SAVE SOUTH MUSKOKA HOSPITAL COMMITTEE

PROMISES VERSUS REALITY: SUPPORTING RESEARCH APPENDICES PREPARED BY THE SAVE SOUTH MUSKOKA HOSPITAL COMMITTEE IDENTIFYING MAJOR GAPS AND COMMUNITY CONCERNS IN THE MAHC FOI-PROVIDED RECORDS

Save South Muskoka Hospital Committee
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www.ssmh.ca

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INTRODUCTION

The materials in these supporting research appendices were developed by volunteers with the Save South Muskoka Hospital Committee (SSMHC) to assist the community and decision-makers in understanding concerns arising from the recently obtained FOI documents from Muskoka Algonquin Healthcare (MAHC).

They represent a preliminary analysis and are not intended to be exhaustive, definitive, or technically complete. The SSMHC's review of the FOI materials is ongoing, and these documents will be refined and updated as additional information becomes available and further analysis is undertaken. We ask that readers interpret this package as a guide to the issues and as a basis to facilitate further inquiry and investigation.

The concerns raised in this package reflect the community's deep reservations about the long-term sustainability, accessibility, and equity of the proposed hospital redevelopment plans for South Muskoka. SSMHC is especially troubled by the gap between what has been publicly promised—regarding obstetrical services, site suitability, and the sustainability of the hospital—and what the FOI-released documents actually reveal. This is not a critique for its own sake; it is an effort to ensure that decisions affecting the health and well-being of our community are grounded in accurate information, transparent processes, and a genuine commitment to protecting local services.

Further information, including updated versions of this package, additional position papers, and related materials, will be made available on the SSMHC website at www.ssmh.ca as they become available. Readers are encouraged to check the site periodically for revisions, new analyses, and supporting documents that may refine or expand on the points raised in this package. For questions about the contents of this package or the FOI materials more broadly, please contact the Save South Muskoka Hospital Committee at ssmh@ssmh.ca.

Reference Summary of MAHC Stage 1.3 Functional Plan Concerns

This summary focuses on the **2031/32 Opening Year** as defined in the **Stage 1.3 Submission (Nov 2024)**. This summary is based upon the final approved "Made-in-Muskoka" model:

1. Transportation Plan: The "Shuttle-Based" Reality

The Stage 1.3 submission does not include a formal, independent "Transportation Plan" or an impact study from District Paramedic Services.

- **The Proposal:** The 2032 model relies on **Inpatient Consolidation**. Because Huntsville holds all 37 "Reactivation/Long-stay" beds and the Level 3 ICU, the plan assumes a high volume of inter-site transfers.
- **The Missing Piece:** There is no documented agreement or budget for who manages these transfers. If a patient in Bracebridge requires more than 6 days of care, they must be moved. The SSMHC flags this as a hidden cost that will pull 911 ambulances off the road to serve as hospital shuttles.

2. Stantec Report & Pine Street Costs

The Stantec Report (and technical appendices) identifies **300 Pine Street** as a high-risk site due to its history as a quarry.

- **The Findings:** The site requires massive leveling and "rock-munching." Engineering estimates suggest site preparation could cost up to **$180 million** before a single brick is laid.
- **The Implication:** This "dirt cost" must be paid for by the **Local Share** (the community). The Stage 1.3 submission mentions updated cost estimates but does not provide a public breakdown of how the $180M in site prep impacts the overall $225M local fundraising goal.

3. Obstetrics: The "Nesting" Model vs. Reality

The 2031/32 model essentially ends a dedicated, 24/7 staffed birthing unit in Bracebridge.

- **The "Nesting Bed":** The Stage 1.3 plan allocates **one (1) obstetrical labor and delivery room** at the Bracebridge site.
- **The Definition:** In clinical terms for this project, "nesting" means an emergency-only space. It is a room within the 46-bed framework used for imminent births that cannot be transferred to the consolidated **Regional Birthing Centre** in Huntsville.
- **The Impact:** As of March 2025, MAHC has already "temporarily" moved all births to Huntsville, citing staffing. The 2032 plan makes this consolidation permanent, leaving Bracebridge with only emergency stabilization capacity.

4. Viability of the Bracebridge Site

The viability of the Bracebridge site in 2031/32 is a "mathematical" concern:

The Bed Deficit:

  - **2019/20 (Current SMMH):** 65 Beds.
  - **2031/32 (New SMMH):** 46 Beds.

- **The 0-Bed Service:** The most critical observation is that **Reactivation and Complex Medical Management** (long-term senior care) goes from 15 beds to **0 beds** in Bracebridge.
- **The Risk:** If the 46 beds at SMMH are full, the hospital has no "overflow" for senior patients. This forces a "gradual reduction" of care where patients are stabilized in the ED and immediately shipped to Huntsville, potentially turning the new Bracebridge hospital into a glorified Urgent Care/Day Surgery center.

“**Made in Muskoka” Technical Summary of Bed & Service Allocations (2031/32 Service Year)**

Service	**SMMH (Bracebridge)**	**HDMH (Huntsville)**
Total Beds	**46**	**121**
Critical Care	4 Beds (Level 2)	10 Beds (Level 3 - Regional)

Service	**SMMH (Bracebridge)**	**HDMH (Huntsville)**
Reactivation (Seniors)	**0 Beds**	37 Beds
Obstetrics	1 Nesting/Emergency Bed	Full Regional Birthing Centre
MRI	No	Yes (Regional Lead)
Nuclear Med/Mammo	Yes (Regional Lead)	No

APPENDIX A - Comparative Analysis of Stantec Stage 1.3 Site Selection Data

1. EXECUTIVE SUMMARY: THE SCORING REVERSAL

Analysis of the **Stantec Stage 1.3 Site Selection Report (May 9, 2023)** reveals a significant discrepancy between technical evaluation and final selection. According to Stantec's Integrated Site Assessment Tool (ICAT):

- **RANK #1: 1975 Muskoka Beach Road (Score: 131.55)**
- **RANK #2: 300 Pine Street (Score: 117.20)**
- **RANK #3: Hwy 118 West Lands (Score: 116.35)**

Despite being the technically superior site by a margin of **14.35 points**, Muskoka Beach Road was bypassed in favor of 300 Pine Street.

2. SITE COMPARISON: PHYSICAL & ENGINEERING CONSTRAINTS

Feature	**1975 Muskoka Beach Road (#1)**	**300 Pine Street (#2)**
Topography	Generally flat; good proportions.	**Extreme:** 30-meter (100ft) elevation drop.
Site Prep	Standard grading.	**Severe:** Requires up to **15m of fill** for sewers.
Usable Land	High efficiency.	**Low:** Former aggregate pit halves usable area.
Infrastructure	Requires extension of services.	**Critical:** Lacks capacity; needs 2 pump station upgrades.
Ownership	Private (Donation offer reported).	Public (Owned by Town of Bracebridge).

3. CRITICAL RISK FLAGS FOR 300 PINE STREET

Stantec identifies several "Cautions" that represent significant financial and operational risks:

- **The "15-Meter Fill" Requirement:** To achieve gravity-draining sewage, massive earthworks are required. This is a primary driver of hidden capital costs.
- **Fire Flow Deficiency:** The current water system cannot support a hospital at Pine Street during fire conditions, requiring a **private, on-site water storage system**.
- **Geotechnical Uncertainty:** Bedrock depth is highly variable (2m to 5m). Foundation stability cannot be fully guaranteed until after expensive site clearing and further boring.
- **Expansion Limits:** The "pit" on the western half effectively reduces the 47-acre site to 22 usable acres, potentially recreating the "landlocked" issues of the current hospital.

4. CONCLUSION & RECOMMENDATION

The selection of 300 Pine Street appears to prioritize **land ownership** over **technical suitability and fiscal prudence**. The "free" nature of the land is offset by the massive costs of site remediation and municipal infrastructure upgrades.

Action Required: Full disclosure of the unredacted **GHD Infrastructure Report** and **Appendix M (Evaluation Results)** to compare total lifecycle costs, including the $10M donation offer for the Muskoka Beach Road site.

APPENDIX B – Proposed Obstetrical Services Discussion

1. The Formal Document Language

In the **Volume 2: SMMH Part B (Functional Program)**, the room is officially categorized under:

- **"Emergency Department - Obstetrical/Neonatal Resuscitation Room"** * Or listed as **"1 LDRP (Labour, Delivery, Recovery, Postpartum) Room"** within the 46-bed allocation.

The document specifies that this room is intended for "emergent births" and stabilization before transfer to the regional hub.

2. Where the term "Nesting" Arises

In the official **Stage 1.3 Functional Program** technical documents, the specific term "nesting bed" is **not used as a formal clinical label** for a department. Instead, it is a term that has emerged from the **clinical planning sessions and MAHC's public engagement "frequently asked questions"** to describe the *function* of the single obstetrical space in Bracebridge.

Here is the breakdown of how the language appears in the actual documents vs. the terminology used in discussions:

The term **"nesting"** was used by MAHC leadership and clinical consultants during the "community chats" and stakeholder meetings (January–March 2024) to explain the compromise. It was a way to describe a room that "nests" or sits within the Emergency Department or the 46-bed Acute Care wing, rather than being part of a stand-alone, 24/7 staffed Obstetrics Department.

3. Why the term is controversial

For our committee, the distinction is vital:

- **In the documents:** It looks like one (1) birthing room.
- **In practice (the "Nesting" concept):** It means there are **no dedicated OB nurses** on site. If a birth happens in that "nesting bed," the staff used will be ED nurses or doctors who happen to be on shift, rather than the specialized maternity team that exists in the current hospital.

Based on the **Stage 1.3 Submission (Nov 2024)** and the accompanying technical documents for the **South Muskoka Memorial Hospital (SMMH)** redevelopment, here is the complete breakdown of the obstetrics (OB) "footprint" for the 2031/32 opening.

3. Physical Allocation & Location

In the new hospital at **300 Pine Street**, obstetrics is no longer a standalone department. Instead, it is integrated into the **Emergency Department (ED)** and **Acute Inpatient** footprints.

- **Quantity: One (1) dedicated Obstetrical/Neonatal Resuscitation Room.**
- **Square Footage:** The room is allocated approximately **32.5 net square meters (~350 sq. ft.)**.
- **Location:** The architectural layout places this room directly adjacent to the **Emergency Department core**. This allows ED staff to provide immediate stabilization for "imminent" births while awaiting transport.
- **Flexibility Strategy:** The Stage 1.3 plan suggests that in an "overflow" situation (more than one birth at a time), a standard **Medical/Surgical (Med/Surg)** room from the 46-bed wing would be used. However, Med/Surg rooms are typically not equipped with specialized gas lines or infant resuscitation equipment.

4. Surgical Capabilities for OB

One of the primary concerns for our committee regarding "safety" is the ability to perform an emergency C-section.

- **Surgical Access:** There are **two (2) Operating Rooms (ORs)** planned for the Bracebridge site.
- **The Conflict:** While the physical ORs exist, the model is built around **Day Surgery**. To perform a C-section, the hospital would need a 24/7 on-site **obstetrical surgical team** (Anesthesia, OB-GYN, and specialized Scrub Nurses).
- **The Reality:** The Stage 1.3 plan does not fund a dedicated 24/7 OB surgical team for Bracebridge. If a C-section is required, it must either be performed by the general surgery/anesthesia team on-call (if they have the specific credentials) or the patient must be transferred to the **Regional Birthing Centre in Huntsville**.

5. OB Service Comparison (2031/32)

SSMHC Key "Finds":

- **The "March 2025" Factor:** Although the new hospital doesn't open until ~2032, MAHC has already "temporarily" moved labor and delivery to Huntsville as of **March 11, 2025**. The Stage 1.3 infrastructure (with only 1 room in the ED) effectively locks in this "temporary" move as a permanent design choice.
- **Lack of "Postpartum" Beds:** There are **zero** dedicated postpartum beds in the 2031/32 Bracebridge plan. This confirms that even if a mother delivers in the "nesting" room, she and the baby will likely be transferred to Huntsville for the recovery period (stays typically lasting 24–48 hours).

Strategic Summary: The "Obstetrics" presence in the future Bracebridge hospital is effectively a **room**, not a **program**. It is designed for stabilization and transfer, not for the "Choice of Birth" experience currently available to South Muskoka residents.

APPENDIX C - Travel Distances to Healthcare and Resource Misalignment for South Muskoka Region

1. The CT Paradox: Technology vs. Protocol

The most glaring inefficiency in the current system—which the 2032 plan fails to rectify—is the administrative underutilization of the Bracebridge (SMMH) CT scanner.

- **The Reality:** SMMH currently possesses a functional CT scanner capable of diagnosing a stroke.
- **The Current Protocol (2026):** Under existing EMS Bypass Protocols, ambulances are prohibited from stopping at SMMH for stroke patients. They must drive past the Bracebridge CT scanner to reach the "Designated Stroke Centre" in Huntsville.
- **The 2032 Entrenchment:** Instead of using the new build to fix this bypass (by designating SMMH as a Telestroke site), the 2032 plan entrenches this model by moving all specialized support beds and the region's only MRI to the North.

2. The South Muskoka "Dead Zone" Defined

The proposed 2031/32 Made in Muskoka model will separate a massive geographic territory from time-sensitive care (i.e. <45 minutes access) within this identified corridor:

- **North/South:** Stephenson Road 1 & 2 down to Kilworthy Road/Severn Bridge.
- **East/West:** Vankoughnet/Black River across to Bala/Wahta Territory.

3. The "Toronto Retrace": A Life-Safety Systemic Loop

For a **Hemorrhagic Stroke (Brain Bleed)**, the current bypass creates a logistical absurdity that risks lives.

1. **The Pickup:** A patient is picked up in South Muskoka (e.g., Gravenhurst or Bala).
2. **The Forced Detour:** Per protocol, the ambulance drives **50–65 minutes North** to Huntsville for a CT scan, bypassing the SMMH scanner.
3. **The Diagnosis:** The scan confirms a hemorrhage. **Neurosurgery is required.**

4. **The Toronto Retrace:** Since neurosurgery is **only available in Toronto**, the patient is put back in an ambulance/helicopter and driven **South**.
5. **The "Wasted Hour":** The patient drives past the Bracebridge hospital for the **second time**. They have wasted nearly **100km of travel** navigating a detour before even beginning the trip to the surgical team in Toronto.

4. Real-World Transit Realities

Planners ignore the "Muskoka Factor." Even in clear conditions, the detour is excessive:

Point of Origin	**Destination**	**Drive Time (Clear)**	**Drive Time (Winter/Traffic)**
Bala	HDMH (Huntsville)	**1 Hour**	1.5 – 2 Hours
Bracebridge (Central)	HDMH (Huntsville)	**50 Minutes**	1 Hour +
Bracebridge (Central)	**SMMH (Local CT)**	**8 Minutes**	12 Minutes

5. The "Triple Threat" to Emergency Transit

Highway 11 is a fragile link. Three factors frequently break the "clinical conveyor belt":

- **1. The Wildlife Hazard:** Emergency transfers often occur at night/dawn. High-speed runs on Highway 11 face constant **moose and deer** collision risks.
- **2. The Tourist Surge:** In summer, Highway 11 congestion can turn a 50-minute transfer into a **90-minute crawl**.
- **3. The Winter Bottlenecks:** Snow squalls ("streamers") off Georgian Bay frequently sever the North/South link at:

- **High Falls** (Primary corridor)
- **Severn Bridge to Kilworthy** (Southern gateway)
- **Hwy 118 East to Doe Lake Road**
- **Port Sydney**

6. Summary Table: Current Protocol vs. Clinical Potential

Step	**If SMMH was utilized as a Stroke Site**	**Current Protocol (Bypassing SMMH)**	**Time/Resource Loss**
Diagnostic CT	**On-site (Bracebridge)**	**Forced Transfer North to HDMH**	**+50-65 mins**
Treatment (Hemorrhage)	Direct South to Toronto	**Retrace South past SMMH**	**+45 mins (The Loop)**
911 Resources	1 High-Priority Trip	**2 High-Priority Trips**	**Double the EMS Drain**

Strategic Conclusion:

The Made in Muskoka plan misses the opportunity to fix a broken protocol. We are building a new hospital that continues to administratively 'handcuff' its own CT scanner.

We are asking the Ministry: Why are we building a 'modern' healthcare system that still requires a patient to drive an hour in the wrong direction while their brain tissue is dying?

APPENDIX D – Sustainability of SMMH at Risk: Bed and Service Disparity Between HDMH and SMMH

This table directly compares the current **2024 operational reality** with the **2031/32 opening-day projections** as finalized in the Stage 1.3 submission.

This is arguably the most powerful visual tool, as it identifies exactly what is being "exchanged" or lost in the name of modernization.

Service Comparison: South Muskoka (Bracebridge Site)

Service Category	**Current Status (2024)**	**New SMMH (2031/32)**	**Net Change / Impact**
Total Inpatient Beds	**~65 Beds**	**46 Beds**	**-19 Beds (-30%)**
Reactivation (Senior Rehab)	15 Beds	**0 Beds**	**Total Removal**
Acute Medicine / Surgery	~46 Beds	41 Beds	-5 Beds
Critical Care (ICU)	5 Beds (Level 2)	4 Beds (Level 2)	-1 Bed
Obstetrics (Birthing)	Active Unit (Historically)	**"Nesting" Room only**	**Program Loss**
Postpartum Recovery	2-3 Dedicated Beds	**0 Beds**	**Total Removal**
Surgical Focus	Mixed (Inpatient/Day)	**98% Day Surgery**	Loss of complex surgery
MRI	No (Mobile/None)	**No** (Remains North)	**No Local Access**
Nuclear Med / Mammography	Baseline	**Regional Lead**	**Significant Increase**

Strategic Analysis of the "2024 vs. 2032" Data

1. The Senior Care Deficit

The most glaring change is the reduction from **15 Reactivation beds to zero**.

- **In 2024:** A senior recovering from a stroke or hip surgery stays in Bracebridge.
- **In 2032:** That same senior is stabilized in a 41-bed acute wing and then **immediately transferred to Huntsville** because there are no longer any "recovery" beds in the South.

2. The Obstetrics "Phantom Unit"

While MAHC claims obstetrics is "preserved," the 2032 model removes the infrastructure that makes a program viable:

- **In 2024:** There is a dedicated floor/wing for moms and babies.
- **In 2032:** There is a single room in the Emergency Department. Without postpartum beds or a dedicated nursing team, it functions as a "waiting room for an ambulance" to Huntsville.

3. The Surgical "Hollowing Out"

Although the *number* of procedures in Bracebridge will technically rise to over 9,000, the *type* of surgery is restricted.

- **The Reality:** By 2032, Bracebridge loses the ability to keep surgical patients overnight in any significant capacity. It effectively becomes a "Factory" for cataracts, scopes, and minor urology, while any resident needing a gall bladder or orthopedic surgery that requires a 2-night stay is sent North.

4. The Diagnostics "See-Saw"

The table reveals a clear trade-off. Bracebridge is "given" the high-volume screening (Mammography/Nuclear Med) to keep the building busy, but denied the high-complexity tool (MRI).

- **The Argument:** If the MRI is essential for the **Seniors** (strokes, dementia) and the **Surgical** patients (complications), why is it being placed 40km away from where 98% of the day procedures and the bulk of the senior population reside?

APPENDIX E - Proposed Pine Street SMMH Site Layout – Fire Access and Emergency Flow

1. The "Perimeter Access" Failure (Fire Safety)

Based on the current Block Schematic for the Pine Street site, there is a significant risk regarding **Fire Department (FD) Access** as mandated by the **Ontario Building Code (OBC)**.

- **The Constraint:** The site is "pinched" between a granite quarry to the West and a steep 100ft elevation drop toward Highway 11 to the East.
- **The Regulation (OBC 3.2.5.4):** For a high-occupancy "Group B" building (Hospital), the code require3s access routes to at least **two separate building faces**. If the building backs up directly to the slope, the "Highway side" becomes inaccessible to heavy apparatus.
- **The Aerial Risk:** Modern ladder trucks require a level, stabilized "setback" to deploy outriggers. If the land slopes away steeply to the East, the FD cannot deploy ladders to reach upper-floor windows for rescue or ventilation on that entire side of the building.

2. The "Retail Gauntlet" (Ambulance Logistics)

The proposed route for emergency vehicles to reach the new SMMH is a violation of established **Clinical Logistics Standards**.

- **The Route:** Ambulances must navigate **Depot Drive**, passing a high-volume Tim Hortons, Walmart, and Home Depot.
- **The Conflict (CSA Z8000-18):** This Canadian Standard for Healthcare Facilities explicitly states that **"Ambulance traffic shall be separated from public and service vehicle traffic."** * **The Tourist Surge:** During peak summer weekends, Depot Drive is a known bottleneck. Forcing an ambulance—carrying a stroke or trauma patient—to fight retail traffic creates an unmitigated "Transit Delay" that has not been addressed in the Stage 1.3 documents.

3. Pedestrian Conflict Zones

Modern hospital design prioritizes a "Clean Site Flow" where sirens and high-speed emergency vehicles never interact with the public entrance.

- **The Sketch Reality:** The current layout shows ambulances driving **past the front entrance** (between the hospital and the parking lot) to reach the ER bays.
- **The Danger:** This creates a **High-Risk Pedestrian Conflict Zone**. Elderly patients, families with children, and staff moving to/from the parking lot are placed directly in the path of responding emergency vehicles. This is a fundamental failure in **Wayfinding and Safety Design**.

4. The "Wildlife Funnel" Hazard

The Pine Street site sits on the edge of a natural wildlife corridor.

- **The Risk:** By placing a 24/7 high-intensity facility with frequent siren activity right against the "slope land" to Highway 11, the hospital creates a collision-rich environment.
- **The Impact:** Paramedics responding at high speeds—already stressed by the "Depot Drive Gauntlet"—must navigate a site where moose and deer are naturally funneled between the highway and the quarry.

5. Summary Table: Regulatory & Safety Gaps

Stakeholder	**The 2032 Design Risk**	**Regulatory/Policy Standard**
Fire Department	Lack of 360-degree aerial ladder access.	**OBC 3.2.5.4** (Multiple Face Access)
Paramedics	Access via retail corridor (Depot Drive).	**MOH Site Flow Guidelines**
Public Safety	Ambulances cross main public entrance.	**CSA Z8000** (Dedicated Emergency Route)
Patient Safety	Delayed "Time to Treatment" via bottlenecks.	**The Golden Hour Rule**