

Integrated Service Plan for Northwestern Ontario

Report of the Special Advisor, Tom Closson

June 2005



Vision for the Restructuring of Health Services in Northwestern Ontario

Improve the health status of people in Northwestern Ontario through an emphasis on health education, disease prevention, health maintenance and access to health services that incorporates the physical and mental health of the population.

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Vision for the Restructuring of Health Services in Northwestern Ontario

Improve the health status of people in Northwestern Ontario through an emphasis on health education, disease prevention, health maintenance and access to health services that incorporates the physical and mental health of the population.

This vision requires significant attention to the restructuring, integration and enhancement of primary community care and primary hospital care. The recommendations in this report will maximize the populations' access to health services by integrating services along the continuum of care, emphasizing culturally sensitive service delivery and providing services as close to home as is feasible with respect to the safety of care, quality of care and the economics of the care delivery systems.

The Report of the Special Advisor contains the recommendations that will provide the best opportunities for system enhancement, while clarifying the important role of the Thunder Bay Regional Health Sciences Centre (TBRHSC) within the system. The Hay Report to the Special Advisor includes all of the data gathered over the past nine months in Northwestern Ontario, literature reviews, summaries of consultations that took place during that time and summaries of over 70 submissions received from the community with regard to the work of the Special Advisor. In addition, the Special Advisor received invaluable advice and assistance from a Steering Committee made up of community leaders and health care professionals who live and work throughout Northwestern Ontario.

These recommendations, if implemented, will make it possible for more people to receive more care closer to home. In an area as large as Northwestern Ontario with its relatively small population, it is not possible to avoid the necessity of having people travel for some of their care. But, by planning for more integration and interaction of services across Northwestern Ontario it should reduce the need for travel for services that can be provided effectively in, or close to, the patient's home community. It should be emphasized that these recommendations will take time to implement but that significant improvements could be realized within six months if some of the recommendations are targeted for aggressive implementation.

In addition to the challenges of size, Northwestern Ontario has a number of isolated communities that have no land access except for a short period during the winter months. Therefore, all patients who must travel for healthcare must fly in and out of these communities. These are largely First Nations communities, which means that some services are provided by the Province of Ontario, some by the federal government and some services are provided on reserve through the band council's office. This complexity of funding and responsibility is frequently a barrier to access to health services.

This project started because Thunder Bay Regional Health Sciences Centre was often “closed to the region” and citizens of Northwestern Ontario outside of Thunder Bay could not access the expertise and services of their regional hospital. These recommendations, if adopted and implemented by the Local Health Integration Network, will resolve this problem for the long term. In the short term three ‘actions’ will immediately assist in easing the pressure on TBRHSC: an immediate investment into long term care places in the City of Thunder Bay, the District of Thunder Bay and the city of Kenora; aggressive utilization management by TBRHSC to ensure that all patients in their beds require the services of an acute care facility; and a focus on repatriating patients from TBRHSC to their local hospital as soon as it is possible to make the transfer.

Primary Community Care in Isolated and Remote Communities

Northwestern Ontario has a number of primary care delivery models that could be expanded, although expansion will always depend on the availability of health care professionals who desire to work in this manner. Several models should be used, depending on the location in the Northwest.

Isolated and Remote Communities

There should be an expansion of the use of Nurse Practitioners (NPs) who will be located in isolated and remote communities; the smallest of these communities would be served by regular visits by travelling Nurses and Nurse Practitioners. It is also recommended that these communities expand the use of point-of-care diagnostic technologies which will support decision-making as to whether patients need to move from isolated or remote care settings to another health care setting. In addition, it is recommended that the care providers working in the isolated and remote communities work together as a ‘virtual’ health care team to serve the widely dispersed populations in these communities. This would provide phone, telemedicine, and visiting support from a variety of health care professions to each of the remote communities. Importantly, the Nurse Practitioners in these smaller communities should have 24-hour access to the Emergency Departments at the District and Regional level using telemedicine linkages.

Recommendation (1) – The MOHLTC should adapt primary health models for isolated and remote communities to include ‘virtual teams that make use of Nurse Practitioners and nurses as the primary care givers linked together and to a supporting family practitioner and other health professionals by telemedicine technologies.

Recommendation (2) - The LHIN should ensure that all isolated communities have a 24-hour telemedicine link to their closest District Hospital and to TBRHSC.

Primary Care/CCACs and Hospitals

Primary care should be provided through integrated, multidisciplinary teams. These teams would focus on health education, suicide and injury prevention, disease prevention and health maintenance. Family Health Teams (FHTs) outside of Thunder Bay, to the extent possible, should be operationally integrated with the services of the CCAC and the closest hospital. Within this context, pre-natal care and midwifery should be provided locally in as many communities as possible with birthing at the District Hospitals

operating under the Society of Obstetricians and Gynaecologists of Canada MORE (Managing Obstetrical Risk Efficiently) program.

Recommendation (3) – The MOHLTC should ensure that each Family Health Team (FHT) approved outside Thunder Bay, to the extent possible, is operationally integrated with the services of the CCAC and the closest hospital.

Restructuring of Hospital Services: Formal Designations of Local and District Hospitals

Building up the capacity of the District and Local Hospitals will take the pressure off Thunder Bay Regional Health Sciences Centre and will allow people to receive their care closer to home.

Hospitals in Northwestern Ontario should have clearly designated roles and responsibilities in responding to the needs of the population in the region. Hospitals should be designated as Local, District or Regional Hospitals with roles and responsibilities as defined below.

The designation as a Local Hospital would mean that the hospital would provide support for office and treatment space for Family Health Teams, diagnostic technologies (e.g., ultrasound) that would allow care decisions to be made locally, emergency care, inpatient medical care for observation, treatment and stabilization, general practitioner procedures and surgeries, and continuation of treatment and recovery for local patients after they have received their initial stages of acute care treatment in a District or the Regional hospital.

The designation as a District Hospital would mean that a facility would provide advanced diagnostic technologies (e.g., CT scanners), emergency care, general inpatient medicine, specialty outpatient medicine services, some inpatient general surgery, selected subspecialty surgery by visiting surgeons, low risk birthing by general practitioners, visiting paediatricians and visiting psychiatrists. Hospitals in Kenora, Dryden, Sioux Lookout, Fort Frances and Marathon should be designated as District Hospitals. The services of the hospital in Geraldton should also be enhanced given this area's isolation by road from other hospitals.

The airport in Sioux Lookout receives medical transfers for approximately 90,000 patient visits per year. These patients are from isolated communities travelling to receive health care in the hospital in Sioux Lookout or points further south. Given the geography and transportation services of the Northwest, the need to access care from all points north, and the fact that most of these patients require care that is sensitive to their culture and language, the Province of Ontario should commit to an investment in the Meno-Ya-Win Hospital which would allow it to serve as a District Hospital and provide more care and procedures than currently.

The facility should continue its focus on providing culturally sensitive care and should be given a formal responsibility to lead the region in developing and implementing this approach to care throughout Northwestern Ontario.

Recommendation (4) – The MOHLTC should invest in the redevelopment of Meno-Ya-Win Hospital as a Centre of Excellence which will enable it to serve as a District Hospital and to assume leadership in Northwestern Ontario for the development of region-wide, culturally sensitive care.

Recommendation (5) – The MOHLTC should invest in the redevelopment of Wilson Memorial General Hospital in Marathon to enable it to serve as a District Hospital. Consideration should also be given to capital investment to enable increasing the services available at the hospital in Geraldton.

Tertiary Care in Northwestern Ontario

Cardiac Revascularization and Neurosurgery are tertiary services requiring specific attention in Northwestern Ontario.

Revascularization/Cardiac Surgery

There are insufficient patients requiring cardiac surgery in Northwestern Ontario for the development of a cardiac surgery program. Patients should continue to be referred to programs in southern Ontario for cardiac surgery.

TBRHSC should develop an angioplasty service which would receive its emergency cardiac surgery back-up in Duluth. In doing so, there is a small risk that patients who experience a perforation during angioplasty might not survive a trip to Duluth for cardiac surgery. But, this risk is small and there is a risk of death associated with the wait for transportation for an angioplasty in Southern Ontario.

Recommendation (6) – The MOHLTC should establish an angioplasty service in Thunder Bay with a formal agreement for emergency cardiac surgery backup in Duluth.

Neurosurgery

Neurosurgery is required to support the trauma program located at TBRHSC. In order to provide coverage on a 24-hour, seven-day-a-week basis which is a fundamental requirement of a trauma program, TBRHSC should have a minimum of three neurosurgeons on staff. As the numbers of patients requiring the services of a neurosurgeon is insufficient to financially support the practice of three neurosurgeons through OHIP billings, it will require an Alternate Payment Plan. Those surgeons could augment their general neurosurgery practice with complex spinal surgery, and neuroradiology. Also, the establishment of the Northern Medical School will provide academic opportunities and commitments for these staff.

Recommendation (7) - The MOHLTC should establish an Alternate Payment Plan (APP) for Neurosurgery that supports 3 neurosurgeons to enable 24/7 coverage for trauma.

Out-Of-Region Services

There is a perception that very large numbers of patients in Northwestern Ontario receive their care in Winnipeg, Duluth and Southern Ontario. However, only 4.2% of inpatient hospitalizations by residents of Northwestern Ontario are in Winnipeg hospitals and 4.5 % of inpatient hospitalizations require travel outside of Northwest Ontario for emergency or very specialized care. This information should be used to repatriate as many of these cases as possible taking into account quality of care, patient safety and economics.

Travel for emergency and very specialized care to Winnipeg and Southern Ontario will and should continue. However, it is anticipated that, by increasing the capabilities in hospitals designated as District Hospitals that the need for some of the travel to Winnipeg can be eliminated and by increasing the capabilities of TBRHSC the need for some of the travel to Southern Ontario can be eliminated.

There are patient volume requirements to ensure the continuing clinical capabilities of TBRHSC and to provide sufficient caseload to support its emerging academic mission. To this end, it will be important for much of the secondary care and most of the tertiary care for residents of NW Ontario to be provided by TBRHSC. This includes care for some First Nations people who are currently sent by the Federal Government to Winnipeg. It is recognized that, because of the differences in driving time and distance, people drive from Kenora to Winnipeg for emergency care and for assessments and treatments by medical specialists and subspecialists rather than going to Thunder Bay. This pattern of hospital use will and should continue and ground ambulance should continue to travel from the Kenora area to Winnipeg. However, to address the patient volume requirements of the specialized services that need to be provided and of the academic programs at TBRHSC, all air ambulance service should go to Thunder Bay rather than Winnipeg.

There will be circumstances when Winnipeg Regional Health Authority (WRHA) is the appropriate provider of care for residents of the western part of Northwestern Ontario. At present, WRHA is providing an *ad hoc* service to the residents of Northwestern Ontario. A more formal recognition of the use of Manitoba's health service by Ontario residents would do much to ease the concern that access to the services will close. Given the geographic realities of this part of the Province of Ontario it is appropriate for the governments of the Provinces of Ontario and Manitoba to formalize the provision of selected elective and emergency and urgent services by Winnipeg Regional Health Authority for the residents of Kenora and when TBRHSC cannot meet the surge demands of the population of the Northwest.

The expectation should be that the providers in Northwestern Ontario plan to provide almost all of the services to local residents but that some formal provision be made for

Ontario residents to access services in Manitoba when surges are being experienced that cannot be met within the Northwest.

Throughout the period of consultation, the issue of travel grants for transportation of patients came up many times. Stories of individuals transported by ambulance and/or air ambulance in an emergency situation and then ‘stranded’ in a location remote from their home were common. The MOHLTC’s policy is that patients who are transported for medical reasons and who continue under care, are transported back via ambulance or air ambulance. Given the distances, the financial difficulties faced by those who travel for health care, and the lack of public transportation in many areas, the LHIN should take a look at travel grants, policies governing transportation of patients and determine how many cases of ‘stranded’ patients there are within the region.

Recommendation (8) – The LHIN should plan to provide capacity within the region for almost all of the health services needed by Northwestern Ontario’s residents. Negotiations should take place with the Federal Government to have all First Nations people who reside within Ontario’s boundaries, be cared for within the Ontario system.

Recommendation (9) – The LHIN and the MOHLTC should negotiate a formal agreement with the Winnipeg Regional Health Authority to provide emergent and elective tertiary care for residents of Sioux Lookout & Isolated Communities and environs.

Recommendation (10) – The LHIN and the MOHLTC should negotiate a formal agreement with the Winnipeg Regional Health Authority to address situations when the facilities in Northwestern Ontario cannot meet surge demands for care.

Integration of Planning for All Levels of Long Term Care

There needs to be a focus of planning for the expansion of long term care ‘places’ with the desire that people be placed along the continuum of care as close to home as possible. The principles of expanding capacity in this area should include maximization of independence, maximizing social interaction in all ‘places’, a preference for long-term care in the local community, a preference for ‘in-home’ care over congregate care, a preference for supportive housing over nursing home care, and the provision of psycho-geriatric care in all treatment settings.

The current use of complex continuing care at St. Joseph’s in Thunder Bay for short-term transitional care is delaying placement of patients into other locations including long-term care and home care. This use of beds is contributing to the ‘backup’ in the inpatient acute care beds at TBRHSC and needs to be immediately addressed by using complex continuing care beds for continuing care rather than transitional care.

The data collected to complete this report confirms that the District of Thunder Bay, City of Thunder Bay and the City of Kenora do not have enough long term care places to respond to the needs of those in the community who require a level of long term care, whether it be a nursing home space, a supportive housing space or a space in a long term

care facility. Across these three districts, additional long-term care places will be required but all three levels of care need to be used to address the needs of these populations. The addition of these places in these communities would better respond to the need for long term care and will keep individuals requiring care closer to their social support networks.

Recommendation (11) -- The MOHLTC should expand long-term care places in Northwestern Ontario to provide:

- ***29 supportive housing units in Kenora;***
- ***192 supportive housing units, and 149 equivalent long-term home care places in Thunder Bay; and***
- ***58 supportive housing places, 93 equivalent long term home care places, and 57 nursing home beds in the District of Thunder Bay.***

Mental Health & Addiction Services

This area of services was more frequently commented on than almost any other area. There is insufficient access to these services across Northwestern Ontario and, where there are services, the ‘special vote’ funding approach used by the MOHLTC means that money cannot be moved from one type of service to another, despite the fact that those who deliver these services have far greater knowledge of what is needed in their communities than do those responsible for the funding envelopes within the Ministry in Toronto. Removing bureaucratic red tape, allowing individuals in the communities to work together and deliver the best services they can for the total dollars they receive would go some way towards assisting Northwestern Ontario in providing more effective mental health and addiction services.

Recommendation (12) -- The MOHLTC should discontinue the ‘special vote’ approach to funding mental health and addiction services and provide sufficient funds in a global manner to the LHIN so that decisions can be made locally in a flexible manner on how best to use these funds.

Governance and Management

There are many examples of how individual institutions in Northwest Ontario have come together to plan and implement the delivery of care across institutions. For further examples of how consolidation could take place, the institutions in the region should look at the work being done by Grey Bruce Health Services. In that instance, the Centre Grey Hospital, Bruce Peninsula Health Services, the Meaford General Hospital, and the Grey Bruce Regional Health Centre have all come together with one board, a common structure for information management, quality improvement, common credentialing and human resources planning and recruitment.

The creation of a hierarchy of facilities with increasing capabilities along the continuum means that TBRHSC will need to adopt a regional approach to patients as they move through the system. It also requires formal recognition and acceptance by TBRHSC and its medical staff that their role is to provide necessary secondary and tertiary subspecialty

care for the population of the entire Northwest and active support for specialists and primary care providers practicing in communities and hospitals outside of Thunder Bay.

To facilitate this new hospital/health services organizational continuum there should be District Governance and management structures for each of six districts:

- Sioux Lookout & isolated communities,
- Kenora,
- Dryden-Red Lake,
- Fort Frances-Rainy River,
- Thunder Bay District
- Thunder Bay City

These new District governance and management structures would lead management of health care in the Northwest. These new entities would be challenged to introduce a new focus on integrated management of health services across the continuum at the District level. Planning and funding allocations among the Districts would be led by the LHIN. This new model will require dissolution of most existing local service delivery governance structures. Special consideration will need to be given to governance of religious service delivery agencies such as the St. Joseph's Care Group.

Recommendation (13) – The Ministry of Health and Long Term Care should implement a District Governance model for service delivery replacing most existing local service delivery governance structures to enhance the responsiveness of health services in Northwestern Ontario to the needs of the population.

Medical Advisory Committee

The population in Northwestern Ontario justifiably desires and expects the integration of health care services. Given the interdependency of hospitals in the Northwest and the amount of necessary patient transfer among facilities, it is not unreasonable for residents to expect a single admission for a single, integrated episode of care in response to a single incident of accident or ill health. The patient would be cared for within one admission from Local, to District to the Regional hospital, and back, as appropriate. By setting up structures and processes which focus on a seamless 'trip' for each patient through the system, and by focusing each individual organization's efforts on their portion of the patient's trip, it is anticipated that more people can be treated closer to their homes and social support networks. Also, this will serve to optimize the use of the limited resources of the regional hospital in Thunder Bay by focusing its services to patients from Thunder Bay and from outside the city on services and levels of care that can only be provided in a regional centre. The integration of services will be facilitated by the assignment of clearly articulated hospital roles and responsibilities supported by District and inter District structures, processes and governance.

A Northwestern Ontario Medical Advisory Committee (MAC) can facilitate integrating hospital care along the continuum. The Joint MAC would ensure consistency and continuity in medical practice and processes in all hospitals in the region. The Joint

MAC would serve as the MAC of each of the new District Governance entities in Northwest Ontario and would be responsible for the quality of medical care throughout the Northwest. Medical staff of individual Districts, as appropriate, could form district advisory committees that would become sub-committees of the Joint Northwestern Ontario MAC allowing local issues to be identified at the individual facility/district and local interests and needs to be brought to the attention of the Northwestern Ontario Joint MAC. This approach would encourage and facilitate the clinical interaction of physicians across the northwest and continuity of care for patients as they move along the continuum of care.

Recommendation (14) – The LHIN should establish a Joint Medical Advisory Committee (MAC) to facilitate the continuity of care for patients as they move along the continuum of care.

Recommendation (15) – Each District should recognize the Joint MAC as fulfilling the District’s requirement for an MAC for each of its hospitals under the Public Hospitals Act.

Utilization Management for Northwestern Ontario

During this study, the admission rates for a variety of illnesses and procedures were looked at with a view to determining whether Northwestern Ontario’s hospital utilization rates were comparable to other Ontario communities. The data collected for this study demonstrates a high use of inpatient hospital care in Northwestern Ontario compared to other areas in the province. These differences are especially apparent for residents of Thunder Bay. There was an expectation that there would be modestly higher rates of hospitalization in the isolated and remote areas, given the vast distances that individuals must travel and a tendency to admit for services that a local resident might receive as an outpatient. However, it was somewhat surprising to see the higher use of inpatient care by residents of Thunder Bay. There should be an aggressive, Northwest-wide utilization management program that ensures that patients are cared for in the place which is most suited to their clinical needs. The recommended structure of District governance and expanded capacity for long-term care places greatly enhances the chances of success for such a program.

Recommendation (16) – The LHIN should establish a Northwest-wide program for utilization management to ensure that patients are cared for in the most appropriate setting reducing the utilization of inpatient beds at TBRHSC to enable it to respond to the needs of the region.

A Northwestern Ontario Approach to Health Human Resources Planning

There is a severe shortage of health human resources in Northwestern Ontario and it continues to be extremely difficult to attract staff. At the present time, communities and hospitals are competing for physicians, nurses, and allied health professionals. A collaborative, unified approach to recruiting staff to Northwestern Ontario will be much more effective than current disjointed approaches. The needs of the population of

Northwestern Ontario will be better served by comprehensive planning for health human resources and collective implementation of the plans within the new health Districts.

Recommendation (17) – The LHIN should establish a Northwestern Ontario-wide approach to all health human resources planning

It is critical for the MOHLTC to come to agreement around Alternate Payment Plans for specialists practicing in Northwestern Ontario. In order to assist TBRHSC in recruiting and retaining medical specialists and subspecialists to address its clinical and academic requirements there needs to be a successful negotiation of an Alternative Payment Plan. The current “fee-for-service” physician compensation model and the relatively small population base in Northwestern Ontario makes it all but impossible for TBRHSC to attract and retain enough specialists to cover on-call requirements for many medical specialties. There are insufficient cases to support an adequate complement of specialists in these disciplines if the only source of income for these physicians is through billings. The requirement to assume teaching and research duties within the Northern Medical School also will require an alternative way to compensate these physicians.

Within the APP negotiations, there must be an understanding that these physicians have an obligation to support all of Northwestern Ontario through telemedicine and by providing visiting clinics/services within the District Hospitals and support for specialists and primary care providers outside of the Thunder Bay area. There is a need to formalize the role for TBRHSC and its medical staff with regard to their responsibility for the delivery of specialty and subspecialty care for the population of the entire region. There are other places in Ontario such as the work being done from the Ottawa Hospital which has reached out to provide support throughout the Ottawa Valley – where an academic centre has assumed responsibility for care throughout the region. Given the size of this region and the designated role of TBRHSC, it is important that the hospital and its physicians assume a regional responsibility.

Recommendation (18) -- The MOHLTC should establish Alternative Payment Plans for specialist physicians in Northwestern Ontario to attract and retain enough of them to provide 24/7 service coverage for patients from the entire region. The APP must formalize their regional and academic responsibilities.

Increased Use of Telemedicine& Other E-Health Strategies

Northwestern Ontario is leading most other areas of the province in its adoption of telemedicine and the delivery of health care services through other e-health strategies. This is applauded, encouraged and should be expanded. All isolated communities that are not already linked/partnered for telehealth services should be provided with the infrastructure for such work as soon as possible. Also, the isolated communities should have a 24-hour link to the emergency facilities at their closest District Hospital and TBRHSC should expand its ability to provide 24-hour emergency consultation to all isolated and remote communities.

In addition, Northwestern Ontario would benefit from a formal partnership for access to telemedicine and outreach support with a large psychiatric program elsewhere in the province which could then provide much greater availability of psychiatric services throughout the Northwest. The LHIN should explore the sufficiency of the type of support available from the Ontario Psychiatric Outreach Program (OPOP). There are additional services, which would be expanded in the telemedicine program over time, but augmenting mental health services would address a current and pressing need.

Recommendation (19) – The LHIN should ensure that all isolated communities have a 24-hour telemedicine link to their closest District Hospital and to TBRHSC.

Recommendation (20) – The LHIN should establish a telemedicine and outreach partnership to provide psychiatric support to community and hospital mental health services in Northwestern Ontario.

The significant amount of movement of patients from facility to facility along the care continuum in Northwestern Ontario mandates that information about their current needs and treatments and about pre-existing and concurrent treatment follow the patient from facility to facility. Moving paper records from facility to facility is a cumbersome, time consuming and inefficient process that often results in delays in treatment. More importantly, there is not one repository of information regarding the patients' episodes of in-hospital care. When a patient next presents at a hospital, it is not likely that the clinicians will have timely access to important clinical (and non-clinical) information that will be important to effectively address the patient's problem. Integration of care along the continuum and integration of information related to each episode of hospital care for a patient will be facilitated and enhanced through the creation of a fully integrated electronic health record that is used by each of the hospitals in Northwestern Ontario. The creation of the integrated electronic record will be facilitated by the work already completed by the Northwest Health Network and the considerable pre-existing investments in information systems by the hospitals in the Northwest.

Once the hospital records are integrated across facilities, the next step will be to add in the patients' interactions with providers in the community to create a Northwestern Ontario Health Information Network and an integrated electronic health record including participation by physicians' offices, pharmacies, CCACs, etc. Again, this extension of the electronic record to include community interaction will be facilitated by the current work of the Northwest Health Network.

Recommendation (21) --The LHIN should ensure the continuation of the work of the Northwest Health Network to develop a Northwestern Ontario Health Information Network and implement an Integrated Electronic Health Record for each of the residents of Northwestern Ontario.

Implementation and Operating Costs

Some of the recommendations presented here can be implemented by refocusing current health services spending in Northwestern Ontario. However, some of these will require investments in capital and additional spending on operations. The table following presents a best estimate of the required funding of all of the recommendations made this report.

Initiatives	Capital & One Time Costs	Operating Costs	Comment
Improve Primary Care			
Increase NPs in Isolated Communities		\$500,000	Add 5 Nurse Practitioners @ \$100,000
Increase FHTs in NW Ontario		\$0	No new costs; part of funding for Health Results Team Transformation Initiatives
Reduced Hospital Admissions for Avoidable Conditions		-\$1,100,000	Reduce 514 annual admissions @ \$2220
Increased Acute Care Volumes for Population of Northwestern Ontario due to demographic changes		\$3,360,000	507 additional cases or 1,347 wtd cases @ \$2,491/wtd case
Restructuring of Acute Care			
Additional acute care capability and capacity in Marathon	\$5,000,000	\$0	Increase operating cost in Marathon offset by decrease at TBRHSC
New, enhanced acute care facility in Sioux Lookout.	\$60,000,000	\$0	46 beds acute, surgery and LDR, extensive diagnostics, ambulatory care, 25 beds CCC/LTC/ Increase operating cost offset by decrease at TBRHSC, Dryden & Winnipeg
Completion of Hospital Care in District and Local hospitals		\$1,018,563	1463 transfers from TBRHSC requiring 3,731 additional days @ \$273/day
Medical Transportation to District & Local hospitals		\$731,500	1,463 medical transportation transfers @ \$500/trip
Clinical Efficiency at TBRHSC		-\$2,400,000	Reduction of 8,719 days or 956.7 equivalent wtd cases at \$2,492/wtd case
Introduction of Angioplasty at TBRHSC			
Procedure and acute care costs		\$0	Increase at TBRHSC (estimated at \$1.5 million) offset by decrease in southern hospitals
Reduction in Days Waiting for Transfer		-\$775,200	143 patients admitted to TBRHSC used 1938 patient days @ \$400/day waiting for transfer
Reduction in Travel Grants		-\$700,000	Approximately 200 commercial transfers @ \$1,000 and 100 air ambulance transfers @ \$5,000
Emergency Surgery in Duluth		\$240,000	2% of patients, 6 patients require emergency surgery in Duluth @ \$40,000 per occurrence .
Add long-term care capacity			
Long Term Home Care		\$2,420,000	242 places @ \$10K/place/year
Supportive Housing	\$41,850,000	\$1,674,000	279 places @ \$150K/place and \$6K/place/year
Nursing Home Beds	\$8,550,000	\$1,453,500	57 beds @ 150K/bed and \$25.5K/bed/year

Initiatives	Capital & One Time Costs	Operating Costs	Comment
Substitution of NH Beds for CCC Beds		-\$8,500,000	Reduce 165 CCC beds @ \$200/day and replace with 143 NH beds @ \$70/day
Substitution of in-home for inpatient palliative care in Thunder Bay		-\$1,200,000	27 beds @\$200/day converted to 27 long-term home care places @ \$70/day
Creation of District Governance & Management		-\$1,440,000	Reduction of 3 administrative positions per site in new multi-hospital Districts
APP for Specialists and Subspecialists.		\$3,300,000	11 positions @ \$300K
ICT Initiatives			
Enhancement to Telemedicine	\$0	\$0	Included in mandate of North Network
Electronic Hospital Record	\$28,000,000	\$3,300,000	Based on communication from TBRHSC and Northern Ontario Blueprint
Electronic Health Record	\$19,000,000	\$2,200,000	Based on communication from TBRHSC and Northern Ontario Blueprint
Total Net Costs of Restructuring	\$162,400,000	\$4,082,363	
Potential Private Sector Financing of LTC Places	\$50,400,000		
Net Cost to MOHLTC and Local Communities	\$112,000,000	\$4,082,363	

