Part A - Program and Service

	Issue/Comment Status Indicator	Date of Submission (yyyy-mm-	Submission Reference (Item/Pg	Issues/Comments	Issue/ Comment Source	Date of Response (yyyy-mm-	Response Source	Response (Comment or Reference Document Name)	Response Source	Issue/ Comment Resolved?
1		2016-10-12		Despite the LHIN endorsement dated 2016-11-22 for the stage 1 submission, the ministry expects the hospital to seek LHIN endorsement on programs and services and the projected operating costs for new programs and clinics after alignment with the ministry.	MOH-1			Noted. The NSM LHIN continues to look at programs and services in relation to the larger NSM region. The LHIN will continue to work with CGMH and examine program and service volumes and where needed work with CGMH to refine these		
2		2016-10-12	1.1.62 -66	Is there a formal Agreement with the Rural Ontario Medical Program (ROMP) ?	MOH-1			At present there is a formal agreement with ROMP is for the leasing of space from CGMH		
3		2016-10-12	1.1.72-73	Has the LHIN endorsed and provided Operating funds for increase in regional outpatient Mental Health and Addiction services?	MOH-1			At this time, the NSM LHIN has not endorsed the provision of increased operating dollars for regional OP MHA.		
4		2016-10-12	1.1.99	Has the LHIN designated CGMH as the Regional Rehabilitation Centre? If so, is the LHIN planning to transfer the operating funds from the other hospitals to Collingwood?				The NSM LHIN is in the midst of formalizing a regional rehab plan. As of today, CGMH will not be considered a regional rehab site however, the LHIN is aware of rehab programming needs related to MSK and stroke for instance. Based on the Regional Rehab needs, CGMH would have Rehab Beds for populations to meet the current service gap within the South Georgian Bay region and align with our Orthopedic program. Currently, South Georgian Bay residents have only 40% of the provincial average access to inpatient rehab beds.		
5		2016-10-12	1.1.11	Please provide CCO Oncology satellite support and funding letter. Will pharmacy renovation be needed? If so, please consult the Ontario College of Pharmacists guidelines.	MOH-1			A letter of support from Royal Victoria Regional Health Centre (RVH) was included as an appendices to the Stage 1 submission <reattached>. Renovations to the CGMH Pharmacy will not be required as a consequence of providing an Oncology Satellite Clinic. Chemotherapy medications will be provided from the RVH Pharmacy and shipped to CGMH on a daily basis.		
6		2016-10-12	1.1.37.8	Has the LHIN endorsed and provided Operating funds for proposed new Senior Day Hospital services?	MOH-1			The Seniors Day Hospital was included as a program for future consideration and not included in the Stage 1A/1B and therefore, funding is not required at this time.		
7		2016-10-12	1.1.11	Has CCN supported the need for a Pacemaker Clinic and what is the source of the Operating funds? Does Collingwood have the necessary Human Resources to support this program?				The NSM LHIN notes that the work for the Pacemaker Clinic is still under review. Discussions have occurred with RVH regarding the potential for a future pacemaker clinic at collingwood, which is envisioned to be a follow up clinic initially with consideration to move to implant status at a later date in time if feasible and would anticipate further investigation would be required at that time.		
8		2016-10-12	14 and 1.1.23	MOHLTC supports the use of Ontario Telemedicine Network (OTN) in generic exam room space.	MOH-1			Noted. This will be explored in more detail in Stage 2.		
9		2016-10-12	1.1.11	Has the LHIN endorsed and provided Operating funding for the new Pain Management services?	MOH-1			At this time the NSM LHIN has not currently endorsed the provision of operating dollars for pain mgt services		
10		2016-10-12		Consider the use of technology advancements and self registration options.	MOH-1			Noted. This will be explored in more detail in Stage 2.		
11		2016-10-12	2.2.3-12 and 2.2-8	If approval is provided to proceed to Stage 2, please provide revised inpatient and outpatient Human Resource Plan for program growth.	MOH-1			Noted. This will be exlpored in more detail in Stage 2.		
12		2016-10-12	2.2-14 and ES-1A-20	If approval is provided to proceed to Stage 2, Please provide Human Resource Plan for Support Programs.	MOH-1			Noted. This will be explored in more detail in Stage 2.		
13		2016-10-12	ES-1A-18	The ministry supports 8% of acute care beds for ICU.	MOH-1			Noted. The Stage 1A called for 14 Special Care Unit beds, which includes step down and ICU beds. At the MOH projection for 96 Medical/Surgical beds for 2034/35, 8% corresponds to 9 ICU beds. If CGMH plans for 5 step-down beds (which could be included as part of the Medical/Surgical complement), the Stage 1A is consistent with MOH on ICU beds.		

14		2016-10-12	1.1.6	Regarding inpatient bed planning, please explain the bed need change from 68 (based on bed census) adult beds to projected 102 beds. (Refer to comment #26) . The provincial average for medical beds is 7.1 days and CGMH is 8.7 days. How do you plan to reduce ALOS to 5.8?	MOH-1			It appears that the Stage 1 A double counted obstetric beds. Obstetric activity is not double counted in the days, but the bed totals should not include obstetric beds since they are reported under Med/Surg. After this correction, we are consistent with MOH on starting number. For 2018/19, the Stage 1A shows 102 total beds, but this total includes obstetrics and rehab beds not included in the MOH's 86 beds. If we exclude 10 rehab and 5 obstetric beds, the Stage 1A has 87 total beds, which consistent with MOH's 86. To derive the future ALOS, we planned on the peer 50th percentile acute ALOS and on ALC at 12 percent. Our calculations are case mix adjusted so the difference between the MOH 7.1 and the planned 5.8 may also have to do with who we count as medical. Plans for ALOS reductions are included in the Stage 1A.		
15		2016-10-12	1.1.57	Please provide the support letter from CCO for the Ontario Breast Screening Program (OBSP) planned program.	MOH-1			As of January 24, 2017, CGMH became an affiliated OBSP site. Please refer to the attached CCO letter dated November 4, 2016 outlining CGMH's funding agreement.		
16		2016-10-12	1.1.55	Has the application for new MRI unit been submitted to LLB?	MOH-1			The MRI has been proposed in Stage 1. Upon approval, CGMH would move forward with an application to LLB.		
17		2016-10-12	1.1.24	On page 1.1.24 it appears Inpatient Physiotherapy has been moved out of hospital and outpatient physiotherapy remains. Please explain.	MOH-1			Inpatient Physiotherapy has been shown in the ambulatory section to reference its existence, but bracketed so as not to count the volume within ambulatory totals, because the volume is included in the Inpatient Rehabilitation section - see page 1.1.99 - 1.1.103.		
18		2016-10-12	1.1.13.2	What is the plan to reduce surgical beds by 18 ? And given this reduction what is then the rationale for the increase in the Anaesthetists and surgeons?	MOH-1			The existing medical/surgical beds at CGMH are a mixed unit. The reported total beds for each category is not reflective of their actual use. i.e. approx 20 of the 33 'Surgical Inpatient' beds were used for medical patients in 2014/15. The projected beds represent a reallocation of medical and surgical beds based on utilization and future need, not a reduction. There is therefore growth in the program - based on actual current use - and this necessitates the growth of the surgical staff, also reflecting an increase in surgical day care cases.		
19		2016-10-12	1.1.13.2 and 1.1.14.6	What is the source of funding for the Rehabilitation services?	MOH-1			Rehabilitation Services currently exist on-site, funded through the current CGMH budget. The proposed change to rehabilitation at CGMH is the addition of a dedicated inpatient unit, anticipating potential recommendations from the NSM LHIN.		
20		2016-10-12	1.2.1	The Staffing Plan projection show an increase of 32% from 2014-15 to 2023-24. What is the source of Operating funding?	MOH-1			Increased staffing and operational costs related to all service volume increases will be addressed through maximizing operating efficiencies to improve the hospital's performance within the Health System Funding Reform's HBAM funding model, as well as through future growth funding negotiations, which will be detailed as part of the PCOP estimate included with the Stage 2 Functional Program submission.		
21		2016-10-12	1.1.79	Page 1.1.79 describes delivery of medical gases to patient areas - is this for transporting patients?	MOH-1			Yes - this is only for the transport of patients.		
22		2016-10-12		The document notes alignment with ORN - please confirm that the ORN has reviewed the submission documents.	Provincial Program			Yes, the ORN assisted in the development of the documentation for the hemodialysis section, to ensure alignment with their regional plans and vision. A letter of support is included in the Appendices of Stage 1a.		
23		2016-10-12	Part A. P.56	Please confirm that the plan and location of the projected dialysis aligns with ORN plans.	Provincial Program			The CGMH hemodialysis plans are in alignment with the ORN projections and plans and the 2015-2025 North Simcoe Muskoka LHIN Dialysis Capacity Assessment		

24		2016-10-12	1.1.56	What is the rationale for growth in some inpatient diagnostic services (> 70% for x-ray, CT, US) higher than growth in inpatient admissions (64%)?	MOH-4			In the Stage 1A, separations grew from 4,275 to 7,366, or an increase of 73%. Inpatient X-Rays increase from 3,060 to 5,300 (73%) and inpatient CTs from 903 to 1,565 (73%). This may require further discussion with the MoH to clarify.		
25		2016-10-12	General	In the Stage 1 submission, 5 maternal beds are listed in current operation. The ministry can not verify the number from the hospital Trial Balance and Bed Census Summary (BCS) reported to ministry. Please clarify if these 5 maternal beds were grouped in the combined Med/Surgical beds and if not, confirm where the hospital is reporting these 5 beds in the Bed Census Summary and Trial Balance reports. It is noted that there were 5 level 1 bassinettes reported in BCS.	MOH-2			These 5 maternal beds are reported under a combined Medical/Surgical department (functional centre 71230 within the TB Submission).		
26		2016-10-12	General	The ministry 's HBAM analysis has yielded a different set of projected inpatient beds compared to the hospital projections . Please note that the ministry cannot plan for the additional rehab beds until the LHIN has provided written approval confirming the additional operating funding required to support the additional beds.	MOH-2			Noted.		
27		2016-10-12	General	The ministry projected volumes for the ortho/fracture clinic, dialysis treatment places, oncology visits and mental health visits are higher than the Ministry of Finance projected total population growth and age 65+ population growth. Please provide the rationale to support the higher projected volumes for these services.	MOH-2			Ortho/Fracture Clinic: The Stage 1A planned for a fourth orthopeodic surgeon as per the NSM LHIN MSK strategy to maximise the CGMH ortho program and assist in meeting regional needs. We increased with fracture clinic activity to account for this market share change. This may require further discussion with the MoH. Dialysis: The Stage 1A submission planning for Nephrology was based on discussions with the Ontario Renal Network, and their metrics for planning dialysis stations for maximum efficiency. They reflect NSM LHIN CKD program assumptions for planning regarding home dialysis, palliative care, and transplantation, since these may impact demand for services in the short and longer term. Oncology: Oncology proejctions (1,500 visits for 2018/19) were an estimate based on recommendations from the Simcoe Muskoka Regional Cancer Program, based on a projected number of patients for Orillia Soldiers Memorial Hospital Level 4 Satellite site, based on the Regional Cancer Program assumption that the volumes/need would be similar. This projection was a placeholder for planning purposes and as such, projections beyond 2018/19 were not included. This will be explored further at the next stage of planning. Mental Health: mental health volumes were based on 2013/14 data and grown based on population growth (2014/15 were low due to staffing reductions and a reduction in available clinical hours based on increased crisis worker support to the ED). It should be noted that this is still believed to be an underestimation of need for these services (there is currently a 17+ week wait list) and a general lack of addictions services and at the time ACT Team services, which contribute to increased demand for services.		
28		2016-10-12	General	The ministry HBAM analysis has projected different number of ED visits (lower than hospital 20 year projection.) Please explain why the 2014/15 base year ED visits in the St 1 submission are significantly lower than those from IntelliHealth Ontario.	MOH-2			The ED visits shown in the Stage 1A are consistent with the HIT tool (33,356 in 2014/15).		
29		2016-10-12	General	On the programs and services, future submissions will need to include projected weighted cases and a clear delineation of Quality-Based Procedures (QbP) and procedures funded by wait times. Hospital's acknowledgement is required as the hospital response.	MOH-2			Noted.		

30		2016-10-12	General	PCOP does not fund clinical services that are or will be funded by another ministry or out of province, or those administered by Wait Times, QbPs or community programs. Also, the PCOP does not fund clinical services that relate to program transfers and expects operating costs of the program to be transferred accordingly. The ministry expects the hospital to structure the clinical services with a view to maximizing operating efficiencies to improve its performance within the Health System Funding Reform's HBAM funding model. Hospital's acknowledgement is required as the hospital response.	MOH-2			Noted.		

Part B - Physical and Cost

	Issue/Comment Status Indicator	Date of Submission (yyyy-mm-dd)	Submission Reference (Item/Pg	Issues/Comments	Issue/ Comment Source	Date of Response (yyyy-mm-	Response Source	Response (Comment or Reference Document Name)		
1		2016-10-12	pg.2	The 2010 pre-capital submission proposed a 125 bed facility with 245,000 BGSF (2026/2027). The current submission proposed a 119 beds facility with 337,140 BGSF (2023/24). It is understood that new standards (i.e. CSA Z8000) have driven some increase in facility size. Please identify how this submission differs from the 2010 submission and the drivers for the considerable increase in proposed building size from the earlier submission. The proposed beds have not been agreed upon.	MOH-1			CGMH's 2010 Pre-Capital Submission indicated that the combination of population growth and the changing demographics in the south Georgian Bay region would require an increase of beds to 125 by 2026/27. To arrive at the total BGSF of 245,000 as outlined in the 2010 Pre-Cap, the bed count of 125 was applied to a high-level average of 1900 BGSF/bed, which was an identified industry guideline at the time. In CGMH's revised Pre-Capital Submission in 2015, and its subsequent Stage 1 submission in 2016, more sophisticated and up-to-date methods were used to determine spatial requirements. The revised spatial requirements of 337,140 BGSF as stated in the Stage 1 submission, were based on a more granular level analysis by service/component area. More specifically, instead of an average BGSF/bed to calculate total spatial requirements as presented in the 2010 Pre-Cap, space was identified in CGMH's Stage 1 submission by calculating the net square feet (nsf) for each proposed room or area, multiplied by a planning factor to provide component gross square feet (cgsf); cgsf included space for internal walls and circulation for each service area. The planning factors varied according to the amount of circulation needed for each service/component area.		
2		2016-10-12	2.2-5	Emergency Department: Trauma rooms are only provided to designated trauma centres. Rooms should be designated as Resuscitation Rooms. CSA Z8000-11, table 9.4, is to be interpreted as resuscitation rooms 28 sq.m. per bay, trauma room 35 sq.m. per bay. Please acknowledge.	MOH-1			Noted.		
3		2016-10-12	2.2-6	Critical Care: There appears to be a duplication of the care area and clinical support areas in the Critical care section. Please confirm the number of beds and rooms proposed in this department.	MOH-1			Yes, this was included in duplication as a formatting error. The projected beds for Critical Care included in the Stage 1 submission are 8, 8, and 12 beds for the ICU for 2018/19, 2023/24 and 2033/34 respectively. Two SDC (cardiac) beds have also been included for all time frames.		
4		2016-10-12	2.2-8 - 9	Medical/Surgical/Rehab: The ministry recommends 100% private inpatient bedroom accommodation with private washrooms, in alignment with CSA Z8000 requirements. Hospitals are advised that the ministry is exploring the potential to make the above recommendation a mandatory requirement. Hospitals are asked to consider the impact of this potential policy change and plan for possible future direction to include 100% private accommodation.	MOH-1			Noted.		

5		2016-10-12	2.2-14	Admin & Support Services: The ministry is supportive of any efforts to reduce administrative space and dedicate more space to patient care functions. Please explain how the considerable reduction in space was achieved. (current 13, 877 cgsf; proposed 7500cgsf).	MOH-1			To clarify, the current 13,877 cgsf represents a rolled up total that included areas that have been shown as discrete spaces in the projected totals. (eg. Education/HIS/IPC/IT). Therefore, the projected 7500 cgsf is not a direct comparison, since it does not include the sum total of required spaces. That said, meetings with the planning teams did include discussions regarding applying current workplace standards which in most cases are smaller than current sizing. This will be further explored in Stage 2.		
6		2016-10-12	2.2-16	Registration/Admitting/Discharge: The registration area is very large compared to similar facilities. The ministry encourages the use of self registration kiosks and other technology (home, mobile registration) to improve workflow and limit the spatial requirements for this area. Please update accordingly.	MOH-1			Noted. This will be expored in more detail in Stage 2.		
7		2016-10-12	2.2-17 - 19	Support Services: It is the ministry's understanding that a variety of support services (materials management, laundry, food, lab, pharmacy, MDRD) are currently or may in the future be considering outsourcing some services. Identify the status of any changes to service delivery for each support service. Further identify how changes to the service delivery model impacts loading bay and spatial requirements.	MOH-1			The Stage 1 planning included discussions regarding support services and the potential opportunities to outsource and/or consolidate services. CGMH has, and will continue to explore opportunities to further outsource processes/services where feasible and cost effective. MDRD requires a critical mass to consider outsourcing. NSM LHIN has explored this regionally, but it is not being considered at this time. Pharmacy services are provided (and will continue to provided) onsite. Requirements in support of the future Satellite Chemotherapy program will be provided by RVH, not by the CGMH Pharmacy. Lab services are/will be provided onsite, however microbiology is provided by RVH. It is expected this will continue in future. Laundry services are outsourced; this will continue in future. Materials Management is/will be provided via a just-in-time (JIT) system, for maximum efficiency and use of space resources. Food Services and EVS are currently managed by a third-party. The impact to the loading bay is affected by hospital volumes rather than changes to support service process design.		
8		2016-10-12	3-27	Both the "cloverleaf" and bar/racetrack typologies have been supported by the ministry for past projects. Comment on the hospital preference for one over the other. How will one typology impact operating efficiencies for the hospital?	MOH-1			Stantec presented various inpatient typologies to CGMH clinical staff, who identified the "cloverleaf" layout as their preferred design. This typology provides a horizontal proximity between small groupings of inpatient rooms, which affords efficient staffing practices and functional flexibility. CGMH expressed a strong preference for horizontal relationships between departments rather than vertical stacking. The "cloverleaf" inpatient layout aligns with the expressed interprofessional team's preferred clinical and staffing approach.		

9		2016-10-12	Options Analysis	Option 2 is contingent on acquisition of several parcels of privately owned land adjacent to the current property. The submission indicates that one land owner is not interested in selling (p. 3-46). Provide additional commentary on the viability of this option. How would the inability to acquire one site impact the redevelopment scheme?	MOH-1			At this time, CGMH has communicated that two of the adjacent property owners are currently not interested in selling their land. These are the two properties flanking the primary hospital entrance off of Hume Street; The viability of Option 2 as a realistic development approach is contingent on the acquisition of one of the properties. Without this property, the overall parcel of land available for the project would be an irregular shape not conducive to hospital redevelopment. The other property is less critical to the viability of Option 2, since this land is not within the footprint of the planned building, and makes up one corner of the overall consolidated site. That being said, acquiring this land is strongly advised, as it would provide greater flexibility in optimizing the overall site, parking, and helipad design. Further negotiations between the hospital and these property owners would be required in order to secure these lands. Should an agreement not be reached, other options for land acquisition would be required, which would involve either a municipal or provincial expropriation process.		
10		2016-10-12	Options Analysis	Ministry is asking the hospital to explore an additional option that provides a phased approach to redeveloping the hospital on its current site. This is intended to mean multiple discrete and independent capital projects to deliver the 2023/24 spatial requirements, as opposed to dependent construction phases already provided in option 1. This option anticipates that some functions will remain in the existing building with minimal renovation/intervention (i.e. to address deferred maintenance and end of life infrastructure (as identified on pages 40-41 of the technical building assessment); not to renovate to a new state). Identify short-term program and service priorities for implementation, even if total replacement of the existing facility is envisioned.	MOH-1			Option 1, as submitted, is a phased approach to redeveloping the hospital on its current site. It represents a consideration of the condition of the existing infrastructure (buildings) and required maintenance to propose the maximum amount of reuse of the existing infrastructure possible. Option 1 recommends a phased redevelopment approach that allows for partial reuse of the existing building in order to achieve the 2023/24 requirements, and eventual full replacement of the current hospital to achieve the 2033/34 requirements. The first phase proposes an addition of a new building housing diagnostic and treatment space, and new inpatient units. The lower level of this new wing would provide new loading facilities. All other departments would be accommodated in renovated space in the existing building. Although other options were considered, this is a balanced first phase which envisions the maximum amount of renovation and minimal amount of new construction. It is the minimal amount of new construction in order to support the hospital's clinical needs. Renovation of existing diagnostic, emergency, or surgical services within the current building would result in sub-standard treatment space, due to inadequate space, current floor-plate restrictions, and limited floor-to-floor height. Similarly, the inpatient units within the existing building cannot support current clinical needs. Lastly, the provision for new loading facilities would enable ongoing operation of the hospital through all phases of work (including future development).		
11		2016-10-12	Redevelopment options	The focus of the ministry review/comments on Part B at this point, is on the assessment of the brownfield redevelopment approach and greenfield redevelopment approach. The ministry has not assessed the various siting options for consideration.	MOH-2			Noted. CGMH has provided both a greenfield and brownfield solution.		