Ministry of Health and Long-Term Care
Health Capital Division

Health Capital Investment Branch

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Ministère de la Santé et des Soins de longue durée
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Ontario

November 3, 2016

Ms. Natalie Bubela
Chief Executive Officer
Muskoka Algonquin Healthcare
100 Frank Miller Drive
Huntsville ON P1H 1H7

Dear Ms. Bubela:

Re: Muskoka Algonquin Healthcare – Capital Development Project, Stage 0 - Pre-Capital Submission

The Ministry of Health and Long-Term Care (the ministry) received the Muskoka Algonquin Healthcare (MAHC) Capital Development Project, Stage 0 - Pre-Capital Submission on October 29, 2015 and an endorsement of the programs and services on October 26, 2015 from the North Simcoe Muskoka Local Health Integration Network (NSM LHIN).

The ministry has completed its review of your submission. Any outstanding comments, as provided in the attached "Issues and Comments" form, are to be addressed directly on the form and then incorporated, as appropriate, in the next submission. This letter does not constitute ministry approval of the project or approval to move to Stage 1 Proposal.

Should you have any questions, please contact Linda Novotny, Senior Consultant, at 416-326-1141.

Sincerely,

Anne Barszczewski

Anne Barszczewski
Manager
North and East Capital Projects

Enclosures

c: Jill Tettmann, Chief Executive Officer, North Simcoe Muskoka Local Health Integration Network

Issues/Comments Form

HSP Name: Muskoka Algonquin Healthcare
Project Name: Capital Redevelopment Project
Stage of Project: Pre-Capital
Original Submission Date: 29-Oct-15
Additional Submission Date(s):

Status Indicator Legend:

Resolved	Answer is satisfactory
In Progress	Ministry is asking for additional follow up info that will be logged as a new question
Outstanding	Ministry question remains unanswered

Part A - Program and Service

	Issue/Comment Status Indicator	Date of Submission (yyyy-mm-dd)	Submission Reference (Item/Pg. No.)	Issues/Comments	Issue/ Comment Source	Date of Response (yyyy-mm-dd)	Response Source	Response (Comment or Reference Document Name)	Date of Response (yyyy-mm-dd)	Response Source	Response (Comment or Reference Document Name)	Issue/ Comment Resolved? (Y/IP/N)
1	Resolved	2015-10-29	P. 6 & 7	Using the workload tab, please provide rationale for negative variances or >+20%.	MOH-1	2016-01-25	HSP	A line by Line explanation of the negative variances and variances >20% is included in the workload tab.	2016-02-19	MOH-1	Workload tab information reviewed	Yes
2	Resolved	2015-10-29	P. 6	Under ambulatory Services Fracture Clinic (in ED) and Cardiology ED Procedures are identified, were these procedures double counted e.g. as part of ED and also under Ambulatory?	MOH-1	2016-01-25	HSP	Visits to the Fracture Clinic occur in Emergency Department space, however, the workload has been recorded separately from the Emergency Department workload in the forecast estimates. In 2013-14 these visits were recorded with the ED visit workload.	2016-02-19	MOH-1	Is there a plan to continue to see Fracture room Clinic patients in ED? Please use #13 for response	Yes
3	Resolved	2015-10-29	P. 6	Dialysis is reported as Annual Treatments, are these patients being dialyzed or are these follow up clinic visits?	MOH-1	2016-01-25	HSP	Dialysis annual treatments reflects patients being dialyzed. MAHC's Dialysis Unit has six treatment stations operating over two shifts, administering 12 treatments per day, six days per week.	2016-02-19	MOH-1		Yes
4	Resolved	2015-10-29	P. 6	Pacemaker volumes were provided for 2012-13 however nothing in subsequent years, where are pacemakers now being implanted?	MOH-1	2016-01-25	HSP	MAHC's Pacemaker Clinic is for follow-up care only (post implantation). In 2013-14 the reporting of visit volume was moved under the category of Cardiology Outpatient procedures.	2016-02-19	MOH-1		Yes
5	Resolved	2015-10-29	P. 8	Please identify when the decision related to 10 stroke rehab beds will be made (currently not in projected bed complement)	MOH-1	2016-01-25 2016-10-07	HSP	At the direction of the NSM LHIN. Currently a pilot project is being conducted between RVH and Collingwood to help better understand the model, business case, etc. This will help guide the future rollout of the NSM LHIN regional plan with respect to the provision of acute stroke care and rehabilitation. Noted	2016-02-19	MOH-1	This information will be required at the next stage to inform physical space planning. Moved to Stage 1	Yes
6	Resolved	2015-10-29	P. 8/11	Is the HSP planning for a "campus of care service model" that includes space for partners in the proposed new hospital building?	MOH-1	2016-01-25 2016-10-07	HSP	MAHCs future planning includes thinking about how programs and services are integrated, coordinated and planned throughout the District, regardless of the location of service providers. Planning collaboratively with Health Links, and relying heavily on the Price/Baker report and the Ministry Patients First document, system thinking will be prevalent at all levels of planning. Special focus on Muskoka specific challenges such as outreach, and travel will be further explored in Stage 1. Currently, office space is provided for CCAC and SASOT (Seniors Assessment and Support Outreach Team) and has been included in the future building footprint. Accommodating other organizations such as the Family Health Team, Hospice and a satellite of One Kids Place, currently located on MAHC hospital sites, is not formally part of the proposed development as noted in Part 1B of the Pre-Cap but will also be explored in a Stage 1 Proposal. Noted	2016-02-19	MOH-1	Agreement must be reached on programs to be included with funding source by the next stage, Moved to Stage 1	Yes
7	Resolved	2015-10-29	P. 10	Please provide the information related to the various service models that were "developed and tested".	MOH-1	2016-01-25 2016-10-07	HSP	As part of the master programming process, a series of workshops were conducted involving multiple groups of stakeholders and senior leadership with the intent of assessing various models for program/service delivery. Seven clinical user groups were formed focusing on key clinical services, namely, Emergency Services, Ambulatory Care, Surgical Services, Maternal Child and Inpatient Services. Linking efforts from MAHC's recent refreshed strategic planning work created a nice segue from a 1-3 year planning view to a 20-year horizon, allowing for the groups to consider what the market context might be in that time, how the service delivery model might change to succeed in that environment and what implications such changes had for facilities. The workshops focused on several objectives including: • Understanding how MAHC's services are utilized by the catchment population i.e. the drivers of healthcare demand • Reviewing anticipated changes in demographics for the catchment population over a 20-year horizon • Reviewing the impact of 20-year projections on workload and service delivery • Assessing service planning opportunities over the 20 year planning horizon, addressing consolidation potential, program/operational process standardization and service siting options. • Factoring the impact of technology on service delivery • Ensuring changes to the service delivery model align with MoHLTC and LHIN priorities. The advantages and disadvantages of the various siting options for each of the models along with all of the demographic and workload analysis is highlighted in the recently completed Master Program document, now posted to the MAHC website - http://www.mahc.ca/en/about/resources/0.MAHCMasterProgramOctober2015recvdOct2815.pdf. An outcome of the workshops was the development of nine potential service options which eventually were distilled to three possible development options: **A**. 2 Full Service Acute Sites - attempting to maintain current services across both sites **B**. Centres of Focus (Hybrid) - distributing workload across both sites in a rationalized approach **C**. One Hospital, (Centrally Located). See Response provided to Issue 14	2016-02-19	MOH-1	Have the new proposed models been trialled where possible to inform the new design? Please insert response in row 14	Yes
8	Resolved	2015-10-29	P. 6	Given that 65% of projected Emergency Department (ED) visits (CTAS 4/5 and 50% of CTAS 3) are low acuity, has planning been undertaken to decant more of this activity to community providers versus retaining the activity in the ED/hospital?	MOH-1	2016-01-25	HSP	During the master programming process, the Emergency Department user group reviewed all CTAS data and established improved utilization targets for 'avoidable' ED visits i.e., CTAS 4 and 5 and a portion of CTAS 3. Incorporated into the planning is a targeted decrease of avoidable ED visits closer to the 75th percentile rate of the Province. A fundamental assumption to the targeted utilization is that several initiatives established over the past few years such as nurse practitioner clinics, involvement of CCAC in ED, and extended after-hours coverage by family physicians will result in lower utilization targets for the avoidable ED visit. MAHC is currently working with Health Links towards a new model of primary care delivery, aligned with Patient Care Groups consistent with the recommendations of the Price/Baker report and the Patients First Discussion Paper. Muskoka Community Health Link recently introduced three new Health Hubs and a Mobile Unit in Muskoka to meet the needs of remote and underserviced areas. These initiatives along with continued partnerships with other community agencies, LHIN focus, and ever evolving practices will assist MAHC in achieving the projected targets in the planned time frame.	2016-02-19	MOH-1		Yes
9	Resolved	2015-10-29	P. 6	How does the plan to reduce the ALC rate from 28% to 9.5% over 20 years (p. 6) align with the LHIN target for ALCs? How will this be accomplished?	MOH-1	2016-01-25 2016-10-07	HSP	MAHC ALC targets are aligned with the NSM LHIN targets. MAHC is working closely with community primary care providers to develop joint Quality Improvement Plans and align targets. As noted in response to question #8 the recently announced three new Health Hubs and a Mobile Unit along with continued partnerships with other community agencies will assist MAHC in achieving the projected targets in the planned time frames. Continued focus of the NSMLHIN on ALC as its top priority will continue to identify opportunities and strategies to meet ALC targets. NSM LHIN and its Leadership council continue to focus on the ALC issues. Health Hubs and mobile units are already making an impact with providing care to underserviced areas. Improved primary care, identification of issues sooner, better treatment of chronic conditions, will all contribute to a decreased need for ALC. Within Muskoka, the Muskoka and Area Health System Transformation Council is being formed, with the mandate to look across the continuum of care to meet the health needs of residents of Muskoka. Many of these initiatives should have a positive impact on ALC as well.	2016-02-19	MOH-1	What strategies are planned to reduce ALC rates, it is not clear how Health Hubs and Mobile Units will address this issue. See Line #15 Moved to Stage 1	Yes
10	Resolved	2016-01-13	General Comment	The ministry expects the stage 1 submission will explore and evaluate the option of new build versus renovation of existing sites and the option of a one site consolidation or continued operation on two sites.	MOH-1	2016-01-25	HSP	Agreed. As part of the Stage 1 process the Hospital plans to undertake a thorough assessment of all development options including the operational and economic impact of the various options on hospital funding and community/regional infrastructure resources. MAHC is already working with the NSMLHIN and local municipalities exploring and refining options.				Yes

Issues/Comments Form

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Project Name: Capital Redevelopment Project
Stage of Project: Pre-Capital
Original Submission Date: 29-Oct-15
Additional Submission Date(s):

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11	Resolved	2016-02-03		Provide the volume of births historical, current and projected. Indicate number of C-Sections.	MOH-1	2016-03-11 2016-10-07	HSP	<table><tr><th></th><th>Current</th><th colspan="3">Projected</th></tr><tr><td>Maternal/Child</td><td>2014-15</td><td>2019-20</td><td>2024-25</td><td>2034-35</td></tr><tr><td>Births:</td><td>275</td><td>266</td><td>263</td><td>267</td></tr><tr><td>- Vaginal</td><td>193</td><td>187</td><td>185</td><td>188</td></tr><tr><td>- C-section</td><td>82</td><td>79</td><td>78</td><td>79</td></tr></table> • In October 2012, the SOGC published a position paper entitled: Rural Maternity Care. "Canadian women deserve quality maternity care regardless of whether they live in urban, rural, or remote communities." "While volume units face unique challenges, there is no evidence that a minimum number of deliveries is required to maintain competence. The question is not whether to provide birthing services but what level of services is feasible and sustainable." • To assist our RN team in maintaining competence and skill, MAHC has engaged in a three-year commitment with MOREOB. MOREOB is a quality improvement program designed to enhance the knowledge of the interprofessional team in managing all deliveries, but particularly deliveries that may result in a higher risk profile. MOREOB integrates the professional practice standards and best practices with evolving safety concepts, principles, and tools. Through this program, the skills and strategies built and employed are specifically designed to improve patient outcomes and patient satisfaction. • In addition, we have provided a select group of RNs with advanced training in obstetrical care including a three-month orientation and clinical mentorship at the Royal Victoria Regional Health Centre Birthing Centre. This provides the specialized team of RNs with hands-on experience in labour and delivery best practices in a centre where volumes are in excess of 2,200 deliveries annually. The learning linkage and practice collaborative extends beyond the orientation period with ongoing knowledge transfer through continuing education, policy sharing, and best practice updates. Ongoing training will continue to be provided both In-house and in conjunction with our regional partners in Orillia and Barrie. • From an efficiency perspective, these nurses with additional obstetrical training also have experience in caring for medical/surgical inpatients and as a result are built into our nursing baseline schedule for the medical/surgical unit at each site. While not caring for an Obstetrical patient, these nurses carry a regular assignment, but when their clinical OB expertise is required, they are able to seamlessly take the specialized OB caseload, and the rest of the team shifts to accomodate their previous patients.	6/21/2016	MOH-1	How will efficiency be maintained given the low projected volumes. Targets for quality and efficiency are included. OBSTETRICS - Target minimum size for quality = 2,000 births/year - Target minimum size for efficiency of labour/delivery/recovery = 2,409 births/year	Yes
12	Resolved	2016-02-03		Please provide further rationale at the next stage for the projected growth in medical surgical activity. Include any plans to shift in patient activity to outpatient activity.	MOH-1	2016-03-11	HSP	An extensive data review was undertaken by the Consultant team to assess opportunities to improve utilization and address changes in the catchment population over the 20-year horizon. The medical surgical beds have been forecasted at the demographic rate with adjustments based on the following assumptions: • MAHC will reduce ALC days to approach the LHIN target of 9.5% • Low acuity ICU bed use will be addressed through a review of admission criteria / process Other changes in MAHC utilization that have been incorporated into the workload forecast include: • Low acuity ED visits will be targeted by considering other primary care initiatives, health links, etc. • Reduction in screening endoscopies due to adoption of best practice guidelines and substitution of non-invasive diagnostics Of note, MAHC has performed well in terms of CCC, Obstetrics and Day Surgery utilization: • MAHC residents are low users of CCC beds, well below the Provincial average rate of CCC days per capita • The proportion of total surgeries done as day surgery at MAHC is higher than the Provincial average • MAHC's length of stay for Obstetrics patient is shorter than the provincial average At the next stage of planning MAHC will continue to review growth assumptions ensuring that utilization rates are in line with LHIN expectations and peer organizations.		MOH-1	Thank you, look forward to futher detail at stage 1 Moved to Stage 1	Yes
13	Resolved	2016-02-03		See #2		2016-03-11	HSP	Fracture Room Clinic patients are planned for within Ambulatory Care, and would not continue to be seen in ED. The space requirements are included in the Ambulatory Care footprint projected for the 5-10-20 year horizons.		MOH-1	Please ensure that the volume of Fracture Room patients have been excluded from the ED projections.	Yes
14	Resolved	2016-02-03		See #7		2016-03-11 2016-10-07	HSP	We understand the importance of exploring the proposed new models in much greater detail to ensure maximum efficiencies are achieved and best use of space. During the development of the Pre-Cap/Master Program work the Consultant team assessed workload throughput, capacity and space utilization against industry guidelines such as CSA Z8000, GOS and MoHLTC guidelines/targets in order to derive reasonable space projections for the 5-10-20 year horizons. Factors such as extended hours, single siting of services, logistics flow, new technology all contributed to the capacity analysis to ensure an efficient space model. That work will be tested again and in more detail through various LEAN processes as part of the Stage 2 Functional Programming work so that design can incorporate results of modelling and testing. We look foward to the more detailed planning in future stages around some of the established and emerging models and approaches to improving patient flow, system design, and value engineering. Models will be trialed, site visits will be conducted, and expertise sought from a wide variety of experts to help inform.		MOH-1	Thank you, before Functional program the Ministry would expect to see actual mock ups completed and tested to ensure proposal meets the anticipated need. Moved to Stage !	Yes
15	Resolved	2016-02-03		See#9		2016-03-11	HSP	Muskoka is engaging a multi-disciplinary team in the development of Care Plans for high users of the system. This will ensure that patients are better supported and receiving the right care, at the right time, in the right place. With earlier, and focused care, patients who previously may have been waiting for LTC placement, can be well maintained with a lower level of care, often remaining in their homes with support. The District of Muskoka is also working on housing strategies, another area that has been identified as a gap in the options available to patients currently designated as ALC. The introduction of Health Hubs, and Mobile Units will provide better access to primary care, and supports in local communities allowing for earlier and safer return of patients to their home communities.		MOH-1	Thank you, I look forward to learning more about this in functional program Moved to next stage	Yes
16	In Progress	2016-02-03	General Comment	Projected weighted cases and QBP will have to be included in the next submission	MOH-2					MOH-2	In the next submission, please indicate the QBP portion of the projected weighted cases.	In Progress
17	In Progress	2016-06-21	P. 6	Please provide clarification on the projected growth in Ambulatory Services in the next submission - see colored areas identified in the "Ambulatory Services" Tab below.	MOH-2					MOH-2	In the next submission, please provide clarification on the projected growth in Ambulatory Services , particularly where MAHC projections are significantly higher than population growth - see colored areas identified in the "Ambulatory Services" Tab below.	In Progress

Issues/Comments Form

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Part B - Physical and Cost

	Issue/Comment Status Indicator	Date of Submission (yyyy-mm-dd)	Submission Reference (Item/Pg. No.)	Issues/Comments	Issue/ Comment Source	Date of Response (yyyy-mm-dd)	Response Source	Response (Comment or Reference Document Name)	Date of Response (yyyy-mm-dd)	Response Source	Response (Comment or Reference Document Name)	Issue/ Comment Resolved? (Y/IP/N)
1	Resolved	2015-10-29	Item 7. Space Requirements	Explain the 21% increase in proposed BGSF (to 2019-20 planning horizon) from the current total BGSF combined across both MAHC sites. It is anticipated that some space savings should be gained through efficiencies as identified in question 10. This is to be addressed in detail in the Stage 1 submission.	MOH-1	2016-10-07	HSP	Detailed response to be included in Stage 1	2016-10-28	MOH-1	No further comments at this time.	Yes
2	Resolved	2015-10-29	Item 9. Renovation Practicality	The stage 1 submission is required to contain a Technical Building Assessment for both existing facilities. Note that the VFA reports, referenced in the pre-capital submission, are not sufficient for evaluation of stage 1 submission. A full building condition assessment (i.e. the BCA performed by Stantec) is required to be included in the Stage 1 submission.	MOH-1	2016-10-07	HSP	A technical Building Assessment has been conducted by Stantec and forms part of our Master Plan January 2016 (Appendix A) on our website at http://www.mahc.ca/en/about/Master-Program---Master-Plan.asp	2016-10-28	MOH-1	No further comments at this time.	Yes
3	Resolved		Item 13. Alternative Infrastructure Solutions	Before proceeding to the detailed Options Analysis to be provided in Stage 1, the ministry requires additional detail on how the short list of options was arrived at. Please provide a detailed explanation of the evaluation criteria outlined in Appendix B and how the development options were evaluated. Explain why the 5 alternate development options were eliminated from the final options list and what criteria were used. Describe the assumptions made for each development proposal regarding the extent of reuse, renovation or redevelopment of existing facilities for the options that retain existing sites.	MOH-1	2016-10-07	HSP	A detailed presentation was provided to Jeffrey Jerome Sept 02, 2016 for review. It outlines the Option analysis done Oct. 2014 on the nine models (all outlined in our Master Plan, Appendix C, 2.6 Master Building Plan) which you can find on our website at http://www.mahc.ca/en/about/Master-Program---Master-Plan.asp. This shows Options/Drawings/Engineering Considerations/etc. for the 9 models. It was felt that nine models were too many to analyze at the next level of analysis, and that several were very much variations on a theme, so three models were dropped from the scoring exercise. Six models were analyzed, although some documents refer to five models being analyzed as there was a 1a and 1b (one acute care site Huntsville, one acute care site Bracebridge). I know, very confusing. Once the scoring of the six models was done, it was clear there were three main themes: One Acute Care Hospital; One Ambulatory/One Acute Care site; Two Acute Care Sites (not status quo). It was decided that more work needed to be done to try to harmonize the benefits from these three models further into a single preferred model, and work began on what was referred to as the Hybrid Model, which became the Centres of Focus model. These final three models were further refined and revised (main change was around the One Hospital Model being Centrally located as further information became available with respect to the viability of that). The process with respect to the Final 3 Models is described in detail within the Pre-Capital Submission.	2016-10-28	MOH-1	The additional information provided was helpful in understanding how the 3 options detailed in the master plan were arrived at. Further review and discussion of the options analysis will occur with the submission of the Stage 1 proposal. Please note that the ministry continues to be interested in the viability of Model 2, which was not in the the hospital's shortlist of final options (1 ambulatory care and 1 acute care site, master plan page 2.6.1-1). The ministry requests that the hospital identify which version of model 2 is preferred (designated as option 2 and option 3 in the master plan) and include it in the shortlist of "final options". The ministry further requests that any additional information in support or opposition to this model are included with the next submission for discussion with the ministry.	Yes
4	Resolved	2015-10-29	Item 13. Alternative Infrastructure Solutions	When approved to proceed to Stage 1, the detailed options analysis shall identify which options may support an alternate (i.e. phased) implementation and the challenges/benefits that may be associated with an alternate implementation. To be included in the Stage 1 options analysis.	MOH-1				2016-10-28	MOH-1	No further comments at this time.	Yes
5	In Progress	2015-10-29	General Comment	Capital Planning Bulletins on Master Planning and Flexibility and Adaptability provide additional information to support the development of the Stage 1 proposal. The ministry will be provide these at the next stage submission.	MOH-1				2016-10-28	MOH-1	No further comments at this time.	Yes
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