'Care Close to Home (V2)'

Submitted to Muskoka Algonquin Healthcare
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Dave Ufflemann, Board Chair

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INTRODUCTION:

'Care Close to Home V2' is based on the knowledge and expertise of physicians and other healthcare providers with many decades of experience in South Muskoka. The proposal reflects that experience and our understanding of the principles driving provincial health policy, quality of care and patient safety.

A central plank of the provincial health policy is making healthcare more convenient for Ontarians by providing **care closer to home**. As physicians with a significant commitment to Muskoka, we have adopted that as our goal.

This paper assesses the *'Made in Muskoka'* capital redevelopment plan proposal by Muskoka Algonquin Healthcare (MAHC) and contrasts that model with an updated version (#2) of our *'Care Close to Home'* model.

REVIEW - 'MADE IN MUSKOKA'

The table below depicts the proposed bed allocation in the *'Made in Muskoka*' model.

MADE IN MUSKOKA MODEL **Total Beds = 157**			
Program Classification		**Huntsville Site**	**Bracebridge Site**
Acute Care	Acute- 0-6 Day Stay	31	31
	Obstetrics	2	1
	ICU	10	4
Longer-Stay Beds	Post-Level 3 ICU Longer-Stay	9	
	7-Days+ Medical Reactivation	18	
	Acute Rehabilitation	14	
	Activation/ALC	37	
Total Beds		**121**	**36**

In our opinion, this model fails the patient, their family and providers for the following reasons:

- By requiring that residents of south Muskoka travel to Huntsville for acute care it fails to respect patients' preference for care close to home.
- Because those patients will be geographically separated from friends, family and other caregivers while in hospital, they are less likely to receive the emotional and instrumental support they need and more likely to experience unnecessary stress and anxiety.
- Since there is no comprehensive public transit system in Muskoka, South Muskoka patients who don't have their own means to travel will find follow up care inaccessible while those in the north will be challenged to access some even routine ambulatory diagnostic services.
- The significant difference in the number of beds proposed for north and south Muskoka creates inequity among communities.
- The number of beds allocated to restorative, rehabilitation, activation and Alternate Level of Care (ALC) is inappropriate and will also negatively impact the ability for South Muskoka to have the number of acute care beds required to serve its local population.
- Few specialists will choose to practice at the south Muskoka site because of its limited number of beds. That will have two undesirable effects:
    - Emergency room physicians will not have access to the specialist support they need

  - Any specialist who does choose to practice at the Bracebridge site will be unable to establish and maintain a healthy work/life balance
- The proposed number of beds at the South Muskoka site will not meet even the current needs of South Muskoka and will fail to address the significant population increase projected over the next decades.

OUR PROPOSAL - 'CARE CLOSE TO HOME (V2) '

Our proposal includes recommendations for Acute Care, Alternate Level of Care and Ambulatory Care.

Acute Care

The table that follows details our proposed bed allocation:

CARE CLOSE TO HOME V2 MODEL **Total Beds = 157**			
	Program Classification	**Huntsville Site**	**Bracebridge Site**
Acute Care	Acute/Subacute*	50	53
	Obstetrics	2	1
	ICU (level 3)	8	
	ICU (level 2)		6
Restorative Care	Rehabilitation/Reactivation	37	
Total Beds		**97**	**60**

**Subacute care is provided on an inpatient basis for those patients needing services that are more intensive than those typically received in skilled nursing facilities but less intensive than acute care.*

In our view, *'Care Close to Home (V2)'* addresses the deficits in *'Made in Muskoka'* and offers a number of other significant benefits. If implemented, our model will:

- be more equitable than 'Made in Muskoka' As a result:
  - Patients' preferences for care close to home will be respected
  - Travel requirements for patients and families will be significantly reduced
  - Needless and expensive patient transfers will be reduced or eliminated
  - Adverse effects on the patient/family will be avoided
- be more patient/family focused
- provide adequate inpatient services to support the local population
- ensure that primary care providers in South Muskoka can continue to see their patients if/when they require acute care
- support an adequate number of physician specialists in both communities
- provide sufficient specialist support of emergency physicians
- be flexible enough to respond to the current and future needs of both communities
- protect medical education at both sites
- improve continuity of care, quality and patient safety
- support recruitment and retention of physicians and staff
- allow for improved patient, physician and staff satisfaction

Alternate Level of Care (ALC)

Muskoka's population is aging rapidly. Given that, it is critical that any health system redesign address the ALC issue.

For a variety of reasons, ALC is better provided in the community than in an acute care setting. Providing this care close to home is better for patients and their families and far less expensive than when it's provided, in hospital. A senior-friendly social planning strategy that provides assisted living opportunities and better home care would permit hospitals to focus on acute care and give better value for our acute care capital dollars. Spending less on the creation of ALC beds would allow for an appropriate number of acute care beds in each community.

Given these factors, we strongly support MAHC, the District of Muskoka, the Ministry of Health, the Ministry of Long-term Care, municipalities, partner agencies and other stakeholders to work together to create a patient-focused and cost-effective plan to increase ALC capacity, restorative care and community-based supports in north and south Muskoka.

Ambulatory Care:

Ambulatory care is the area in which we believe the greatest innovation can occur.

a. Surgical Services

As both sites are already planning for two operating room suites, all surgery will be performed and be available at the most appropriate site, thereby reducing travel of patients and their family.

b. Diagnostic Imaging

As both sites are already planning for two diagnostic imaging departments, with the exception of Bone Density, Nuclear Medicine and MRI, people will attend at whichever site is more convenient (as they do today). It is hoped by the time of the build, the South Muskoka site will also have an MRI.

c. Specialty Clinics

The list of specialty clinics should be reviewed to confirm the optimal location for each type of clinic. Outpatient Clinics such as Internal Medicine (designed to prevent admissions), and Family Practice (supported by MAHC administration) should be considered.

SUMMARY:

We believe that *'Care Close to Home (V2)'* will better meet the acute and ambulatory care needs of the people of Muskoka and surrounding area. Further, we believe that our model is congruent with the District's initiatives and planning project for a joint effort to find, build and create community solutions to the current ALC capacity concerns across Muskoka.

Respectfully submitted,

ENDORSEMENTS

The *'Care Close to Home V2'* is endorsed by the following physicians of South Muskoka and other healthcare providers with many decades of experience.

Keith Cross, MD, FCFP	Michael Mason, MD, CCFP (EM)	Anthony Drohomyrecky MD, FRCSC
Scott Whynot, MD, M.Sc (PT), CCFP	Sandi Adamson, MD, MBA, CFPC	Victoria Dawson MD, CCFP
Luke Wu, MD, M.Sc., FRCPC (IM)	Joseph T. Gleeson, MD, CCFP, FCFP	Thomas Irvine MD, CCFP, FCFP
William Hemens, MD, M.Sc., CCFP	Martin O'Shaughnessy, MD	Florian Kirstein MD
Timea Maxim, MD, CCFP, AAFP	Shannon Lees, MD, BSc, M.Sc., CCFP	Rob Sansom MD, CCFP (FPA)
Christopher LaJeunesse, MD, DABFM, CCFP	Karen Martin, MD	Don Scott, CEO Joseph Brant Hospital(ret.)
Lorraine Johnston, Executive Director CCFHT	Jeff Pitcher MD, CCFP	Jessica Nairn, MD, CCFP
David Kent, MD, CCFP	Kristen Jones, MD, CCFP	Tina Kappos, MD, B.Sc (Hons), CCFP
Bharti Mittal, MBBS, CCFP	Steve Rix, MB.BS, MRCS(Ed), PgDip-SEM, CCFP	Chris Richardson, MD, CCFP (FPA)
Lisa Tsugios, MD, CCFP	James Moran MD, MBBS	Kimberley Forester, MD, CCFP
Graeme Gair, MD, Past COS SMMH	William Caughey, MD, FRCP(C)	Kersti Kents, MD, CCFP (EM), PgDip (Derm)
David McGregor MD	Cole Krensky, MD, CCFP	Richard Daniel, MD, B.Sc, MB, CCFP
Kent Phillips, MD, FCFP	Keith Moran, MD, RCPSC, DABIM, RCS	Jennifer Hammell, MD, CCFP
Rohit Gupta, MD, DNB, FRCSC	Jonathan Rhee, MD, FRCSC	Faizal Bawa, MD, CCFP
Jessica Reid, MD, M.Sc., FRCSC	Peter Maier, MD, CCFP, FCFP, AAFP	Ardyn Todd, MD, CCFP
Dave Hillyard, MD, CCFP	Ken Hotson, MD, FCFP, BSc(Med), BA, BSc	Vicki Dechert, MD, COE
Paulette Burns, MD	Jody Phillips. V.P Care Partners	Shane Williams MD.FRCPC
Terry Holman, MD	Andy Wilson, MD, FRCPC	Adam McLennan, MD, CCFP
Rand Simpson, MD, FRCSC	Terry Bridle, MD	Marsha Barnes, Board Member, CCHFT
John Richardson, MD, MBBS	Courtney Potts, MD, CCFP	Alex Webb, MD, MSc, FRCSC

NOTE:

MAHC representatives have indicated that the signatories to the physician letter opposing 'Made in Muskoka' represented only a small percentage of the credentialed staff. It must be understood, however, that ALL physicians working at MAHC , including those who are part time, those who fill one-week summer locums and those whose primary practice is elsewhere in the province, must be credentialed. As a result, this factor inflates the number of physicians on MAHC staff.

It must also be noted that, contrary to statements made by MAHC representatives, opposition to the MAHC model is virtually unanimous among full-time physicians resident in South Muskoka.