NSM LHIN – Healthcare Task Force

Presentation Notes: Towns of Huntsville and Bracebridge

Background

The Mayor of Huntsville created a working group in August 2015 to advise him and council regarding proposed changes at MAHC. The group consists of 8 individuals with a range of skills and backgrounds including a medical doctor (Past Chief of Staff, Director at College of Family Physicians), a past Mayor and lawyer, past counsellors, a few with MAHC board experience, and the balance with backgrounds in real estate, health care planning, business, and change management.

The group redefined its mission to "maintain and expand the Huntsville Hospital site as a 'Community Campus of Care' with or without acute care services," recognizing that a pan-Muskoka perspective was required and in the best interests of everybody. The group retained the health care consulting firm Prism to analyze the MAHC pre-capital submission and benchmark other successful and unsuccessful capital proposals in the province. Numerous interviews were conducted with MAHC administration, LHIN board members, philanthropists, industry participants, technology providers, non-government organizations, academics, other consultants, politicians, bureaucrats, and doctors. In September, the group began working closely with Bracebridge to identify solutions that work across Muskoka.

1) The Healthcare Funding Model Does Not Work for Muskoka

MAHC has continued to struggle to address operating deficits over the last 20 years. They have done a fantastic job attempting to address these deficits by consolidating operations and administration wherever possible, and reducing or eliminating services. While the deficit may be eliminated for a few years, invariably it returns. This year, similar to last year, the MAHC board is faced with an operating deficit of between $1-$2 million dollars.

We believe the "one central hospital proposal" fails to address the root cause of the situation - Muskoka does not fit the current provincial funding model which is designed for either large urban centers (over 30,000 people) or rural (less than 10,000). We are neither. We have two small urban areas, separated by a 30 minute drive. There is no center. Moreover we have a large seasonal variation, with our population more than doubling during the summer months, which exacerbates the situation.

Administration and physicians have cited numerous examples where the funding formula or the current LHIN boundaries get in the way of doing the right thing to improve patient care or reduce overall healthcare costs in Muskoka. We have heard about the challenges of high alternative level of care populations (23% at MAHC versus the 9% provincial benchmark), over 50% of emergency visits that are CTAS

level 4 and 5, and the challenges of providing integrated care between the hospital, long term care, primary care and home health care providers, especially when the home health care organization is part of a different LHIN and care strategy. The growth of the Nurse Practitioner practice, while cost effective and positive, is lowering emergency room visits which in turn lowers revenues and increases the deficits at MAHC. The funding formula and current LHIN boundaries do not work in Muskoka.

In February, the Mayors of Bracebridge and Huntsville met with the Minister of Health. He acknowledged in that conversation that the current funding formula penalizes Muskoka and 5 other hospital organizations in Ontario.

Conclusion: Muskoka needs modification to the funding formula, and LHIN boundaries in the north need to include communities in East Parry Sound that predominantly use our health care system.

Recommendation: MAHC, NSM LHIN, the municipalities and other health care providers need to work together to get the Ministry to modify the funding model so that it works for Muskoka and the 5 other similar areas in Ontario, one that systematically rewards excellence in patient care and cost control. Concurrently the LHIN boundaries in the north should be modified slightly so that NSM LHIN includes East Parry Sound communities that predominantly use Muskoka health care physicians and acute care so that patient care can be improved.

2) The Pre-Capital Submission Is Too Expensive and Unlikely To Be Approved

The revised MAHC pre-capital submission proposes a central hospital for a total of $349 Million excluding district and municipal costs to provide services (sewer, water, transportation etc.). We asked our consultants and many others, "is this likely to be approved if supported publicly?"

The answer was consistently "No".

All pointed to the huge deficit situation facing the Province. Health care costs are almost 50% of the Province's budget and still rising quickly. The only large capital projects being approved are the ones focused on areas with the largest population growth and typically in the large urban centers such as Vaughan, Toronto, Milton, Scarborough and Windsor, and often funded via the Infrastructure Ontario program.

The community share in the current proposal would be in the $85 Million range and the District would incur significant additional servicing costs in the $15 to $40 Million range. Those are very large dollar amounts for a community our size.

We had our consultants benchmark other hospital capital projects in similar communities. We found a few examples of projects for new builds that were rejected or worse, sat in the queue for up to 6 years with no official feedback. Those

that have been approved, or have received favorable feedback tended to be much smaller from both an aggregate amount and on a per bed basis.

For example, the Georgetown Hospital (built 1961, 32k ED visits, 33 acute + 20 CCC beds) addressed its priority capital redevelopment projects in small discrete packages with the last two phases focused on a new emergency department and a renovated centralized diagnostic imaging department. These capital projects were funded through a variety of sources, including the Town of Halton Hills and the MOHLTC.

Another example is South Bruce Grey Health Centre and their plans to redevelop the Kincardine Hospital (currently 45k visits, 85 acute care beds). The first plan was for a new hospital in the $80 to $100 million range. Despite receiving MOHLTC approval to build a new hospital in August 2011, the province scrapped the plans following the provincial election. A subsequent plan for a much smaller capital expansion/renovation project costing $35 million was also rejected by the province. More recently, South Bruce Grey Health Centre has been working with the Southwest LHIN on a plan that is retrofit based and designed to remedy the priority infrastructure needs in 2 to 3 staged projects of under $10 million each.

Stevenson Memorial (built 1964, currently 33k ED visits, 32 acute beds, 55,000 catchment growing to 90,000) in Alliston is another case in point. Originally a new build was proposed back in 2008. After no official response, the board has resubmitted a second proposal with a significantly lower price tag of $136M that uses a combination of renovations and new build with a significantly lower price tag. They are currently awaiting Stage 1 approval.

Lastly, in June of 2015, the province announced a new hospital to replace the old Groves Memorial Hospital in Fergus. It will be an Infrastructure Ontario project using a Design-Build-Finance approach. Currently the Groves Memorial has 44 acute beds and serves a population of just over 34,500. The new hospital is to be built in Aboyne Ontario which is located 1 kilometre away from Fergus and Elora. Although Infrastructure Ontario financials are not public in the planning stage, we estimate the total cost at $59.2 million or approximately $1.3 M per bed versus $2.5 M in the current pre capital submission.

Conclusion: The Ministry is unlikely to approve the current submission and will direct that the redevelopment has a much lower price tag.

Recommendation: MAHC and NSM LHIN need to revisit the Pre-Capital Submission and find solutions that lower the cost significantly so that we have a much higher probability of gaining approval.

3) The Redevelopment of Existing Hospital Sites Must be Included in the Plan

Successful projects in other small communities had a few common characteristics – a Campus of Care approach, and "renovation" versus "new build" wherever possible. In most cases the projects have proposed a "Campus of Care" with multiple health care providers co-located on one contiguous site. Many include long term care, ambulatory care, counseling, chronic care, community health, and primary care on one site. The advantages of this approach are many – improved access to care, opportunities to share costs and health care professionals, lower travel costs, and better urban planning as we heard earlier.

The other consistent approach in smaller communities is the redevelopment or renovation of existing hospitals to house both acute care and other health care related uses. To achieve the lowest possible costs, these projects are using a "wrap around" approach, building new facilities around the current hospital, but without attaching the facilities, so that current operations are not disrupted, and air systems are not integrated leading to infectious disease issues. For the portion of new build, the costs are similar to the MAHC proposal. However renovated space costs, especially for lower levels of care are in the neighborhood of $400-$500 per BGSF as sections of the renovation can be isolated from the operating hospital and renovated at much lower costs when planned appropriately.

We believe Muskoka has a significant advantage in implementing a "wrap around" approach as staging the development without significant disruption of services is possible given the current existence of two active acute care sites.

We noted that in the pre-cap submission the second lowest cost option (Option 3) was only a 2% higher cost than the "One Central Hospital" yet somehow failed to make the summary or the revised pre-capital submission. Option 3 called for renovating the Bracebridge site into an ambulatory care site, and building a new acute care site in Huntsville. MAHC consultants used a total blended new/renovation cost of $1,113 per BGSF on option 3 (versus $1,155 for an all new "one central hospital" cost per BGSF). They did not assume a "wrap-around" approach. Nor did this option substantially renovate the existing Huntsville Hospital which would help drive the costs much lower.

We suggest that there are significant project cost reduction opportunities by revisiting the redevelopment of both the Bracebridge and Huntsville sites, and adopting a Campus of Care approach at both. Our preliminary estimates indicate that project costs could be reduced between $75-$125 M by changing the build strategy from that proposed by the previous consultants, and by reducing the

facilities required as other elements of recommendations are adopted that reduce the demand on the acute care system[1].

The current proposal highlighted concerns over the topography and size of the existing sites. Our preliminary discussions with construction experts have indicated that costs for leveling sites will be minimal and there is more than adequate space already not only for the acute care portions but multiple other health care providers. As a start, we recommend that Fairvern Nursing Home be located on the current Huntsville Hospital site.

The benefits of this approach are many: community support will be easier to obtain, as re-development of both sites will likely occur, even if a one-site acute care model is adopted; community financial share will be lower creating less demand on the foundations; municipal costs will be lower as existing services are fully leveraged; a phased approach becomes possible, as renovations and new builds can be done in smaller projects; Ministry approval is more likely; and operating deficits could be addressed sooner rather than later.

Conclusion: Significant patient care improvements and capital cost reductions are available by adopting a "Campus of Care" approach, and utilizing creative renovation strategies at both the Bracebridge and Huntsville sites.

Recommendation: MAHC and NSM LHIN need to revisit the Pre-Capital Submission and their recommendations utilizing lower cost renovation strategies and a Campus of Care approach in both communities.[2]

4) Muskoka has an Opportunity to Work Together across Organizational Boundaries to Make Healthcare More Sustainable and Community Focused

We want to revisit some of the work done through the Health Links initiative. This cross organizational initiative highlighted significant challenges to patient access, and the quality of care, specifically getting the right care to the right patient at the right time. Looking at it from a numbers perspective, the District estimated that the total Ministry spend on healthcare in Muskoka is $225 M spread over 70 different providers. Two thirds of this money is spent by physicians and organizations other than MAHC. Communication is poor between these organizations, and as we know with the ALC issue at MAHC, often leads to significantly higher costs, and more importantly lower levels of patient care, with patients getting "trapped" between health care providers.

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[1] It should be noted that we have been unable to perform a thorough review of the Pre-cap cost analysis of the various options as the related conceptual drawings and detailed cost estimates have still not been released. Similarly we have not had access to the Master Plan which is critical to this planning step. We respectively request that this information be released to this task force so that an appropriate peer review for Bracebridge and Huntsville sites can be undertaken.

[2] Note: these solutions should include having acute care at only one of the sites, with Urgent Care only at the other.

We propose that the largest opportunity to improve patient care and reduce overall health care costs in Muskoka will be to look across the continuum of care and find ways to keep people out of the hospitals altogether. Moreover we believe we should be addressing this as a higher priority now since it will address the current funding issues at the hospital. HealthLinks is on the right path here, but needs to be expanded and accelerated.

I want to come back to a comments made by MAHC CEO Natalie Bubela and Dr. Van Iersel of the LHIN in the previous session. Natalie commented that 50% of the emergency room visits were at a CTAS level 4 or 5 and did not need to go to the emergency room. Dr. Van Iersel stated that "we need to get people to stop going to the hospital first, and instead utilize the primary care system". Imagine if both the Bracebridge and Huntsville Hospitals are converted into HealthLink Hubs, complete with primary care in the existing hospitals with perhaps acute or urgent care facilities in the back. Patients may think they are still "going to the hospital" while in fact they are being treated by primary care providers, both doctors and nurse practitioners. These Hubs would be more cost-effective and provide the patient with the right care at the right time. What better way to do this than to redevelop both the Bracebridge and Huntsville sites to be the primary care hubs, with multiple other services available at these same sites.

We believe this approach is 100% supported by the new policies and projects being adopted by this government and our LHIN. Prior to this meeting, our LHIN distributed the Second Curve Planning Principles which emphasized a focus on community need, primary care as the foundation, and integration across the continuum of care. The Price Report (Patient Care Groups) suggested utilizing super HealthLinks organizations that brings disparate health care providers, Family Health Teams and other providers together to provide more integrated care with stronger links to hospitals. The recent announcements regarding the collapse of the CCAC into the LHIN will get rid of one organization boundary. The Premier's Special Advisor on Community Hubs, Karen Pitre, just released a report "Community Hubs in Ontario: A Strategic Framework and Action Plan". The Provincial Government has indicated its full support and is moving forward with implementation. Our model for a Campus of Care aligns very closely with that report. Lastly, Chatham Kent has just piloted a new integrated health hub approach and demonstrated a reduction of 40% in ED visits. They are in the process of rolling this approach out in other LHINs. Preliminary discussions with this group have been positively received.

We only build new facilities every 40 to 60 years. It requires a massive investment of both time and dollars to bring these new facilities into existence. We strongly encourage this group to "get it right the first time" and build/renovate facilities that will help Muskoka lead in the health care changes required for the balance of this century.

We believe that together we have an opportunity to provide better patient care in Muskoka at lower overall costs. We think that the current Provincial financial situation, combined with their stated policy direction provides a window to make substantial changes in the way health care is delivered in Muskoka. It will not run like it does in Toronto. Health care providers with be more flexible and have a broader range of skills allowing them to cover a larger variety of patient needs. It will be much more team based, ensuring that the high cost help is fully utilized. We will leverage technology solutions for remote sensing and diagnostics, integrated health information, and create a more skilled ambulatory team that is an extension of our physicians to provide more services at the home or cottage. We will move our patients through the system seamlessly always providing the best care possible either here or at other specialized facilities in Orillia, Barrie, South Lake or Toronto. When fully implemented, we would fully expect to shrink our per capita usage of acute care facilities in Muskoka.

Conclusion: We need to expand the current cross organizational Healthlinks initiative to propose systematic changes, and a Campus of Care approach, that will enhance the delivery of healthcare services in Muskoka without increasing the costs. We should consider launching the integrated health hub model that has been recently piloted in Chatham Kent with great success.

Recommendation: NSM LHIN needs to advocate to the Ministry that Healthlinks needs to be supported, expanded and its implementation accelerated as part of the "Made in Muskoka" solution. Our solution needs to incorporate a Campus of Care approach wherever possible, be consistent with current government policy, and be developed jointly with physicians to fulfill the Ministry's policy direction.

5) Summarize and Peer Review Requested

In summary, we have 4 recommendations for this task force:

1. The Funding Model does not work. We need to work together to make modifications that do;
2. The current submission is too expensive and should be revised;
3. A major opportunity to lower the cost and improve patient care is by utilizing a Campus of Care approach and maximizing the use of renovated space at existing sites;
4. We will only solve this by bringing the health care providers together consistent with government policy and the Health Links vision.

Lastly, I want to add one request.

The Pre-Capital Submission relies on a number of studies (Hanscomb Report, Stantec Report, Agnew Peckham report, VFA facility condition report, driving time report, etc.) and draws conclusions based on these reports. These reports and all other data related to this decision should be made available for a Peer Review

focused on both Huntsville and Bracebridge sites. An expenditure of $350 Million needs an objective third party review. Due diligence needs to be done. If they have not been completed for the revised pre-capital submission, we will do the review on the first submission only.