RECOMMENDATION FOR A HEALTHCARE DELIVERY MODEL AND ACUTE CARE BEDS AT THE FUTURE SOUTH MUSKOKA HOSPITAL SITE

Position Statement
Save South Muskoka Hospital Committee (SSMHC)
September 3, 2024

TABLE OF CONTENTS

INTRODUCTION	1
EXECUTIVE SUMMARY & RECOMMENDATION	1
PROVINCIAL POLICY CONTEXT	2
PRINCIPLES	3
ASSESSMENT: MADE IN MUSKOKA	5
ASSESSMENT CONCLUSION: MADE IN MUSKOKA	7
ASSESSMENT: CARE CLOSE TO HOME V2	7
ASSESSMENT CONCLUSION: CARE CLOSE TO HOME V2	10
DISCUSSION	10
ENDNOTES	12

INTRODUCTION

The Save South Muskoka Hospital Committee ("**SSMHC**") established a Healthcare Advisory Subcommittee to prepare this position statement. This subcommittee is comprised of a diverse set of professionals with decades of healthcare experience, including physicians, nurses, paramedics, occupational therapists, social workers and hospital administrators.

The current hospital redevelopment process requires Muskoka Algonquin Healthcare ("**MAHC**") to submit a plan for a healthcare delivery model as part of the overall Stage 1.3 "functional program". This position statement compares and assesses proposed models for healthcare delivery against established healthcare delivery principles. This position statement addresses, first, the model by MAHC for its "Made in Muskoka" redevelopment proposal, and second, the Care Close to Home (Care Close to Home as revised to Version 2, August 2024) model proposed by a group of South Muskoka-based physicians ("**Care Close to Home V2**")

The aforementioned healthcare delivery principles, their support in the research literature and policy context and the assessment of the models against those principles are set out below. For the purposes of this position statement, the SSMHC has used a concise approach as supported by resources in the endnotes section. Questions or requests concerning this position statement should be directed to the undersigned members of the SSMHC.

EXECUTIVE SUMMARY & RECOMMENDATION

The SSMHC has assessed MAHC's functional delivery model, Made in Muskoka, and the alternative model developed by South Muskoka-based physicians, Care Close to Home V2. These models are proposed as part of the capital redevelopment plans for the MAHC hospital, with a hospital site in Huntsville and a hospital site in Bracebridge (being, South Muskoka Memorial Hospital).

To facilitate this assessment, SSMHC identified a set of eight critical principles that are essential to effective healthcare systems, as listed below. These principles are well-recognized in research literature and derive from the healthcare policy context.

1. Accessibility
2. Equity
3. Patient-Centredness
4. System Integration
5. Continuity of Care
6. Responsiveness to Changing Community Needs
7. Respect for the Quintuple Aim
8. Interdependency

ASSESSMENT CONCLUSIONS

Based on the assessment set out in this position statement, the SSMHC identifies the following conclusions:

- The Made in Muskoka model is significantly flawed: The model is fundamentally inequitable and its implementation would be detrimental to the health, safety and well-being of the residents of South Muskoka.
- The Care Close to Home V2 model is equitable as it includes acute bed allocation that is appropriate to provide effective healthcare delivery to the population of South Muskoka. Overall, the model assessed well when measured against the critical principles.
- Care Close to Home V2 sufficiently incorporates and mitigates travel requirements in the delivery of healthcare relative to the Made in Muskoka model.
- When compared, the Care Close to Home V2 model respects the critical principles set out in this position statement better than MAHC's Made in Muskoka model.

RECOMMENDATION

The SSMHC strongly supports and recommends that the South Muskoka-based physicians' Care Close to Home V2 model be used as the healthcare delivery plan for the MAHC hospital redevelopment proposal to the Ontario Ministry of Health. When compared to the Made in Muskoka model, the Care Close to Home V2 model offers an equitable minimum sixty (60) acute care bed model for the South Muskoka hospital site. The Care Close to Home V2 model is best suited to ensure local hospital care that will benefit people across all of Muskoka and, importantly, reduce the need for travel.

PROVINCIAL POLICY CONTEXT

The Ontario Minister of Health, Sylvia Jones, made the following commitment in her preface to *Your Health: A Plan for Connected and Convenient Care*: "Our goal is to make health care more convenient for Ontarians by connecting you to care closer to home."

To achieve that goal, Pillar One of the provincial health strategy is identified as, *The Right Care in the Right Place,* which reads in part as follows:

> "When people have health care available in their communities, and in ways that are convenient for them, they are more likely to seek and receive the treatment they need when they need it and stay healthier. Delivering convenient care to people in their communities will help keep Ontario healthier by diagnosing illnesses earlier, starting treatment as soon as possible, and keeping emergency room wait times down when you and your family need urgent care." [i]

Ontario Health[ii] has also identified two related and supporting strategic priorities:

1. **"Reduce Health Inequities**: Addressing disparities in health outcomes across different populations.

2. **Transform Care with the Person at the Centre**: Ensuring that healthcare services are patient-centered and responsive to individual needs."[iii]

The SSMHC asserts that plans for the redevelopment of the Muskoka hospital by MAHC must be assessed against the Minister's identified Pillar One of Ontario Health's Strategic Priorities and the following eight (8) core principles as detailed in the section below.

PRINCIPLES

1. Accessibility

The model is accessible, as defined under the *Canada Health Act*, i.e., "Accessibility is defined as meaning that people have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, … unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances)." [iv]

2. Equity

The model achieves the objectives of health equity as defined by the World Health Organization, i.e., "Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality..."[v]

3. Patient-Centredness

The model is patient-centred. As described by the US Institute of Medicine (2001) "patient-centeredness" and Health Quality Ontario is assessed along the following six dimensions:

1) Respect for patients' values, preferences, and expressed needs
2) Coordinated and integrated care
3) Providing information, communication, and education
4) Ensuring physical comfort
5) Providing emotional support, relieving fear and anxiety
6) Involving family and friends.[vi]

4. System Integration

The model recognizes that acute care services are one of many partners in a comprehensive health care system that must work collaboratively to provide integrated healthcare services to

patients. Staff shortages, continuing cost inflation and service demand have intensified the call for more effective and efficient use of scarce resources through integrated service delivery.

5. Continuity of Care

The model supports continuity of care. According to the Merck Manual:

> "Continuity of care is an ideal in which health care is provided for a person in a coordinated manner and without disruption despite all the complexities of the health care system and the involvement of different practitioners in different care settings. Also, all people involved in a person's health care, including the person receiving care, communicate and work with each other to coordinate health care and to set goals for health care." [vii]

6. Responsiveness to Changing Community Needs

The model anticipates and allows for future population growth and changes in the demographic profiles of communities. The post pandemic influx of former city dwellers into rural areas – Muskoka among them – is one such change that must be factored into any health system design.

7. Respect for the Quintuple Aim

The model achieves the "quintuple aim" as reflected in ***"****The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity."* [viii]

i. Improving the patient and caregiver experience
ii. Improving the health of populations
iii. Improving cost efficiency
iv. Enhancing care team satisfaction and collaboration
v. Improving health equity.

8. Interdependency

Acute care is a complex ecosystem comprised of multiple inter-related parts, NOT a single entity. An emergency department, for example, does not operate effectively without access to core specialties to provide support.

The model must have an adequate number of acute care beds to provide enough work for groups of general internists and general surgeons to cover both routine work and after hour's on-call.

ASSESSMENT: MADE IN MUSKOKA

For ease, the table below indicates the proposed bed allocation set out in the Made in Muskoka model:

MADE IN MUSKOKA 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 view, the Made in Muskoka model proposed by MAHC significantly fails to address the critical principles identified for effective healthcare delivery:

Accessibility: In the absence of a publicly funded transit system, patients of limited means who are required to travel for testing or outpatient surgery will have no other affordable travel options. Follow up care will also be financially inaccessible to some residents of South Muskoka.

Equity**:** The Made in Muskoka model is fundamentally inequitable in that it treats residents of South Muskoka (i.e., Gravenhurst, Bracebridge, Port Carling, Bala, Torrance, Vankoughnet, Kilworthy etc.) differently from those in the north – effectively disadvantaging both groups. Those in the south will be separated from family and friends when they require acute care while residents of North Muskoka will have to travel significant distances for routine ambulatory diagnostic and surgical services.

Patient-Centredness**:** The Made in Muskoka model fails on four of the six dimensions of patient-centred care:

- It fails to respect patients' preference and their expressed need for care close to home.
- It fails to provide coordinated and integrated care by separating patients in South Muskoka from their primary care provider while they need acute care.
- By requiring that they and their families travel in often difficult conditions, it fails to

provide emotional support and may, in fact, exacerbate fear and anxiety.
- The Made in Muskoka model separates patients from their family and friends, rather than involving them, at a time when they are most vulnerable and most in need of support.

***System Integration*:** To the best of our knowledge, MAHC has not yet developed strategies for ensuring that its services are linked to either the primary care system or other health and social service resources in the community. Consequently, we are unable to assess MAHC's understanding of its role in Muskoka's health care ecosystem.

***Continuity of Care**:* If continuity of care involves care provided in "… a coordinated manner and without disruption …*"* then the proposed Made in Muskoka model is deficient when measured against this principle. Disruption is inevitable in a model which requires that patients be transferred to another location after a specified number of days at the facility where their care began.

Responsiveness to Changing Community Needs: The Made in Muskoka model is inadequate to meet even the current needs of South Muskoka. Given the significant population increase anticipated over the next decades and the projected aging of the population, the Made in Muskoka model would be even less able to address the needs of South Muskoka in years to come.

***Respect for the Quintuple Aim*:** We find the Made in Muskoka model significantly lacking with respect to at least four of the five "aims":

i. **Improving the patient and caregiver experience**
   As noted above, the model fails to address most of the dimensions on which 'patient centeredness' is measured, thus potentially worsening, rather than improving, the patient and caregiver experience.
ii. **Improving the health of populations**
   Concentrating diagnostic services in the southern site will discourage residents of North Muskoka from obtaining regular health assessments (e.g., mammograms). Population health could be compromised, rather than enhanced, as a result.
iii. **Improving cost efficiency**
   Because MAHC has not released the costing assumptions on which its plan is based, we have been unable to determine the cost efficiency of the model.
iv. **Enhancing care team satisfaction and collaboration**
   South Muskoka physicians have indicated that the MAHC's Made in Muskoka model would result in a significant deterioration in their professional experience and may, in fact, cause both new graduates and seasoned physicians to avoid Muskoka as a location for their practice. Should that happen, South Muskoka will lack the critical mass of physicians necessary to ensure a robust on-call system, thus further putting those who remain at risk of burnout.

v. Improving Health Equity

As noted, the Made in Muskoka model fails to achieve health equity, as defined by the World Health Organization.

Interdependency:

Although the Made in Muskoka model proposes an increase in the square footage of both emergency departments, the lack of a critical mass of in-patient beds in South Muskoka means that specialists will not likely be attracted to practice at that site. Consequently, specialist support of Emergency Room physicians would be compromised.

ASSESSMENT CONCLUSION: MADE IN MUSKOKA

After a thorough analysis of the functional program proposed by MAHC, SSMHC concludes that the Made in Muskoka model is significantly flawed. Specifically, SSMHC identifies that Made in Muskoka is fundamentally inequitable and that its implementation would be detrimental to the health of the residents of South Muskoka. Consequently, SSMHC rejects the Made in Muskoka model for the hospital redevelopment as we are unable to support it.

ASSESSMENT: CARE CLOSE TO HOME V2

For ease, the table below is included to highlight the proposed bed allocation set out in the Care Close to Home V2 model:

CARE CLOSE TO HOME V2 **Total Beds = 157**			
	Program Classification	**Huntsville Site**	**Bracebridge Site**
Acute Care	Acute/Sub Acute*	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.*

SSMHC has assessed the Care Close to Home V2 model against the critical principles set out in this position statement for effective healthcare delivery. In our view, Care Close to Home V2 model meets or exceeds many of the principles as explained below:

Accessibility: This model includes enough acute care beds at the South Muskoka site to ensure that residents of South Muskoka are able to access those services when they need them. In doing so it also addresses Minister Jones' goal of *"Care Close to Home"* and Pillar One of the provincial health strategy.

Equity: The model equalizes access to acute care across Muskoka, thus achieving geographic equity as defined by the World Health Organization.

Patient-Centredness: The thousands of South Muskoka residents who have expressed concern about MAHC's redevelopment online, participated in rallies, posted signs or devoted countless hours to SSMHC have made it clear that they need access to acute care closer to home. This model achieves that goal.

By providing care in the local community, it allows for the involvement of family and friends who can provide emotional support and help relieve the fear and anxiety of their loved ones while they are receiving acute care.

System Integration: Physician and other healthcare providers developed the Care Close to Home V2 model based on their extensive knowledge of the system. As partners in the development of this comprehensive health care model, it is reasonable to assume that they will be committed to working collaboratively within it to provide integrated healthcare services.

In demonstration of that commitment Care Close to Home V2 is developing strategies for ensuring that its services are linked to both the primary care system and other health and social service resources in the community.

The model also positions the hospital well in regard to physician and staff recruitment and retention, therefore addressing staff shortages, reducing costs and ensuring more effective and efficient use of scarce resources.

Continuity of Care: In this model, family physicians in South Muskoka will continue to follow their own admitted patients rather than seeing their patients transferred to the Huntsville site to a new attending physician (i.e., a hospitalist).

The family physician has extensive knowledge of their patient's medical history which will ensure continuity and quality of care as well as seamless transitions.

***Responsiveness to Changing Community Need*:** Demographic projections indicate significant growth in the population of South Muskoka over the coming decades. Demographers also anticipate an increased number of seniors – the group most likely to need acute care services. By locating additional acute care beds at the South Muskoka site, MAHC would enhance its capacity to respond to that growing need.

***Respect for the Quintuple Aim**:* Our analysis of Care Close to Home V2 has led us to conclude that the model is responsive to at least four of the 'Quintuple Aims':

i. **Improving the patient and caregiver experience**

By providing care closer to home, the model enhances the following dimensions by which 'patient centeredness' is measured:

- respecting patients' values, preferences and expressed needs,
- relieving fear and anxiety
- facilitating involvement of providing family and friends.

We believe that the patient and caregiver experience will be enhanced as a result.

ii. **Improving the health of populations**

Locating diagnostic services at both sites will encourage and support all Muskoka residents in obtaining regular health assessments, thus enhancing population health.

iii. **Improving cost efficiency**

In the absence of detailed costing assumptions from MAHC we are unable to compare the projected costs of the Care Close to Home V2 model with those of Made in Muskoka. Once such information is made available to us, we will undertake a detailed analysis to determine the cost efficiency of this model.

iv. **Enhancing care team satisfaction and collaboration**

Care Close to Home V2 has been developed by South Muskoka physicians themselves. The model reflects their collective expertise and their experience in a wide variety of acute care settings. Given that, it is safe to assume that this model is 'provider-friendly'. Consequently, we believe that its implementation would enhance care team satisfaction and support physician recruitment and retention.

v. **Improving health equity**

The Care Close to Home V2 model achieves a more equitable balance between the needs of north and south Muskoka, than does the Made in Muskoka model proposed by MAHC.

Interdependency: The Care Close to Home V2 model reflects the fact that acute care is a complex system of many inter-related elements and multiple component parts.

The model proposes enough beds at the South Muskoka site to offer sufficient work for groups of internists and general surgeons to cover both routine work and after-hours on call. As a result, the ability of the South Muskoka site to attract and retain specialists in support of Emergency Department physicians will be assured.

ASSESSMENT CONCLUSION: CARE CLOSE TO HOME V2

The Care Close to Home V2 developed by South Muskoka-based physicians respects the principles identified above better than the Made in Muskoka model. As a result, we support the physicians in their efforts to ensure that the redevelopment of the MAHC hospital benefits people across all of Muskoka.

DISCUSSION

In October 2023, MAHC made the following commitment to the District of Muskoka:

> ***"The redevelopments once approved, will result in additional beds at each site."***
> District Committee of the Whole Minutes, October 16/23 19 (2023).

However, subsequent iterations of the proposed Made in Muskoka model reduced the acute care bed count at the South Muskoka site to thirty-six (36) from the sixty-seven (67) currently in operation.

MAHC's abrupt departure from its public commitments has caused the residents of South Muskoka to doubt the integrity of MAHC's redevelopment process. Unfortunately, ongoing expressed commitments by MAHC for consultation with community stakeholders are without substance. For instance, requests for information disclosure of key metrics and studies supporting MAHC's redevelopment proposal are ignored or rebuffed. SSMHC is firmly of the view that proper and meaningful consultation means that relevant information is to be shared with sufficient timeliness to allow for dialogue and fair participation by stakeholders. MAHC has failed or refused to improve upon its handling of its consultation process despite SSMHC having raised many concerns and complaints. We identify this a serious shortcoming with respect to the entire hospital redevelopment process that MAHC has facilitated.

On the substance of the MAHC's Made in Muskoka healthcare plan, the SSMHC is alarmed by the model's many shortcomings. Based on our assessment, the Made in Muskoka model is fundamentally inequitable and would, if implemented, be detrimental to the health, safety and well-being of the residents of South Muskoka well into the future. Given MAHC's ongoing failure and refusal to run a proper consultation, as described above, this result further compounds the sense within the community at large that the **Made in Muskoka model must be rejected**. There is resultantly a need for a different healthcare model that meets stakeholder input and requirements. On this, the SSMHC fully endorses and recommends that adoption of the Care Close to Home V2 model.

Specifically, SSMHC identifies that the Care Close to Home V2 model will result in numerous benefits, including:

- Adequate inpatient services will support the local population
- MAHC will be better positioned to manage occupancy levels
- The amount of travel required by patients and their families will be reduced
- Needless and expensive patient transfers will be reduced or eliminated
- Continuity of care will be improved
- Adverse effects on the patient/family will be reduced
- Quality and patient safety will be improved
- Medical education at both sites will be protected
- Recruitment and retention of physicians and staff will be supported
- Patient, physician and staff satisfaction rates will be improved

The SSMHC notes that the opinion identified in this position statement is contingent on Alternate Level of Care services and capacity being increased in the communities in tandem with the hospital redevelopment as part of an overall healthcare delivery strategy for the future.

Applying an overall comparison of the healthcare models, the SSMHC's decision to support the Care Close to Home V2 model rests on our opinion that it is, in every respect, more congruent with each of the identified critical principles than MAHC's Made in Muskoka model. Consequently, we assert that the Care Close to Home V2 will better meet the healthcare needs of the people of Muskoka.

Respectfully Submitted,

Bruce Kruger
Chair, Save South Muskoka Hospital Committee

Peter Cross
Vice Chair, Save South Muskoka Hospital Committee

Date

ENDNOTES

[i] *Your Health: A Plan for Connected and Convenient Care*, Feb 2/23 accessed online August 11/24 at: https://files.ontario.ca/moh-your-health-plan-connected-convenient-care-en-2023-02-02-v3.pdf

[ii] Ontario Health is *"an agency created by the Government of Ontario to connect, coordinate and modernize our province's health care system."* Accessed online August 16/24 at: https://www.ontariohealth.ca/about-us

[iii] Accessed online August 16/24 at: https://www.ontariohealth.ca/about-us/governance-accountability/strategic-priorities-business-plan

[iv] Canada Health Act accessed online August 16/24 at: **16https://sencanada.ca/en/content/sen/committee/372/soci/rep/repoct02vol6part7-e#:~:text=It%20ensures%20that%20access%20to,%2C%20age%2C%20and%20health%20status**

[v] World Health Organization accessed online August 14/23 at: https://www.who.int/data/inequality-monitor/about#:~:text=Health%20equity%20is%20the%20absence,in%20health%20across%20population%20subgroups.

[vi] US Institute of Medicine, 2001Institute for Patient and Family-Centered Care (ipfcc.org) Health Quality Ontario (HQO) - Institute for Patient and Family Centered Care (hqontario.ca)

[vii] *Continuity of Care,* Debra Bakerjian, PhD, APRN, University of California Davis, Reviewed/Revised Oct 2022 accessed online August 14/24 at: https://www.merckmanuals.com/en-ca/home/older-people%E2%80%99s-health-issues/providing-care-to-older-people/continuity-of-care

[viii] *The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity* Nundy S, Cooper LA, Mate KS., *JAMA*. 2022;327(6):521-522 accessed online August 14/24 at: https://jamanetwork.com/journals/jama/article-abstract/2788483#google_vignette .