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## **Review of the Muskoka Algonquin Healthcare Redevelopment Proposal**

### **Commissioned by:**

#### **The Town of Bracebridge**

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## Table of Contents

Engagement Task	3
Executive Summary	3
General Observations	4
The Submission Process	6
Current Proposal	8
Plan Review	10
Opposition to the MAHC Planning Process	12
Summary	13
SWOT Summary	14

Appendix A – Hospital Bed Numbers

## **Review of Muskoka Algonquin Healthcare Redevelopment Proposal**

### **On Behalf of the Town of Bracebridge**

#### **D. Murray – Medcura Health – October 2024**

#### **Engagement Task**

Medcura Health was hired by the Town of Bracebridge to review the planning efforts and proposal that has been brought forward by Muskoka Algonquin Healthcare, (MAHC) regarding hospital renewal in the Muskoka area. The municipality has committed \$10 million of public money towards the local share of the project and wished to have a review done by a third party to ensure the plan will meet the needs of Bracebridge residents before finalizing such a substantial commitment.

#### **Executive Summary**

While planning has taken several years and there has been much local debate on various options, Medcura Health feels that the current proposal that is being submitted to the Ministry for consideration meets the needs of the people of MAHC's broader catchment area, and more specifically the residents of the Bracebridge area. The recent addition of ten beds further enhances the proposal and provides a greater emphasis on creating capacity to meet local needs.

Prior to the addition of the ten beds, the plan was still viable in that it sought to develop the Bracebridge site as the main surgical centre with a significant focus on emergency care, diagnostics, and out-patient services and procedures. The plan builds on trends that have become the norm over the past twenty years such as the move to outpatient care from inpatient services. The 31 beds originally designated for acute care were marginally sufficient but would have left less room for growth, possible surge events and flexibility to meet evolving needs. The addition of 10 more beds provides a more robust local solution. It should be noted there is still strong community support for a greater acute care presence in the Bracebridge area.

The development of the Huntsville site with additional resources dedicated to stroke, rehabilitation and long stay patients makes that site significantly larger and creates critical mass for a centre to serve the northern part of MAHC's catchment area.

## General Observations

To fully understand the current situation Medcura has engaged in conversations with over twenty different individuals and groups across the region. These conversations, along with the reviewing of extensive planning documents, have helped to provide a basis for the findings in this report. Some general observations are offered to set the context.

1. While the area is very supportive of facility renewal, the division of the catchment area into two regions that are almost identical in size and population, make the planning for a comprehensive single solution that balances the need to serve two areas, with a need to not duplicate many services, creates a unique and challenging planning environment. One person likened it to Noah's Ark – everything in Huntsville/Bracebridge has to be two by two where both communities have the same services as the other.
2. There is a unique situation in Bracebridge and Huntsville caused by the Muskoka area. Muskoka is one of the most sought after seasonal destinations in Canada and has been such for over 100 years. This causes the seasonal population to double on average over the summer months and spike at even higher numbers during certain times of the summer months. An area with a traditional population of around 60,000 residents can often see 120,000 – 140,000 residents in the area for periods of time during the peak summer seasons. Planning for this migration of residents from the GTA requires certain services, (ED/ICU) to be enhanced beyond what would normally be considered for servicing the year round population.
3. The two catchment areas of Bracebridge and Huntsville have a long history of competing with one another in all manner of issues. Another person interviewed, likened it to the rivalry that develops between communities as “hockey rivals” – a definition that most Canadians easily understand! Whatever the history, the communities naturally continue to compete with one another and a tug of war over the planning process for the new hospitals is an extension of the longstanding history of the area.
4. The planning process in this case has been thorough. The firms that have been hired to do the planning are well known and have done this work repeatedly across the country with excellent results. The depth and length of time that has been devoted to the planning process is significant. The analysis of the current system, the needs, demographic trends and plans for the future have been extensive. The planning efforts have been in depth, driven by data and innovative. The process has been undertaken in a manner that follows the Ministry capital planning process. Local conditions have required a constant reflection on plans and the need to amend the plans to meet local needs. This

should be seen as a positive for all parties as it has resulted in a submission that will serve the communities well and also meets the Ministry requirements.

5. Given the depth of planning and analysis, the reality is that planning for a future state that will be decades away incurs risks, and requires making assumptions about the future and possible future challenges. When one considers the extreme impact that Covid has had on our country in terms of work practices, travel, employment, public expenditures and especially the hobbling of our health care system, we need to realize that unforeseen things may occur that radically challenge our plans and approaches. The need to ensure future flexibility is key in making long range plans.
6. Much of the discussion and debate around the proposed redevelopment has centred around the number of beds in each community and bed numbers seem to be used as a proxy for overall health services. This is not unique to the Muskoka area. Beds per thousand people are a measure of hospital capacity and indicates how resources are dedicated in the health care system. Variations in this number are large. The number of beds per thousand people has dropped across Canada from almost 7 beds per thousand in the 1970s to around 2.6 beds per thousand today. This represents a reduction of over 60%. Within the current average of 2.6 there is significant variation across the country with Ontario having the lowest beds per thousand with 2.3 per thousand population and Newfoundland having 4.43 beds per thousand. Factors such as geography, population size and density contribute to these numbers. Muskoka will have more beds per thousand than the Ontario average primarily driven by the seasonal population fluctuations.

Another key determinant of beds is the ability to invest resources in areas that provide services in a non-hospital or ambulatory settings. Variations in bed numbers per thousand residents occur across Ontario, Canada and internationally. The number of beds does not serve as a reliable proxy for comprehensive health care services but unfortunately, bed numbers are the easiest way to provide a measure of system capacity, even if such a measurement is not the best way to plan services. (For a more detailed overview of hospital bed numbers please see Appendix A)

7. The region has tremendous support from the Ministry and government to renew their infrastructure. This is a significant opportunity that is not guaranteed to carry on indefinitely. There are dozens of communities and regions across Ontario that are vying for the support that Muskoka enjoys. There is a need to move forward decisively and in a unified manner in order that this opportunity is realized for the current and future residents of the area.

8. Notwithstanding the previous caution about bed numbers, the decision to locate longer term services at Huntsville skews the local bed numbers significantly. Not all hospital beds are the same. Huntsville is proposed to be the location of significant services that support long stay patients for stroke, rehab, continuing complex care and ALC patients – services that require more beds.
9. Planning services at smaller sites is changing with trending developments in the health care system. The ability to provide services in new and innovative ways such as virtual care, the use of artificial intelligence, ambulatory and non-hospital settings, etc., allows smaller centres to offer a broader range of services. There has also been an increase in the need to provide services that are “safe”. The focus on patient safety becomes more clearly defined as data is now available on interventions, their success and the impact that volumes have on quality of outcomes and patient safety. Planners must limit service offerings to those areas where the service can be provided in a setting where the providers and staff do enough procedures to remain competent and the necessary infrastructure and equipment is available, so the result is that the service is provided safely.
10. Several people who have been involved in the planning process have noted that there is a lack of strategy and policy by the Ministry and government when it comes to smaller health care settings, especially in the north. Planning for northern and rural settings seems to follow a pattern of smaller versions of urban health care planning which does not work effectively in the north. This is challenging for planners and local health care leaders as they are not sure of what the overarching goals and strategies are concerning the health care of their area. Small, rural and northern areas depend on other areas for certain services but there is no strategy or policy that outlines what should be planned for locally, what should be regional or provincial, and how patients will move between these various locales.

## **The Submission Process**

In Ontario, hospital capital planning is a carefully detailed step by step process to ensure capital plans are done in a consistent and structured manner.

The Ministry has published the Hospital Capital Planning and Policy Manual (HCPPM) which establishes an overarching framework for managing capital assets in the hospital sector and for setting out policies governing capital projects and processes, including approved capital funding. The HCPPM describes the submission requirements for hospitals proposing to undertake a capital project, and the subsequent review and approval processes carried out by the Ministry based on strategic advice from the Ontario Health Agency. The specific objectives of the HCPPM are to:

1. Communicate the Ministry's capital planning and approval processes, policies and guidelines to stakeholders;
2. Ensure compliance with Ministry and government policies to maintain legislative and fiscal accountability;
3. Provide direction on how to effectively navigate the capital submission and review process; and
4. Facilitate the development of capital submissions that foster the delivery of high-quality care through patient-centred design.

The planning process is a “gated” approach. To move through the process, submissions must be made to answer specific questions concerning the various elements of the project. Once the submission has been prepared and submitted to the Ministry it will be approved or the Ministry may seek further modifications to the submission. The project cannot move forward to the next level until the Ministry has agreed to the current submission.

The overall process is divided into three major sections:

### **Early Planning**

Submission Summary

Stage 1.1: Pre-Capital Submission (Part A&B) Submission Summary Stage - Description of program/service needs and rationale for capital investment

Stage 1.2 Proposal Development: Detailed business case, including proposed options and associated costs

Stage 1.3 Functional Program: Size and scope of capital solution defined

### **Detailed Planning**

Submission Summary

Stage 2.1 Block Schematics: Physical realization of functional program through preliminary design

Stage 2.2 Sketch Plan: Advanced design, includes integrated site plan

Stage 2.3 Contract Documents: Final tender documents for open, competitive procurement

### **Construction**

Submission Summary

Stage 3.1 Award of Contract: Identification of successful bidder

Stage 3.2 Construction: Progress certificates and change orders documented and assessed

Stage 3.3 Settlement: Reconciliation of actual costs against estimated costs for the approved capital project

The process is thorough and time consuming. Given the scale and longevity of the investments being made, the process used by the Ministry has demonstrated exceptional outcomes for the people of Ontario. The early planning phase is the most difficult as it requires significant analysis and engagement with local stakeholders. This step requires that the hospital remain focused on solutions that are affordable, sustainable and safe, as service plans have both a capital component as well as an ongoing component related to the staffing and activity of the facility.

Planning services that cannot be staffed or are of low volume creates situations where significant resources may be expended and do not benefit the local population. The realities of costs and staff availability require planners to be realistic in their assessments of what services are needed today and into the foreseeable future. Given the significant local cost sharing component it is important to build facilities that are affordable and sustainable.

## **Current Proposal**

Muskoka Algonquin Healthcare is at Stage 1.3 where they will be submitting what is known as the Functional Program. Getting to this point is one of the most difficult in the capital planning process as it defines what services will be delivered today, into the foreseeable future, where those services will be delivered, and estimate the capital needs to deliver those services. Several iterations of the proposal have been developed over the last few years with ongoing feedback from the communities. The final service and bed configuration are as follows:

## **BOTH SITES**

- Expanded emergency departments
- Labour and delivery services
- ICU (Level 2 in Bracebridge, Level 3 in Huntsville)
- General Surgery (Inpatient and Outpatient)

Both sites will have expanded emergency departments, obstetrics and ICU capabilities, as well as general surgery programs supporting both inpatient and outpatient services. These core services will allow both sites to each meet the vast majority of the needs of

their catchment areas. While this is a clear duplication of services, the population size, seasonal fluctuations, density and locations make the provision of these capabilities at two sites the preferred choice. This makes sense from a service standpoint allowing residents to access needed care close to home, as well as creating an “internal redundancy” where if one site has a particular difficulty in providing service, the other site can assist in meeting local needs. The need for this type of redundancy was clearly demonstrated during Covid.

While both sites will have core services, the model proposed has been developed with characteristics that build upon current care patterns and projected growth. The individual site plans are as follows:

### **BRACEBRIDGE SITE**

- Surgical centre of excellence
- Enhanced diagnostic imaging
- Regional cancer care home
- Specialty clinics for women and seniors

### **HUNTSVILLE SITE**

- Level 3 ICU
- Designated stroke unit
- Reactivation
- Rehabilitation

**PROPOSED BEDS NUMBERS TO SUPPORT THE PLAN**

<b>BRACEBRIDGE</b>	<b>BED TYPE</b>	<b>HUNSTVILLE</b>
<b>41</b>	<b>Acute</b>	<b>31</b>
<b>1</b>	<b>Obstetrics – Labour and Delivery</b>	<b>2</b>
<b>4</b>	<b>Intensive Care Unit</b>	<b>10</b>
	<b>Long Stay</b>	<b>64</b>
	<b>Stroke/Rehabilitation</b>	<b>14</b>
<b>46</b>	<b>Total</b>	<b>121</b>

**Plan Review**

Since there was little public support for a single site model to be located between the two communities there was a need to develop a two-site model that would stay away from the “Noah’s Ark” approach and not duplicate services in both communities. The proposal recognizes this and has been developed with a view to having two sites with some services duplicated such as emergency, obstetrics and some acute capacity but the roles of the two sites will be quite different.

The sites will have different but interdependent roles. Bracebridge will offer a more robust surgical program that will have inpatient capacity, but will also focus on day surgeries, outpatient procedures and services such as cancer care. Most outpatient services are offered on a more traditional day/evening schedule Monday to Friday. These types of services represent the majority of activity in hospitals today. These services tend to be provided on a scheduled basis and may be elective in nature. Such settings tend to be easier in staff recruitment as they offer day/evening employment opportunities and often do not operate on weekends.

Patients who become long stay patients or ALC patients will be transferred to Huntsville. All hospitals across Ontario struggle with ALC patients and the cost to the system is extreme. Traditionally one in six hospital beds has a patient who should not be in hospital. This reduces the hospital's ability to fulfil its core mandate as capacity is compromised. Bracebridge will benefit from having the ability to transfer ALC and long stay patients to Huntsville as it will keep the Bracebridge site capable of focusing its resources on its core services.

To put this transfer capacity into perspective, if Bracebridge was a stand-alone hospital there would need to be approximately ten additional beds to accommodate the ALC patients that would be at the hospital. The ALC issue has been a significant challenge in Ontario hospitals for the past twenty years. Not only is it unfair to patients who are waiting to get the care they need, it is a huge cost to the system in terms of lost capacity, and there is a measurable decline that ALC patients experience being in a hospital when they should be in a more appropriate setting. Successive governments have tried on numerous occasions to deal with the ALC issue, but it persists. The addition of more LTC and better home and community care will help to alleviate the ALC issue, but these changes and investments will take time to implement. The Bracebridge site will benefit from not having to deal with the ALC issue at their site.

The Huntsville site will offer some acute services as well as emergency services and an ICU. The majority of services will be in the areas of long stay patients such as ALC and those who need extended stays for rehabilitation or complex continuing care. The designation of Huntsville as a stroke centre has created capacity and expertise in dealing with stroke patients. The plan seeks to build upon this expertise. The treatment of stroke patients continues to evolve and should be evaluated by MAHC on an ongoing basis as stroke interventions are changing the numbers of, and often the trajectory of care for stroke patients. MAHC should continue to ensure that the resources dedicated to these efforts are warranted.

The coordination of ALCs at the Huntsville site will alleviate the inpatient pressures at Bracebridge. Overall, Huntsville will have a greater complement of beds, and this may be seen as a desired outcome to regional planners. Currently the closest large facilities to Muskoka are Orillia (213 beds) to the south and North Bay (433 beds) to the north. Bracebridge is 55 km from Orillia making it a viable referral centre for Bracebridge patients who need to travel outside of their community for specialized services. For residents of Huntsville and the surrounding areas Orillia is 100 km to the south and North Bay is 120 km to the north. Huntsville does not have a major referral centre close by, hence the rationale for the development of Huntsville as a service hub with expanded ICU capabilities.

## **Opposition to the MAHC Planning Process**

A review of the planning process would not be complete without mentioning the significant community support in Bracebridge to oppose the initial option put forward by MAHC. The physicians in the Bracebridge area indicated their opposition to the original plan put forward that suggested 14 beds for the Bracebridge site, (a reduction from the current 67 beds), that from their perspective, put the future viability of the Bracebridge site in question. The community responded by creating the Save South Muskoka Hospital Committee. The committee has been very active and has attracted over 7,500 signatures to their first petition and continue to raise issues around the planning process and advocating for more resources in the Bracebridge area. The committee has identified four ongoing issues that they feel need to be resolved. In some cases these issues go beyond the scope of this review but are offered for context purposes.

## **Beds**

Currently there are 67 beds at the Bracebridge site and early indications were that there would be an increase in the number of beds at the Bracebridge site. The current 46 beds still fall short of a commitment that the committee feels was made at the outset of the process. This review has dealt with the issue of beds and the 46 beds should be sufficient to support the services that are planned for the Bracebridge site, especially with ALC and long stay patients being cared for at the Huntsville site.

## **Refurbishing of Existing Site**

There was a belief that the current infrastructure could be refurbished more economically, and this would allow for more resources for expansion. The refurbishment issue is often cited in capital programs. The newer standards required for space, infection control, air quality and other factors make retrofitting hospital space very expensive, and it is often more economical to build new space. This is an analysis that must be completed by professionals in those areas. Assessment of the structural condition of the existing facility goes beyond the scope of this review.

## **Site Selection**

Site selection was raised by some as an ongoing challenge. This is an area that the municipality has taken a leadership role in as the specific site settled upon will require significant preparation and servicing as well as potential rezoning. Reviewing the current site selection goes beyond the scope of this review.

## **Transportation and Transfers**

There have been many who have noted the proposed plan tends to move patients or have patients move between Bracebridge and Huntsville. This is seen as

inconvenient and there are few affordable transportation resources available. It was pointed out that a taxi ride between the two communities would cost \$100.

The need to travel to access health care is well documented all across Ontario. In the GTA, patients will often travel from Oshawa or Milton to access specialty services in downtown Toronto. Bracebridge and Huntsville are about twenty minutes apart so the travel issue, while inconvenient, is not one which should weigh heavily in the decision about service location. The area municipalities, providers and service organizations will need to develop strategies around the moving of patients between facilities as required. In areas of the north, scheduled transfer services have been developed to move patients between communities for appointments. There are many workable models that can be explored by MAHC.

## **Summary**

The plan as proposed will meet the needs of residents all across the Muskoka catchment area in a way that reduces duplication of services and allows each site to develop distinct expertise and programs. There will need to be ongoing reviews to ensure the plan meets current and future needs. While it is our contention that the plan will meet the area's needs it should be noted that there are still many in the Bracebridge area who will continue to advocate for further changes and enhancements in capacity at the Bracebridge site.

There is a need to unify efforts to move this project forward. Ensuring future flexibility in space and program will allow all residents of Muskoka to enjoy truly comprehensive services throughout the area. This is a generational development that will provide the cornerstone of excellent health care for the residents of Muskoka today and in the future.

A Strengths, Weaknesses, Opportunities and Threats (SWOT) chart follows outlining key issues identified during the review process.

<b>SWOT SUMMARY MAHC PROPOSAL</b>	
<p style="text-align: center;"><b>STRENGTHS</b></p> <p>The area enjoys provincial political support for the proposed redevelopment.</p> <p>The government has committed \$742 million towards redevelopment</p> <p>The public has been very engaged in planning efforts</p> <p>The area municipalities, individuals and organizations have committed \$225 million towards the project</p> <p>Population projections recognize the impact of seasonal populations within the Muskoka area</p> <p>Proposal seeks to create centres of excellence to better meet local needs and create efficiencies</p>	<p style="text-align: center;"><b>WEAKNESSES</b></p> <p>There has been some difficulty in the communications used during the planning process which has resulted in the residents of the Bracebridge area challenging the plans, proposals and processes used.</p> <p>This has led to a lack of trust between many of the residents of Bracebridge and Muskoka Algonquin Healthcare</p> <p>Many have noted a lack of a provincial overarching policy, planning, strategy or direction for northern and small communities. This leaves communities to explore and out forward local solutions that they hope will be acceptable to the Ministry</p>
<p style="text-align: center;"><b>OPPORTUNITIES</b></p> <p>The planning has allowed for innovative solutions that will see a division of responsibilities between the two sites.</p> <p>The plan also allows for future capacity needs and flexibility in service delivery and MAHC could play a larger role in repatriation of patients from urban centres.</p> <p>The sites may also be able to increase utilization of their facilities for additional services by visiting specialists and teams in the areas of OR and other ambulatory services</p>	<p style="text-align: center;"><b>THREATS</b></p> <p>There is strong political support, but this could change depending on the provincial situation.</p> <p>The government’s fiscal situation may also impact both amounts and timing of provincial funds being made available</p> <p>Continued local infighting could derail the project and delay it for years.</p> <p>Health Human Resources challenges continue all across Ontario</p> <p>Cost escalation due to building inflation</p>

## Appendix A – Hospital Bed Numbers

The use of bed numbers in assessing health care systems is a confounding experience. The variation in the numbers of beds is staggering and indicates very different approaches to delivery of health care services. Internationally, according to the Organization for Economic Co-operation and Development (OECD) Mexico has less than 1 bed per thousand population (.99) while Japan has 12.63 beds per thousand. Some of the difference is no doubt driven by the relative wealth of the two countries but when you consider other industrialized countries such as US(2.35), UK (2.43), and Canada (2.55) there continue to be significant differences in the number of beds. The OECD average is 4.7 beds per thousand people. Within this international variation comparisons are difficult. As an example Japan has more than a million hospital beds, for a population of roughly 126 million, the majority are for the mildly sick – not for critically ill people. The country has only about 5 intensive care beds per 100,000 people, while Germany has nearly 34, the highest in the OECD, and America has nearly 26.

Looking at the US, American Hospital Association data indicates that the variation by state is also significant with Washington state having 1 bed per thousand population, while the District of Columbia has 5 beds per thousand. As an example South Dakota has 4.61 beds per thousand people. In the US we see a five-fold variation in the number of beds. The average of the entire US is 2.35 beds

The Canadian Institute for Health Information (CIHI) data for hospital beds in 2021 shows that the variation in the numbers of hospital beds is also significant with Newfoundland having the highest number of beds with 4.4 per thousand population. Ontario has the fewest hospital beds per thousand population with 2.3. The Canadian average is 2.55. Differences in the Canadian data can somewhat be attributed to demographics and geography. Provinces that have small populations and large geography tend to have more beds, whereas large urban population tend to have less beds per thousand.

When assessing the number of beds, the types of beds must also be considered. There are traditional acute care beds, but hospitals also operate specialized beds such as Intensive Care Unit (ICU) beds and obstetric beds. In addition there are beds to serve longer stay clients such as rehabilitation beds and complex continuing care beds. Another challenging factor that has proven difficult to manage, (and plan for), is the use of beds for other purposes, now called Alternative Level of Care (ALC). Across Ontario roughly 16% of hospital beds are being used for patients who should be somewhere else. These patients should be at home with home care, in a Long Term Care facility, or in another specialized facility (brain injury, etc.). Lack of capacity in these other areas forces patients to remain in hospital severely compromising the hospital's ability to carry on its normal functions. This demonstrates the need to plan for the entire system and not just the hospital.