.
3. The on-call rooms will be shared and located within easy access of the ED, ORs, and Maternal/Child inpatient unit.

Main Lobby Services

Scope of Service Assumptions

Main Lobby Services will provide a broad range of services for patients and families coming to the hospital. In keeping with best practices in patient and family-centered care, the main lobby(s) will provide an excellent patient experience. The environment will be friendly and welcoming and easily navigated.

The Main Lobby will accommodate:

- main entry vestibule
- main waiting area
- public washrooms
- vending machines.

Other elements of the Main Lobby will include:

- greeter/information desk
- security presence
- Foundation office *(refer to the Foundation section)*
- donor recognition
- public information display facilities.

In addition there may be a café/coffee shop operated by the Auxiliary on each site.

Workload

n/a

Location Priorities

In order of priority:

1. The Main Lobby will be the main entrance to the hospital and will be connected to the main public circulation routes.
2. A critical success factor to the Main Lobby and its relationship with the numerous other services within the hospital(s) will be wayfinding.
3. Café and Gift shop to the Hospital Main Entrance.
4. Café and Gift Shop to Ambulatory Care.
5. Café and Gift Shop to Emergency Services.

C) Options for Service Delivery

C) OPTIONS FOR SERVICE DELIVERY

Clinical Services & Model of Services Delivery

During the Pre-Capital Submission and this Master Program development, MAHC thoroughly analyzed their current and future provision of clinical services and future workload demands. While it is estimated that visit volumes and bed numbers will marginally increase over the 20 year timeframe to accommodate the needs of a growing and aging population, this increase has been tempered by the reduction in some volumes to align with provincial averages, and the relocation of some emergency visits and clinical services to the community. As a result, MAHC will not be substantially changing, or increasing, clinical services and/or programs in the future. There is no plan for MAHC to divest itself of acute care beds and associated services to neighbouring larger hospitals.

The only new clinical service that MAHC may provide in the near future is an Integrated Stroke Program. However, as planning is on-going, and since the Ministry of Health and Long Term Care has not sponsored the proposal at this time, space projections for an Integrated Stroke Program have been excluded.

Throughout the Master Program development, where opportunities existed to enhance service provision (for instance, the implementation of a maternal/child LDRP model) and to move services to the community (for instance, allocating a percentage of Level 4 and 5 emergency visits to community resources), MAHC has continued to model their service delivery to best suit the community needs. Aligning with the 'right provider, right care, right place, right time' strategy, the model supports an increasingly efficient and sustainable system of care – providing hospital based services for the acutely ill and shifting services out of the hospital to primary care and other appropriate community services; thereby strengthening the provision of services in the community and in patients' homes, where appropriate.

The proposed model supports an increasingly integrated system, wherein the hospital, family health teams, nurse practitioner clinics, CCAC, hospices, and a full range of other on- and off-site community services, will increasingly partner in providing health care for the betterment of the community as a whole.

Note the following pillars of MAHC's service delivery model:

- MAHC will focus on efficient delivery of acute care hospital services.
- MAHC will focus on transferring out of the hospital ambulatory services that can be delivered in the community.

- MAHC will focus on using inpatient beds as efficiently as possible.
- MAHC will provide multidisciplinary care with the focus being coordinated and integrated care in collaboration with the organizations various partners.
- MAHC will emphasize the integration of clinical service with education in collaboration with its educational partners.
- MAHC will focus on integrating chronic disease prevention and management in the delivery of services.
- Senior-friendly and patient/family-centred care will be emphasized.
- As a participant in the continuum of service, MAHC will continue to optimize its operational resources by applying best practice and lean principles.
- Already using telehealth services to a considerable extent, MAHC will enhance the use of Telehealth linking sites.

In addition to enhancing the clinical service delivery, the model further enhances system efficiencies through the integration and collocation of site support and operating systems where possible.

As more detailed planning for the site takes place, further opportunities for service delivery model redesign will continue to be explored.

Exploring the Future Model of Care in Relation to the Site Service Delivery Options

MAHC is close to its limit in improving efficiencies in service delivery as a result of its creative endeavours over the past few years. As indicated earlier in the Master Program, its physical resources continue to be a serious impediment in providing a contemporary health care environment that will support the:

- changes required for improved service delivery models
- patient needs for privacy/confidentiality
- staff needs for a supportive work environment
- efficiencies in service delivery
- provision of a safe environment.

Consultation Process

The MAHC Board of Directors established a 21 member Ad-Hoc Steering Committee, including nine physicians, to lead the Master Program/Master Plan Development process over the past two years. The Ad-Hoc Committee was responsible for the development of the final recommended model that would best provide safe, high quality, sustainable, health care for MAHC's service population in the year 2030 and beyond. The process involved extensive internal and external engagement using more than 20 planning teams with membership (200+ members) (see Appendix B) representing front-line staff including physicians, management, community providers and the Board of Directors. The following stakeholders were consulted:

- Ministry of Health and Long-Term Care – Capital Planning Branch.
- North Simcoe Muskoka Local Health Integration Network.
- MAHC staff, physicians and volunteers.
- Key community service providers including the District of Muskoka Emergency Medical Services, Emergency Medical Services Dispatch, Family Health Teams and Nurse Practitioner Clinics/Nursing Stations, Midwives, Hospices, Muskoka Parry Sound Community Mental Health Service/Addiction Outreach, Simcoe Muskoka District Health Unit, North Simcoe Muskoka Community Care Access Centre, and Muskoka Victim Services.
- Other Hospital corporations including Royal Victoria Regional Health Centre, Orillia Soldiers' Memorial Hospital, Georgian Bay General Hospital, Collingwood General & Marine Hospital, Waypoint Mental Health Centre, West Parry Sound Health Centre, Trillium Health Partners, and North Bay Regional Health Centre.
- External stakeholders including Muskoka and East Parry Sound community members, municipal, provincial and federal leaders, community special interest/service groups, donors, and cottager/lake associations. The various communication tools utilized included information sessions, Town Halls meetings, internal memos and news releases, CEO Blogs, MAHC Annual General Meetings, and community newsletters.

Clinical Services Workshops

During the Master Program development specifically, a series of workshops were conducted to discuss and brainstorm various options for delivering MAHC's clinical services across hospital sites. These workshops were attended by representatives from all of MAHC's programs and services, key community service providers as well as a member of the Board to ensure the discussions balanced the clinical benefits to the patients with operational efficiencies and the organization's strategic directions.

The Clinical Services Workshops focused on MAHC's anchor programs:

- Ambulatory Care Services
- Emergency Services
- Surgical Services
- Maternal and Child Services
- Medical/Surgical, ICU, and CCC.

Workshop attendees discussed/debated:

- the strengths of the present care processes
- opportunities to provide care in different ways
- future model(s) of care that would enhance patient and staff experience, improve patient outcomes, and improve operational effectiveness.

Service Model Options

Several options were explored for providing MAHC's clinical services. All options considered balancing the clinical benefits with the patients' needs aligned with operational efficiencies and the organization's strategic directions. At the beginning of the planning exercise nine potential options were explored, which eventually were distilled to three viable options:

1. Two Full Service Acute Sites - attempting to maintain current services across both sites
2. Centres of Focus (Hybrid) - distributing workload across both sites in a rationalized approach (both having an Emergency Department)
3. One Hospital (Centrally Located).

Throughout the entire planning process it was evident that maintaining the current service model across two sites would not be sustainable in the long-term, both operationally and from a capital investment perspective. As a result, variations to the two-site service delivery model were explored extensively with the intent of ensuring appropriate services in each of the communities, and at the same time offering access to services that have sufficient volumes to maintain clinical expertise that can also be operated efficiently. As much as possible service integration with other providers was explored and factored into the workload projections. Service redesign in terms of reducing Alternate Level of Care patients, lower admission rates, and shifting to community and outpatient care were all factored into the future service models.

Workshop Planning Principles

The following workshop planning principles reflect the principles and guidelines for healthcare delivery as outlined in:

- Ontario's Action Plan for Health Care (MOHLTC)
- Ontario's Priority Programs
- Ontario's Rural and Northern Health Care Report
- NSM LHIN's Integrated Health Service Plan (IHSP)
- NSM LHIN's Care Connections
- MAHC's Strategic Action Plan for 2015-18.

Key guidelines for each of the above documents are more fully described in the Program Parameters section of this Master Program document.

Current planning for health care delivery is looking for ways to:

- Improve patient outcomes.
- Improve experience - optimize the patient and family experience through the eyes of the patient; "*(The key to providing excellent, patient-centered care is to truly understand the patient experience)" quote from Healthscape Enhancing the Patient Experience Feb 27, 2014).*
- Improve operational effectiveness - increase volumes without increasing space, create non-duplicated services across sites, implement standardization and flexibility, eliminate service fragmentation.
- Enhance safety; minimize risk - the safety and wellness of patients, staff, physicians, and volunteers is paramount.
- Integrate delivery of care across sites (as appropriate).
- Support the health needs of the community.
- Promote prevention - increasingly, healthcare providers must adopt a leadership role in health promotion as well as the treatment of disease.
- Support a sustainable future - financially viable and environmentally responsible; i.e., does it represent prudent use of resources allocated wisely on the basis of fair and publicly- defensible reasons and procedures?
- Integrate smart technology - to optimize patient, staff and physician experience.
- Enable innovation and education.
- Inspire human-to-human connection and collaboration; i.e., does it support partnerships in care provision.

- Optimize the staff experience; provide a critical mass to continually improve staff competencies/skill sets.

Note: travel distances would be considered within 'improve patient experience'.

Workshop Outcomes

In all workshop sessions, care close to home, the communities' strong connections to their local hospitals and the related fund raising opportunities within the local communities, the travel distances to care and current lack of convenient public transportation were discussed as key advantages of retaining the current model of two acute care hospital sites.

The key advantages of moving from the current model to either a centres of focus two site model or a single site model include - less duplication of services, enhanced efficiencies in service delivery and staffing models, opportunities to develop new models within services due to the increased critical mass, and overall decreased operating costs.

Following the discussions at the clinical workshops a series of criteria and the guiding principles were established to assist the decision makers with the options selection process. The principles addressed operational benefits, access to care, community and government support, sustainability, capital cost, growth potential and opportunities to develop a campus of care service model. A listing of all the criteria and evaluation scoring is included under separate cover in the 2015 Master Plan document. The Ad-Hoc Steering Committee outlined the advantages/opportunities, disadvantages/challenges as well as key considerations for each of the final options, and shared this overview with internal and external stakeholders during the final engagement sessions in March 2015. All stakeholders were encouraged to provide MAHC with feedback and suggestions as to any further considerations with respect to these final three options. Several issues for further consideration emerged as the models were presented, specifically access to emergency services, and ensuring reasonable drive times and access by the majority of the population served.

The final three options were rated by the Steering Committee based on the guiding principles and evaluation criteria developed. The preferred ***Option 3 - One Hospital Site*** was based on the model that would best provide accessible, safe, high quality, cost efficient and sustainable health care in the year 2030 and beyond. An analysis of drive times and access to an Emergency Department (ED) determined that a central location between the Towns of Huntsville and Bracebridge would best serve the entire service population.

The proposed single site service delivery model will afford MAHC the opportunity to consolidate clinical and other services to achieve evidence-based best practices and critical mass integration. In addition, a single site promotes seamless care with primary care providers. A single site model supports efforts to reduce hospital admissions and ED visits and improves techniques to reduce length of stay. Ensuring sufficient human resource capacity within the LHIN to support these transitions will be fundamental. Other benefits of the single site model include:

- Ensuring a stable environment that attracts and retains doctors and sub-specialties, and offers optimal working conditions that help to recruit staff.
- Protecting the viability of core services
- Meeting future growth needs with flexibility and growth potential and existing physical assets would become surplus.

The proposed model is better able to operate within the health system funding reform model as one facility could more easily withstand the impacts of funding reform and health system transformation. In essence, one larger facility is more able to adjust service delivery to maintain and retain services and prevent service elimination, and/or potentially add services compared to smaller, fragmented separate sites.

To further support the option's analysis, an estimate of the potential operating savings was calculated at the 10-year horizon if all services are consolidated on a single site (Table 31 below). The savings were calculated by taking the cost differential between the average cost of running two separate sites (including reduced operating costs for heat, lighting, snow removal, etc.) compared with the efficiencies of a single site using the mid point between the 25th percentile and peer average of comparable facilities. The calculation is based upon achieving improved efficiencies in both direct and indirect costs. A more refined operating cost estimate will be developed in the Stage 1 Proposal.

Table 31: Potential Operating Savings @ 10-year Horizon

Cost Centre	
Inpatient Nursing	$478,000
Emergency	$109,000
Ambulatory Clinics	$489,000
Surgery	$463,000
Diagnostic and Therapeutic	$3,551,000
Direct Patient Care	**$5,090,000**
Overhead	$2,421,000
Nursing Administration	$37,000
Indirect	**$2,458,000**
Total Potential Savings	$7,548,000

Factored into the recommendation of the preferred option is the physical evaluation of current buildings, systems, sites and capacities that has been documented in the Master Plan report under separate cover. A capital cost analysis of the three options was also prepared and included in the Master Plan.

For reference and information, an outline of the advantages and disadvantages for service options by clinical program is included in Appendix A.

SPATIAL REQUIREMENTS

SPATIAL REQUIREMENTS

Preamble

Projected space requirements at the three planning horizons have been developed for the three service delivery options described in Section C, with the following parameters:

1. A **two site option (acute care/acute care)**, which would leave the sites, and services, (basically) as they are and over a series of phased planning projects, renovate and add-on to the existing facilities to enhance service provision. This option does not preclude future reallocation or consolidation of program/services between the existing sites.
2. A **centres of focus (hybrid) option**, is a variation of the two site acute model distributing the workload across both sites in a rationalized approach. For this option, the sites are clinical focused aligned to similar population groupings (e.g., medicine, complex care and stroke at one site with surgery and obstetrics and the other site), while both sites retain an Emergency Department.
3. A **single site option**, wherein all staff and services are located on one site. At this very early stage in the planning process, while a site has not been identified, it has been assumed it would be located centrally in the catchment area somewhere between the two existing sites.

During Master Planning, the architects, in collaboration with MAHC staff/stakeholders and RPG, considered variations within the options to deliver the one and two site options, based on the site and capacity of the existing buildings in Huntsville and Bracebridge (refer to the MAHC Master Plan document). A refinement to the master program options and specifically the preferred option is documented for costing and evaluation purposes in the Master Plan report (under separate cover).

Major Planning Elements

Major elements that will affect the space planning required to address the challenges that MAHC is facing with their existing facilities include:

- plan for facilities that will locate MAHC staff and services and select Community Services so as:
  - to support an integrated/inter-professional model of care delivery
  - to support an efficient model of service delivery
  - to provide patient and family-centered care.

- increase the capacity of MAHC to correct current deficiencies and provide for modest projected growth:
  - to improve access to care
  - to improve wait times
  - to improve operational efficiencies and sharing of common areas
  - to support organized long-term growth and change and flexible use of space over time.
- update the size of the spaces to meet current evidence based design standards for community hospitals:
  - to provide efficient delivery of patient care services
  - to improve accessibility
  - to improve safety
  - to provide for the flexible use of space into the future.
- create optimal location and functional adjacencies among service delivery areas:
  - to support an integrated model of care delivery
  - to improve workflow
  - to improve patient flow and wayfinding
  - to provide for the flexible use of space into the future
  - to provide for sharing of spaces among services.
- provide a well-organized layout for each service delivery area:
  - to improve operational efficiency
  - to improve staff work environments
  - to improve safety
  - to improve patient privacy and confidentiality.
- ensure optimal circulation throughout the Hospital(s) – as possible separate 'front of the house' public spaces from the 'back of the house' activities:
  - to improve traffic flow
  - to improve wayfinding
  - to improve accessibility by all, including strategies for creation of an elder friendly hospital
  - to ensure optimal patient privacy.
- update infection prevention and control capabilities:
  - to improve safety for all.

- provide an environment for patients and staff conducive to healing and well being; one that is supportive of individuals taking an active role in their health care.

Note: the impact of technology on the future health care services, and how the space configuration can support the technological advances will require further and more detailed exploration.

Key changes to space include:

1. a minimum of 80% of single bedrooms to accommodate acute medical/surgical inpatients; each bedroom will have a three piece ensuite washroom
2. addition of 1-2 airborne precaution/isolation rooms for each inpatient unit and in other clinical areas including the ED, Medical Day Care, Hemodialysis Clinic
3. inclusion of a much greater percentage of enclosed treatment rooms in the ED, and other patient care clinic areas throughout the new facility
4. right-sizing of the endoscopy, minor procedures and diagnostic imaging procedure rooms to accommodate new procedures, processes, protocols and equipment
5. inclusion of spaces to support and enhance staff and student education on the site.

Table 32: Summary of Space by Option

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	SMMH	Year 5	Year 10	Year 20
OPTION 1: TWO FULL SERVICE ACUTE SITES	**76,730**	**84,415**	**276,533**	**294,545**	**333,852**
SITE #1: ACUTE CARE HOSPITAL (HDMH)					
Clinical Program and Services	44,100	n/a	64,143	66,865	77,292
Clinical Support Services	10,410	n/a	22,420	24,540	27,640
Education and Training Service	n/a	n/a	5,500	5,500	6,000
Admin and General Support Services	21,210	n/a	42,300	43,600	48,000
Community Services - On-site	650	n/a	900	900	1,200
SUBTOTAL: CGSF	***76,370***	***n/a***	***132,263***	***141,405***	***160,132***
SITE #2: ACUTE CARE HOSPITAL (SMMH)					
Clinical Program and Services	n/a	48,090	77,150	83,600	97,280
Clinical Support Services	n/a	12,460	19,920	21,040	23,140
Education and Training Service	n/a	1,230	4,500	4,500	4,800
Admin and General Support Services	n/a	22,310	42,300	43,600	48,000
Community Services - On-site	n/a	325	400	400	500
SUBTOTAL: CGSF	***n/a***	***84,415***	***144,270***	***153,140***	***173,720***
OPTION 2: CENTRES OF FOCUS (HYBRID)	**76,370**	**84,415**	**246,260**	**253,970**	**291,600**
SITE #1: ACUTE CARE HOSPITAL					
Clinical Program and Services	n/a	n/a	61,065	63,795	72,195
Clinical Support Services	n/a	n/a	20,790	21,290	23,790
Education and Training Service	n/a	n/a	5,500	5,500	6,000
Admin and General Support Services	n/a	n/a	26,095	26,095	28,675
Community Services - On-site	n/a	n/a	700	700	900
SUBTOTAL: CGSF	***n/a***	***n/a***	***114,150***	***117,380***	***131,560***
SITE #2: ACUTE CARE HOSPITAL					
Clinical Program and Services	n/a	n/a	68,205	72,335	86,075
Clinical Support Services	n/a	n/a	22,190	22,540	26,390
Education and Training Service	n/a	n/a	4,500	4,500	5,000
Admin and General Support Services	n/a	n/a	36,515	36,515	41,675
Community Services - On-site	n/a	n/a	700	700	900
SUBTOTAL: CGSF	***n/a***	***n/a***	***132,110***	***136,590***	***160,040***

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	SMMH	Year 5	Year 10	Year 20
OPTION 3: ONE HOSPITAL (CENTRALLY LOCATED)	**76,370**	**84,415**	**204,797**	**215,791**	**245,843**
Clinical Program and Services	44,100	48,090	121,677	127,451	147,283
Clinical Support Services	10,410	12,460	27,320	29,740	32,960
Education and Training Service	n/a	1,230	5,500	5,500	6,000
Admin and General Support Services	21,210	22,310	49,000	51,700	57,900
Community Services - On-site	650	325	1,300	1,400	1,700

Note:
1. The current space by department/component at each site is outlined in the Muskoka Algonquin Healthcare Pre-Capital Submission (October 15, 2012), Functional Space Assessment section

OPTION 1: TWO FULL SERVICE ACUTE SITES

Space Estimates & Clinical Space Drivers

A **Two Acute Site Option**, which would leave the sites, and services, (basically) as they are and over a series of phased planning projects, renovate and add-on to the existing facilities to enhance service provision. This option does not preclude the future consolidation or reallocation of programs/services across the sites.

Table 33: Option 1: Two Full Service Acute Sites

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	SMMH	Year 5	Year 10	Year 20
SITE #1: ACUTE CARE HOSPITAL (HDMH)	**76,370**	**84,415**	**132,263**	**141,405**	**160,132**
CLINICAL PROGRAM AND SERVICES:					
Ambulatory Care					
Area:	**9,360**	**2,745**	**18,500**	**18,700**	**19,600**
Space Drivers:					
Clinics (Multi-Use):					
Exam / Consult Room Multi-Use	*n/a*	*n/a*	*3*	*3*	*3*
Med Learners Exam / Consult Room	*n/a*		*2*	*2*	*2*
Cast Room (2 Stretchers)	*1*	*1*	*1 shared*	*1 shared*	*1 shared*
Diabetes Care:					
Education Room Multi-Use	*n/a*	*n/a*	*1*	*1*	*1*
Foot Care	*n/a*	*n/a*	*1*	*1*	*1*
Medical Day Care:					
MDC (Recliner)	*n/a*	*n/a*	*3*	*3*	*3*
MDC Exam / Consult Room	*n/a*	*n/a*	*1*	*1*	*1*
Minor Procedure / Cataract Rooms:	*incl.*	*incl.*	*2*	*2*	*2*
Pre and Post (Adjacent MDC)	*n/a*	*n/a*	*3*	*3*	*3*
Dialysis Services:	*2,070*	*n/a*			
Dialysis Treatment Stations	*6*	*n/a*	*5*	*5*	*5*
Dialysis Treatment Room	*n/a*	*n/a*	*1*	*1*	*1*
Chemotherapy Service:	*1,440*	*925*			
Chemo Treatment Stations	*6*	*6*	*5*	*5*	*5*
Chemo Treatment Room	*n/a*	*n/a*	*1*	*1*	*1*
Exam/Consult Room	*n/a*	*n/a*	*2*	*2*	*2*
Satellite Pharmacy	*n/a*	*n/a*	*1*	*1*	*1*
Rehabilitation Services:	*2,790*	*1,820*			
Treatment Cubicles	*4*	*6*	*4*	*4*	*4*
Treatment Rooms	*n/a*	n/a	*2*	*2*	*2*
Gymnasium	*1*	*1*	*1*	*1*	*1*
Splinting	*1*	*1*	*1*	*1*	*1*
Workstations	*2*	*2*	*3*	*3*	*3*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Allied Health:					
Physiotherapy Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
Occupational Therapy Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
SLP Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
Emergency Services					
Area:	**6,320**	**9,290**	**6,143**	**6,465**	**7,192**
Space Drivers: treatment places	17	17	14	15	16
Trauma / Resuscitation	*2*	*2*	*1*	*1*	*1*
Crisis / Procedure	*n/a*	*n/a*	*1*	*1*	*1*
Acute Treatment	*9*	*8*	*6*	*7*	*8*
See and Treat	*5*	*2*	*3*	*3*	*3*
Cast Room	*1 shared*	*1 shared*	*1 shared*	*1 shared*	*1 shared*
Holding / Obs (Stretchers)	*2*	*2*	*2*	*2*	*2*
Surgical Services					
Area *(existing includes endoscopy)*	**8,450**	**7,090**	**11,000**	**14,000**	**17,000**
Space Drivers: cases					
SDU Places	*5*	*6*	*7*	*7*	*8*
Prisoners Prep and Recovery (WC)	*--*	*--*	*1*	*1*	*1*
Operating Rooms	*2*	*2*	*2*	*2*	*2*
Urology Room	*1*	*--*	*1*	*1*	*1*
Endo Procedure Room	*2*	*1*	*2*	*2*	*2*
Phase 1: PACU Stretchers	*5*	*4*	*5*	*5*	*7*
Phase 2 Recliners	*--*	*--*	*5*	*6*	*6*
Satellite Scope Reprocessing	*--*	*--*	*1*	*1*	*1*
Inpatient Services					
Medical / Surgical Inpatient Service:					
Area:	**8,970**	**14,150**	**19,200**	**20,400**	**25,200**
Space Drivers: *beds*	28	41	32	34	42
Single Bedrooms (80%)	*n/a*	*n/a*	*26*	*28*	*34*
Double Bedrooms (20%)	*n/a*	*n/a*	*1*	*1*	*2*
Ward Bedrooms (2x2 beds)	*n/a*	*n/a*	*1*	*1*	*1*
Critical Care:					
Area:	**1,900**	**2,165**	**3,000**	**4,000**	**5,000**
Space Drivers: *beds*	5	4	3	4	5
Single Bedrooms (100%)	5	4	*3*	*3*	*3*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Maternal/ Child:					
Area:	**2,440**	**4,800**	**3,300**	**3,300**	**3,300**
Space Drivers: *beds*	3	2	2	2	2
LDRP w/Shared Water Bath	*n/a*	*n/a*	*2*	*2*	*2*
Post Partum Room	*n/a*	*n/a*	*1*	*1*	*1*
Infant Obs Area - Bassinets	*2*	*1*	*2*	*2*	*2*
Early Labor Lounge - Recliners	*n/a*	*n/a*	*2*	*2*	*2*
Examination Room	*n/a*	*n/a*	*1*	*1*	*1*
Family Support Area	*0*	*1*	*1*	*1*	*1*
Complex Continuing Care					
Area:	**6,660**	**7,850**	**n/a**	**n/a**	**n/a**
CLINICAL SUPPORT SERVICES:					
Cardiorespiratory Services					
Area: (includes pacemaker)	**1,020**	**1,515**	**4,000**	**4,300**	**4,600**
Space Drivers:					
Holter	*n/a*	*n/a*	*1*	*1*	*1*
Stress Test	*1*	*1*	*1*	*1*	*1*
Pulmonary Function Test / Office	*1*	*1*	*1*	*1*	*1*
Exam / Consult Pacemaker)	*n/a*	*n/a*	*1*	*1*	*1*
Consult / Education	*n/a*	*n/a*	*1*	*1*	*1*
RRT Services / Workroom	*n/a*	*1*	*1*	*1*	*1*
Office (Shared)	*n/a*	*1*	*1*	*1*	*1*
Clinical Laboratory					
Area:	**3,250**	**3,290**	**5,500**	**6,000**	**6,500**
Space Drivers:					
Phlebotomy ECG	*1*	*1*	*1*	*1*	*1*
Accessioning and Sorting	*1*	*1*	*1*	*1*	*1*
Core Lab incl. Blood Bank	*1*	*1*	*1*	*1*	*1*
Microbiology	*1*	*n/a*	*--*	*1*	*1*
Pathology	*n/a*	*1*	*--*	*1*	*1*
Cytology	*n/a*	*1*	*--*	*1*	*1*
Administration and Support	*1*	*1*	*1*	*1*	*1*
POC Testing Workroom	*1*	*1*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Diagnostic Imaging					
Area:	**4,960**	**6,550**	**10,000**	**11,000**	**13,000**
Space Drivers:					
X-ray	*2*	*2*	*2*	*2*	*3*
Ultrasound	*2*	*2*	*3*	*3*	*3*
Mammography and Stereotactic	*1*	*1*	*2*	*2*	*2*
Bone Mineral Densitometry	*1*	*1*	*1*	*1*	*1*
CT Scan	*1*	*1*	*1*	*1*	*1*
ECHO	*1*	*1*	*1*	*1*	*1*
Nuclear Medicine	*1*	*n/a*	*1*	*1*	*1*
Interventional Fluoroscopy	*1*	*n/a*	*1*	*1*	*1*
MRI / Additional Equipment	*n/a*	*n/a*	--	1	2
Teaching Room	*n/a*	*n/a*	*1*	1	1
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*
Pharmacy Services					
Area:	**1,090**	**815**	**2,800**	**3,000**	**3,300**
Space Drivers:					
Reception / Outpatient Pick-up	*1*	*1*	*1*	*1*	*1*
Central Pharmacy / Inpt. Dispensing	*1*	*1*	*1*	*1*	*1*
Administration / Support	*1*	*1*	*1*	*1*	*1*
Office, Pharmacist / Resource library	*1*	*1*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*
Satellite Pharmacy (with Chemo)	*n/a*	*n/a*	*(1)*	*(1)*	*(1)*
Infection Prevention and Control					
Area:	**90**	**290**	**120**	**240**	**240**
Space Drivers:					
Office	*n/a*	*n/a*	*1*	*2*	*2*
EDUCATION AND TRAINING SERVICES:					
Area:	**n/a**	**1,230**	**5,500**	**5,500**	**6,000**
Educators Office (per site)	*1*	*1*	*1*	*1*	*1*
Classroom (30)	n/a	n/a	*1*	*1*	*1*
Computer Training (10)	n/a	n/a	*1*	*1*	*1*
Diabetes Education Room (in Ambulatory)	n/a	n/a	*incl.*	*incl.*	*incl.*
Conference Room (25)	*1*	*1*	*1*	*1*	*1*
Student Training Rooms/ OTN	n/a	n/a	*2*	*2*	*2*
Student Work Rooms (1 per flr)	n/a	n/a	*4*	*4*	*4*
Simulation Room (incl. Computer)	n/a	n/a	*1*	*1*	*1*
Lecture Theatre (70)	n/a	n/a	*1*	*1*	*1*
Library (Virtual in Future)	*1*	*1*	*0*	*0*	*0*
Support Facilities (WC, Kitchenette)	*1*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
ADMINISTRATION & SUPPORT SERVICES:					
Administration					
Area: *(excludes boardroom)*	**3,950**	**4,645**	**2,500**	**3,000**	**3,500**
Space Drivers:					
Offices	*6-7*	*4-6*	*8*	*8*	*9*
Workstations - Dedicated	*1-2*	*1-2*	*2*	*2*	*3*
Workstations - Shared	*n/a*	*n/a*	*2*	*2*	*2*
Meeting/ Interview Room	*n/a*	*n/a*	*1*	*1*	*1*
Foundation					
Area:	**Off-site**	**470**	**1,000**	**1,000**	**1,500**
Space Drivers:					
Office	*2*	*1*	*2*	*2*	*2*
Workstation - Dedicated	*1*	*1*	*1*	*1*	*1*
Workstation - Shared	n/a	n/a	*1*	*1*	*1*
Meeting Room (Shared)	*shared*	*shared*	*1*	*1*	*1*
Work Room	n/a	n/a	*1*	*1*	*1*
Auxiliary					
Area:	**450**	**765**	**1,100**	**1,100**	**1,500**
Space Drivers:					
Office	*1*	*1*	*2*	*2*	*2*
Meeting Room	*1*	n/a	*1*	*1*	*1*
Volunteer Work area	*1*	*1*	*1*	*1*	*1*
Volunteer Lounge (4 Places)	*1*	*1*	*1*	*1*	*1*
Coat Storage	*n/a*	*n/a*	*1*	*1*	*1*
Storage	*n/a*	*n/a*	*1*	*1*	*1*
Spiritual Care					
Area:	**290**	**n/a**	**600**	**600**	**600**
Space Drivers:					
Meditation Room	*1*	*n/a*	*1*	*1*	*1*
Office / Consult Room	*n/a*	*n/a*	*1*	*1*	*1*
Health Records					
Area: *(depends on record storage)*	**1,200**	**1,130**	**2,400**	**2,400**	**1,000**
Space Drivers:					
Workstations	*2-3*	*2-3*	*2-3*	*2-3*	*3*
File Storage Room	*1*	*1*	*1*	*0.5*	*n/a*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Information and Telecommunications					
Area:	**530**	**n/a**	**2,500**	**2,800**	**3,000**
Space Drivers:					
Server Room	*n/a*	*n/a*	*1*	*1*	*1*
Wiring Entry Room	*n/a*	*n/a*	*1*	*1*	*1*
Wiring Closet	*n/a*	*n/a*	*2*	*2*	*2*
Office / Storage (Landing Pad)	*n/a*	*n/a*	*1*	*1*	*1*
Switchboard	*530*	*n/a*	*1*	*1*	*1*
GENERAL SUPPORT SERVICES:					
Plant Operations and Management					
Area: ***(historic is vacant space)***	**270**	**n/a**	**3,800**	**3,800**	**4,900**
Space Drivers:					
Engineering / Physical Plant	*1*	*1*	*1*	*1*	*1*
Biomedical Engineering	*1*	*1*	*1*	*1*	*1*
Waste Management	n/a	n/a	*0*	*0*	*0*
Long Term Storage	*1*	*1*	*1*	*1*	*1*
Morgue (Stretchers)	*1*	*1*	*1*	*1*	*1*
Environmental Services					
Area:	**100**	**140**	**1,100**	**1,100**	**1,500**
Space Drivers:					
Central Equipment Room	*1*	*1*	*1*	*1*	*1*
Housekeeping Office	*1*	*1*	*1*	*1*	*1*
Materials Management					
Area: ***(depending on stores/supply)***	**5,660**	**5,480**	**8,000**	**8,000**	**8,000**
Space Drivers:					
Shipping / Receiving (Docks 1 per site)	*1*	*1*	*1*	*1*	*1*
Laundry / Linen Distribution / Storage	*1*	*1*	*1*	*1*	*1*
Purchasing Office	*1*	*1*	*1*	*1*	*1*
Stores Warehouse	*1*	*1*	*1*	*1*	*1*
Mail Room	*1*	*1*	*1*	*1*	*1*
Medical Devices Reprocessing Dept.					
Area:	**1,330**	**1,060**	**5,000**	**5,500**	**5,700**
Space Drivers:					
Decontamination	*1*	*1*	*1*	*1*	*1*
Washer / Disinfector / Sterilization	*1*	*1*	*1*	*1*	*1*
Scope Reprocessing	*1*	*1*	*1*	*1*	*1*
Packing and Cart Marshalling	*1*	*1*	*1*	*1*	*1*
Storage	*In OR*	*In OR*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Nutrition and Food Services					
Area:	**4,520**	**4,830**	**6,800**	**6,800**	**7,800**
Space Drivers:					
Receiving and Storage	*incl.*	*incl.*	*1*	*1*	*1*
Kitchen	*incl.*	*incl.*	*1*	*1*	*1*
Dietician	*1*	*1*	*1*	*1*	*1*
Lunchroom	*1*	*1*	*1*	*1*	*1*
Main Lobby Services					
Area:	**1,250**	**850**	**4,000**	**4,000**	**5,000**
Space Drivers:					
Lobby space	*930*	*560*	*1*	*1*	*1*
Info Desk / Cashier	*incl.*	*incl.*	*1*	*1*	*1*
Gift Shop	*320*	*290*	*1*	*1*	*1*
Patient Registration	*incl.*	*incl.*	*1*	*1*	*1*
Waiting	*incl.*	*incl.*	*1*	*1*	*1*
Physician and Staff Support					
Area:	**1,660**	**2,940**	**3,500**	**3,500**	**4,000**
Space Drivers:					
Physician Coat Locker	*1*	*1*	*1*	*1*	*1*
Central Locker Room (Male / Female)	*2*	*2*	*2*	*2*	*2*
On-call Rooms	*2*	*2*	*2*	*2*	*2*
Staff Lounge / Meeting (on I/P Units)	*--*	*--*	*--*	*--*	*--*
COMMUNITY SERVICES (ON-SITE):		**n/a**			
NSM CCAC					
Area:	**650**	**325**	**400**	**400**	**500**
Space Drivers:					
Offices	*3*	*4*	*4*	*3*	*4*
SASOT					
Area: (incl. in ambulatory)	**n/a**	**n/a**	**500**	**500**	**700**
Space Drivers:					
Offices	4	n/a	4	4	6

	Current HDMH	Current SMMH	Projected 5-Year	Projected 10-Year	Projected 20-Year
SITE #2: ACUTE CARE HOSPITAL (SMMH)	**76,370**	**84,415**	**144,270**	**153,140**	**173,720**
CLINICAL PROGRAM AND SERVICES:					
Ambulatory Care					
Area:	**9,360**	**2,745**	**8,500**	**9,000**	**9,500**
Space Drivers:					
Clinics (Multi-Use):					
Exam / Consult Room Multi-Use	*n/a*	*n/a*	*3*	*3*	*3*
Med Learners Exam/Consult Room	*n/a*		*2*	*2*	*2*
Cast Room (2 Stretchers)	*1*	*1*	*1 shared*	*1 shared*	*1 shared*
Diabetes Care:					
Education Room Multi-Use	*n/a*	*n/a*	*1*	*1*	*1*
Foot care	*n/a*		*1*	*1*	*1*
Medical Day Care:					
MDC (Recliner)	*n/a*	*n/a*	*3*	*3*	*3*
MDC Exam / Consult Room	*n/a*	*n/a*	*1*	*1*	*1*
Minor Procedure / Cataract Rooms:	*incl.*	*incl.*	*2*	*2*	*2*
Pre and Post (Adjacent MDC)	*n/a*	*n/a*	*3*	*3*	*3*
Rehabilitation Services:	*2,790*	*1,820*			
Treatment Cubicles	4	*6*	*4*	*4*	*4*
Treatment Rooms	*n/a*	n/a	*2*	*2*	*2*
Gymnasium	*1*	*1*	*1*	*1*	*1*
Splinting	*1*	*1*	*1*	*1*	*1*
Workstations	*2*	*2*	*3*	*3*	*3*
Allied Health					
Physiotherapy Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
Occupational Therapy Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
SLP Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
Emergency Services					
Area:	**6,320**	**9,290**	**7,780**	**8,200**	**9,000**
Space Drivers: *tx places*	*17*	*17*	*14*	*15*	*16*
Trauma / Resuscitation	*2*	*2*	*1*	*1*	*1*
Crisis / Procedure	*n/a*	*n/a*	*1*	*1*	*1*
Acute Treatment	*9*	*8*	*6*	*7*	*8*
See and Treat	*5*	*2*	*3*	*3*	*3*
Cast Room	*1 shared*	*1 shared*	*1 shared*	*1 shared*	*1 shared*
Holding / Obs (Stretchers)	*2*	*2*	*2*	*2*	*2*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Surgical Services					
Area *(existing includes endoscopy)*	**8,450**	**7,090**	**11,000**	**14,000**	**17,000**
Space Drivers: cases					
SDU Places	*5*	*6*	*7*	*7*	*8*
Prisoners Prep and Recovery (WC)	*--*	*--*	*1*	*1*	*1*
Operating Rooms	*2*	*2*	*2*	*2*	*2*
Urology Room	*1*	*--*	*1*	*1*	*1*
Endo Procedure Room	*2*	*1*	*2*	*2*	*2*
Phase 1: PACU Stretchers	*5*	*4*	*5*	*5*	*7*
Phase 2 Recliners	*--*	*--*	*5*	*6*	*6*
Satellite Scope Reprocessing	*--*	*--*	*1*	*1*	*1*
Inpatient Services					
Medical / Surgical Inpatient Service					
Area:	**8,970**	**14,150**	**28,800**	**30,000**	**37,200**
Space Drivers: *beds*	*28*	*41*	*48*	*50*	*62*
Single Bedrooms (80%)	*n/a*	*n/a*	*38*	*40*	*50*
Double Bedrooms (20%)	*n/a*	*n/a*	*3*	*3*	*4*
Ward Bedrooms (2x2 beds)	*n/a*	*n/a*	*1*	*1*	*1*
Critical Care:					
Area:	**1,900**	**2,165**	**4,000**	**4,000**	**5,000**
Space Drivers: *beds*	*5*	*4*	*4*	*4*	*5*
Single Bedrooms (100%)	*n/a*	*n/a*	*4*	*4*	*5*
Maternal / Child Services					
Area:	**2,440**	**4,800**	**3,300**	**3,300**	**3,300**
Space Drivers: *beds*	3	2	2	2	2
LDRP w/ Share Water Bath	*n/a*	*n/a*	*2*	*2*	*2*
Post Partum room	*n/a*	*n/a*	*1*	*1*	*1*
Infant Obs Area - Bassinets	*2*	*1*	*2*	*2*	*2*
Early Labor Lounge - Recliners	*n/a*	*n/a*	*2*	*2*	*2*
Examination Room	*n/a*	*n/a*	*1*	*1*	*1*
Family Support Area	*n/a*	*1*	*1*	*1*	*1*
Complex Continuing Care					
Area:	**6,660**	**7,850**	**13,770**	**15,100**	**16,280**
Space Drivers: *beds*	--	24	18	20	22
Single Bedrooms (80%)	*n/a*	*n/a*	*12*	*12*	*12*
Double Bedrooms (20%)	*n/a*	*n/a*	*1*	*2*	*3*
Ward Bedrooms (2x2 beds)	*n/a*	*n/a*	*1*	*1*	*1*
On-unit Activation / Rehab space	*n/a*	*n/a*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
CLINICAL SUPPORT SERVICES:					
Cardio Respiratory Services					
Area:	**1,020**	**1,515**	**4,000**	**4,300**	**4,600**
Space Drivers:					
Holter	*n/a*	*n/a*	*1*	*1*	*1*
Stress Test	*1*	*1*	*1*	*1*	*1*
Pulmonary Function Test / Office	*1*	*1*	*1*	*1*	*1*
Exam / Consult (Pacemaker)	*n/a*	*n/a*	*1*	*1*	*1*
Consult/Education	*n/a*	*n/a*	*1*	*1*	*1*
RRT Services / Workroom	*n/a*	*1*	*1*	*1*	*1*
Office (Shared)	*n/a*	*1*	*1*	*1*	*1*
Clinical Laboratory					
Area:	**3,250**	**3,290**	**4,000**	**4,500**	**5,000**
Space Drivers:					
Phlebotomy ECG	*1*	*1*	*1*	*1*	*1*
Accessioning and Sorting	*1*	*1*	*1*	*1*	*1*
Core Lab incl. Blood Bank	*1*	*1*	*1*	*1*	*1*
Microbiology	*1*	*n/a*	*--*	*--*	*--*
Pathology	*n/a*	*1*	*--*	*--*	*--*
Cytology	*n/a*	*1*	*--*	*--*	*--*
Administration and Support	*1*	*1*	*1*	*1*	*1*
POC Testing Workroom	*1*	*1*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*
Diagnostic Imaging					
Area:	**4,960**	**6,550**	**9,000**	**9,000**	**10,000**
Space Drivers:					
X-ray	*2*	*2*	*2*	*2*	*3*
Ultrasound	*2*	*2*	*3*	*3*	*3*
Mammography and Stereotactic	*1*	*1*	*2*	*2*	*2*
Bone Mineral Densitometry	*1*	*1*	*1*	*1*	*1*
CT Scan	*1*	*1*	*1*	*1*	*1*
ECHO	*1*	*1*	*1*	*1*	*1*
Nuclear Medicine	*1*	*n/a*	*--*	*--*	*--*
Interventional Fluoroscopy	*1*	*n/a*	*1*	*1*	*1*
MRI / Additional Equipment	*n/a*	*n/a*	*--*	*--*	*1*
Teaching Room	*n/a*	*n/a*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Pharmacy Services					
Area:	**1,090**	**815**	**2,800**	**3,000**	**3,300**
Space Drivers:					
Reception / Outpatient Pick-up	*1*	*1*	*1*	*1*	*1*
Central Pharmacy / Inpt. Dispensing	*1*	*1*	*1*	*1*	*1*
Administration / Support	*1*	*1*	*1*	*1*	*1*
Office, Pharmacist / Resource Library	*1*	*1*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*
Satellite Pharmacy (with Chemo)	n/a	n/a	*(1)*	*(1)*	*(1)*
Infection Prevention and Control					
Area:	**90**	**290**	**120**	**240**	**240**
Space Drivers:					
Office	*n/a*	*n/a*	*1*	*2*	*2*
EDUCATION AND TRAINING SERVICES:					
Learning Centre:					
Area:	**n/a**	**1,230**	**4,500**	**4,500**	**4,800**
Space Drivers:					
Educators Office (per site)	*1*	*1*	*1*	*1*	*1*
Classroom (30)	*n/a*	*n/a*	*1*	*1*	*1*
Computer Training (10)	*n/a*	*n/a*	*1*	*1*	*1*
Diabetes Education Room (in Ambulatory)	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
Conference Room (25)	*1*	*895*	*1*	*1*	*1*
Student Training Rooms / OTN	*n/a*	*n/a*	*2*	*2*	*2*
Student Work Rooms (1 per flr)	*n/a*	*n/a*	*4*	*4*	*4*
Simulation Room (incl. Computer)	*n/a*	*n/a*	*1*	*1*	*1*
Lecture Theatre (70)	*n/a*	*n/a*	*--*	*-*	*-*
Library (Virtual in Future)	*1*	*335*	*0*	*0*	*0*
Support Facilities (WC, Kitchenette)	*1*	*1*	*1*	*1*	*1*
ADMNISTRATION & SUPPORT SERVICES:					
Administration					
Area: *(excludes boardroom)*	**3,950**	**4,645**	**2,500**	**3,000**	**3,500**
Space Drivers:					
Offices	*6-7*	*4-6*	*8*	*8*	*9*
Workstations - Dedicated	*1-2*	*1-2*	*2*	*2*	*3*
Workstations - Shared	*n/a*	*n/a*	*2*	*2*	*2*
Meeting/ Interview Room	*n/a*	*n/a*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Foundation					
Area:	**off-site**	**470**	**1,000**	**1,000**	**1,500**
Space Drivers:					
Office	*2*	*1*	*2*	*2*	*2*
Workstation - Dedicated	*1*	*1*	*1*	*1*	*1*
Workstation - Shared	*n/a*	*n/a*	*1*	*1*	*1*
Meeting Room (Shared)	*shared*	*shared*	*1*	*1*	*1*
Work Room	*n/a*	*n/a*	*1*	*1*	*1*
Auxiliary					
Area:	**450**	**765**	**1,100**	**1,100**	**1,500**
Space Drivers:					
Office	*1*	*1*	*2*	*2*	*2*
Meeting Room	*1*	*n/a*	*1*	*1*	*1*
Volunteer Work Area	*1*	*1*	*1*	*1*	*1*
Volunteer Lounge (4 Places)	*1*	*1*	*1*	*1*	*1*
Coat Storage	*n/a*	*n/a*	*1*	*1*	*1*
Storage	*n/a*	*n/a*	*1*	*1*	*1*
Spiritual Care					
Area:	**290**	**n/a**	**600**	**600**	**600**
Space Drivers:					
Meditation Room	*1*	*n/a*	*1*	*1*	*1*
Office / Consult Room	*n/a*	*n/a*	*1*	*1*	*1*
Health Records					
Area: ***(depends on record storage)***	**1,200**	**1,130**	**2,400**	**2,400**	**1,000**
Space Drivers:					
Workstations	*2-3*	*2-3*	*2-3*	*2-3*	*3*
File Storage Room	*1*	*1*	*1*	*0.5*	*n/a*
Information and Telecommunications					
Area:	**530**	**n/a**	**2,500**	**2,800**	**3,000**
Space Drivers:					
Server Room	*n/a*	*n/a*	*1*	*1*	*1*
Wiring Entry Room	*n/a*	*n/a*	*1*	*1*	*1*
Wiring Closet	*n/a*	*n/a*	*2*	*2*	*2*
Office / Storage (Landing Pad)	*n/a*	*n/a*	*1*	*1*	*1*
Switchboard	*530*	*n/a*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
GENERAL SUPPORT SERVICES:					
Plant Operations and Management					
Area: *(historic is vacant space)*	**270**	**n/a**	**3,800**	**3,800**	**4,900**
Space Drivers:					
Engineering / Physical Plant	*1*	*1*	*1*	*1*	*1*
Biomedical Engineering	*1*	*1*	*1*	*1*	*1*
Waste Management	n/a	n/a	*0*	*0*	*0*
Long Term Storage	*1*	*1*	*1*	*1*	*1*
Morgue (Stretchers)	*1*	*1*	*1*	*1*	*1*
Environmental Services					
Area:	**100**	**140**	**1,100**	**1,100**	**1,500**
Space Drivers:					
Central Equipment Room	*1*	*1*	*1*	*1*	*1*
Housekeeping Office	*1*	*1*	*1*	*1*	*1*
Materials Management					
Area: *(depending on stores/supply)*	**5,660**	**5,480**	**8,000**	**8,000**	**8,000**
Space Drivers:					
Shipping / Receiving (docks 1 per site)	*1*	*1*	*1*	*1*	*1*
Laundry / Linen Distribution / Storage	*1*	*1*	*1*	*1*	*1*
Purchasing Office	*1*	*1*	*1*	*1*	*1*
Stores Warehouse	*1*	*1*	*1*	*1*	*1*
Mail Room	*1*	*1*	*1*	*1*	*1*
Medical Devices Reprocessing Dept.					
Area:	**1,330**	**1,060**	**5,000**	**5,500**	**5,700**
Space Drivers:					
Decontamination	*1*	*1*	*1*	*1*	*1*
Washer / Disinfector / Sterilization	*1*	*1*	*1*	*1*	*1*
Scope Reprocessing	*1*	*1*	*1*	*1*	*1*
Packing and Cart Marshalling	*1*	*1*	*1*	*1*	*1*
Storage	*In OR*	*In OR*	*1*	*1*	*1*
Nutrition and Food Services					
Area:	**4,520**	**4,830**	**6,800**	**6,800**	**7,800**
Space Drivers:					
Receiving and Storage	*incl.*	*incl.*	*1*	*1*	*1*
Kitchen	*incl.*	*incl.*	*1*	*1*	*1*
Dietician	*1*	*1*	*1*	*1*	*1*
Lunchroom	*1*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Main Lobby Services					
Area:	**1,250**	**850**	**4,000**	**4,000**	**5,000**
Space Drivers:					
Lobby	*930*	*560*	*1*	*1*	*1*
Info Desk / Cashier	*incl.*	*incl.*	*1*	*1*	*1*
Gift Shop	*320*	*290*	*1*	*1*	*1*
Patient Registration	*incl.*	*incl.*	*1*	*1*	*1*
Waiting	*incl.*	*incl.*	*1*	*1*	*1*
Physician and Staff Support					
Area:	**1,660**	**2,940**	**3,500**	**3,500**	**4,000**
Space Drivers:					
Physician Coat Locker	*1*	*1*	*1*	*1*	*1*
Central Locker Room (Male / Female)	*2*	*2*	*2*	*2*	*2*
On-call Rooms	*2*	*2*	*2*	*2*	*2*
Staff Lounge / Meeting (on I/P units)	*--*	*--*	*--*	*--*	*--*
COMMUNITY SERVICES (ON-SITE):					
NSM CCAC					
Area:	**650**	**325**	**400**	**400**	**500**
Space Drivers:					
Offices	*3*	*4*	*4*	*4*	*4*
SASOT					
Area: (incl. in ambulatory)	**n/a**	**n/a**	**0**	**0**	**0**
Space Drivers:					
Offices	*4*	n/a	*--*	*--*	*--*

Note:
1. The current space by department/component at each site is outlined in the Muskoka Algonquin Healthcare Pre-Capital Submission (October 15, 2012), Functional Space Assessment section

OPTION 2: CENTRES OF FOCUS (HYBRID)

Space Estimates & Clinical Space Drivers

A **Centers of Focus** (**Hybrid) Option** distributes the workload across both sites in a rationalized approach**.**

Table 33: Option 2: Centres of Focus (Hybrid)

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
SITE #1: ACUTE CARE HOSPITAL	**76,370**	**84,415**	**114,150**	**117,380**	**131,560**
CLINICAL PROGRAM AND SERVICES:					
Ambulatory Care					
Area:	**9,360**	**2,745**	**8,975**	**8,975**	**10,375**
Space Drivers:					
Clinics (Multi-Use):					
Exam/Consult Room Multi-Use	*n/a*	*n/a*	*3*	*3*	*4*
Med Learners Exam / Consult Room	*n/a*		*2*	*2*	*2*
Cast Room (2 Stretchers)	*1*	*1*	*1 shared*	*1 shared*	*1 shared*
Diabetes Care:					
Education Room Multi-Use	*n/a*	*n/a*	*1*	*1*	*1*
Foot Care	*n/a*	*n/a*	*1*	*1*	*1*
Medical Day Care:					
MDC (Recliner)	*n/a*	*n/a*	*3*	*3*	*4*
MDC Exam / Consult Room	*n/a*	*n/a*	*1*	*1*	*1*
Minor Procedure / Cataract Rooms:	*incl.*	*incl.*	*2*	*2*	*2*
Pre and Post (Adjacent MDC)	*n/a*		*3*	*3*	*3*
Rehabilitation Services:	*2,790*	*1,820*			
Treatment Cubicles	*4*	*6*	*4*	*4*	*4*
Treatment Rooms	*n/a*	*n/a*	*2*	*2*	*2*
Gymnasium	*1*	*1*	*1*	*1*	*1*
Splinting	*1*	*1*	*1*	*1*	*1*
Workstations	*2*	*2*	*3*	*3*	*3*
Allied Health:			incl. above	incl. above	incl. above
Physiotherapy Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
Occupational Therapy Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
SLP Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
Emergency Services					
Area:	**6,320**	**9,290**	**7,770**	**8,300**	**9,000**
Space Drivers: Treatment Places	*17*	*17*	*14*	*15*	*16*
Trauma / Resuscitation	*2*	*2*	*1*	*1*	*1*
Crisis / Procedure	*n/a*	*n/a*	*1*	*1*	*1*
Acute Treatment	*9*	*8*	*6*	*7*	*8*
See and Treat	*5*	*2*	*3*	*3*	*3*
Cast Room	*1 shared*	*1 shared*	*1 shared*	*1 shared*	*1 shared*
Holding / Obs (stretchers)	*2*	*2*	*2*	*2*	*2*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Surgical Services					
Area *(existing includes endoscopy)*	**8,450**	**7,090**	**18,000**	**18,000**	**18,500**
Space Drivers: cases					
SDU Places	*5*	*6*	*7*	*7*	*8*
Prisoners Prep and Recovery (WC)	*--*	*-*	*1*	*1*	*1*
Operating Rooms	*2*	*2*	*2*	*2*	*2*
Urology Room	*1*	*-*	*1*	*1*	*1*
Endo Procedure Room	*2*	*1*	*2*	*2*	*2*
Phase 1: PACU Stretchers	*5*	*4*	*5*	*5*	*7*
Phase 2: Recliners	*-*	*-*	*5*	*6*	*6*
Satellite Scope Reprocessing	*-*	*-*	*1*	*1*	*1*
Inpatient Services					
Medical / Surgical Inpatient Service:					
Area:	**8,970**	**14,150**	**19,200**	**20,400**	**25,200**
Space Drivers: *beds*	*28*	*41*	32	34	42
Single Bedrooms (80%)	*n/a*	*n/a*	*26*	*28*	*34*
Double Bedrooms (20%)	*n/a*	*n/a*	*1*	*1*	*2*
Ward Bedrooms (2x2 beds)	*n/a*	*n/a*	*1*	*1*	*1*
Critical Care:					
Area:	**1,900**	**2,165**	**3,000**	**4,000**	**5,000**
Space Drivers: *beds*	*5*	*4*	*3*	*4*	*5*
Single Bedrooms (100%)	*5*	*4*	*3*	*4*	*5*
Maternal/ Child:					
Area:	**2,440**	**4,800**	**4,120**	**4,120**	**4,120**
Space Drivers: *beds*	*3*	*2*	*4*	*4*	*4*
LDRP with Shared Water Bath	*n/a*	*n/a*	*2*	*2*	*2*
LDRP	*n/a*	*n/a*	*1*	*1*	*1*
Post Partum Room	*2*	*1*	*2*	*1*	*2*
Infant Obs Area - Bassinets	*n/a*	*n/a*	*2*	*2*	*2*
Early Labor Lounge - Recliners	*n/a*	*n/a*	*1*	*2*	*1*
Examination Room	*n/a*	*n/a*	*1*	*1*	*1*
Family Support Area	*0*	*1*	*1*	*1*	*1*
Complex Continuing Care					
Area:	**6,660**	**7,850**	**0**	**0**	**0**

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
CLINICAL SUPPORT SERVICES:					
Cardiorespiratory Services					
Area: (includes pacemaker)	**1,020**	**1,515**	**750**	**750**	**750**
Space Drivers:					
Holter	*n/a*	*n/a*	*0*	*0*	*1*
Stress Test	*1*	*1*	*0*	*0*	*1*
Pulmonary Function Test / Office	*1*	*1*	*0*	*0*	*1*
Exam/Consult Pacemaker)	*n/a*	*n/a*	*0*	*0*	*1*
Consult / Education	*n/a*	*n/a*	*0*	*0*	*1*
RRT Services / Workroom	*n/a*	*1*	*1*	*1*	*1*
Office (Shared)	*n/a*	*1*	*1*	*1*	*1*
Clinical Laboratory					
Area:	**3,250**	**3,290**	**4,500**	**4,500**	**5,500**
Space Drivers:					
Phlebotomy ECG	*1*	*1*	*1*	*1*	*1*
Accessioning and Sorting	*1*	*1*	*1*	*1*	*1*
Core Lab incl. Blood Bank	*1*	*1*	*1*	*1*	*1*
Microbiology	*1*	*n/a*	*--*	*--*	*--*
Pathology	*n/a*	*1*	*1*	*1*	*1*
Cytology	*n/a*	*1*	*1*	*1*	*1*
Administration and Support	*1*	*1*	*1*	*1*	*1*
POC Testing Workroom	*1*	*1*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*
Diagnostic Imaging					
Area:	**4,960**	**6,550**	**15,000**	**15,500**	**17,000**
Space Drivers:					
X-ray	*2*	*2*	*2*	*2*	*3*
Ultrasound	*2*	*2*	*7*	*7*	*8*
Mammography and Stereotactic	*1*	*1*	*3*	*4*	*4*
Bone Mineral Densitometry	*1*	*1*	*1*	*1*	*1*
CT Scan	*1*	*1*	*1*	*1*	*1*
ECHO	*1*	*1*	*0*	*0*	*0*
Nuclear Medicine	*1*	*n/a*	*0*	*0*	*0*
Interventional Fluoroscopy	*1*	*n/a*	*1*	*1*	*1*
MRI/ Additional Equipment	*n/a*	*n/a*	*0*	*0*	*0*
Teaching Room	*n/a*	*n/a*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Pharmacy Services					
Area:	**1,090**	**815**	**400**	**400**	**400**
Space Drivers:					
Reception / Outpatient Pick-up	*1*	*1*	*0*	*0*	*0*
Central Pharmacy / Inpt. Dispensing	*1*	*1*	*0*	*0*	*0*
Administration / Support	*1*	*1*	*0*	*0*	*0*
Office, Pharmacist / Resource Library	*1*	*1*	*0*	*0*	*0*
Office, Director (1 per site)	*1*	*1*	*0*	*0*	*0*
Satellite Pharmacy (with Chemo)	*n/a*	*n/a*	*1*	*1*	*1*
Infection Prevention and Control					
Area:	**90**	**290**	**140**	**140**	**140**
Space Drivers:					
Office	*n/a*	*n/a*	*1*	*1*	*2*
EDUCATION AND TRAINING SERVICES:					
Area:	**n/a**	**1,230**	**5,500**	**5,500**	**6,000**
Educators Office (per site)	*1*	*1*	*1*	*1*	*1*
Classroom (30)	n/a	n/a	*1*	*1*	*1*
Computer Training (10)	n/a	n/a	*1*	*1*	*1*
Diabetes Education Room (in Ambulatory)	n/a	n/a	*incl.*	*incl.*	*incl.*
Conference Room (25)	*1*	*1*	*1*	*1*	*1*
Student Training Rooms/ OTN	n/a	n/a	*2*	*2*	*2*
Student Work Rooms (1 per flr)	n/a	n/a	*4*	*4*	*4*
Simulation room (incl. Computer)	n/a	n/a	*1*	*1*	*1*
Lecture Theatre (70)	n/a	n/a	*1*	*1*	*1*
Library (Virtual in Future)	*1*	*1*	*0*	*0*	*0*
Support Facilities (WC, Kitchenette)	*1*	*1*	*1*	*1*	*1*
ADMINISTRATION & SUPPORT SERVICES:					
Administration					
Area: ***(excludes boardroom)***	**3,950**	**4,645**	**2,075**	**2,075**	**2,075**
Space Drivers:					
Offices	*6-7*	*4-6*	*5*	*5*	*5*
Workstations - Dedicated	*1-2*	*1-2*	*1*	*1*	*1*
Workstations - Shared	*n/a*	*n/a*	*2*	*2*	*2*
Meeting / Interview Room	*n/a*	*n/a*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Foundation					
Area:	**Off-site**	**470**	**1,000**	**1,000**	**1,500**
Space Drivers:					
Office	*2*	*1*	*2*	*2*	*2*
Workstation - Dedicated	*1*	*1*	*1*	*1*	*1*
Workstation - Shared	n/a	n/a	*1*	*1*	*1*
Meeting Room (Shared)	*shared*	*shared*	*1*	*1*	*1*
Work Room	n/a	n/a	*1*	*1*	*1*
Auxiliary					
Area:	**450**	**765**	**1,100**	**1,100**	**1,500**
Space Drivers:					
Office	*1*	*1*	*2*	*2*	*2*
Meeting Room	*1*	n/a	*1*	*1*	*1*
Volunteer Work Area	*1*	*1*	*1*	*1*	*1*
Volunteer Lounge (4 Places)	*1*	*1*	*1*	*1*	*1*
Coat Storage	*n/a*	*n/a*	*1*	*1*	*1*
Storage	*n/a*	*n/a*	*1*	*1*	*1*
Spiritual Care					
Area:	**290**	**n/a**	**300**	**300**	**300**
Space Drivers:					
Meditation Room	*1*	*n/a*	*1*	*1*	*1*
Office / Consult Room	*n/a*	*n/a*	*1*	*1*	*1*
Health Records					
Area:	**1,200**	**1,130**	**500**	**500**	**500**
Space Drivers:					
Workstations	*2-3*	*2-3*	*1-2*	*1-2*	*1-2*
File Storage Room	*1*	*1*	*1*	*1*	*1*
Information and Telecommunications					
Area:	**530**	**n/a**	**1,000**	**1,000**	**1,000**
Space Drivers:					
Server Room	*n/a*	*n/a*	*1*	*1*	*1*
Wiring Entry Room	*n/a*	*n/a*	*1*	*1*	*1*
Wiring Closet	*n/a*	*n/a*	*2*	*2*	*2*
Office / Storage (Landing Pad)	*n/a*	*n/a*	*1*	*1*	*1*
Switchboard	*530*	*n/a*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
GENERAL SUPPORT SERVICES:					
Plant Operations and Management					
Area: *(historic is vacant space)*	**270**	**n/a**	**1,200**	**1,200**	**1,200**
Space Drivers:					
Engineering / Physical Plant	*1*	*1*	*1*	*1*	*1*
Biomedical Engineering	*1*	*1*	*1*	*1*	*1*
Waste Management	n/a	n/a	*0*	*0*	*0*
Long Term Storage	*1*	*1*	*1*	*1*	*1*
Morgue (Stretchers)	*1*	*1*	*1*	*1*	*1*
Environmental Services					
Area:	**100**	**140**	**400**	**400**	**400**
Space Drivers:					
Central Equipment Room	*1*	*1*	*1*	*1*	*1*
Housekeeping Office	*1*	*1*	*1*	*1*	*1*
Materials Management					
Area: *(depending on stores/supply)*	**5,660**	**5,480**	**2,000**	**2,000**	**2,000**
Space Drivers:					
Shipping/Receiving (Docks 1 per site)	*1*	*1*	*1*	*1*	*1*
Laundry / Linen Distribution / Storage	*1*	*1*	*1*	*1*	*1*
Purchasing Office	*1*	*1*	*1*	*1*	*1*
Stores Warehouse	*1*	*1*	*1*	*1*	*1*
Mail Room	*1*	*1*	*1*	*1*	*1*
Medical Devices Reprocessing Dept.					
Area:	**1,330**	**1,060**	**5,500**	**5,500**	**5,700**
Space Drivers:					
Decontamination	*1*	*1*	*1*	*1*	*1*
Washer / Disinfector / Sterilization	*1*	*1*	*1*	*1*	*1*
Scope Reprocessing	*1*	*1*	*1*	*1*	*1*
Packing and Cart Marshalling	*1*	*1*	*1*	*1*	*1*
Storage	*In OR*	*In OR*	*1*	*1*	*1*
Nutrition and Food Services					
Area:	**4,520**	**4,830**	**4,100**	**4,100**	**4,500**
Space Drivers:					
Receiving and Storage	*incl.*	*incl.*	*1*	*1*	*1*
Kitchen	*incl.*	*incl.*	*1*	*1*	*1*
Dietician	*1*	*1*	*1*	*1*	*1*
Lunchroom	*1*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Main Lobby Services					
Area:	**1,250**	**850**	**3,420**	**3,420**	**4,000**
Space Drivers:					
Lobby Space	*930*	*560*	*1*	*1*	*1*
Info Desk / Cashier	*incl.*	*incl.*	*1*	*1*	*1*
Gift Shop	*320*	*290*	*1*	*1*	*1*
Patient Registration	*incl.*	*incl.*	*1*	*1*	*1*
Waiting	*incl.*	*incl.*	*1*	*1*	*1*
Physician and Staff Support					
Area:	**1,660**	**2,940**	**3,500**	**3,500**	**4,000**
Space Drivers:					
Physician Coat Locker	*1*	*1*	*1*	*1*	*1*
Central Locker Room (Male / Female)	*2*	*2*	*2*	*2*	*2*
On-call Rooms	*2*	*2*	*2*	*2*	*2*
Staff Lounge / Meeting (on I/P Units)	--	--	--	--	--
COMMUNITY SERVICES (ON-SITE):		**n/a**			
NSM CCAC					
Area:	**650**	**325**	**400**	**400**	**500**
Space Drivers:					
Offices	*3*	*4*	*3*	*3*	*4*
SASOT					
Area: (incl. in ambulatory)	**n/a**	**n/a**	**300**	**300**	**400**
Space Drivers:					
Offices	4	n/a	*2*	*2*	*3*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
SITE #2: ACUTE CARE HOSPITAL	**76,370**	**84,415**	**132,110**	**136,590**	**160,040**
CLINICAL PROGRAM AND SERVICES:					
Ambulatory Care					
Area:	**9,360**	**2,745**	**14,180**	**14,180**	**16,500**
Space Drivers:					
Clinics (Multi-Use):					
Exam / Consult Room Multi-Use	*n/a*	*n/a*	*0*	*0*	*0*
Med Learners Exam / Consult Room	*n/a*		*0*	*0*	*0*
Cast Room (2 Stretchers)	*1*	*1*	*0*	*0*	*0*
Diabetes Care:					
Education Room Multi-Use	*n/a*	*n/a*	*1*	*1*	*1*
Foot Care	*n/a*		*1*	*1*	*1*
Dialysis Services:	*2,070*	*n/a*			
Dialysis Treatment Stations	*6*	*n/a*	*5*	*5*	*6*
Dialysis Treatment Room	*n/a*	*n/a*	*1*	*1*	*1*
Medical Day Care:					
MDC (Recliner)	*n/a*	*n/a*	*3*	*3*	*3*
MDC Exam/Consult Room	*n/a*	*n/a*	*1*	*1*	*1*
Chemotherapy Service:	*1,440*	*925*			
Chemo Treatment Stations	*6*	*6*	*5*	*5*	*5*
Chemo Treatment Room	*n/a*	*n/a*	*1*	*1*	*1*
Exam / Consult Room	*n/a*	*n/a*	*2*	*2*	*2*
Satellite Pharmacy	*n/a*	*n/a*	*1*	*0*	*1*
Minor Procedure / Cataract Rooms:	*incl.*	*incl.*	*1*	*1*	*2*
Pre and Post (Adjacent MDC)	*n/a*		*0*	*0*	*3*
Rehabilitation Services:	*2,790*	*1,820*	*incl. above*	*incl. above*	*incl. above*
Treatment Cubicles	*4*	*6*	*4*	*4*	*4*
Treatment Rooms	*n/a*	*n/a*	*2*	*2*	*2*
Gymnasium	*1*	*1*	*1*	*1*	*1*
Splinting	*1*	*1*	*1*	*1*	*1*
Workstations	*2*	*2*	*3*	*3*	*3*
Allied Health					
Physiotherapy Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
Occupational Therapy Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
SLP Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Emergency Services					
Area:	**6,320**	**9,290**	**8,455**	**9,055**	**11,095**
Space Drivers: *tx places*	*17*	*17*	*11*	*12*	*14*
Trauma / Resuscitation	*2*	*2*	*1*	*1*	*1*
Crisis/Procedure	*n/a*	*n/a*	*1*	*1*	*1*
Acute Treatment	*9*	*8*	*6*	*7*	*9*
See and Treat	*5*	*2*	*3*	*3*	*3*
Cast Room	*1 shared*	*1 shared*	*0*	*0*	*0*
Holding / Obs (Stretchers)	*2*	*2*	*2*	*2*	*2*
Surgical Services					
Area *(existing includes endoscopy)*	**8,450**	**7,090**	**0**	**0**	**0**
Space Drivers: cases					
SDU Places	*5*	*6*			
Prisoners Prep and Recovery (WC)	*--*	*--*			
Operating Rooms	*2*	*2*			
Urology Room	*1*	*--*			
Endo Procedure Room	*2*	*1*			
Phase 1: PACU Stretchers	*5*	*4*			
Phase 2: Recliners	*-*	*-*			
Satellite Scope Reprocessing	*-*	*-*			
Inpatient Services					
Medical / Surgical Inpatient Service					
Area:	**8,970**	**14,150**	**28,800**	**30,000**	**37,200**
Space Drivers: *beds*	*28*	*41*	*48*	*50*	*62*
Single Bedrooms (80%)	*n/a*	*n/a*	*38*	*40*	*50*
Double Bedrooms (20%)	*n/a*	*n/a*	*3*	*3*	*4*
Ward Bedrooms (2x2 beds)	*n/a*	*n/a*	*1*	*1*	*1*
Critical Care:					
Area:	**1,900**	**2,165**	**3,000**	**4,000**	**5,000**
Space Drivers: *beds*	*5*	*4*	*3*	*4*	*5*
Single Bedrooms (100%)	*n/a*	*n/a*	*3*	*4*	*5*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Maternal/ Child:					
Area:	**2,440**	**4,800**	**0**	**0**	**0**
Space Drivers: *beds*	*3*	*2*			
LDRP with Shared Water Bath	*n/a*	*n/a*			
LDRP	*n/a*	*n/a*			
Post Partum Room	*2*	*1*			
Infant Obs Area - Bassinets	*n/a*	*n/a*			
Early Labor Lounge - Recliners	*n/a*	*n/a*			
Examination Room	*n/a*	*n/a*			
Family Support Area	*0*	*1*			
Complex Continuing Care					
Area:	**6,660**	**7,850**	**13,770**	**15,100**	**16,280**
Space Drivers: *beds*	--	24	18	20	22
Single Bedrooms (80%)	*n/a*	*n/a*	*12*	*12*	*12*
Double Bedrooms (20%)	*n/a*	*n/a*	*1*	*2*	*3*
Ward Bedrooms (2x2 beds)	*n/a*	*n/a*	*1*	*1*	*1*
On-unit Activation / Rehab space	*n/a*	*n/a*	*1*	*1*	*1*
CLINICAL SUPPORT SERVICES:					
Cardiorespiratory Services					
Area:	**1,020**	**1,515**	**4,500**	**4,850**	**5,300**
Space Drivers:					
Holter	*n/a*	*n/a*	*1*	*1*	*1*
Stress Test	*1*	*1*	*1*	*1*	*1*
Pulmonary Function Test / Office	*1*	*1*	*1*	*1*	*1*
Exam/Consult (Pacemaker)	*n/a*	*n/a*	*1*	*1*	*1*
Consult/Education	*n/a*	*n/a*	*1*	*1*	*1*
RRT Services / Workroom	*n/a*	*1*	*1*	*1*	*1*
Office (Shared)	*n/a*	*1*	*1*	*1*	*1*
Clinical Laboratory					
Area:	**3,250**	**3,290**	**6,000**	**6,000**	**7,350**
Space Drivers:					
Phlebotomy ECG	*1*	*1*	*1*	*1*	*1*
Accessioning and Sorting	*1*	*1*	*1*	*1*	*1*
Core Lab incl. Blood Bank	*1*	*1*	*1*	*1*	*1*
Microbiology	*1*	*n/a*	*1*	*1*	*1*
Pathology	*n/a*	*1*	--	--	--
Cytology	*n/a*	*1*	--	--	--
Administration and Support	*1*	*1*	*1*	*1*	*1*
POC Testing Workroom	*1*	*1*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Diagnostic Imaging					
Area:	**4,960**	**6,550**	**7,550**	**7,550**	**8,600**
Space Drivers:					
X-ray	*2*	*2*	*2*	*2*	*2*
Ultrasound	*2*	*2*	*1*	*1*	*2*
Mammography and Stereotactic	*1*	*1*	*0*	*0*	*0*
Bone Mineral Densitometry	*1*	*1*	*0*	*0*	*0*
CT Scan	*1*	*1*	*1*	*1*	*1*
ECHO	*1*	*1*	*1*	*1*	*2*
Nuclear Medicine	*1*	*n/a*	*1*	*1*	*1*
Interventional Fluoroscopy	*1*	*n/a*	*1*	*1*	*1*
MRI / Additional Equipment	*n/a*	*n/a*	*--*	*1*	*1*
Teaching Room	*n/a*	*n/a*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*
Pharmacy Services					
Area:	**1,090**	**815**	**4,000**	**4,000**	**5,000**
Space Drivers:					
Reception / Outpatient Pick-up	*1*	*1*	*1*	*1*	*1*
Central Pharmacy / Inpt. Dispensing	*1*	*1*	*1*	*1*	*1*
Administration / Support	*1*	*1*	*1*	*1*	*1*
Office, Pharmacist / Resource Library	*1*	*1*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*
Infection Prevention and Control					
Area:	**90**	**290**	**140**	**140**	**140**
Space Drivers:					
Office	*n/a*	*n/a*	*1*	*1*	*1*
EDUCATION AND TRAINING SERVICES:	**n/a**	**n/a**			
Learning Centre:					
Area:		**1,230**	**4,500**	**4,500**	**5,000**
Space Drivers:					
Educators Office (per site)	*1*	*1*	*1*	*1*	*1*
Classroom (30)	*n/a*	*n/a*	*1*	*1*	*1*
Computer Training (10)	*n/a*	*n/a*	*1*	*1*	*1*
Diabetes Education Room (in Ambulatory)	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
Conference Room (25)	*1*	*895*	*1*	*1*	*1*
Student Training Rooms / OTN	*n/a*	*n/a*	*2*	*2*	*2*
Student Work Rooms (1 per flr)	*n/a*	*n/a*	*4*	*4*	*4*
Simulation Room (incl. Computer)	*n/a*	*n/a*	*1*	*1*	*1*
Lecture Theatre (70)	*n/a*	*n/a*	*--*	*-*	*-*
Library (Virtual in Future)	*1*	*335*	*0*	*0*	*0*
Support Facilities (WC, Kitchenette)	*1*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
ADMINISTRATION & SUPPORT SERVICES:					
Administration					
Area: *(excludes boardroom)*	**3,950**	**4,645**	**2,075**	**2,075**	**2,075**
Space Drivers:					
Offices	*6-7*	*4-6*	*5*	*5*	*5*
Workstations - Dedicated	*1-2*	*1-2*	*1*	*1*	*2*
Workstations - Shared	*n/a*	*n/a*	*2*	*2*	*2*
Meeting/ Interview Room	*n/a*	*n/a*	*1*	*1*	*1*
Foundation					
Area:	**off-site**	**470**	**1,000**	**1,000**	**1,500**
Space Drivers:					
Office	*2*	*1*	*2*	*2*	*2*
Workstation - Dedicated	*1*	*1*	*1*	*1*	*1*
Workstation - Shared	*n/a*	*n/a*	*1*	*1*	*1*
Meeting Room (Shared)	*shared*	*shared*	*1*	*1*	*1*
Work Room	*n/a*	*n/a*	*1*	*1*	*1*
Auxiliary					
Area:	**450**	**765**	**1,100**	**1,100**	**1,500**
Space Drivers:					
Office	*1*	*1*	*2*	*2*	*2*
Meeting Room	*1*	*n/a*	*1*	*1*	*1*
Volunteer Work Area	*1*	*1*	*1*	*1*	*1*
Volunteer Lounge (4 Places)	*1*	*1*	*1*	*1*	*1*
Coat Storage	*n/a*	*n/a*	*1*	*1*	*1*
Storage	*n/a*	*n/a*	*1*	*1*	*1*
Spiritual Care					
Area:	**290**	**n/a**	**600**	**600**	**600**
Space Drivers:					
Meditation Room	*1*	*n/a*	*1*	*1*	*1*
Office / Consult Room	*n/a*	*n/a*	*1*	*1*	*1*
Health Records					
Area: *(depends on record storage)*	**1,200**	**1,130**	**2,800**	**2,800**	**3,200**
Space Drivers:					
Workstations	*2-3*	*2-3*	*3-4*	*3-4*	*4-5*
File Storage Room	*1*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Information and Telecommunications					
Area:	**530**	**n/a**	**2,000**	**2,000**	**2,000**
Space Drivers:					
Server Room	*n/a*	*n/a*	*1*	*1*	*1*
Wiring Entry Room	*n/a*	*n/a*	*1*	*1*	*1*
Wiring Closet	*n/a*	*n/a*	*2*	*2*	*2*
Office/Storage (Landing Pad)	*n/a*	*n/a*	*1*	*1*	*1*
Switchboard	*530*	*n/a*	*1*	*1*	*1*
GENERAL SUPPORT SERVICES:					
Plant Operations and Management					
Area: *(historic is vacant space)*	**270**	**n/a**	**3,455**	**3,455**	**4,000**
Space Drivers:					
Engineering / Physical Plant	*1*	*1*	*1*	*1*	*1*
Biomedical Engineering	*1*	*1*	*1*	*1*	*1*
Waste Management	n/a	n/a	*0*	*0*	*0*
Long Term Storage	*1*	*1*	*1*	*1*	*1*
Morgue (Stretchers)	*1*	*1*	*1*	*1*	*1*
Environmental Services					
Area:	**100**	**140**	**700**	**700**	**1,000**
Space Drivers:					
Central Equipment Room	*1*	*1*	*1*	*1*	*1*
Housekeeping Office	*1*	*1*	*1*	*1*	*1*
Materials Management					
Area: *(depending on stores/supply)*	**5,660**	**5,480**	**6,500**	**6,500**	**6,500**
Space Drivers:					
Shipping / Receiving (Docks 1 per site)	*1*	*1*	*1*	*1*	*1*
Laundry / Linen Distribution / Storage	*1*	*1*	*1*	*1*	*1*
Purchasing Office	*1*	*1*	*1*	*1*	*1*
Stores Warehouse	*1*	*1*	*1*	*1*	*1*
Mail Room	*1*	*1*	*1*	*1*	*1*
Medical Devices Reprocessing Dept.					
Area:	**1,330**	**1,060**	**800**	**800**	**800**
Space Drivers:					
Decontamination	*1*	*1*	*1*	*1*	*1*
Washer / Disinfector / Sterilization	*1*	*1*	*1*	*1*	*1*
Scope Reprocessing	*1*	*1*	*1*	*1*	*1*
Packing and Cart Marshalling	*1*	*1*	*1*	*1*	*1*
Storage	*In OR*	*In OR*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Nutrition and Food Services					
Area:	**4,520**	**4,830**	**7,985**	**7,985**	**9,500**
Space Drivers:					
Receiving and Storage	*incl.*	*incl.*	*1*	*1*	*1*
Kitchen	*incl.*	*incl.*	*1*	*1*	*1*
Dietician	*1*	*1*	*1*	*1*	*1*
Lunchroom	*1*	*1*	*1*	*1*	*1*
Main Lobby Services					
Area:	**1,250**	**850**	**4,000**	**4,000**	**5,000**
Space Drivers:					
Lobby	*930*	*560*	*1*	*1*	*1*
Info Desk / Cashier	*incl.*	*incl.*	*1*	*1*	*1*
Gift Shop	*320*	*290*	*1*	*1*	*1*
Patient Registration	*incl.*	*incl.*	*1*	*1*	*1*
Waiting	*incl.*	*incl.*	*1*	*1*	*1*
Physician and Staff Support					
Area:	**1,660**	**2,940**	**3,500**	**3,500**	**4,000**
Space Drivers:					
Physician Coat Locker	*1*	*1*	*1*	*1*	*1*
Central Locker Room (Male / Female)	*2*	*2*	*2*	*2*	*2*
On-call Rooms	*2*	*2*	*2*	*2*	*2*
Staff Lounge/Meeting (on I/P units)	*--*	*--*	*--*	*--*	*--*
COMMUNITY SERVICES (ON-SITE):					
NSM CCAC					
Area:	**650**	**325**	**400**	**400**	**500**
Space Drivers:					
Offices	*3*	*4*	*3*	*3*	*4*
SASOT					
Area: (incl. in ambulatory)	**n/a**	**n/a**	**300**	**300**	**400**
Space Drivers:					
Offices	*4*	*n/a*	*2*	*2*	*3*

Note:
1. The current space by department/component at each site is outlined in the Muskoka Algonquin Healthcare Pre-Capital Submission (October 15, 2012), Functional Space Assessment section

OPTION 3: ONE HOSPITAL (CENTRALLY LOCATED)

Space Estimates & Clinical Space Drivers

A **Single Site Option**, wherein all staff and services are located on one site in the future. At this very early stage in the planning process, a site has not been identified.

Table 34: Option 3: One Hospital (Centrally Located)

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	SMMH	Year 5	Year 10	Year 20
ONE HOSPITAL (CENTRALLY LOCATED)	**76,370**	**84,415**	**204,797**	**215,791**	**245,843**
CLINICAL PROGRAM & SERVICES:					
Ambulatory Care					
Area:	**9,360**	**2,745**	**21,500**	**21,900**	**23,100**
Space Drivers:					
Clinics (Multi-Use):					
Exam / Consult Room Multi-Use	*n/a*	*n/a*	*5*	*5*	*6*
Med Learners Exam / Consult Room	*n/a*	*n/a*	*2*	*2*	*2*
Cast Room (2 Stretchers)	*1*	*1*	*1 shared*	*1 shared*	*1 shared*
Diabetes Care:					
Education / Family Consult Room	*n/a*	*n/a*	*1*	*1*	*1*
Foot Care	*n/a*	*n/a*	*1*	*1*	*1*
Medical Day Care:					
MDC (Recliner)	*n/a*	*n/a*	*4*	*5*	*6*
MDC Exam / Consult Room	*n/a*	*n/a*	*1*	*1*	*1*
Minor Procedure / Cataract Room	*incl.*	*incl.*	*3*	*3*	*3*
Pre & Post (Adjacent MDC)	*n/a*	*n/a*	*3*	*3*	*3*
Dialysis Services:	*2,070*	*n/a*			
Dialysis Treatment Stations	*6*	*n/a*	*5*	*5*	*5*
Dialysis Treatment Room	*n/a*	*n/a*	*1*	*1*	*1*
Chemotherapy Service:	*1,440*	*925*			
Chemo Treatment Stations	*6*	*6*	*5*	*5*	*5*
Chemo Treatment Room	*n/a*	*n/a*	*1*	*1*	*1*
Exam / Consult Room	*n/a*	*n/a*	*2*	*2*	*2*
Satellite Pharmacy	*n/a*	*n/a*	*1*	*1*	*1*
Rehabilitation Services:	*2,790*	*1,820*			
Treatment Cubicles	*4*	*6*	*4*	*4*	*4*
Treatment Rooms	*n/a*	*n/a*	*2*	*2*	*2*
Gymnasium	*1*	*1*	*1*	*1*	*1*
Splinting	*1*	*1*	*1*	*1*	*1*
Workstations	*2*	*2*	*3*	*3*	*3*
Allied Health:					
Physiotherapy Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
Occupational Therapy Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
SLP Workstation	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Emergency Services					
Area:	**6,320**	**9,290**	**12,287**	**12,931**	**14,383**
Space Drivers: treatment places	*17*	*17*	*25*	*26*	*29*
Trauma / Resuscitation	*2*	*2*	*2*	*2*	*2*
Crisis / Procedure	*n/a*	*n/a*	*1*	*1*	*1*
Acute Treatment	*9*	*8*	*12*	*13*	*15*
See & Treat	*5*	*2*	*5*	*5*	*6*
Cast Room	*1 shared*	*1 shared*	*1 shared*	*1 shared*	*1 shared*
Holding / Obs (Stretchers)	*2*	*2*	*4*	*4*	*4*
Surgical Services					
Area: (includes endoscopy)	**8,450**	**7,090**	**15,000**	**15,000**	**18,000**
Space Drivers: cases					
SDU Places	*5*	*6*	*8*	*8*	*10*
Prisoners Prep & Recovery (WC)	*--*	*--*	*1*	*1*	*1*
Operating Rooms	*2*	*2*	*3*	*3*	*4*
Urology Room	*1*	*--*	*1*	*1*	*1*
Endo Procedure Room	*2*	*1*	*2*	*2*	*2*
Phase 1: PACU Stretchers	*5*	*4*	*6*	*6*	*8*
Phase 2 Recliners	*--*	*--*	*6*	*6*	*7*
Satellite Scope Reprocessing	*--*	*--*	*1*	*1*	*1*
Inpatient Services					
Medical / Surgical Inpatient Services					
Area:	**8,970**	**14,150**	**48,000**	**50,400**	**62,400**
Space Drivers: beds	*28*	*41*	*80*	*84*	*104*
Single Bedrooms (80%)	*n/a*	*n/a*	*64*	*68*	*84*
Double Bedrooms (20%)	*n/a*	*n/a*	*6*	*6*	*8*
Ward Bedrooms (2x2 Beds)	*n/a*	*n/a*	*1*	*1*	*1*
Critical Care					
Area:	**1,900**	**2,165**	**7,000**	**8,000**	**9,000**
Space Drivers: beds	*5*	*4*	*5+2*	*6+2*	*7+2*
Single Bedrooms (100%)	*n/a*	*n/a*	*7*	*8*	*9*
Maternal / Child Services					
Area:	**2,440**	**4,800**	**4,120**	**4,120**	**4,120**
Space Drivers: beds	*3*	*2*	*4*	*4*	*4*
LDRP with Shared Water Bath	*n/a*	*n/a*	*2*	*2*	*2*
LDRP	*n/a*	*n/a*	*1*	*1*	*1*
Post Partum Room	*n/a*	*n/a*	*1*	*1*	*1*
Infant Obs Area - Bassinets	*2*	*1*	*2*	*2*	*2*
Early Labor Lounge - Recliners	*n/a*	*n/a*	*2*	*2*	*2*
Examination Room	*n/a*	*n/a*	*1*	*1*	*1*
Family Support Area	*n/a*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Complex Continuing Care					
Area:	**6,660**	**7,850**	**13,770**	**15,100**	**16,280**
Space Drivers: *beds*	--	24	18	20	22
Single Bedrooms (80%)	*n/a*	*n/a*	*12*	*12*	*12*
Double Bedrooms (20%)	*n/a*	*n/a*	*1*	*2*	*3*
Ward Bedrooms (2x2 beds)	*n/a*	*n/a*	*1*	*1*	*1*
On-unit Activation / Rehab Space	*n/a*	*n/a*	*1*	*1*	*1*
CLINICAL SUPPORT SERVICES:					
Cardiorespiratory Services					
Area:	**1,020**	**1,515**	**5,500**	**6,000**	**6,300**
Space Drivers:					
Holter	*n/a*	*n/a*	*1*	*1*	*1*
Stress Test	*1*	*1*	*1*	*1*	*1*
Pulmonary Function Test / Office	*1*	*1*	*1*	*1*	*1*
Exam / Consult (Pacemaker)	*n/a*	*n/a*	*1*	*1*	*1*
Consult / Education	*n/a*	*n/a*	*1*	*1*	*1*
RRT Services / Workroom	*n/a*	*1*	*1*	*1*	*1*
Office (Shared)	*n/a*	*1*	*1*	*1*	*1*
Clinical Laboratory					
Area:	**3,250**	**3,290**	**5,500**	**6,000**	**6,500**
Space Drivers:					
Phlebotomy ECG	*1*	*1*	*1*	*1*	*1*
Accessioning & Sorting	*1*	*1*	*1*	*1*	*1*
Core Lab & Blood Bank	*1*	*1*	*1*	*1*	*1*
Microbiology	*1*	*n/a*	*--*	*1*	*1*
Pathology	*n/a*	*1*	*--*	*1*	*1*
Cytology	*n/a*	*1*	*--*	*1*	*1*
Administration & Support	*1*	*1*	*1*	*1*	*1*
POC Testing Workroom	*1*	*1*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*
Diagnostic Imaging					
Area:	**4,960**	**6,550**	**13,000**	**14,000**	**16,000**
Space Drivers:					
X-ray	*2*	*2*	*4*	*4*	*5*
Ultrasound	*2*	*2*	*5-6*	*5-6*	*5-6*
Mammography & Stereotactic	*1*	*1*	*2*	*2*	*2*
Bone Mineral Densitometry	*1*	*1*	*1*	*1*	*1*
CT Scan	*1*	*1*	*1*	*1*	*1*
ECHO	*1*	*1*	*1*	*1*	*1*
Nuclear Medicine	*1*	*n/a*	*1*	*1*	*1*
Interventional Fluoroscopy	*1*	*n/a*	*1*	*1*	*1*
MRI / Additional Equipment	*n/a*	*n/a*	*--*	*1*	*2*
Teaching Room	*n/a*	*n/a*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Pharmacy Services					
Area:	**1,090**	**815**	**3,200**	**3,500**	**3,800**
Space Drivers:					
Reception / Outpatient Pick-up	*1*	*1*	*1*	*1*	*1*
Central Pharmacy / Inpt. Dispensing	*1*	*1*	*1*	*1*	*1*
Administration / Support	*1*	*1*	*1*	*1*	*1*
Office, Pharmacist / Resource Library	*1*	*1*	*1*	*1*	*1*
Office, Director (1 per site)	*1*	*1*	*1*	*1*	*1*
Satellite Pharmacy (with Chemo)	*n/a*	*n/a*	*(1)*	*(1)*	*(1)*
Infection Prevention & Control					
Area:	**90**	**290**	**120**	**240**	**360**
Space Drivers:					
Office	*n/a*	*n/a*	*1*	*2*	*3*
EDUCATION & TRAINING SERVICES:					
Area:	**n/a**	**1,230**	**5,500**	**5,500**	**6,000**
Space Drivers:					
Educators Office (per site)	*1*	*1*	*1*	*1*	*1*
Classroom (30)	*n/a*	*n/a*	*1*	*1*	*1*
Computer Training (10)	*n/a*	*n/a*	*1*	*1*	*1*
Diabetes Education Room (in Ambulatory)	*n/a*	*n/a*	*incl.*	*incl.*	*incl.*
Conference Room (25)	*1*	*895*	*1*	*1*	*1*
Student Training Rooms / OTN	*n/a*	*n/a*	*2*	*2*	*2*
Student Work Rooms (1 per flr)	*n/a*	*n/a*	*4*	*4*	*4*
Simulation Room (incl. Computer)	*n/a*	*n/a*	*1*	*1*	*1*
Lecture Theatre (70)	*n/a*	*n/a*	*1*	*1*	*1*
Library (Virtual in Future)	*1*	*335*	*0*	*0*	*0*
Support Facilities (WC, Kitchenette)	*1*	*1*	*1*	*1*	*1*
ADMINISTRATION & SUPPORT SERVICES:					
Administration					
Area: ***(excludes boardroom)***	**3,950**	**4,645**	**4,000**	**4,500**	**5,000**
Space Drivers:					
Offices	*6-7*	*4-6*	*10*	*11*	*13*
Workstations - Dedicated	*1-2*	*1-2*	*2*	*3*	*3*
Workstations - Shared	*n/a*	*n/a*	*2*	*2*	*2*
Meeting / Interview Room	*n/a*	*n/a*	*2*	*2*	*2*
Foundation					
Area:	**off-site**	**470**	**1,000**	**1,000**	**1,500**
Space Drivers:					
Office	*2*	*1*	*2*	*2*	*2*
Workstation - Dedicated	*1*	*1*	*1*	*1*	*1*
Workstation – Shared	*n/a*	*n/a*	*1*	*1*	*1*
Meeting Room (Shared)	*shared*	*shared*	*1*	*1*	*1*
Work Room	*n/a*	*n/a*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Auxiliary					
Area:	**450**	**765**	**1,100**	**1,100**	**1,500**
Space Drivers:					
Office	*1*	*1*	*2*	*2*	*2*
Meeting Room	*1*	*n/a*	*1*	*1*	*1*
Volunteer Work area	*1*	*1*	*1*	*1*	*1*
Volunteer Sign-in / Lounge (4 Places)	*1*	*1*	*1*	*1*	*1*
Coat Storage	*n/a*	*n/a*	*1*	*1*	*1*
Storage	*1*	*1*	*1*	*1*	*1*
Spiritual Care					
Area:	**290**	**n/a**	**800**	**800**	**800**
Space Drivers:					
Meditation Room	*n/a*	*n/a*	*1*	*1*	*1*
Office / Consult Room	*n/a*	*n/a*	*1*	*1*	*1*
Health Records					
Area: ***(depends on record storage)***	**1,200**	**1,130**	**3,000**	**3,000**	**1,000**
Space Drivers:					
Workstations	*2-3*	*2-3*	*5*	*5*	*5*
File Storage Room	*1*	*1*	*1*	*0.5*	*0*
Information & Telecommunications					
Area:	**530**	**n/a**	**2,500**	**2,800**	**3,000**
Space Drivers:					
Server Room	*n/a*	*n/a*	*1*	*1*	*1*
Wiring Entry Room	*n/a*	*n/a*	*1*	*1*	*1*
Wiring Closet	*n/a*	*n/a*	*2*	*2*	*2*
Office / Storage	*n/a*	*n/a*	*1*	*1*	*1*
Switchboard	*530*	*n/a*	*1*	*1*	*1*
GENERAL SUPPORT SERVICES:					
Plant Operations & Management					
Area: ***(historic is vacant space)***	**270**	**n/a**	**3,800**	**4,200**	**4,900**
Space Drivers:					
Engineering / Physical Plant	*1*	*1*	*1*	*1*	*1*
Workshop	*1*	*1*	*1*	*1*	*1*
Biomedical Engineering (incl. above)	*n/a*	*n/a*	*0*	*0*	*0*
Waste Management	*1*	*1*	*1*	*1*	*1*
Long Term Storage	*1*	*1*	*1*	*1*	*1*
Morgue (Stretchers)	*2*	*2*	*2*	*2*	*3*
Environmental Services					
Area:	**100**	**140**	**1,100**	**1,100**	**2,000**
Space Drivers:					
Central Equipment Room	*1*	*1*	*1*	*1*	*1*
Housekeeping Office	*1*	*1*	*1*	*1*	*1*

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
Materials Management					
Area: *(assume JIT in 20 yrs)*	**5,660**	**5,480**	**8,000**	**8,000**	**9,000**
Space Drivers:					
Shipping / Receiving (docks 1 per site)	*1*	*1*	*1*	*1*	*1*
Laundry / Linen Distribution / Storage	*1*	*1*	*1*	*1*	*1*
Purchasing Office	*1*	*1*	*1*	*1*	*1*
Stores Warehouse	*1*	*1*	*1*	*1*	*1*
Mail Room	*1*	*1*	*1*	*1*	*1*
Medical Devices Reprocessing Dept.					
Area:	**1,330**	**1,060**	**5,700**	**5,700**	**6,000**
Space Drivers:					
Decontamination	*1*	*1*	*1*	*1*	*1*
Washer / Disinfector / Sterilization	*1*	*1*	*1*	*1*	*1*
Scope Reprocessing	*1*	*1*	*1*	*1*	*1*
Packing / Cart Marshalling	*1*	*1*	*1*	*1*	*1*
Storage	*In OR*	*In OR*	*1*	*1*	*1*
Nutrition & Food Services					
Area:	**4,520**	**4,830**	**9,000**	**10,000**	**12,000**
Space Drivers:					
Receiving & Storage	*incl.*	*incl.*	*1*	*1*	*1*
Kitchen	*incl.*	*incl.*	*1*	*1*	*1*
Cafe	*n/a*	*n/a*	*1*	*1*	*1*
Lunchroom	*1*	*1*	*n/a*	*n/a*	*n/a*
Dietician	*1*	*1*	*1*	*2*	*3*
Main Lobby Services					
Area:	**1,250**	**850**	**4,000**	**4,500**	**5,200**
Space Drivers:					
Lobby	*930*	*560*	*1*	*1*	*1*
Info Desk / Cashier	*incl.*	*incl.*	*1*	*1*	*1*
Gift Shop	*320*	*290*	*1*	*1*	*1*
Patient Registration	*incl.*	*incl.*	*1*	*1*	*1*
Waiting	*incl.*	*incl.*	*1*	*1*	*1*
Physician & Staff Support					
Area:	**1,660**	**2,940**	**5,000**	**5,000**	**6,000**
Space Drivers:					
Physician Coat Locker	*1*	*1*	*1*	*1*	*1*
Central Locker Room (Male / Female)	*2*	*2*	*2*	*2*	*2*
On-call Rooms	*2*	*2*	*2*	*2*	*2*
Staff Lounge / Meeting (on I/P units)	--	--	--	--	--

	Existing Area (CGSF)[1]		Projections (CGSF)		
	HDMH	**SMMH**	**Year 5**	**Year 10**	**Year 20**
COMMUNITY SERVICES (ON-SITE):					
NSM CCAC					
Area:	**650**	**325**	**800**	**900**	**1,000**
Space Drivers:					
Offices	*3*	*4*	*6*	*7*	*8*
SASOT					
Area: (incl. in ambulatory)	**n/a**	**n/a**	**500**	**500**	**700**
Space Drivers:					
Offices	*4*	*n/a*	*4*	*4*	*6*

Note:
1. The current space by department/component at each site is outlined in the Muskoka Algonquin Healthcare Pre-Capital Submission (October 15, 2012), Functional Space Assessment section

APPENDICES

Appendix A: Clinical Workshop Summary of Findings

For reference and information, the following tables outline (in bullet point) the discussions held and outcomes of each of the five clinical workshop sessions. The bullet points are noted as advantages and disadvantages to the site model being explored.

Ambulatory Care (AC) Services Workshop

AC Two Site Model: ambulatory care services continuing to be provided across the two existing hospital sites.

Some ambulatory care services will remain on one site. These currently are dialysis, chemotherapy services, and the biologic and anti-inflammatory clinic. In the future, the anti-inflammatory clinic will be provided in medical day care.

Advantages
• providing care closer to home
• travel distances

Disadvantages
• duplication of services and spaces

AC One Site Model: ambulatory services provided on one site. This approach to the location of services includes the option to:

- provide an acute care site and an ambulatory care site; and
- as well as, the option for a single hospital site, including ambulatory care.

Advantages	Disadvantages
• opportunities to develop a women's health clinic including mammo and BMD	• cataract and endoscopy clinics would require anaesthesia support on the site; though this support could be scheduled
• opportunities to develop a men's health clinic	• chemotherapy systemic services would require pharmacy, laboratory and physician support
• opportunity to treat complex wounds	• issue if the urology men's health services were located in a stand alone ambulatory centre away from the acute care site; due to the need for physician coverage
• opportunities to provide virtual care treatment of wounds and others	• location and travel distances
• benefit in the critical mass to staffing ratio	• surgeons preference to locate endoscopy services adjacent to the main operating rooms [1]
• ability to streamline access to services	• physician support to the site [2]
• opportunities to share and partner with the community in the development of a Wellness Hub with health care, education/learning environments, physician offices, etc.	

Notes and Assumptions to AC One-Site Model:

1. Endoscopy - subsequent discussions with the surgeons identified the need to locate endoscopy services with the main surgical operating rooms for sharing of staff and pre and post procedure spaces.
2. Support Services - subsequent discussions with the clinical and general support services identified additional challenges in supporting a stand alone ambulatory care site.

Emergency Services (ED) Workshop

ED Two Site Model: full CTAS Levels 1-5 Emergency Services continuing to be provided on both of the two existing hospital sites (as per current).

Advantages
• all of the communities would feel they are being served closer to home
• Maintain donations from each community
• tImely access, shorter travel distances
• economic benefit for each town
• paced environment for staff (decreased volumes)
• ambulance transfer times remain the same
• surge capacity available
• comfort / re-assurance re: consumer choice
• AFA agreement (volume dependent) safeguarded
• disaster planning support in each community

Disadvantages
• increased costs because need 2 of everything (DI, CT, lab, infrastructure)
• sharing expertise problematic (multidisciplinary consultation)
• increased capital costs; increased renovation costs
• 2 sites can promote competition and be divisive (political)
• increased OT costs
• diluted oversight (management)
• lack of standardization
• 2 sets of specialists to cover

ED Two Site Model: CTAS Levels 1 to 5 Emergency Services provided on an acute care site and Urgent Care Services, open for 12 to 16 hours of each day, provided on a stand alone ambulatory care site. *Neither service would care for scheduled ambulatory care visits.*

Advantages
• decrease operating costs because of decreased hours of operation for urgent care
• increased satisfaction for CTAS 4 and 5 because 'purpose designed' urgent care – less waiting
• spread out volumes even out the distribution

Disadvantages
• duplication of services and spaces
• travel time increased to get to ED after hours
• consumer confusion re: purpose of each site (need to educate community)
• negative impact on inpatient. services, and recruitment and retention of staff and MDs (retention of medical staff due to reimbursement)

ED One Site Model: with all hospital services provided on <u>one</u> site.

Advantages
• economies of scale
• need less equipment
• less duplication
• long term efficiencies; short term inefficiencies
• critical mass program and service
• recruit and retain staff – increased development opportunities
• decreased staff costs
• decreased maintenance costs
• benchmarking disadvantaged by 2 sites
• increased funding
• sustainability (strengthened with increased size)
• may have critical mass for short stay
• decreased physician manpower requirements

Disadvantages
• Increased travel for patients and staff
• loss of staff
• political issues – one community
• fundraising negatively impacted
• opposite site risk if not central site
• medical staff r-recruitment and retention
• emergency preparedness
• decreased transportation; increased impact for underprivileged and elderly
• increased EMS budget - transport
• existing primary care infrastructure

Surgical Services (SS) Workshop

SS Two Site Model: full surgical services provided on the two existing hospital sites.

Advantages
• surge capacity
• population capture, demographics, accessibility
• supports existing hospital services including – emergency services and maternal services
• community identifies with their hospital and the services provided by their local hospital
• foundation support
• recruitment of personnel

Disadvantages
• capital costs
• operating efficiencies negatively impacted
• HFR disadvantage; fund raising negatively impacted
• missed economies of scale
• lack of uniformity
• two call schedules

SS Two Site Model (Specialized) Model:

1. *One site:* Ambulatory Surgery, Ophthalmology, ENT, Plastics, Endoscopy.
2. *One site:* Inpatient Surgery, Gynecology, Urology, General Surgery.

Advantages
• surge capacity
• allows for specialization and for critical volumes
• economy of scale
• can afford new technology and innovation

Disadvantages
• decreased ability to support maternal services (c-sections)
• decreased ability to support the ED
• physicians would need to travel
• decreased surge capacity
• decreased retention of skill sets
• impact on MDRD

SS Two Site Model (Specialized) Model: anesthesia supported procedures on one site.

1. *One site:* with anesthesia supported procedures; 2 operating rooms at same time.
2. *One site:* without anesthesia supported procedures.

Advantages
• pooling of emergent OR cases on one site
• decreased staffing costs
• increased efficiency

Disadvantages
• decreased ability to support maternal services (c-sections) located on the other site
• decreased ability to support the ED located on the other site
• surgeons and anaesthetists would need to travel
• decreased access by patients

SS One Site Model: all hospital services on one site.

Advantages
• capital cost savings
• better utilization - better use of capital dollars OR time, and clinicians and anesthetists' time
• concentration of expertise
• team camaraderie
• improved scheduling of OR staffing and on call staffing
• opportunity (due to concentration of surgical cases on one site) to develop a pre-op clinic; provide a one-stop shop
• savings in staffing
• decrease in administration staffing (scope)
• centralized booking; (this also could be used with two sites)
• standardization; (this also could be used with two sites)
• critical mass
• recruit and retain both specialists (increased access to specialists) and anaesthetists (support to ED)
• students
• centre of excellence
• increased confidence
• emergencies easier dealt with
• staffing flow improved
• consult
• recovery
Opportunities:
• include offices in the Hospital
• economic advantage to build up the site.

Disadvantages
• decrease in redundancy
• if one site model on an existing site – 1 less ED
• if net new U.G.H. – no issue
• distance and travel time; (potential issue depending on the site location)
• community sense of loss
• fundraising issues
• impact on office site *(for physician offices)*
• larger centre could be intimidating

Maternal/Child (M/C) Workshop

M/C Two Site Model: Maternal/Child Services on both sites (as per current).

Advantages
• accessibility
• demographic focus including single car families and transportation difficulties
• community acceptance
• local fundraising
• services delivered in the community
• supports the current 2-site surgery and emergency services
• supports volumes remaining in Muskoka
• supports east Parry Sound and some Central East LHIN volume/patients
• variety of care for providers
• supports local access for primary care provider; keeps the local physicians engaged with the hospital
• decreased travel
• Muskoka flexibility; 2-sites support surge capacity

Disadvantages
• inefficient staffing model
• increased staffing costs; 4 versus 3
• inefficient capital costs; duplication of spaces
• recruitment retention
• current model has IPAC issues
• not enough critical mass for staffing model; staff can't focus on maternal services; dilution of care focus
• perception that there are not enough deliveries to maintain staffing competencies; (evidence does not support this as a risk)
• increased costs limit choices and has other program impacts

M/C One Site Model: with all Maternal/Child services on one site.

Advantages
• integration of maternal care
• more people to draw from in a crisis
• ability to promote branding
• inter-professional involvement improved
• allow RNs to concentrate on obstetrics
• operational efficiencies - better use of capital dollars and staffing
• updated facility(s)
• consolidation of resources
• consistent practice
• make the 30 minute c-section on-call surgical service efficient by incorporating the obgyn = critical volumes
• depending on where the hospital is -may improve speed to neonatal care
• may allow for renovations
• clinic model of care may improve (LDRP model for instance)

Disadvantages
• access to both communities
• assumed decrease in fund raising; impact on the foundation
• loss of sense of community
• distance to a neonatal centre(s)
• potential loss of antenatal clinic
• what if a patient goes to another site; how to keep staff on that site current; may still need equipment
• low income patients have difficulties with transportation
• reduced number of patients going to one site
• reduced number of RNs required

Inpatient Services (IP) Workshop

Note: includes Medical/Surgical, ICU, CCC, Stroke Services.

IP Two Site Model: inpatient services on both sites (as per current).

Advantages
• flexibility – co-locate like services
• community support
• fundraising local
• surge/crisis planning
• allow staff / MDs to live and work closer to home
• town economic development
• care closer to home
• link to primary care in community
• healthy competition
• beds on 2 site supporting different focus
• flexibility to adjust to new opportunities
• campus of care
• less travel
• familiarity – local hospital
• patients want new state of the art

Disadvantages
• duplication
• decreased efficiency
• increased costs
• division of staff resources
• expertise decreased due to decreased volume
• inability to take advantage of the combined volume
• ICU patient acuity not matched to staff expertise
• unhealthy competition
• competition = perception of us vs them; better/worse
• status quo doesn't create a burning platform
• travel = leadership, management, MDs/COS, etc.
• if not replica x2 = confusion of what located where and back and forth travel
• confidentiality

IP One Site Model: all hospital services on one site.

Advantages
• critical volumes
• focused supports
• enhanced expertise/services
• cost efficiencies; hospital funding reform (HFR)
• decreased staffing
• patient flow – from service to service
• standardization
• recruitment/retention
• reduced capital cost
• decreased on-call 2 site coverage
• service /program offerings e.g. pulmonary/cardiac rehabilitation
• OTN expansion
• satellite sites

Disadvantages
• Initial capital costs
• access
• IT costs
• decreased staffing
• integration of auxiliary/foundation
• community impact for the district
• ambulance impact for the district
• family physician engagement
• staff travel time

Appendix B: Communications Record

Master Program/Master Plan Communications Record – March 2014 to March 2015

Updated: July 31, 2015 *please note the following chronology does not include individual media inquiries or letters/emails received and responded to by MAHC on this topic

Timeline/ Date	Audience	Tool
March 13, 2014	Internal – Board of Directors	Board Meeting – Verbal Update
April 10, 2014	Internal – Board of Directors	Board Update
April 4, 2014	Internal – Staff, Physicians, Volunteers	Town Hall Meeting Notice
April 17, 2014	Internal – Staff, Physicians, Volunteers	Town Hall Meeting
April 23, 2014	External - NSM LHIN	Briefing/Planning meeting
May 8, 2014	Internal – Board of Directors	Board Update
May 16, 2014	External - Community - (Public/Patients)	Newspaper advertisements
May 21, 2014	External - Community - (Public/Patients)	Dedicated MP/MP Webpage
May 21, 2014	Internal - Board of Directors/Foundations Board of Directors	Key Messages
May 22, 2014	External – Leaders – Mayors, MP, MPP, LHIN CEO & Board Chair	Letter
May 22, 2014	Internal - Staff, Physicians, Volunteers; MP/MP Ad-Hoc Steering Committee	Email Notice of Info Sessions
May 23, 2014	External – Media	Email Notice of Info Sessions
May 26, 2014	External - Community – Huntsville	Community Info Session
May 27, 2014	External - Community - Bracebridge	Community Info Session
May 28, 2014	External - Community - Gravenhurst	Community Info Session
May 30, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting Communication Brief
June 2014	External – Community reps	Create Focus Groups
June 9, 2014	External – Municipal Leaders	Lunch Meeting
June 9, 2014	External – Community	Huntsville Forester
June 26, 2014	External – Community	CEO Blog
June 23, 2014	Internal/External	AGM
June 30, 2014	External – Community Groups	Invitation for Speakers Bureau
July 7, 2014	Internal/External Stakeholders	Workshop #1
July 12, 2014	External – Lake of Bays Association	Speakers Bureau
July 17, 2014	External – Community - (Public/Patients)	Community Health Bulletin
July 18, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
July 20, 2014	External - Donors	Speakers Bureau

Timeline/ Date	Audience	Tool
July 24, 2014	External – Municipal Council Candidates	Information Package
July 29, 2014	Internal – MP/MP Planning Participants	Workshop #2
July 30, 2014	External – Huntsville Rotary Club	Speakers Bureau
August 5, 2014	Internal/External	Key Messages
August 8, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
August 8, 2014	Internal – Staff, Physicians, Volunteers	Update Memo
August 11, 2014	Internal – MP/MP Planning Participants	Workshop #3
August 12, 2014	External – District of Muskoka	Planning Meeting
August 13-14 & 20-21	External - Community - (Public/Patients)	Newspaper advertisements
August 13, 2014	External –Probus Club of Central Muskoka	Speakers Bureau
August 13, 2014	External – Media/Community	Media Release
August 15, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
August 20, 2014	Internal – Staff, Physicians, Volunteers	Town Hall Meeting Memo
August 21, 2014	Internal – Board of Directors	Information Session
August 26, 2014	Internal – Staff, Physicians, Volunteers	Town Hall Meeting
August 26, 2014	External - Community – Huntsville	Community Info Session
August 27-28, 2014	Internal – Physicians	Physicians Forum
August 27, 2014	External - Community – Gravenhurst	Community Info Session
August 28, 2014	External - Community – Bracebridge	Community Info Session
August 28, 2014	External – Community	Webpage update
August 29, 2014	External – Community	CEO Blog
September 2, 2014	Internal – Staff, Physicians, Volunteers	Update Memo
September 2-14, 2014	Internal – Staff, Physicians, Volunteers	Options Display - HDMH
September 5, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
September 8, 2014	External – Leaders – Mayors, MP, MPP, LHIN CEO & Board Chair	Lunch Meeting
September 11, 2014	Internal – Board of Directors	Update
September 15-26, 2014	Internal – Staff, Physicians, Volunteers	Options Display - SMMH
September 18, 2014	External – District of Muskoka	Planning Meeting
September 23, 2014	External – Bracebridge-Muskoka Lakes Rotary Club	Speakers Bureau
September 26, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting

Timeline/ Date	Audience	Tool
September 29, 2014	External – Foundations/Auxiliaries	Key Messages
October 2, 2014	External - Rotary Club of Huntsville/Lake of Bays	Speakers Bureau
October 10, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
October 30, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting (Evaluation of Models)
November 6, 2014	Internal/External	Key Messages
November 10, 2014	Internal – Steering Committee	Email Update Letter
November 10, 2014	Internal – Proposed Hybrid Workshop Members	Email Letter
November 13, 2014	Internal – Board of Directors	PowerPoint Update
November 14, 2014	Internal – Leadership Team (Managers)	Update Memo
November 14, 2014	Internal – Staff, Physicians, Volunteers	Update Memo
Week of November 17, 2014	External – Leaders – Mayors, MP, MPP, LHIN CEO & Board Chair	Letter/In-person meetings
November 18, 2014	External – Community/Media	Media Release
November 18, 2014	External – Community	Webpage Update
November 25, 2014	Internal – Leadership Team (Managers)	Leadership Forum
November 25, 2014	Internal – Hybrid Model Working Group	Workshop Meeting
December 18, 2014	Internal – Hybrid Model Working Group	Workshop Meeting
January 6, 2015	Internal – Staff, Physicians, Volunteers	Memo re Operational Assessment
January 8, 2015	External – North Muskoka Probus Club	Speaker's Bureau
January 9, 2015	External – Bracebridge Rotary Club	Speaker's Bureau
January 13, 2015	External – Community	CEO Blog
January 14, 2015	External - Leaders – Mayors, MP, MPP	Lunch Meeting
January 28, 2015	Internal – Staff, Physicians, Volunteers	Update Memo
January 29, 2015	Internal – Staff, Physicians, Volunteers	Memo re Petition
February 4, 2015	External – Bracebridge Probus Club	Speaker's Bureau
February 12, 2015	External – Community	Big Ideas Column by Natalie Bubela
February 17, 2015	External - Leaders – Mayors, MP, MPP External – Foundation Boards External – Media (Radio & Newspapers); Website (posted online)	Open Letter from Board Chair
February 25, 2015	Internal – Staff, Physicians, Volunteers	Town Hall Meeting with MP/MP Update
February 26, 2015	Internal – Sub-Hybrid Model Working Group	Workshop Meeting
March 2, 2015	Internal – Staff, Physicians, Volunteers	Letter from Board Chair & Invitation to Info Sessions

Timeline/ Date	Audience	Tool
March 4, 2015	Internal - Hybrid Model Working Group	Workshop Meeting
March 4, 2015	External – Community (Public/Patients) (flyer in What's Up Muskoka)	Letter from Board Chair & Invitation to Info Sessions
March 6, 2015	External – Meeting with District of Muskoka	Planning Meeting
March 5/6, 2015	External – Seasonal Residents via Muskoka Lakes Association	Email NewsBite re: Letter & Invitation to Info Sessions
March 9, 2015	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
March 12, 2015	Internal – Board of Directors	Regular Meeting
March 12, 2015	External – Media, Community	Media Release
March 12, 2015	External – Community (Public/Patients)	Community Health Bulletin
March 13, 2015	External – Leaders - Mayors, MP, MPP, LHIN CEO & Board Chair	Information Luncheon
March 18, 2015	External – Community (Public/Patients)	What's Up Muskoka Advertisement
March 19, 2015	External – Community (Public/Patients)	MuskokaRegion.com Advertisement
March 20, 2015	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
March 23, 2015	Internal – Staff, Physicians, Volunteers	Town Hall Meeting
March 23, 2015	External – Huntsville Town Council	Invitation to Regular Meeting
March 24, 2015	Internal – Leadership Team	Regular Meeting
March 23, 2015	External – Gravenhurst Community	Community Information Session
March 24, 2015	External - Bracebridge Community	Community Information Session
March 25, 2015	External – Huntsville Community	Community Information Sessions
March 25, 2015	External – Community (Public/Patients)	Webpage update – feedback period begins
March 25, 2015	External – Community (Public/Patients)	Muskoka Magazine advertisement – Board Chair letter
March 30, 2015	External – Community (Public/Patients)	CEO Blog
March 30, 2015	External – Gravenhurst Rotary Club	Speaker's Bureau
March 30, 2015	External – Almaguin Highlands Health Centre Committee	Meeting
April 2, 2015	External – NSM LHIN CEO, Vice Chair	Update Meeting
April 8, 2015	Internal – Physicians	Town Hall Meeting
April 15, 2015	External – Community	Feedback period closed
April 20, 2015	Internal - Medical Advisory Committee	Regular Meeting
April 23, 2015	External – District of Muskoka	Meeting with Public Works & Planning, Stantec
April 23, 2015	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting

Timeline/ Date	Audience	Tool
May 1, 2015	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
May 11, 2015	External – Media/Community	News Release re: Board Decision Meeting Date
May 21, 2015	External - Donors	South Muskoka Hospital Foundation Campaign Launch
May 25, 2015	External – NSM LHIN	Update at Board of Directors Meeting
May 27, 2015	Internal – Board of Directors	Meeting
May 27, 2015 – immediately following decision	Internal – MP/MP Ad-Hoc Steering Committee	Email
May 27, 2015 – immediately following decision	Internal – Staff, Physicians, Volunteers	Memo
May 27, 2015 -immediately following decision	Internal – Staff, Physicians, Volunteers	Huddles in all areas/depts
May 27, 2015 – immediately following decision	Internal – Bargaining Units	Letter
May 27, 2015 -immediately following decision	External – Media/Community	Press Conference / Media Release
May 27, 2015-immediately following decision	Internal – Foundations Board of Directors / Auxiliaries Executive	Letter
May 27, 2015 -immediately following decision	External – Muskoka Mayors, District Chair, East Parry Sound Reeves, MPP, MP	Letter
May 28, 2015	Internal - Managers	Leadership Meeting
May 28, 2015	Internal – Staff, Physicians, Volunteers	Huddles in all areas/depts
May 28, 2015	Internal – Staff, Physicians, Volunteers	Town Hall Meeting & OTN webcast
May 28, 2015	External – Partners • North Simcoe Muskoka LHIN • OSMH, RVH, CGMH, GBGH, WPSHC, CCAC, EMS, Hospice, SMDHU • Cottage Country Family Health Team • Algonquin Family Health Team • Burk's Falls Family Health Team • Nurse Practitioner Clinics • Almaguin Highlands Health Centre	Media Release
May 28, 2015	External – Key Donors	Special Letter
May 28, 2015	External – Media, Community, Cottager Associations	Media Release
May 28, 2015	External - Community	Webpage Update
May 29, 2015	Internal – Staff, Physicians, Volunteers	Huddles in all areas/depts
May 29, 2015	Internal – Staff, Physicians, Volunteers	Town Hall Meeting & OTN webcast
June 1, 2015	External - Donors	Dave Ellis Pro/Am (South Muskoka Hospital Foundation)
June 3, 2015	External - Community	CEO Blog

Timeline/ Date	Audience	Tool
June 3, 2015	External - Community	Board Chair Letter (What's Up Muskoka ad)
June 3, 2015	Internal – South Muskoka Hospital Foundation Board of Directors/ South Muskoka Memorial Hospital Auxiliary Executive (or reps)	Meeting
June 3, 2015	External – Town of Bracebridge	CEO/Board Chair Meeting with Mayor & CAO
June 5, 2015	Internal – Huntsville Hospital Foundation Board of Directors / Huntsville Hospital Auxiliary Executive (or reps)	Meeting
June 6, 2015	External – Community	Presentation at Salvation Army Church, Bracebridge
June 10, 2015	Internal – Huntsville Hospital Auxiliary	Annual General Meeting CEO report
June 15, 2015	Internal – Medical Advisory Committee	Meeting
June 16, 2015	External – Community – Muskoka Lakes Probus Club	Presentation
June 17, 2015	External – Community – Muskoka Ratepayers Association	Board Chair Letter (What's Up Muskoka ad)
June 17, 2015	External - Donors	South Muskoka Hospital Foundation Golf Tournament
June 18, 2015	Internal – Huntsville Hospital Foundation Board of Directors	AGM CEO report
June 22, 2015	External – Members of the Corporation	AGM Board Chair report
June 24, 2015	External – Community – Muskoka Lakes Association	e-NewsBites
June 25, 2015	Internal – South Muskoka Memorial Hospital Auxiliary	AGM Speaking Notes
June 25, 2015	External - Donors	Huntsville Hospital Foundation Bigwin Golf Tournament
July 2, 2015	External - Donors	Huntsville Hospital Foundation Docktails Event
July 4, 2015	External – Cottager/Lake Association	Kawagama Lake Cottagers Association AGM, Dorset
July 11, 2015	External – Cottager/Lake Association	Mary Lake Association AGM
July 11, 2015	External – Cottager/Lake Association	Lake of Bays Association AGM, Baysville
July 12, 2015	External - Donors	Beaumaris Community, Milford Bay
July 12, 2015	External – Cottager/Lake Association	Clam Lake Property Owners, Kearney
July 23, 2015	External – Donors	Huntsville Hospital Foundation event