MUSKOKA ALGONQUIN HEALTHCARE

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared:	**August 3, 2018**	Meeting Date Prepared for:	**August 8, 2018**
Subject:	**Capital Plan Development Task Force Preferred Service Delivery Model Recommendation (Stage 1 Part A)**		
Prepared by:	**Cameron Renwick, Task Force Chair; Don Mitchell, Task Force Vice Chair; Harold Featherston, Chief Executive Diagnostics, Ambulatory & Planning**		

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

RECOMMENDATION

THAT the Capital Plan Development Task Force recommends to the MAHC Board of Directors that Two Acute Site Model be selected.

SITUATION & BACKGROUND

- The Ministry of Health and Long-Term Care's (Ministry) Capital Planning Process involves five (5) stages in addition to a Pre-Capital Submission and Master Program/Master Plan process. The capital planning process is very lengthy, in some cases taking up to 15 to 20 years to complete, as the model is refined at the various stages of the Ministry's planning process.
- Muskoka Algonquin Healthcare (MAHC) submitted a Pre-Capital submission to the North Simcoe Muskoka Local Health Integration Network (NSM LHIN) and the Ministry in October 2012. The Ministry responded in March 2013 directing MAHC to complete a Master Program/Master Plan.
- To oversee this planning work, a Steering Committee was formed and in September 2013, MAHC engaged Resources Planning Group (RPG) to assist with the development of a Master Program/Master Plan.
- An initial Pre-Capital Submission Form and a Master Program/Master Plan was submitted to the NSM LHIN on August 5, 2015.
- In response to the August 5, 2015 submission, the Towns of Bracebridge, Huntsville and Gravenhurst and the Township of Muskoka Lakes submitted a report to the NSM LHIN voicing concerns with the Pre-Capital Submission.
- In response to community and political concern expressed with respect to the MAHC's preferred model recommendation, a NSM LHIN-led Capital Planning Task Force was created and subsequently the Muskoka and Area Health System Transformation (MAHST) Council was established. This initiative brought together representatives from across the region to make recommendations to transform the health system model for Muskoka and area.
- In October 2015, MAHC submitted a revised Master Program/Master Plan and Pre-Capital Submission to the NSM LHIN and Ministry. This recommendation was for a single hospital, centrally located as the preferred future service delivery model.
- In 2017, MAHC received approval from the Health Capital Investment Branch of the Ministry to proceed with the next stage of planning to develop the Stage 1 proposal. This approval was accompanied with up to $1 million in planning grant funds. A planning agreement from the Ministry directed MAHC to further explore programs/services and physical infrastructure and to provide more detailed planning and further analysis of all the different models considered in MAHC's 2015 Pre-Capital Submission.

MAHC CURRENT ENVIRONMENT

Aside from meeting the Ministry's capital planning requirements, a priority for MAHC is to ensure that we will continue to deliver the very best in health care to the communities we serve. This work ensures that investments in services and aging buildings, and most importantly in the people we serve are thoughtful, prudent, appropriate and effectively meet demands – both of the health care system and of the people we serve – for the long term. MAHC faces a number of challenges in meeting this priority, which further reinforces the importance of proceeding through the capital planning process. These challenges include:

- The HDMH site was built in 1978 and SMMH site was built 1964. Facility condition assessments conducted by the Ministry for both sites has determined that both MAHC sites are in poor condition.

- Staffing challenges including vacancies, gridlock, on-call coverage.
- Recruitment of specialty staff and physicians.
- Aging infrastructure requires significant investment (urgent needs $40 million).
- Lack of physical space for care/equipment needs and storage.
- Lack of and in some cases outdated equipment.
- Critical mass challenges (with challenges in appropriately splitting volumes across sites/some inefficient staffing models).
- Alternate Level of Care (ALC) patient flow issues.
- General capacity issues – MAHC operating between 100-140% occupancy.
- Fiscal challenges both operational and capital.
- Struggle to provide services to fluctuating population while maintaining quality.
- Significant duplication of both capital and operational costs.

MAHC sites consistently experience occupancy rates exceeding 100% with no relief in sight and continue to experience high rates of Alternate Level of Care patients who no longer require acute care, despite extensive work on the broader health care system to prepare for an aging population.

In addition, MAHC is experiencing recruitment challenges based on a competitive labour force and the nature of temporary and part-time job opportunities at MAHC.

Our Foundations report that concerns with respect to uncertainty around the future model have been expressed by some in the donor base impacting the Foundations' current fundraising abilities.

It is imperative that MAHC develop a long-range facility plan so that investments that are needed today to address some of the issues identified are made in a way that is consistent with the long-range plan. Dollars spent today need to be aligned with the plan for the future to ensure that they are a solid investment for our communities.

STAGE 1 PROPOSAL PLANNING

To assist with the work required to complete the Stage 1 Proposal, the Board of Directors established a Capital Plan Development Task Force (Task Force) with broad representation including hospital medical staff, hospital foundations and auxiliaries, primary care providers, municipal representatives from the District of Muskoka, North Muskoka, South Muskoka and East Parry Sound, representatives of Muskoka and Area Health System Transformation (MAHST), the NSM LHIN, MAHC Board, administration and patients/families from the greater Muskoka community. This Task Force of 25 members was charged with developing the recommended service delivery model that would best provide safe, quality, sustainable health care for MAHC's service population in the year 2030 and beyond.

The process has involved extensive external and internal engagement with clinicians (doctors, nurses, nurse practitioners, midwives, allied health, etc.) and other community care providers such as public health, paramedic services, mental health, home & community care, etc., MAHC's leadership team, Task Force members, municipal representatives, and representatives of the MAHC Board.

Beyond the engagement component, over the course of the project MAHC provided upwards of 30 separate information opportunities for different stakeholders. The Task Force began its work with the three models considered in 2015. A series of workshops were held which resulted in the following three refined service delivery model options for evaluation. These were further validated through discussion in consultation with the NSM LHIN and the Ministry:

- Two Acute Sites
- Inpatient Site/Outpatient Site
- One Site

CHANGES IN THE PLANNING ENVIRONMENT SINCE 2015

From a planning perspective, there were several new developments and initiatives that needed to be taken into consideration during the model evaluation:

- Ministry approval to proceed to Stage 1 accompanied by $1 million planning grant with direction to provide more detailed planning of all the different models considered in 2015;
- Health Hubs introduced in Muskoka, expanding primary and urgent care access across region;
- Patients First Act became law in 2016;
- Growing primary care focus and engagement;
- MAHST formed in spring of 2016;
- Population growth projections showing slow growth;

- Advancing innovation and technology integration requires continued consideration of impact
- Broader membership of Task Force – including Municipal representation
- Several criteria recommended to be added to the model evaluation tool including economic impact and land-use planning

CONSULTED WITH:

- Capital Plan Development Task Force
- North Simcoe Muskoka Local Health Integration Network
- Ministry of Health and Long-Term Care – Health Capital Investment Branch
- In excess of 150 health care providers/partners reviewing programs and services over next 20-year horizon, including staff, physicians, volunteers, community care practitioners, District of Muskoka, Emergency Medical Services, Family Health Teams, Nurse Practitioner Clinics, Hospice, Muskoka Parry Sound Community Mental Health Association, Simcoe Muskoka District Health Unit, Home & Community Care, etc. as well as public at large
- Guidance with respect to planning provided by other hospital corporations including Royal Victoria Regional Health Centre, Orillia Soldiers' Memorial Hospital, Georgian Bay General Hospital, Collingwood General & Marine Hospital, Trillium Health Partners, North Bay Regional Health Centre.
- Consultants: Resources Planning Group (RPG), Preyra Solutions Group (PSG), Stantec, Hanscomb

OPTIONS CONSIDERED & ANALYSIS:

Through workshops with clinicians and various other stakeholders, the models evolved from high-level concepts to more in-depth descriptions of the programs and services that are proposed in each of the models. At the end of March 2018, the Task Force achieved a significant milestone by coming to consensus on the details of the programs and services proposed in each of the models. To meet Ministry direction to explore and demonstrate the potential shift of appropriate services from hospital to the community, the Task Force identified services that are currently provided in the hospital that could potentially be community-based in the future. This would only be possible if said services could be more effectively and fiscally efficiently delivered in another setting and the greater health care system integration supported this transition.

Two Acute Sites

The Two Acute Sites model proposes to maintain core acute care services at two sites, including inpatient beds, emergency departments, general surgery, obstetrics and intensive care. These would be supported by other core diagnostic services and allied health and support services in both sites. Specialty surgeries and programs such as Chemotherapy and Complex Continuing Care, that are currently single sited, are proposed to continue to be in one site only. The future model also proposes to add a Stroke Rehabilitation Unit and MRI capabilities at one site.

Programs and Services	MAHC Current State 2017	Two Acute Sites	Inpatient Site / Outpatient Site	One Site
Emergency Department	Dual Sited	Dual Sited	Dual Sited	Single Sited
Endoscopy	Dual Sited	Dual Sited	Dual Sited	Single Sited
Diagnostic Imaging (e.g. X-ray, Ultrasound, CT)	Dual Sited	Dual Sited	Dual Sited	Single Sited
Core Laboratory	Dual Sited	Dual Sited	Dual Sited	Single Sited
General Surgery	Dual Sited	Dual Sited	Single Sited	Single Sited
Obstetrics	Dual Sited	Dual Sited	Single Sited	Single Sited
Beds	Dual Sited	Dual Sited	Single Sited	Single Sited
Intensive Care	Dual Sited	Dual Sited	Single Sited	Single Sited
Specialty Surgery (e.g. Cataract, Urology, Gynaecological)	Single Sited	Single Sited	Single Sited	Single Sited
Specialty Programs (e.g. Chemotherapy, Dialysis, Cytology, Nuclear Medicine, Pathology)	Single Sited	Single Sited	Single Sited	Single Sited

Inpatient Site / Outpatient Site

The Inpatient Site / Outpatient Site model proposes to include emergency departments at two sites and to separate outpatient and inpatient services between two sites. The Inpatient Site would include all hospital beds, surgical services, obstetrics, and intensive care, and would be supported by other core diagnostic services and allied health and support services in both sites. The Inpatient Site also proposes the addition of a Stroke Rehabilitation Unit and MRI capabilities. The Outpatient Site would include services that do not require an overnight stay in hospital such as endoscopies, x-rays and other diagnostic imaging, and services like chemotherapy.

One Site

Early in its work and having heard community feedback, the Task Force supported a position that given the significant work completed in 2015 on the One Site model, it was generally well understood. As a result, the workshops and analysis focused attention on fleshing out the two two-site models. The One Site model proposes to provide all programs and services on a single site, including the addition of a Stroke Rehabilitation Unit and MRI capabilities.

Shift of Programs and Services to Community

One of the deliverables from the Ministry was to demonstrate a shift of services from hospital to community. Through the workshops, several programs and services were identified that with proper design and planning could be shifted to the community. These included Prenatal Care, Seniors Assessment and Support Outreach Team, Dialysis, Paediatric Clinics, Diabetes Education, Microbiology, Pacemaker Clinic, Outpatient Dietitian, and Cytology.

Evaluation Criteria

Through a variety mechanisms including workshops, Task Force meetings, internal and external stakeholder engagement and guidance from NSM LHIN, Ministry and consultants, the Task Force developed objective criteria that would be used to evaluate the models.

CRITERIA	SUB-CRITERIA
Patient & Family Centered Care	• Facilitates Clinical Effectiveness and responsiveness • Assists recruitment/retention of staff, physicians, volunteers • Provides access to care with reasonable travel times • Impact on access to services
Financial	• Cost to build • Cost to operate
Alignment	• Aligns with Ministry/NSM LHIN Priorities • Demonstrates shift of programs/services to community
Municipal Impact	• Consistent with Provincial, Municipal and District planning principles • Maintains strong local economies
Community Support	• Fundraising capability required local share • Community Support

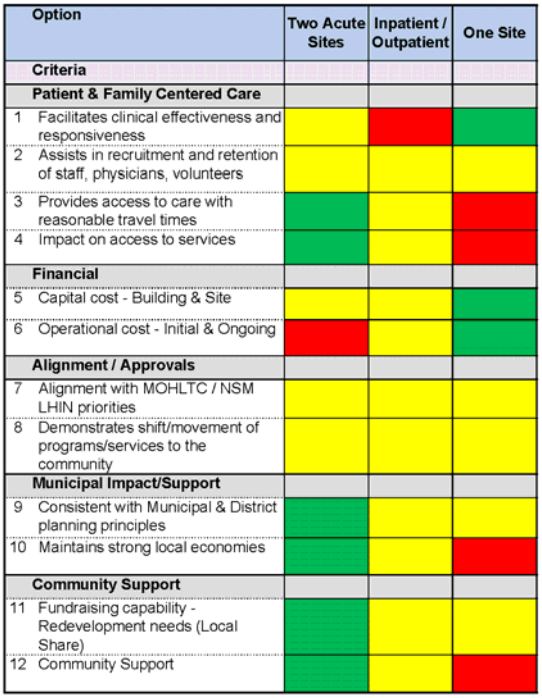
Supporting Documentation

As much as this is an emotional issue, the Task Force sought data to drive the decision-making to ensure an objective approach was used to analyze the different models. In order to better understand different components of the evaluation, the Task Force collected and/or commissioned various data, reports and studies/analyses to help inform and support the evaluation exercise, which resulted in nearly 500 pages of information to consider. The following is a list of some of these reports used in the process of evaluation:

1. Bed/Activity Projections by Model
2. Space Projections by Model
3. Preliminary Capital Cost Estimate by Model
4. Operating Cost Forecast by Model
5. Human Resources Impact Report
6. Travel Times Analysis
7. Siting Report
8. Land Use & Community Planning Analysis
9. Economic Impact Study

Model Evaluation Scoring

The Task Force completed an exhaustive evaluation of the three models. Each member scored each of the models based on the criteria and sub-criteria. The results of the submissions were collated into the evaluation summary shown at right. Colour coding identified the order in which Task Force members felt the sub-criteria best aligned with each model – green being the highest, red being the lowest, and yellow falling in between the highest and lowest.



Option	Two Acute Sites	Inpatient / Outpatient	One Site
Criteria			
Patient & Family Centered Care			
1 Facilitates clinical effectiveness and responsiveness			
2 Assists in recruitment and retention of staff, physicians, volunteers			
3 Provides access to care with reasonable travel times			
4 Impact on access to services			
Financial			
5 Capital cost - Building & Site			
6 Operational cost - Initial & Ongoing			
Alignment / Approvals			
7 Alignment with MOHLTC / NSM LHIN priorities			
8 Demonstrates shift/movement of programs/services to the community			
Municipal Impact/Support			
9 Consistent with Municipal & District planning principles			
10 Maintains strong local economies			
Community Support			
11 Fundraising capability - Redevelopment needs (Local Share)			
12 Community Support			

The Task Force considered both the results of the quantitative analysis (the scoring) along with extensive discussion and debate relative to the qualitative analysis.

MAHC's Ethical Decision Making Framework was also utilized to provide an alternate lens to reassess responses and discussions from an ethical, values-based perspective and ensure that members had the opportunity to assess their own biases and influences. Task Force members discussed the models and options at length, ensuring all aspects of selecting a preferred model had been considered.

Rationale for Selection of Preferred Model:

Using the evaluation criteria, some of the key areas that contributed to the Task Force recommendation included:

Patient- and Family-Centered Care

While the scoring identified the One Site model did provide some perceived advantages under the clinical effectiveness and responsiveness category, it was felt that the other quality and patient- and family-centered care criteria were equally important. The Task Force felt that on the whole, the Two Acute Sites model more fully met the needs of the local community. The Task Force acknowledged that clinical effectiveness could not be captured or measured solely by assigning a numerical scoring. For example, aiming for efficiencies and economies of scale is of value, but only in so much as managing financial cost. Efficiencies do not necessarily translate into better clinical effectiveness, which is always the goal for MAHC in caring for people and their health. Costs are much easier to measure than outcomes, and the Task Force recognized there is data showing access to care improves clinical outcomes. The degree of the scoring difference was small and was not felt to relate to a substantive difference in quality care.

One of the key pieces of data that impacted the scoring in this category was regarding travel times. While work done in 2015 was based on the assumption that a One Site model could be built centrally, work done in the 2018 analysis (see Municipal Impact section below) challenged that assumption. For models where programs and services were single sited, travel times were based on the impact of getting to one of the two urban centres. Further analysis with respect to average provincial travel times indicated that Muskoka and area already experience high average travel times. Moving to one of the single sited models would increase that to the point where Muskoka and area would have the second longest travel times to acute care in a sub-geographic region of Ontario.

Financial

Analysis completed by Stantec determined that the cost to build the three different models was so similar in scale that this should not be used to differentiate between models. The Task Force also recognized the requirement to raise the local share is so dependent on community support, that none of the models stand a chance without community support.

The cost to operate analysis did indicate that the least expensive model to operate was the One Site model, and the most expensive model was the Two Acute Sites model. While the Task Force acknowledged this, they did not feel this should be a limiting factor as all other evaluation criteria indicated that the Two Acute Sites model was the preferred approach. MAHC, the local municipalities, the Ontario Hospital Association, and the Ministry have all acknowledged that the funding formula for medium-size hospitals needs to be fixed, and one of the assumptions this recommendation is based upon is that the adjustments to the funding formula going forward will support the recommended Two Acute Sites model of care.

Alignment

The evaluation scoring demonstrated that the three models equally met Ministry and the LHIN priorities. All three models demonstrated a shift of programs and services to the community. It is understood that there needs to be a focus on helping patients and their families access the health care they need more quickly and closer to home. It has been a stated goal of the Ministry that system changes need to lead to a more local and integrated health care system, improving the patient experience and delivering higher-quality care. Systems need to be tailored to the needs of their specific community. The Task Force felt that this further supported the selection of the Two Acute Sites model as it best aligns with these principles.

Municipal Impact

New to the analysis from 2015, was a more extensive consideration of the municipal impact. As more and more organizations turn to the local municipalities to assist with the local share, local municipalities are expecting more consideration of the planning impacts on them. A detailed Land Use & Community Planning Analysis was presented to the Task Force and it clearly outlined that planning for a new hospital structure outside designated urban centres was not recommended. Further consideration of the One Site model required the assumption that it would be built in one of the two current urban centres. In addition, a siting report conducted by Stantec further reinforced this position. Based on these analysis, as well as community feedback, the concept of a “centrally located” One Site model was abandoned.

An Economic Impact Study was also conducted, and while it determined that the overall impact of all three of the models was positive in the District of Muskoka and surrounding areas, the One Site model and in the Inpatient Site/Outpatient Site model would mean a positive impact on one area while potentially having a negative impact on another area at the local municipal level. While there were always significant challenges with the One Site model, this recent economic analysis information had a dramatic impact on the viability of a One Site model.

Community Support

Through extensive engagement, the Task Force was aware that overwhelming feedback from the community has continued to support a Two Acute Sites model. The physician community also felt this was the best model to provide comprehensive, accessible emergency health care to Muskoka and East Parry Sound. The community has consistently identified access as one of the most valued criteria. The Two Acute Sites model was identified as the one that best able to meet this very real need.

One of the key deliverables for a Stage 1 submission is a Local Share Plan. The ability to raise the local share is an integral component of any planning. The Task Force weighed heavily the fact that no model would ever be completed if those responsible for raising the money were not supportive of the option selected. A clear message was received from the municipalities that their willingness to consider contributions to the local share depended a great deal on the model selected, and municipal preference was for the Two Acute Sites model.

Other Considerations

The Task Force considered several other aspects of the models and these were felt to be influential:

Long-term viability:

The long-term effects of the different models on the long-term stability of the proposed approach were considered. It was felt that the One Site model had so many challenges and issues associated with it that it would never get to a state where it could be approved. The Inpatient Site/Outpatient Site model was felt to be at risk of not being sustainable and that recruitment and retention of providers would be challenged. It was also felt that the community might self-select to the more acute-based site, further destabilizing the outpatient site.

Model looks similar to today:

The Task Force acknowledged that the model proposed looks similar (but not the same) as the model today. The Task Force was aware that the Ministry is always looking for bold, new thinking, and acknowledged this may not be perceived as transformative enough. The Task Force felt that MAHC has done a significant amount of work over the past decade to create an efficient operation since amalgamating two acute care hospitals. There have been successes in reducing duplication, eliminating waste, and instituting efficiencies wherever possible. How MAHC exists and operates today was felt to be an excellent example of a medium-size hospital operating two acute care sites. The Task Force has determined that if two acute care sites are required, there are few dramatic changes left to be made to the current MAHC medium-size hospital operating two acute care sites model. Opportunities exist, however, to significantly and dramatically alter the integration of all community health provision with the hospital acting as only one component of a greater system. The model proposed does try to mitigate against rapid bed growth and is aligned with Ministry required bed projections. It looks to move programs and services into the community (where this shift is economically rational and appropriate) and has considered the future needs of the community with the recommendation to add some key new programs and services to meet the projected needs of the population.

What will health care look like in 30 years:

The Task Force felt that planning for what healthcare needs are 30 years from now is next to impossible. Change in the health care sector, best practice, advancements in technology, Ministry direction, and health care reform all will have significant impact on the role of hospitals, the programs and services they provide, and the models under which they are provided. The Task Force also acknowledged that you have to start somewhere. MAHC has significant challenges today, and investments need to be made in the very near future. The Task Force felt that the preferred model being recommended is flexible enough to accommodate further changes as technology, practice and systems evolve.

Advantages / disadvantages of models:

All models were felt to have advantages and disadvantages. A preferred model recommendation was based on extensive consideration of all factors, including recognition that ultimately acute care is only one component of a larger integrated system and does not stand alone from the broader system. In completing the evaluation exercise, Task Force members agreed that no criteria could stand alone to evaluate the models. Several criteria are inter-related and the relationships between the criteria were influential to the evaluation. While the group did not apply weight to any of the sub-criteria, some were felt to be more highly valued than others. The Task Force focused the qualitative discussion on criteria of high importance that meet the needs of the community, such as quality and clinical impact, access to care and travel times, community support, and future viability of the model. For example, quality was considered beyond the physical infrastructure of a preferred model and in the context of a broader local health system where access is key. No criteria were scored more highly than for the Two Acute Sites model with the exception of operating cost. With that in mind, the Task Force acknowledged that some things have a greater likelihood to change in the future, such as funding models and technology. The Task Force determined it could not be bound by the current funding formula that could change dramatically with time. It was further emphasized that a preferred model would need to be designed to be nimble and flexible to ensure its viability and sustainability. It was acknowledged that no model could proceed without the support of the community – both financial and otherwise.

IMPACT ANALYSIS / RISK ASSESSMENT / DECISION CRITERIA

Key Differences Between 2015 and 2018 Analysis

As noted above, a more extensive consideration of the municipal impact occurred in this next stage of planning. The Land Use Planning Report and Siting Reports highlighted significant challenges in development options in non-urban settings resulting in the concept of "centrally" located needing to be abandoned. This had a significant impact on the average travel times under the One Site and Inpatient Site/Outpatient Site models. MAHC average travel times are already high relative to provincial averages, and would become one of longest in province under the One Site and Inpatient Site/Outpatient Site models. Access was a significant factor for the community and the Task Force; the Two Acute Site model best addressed access concerns.

As a result of additional design work focused on the 2 Acute Site Model, cost to build was determined to be much closer across the three models than previously projected and as a result became much less influential in decision making. The cost to operate continues to be projected to be lowest in the One Site model, but come much closer in the 2 Acute Sites and Inpatient Site/Outpatient Site models.

Community and Municipal support were deemed to be a critical success factor. Without these, no model would proceed, and no local share could be raised.

The preferred model is recommended as it:
- provides patient- and family-centered care
- aligns with NSM LHIN and Ministry direction
- garners the greatest municipal support
- garners the greatest community support
- provides the best access to care
- ensures the viability of the acute care system across Muskoka and area
- provides a model that is nimble and can be flexible over time
- is positioned to meet the community's needs today and into the future
- addresses land use planning and site servicing issues related to facility development

Ongoing consideration for the following must occur:
- the preferred model must remain flexible to accommodate future needs
- the plan will need to continue to be evaluated and refreshed at each stage of planning to ensure the future plan is based on evolving technology, best practice, system integration and community needs
- the funding formula must evolve to create financial sustainability
- the LHIN supports the proposed programs and services model

IMPLEMENTATION & NEXT STEPS

- The preferred model will be presented to the MAHC Board and community in a public session
- The MAHC Board will consider the recommendation from the Task Force

- The MAHC Board will communicate the outcome of its deliberations on August 10, 2018.
- If the preferred model is endorsed, the Task Force will begin working on Part B with a goal to have a completed Stage 1 Proposal submission for the North Simcoe Muskoka LHIN and the Ministry's Health Capital Investment Branch in 2019.

SUPPORTING DOCUMENTS/ATTACHMENTS

- Stage 1 Service Delivery Model Report

MUSKOKA ALGONQUIN HEALTHCARE

ISSUE FOCUSSED ETHICAL DECISION MAKING FRAMEWORK

The intent of this framework is to enable decision makers at Muskoka Algonquin Healthcare to address complex and challenging issues in a comprehensive and logical manner. It is a reflective process intended to stimulate discussion among decision makers that will enable them to identify explicit reasons for or against a proposed course of action, and to do that in the context of the Mission, Vision and Values. Questions relevant to Issue Focused Ethics are provided in the guideline below; some questions may not apply to every issue and other questions may need to be added.

CONTEXT

1. Identify the Issue and Decision-Making Process
- Reflective Practice
- State the conflict or dilemma
- Determine best process for decision making

2. Study the Facts
- Stakeholder perspectives
- Evidence
- Contextual Features (political, economic, stakeholder satisfaction)

3. Select Reasonable Options
- Brainstorm options first without evaluating
- Start by describing your 'ideal' situation

VALUES & ETHICS

4. Understand Values & Duties
- Which values are in conflict?
- Professional or legal obligations or standards to consider?
- Alignment with Strategic Directions, Mission, Vision and Values

STEWARDSHIP

5. Evaluate & Justify Options
- Possible harm to various stakeholders?
- Benefits?
- Patient outcomes – quality of care
- Human resource implications
- Using Resources properly?
- Evaluation Plan to monitor impact?
- Financial implications?

6. Sustain & Review the Plan
- Formal evaluation process in place to monitor progress, good practices and opportunities for improvement
- Appeal process?
- Evaluation of how the decision-making process worked

Stage 1 Service Delivery Model Report

Prepared on behalf of the MAHC Capital Plan Development Task Force

August 3, 2018

Contents

Introduction

At Muskoka Algonquin Healthcare (MAHC), we understand the importance of developing a future plan that responds to the critical and acute care needs of future generations of Muskoka and East Parry Sound residents and visitors. The health care needs of our population are changing, and so are the ways that we provide care. We are preparing for changing demographics in our communities, new demands on the health care system, advances in technology that impact the way care is delivered, and aging buildings that no longer meet minimum standards for safe, high-quality care and have been assessed by the Ministry of Health and Long-Term Care (Ministry) as being in poor condition.

MAHC's priority is to ensure that we will continue to deliver the very best in health care to the communities we serve. Planning for the future ensures that investments in our services, our staff and our aging buildings are thoughtful, prudent, appropriate and effectively meet the demands – both of the health care system, and most importantly of the people we serve for the long term.

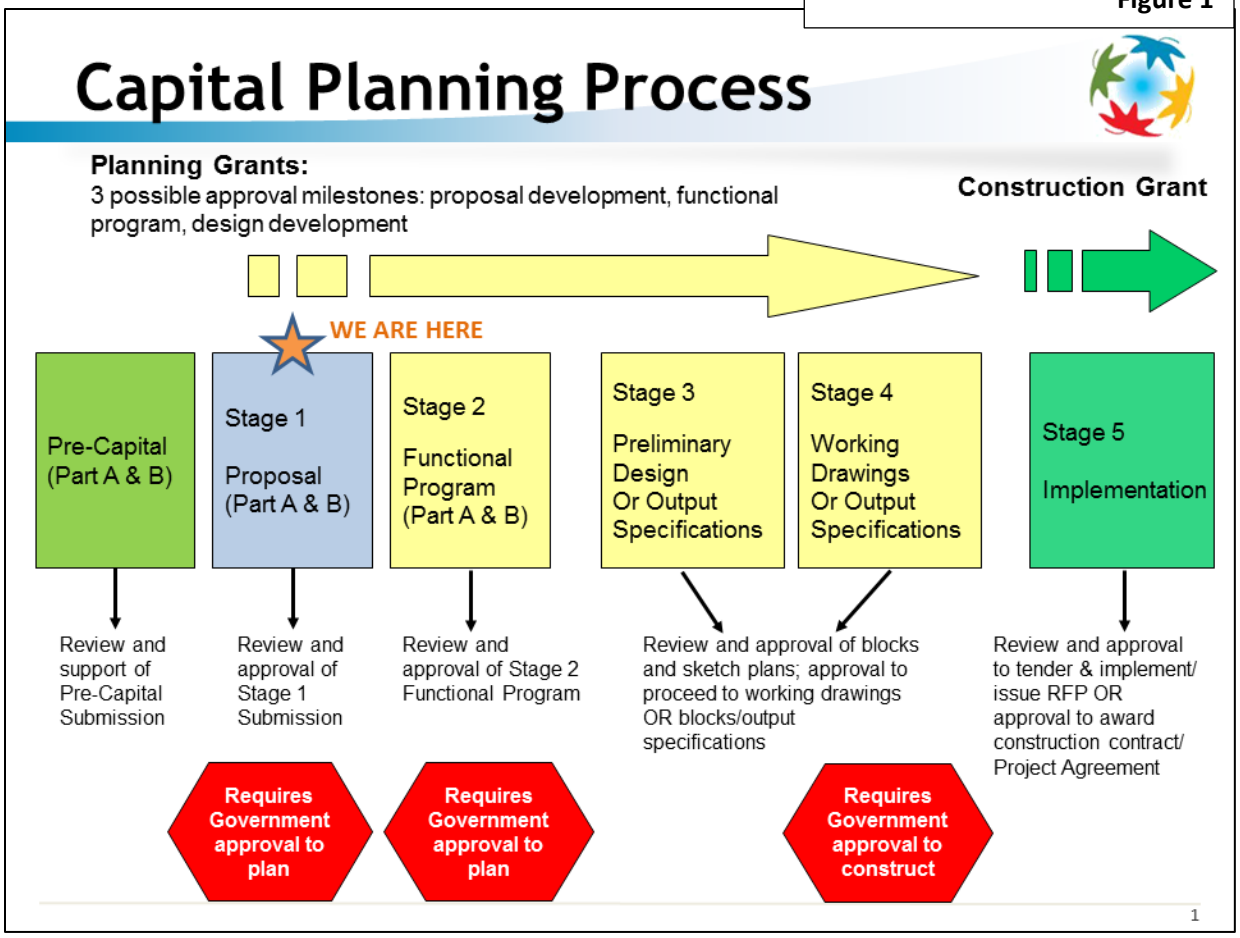
Background & History

Long-range planning is all about forecasting what our community will need in the future and how we can respond to their care needs. In 2012, MAHC began working through the Ministry's capital planning process, which includes five distinct stages, some of which require Ministry approval to move to the next stage.

The Ministry's capital planning process (*see Figure 1*) takes years to complete and requires that plans are revisited at each stage so they can be refreshed and "ever-greened" according to community and greater health system changes. This planning is necessary because our buildings, which were built to support the type of care provided decades ago, continue to age and pose space restrictions today for required growth. In some cases our facilities do not meet minimum standards to protect patients and staff and are not well positioned to meet evolving standards in health care and best practice evidence that the people we serve expect and deserve. Regardless of any future model, it is recognized that the current infrastructure requires significant investments in the next few years. MAHC sites consistently experience occupancy rates exceeding 100% with no relief in sight and continue to experience high rates of Alternate Level of Care patients who no longer require acute care, despite extensive work on the broader health care system to prepare for an aging population. At the same time, MAHC needs to continue to recruit and retain skilled health care providers, ensure critical mass and clinical expertise to sustain high-quality programs, secure adequate operating funding and continue to seek efficiencies wherever possible, and reduce unnecessary duplication of capital costs that compete with the ability to consider new and advancing technology.

Through the Ministry's planning process, we must look ahead 8, 15, 20 and 30 years for programs and services, and 50 years for facilities based on the best information currently available. This planning work considers everything from projected population growth and demographics to projections of disease prevalence, as well as potential advancements in research technology and attempts to balance them with standards of care and best practices, space needs and community needs.

Figure 1



Master Program/Master Plan

Throughout 2013, MAHC planning teams worked collaboratively to identify a vision for our programs and services and the facilities that would be required to deliver those programs and services in the future. This work led to a first iteration of a Master Program and Master Plan for MAHC. The Master Program reflects a health service provider's present and future service role and outlines the programs and services intended to be provided at 5-, 10- and 20-year planning horizons. The Master Plan identifies the physical space requirements for the future by outlining the buildings and infrastructure those services will require to be delivered, including long-term development strategies looking out 50 years.

This work was led by the Master Program/Master Plan Ad-Hoc Steering Committee made up of hospital administrators, physicians, hospital foundation representatives and members of the Board of Directors and greater community. Community engagement was also critical to this process and in May and August 2014 and again in March 2015, MAHC presented progress updates and received public feedback on the potential models of care that helped to influence the evolution of the models. With public input from various corners of our communities and data driven decision-making, the Steering Committee completed an evaluation of the models and in May 2015 presented a report to the Board of Directors in support of its recommendation for a single centrally-located hospital as the future service delivery model to inform a Pre-Capital Submission to the North Simcoe Muskoka Local Health Integration Network (NSM LHIN) and Ministry.

Pre-Capital Submission

The Pre-Capital Submission Form is the official entry point into the Ministry's capital planning process. The Pre-Capital is comprised of a Part A and Part B, each which pose a number of questions to paint a picture of MAHC's role as a health care provider in the local health system, as well as the redevelopment initiative being proposed. Following the decision of the Board on the future model, work was undertaken to draft a Pre-Capital Submission Form for consideration by the NSM LHIN and the Ministry.

A Pre-Capital Submission Form was submitted to the NSM LHIN Board of Directors in October 2015 and subsequently the Ministry. The Pre-Capital Submission explored three potential models for the future and ultimately proposed a single hospital as the future service delivery model.

NSM LHIN-Led Capital Planning Task Force

In response to MAHC's Pre-Capital submission to the NSM LHIN, the Towns of Bracebridge, Huntsville and Gravenhurst and the Township of Muskoka Lakes submitted a report to the LHIN voicing concerns with the Pre-Capital Submission.

Although the municipalities in Muskoka recognized and appreciated the importance of the acute care hospital services provided by MAHC; the dedication and hard work of the doctors, nurses and other staff who are part of the MAHC team; and the need to proactively conduct long-term planning for sustainable hospital services, the municipalities disagreed with the model selected by MAHC.

The municipalities recommended to the NSM LHIN that MAHC undertake additional planning based on broad community consultation, additional analysis with a focus on integration, accessibility and the provision of patient-focused hospital services. The municipalities recommended that the following items be included as factors to be evaluated:

- Land use planning legislation and policies;
- Community economic impacts of any long-term plans for hospitals;
- The ability to raise the funds required for sustainable hospital services;
- Operating and cost impacts of any long-term plans for hospitals on both the lower and upper-tier levels of government including cost implications on Emergency Medical Services (EMS), water treatment services, sanitary sewer services, transit, etc.; and
- Direct impact on local health care service providers.

After reviewing the submission by the municipalities, the NSM LHIN Board of Directors' endorsed the revised Pre-Capital Submission Part A with direction by resolution to NSM LHIN staff to facilitate further engagement between MAHC and the local municipal government that would support more intimate involvement in planning, enhanced awareness, and their endorsement for the future health service delivery model. A NSM LHIN-led Capital Planning Task Force was formed to establish a common vision for the future. The NSM LHIN-led Capital Planning Task Force met for six months and identified the need for a broader vision for health care delivery in the community, not just acute care. The NSM LHIN-led Capital Planning Task Force supported the idea of defining a broader vision for health care delivery in the area in 2016 through a unique "made in Muskoka" solution.

MAHST (Muskoka and Area Health System Transformation)

The Muskoka and Area Health System Transformation (MAHST) Council was established in the spring of 2016 to design and develop a community-based model for a person-centered integrated health system, and a plan to implement it. MAHC contributed significantly to this project through participation on the Executive Committee, General Council and the Programs and Services Working Group. Fundamental to the model is the understanding that acute care (the hospital) is just one component of the integrated health system and acute care planning needs to be done in the context of the entire system.

On June 30, 2017, the MAHST Council submitted a comprehensive report to the NSM LHIN titled "Charting the Course for Muskoka and Area Health Care Transformation – A Community Plan for System Integration and Sustainability". After reviewing the comprehensive recommendations set out in the report, the NSM LHIN accepted the report for information purposes. In accepting the MAHST report, the NSM LHIN commented on its expectations that MAHC's Stage 1 capital planning would further explore what services need to be delivered in an acute care setting and what services would be more appropriate to be delivered in a community setting.

Stage 1 Objective & Guiding Principles

Following the submission of the Pre-Capital in October 2015, the Health Capital Investment Branch and MAHC engaged in dialogue for over a year to successfully satisfy Ministry inquiries and questions of clarification on the Pre-Capital Submission Form. This led to Ministry approval for MAHC to proceed to Stage 1 in the Capital Planning Process in 2017, along with a $1 million planning grant subject to execution of a planning agreement (Appendix A). The agreement provided specific project elements and planning parameters for the Stage 1 Proposal work, representing a new chapter for MAHC's planning for the future.

The Stage 1 Proposal further explores programs/services and physical infrastructure planning in greater detail and in consultation with both internal and external health service provider stakeholders. It represents more detailed planning and further analysis of the different models presented in MAHC's Pre-Capital Submission to evaluate acute care capital development options for a future model of hospital care.

The objective of Stage 1 is to create a more detailed depiction of the proposed acute care capital development initiative with descriptions and analysis of program and service elements (Part A), as well as physical and cost elements (Part B). This stage includes refreshing bed and service projections, further exploring potential capital costs and local share fundraising, a human resources plan, and consideration of the use of or potential re-purposing of the existing hospital sites.

Stage 1 has two components: Part A is essentially *what* programs and services are proposed to be provided in the service delivery model; and Part B is *how* you would build the model (ie: renovation of existing facilities, new build, or a combination of both) and how MAHC would raise the required local share to pay for it. The Stage 1 Proposal has a number of Ministry requirements further outlined in the table below:

Part A	Part B
Service Delivery Model Report - Present and future service delivery model - Projected future workloads and volumes (8, 15, 20, 30 years) - Options for delivering the changes in service delivery - Human Resource Plan - Preliminary operating cost estimate	Service Support Infrastructure Report - Spatial requirement - Multi-year infrastructure plan - Technical Building Assessment - Master Site Plan - Master Building Plan - Options for Master Plan Business Case / Option Analysis Facility Development Plan - Proposed floor plans - Proposed space summary - Implementation / phasing plan - Schedule - Other operational issues - Funding/financing plan - Project estimates

Methodology & Approach

To move forward with Stage 1 planning and detailed analysis of the different service delivery models being considered for future hospital care, increased engagement and consultation were of primary importance to the Board of Directors. As such, the MAHC Board of Directors directed the creation of a Capital Plan Development Task Force (Task Force) that included broader representation of specific stakeholder groups – hospital medical staff, hospital foundations and auxiliaries, primary care providers, municipal representatives from the District of Muskoka, North Muskoka, South Muskoka and East Parry Sound, representatives of Muskoka and Area Health System Transformation (MAHST), the NSM LHIN, MAHC Board, administration and patients/families from the greater Muskoka community. The role of the Task Force was to oversee the Stage 1 Proposal planning (Part A and Part B) and to report and make recommendations to the Board that would culminate in the completion of a Stage 1 Proposal submission to the Ministry's Health Capital Investment Branch.

In July 2017, the Board approved the Terms of Reference (Appendix B) outlining the roles and expectations of the 25-member Task Force, as well as its membership. Through July and August, Task Force members were recruited and the Task Force membership (Appendix C) was finalized and a biweekly meeting schedule (Appendix D) was developed. Additional resources at Task Force meetings included two MAHC administrative staff, as well as external consultant groups including Resource Planning Group (RPG), Preyra Solutions Group (PSG), and Stantec for architectural and engineering support. Task Force meetings were generally two hours in length and 22 meetings have been held since August 21, 2017. Early meetings represented an orientation to the Ministry's Capital Planning Process, MAHC's previous planning work (Master Program/Master Plan, Pre-Capital Submission Form) and education about acute care and MAHC's role in the health care system.

Over the course of the past 11 months, the Task Force:

- approved an Integrated Project Management Framework (Appendix E)
- guided various consultation strategies to engage key stakeholders in planning discussions
- solicited public input and was responsive to community feedback via surveys, written submissions, delegations
- led the work to define three potential service delivery models through five interdisciplinary workshops
- approved and finalized the programs and services proposed in each model
- developed and approved objective, stakeholder-informed model evaluation criteria and sub-criteria, as well as an evaluation tool
- collected and examined data, reports, studies to inform and support the evaluation of the models
- individually completed a confidential evaluation of the models
- communicated regular updates on its work to stakeholders

As with any project, there were delays within the project's timeline due to several factors that ultimately impacted the schedule. Throughout the planning process, the Task Force expressed that it would take the time necessary to do the best job possible.

Engagement & Communication

Broad stakeholder engagement and communication are essential parts of the planning process. In order to put forward the best service delivery model to the Ministry, there was a strong Task Force commitment to information sharing and internal and external stakeholder consultation through various approaches and tactics.

Community Information Sessions

As part of the engagement plan, a series of eight information sessions were held August 28 to September 1, 2017 in five different geographic areas across the Muskoka and area region to inform stakeholders about the commencement of the Stage 1 planning project. Internal communiques, newspaper advertisements, radio commercials, media releases, social media, MAHC website, and emails to various groups including lake associations, community partners, chambers of commerce, service clubs, political leaders/municipal CAOs, were used to spread the word about the sessions. Stakeholder groups were welcomed to each session by the Chair of the Task Force. A 60-minute PowerPoint presentation was given by four different presenters representing each of the different key focuses of the presentation listed below:

- an overview of Muskoka and Area Health System Transformation (MAHST),
- the evolution of primary care and potential for change through MAHST,
- MAHC's future planning journey to date,
- an overview of the Stage 1 process and timeline,
- service delivery models for consideration,

- draft criteria to evaluate the models, and
- a feedback survey.

A two-fold information brochure was developed and printed, and distributed at each session. The brochure and the slide deck presented at the sessions are posted on the MAHC website. Each of the presentations given in Gravenhurst, East Parry Sound, Bracebridge, Huntsville and Muskoka Lakes were followed by an opportunity to ask questions of clarification regarding the information presented. All stakeholders were invited to provide written input on the models presented and the draft evaluation criteria by completing the feedback survey. Nearly 300 people attended the sessions.

Throughout the fall and winter of 2017 and spring of 2018, an additional 11 information presentations were arranged for community special interest groups (Lions Club, Probus, Rotary etc.) and collectively reached nearly 500 participants.

Feedback Survey (Opinion)

As part of community engagement and consultation, MAHC created a survey to seek preliminary anonymous feedback from stakeholders. The feedback survey was available electronically on the MAHC website from August 28 to October 13, 2017 with hard copies available in key locations across the region and upon request. Eleven questions were posed, and for some questions respondents were able to select more than one response. The survey was structured so that respondents were not limited in the number of times they could respond. This was important to ensure there were no barriers for members of any given household to complete the survey from the same computer or a shared device.

The electronic survey link was shared broadly through local media and social media, while hard copies of the survey were made available at the two hospital sites, in public facilities such as Municipal Offices, libraries, recreation facilities and physician offices, and by mail upon request.

The purpose of the feedback survey was to identify what was important to respondents by seeking written input on the models presented, and the draft criteria that would be used to evaluate the models. The survey was not designed as a rigorous, scientific tool. It was created to garner feedback on what is important to our communities with respect to future hospital planning.

There were three main objectives for the survey:

- to help shape the criteria that would be used to evaluate different potential hospital models by asking respondents what was most important to them with respect to proposed criteria,
- to provide an opportunity for respondents to identify if any criteria were missing,
- to understand at a high level what respondents liked and disliked about three different potential hospital models for the future (although the three models were not fully developed at the time of the survey).

During the seven-week survey period, 2,183 responses were received either electronically or in hard copy. Survey results were reviewed by the Task Force with each member analyzing a subset of results and identifying recurring themes. A Feedback Survey (Opinion) Results Report – (Appendix F) was developed and approved by the Task Force and posted on the MAHC website.

Workshops/Focus Groups

Key stakeholders were also engaged through interdisciplinary planning team workshops and focus group-style meetings. Five workshops were organized with approximately 80 key stakeholders invited, including clinicians (doctors, nurses, nurse practitioners, midwives, allied health, etc.) and other community care providers such as public health, paramedic services, mental health, home & community care, etc., MAHC's leadership team, Task Force members, municipal representatives, and representatives of the MAHC Board.

The workshops provided a forum to listen to and ask questions of clarification of the consultants, gather and validate data, participate in breakout sessions and provide feedback on the three models being considered. Ultimately these workshops were key to refining and defining the programs and services contemplated in each of the three models, as well as programs and services that could be appropriate to shift to the community.

To support some of the data validation related to the Stage 1 work and to generate a common understanding of current and future state, the interdisciplinary planning team's input was critical to helping shape the future vision of our clinical services and facilities. The first workshop was held September 7, 2017 with consultants from Resource Planning Group and Preyra Solutions Group. At this workshop, participants reviewed demographic projections, an overview of MAHC activity trends and utilization, preliminary analysis of travel times, and forecasting of the various resources required for programs and services that could be provided in the future. Then, with a shared sense of future pressures, challenges and opportunities, discussion occurred with respect to how innovation and technology changes will impact the way care is provided in the future.

A subsequent data validation session was held November 1, 2017 with Preyra Solutions Group and a working group of Emergency and Surgical Services staff and physicians to facilitate a more thorough look into key data (activity/utilization and projections) in these specific clinical areas.

An all-day workshop with the interdisciplinary planning team was held November 17, 2017 to explore the two different two-site models. The workshop was led by consultants from Resource Planning Group, Preyra Solutions Group and Stantec and reviewed and further analyzed the validated data, before the team began mapping out a straw dog of what the Inpatient Site / Outpatient Site model could look like. The informative session facilitated input from the interdisciplinary team to shape the Inpatient Site / Outpatient Site model and what programs and services could be appropriate to shift to the community.

A further half-day workshop with the interdisciplinary planning team was organized on January 8, 2018 to further discuss the two two-site models. Attendees were asked to review all of the data collated from the November workshop to ensure an accurate reflection of what had been discussed. Participants were also asked to provide feedback on possible advantages and disadvantages of the Inpatient Site / Outpatient model that had been developed. The team broke into four different groups to work through developing potential straw dogs of the Two Acute Sites model, with an emphasis on what services could be shifted to the community, or could evolve through a campus of care scenario.

On February 27, 2018 a fifth workshop with the interdisciplinary planning team was held to continue exploring the Two Acute Sites model with further breakout sessions. Current challenges facing the organization were discussed in detail, such as recruitment and retention, critical mass and capacity issues, infrastructure and space challenges. The team discussed the strengths and weaknesses of the Two Acute Sites model compared to the Inpatient Site / Outpatient Site model.

Throughout the planning process, smaller focus groups/meetings have been formed to advise and/or develop reports for the Task Force. Some of those groups include municipal economic development specialists, municipal land-use/development planning experts, Emergency Medical Services, and fundraising/local share requirements.

Public Meeting

The Task Force was committed to ensuring members of the public had an opportunity to speak directly to the Task Force as the work around possible models for the future continued. On March 1, 2018, a public meeting was held to allow members of the public to address the Task Force directly with oral presentations or in written submissions. The purpose was for the Task Force and representatives of the MAHC Board to listen to the community and hear ideas about hospital future planning, and for Task Force members to ponder and reflect on these ideas before making any recommendations. Internal communiques, newspaper advertisements, radio commercials, media releases, social media, MAHC website, and emails to lake associations, community partners, chambers of commerce, service clubs, political leaders/municipal CAOs, were used to promote the meeting. Online video coverage of the three-hour meeting in its entirety was broadly available for one month by YourTV Muskoka. Approximately 140 people attended the meeting and 16 people from across the region presented their comments. The Task Force also received nearly 100 written submissions that were also distributed to the MAHC Board. During the March 1 meeting, it was evident to the Task Force that people are very passionate about acute care planning for the future. Some of the recurring themes heard from the various speakers included:

- Access to care, especially emergency care is important
- Two full service acute care sites is the community's preferred model
- There is a willingness to support renovation of existing facilities over a number of years versus a new build
- The Ministry needs to adequately fund MAHC operations
- Community hospitals have a unique role in promoting economic development and sustainable communities
- People, businesses and other health care agencies chose their physical whereabouts based on existing hospital locations

In response to questions raised during the meeting, a Q&A was posted on the MAHC website and shared broadly.

A summary of key engagements and attendance are captured in the table below.

Number	Engagement Tactic	Attendance
5	Community Information Sessions (in 5 areas)	220
6	MAHC Stakeholders Info Sessions (Town Halls)	211
5	Workshops with Interdisciplinary Planning Team	70
1	Feedback Survey	2,183
11	Community Presentations (Speakers Bureau)	486
12	Political Leaders	50
1	Public Meeting (*plus 100+ written submissions)*	140 (16 speakers)
3	Focus Group – Land Use Planning	15
2	Focus Group – Economic Impact	17
1	Focus Group – Emergency Medical Service	9
1	Focus Group – Local Share/Fundraising	12

Communication

Throughout the Stage 1 planning work to date, communication with all stakeholders including media has been critically important to the Task Force. Following each Task Force meeting, a Task Force Update (Appendix G) was shared broadly, capturing key messages of the work achieved and/or the discussions around the table to keep stakeholders informed. Significant milestones in the Task Force's work were also reinforced through other MAHC communication tactics, such as news releases (Appendix H). Further, information updates were made as necessary on the MAHC website "Planning for the Future" section.

Elected officials received informative presentations through delegations to municipal councils, and once the models were defined, an invitation was extended to provide additional updates upon request. As well, Muskoka Mayors, the District Chair and the members of provincial and federal parliament also participated in quarterly forums where updates were provided.

Several touch points with the NSM LHIN and Ministry's Health Capital Investment Branch occurred throughout the course of the planning to ensure the NSM LHIN and Ministry were kept abreast of the budget, schedule and scope of work. The meetings provided an opportunity for the NSM LHIN and Ministry to ask questions, and for MAHC to ensure that the planning was aligned with NSM LHIN and Ministry expectations. Updates with respect to planning horizons, assumptions and projections were shared at these meetings and guidance and direction sought as necessary. MAHC took the opportunity at these meetings to ensure that the models as they were being developed aligned with the NSM LHIN and Ministry expectations, to provide a sense of the programs and services being proposed, and a sense of the order of magnitude of size and costing for the models being evaluated.

Open communication between the Board of Directors and Task Force was maintained throughout the process, through both written and verbal updates at each of the monthly Board meetings. Furthermore,

early in this process it was recognized that all Directors would benefit from the opportunity to be involved in many aspects of the consultative work as it would provide a more fulsome understanding of the Task Force's progress and ultimately lead to better decision making. To that end, Directors participated as observers in the workshops held and had the opportunity to hear feedback and input directly from stakeholders.

All communication and engagements associated with the project to date have been documented in the Stage 1 Communication/Engagement Record (Appendix I).

Media attention has been constant throughout the Stage 1 planning work, and since July 2017 there has been in excess of 330 media clips, a portion of which were opinion submissions through letters to the editor or contributed columns.

Options Considered

The Task Force began its work with the three models considered in 2015. As outlined above, a series of workshops were held which resulted in the following three refined service delivery model options for evaluation. These were further validated through discussion in consultation with the NSM LHIN and the Ministry:

- Two Acute Sites
- Inpatient Site / Outpatient Site
- One Site

Having completed extensive consultation through the workshops with clinicians and various other stakeholders, the models evolved from high-level concepts to more in-depth descriptions of the programs and services proposed in each of the models. At the end of March 2018, the Task Force achieved a significant milestone by coming to consensus on the details of the programs and services proposed in each of the models. To meet Ministry direction to explore and demonstrate the potential shift of appropriate services from hospital to the community, the Task Force also identified services that are currently provided in the hospital that could potentially be community-based in the future. This would only be possible if said services could be more effectively and fiscally efficiently delivered in another setting and the greater health care system integration supported this transition.

Two Acute Sites Model

Over the course of two workshops in January and February 2018, the interdisciplinary planning team participants worked to create consensus on the programs and service delivery distribution in the Two Acute Sites model.

The Two Acute Sites model proposes to maintain core acute care services in two sites. These core services include inpatient beds, emergency departments, general surgery, obstetrics and intensive care. These would be supported by other core diagnostic services and allied health and support services in both sites. Specialty surgeries and programs such as Chemotherapy and Complex Continuing Care that

are currently single sited are proposed to continue to be in one site only. The future model also proposes to add a Stroke Rehabilitation Unit and MRI capabilities at one site.

Inpatient Site / Outpatient Site Model

Through a workshop in November 2017, the interdisciplinary planning team participants worked to create consensus on the programs and service delivery distribution for the Inpatient Site / Outpatient Site model.

The Inpatient Site / Outpatient Site model proposes to include emergency departments at two sites and to separate outpatient and inpatient services between two sites. The Inpatient Site would include all hospital beds, surgical services, obstetrics, and intensive care, and would be supported by other core diagnostic services and allied health and support services in both sites. The Inpatient Site also proposes the addition of a Stroke Rehabilitation Unit and MRI capabilities. The Outpatient Site would include services that do not require an overnight stay in hospital such as endoscopies, x-rays and other diagnostic imaging, and services like chemotherapy.

One Site Model

Early in its work and having heard community feedback, the Task Force supported a position that given the significant work completed in 2015 on the One Site model, it was generally well understood. As a result, the workshops and analysis focused attention on fleshing out the two two-site models.

The One Site model proposes to provide all programs and services on a single site, including the addition of a Stroke Rehabilitation Unit and MRI capabilities.

Programs and Services That Could be Appropriate to Shift to Community

Contingent on proper system design, appropriate economic analysis and careful transition planning, MAHC proposes in the future that the following services could be safely provided in the community in line with Ministry direction to demonstrate a shift of appropriate services from hospital to community:

- Cytology
- Diabetes Education
- Dialysis
- Microbiology
- Outpatient Dietitian
- Pacemaker Clinic
- Paediatric Clinic
- Prenatal Care
- Seniors Assessment and Support Outreach Team

Descriptions of the finalized proposed models were shared broadly and published on the MAHC website. A “Models on a Page” document – (Appendix J) was developed to describe the programs and services proposed in each of three models at a glance, and in greater detail.

Supporting Documentation & Findings

The Task Force was responsible for evaluating the potential models and sought data to drive the decision-making and to ensure objectivity. In order to better understand different components of the evaluation, the Task Force collected and/or commissioned various data, reports and studies/analyses to help inform and support the evaluation exercise, which resulted in nearly 500 pages of information to

consider. Some reports will be used to support the Ministry-required documents of Part A, while the Task Force deemed others important to a broader evaluation of the models, such as land use/community planning analysis and economic impact. The following is a list of some of these reports and the key findings of each are described, respectively.

1. Bed/Activity Projections by Model
2. Space Projections by Model
3. Preliminary Capital Cost Estimate by Model
4. Operating Cost Forecast by Model
5. Human Resources Impact Report
6. Travel Times Analysis
7. Siting Report
8. Land Use & Community Planning Analysis
9. Economic Impact Study

Bed/Activity Projections by Model

Previous years of utilization data from MAHC was validated through data validation workshops and together with Ministry of Finance projections formed the basis of future bed requirements and activity projections based on a 2031/32 planning horizon. The projections considered the demographics of future hospital users, population growth regionally and provincially, and disease prevalence data was analyzed to indicate which programs will have the fastest demand increases based on the potential implications of the projected population changes.

Figure 2

Beds – 2031/32 Revised

	Current	Future
Program / Service, All beds	**96**	**157**
Medicine / Surgical	67	104
Critical Care	9	12
Stroke Rehabilitation		14
Obstetrics / LDR Suite / PP	4	3
Complex Continuing Care	16	24

Resource Planning Group prepared bed/activity projections (*see Figure 2*) that estimates the need for a total of 157 beds by the year 2031/32, factoring in anticipated occupancy growth and the addition of a Stroke Rehabilitation Unit. Currently, MAHC has 96 beds across both sites.

Figure 3

Select Workload Measures – 2031/32

	Current	Future
Emergency Visits	44,187	49,896
Surgery / Endoscopy Cases	8,314	10,644
Ambulatory Visits	25,380	28,328
Diagnostic Exams	81,201	107,015
Laboratory Procedures	1,989,066	2,949,735

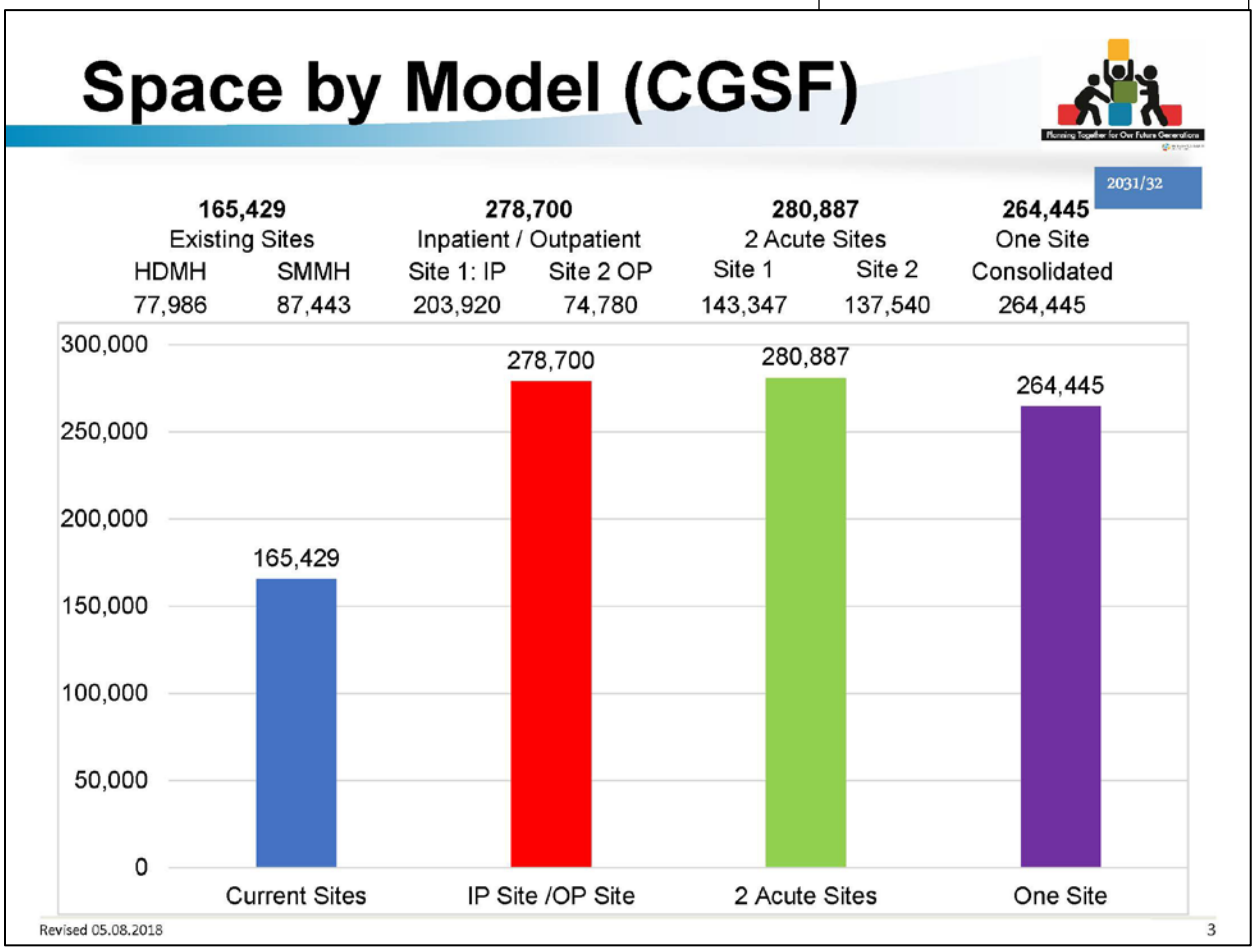
The analysis also projected the future workload activity associated with programs and services reflecting the additional beds, and those proposed to be shifted to the community. The projections assumed emergency department visits would grow by 13%, surgeries and scopes to increase by 28%, diagnostic exams to increase by 32% (including a proposed MRI capabilities), ambulatory visits to go up about 12% (*see Figure 3*).

Space Projections by Model

As an outcome of the bed/activity projections by model, Stantec prepared space projections by model to illustrate the space that would be required to manage the projected activity and the space associated with programs and services proposed to be shifted to the community. Net square feet (NSF), component gross square feet (CGSF) and building gross square feet (BGSF) were estimated for the three models. The space projections reflect impacts and changes in space over time, such as infection prevention and control standards, standards for pharmaceutical production, accessibility under the building code, bariatric access, privacy and confidentiality, new smart technology, controlled circulation to provide separation of clean and soiled flows, etc.

Based on the activity each model would accommodate, the space projections (*see Figure 4*) suggest that in the year 2031/32 an Inpatient Site / Outpatient Site model would require 278,700 CGSF across two sites; the Two Acute Sites model would require 280,887 CGSF across two sites; and the One Site model would require 264,445 CGSF.

Figure 4



Preliminary Capital Cost Estimate by Model

Based on the space requirements identified above, a preliminary capital cost estimate range of the three models was obtained from Hanscomb Ltd. Although detailed costing is a required component of the Part B work, the Task Force wanted to understand a directional sense of the magnitude of cost and whether or not there would be a significant difference between each of the models from a capital cost standpoint to support their evaluation of the three models. Regardless of the model selected, the project will cost hundreds of millions of dollars over time. The Ministry funds approximately 90% of the building's capital cost, while the community is required to fund the remaining 10% through a "local share" as well as the costs of things like parking lots, furnishings and equipment, which can cost as much or more as the local share. In order to provide the Task Force with opportunities to weigh the affordability of the local share component for each model, the preliminary capital cost estimates followed an assumption that the local share percentage would be 25 to 30%. The estimated costs are based on a new build approach so they could be equally considered for evaluation purposes, and do not include potential costs associated with land acquisition and servicing. The cost estimates provided include five years of escalation and an allowance for design scope contingency, site development (not purchase), site work, fittings, furnishings and equipment, and project ancillaries.

The estimates (*see Figure 5*) indicated the Inpatient Site / Outpatient Site model was estimated to cost between $465 and $520 million with an associated 25-30% local share estimated ranging between $115 and $155 million; the Two Acute Sites model was estimated to cost between $470 and $530 million with an associated 25-30% estimated local share ranging between $120 million and $160 million; and the One Site model was estimated to cost between $425 and $480 million with an associated 25-30% estimated local share ranging between $105 to $145 million.

The key findings identify that the capital building costs and the local share of the capital cost are not a differentiating factor between models at this time for evaluation purposes. The estimates of the three models at this time are within approximately 10% of each other.

Figure 5

Model	Expected cost range	Local share percentage	Expected local share range
One Site	$425M - $480M	25% - 30%	$105M - $145M
2 Acute Sites	$470M - $530M	25% - 30%	$120M - $160M
Inpatient / Outpatient	$465M - $520M	25% - 30%	$115M - $155M

The Task Force will study capital costs in greater detail in their Part B work where redevelopment options (i.e.: renovation, phased approach, etc.) are further explored for the preferred model.

Operating Cost Forecast by Model

A high-level operational cost forecast summary (*see Figure 6*) was prepared by Preyra Solutions Group to provide an order of magnitude of the potential operating costs of each model to support Task Force members in their evaluation of the three models. The cost summary estimated the potential operating costs for the year 2031/32 based on the programs and services to be delivered in each model. The cost summary is not an operating budget, but rather is directional for the purposes of comparison and evaluation.

The cost summary considered the potential operating costs in three categories: Patient Care, Diagnostics, and Support Services. The forecast assumes that operating expenses increase in proportion to projected activity growth. The potential operating costs of the three models are based on more beds (96 today versus 157 potentially in 2031/32) and the anticipated staffing costs to support the additional beds, the programs and services to be provided and added services (stroke rehabilitation program and MRI) and the anticipated costs for staff operations of those programs and services, and higher volumes of patients being served in the future.

The cost summary indicated there is an approximate $8 million annual difference in the projected cost of operating the Two Acute Sites model versus the projected cost of operating the One Site model in 2031/32. In other words, it will cost $8 million more to operate the Two Acute Sites model as configured in the workshops than to operate the One Site model with the Inpatient Site / Outpatient Site model falling in between that range. The forecast summary identified there are few economy of scale efficiencies expected in the Two Acute Sites model. The One Site model and, in some cases, the Inpatient Site / Outpatient Site model include expectations for economy of scale efficiencies as a result of service consolidation to one site.

The summary also indicated that over the next 15 years, the difference in operating the Two Acute Sites model is forecasted to increase by about 40%, again relative to more beds, future programs and services, and increased volumes and activity.

The forecast is based on the province's current funding formula for hospitals. It is recognized that these numbers have the potential to change, but was the only current information of how MAHC's funding is allocated. The Task Force understood the operating cost forecast was really meant to be directional to help demonstrate whether or not there would be a significant difference between each of the models from an operating cost standpoint.

Figure 6

2031-32 Operational Budget Forecast Summary

	Current 2016/17	2031/32 2 Acute Sites Model	2031/32 One Site Model	2031/32 IP OP Model
Patient Care Nursing, Emergency, Ambulatory Services, Surgery	$32.4M	$43.9M	$41.0M	$42.0M
Diagnostics Diagnostic Imaging Services, Clinical Laboratory Services, Allied Health Services, Cardiorespiratory Services, Pharmacy Services	$13.8M	$21.0M	$21.0M	$21.0M
Support Services Administration, Housekeeping, Information Technology, Plant Maintenance, Security, Environmental services, Registration, Food Services, Nursing Admin, DI Admin	$20.6M	$28.6M	$23.4M	$27.1M
Total	**$66.8M**	**$93.4M**	**$85.3M**	**$90.1M**

** See next slide for complete list of Support Services*

- The 2031/32 operational budget forecasts range from $85.3M under the one-site model to $93.4M under the 2 Acute Sites model
- All forecasts assume that expenses increase in proportion to projected activity growth. Inflation was not considered.
- The One-Site model and the Inpatient/Outpatient model include expectations for economy of scale efficiencies associated with single siting some services

6

Human Resources Impact Report

The capital planning process will have a significant impact on MAHC's human resources and each of the three models will present benefits and challenges. To determine the impact of each model, the Human Resources Impact Report contemplated a variety of factors including:

- Ability to maintain employment closer to home
- Change management requirements
- Efficiency
- Ability to recruit and retain staff
- Leadership presence
- Job satisfaction
- Demand for health human resources
- Operational flexibility
- Organization sub cultures

In addition to these criteria, consideration must also be given to the changing nature of the workforce in Ontario. Analysis of annual turnover, retirement rates and employee exit data are key to our understanding of the makeup of our workforce in the future.

Annual Turnover & Recruitment

The MAHC annual employee turnover rate of approximately 6.5% is lower than the provincial average for Ontario hospitals at 8.4% (*Ontario Hospital Association Benchmark Data 2017*). Despite MAHC's better-than-average turnover rate, recruitment continues to be a challenge for MAHC in part due to the temporary vacancies created by employee absence for situations such as pregnancy, parental or sick leave. Recruiting to fill these temporary vacancies is a significant challenge in Muskoka and East Parry Sound.

Retirement Rates

While the trend at MAHC has generally been for staff to retire at 60 years of age, 44% of MAHC staff will be eligible for retirement at age 55 within the next five years. Approximately 12% of current staff could imminently retire at age 60. Due to the significant number of retirements within the next five to 10 years, MAHC will need to focus significant training in the specialty areas where we are vulnerable including: Nursing, Dialysis, Oncology, Surgery, Obstetrics and Critical Care.

Exit Data

Among the reasons people leave employment with MAHC, home/family commitments and commuting times are the most common cited. Employees who work at both sites and those who live outside the catchment area of MAHC are most likely to cite commuting time as their biggest issue. Spousal employment is also a significant obstacle in recruiting families to Muskoka and is often why staff leave. Aside from the top two issues cited, another common issue in recruiting staff continues to be a lack of affordable housing options in Muskoka.

With all these considerations, we know that maintaining a supply of skilled labour to work at MAHC will be a challenge and it will be important to conduct human resources planning that will adequately address the challenges and benefits of whichever model is selected and to prepare for the changing nature of the workforce.

Travel Times Analysis

While there are no standards that the Ministry has established, the Task Force reviewed the *Rural and Northern Health Care Framework/Plan* report published by the Ministry.

In 2010. Contained within that report are some planning standards and decision guides that were intended as 'visionary' guidelines for health system planning by the Ministry and the LHINs. The report stated that 90% of residents in a community or local hub will receive emergency services within 30 minutes travel time from their place of residence, and that 90% of residents in a community or local hub will receive basic inpatient hospital services within 60 minutes travel time from their place of residence. The report notes that these standards are not meant to be 'rules' to indicate minimum or maximum access guarantees, or to provide decision on whether to build or close hospitals or inpatient beds. Further, it recognized that these standards might not be feasible for some populations.

Travel times studies were completed by Preyra Solutions Group to analyze and understand each of the different models' impact on the system's ability to provide access to care with reasonable travel times. For the purposes of MAHC's travel times study, the analysis was based on the two travel time frames of 30 minutes and 60 minutes, with an additional 45-minute time frame considered to further understand potential impact. Previous travel time analyses were revisited and augmented with additional studies. The analysis examined the catchment area of Muskoka and East Parry Sound. Muskoka was defined by the boundaries of the District of Muskoka, while East Parry Sound was divided into two subsets based on proximity to acute care facilities. "East Parry Sound 1" included Perry, Burk's Falls, McMurrich/Monteith, Kearney, Armour and Ryerson, and identified MAHC's Huntsville site as their closest acute care facility; "East Parry Sound 2" included Sundridge, Joly, Strong, Magnetawan, South River and Machar and identified another acute care centre (either North Bay or West Parry Sound hospitals) was closer to them than MAHC's Huntsville site. The results demonstrated that based on the current MAHC site locations:

- 76% of Muskoka residents could access one of the sites within 30 minutes
- 93% of Muskoka residents could access one of the sites within 45 minutes
- 100% of Muskoka residents could access one of the sites within 60 minutes
- 26% of East Parry Sound 1 residents could access one of the sites within 30 minutes
- 80% of East Parry Sound 1 residents could access one of the sites within 45 minutes
- 88% of East Parry Sound 1 residents could access one of the sites within in 60 minutes

These travel time frames of 30, 45 and 60 minutes were also examined and calculated for different planning scenarios and points along the Highway 11 corridor (*see Figure 7*).

Figure 7

psg

Access to Hospital Services under Different Planning Scenarios

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

Single siting scenarios	60 minutes			45 minutes			30 minutes		
	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%

The Task Force also looked at average travel times across the province and found that Muskoka residents currently have among Ontario's longest average travel times to acute care at 22 minutes. As shown in the table below (*see Figure 8*), the study indicates that the average travel times associated with a One Site model are more negatively impacted for the catchment area if it was not centrally located between Bracebridge and Huntsville, and is single sited in only one of the urban centres. For example: within Muskoka, only 40-50% of residents would be able to access acute care in 30 minutes, and the average travel time would increase to 31 minutes, placing MAHC as the second longest average travel time in Ontario.

Figure 8

psg

Accessibility:
Driving time implications of siting scenarios

Average Driving Times Under Alternative Siting Scenarios

Travel times for MAHC's patients living in Muskoka sub-region and EPS1	*Siting Scenario*	*Average*	*90th percentile*
Admitted medical and surgical patients	Existing configuration	22	42
	SMMH single site	31	54
	HDMH single site	31	49
	Hwy 11 & Hwy 117	26	47
	Hwy 11 & Hwy 141	26	42

	Siting Scenario	*Average*	*90th percentile*
Emergency department visits	Existing configuration	22	42
	SMMH single site	31	54
	HDMH single site	31	49
	Hwy 11 & Hwy 117	26	47
	Hwy 11 & Hwy 141	26	42

1. MAHC's patients travelled an average of 22 minutes for inpatient and ED care
2. Single siting at either existing MAHC site would increase travel times to 31 minutes
3. Single siting at a new location on Highway 11 would increase current travel times, but by less than single siting on an existing site

How do travel times in Muskoka compare to elsewhere in Ontario?

Sources: DAD and NACRS 2014/15 to 2016/17; Travel times from MapPoint 2013 using centroid of each 2006 Dissemination Area to each site

Siting Report

A Siting Report was developed by Stantec to describe various options for building and/or renovating facilities based on each of the three proposed models to inform the evaluation of the potential models of care. Focused on the architectural and engineering issues related to siting options, the report demonstrated there are multiple approaches to redevelopment that would be further explored and considered in Part B, including the potential for a phased approach, once the model of care is selected. The analysis related to land use and community planning, operating costs, capital costs, clinical impact and social impact were not included in this report.

Two siting options are recommended in Bracebridge: reuse of the existing site for a small to medium size hospital, or a greenfield (new) site ideally close to Highway 11. In Huntsville, only the existing site is recommended for consideration. The report also recommended that any site outside the boundaries of the urban core of the Towns of Bracebridge or Huntsville not be considered

A preliminary summary of the siting options were further provided for each service delivery model:

Model of Care (Service Delivery Model)	**Siting Options**
One Site model	• Huntsville – renovation and addition to the existing hospital on the existing HDMH* site; or • Huntsville – replacement hospital adjacent to the exiting hospital on the existing HDMH site; or • Bracebridge – new hospital on a greenfield site within the Town of Bracebridge
Two Acute Sites model	HDMH site • Huntsville – renovation and addition to the existing hospital on the existing HDMH site; or • Huntsville – replacement hospital adjacent to the exiting hospital on the existing HDMH site SMMH site • Bracebridge – renovation and addition to the existing hospital on the existing SMMH site; or • Bracebridge – new hospital on a greenfield site within the Town of Bracebridge
Inpatient Site / Outpatient Site model	Outpatient Site • Huntsville – renovation and addition to the existing hospital on the existing HDMH site; or • Bracebridge – renovation and addition to the existing hospital on the existing SMMH site Inpatient Site • Huntsville – renovation and addition to the existing hospital on the existing HDMH site; or • Huntsville – replacement hospital adjacent to the exiting hospital on the existing HDMH site; or • Bracebridge – renovation and addition to the existing hospital on the existing SMMH site; or • Bracebridge – new hospital on a greenfield site within the Town of Bracebridge

HDMH = Huntsville District Memorial Hospital; SMMH = South Muskoka Memorial Hospital

Once the recommended service delivery model is established, a comprehensive study and evaluation of the various siting options will be undertaken. Evaluation and selection of the facility development model is work done in Part B and is subject to a detailed study of patient and staff quality of space, engineering details, building configuration, phasing and construction costs.

Land Use & Community Planning Analysis

Although siting work is not required until subsequent stages of the planning process, land use and community planning was deemed an important consideration in Stage 1 and an essential component of the evaluation of the three models. A Land Use and Community Planning analysis was prepared by Urban Strategies Inc. to study the viability of potential general locations for hospitals in the District of Muskoka based on the requirements of a future site (a level site of 30-40 acres, close to Highway 11, allows for flight path etc.). The analysis considered related planning frameworks, such as the Provincial Planning Act and Provincial Planning Statement, as well as the District of Muskoka Official Plan and the Huntsville and Bracebridge Official Plans and Zoning Bylaws, required approvals and potential risks. The report reflects municipal feedback from the District of Muskoka, and the Towns of Bracebridge and Huntsville, which all concurred with the report's findings and recommendations: that urban centres are the best location for large-scale public facilities because they:

- provide for opportunities for complementary uses,
- make use of existing and planned infrastructure, services and amenities,
- allow proximity to concentrations of population and employment
- minimize the need to expand infrastructure and services to rural areas, and reflects an efficient and sustainable land pattern, in accordance with provincial and municipal policy objectives.

The report indicates that locations outside of the limits of the urban centres in rural and waterfront areas, such as Port Sydney, are not recommended. The following site locations provide appropriate locations for large-scale hospitals within the District of Muskoka:

- Existing HDMH Site, Huntsville Urban Centre – Large site within the Huntsville Urban Centre with opportunity for phased redevelopment. Location provides both regional highway and local transportation connectivity, and complementary adjacent land uses; and/or

- Potential Locations at Highway 11 and Taylor Road, Bracebridge Urban Centre – Large sites within the Bracebridge Urban Centre with opportunity for phased redevelopment. Locations provide both regional highway and local transportation connectivity, and complementary adjacent land uses including nearby public facilities and community services and amenities.

From a planning and development perspective, the existing SMMH Site in Bracebridge does not represent an optimal location for a large-scale hospital facility due to its small size and location within a predominantly residential area that does not offer space for complementary land uses. The location does not offer direct regional highway transportation access, which has been identified as a priority feature.

A Site Analysis Summary was provided in the report (*see Figure 9*).

Figure 9

3. Recommendations and Conclusions

Site Analysis Summary - The following table summarizes the site analysis, associated planning risks and recommendations from a land use and community planning perspective:

Site Analysis Summary Table

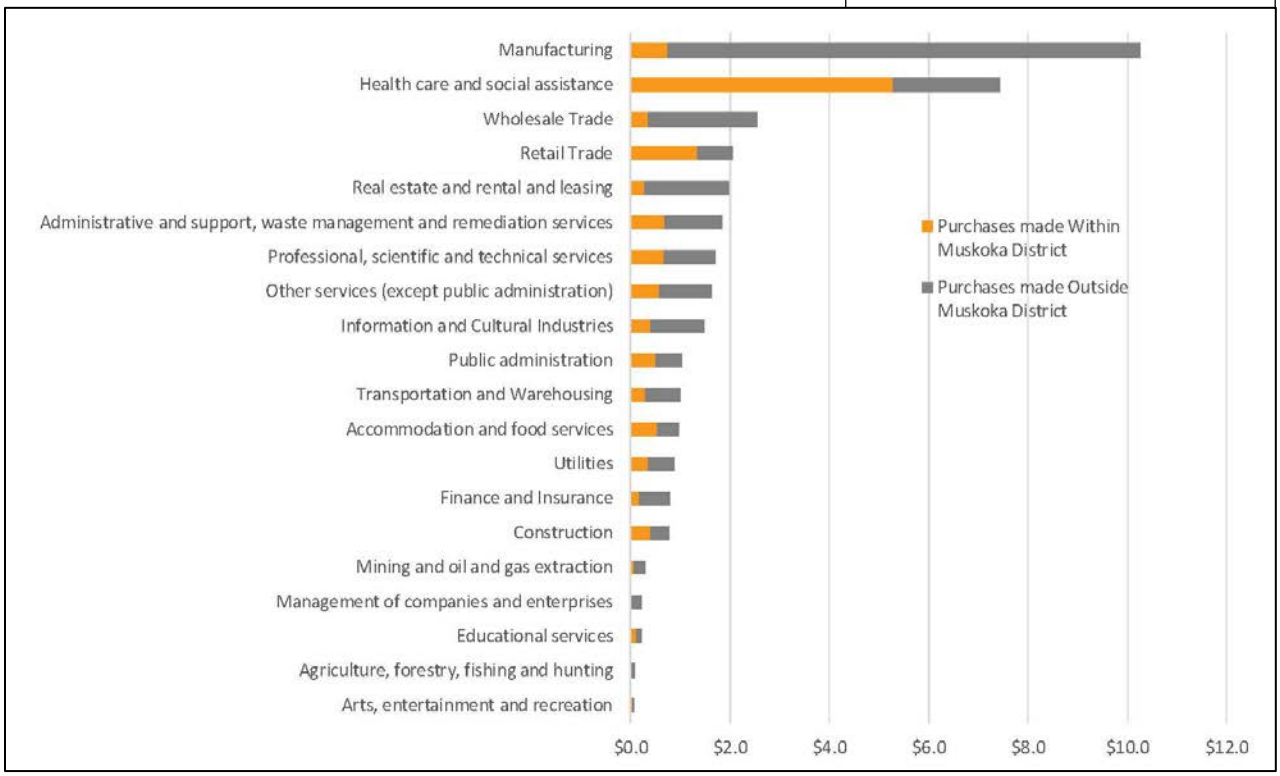
Site	District Official Plan Land Use Designation	Approvals Risk	Planning Analysis Recommendation / Summary
Existing HDMH Site	Huntsville Urban Centre	**Very Low** Amendment to the District (Draft) Official Plan and Huntsville Official Plan would not be required to develop the lands with hospital uses.	The site is appropriate for a large-scale hospital facility.
Existing SMMH Site	Bracebridge Urban Centre	**Low/Moderate,** depending on the scale and nature of development. Amendments to the District Official Plan and Bracebridge Official Plans would not be required to permit a hospital use in this location.	The site is not an appropriate location for a large-scale hospital facility due to size and adjacent residential land uses, and lack of proximity to the regional highway network.
Potential Location – Highway 11 & Taylor Road	Bracebridge Urban Centre* **assuming locations within the Urban Centre boundary*	**Very Low/Low,** assuming the site location is within the Urban Centre boundary. Amendments to the District Official Plan and Bracebridge Official Plans would not be required to permit a hospital use in this location, if the location/proposed use meets the policies of the Official Plan.	The general location is appropriate for a large-scale hospital facility.
Potential Location – Highway 11 & Kirk Line Road	Rural Area / to the north of Bracebridge Urban Centre	**High** Amendments to the District Official Plan and Bracebridge Official Plan would be required.	Locations that are not contiguous nor immediately proximate to the Urban Centre boundary are not appropriate locations for a large-scale hospital facility. Locations that are contiguous to the Urban Centre boundary may be appropriate, if there is a strong health care planning rationale, and but should be discussed further with the District, and would require further study.
Potential Location – Highway 11 & High Falls Road	Rural Area/Waterfront Area, depending on exact site location, to the north of Bracebridge Urban Centre.	**Extremely High** Amendments to the District Official Plan and Bracebridge Official Plan would be required.	Locations that are in the Rural Area, that are not proximate to Urban Centre, and on or in proximity to Waterfront Area are not appropriate locations for a large-scale hospital facility.
Potential Location – Highway 11 & 141	Community Area / Rural Area, depending on exact site location	**Extremely High** Amendments to the District Official Plan and Huntsville Official Plan would be required.	Locations that are in the Rural Area/Community Area are not appropriate locations for a large-scale hospital facility.

Economic Impact Analysis

Economic vitality of communities was also deemed an important consideration in Stage 1 and an essential component of the evaluation of the three models. An independent, third-party assessment of the potential impacts of the three models on the two municipalities from an economic development perspective was prepared by Urban Metrics Inc. The scope of work and objectives of the study were established through a focus group involving municipal Economic Development Officers from Muskoka and East Parry Sound, and representatives of Muskoka Futures. Economic impact estimates were based on statistical and financial data accessed through the Ontario Ministry of Agriculture, Farming and Rural Affairs ANALYST Tool, potential impact on business site selection evaluation, review of case studies and academic research and community resiliency. The consultants considered six different methods and approaches to the analysis. The lack of accessible historical economic development statistical data in Muskoka and East Parry Sound made the study challenging and more anecdotal. The report reflects municipal feedback from the District of Muskoka, and the Towns of Bracebridge and Huntsville.

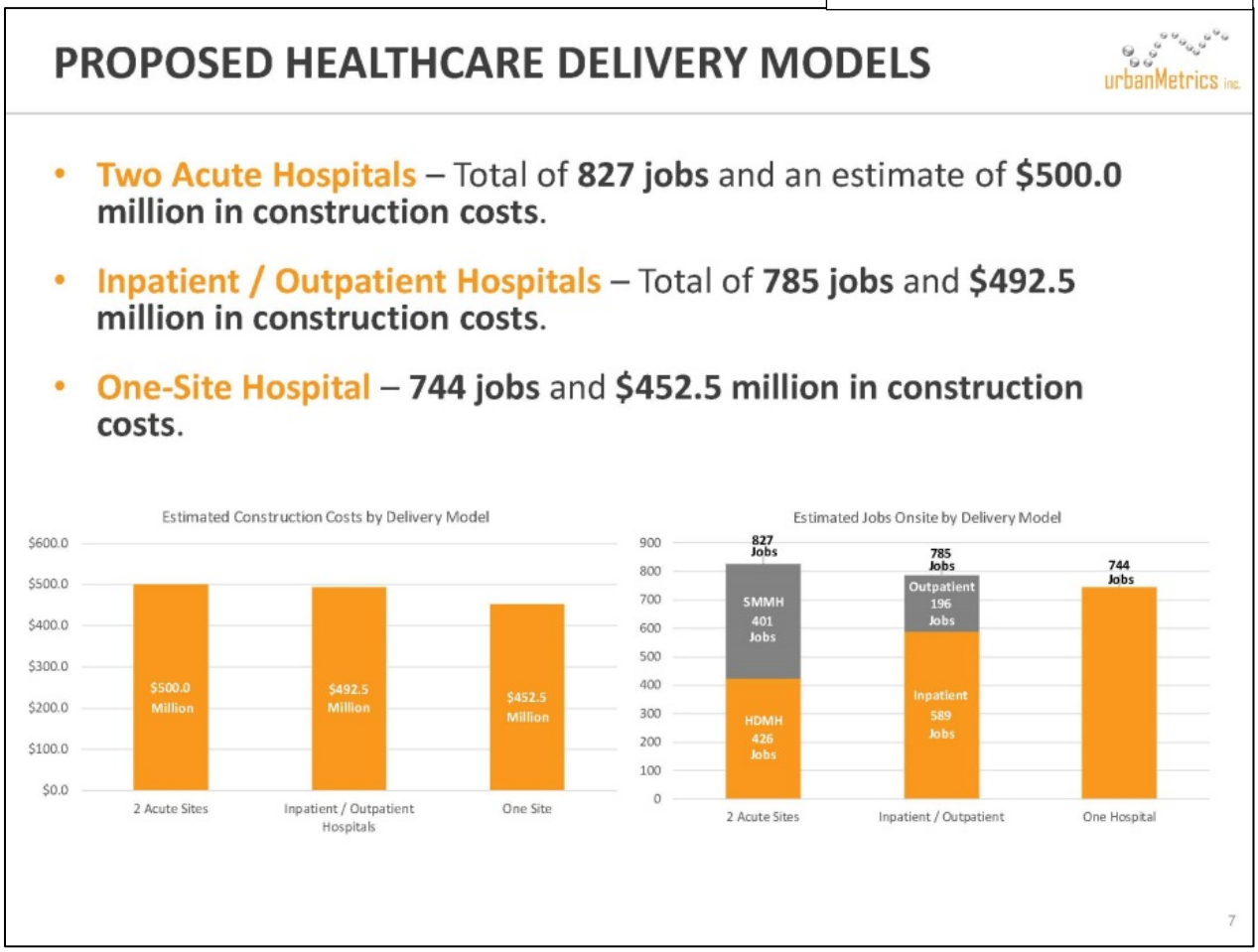
The analysis found that about 34% of hospital industry purchases in Muskoka are made within the region, while the majority of hospital industry purchases take place outside Muskoka (*see Figure 10*). These represent signficant dollars in the Muskoka region and would not vary significantly between models.

Figure 10



The analysis projected the impact of construction costs and jobs associated with each of the three models (*see Figure 11*). It also indicated that depending on the service delivery model ultimately selected, there could be notable positive and negative employment impacts on the local municipalities, but an overall increase in the number of jobs created in Muskoka in 2031/32 will occur.

Figure 11



The analysis concluded that each of the three delivery models would result in positive economic and employment impacts for the region as a whole, and the most positive results would be garnered from the Two Acute Sites model. The Inpatient Site / Outpatient Site model and the One Site model would create uneven distribution of the workforce to the respective municipalities where these models are assigned. Nonetheless on a region-wide basis, each option also represents a net positive benefit overall.

Analysis of Options

The Task Force was tasked with objectively evaluating the three models in order to recommend a preferred service delivery model to the Board of Directors that would inform Part A of the Stage 1 Proposal. This involved carefully considering the risks and benefits, advantages and disadvantages of each model. Acknowledging that hospital planning for the catchment area is a passionate and emotional topic, the Task Force recognized the need for an objective approach to model evaluation, using broad stakeholder-informed criteria and sub-criteria and data to drive decision-making.

Model Evaluation Criteria

In April 2018, the Task Force confirmed that its evaluation of the models would include equally weighted criteria in five areas: patient- and family-centered care, financial, alignment with health system directions, municipal impact and community support. The criteria were shaped by public input and sub-criteria were defined, as well as the various data, reports and studies to help inform and support the evaluation exercise. The approved evaluation criteria (shown below) was shared broadly and published on the MAHC website.

CRITERIA	SUB-CRITERIA
Patient & Family Centered Care	• Facilitates Clinical Effectiveness and responsiveness • Assists recruitment/retention of staff, physicians, volunteers • Provides access to care with reasonable travel times • Impact on access to services
Financial	• Cost to build • Cost to operate
Alignment	• Aligns with Ministry/NSM LHIN Priorities • Demonstrates shift of programs/services to community
Municipal Impact	• Consistent with Provincial, Municipal and District planning principles • Maintains strong local economies
Community Support	• Fundraising capability required local share • Community Support

Model Evaluation Approach

The Task Force adopted a qualitative and quantitative approach to model evaluation and supported the use of a Model Evaluation Tool – (Appendix K). The Task Force understood that 23 of the 25 members would submit a scoring evaluation, as it was acknowledged that the two members representing the NSM LHIN would not participate in scoring as they had been more advisory to the Task Force process and the NSM LHIN is one of the approval bodies to review the Part A component of the Stage 1 Proposal.

Each of the remaining 23 members of the Task Force submitted their individual evaluations and those were compiled into a summary report. Once tabulated, the results were reviewed by the Task Force and there was roundtable discussion to explore areas of concern with the evaluation and identify areas or issues that the group felt the tool did not capture, and further discussion was needed. Overlaying both of these approaches was an ethical decision-making framework that helped ensure that the concepts of context, values and ethics, and stewardship were broadly considered.

Model Evaluation Scoring

The Task Force completed an exhaustive evaluation of the three models. Each member scored each of the models based on the criteria and sub-criteria. The results of the submissions were collated into the following evaluation summary. Colour coding identified the order in which Task Force members felt the sub-criteria best aligned with each model – green being the highest, red being the lowest, and yellow falling in between the highest and lowest as shown below.

	Option	Two Acute Sites	Inpatient / Outpatient	One Site
	Criteria			
	Patient & Family Centered Care			
1	Facilitates clinical effectiveness and responsiveness			
2	Assists in recruitment and retention of staff, physicians, volunteers			
3	Provides access to care with reasonable travel times			
4	Impact on access to services			
	Financial			
5	Capital cost - Building & Site			
6	Operational cost - Initial & Ongoing			
	Alignment / Approvals			
7	Alignment with MOHLTC / NSM LHIN priorities			
8	Demonstrates shift/movement of programs/services to the community			
	Municipal Impact/Support			
9	Consistent with Municipal & District planning principles			
10	Maintains strong local economies			
	Community Support			
11	Fundraising capability - Redevelopment needs (Local Share)			
12	Community Support			

The Task Force considered both the results of the quantitative scoring analysis along with extensive discussion and debate relative to the qualitative analysis. MAHC's Ethical Decision-Making Framework was also utilized to provide an alternate lens to reassess responses and discussions from an ethical,

values-based perspective and ensure that members had the opportunity to assess their own biases and influences.

Qualitative Discussion

Task Force members discussed the evaluation of the models at length to ensure all aspects of selecting a preferred model had been considered. All models were felt to have advantages and disadvantages. A preferred model recommendation was based on extensive consideration of all factors, including recognition that ultimately acute care is only one component of a larger integrated system and does not stand alone from the broader system. In completing the evaluation exercise, Task Force members agreed that no criteria could stand alone to evaluate the models. Several criteria are inter-related and the relationships between the criteria were influential to the evaluation. While the group did not apply weight to any of the sub-criteria, some were felt to be more highly valued than others were. The Task Force focused the qualitative discussion on criteria of high importance that meet the needs of the community, such as quality and clinical impact, access to care and travel times, community support, and future viability of the model. No criteria were scored more highly than for the Two Acute Sites model, with the exception of operating cost. The Task Force felt justified that other criteria like access, community support, and viability were of greater importance than the operating costs, which could be further mitigated through efficiencies and collaborations to make the model as cost effective as possible. As well, the Task Force acknowledged that some things have a greater likelihood to change in the future, such as funding models and technology and could positively impact future potential operating costs. The Task Force determined it could not be bound by the current funding formula that could change dramatically with time. It was further emphasized that a preferred model would need to be designed to be nimble and flexible to ensure its viability and sustainability. It was acknowledged that no model could proceed without the support of the community – both financial and otherwise, and the overwhelmingly clear community feedback has been in favour of the Two Acute Sites model. Understanding this in the context of the obligation to demonstrate a financial feasibility plan to raise the local share for any future model cannot be understated.

Recommendation & Next Steps

The Stage 1 Service Delivery Model Report has been developed by the Task Force to illustrate the process followed to date, and the volume of work associated with recommending a preferred future service delivery model to the MAHC Board of Directors.

On August 8, 2018, the Task Force made a formal presentation to the Board and submitted a Decision Support Document that outlined the rationale for its recommendation that the Two Acute Site Model be selected as the preferred service delivery model for the future.

Should the Board endorse the recommended preferred service delivery model, the Stage 1 Part A submission will be prepared in conjunction with the consultants to recommend the model to the NSM LHIN together with the programs and services to be delivered.

Moving forward, the Task Force will continue to oversee the Stage 1 planning work and will begin working on the requirements of Part B to examine how the preferred model would be supported by

bricks and mortar (i.e.: new build, renovation or a combination of both, and where the model would be located). Once the Part B study is complete by the Task Force, a preferred infrastructure (building) option will be further recommended to the Board for endorsement.

The Task Force expects to have a completed Stage 1 Proposal (Part A & B) for submission to the NSM LHIN and the Ministry's Health Capital Investment Branch in 2019.

Appendices

Appendix A – Stage 1 Planning Agreement *(posted on the MAHC website)*

Appendix B – Capital Plan Development Task Force Terms of Reference

Appendix C – Capital Plan Development Task Force Membership

Appendix D – Capital Plan Development Task Force Meeting Schedule

Appendix E – Integrated Project Management Framework

Appendix F – Feedback Survey (Opinion) Results Report

Appendix G – Capital Plan Development Task Force Updates

Appendix H – MAHC News Releases

Appendix I – Stage 1 Communication/Engagement Record

Appendix J – Model Evaluation Tool