

Transitional Strategy for Managing Alternative Level of Care Patients

**Sudbury Appropriate/ Alternative Level of
Care Steering Group**

Capacity Options for Single Site Occupancy Working Group

May 27, 2009

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EXECUTIVE SUMMARY

Key Facts

- In January 2010 the Hôpital régional de Sudbury Regional Hospital (HRSRH) will consolidate acute services to its single site facility and close the Memorial site. The SJHC will be closed by March 2010.
- The single site facility was planned by Ministry of Health directive to be built to accommodate no Alternative Level of Care Patients (ALC).
- This plan is one (1) of the ten (10) initiatives of the Sudbury Alternative/Appropriate Level of Care Community Steering Group. It assumes the successful accomplishment of other aspects of the ALC Steering Group's work plan.
- The HRSRH faces significant financial pressures. The Hospital is developing a plan to balance its budget for approval by the NELHIN Board. This current strategy does not accommodate for the potential impacts of the Hospital's fiscal recovery strategy but it is aligned.
- The current bed capacity at the HRSRH including 21 transitional beds is 548 beds. The single site has a capacity of 450 beds including the Kirkwood site.
- The system bed capacity will decline from 1860 to 1770 beds between March 2009 and March 2010 after which it will begin to increase to 1936 beds by December 2010.

System Bed Capacity Summary

	Current	Sept-09	Jan-10	Apr-10	Jun-10	Dec-10
Total Acute	548	493	493	450	450	450
Long Term Care	1230	1230	1230	1230	1294	1422
Interim LTC	82	82	26	26	0	0
SCJJJ	0	64	64	64	64	64
System Bed Capacity	1860	1869	1813	1770	1808	1936

- This plan assumes the occupancy of 64 long term care beds at Pioneer Manor by September 2010 and 128 long term care beds at St Joseph's Chelmsford facility by December 2010.
- The HRSRH has on average 100 ALC patients occupying acute medical and surgical beds and 21 in transitional care beds. Additionally, there are 56 Pioneer Manor Interim Long Term Care patients at the HRSRH which will require accommodation for an interim period while they wait for new capacity to be completed on the Pioneer Manor campus. A total of 177 ALC patients require accommodation by January 2010.
- The NELHIN Housing Study identifies a mitigation strategy that could significantly alter the demand for Long Term Care during this period of transition if the goal of building 125 Supportive Housing Units annually is achieved. Unmitigated by alternative strategies the number of Alternative Level of Care patients in acute medical surgical beds will grow to 173 patients by 2010 and over 200 by 2011.

Options

The Sudbury Alternative/Appropriate Level of Care Community Steering Group reviewed several options and models through their discussions. The options are detailed below:

- **Option 1:** This option assumes 56 Pioneer Manor patients will move to the Memorial site as a temporary solution between January 2010 and September 2010 and their beds will be operated as Transitional Care Beds. During this period they would be operated by the HRSRH. This would require the discharge of patients from Pioneer Manor to the HRSRH. Once Pioneer Manor facility is complete the patients would be readmitted to Pioneer Manor. Between January 2010 and September 2010 the HRSRH would operate an additional 94 Transitional Care Beds and 100 beds until December 2010.
- Assuming the SJHC opens the Chelmsford facility in December 2010 the HRSRH would then operate 75 Transitional Care Beds between December 2010 and March 2011 and 100 beds between April 2011 and January 2013.
- **Option 2:** This option assumes that the compliance requirement can be waived and Pioneer Manor and SJHC Chelmsford Facility can operate temporarily in the Memorial Facility. In this option, effective January 2010 Pioneer Manor would operate 56 Interim Beds at the Memorial site and St Joseph's would operate 94 Long Term Care Beds at the Memorial site. The behavioural needs of patients would be provided for through a funded program in one of the long term care facilities.
- In September 2010, once Pioneer Manor moves to their final location, the SJHC or other LTC provider would operate up to 100 beds while the Chelmsford LTC facility is constructed. This facility is scheduled for completion in December 2010. Thereafter compliance renovations would be completed and up to 100 beds would be operated as Interim Long Term Care beds by a long term care facility operator until January 2013 when the facility would close.
- **Option 3:** Assumes that the HRSRH would operate up to 150 Transitional Care Beds on the Memorial site effective January 2010. Pioneer Manor patients would have to be admitted to the HRSRH as transitional care patients. Once Pioneer

Manor site is completed and patients are transferred to the final location the Memorial site would be renovated on a floor by floor basis to bring them into compliance with MOHLTC compliance standards for LTC.

- Once compliance is achieved the facility would be operated by a Long Term Care provider as an Interim Long Term Care facility until January 2013. Patients with complex behavioural needs would be transitioned to a LTC facility funded for the program during this period.

Table 6: Critical Task Summary Cost Comparison of Options

			Option 1		Option 2		Option 3	
			HRSRH Transitional Care Beds		Pioneer Manor Funding 56 Beds and SJHC up to 128 Beds Chelmsford LTC Funding Memorial Interim Bed Compliance		HRSRH Transitional Care Beds and Interim Bed Compliance Option	
Timeframe	Critical Task	Beds	Annual Cost	Period Cost	Annual Cost	Period Cost	Annual Costs	Period Cost
January 2010 – September 2010	Occupancy of Acute Service to Single Site at HRSRH.	150	\$24,856,500	\$18,642,375	\$7,500,750	\$5,625,563	\$24,856,500	\$18,642,375
September 2010-December 2010	Open 64 beds pioneer manor supportive housing capacity available	100	\$16,571,000	\$4,142,750	\$6,400,640	\$4,674,300	\$16,571,000	\$4,142,750
December 2010-March 2011	Occupancy St Joseph's Long Term Care Facility	75	\$12,428,250	\$3,107,063	\$3,750,375	\$937,594	\$4,215,750	\$1,053,938
April 2011 – January 2013	Building LTC and Supportive Housing Capacity	100	\$16,571,000	\$28,999,250	\$5,000,500	\$8,750,875	\$5,000,500	\$8,750,875
January 2013	Close Transitional Beds Memorial Site	0	0	0	0	0	0	0
Total Costs Operating Costs - 36 Months			\$54,891,438		\$19,988,331		\$32,589,938	
Building Operating - Incremental 36 Months			\$0		\$3,189,000		\$1,594,500	
Other Operating			\$0		\$1,200,000		\$1,200,000	
Building Capital - Infrastructure			\$1,353,250		\$1,353,250		\$1,353,250	
Compliance Renovation Costs			\$0		\$2,742,150		\$2,742,150	
Equipment			\$796,100		\$796,100		\$796,100	
Total Solution Cost-36 Months			\$57,040,788		\$29,268,831		\$40,275,938	
Revenue Potential - (Appendix F)			\$15,177,639		\$11,201,037		\$11,201,037	
Net Additional Revenue Required – 36 Months			\$41,863,149		\$18,067,795		\$27,086,600	

Recommendation

The Sudbury ALC Community Steering Group recommends that the North East Local Health Integration Network engage the Ministry of Health and Long-Term Care in selecting a cost-effective solution that will safely meet our clients' needs.

Overview

The Sudbury Alternative/Appropriate Level of Care Community Steering Group was created in December 2008 to address the increasing number of Alternative Level of Care patients at the Hôpital régional de Sudbury Regional Hospital (HRSRH) and in the Sudbury Community. This group is comprised of a cross section of members from all sectors of the health system and the City of Greater Sudbury.

In January 2009 the Group developed a 10 point plan to plan to address both the short term and longer term demands for Long Term Care services in Sudbury (Appendix G). The Group's endorsed strategies include:

- Prevention and Health Promotion
- Supportive Housing
- Alternative Care and Housing Options
- Bed Capacity Options for Single Site
- Long Term Care Outreach
- Specialized Services
- Integrated Clinical Pathways
- Enhanced Primary Care
- Health Human Resources
- Long Term Care Bed Needs

This report is the work of the working Group addressing the bed capacity options for the single site.

In January 2010 the Hôpital régional de Sudbury Regional Hospital (HRSRH) will consolidate services to its single site facility. The Memorial site will close in January 2010 and the SJHC will close in March 2010. Starting in June 2009 services will begin moving at the Laurentian site to their final single site location. The single site consolidation is being done at a time when the demand for institutional and community based services, long term care and supportive housing is increasing. The NE LHIN's Aging at Home programs and services and other fairly recently launched programs for seniors are in the early stages and the full positive impact of their implementation has yet to be seen.

This document provides an overview of the occupancy sequencing and facility options utilizing the current health infrastructure in Sudbury to meet the patient care capacity requirements of the community and to allow for the consolidation of acute services onto a single site.

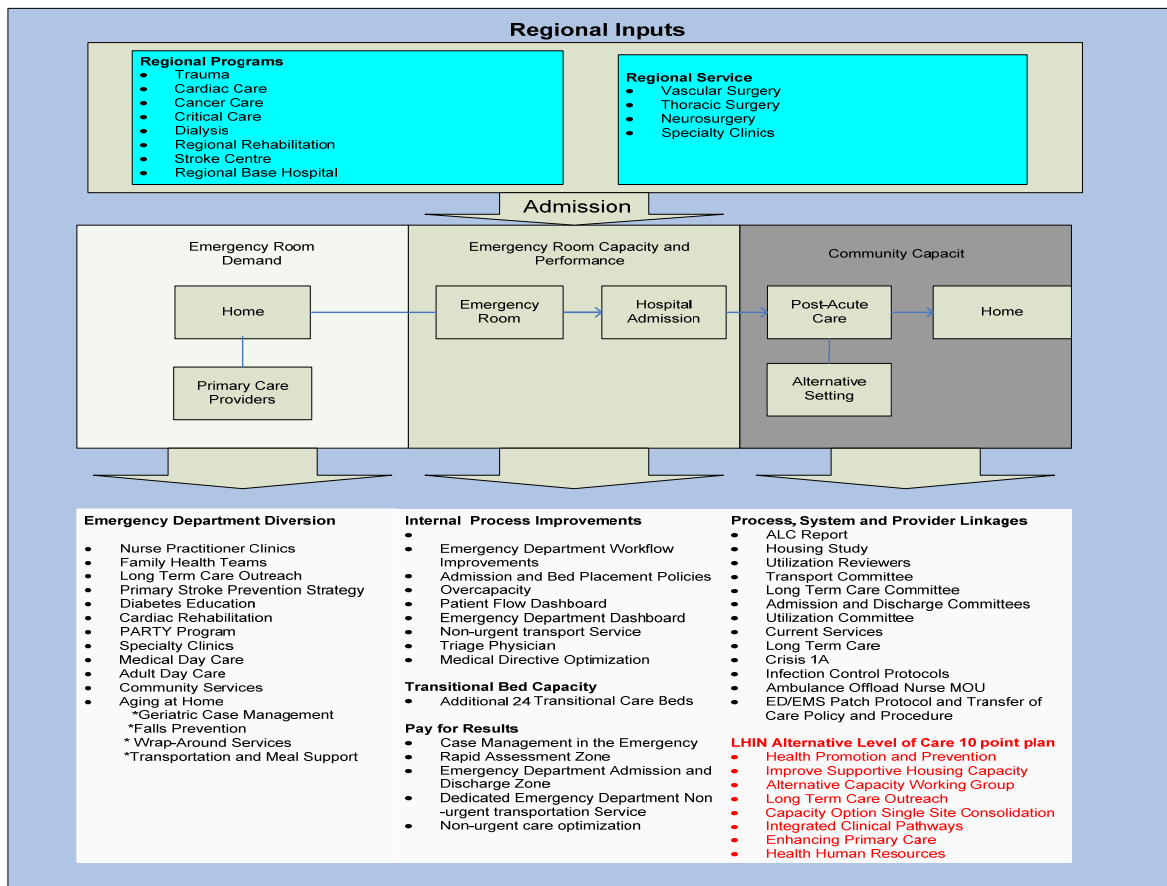
This plan is not intended as a sustainable strategy to accommodate the "long term care" needs of the City of Greater Sudbury. It is a focused plan to accommodate the intense needs of the community over a 36 month period starting January 2010. It is intended as a

bridging strategy that will allow the community to build community home care infrastructure, programs and services, long term care capacity and supportive housing capacity.

Regional Care Capacity and Emergency Department Alternative Level of Care Pay for Performance

Alternative Level of Care patients do impact the ability of the HRSRH to perform its Regional Role and ensure the accessibility of timely access to Emergency Department services. Solving the ALC challenge is important to the entire Northeast who relies on the HRSRH to provide regional services in cardiac care, cancer care, trauma, critical care, dialysis and trauma and regional surgical services in neurosurgery, vascular and thoracic surgery. Approximately 30% of the HRSRH beds are used for people outside the Sudbury District.

The ALC 10 point plan is a critical component of the Emergency Department wait-time and pay for performance initiatives as shown in the diagram below.



Essential to the success of this plan is that other strategies to accommodate the increasing community demand for long term care are implemented simultaneously. No one initiative

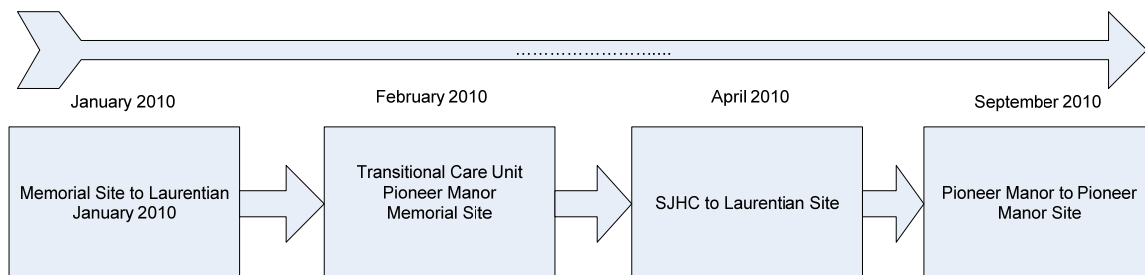
can solve the ALC challenge in Sudbury; it must be confronted from many angles and from many different sectors (hospital, municipality, community support services sector, provincial government to name a few). This plan assumes the availability of 125 incremental supportive housing units annually starting in the 2009/10 fiscal year in combination with the other components of the Alternative Level of Care Steering Committee's Ten (10) point plan. A target which we already no based on our May 25, 2009 Steering Group meeting will not be achieved.

Like many hospitals in the province, the HRSRH is experiencing significant budgetary pressures in the next fiscal year. This plan may be impacted by changes in the operation of the HRSRH as a result of its current fiscal pressure at the HRSRH.

Occupancy Plan Overview HRSRH Single Site

Memorial Site decanting and occupancy will begin in January 2010 and will occur over a two week period. By the middle of January 2010 the Memorial site will no longer function as an acute care facility. After a period of stabilization the HRSRH will begin moving services from the SJHC to the single site in March 2010. This will complete the single site consolidation by April 2010.

A complexity of the consolidation is that Pioneer Manor currently occupies space on levels five (5) and six (6) of the South Tower of the Laurentian site of the HRSRH. The plan needs to accommodate the requirement to place 56 Pioneer Manor patients between January 2010 and September 2010. It is assumed the Pioneer Manor's 64 additional beds will be available no later than September 2010.



The challenge is that there is insufficient long term care capacity to respond to the community's demand for care currently and into the foreseeable future. While planning to accommodate the increasing demand for care is well on its way, there is community consensus around the need for a transitional strategy to allow for the consolidation of acute care services onto a single site. This need is supported unanimously by the Steering Group. Consensus on this need was reaffirmed at it May 25, 2009 meeting. It is a key short-term transitional component of the Committee's 10 point plan. This plan provides an overview of the short-term option to achieve the consolidation of acute service to a single site.

Capacity Options and Analysis

System Bed Capacity

Table 1 below provides a summary of the community bed capacity. The table shows that the system bed capacity will decline from 1868 to 1770 beds between March 2009 and March 2010 after which it will begin to increase to 1936 beds by the December 2010. This assumes the completion of 64 LTC beds at Pioneer Manor and 128 LTC beds at the St Joseph's Long Term Care facility in Chelmsford by December 2010.

Table 1: Overview of System Bed Capacity

	Current	Sept-09	Jan-10	Apr-10	Jun-10	Dec-10
Total Acute	548	493	493	450	450	450
Long Term Care	1230	1230	1230	1230	1294	1422
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System Demand Projections Alternative Level of Care

Utilizing a five year historical growth analysis that takes into account the historical ALC growth, interim long term care and transitional bed capacity changes, the growth in ALC and the demands for long term care is projected in table 2 below. Adding to this, known changes in the LTC capacity over the next two fiscal years and the closure of the Memorial site, the unmet community bed capacity is calculated and summarized in table 2.

In summary, in 2003 there were 54 ALC patients at the HRSRH. This number was projected to rise to 141 by 2009. This number has already been realized. Today there are 21 patients in transitional care beds, 8 in retirement home beds and 112 in medical surgical beds in the hospital.

In addition to the 121 ALC patients occupying acute medical and surgical beds and transitional care beds in the facilities of the HRSRH there are fifty six (56) Interim Long Term Care Pioneer Manor patients that will need to move in January 2010 as the space on the 5th and 6th floors of the South Tower at the Laurentian site must be vacated to accommodate the requirements for single site occupancy. Based on current ALC numbers, there are 177 patients in the facilities of the HRSRH which will require alternative accommodation effective January 2010.

By no later than September 2010 and hopefully earlier, this deficit in Long Term Care beds will be accommodated through the opening of 64 permanent Long Term Care beds at Pioneer Manor. Looking forward to December 2010 things do improve with the addition of 128 LTC beds at the St Joseph's Chelmsford facility. However, in the absence of other strategies the demand for long term care will continue to rise. It is anticipated that even with this additional bed capacity transitional bed capacity must be made available to meet the Long Term Care needs of the community. Factors including system capacity combined with our aging population mean that the demand for care will continue to rise.

Other demand mitigating strategies are essential. Supportive housing is a critical component in mitigating the demand for future Long Term Care and care of seniors. The potential for demand mitigation utilizing supportive housing and aggressive utilization policies is calculated and shown in the table below. This demand mitigation strategy assumes the building and diversion to supportive housing of 125 patients a year starting in 2009/10. We learned at the May 25, 2009 meeting of the Steering Group that this is unlikely to be achieved. It remains unproven if additional supportive housing capacity alone will meet the future medium term demand for care. There remains a strong feeling by some members of the ALC Steering Committee that additional Long Term Care capacity is required as the demand projections are very conservative in terms of future need. Ongoing demand evaluation and the implementation of cost effective service delivery solutions is essential to meet future community need and to reduce dependency on long term care beds. Unmitigated by alternative strategies the number of Alternative Level of Care patients in acute medical

surgical beds will grow to 173 patients by 2010 and over 200 by 2011.

Table 2: Long Term Care/ Transitional Care Demand Capacity Gap

Year	03-04	04-05	05-06	06-07	08-09	09-10	10-11	11-12
Historical Growth HRSRH	54	49	63	81	115	141	173	205
Incremental LTC	This is the known changes in LTC beds				0	-18	128	0
Demand Historical Growth	Projections based on HRSRH historical experience				115	159	45	77
Potential for Demand Mitigation Supportive Housing	Based on LHIN Housing Strategy				0	125	250	375
Supportive Housing Impact on Demand	Potential Diversion				141	191	-62	-155

Capacity Options

The Steering Group reviewed several options to manage the current Alternative Level of Care population. There is currently no capacity in long term care facilities. A review of retirement home capacity was also completed by the “Alternative Care Housing Options Committee”. The results showed that capacity in retirement homes was limited and where supply existed it was not suitable for those patients who were considered ALC. Some limited new capacity is coming on-line and may be available for future use, however, the current demand for retirement home living out strips supply. Close monitoring of the availability of this supply will be ongoing task. Access to any surplus capacity that can not be filled from the community will form an important part of this plan.

Utilizing the NE LHIN’s Wrap-Around funding, the HRSRH has established a partnership with the NECCAC and Autumn-wood Retirement Living to discharge patients from the Hospital to a retirement home facility while they await placement into a Long Term Care facility.

The only immediate capacity available to meet the transitional demands of the community identified by the Alternative Level of Care Steering Committee is the Memorial and SJHC hospital sites. The LHIN ALC Steering Committee is proposing that utilization of the Memorial

site as a transitional location to meet the ongoing Long Term Care needs of the community over a 36 month period starting in January 2010.

An analysis of this option, associated capital and operating costs is provided below,

Bed Capacity

Table 3 below provides a summary of the bed capacity at the Memorial and SJHC that could easily be utilized as Transitional Care Beds. Neither of the proposed bed configurations would meet the MOHLTC Long Term Care (LTC) compliance requirements. Minor renovations are required at the Memorial site. The costs of these renovations are detailed in table 3. An allowance for minor renovations has been allocated for the SJHC.

Table 3: Bed Capacity Options

	Bed Capacity	Recommended Capacity	Renovation Costs
Memorial	225 (not ideal)	150	\$203,250
SJHC	228 (very limited renovations)	150	\$200,000 - Estimate

Memorial vs. SJHC

An analysis of both the Memorial and SJHC sites is summarized below. The details of the building infrastructure and ongoing operating cost requirements are provided in Appendices A and B.

The Memorial site is being decanted first, a decision that was made after extensive analysis with occupancy planning consultants as the sequencing of the capital redevelopment of the HRSRH was being planned. The HRSRH will initiate the final stages of its occupancy plan starting in June 2009 that will culminate in the closure of the Memorial site in January 2010 and the SJHC in March 2010.

In terms of building, the SJHC requires more short-term building infrastructure investments (\$2,678,250) when compared to the Memorial site (\$1,353,250). The SJHC site is not aligned with the occupancy planning requirements of the HRSRH so it has been discounted as a temporary transitional care facility option. In terms of operating costs the ongoing operating costs to the Memorial site (\$1,063,000) are less than the ongoing operating costs of the SJHC (\$2,678,250)

Table 4: Building Infrastructure and Building Operating Costs

	Memorial	SJHC
Capital One-Time		
Building	\$1,353,250	\$2,678,250
Renovations	\$205,250	\$200,000
Equipment	TBD	TBD
Building Operating Annual	\$1,063,000	\$2,678,250

Compliance

Neither the Memorial site nor the SJHC site meets the MOHLTC Long Term Care compliance regulations. The costs to achieve compliance at the Memorial site are detailed below. A similar analysis has not been done for the SJHC as it does not meet the HRSRH occupancy planning timeframe. The details of the scope of work to achieve compliance on the Memorial site are provided in Appendix C of this report. A summary is provided in Table 5 below

Table 5: Cost of Compliance

Scope of Work	Bed Capacity	One Time Building	Compliance Renovation Costs	Total One-time Capital
Compliance	109	\$1,330,000	\$2,742,150	\$4,072,150
Non-Compliance	150	\$1,330,000	\$2,742,150	\$1,553,250

Renovations to achieve compliance would take approximately 6 to 8 weeks per floor. Also, it is important to note that as the facility is renovated to meet Interim Long Term Care compliance standards the number of functioning beds would be reduced although it would create a more suitable and pleasant setting for long term care.

Behavioural Care Patients

A significant number of the ALC patients at the HRSRH have responsive behaviours and have been refused admission to a long term care facility. There are occasions when patients are admitted to the HRSRH from LTC facilities as the patient's behavioural care needs exceeds the resources available to provide safe care in the LTC facility. There are currently 10 patients with responsive behaviours or are on the "hard to serve" list and identified as hard to serve patients

Further evaluation is required to determine how to best meet the needs of this patient population. In the short term, it is recommended that funding be provided to either the St Joseph Villa or Pioneer Manor to operate a behaviour unit. An allocation of \$400,000 per year is recommended with an appropriate accountability agreement.

Convalescent Patients

As part of the transfer agreement process, the St Joseph's Complex Continuing Care agreed to transfer patients which met the admission criteria established by the community for Complex Continuing Care and to provide community capacity to help manage the Alternative Level of Care patient challenge. . The SJCCC will play a critical role in helping the community manage the current ALC challenge. A patient population that can be served at the SJCCC is the convalescent care population most often requiring long stay orthopaedic related convalescent care and patients experiencing functional decline requiring longer periods of convalescence. This would allow the HRSRH to focus on its mandates of Acute Care, Intensive Rehabilitation and General Rehabilitation.

The HRSRH must reduce its transitional care unit capacity from 50 to 24 beds by October 2009 to allow for renovations at the Laurentian site in preparation for the single site occupancy. Having these patients transferred by October 2009 will greatly facilitate the transfer and reduce overall system costs.

Operating Options

The Alternate Level of Steering Group discussed several options and models through their discussions. Below are detailed three options:

- **Option 1:** This option assumes 56 Pioneer Manor patients move to the Memorial site as a temporary solution between January 2010 and September 2010 and are operated as Transitional Care Beds. During this period they would be operated by the HRSRH. This would require the discharge of patients from Pioneer Manor to the HRSRH. Once the Pioneer Manor facility is complete the patients would be readmitted to Pioneer Manor. Between January 2010 and September 2010 the HRSRH would operate an additional 94 Transitional Care Beds. Between September 2010 and December 2010 100 beds would be operated.

- Assuming the SJHC opens the Chelmsford facility in December 2010 the HRSRH would then operate 75 Transitional Care Beds between December 2010 and March 2011 and 100 beds between April 2011 and January 2013. This solution is achievable but requires MOHLTC funding. The total solution cost for a 36 month period is \$41,863,149.
- The **advantages** of this option are that it is achievable using existing building infrastructure. It meets occupancy timelines and provides the most comprehensive model of service delivery providing for patients long term care needs and acute needs during periods of acute exacerbation. A “contract” could be established with Pioneer Manor to continue to care for their patients. Additionally, it assumes the provision of behavioural care.
- The **disadvantage** of this option is that it is the most expensive.
- **Option 2:** Assumes that the compliance requirement can be waived and Pioneer Manor and SJHC Chelmsford Facility can operate temporarily in the Memorial Facility. In this option, effective January 2010 Pioneer Manor would operate 56 Interim Beds at the Memorial site and St Joseph’s would operate 94 Long Term Care Beds at the Memorial site. Patients with responsive behaviours would be provided care through a funded program in one of the long term care facilities.
- In September 2010 once Pioneer Manor moves to their final location the Memorial site would be renovated on a floor by floor basis to achieve MOHLTC Long Term Care compliance standards. The SJHC would operate up to 100 beds while they completed their facility scheduled for completion in December 2010. Thereafter up to 100 beds would be operated as Interim Long Term Care beds until January 2013 when the facility would close.

The **advantages** of this option are that it allows for Pioneer Manor and St. Joseph’s to operate their business in existing health infrastructure. It is also the least expensive option.

The **disadvantage** of this option is that it is not in compliance with MOHLTC regulations. The main compliance issues relate to the size of bathrooms and access to dining room and activity room space. Currently acute care patients are well served at the Memorial site. As a temporary facility patients could be well served at this site.

This model of care assumes that patients with long term care needs would be cared for in these beds. Patients requiring acute intervention would be transferred to the HRSRH Emergency Department as is the current practice. Patients with responsive behaviours would be cared for in an alternative setting.

- **Option 3:** Assumes that the HRSRH would operate up to 150 Transitional Care Beds on the Memorial site effective January 2010. Once the Pioneer Manor site is completed and patients are transferred to the final location renovations would be completed at the Memorial site on a floor by floor basis to bring them into compliance with MOHLTC LTC compliance standards. During this period of time fewer beds would be operated.

- Once compliance is achieved the facility would be operated as by a Long Term Care provider as an Interim Long Term Care facility until January 2013. Patients with complex behavioural needs would be transitioned to a LTC facility funded for the program during this period.
- The **advantages** of this option are that it is achievable, does not require the waiving of the long term care compliance standards and meets the timelines of the HRSRH occupancy plan. It also is cost effective and provides bed capacity to meet future long term care needs in compliance with the MOHLTC interim long term care regulations. It also provides for the behavioural needs of patients.

Table 6: Critical Task Summary Cost Comparison of Options

Timeframe	Critical Task	Beds	Option 1		Option 2		Option 3	
			Annual Cost	Period Cost	Annual Cost	Period Cost	Annual Costs	Period Cost
			HRSRH Transitional Care Beds		Pioneer Manor Funding 56 Beds and SJHC up to 128 Beds Chelmsford LTC Funding Memorial Interim Bed Compliance		HRSRH Transitional Care Beds and Interim Bed Compliance Option	
January 2010 – September 2010	Occupancy of Acute Service to Single Site at HRSRH.	150	\$24,856,500	\$18,642,375	\$7,500,750	\$5,625,563	\$24,856,500	\$18,642,375
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April 2011 – January 2013	Building LTC and Supportive Housing Capacity	100	\$16,571,000	\$28,999,250	\$5,000,500	\$8,750,875	\$5,000,500	\$8,750,875
January 2013	Close Transitional Beds Memorial Site	0	0	0	0	0	0	0
Total Costs Operating Costs - 36 Months			\$54,891,438		\$19,988,331		\$32,589,938	
Building Operating - Incremental 36 Months			\$0		\$3,189,000		\$1,594,500	
Other Operating			\$0		\$1,200,000		\$1,200,000	
Building Capital - Infrastructure			\$1,353,250		\$1,353,250		\$1,353,250	
Compliance Renovation Costs			\$0		\$2,742,150		\$2,742,150	
Equipment			\$796,100		\$796,100		\$796,100	
Total Solution Cost-36 Months			\$57,040,788		\$29,268,831		\$40,275,938	
Revenue Potential - (Appendix F)			\$15,177,639		\$11,201,037		\$11,201,037	
Net Additional Revenue Required – 36 Months			\$41,863,149		\$18,067,795		\$27,086,600	

Recommendation

The Sudbury ALC Community Steering Group recommends that the North East Local Health Integration Network engage the Ministry of Health and Long-Term Care in selecting a cost-effective solution that will safely meet our clients' needs.

Appendix A

Building Capital and Operating Costs Memorial Site

Item	Description	Cost
Boiler Plant	Construction of new boiler plant (current boilers at SHS beyond life expectancy and steam is too expensive). Energy savings equates to 2.5 yr payback	\$1,000,000.00
Roof Repairs	80% of existing roofs have been repaired	\$50,000.00
Stack Repairs	Not required as new stack will be installed with boiler plant	\$0.00
Plumbing Upgrades	Piping will be replaced as necessitated, asbestos will be an issue.	\$50,000.00
Electrical Upgrades	Main electrical room was refurbished when new emergency was constructed, equipment system coordination study, short circuit analysis to be performed	\$30,000.00
A/C upgrades	Chillers have been replaced in last 3 years	\$0.00
Grounds Upgrades	Minor road work required	\$20,000.00
Renovations	Washrooms, showers, tub rooms	\$203,250
	Total One Time Capital Investment	\$1,353,250

Operating Cost Item	Description	Cost
Steam Costs	Steam costs nil if new boiler plant installed, otherwise 680,000 per year for the purchase of steam.	\$0.00
Electricity	30% reduction anticipated if new boiler plant installed and only ALC patients (assuming cath lab, OR's and SPD closed).	\$300,600
Natural Gas	Increased if new boiler plant installed otherwise \$6,000 per year.	\$265,000
Water	15% increase if new boiler plant installed	\$54,600
Salaries	50% reduction in Building Services staff if only ALC patients	\$210,000
Plant Operations	50% reduction	\$96,000
Plant Maintenance	50% reduction	\$72,800
Security	20% reduction	\$64,000
	Total Annual Operating Costs	\$1,063,000

Appendix B

Building Capital and Operating Costs SJHC Site

Item	Description	Cost
Boiler Plant	Boilers (3) and Dearator require replacement as life expectancy has been surpassed by 10 years. Extensive work will be required to open walls or roof for the delivery of new equipment. This is assuming that the facility is to remain open longer than 14 months as the risk level will greatly increase after the 14 month time frame currently planned	\$1,100,000.00
Roof Repairs	70% of existing roofs have or will reach their life expectancy within the next 24 months.	\$450,000.00
Stack Repairs	Yearly maintenance required due to the age	\$10,000.00
Plumbing Upgrades	Piping will be replaced as necessitated, asbestos will be an issue.	\$50,000.00
Electrical Upgrades	Main electrical room was refurbished after fire. Equipment system coordination study, short circuit analysis to be performed on secondary electrical rooms and equipment	\$75,000.00
A/C upgrades	Chiller requires replacement. Life Cycle has been passed. Roof and walls will have to be opened to remove old chiller and install new.	\$750,000.00
Grounds Upgrades	Minor road work required, Repairs will be required to concrete walls in parking lots	\$40,000.00
Renovations	Washrooms, showers, tub rooms (ALC occupancy)	\$203,250
	Total One Time Capital Investment	\$2,678,250.

Item – Operating	Description	Cost
Operating Costs		
Electricity	20% reduction anticipated if OR's, SPD, Laboratory, Mason and "D" wings closed.	\$433,700
Natural Gas	20% reduction anticipated if OR's, SPD, Mason and "D" wings closed.	\$529,800
Water	20% reduction anticipated if OR's, SPD, Mason and "D" wings closed.	\$210,400
Salaries	50% reduction if only ALC patients	\$450,200
Plant Operations	20% reduction anticipated if OR's, SPD, Mason and "D" wings closed.	\$95,800
Plant Maintenance	20% reduction anticipated if OR's, SPD, Mason and "D" wings closed.	\$74,000
Security	60% reduction	\$82,000
	Total Annual Operating Costs	\$1,875,900

Appendix C

Long Term Care Compliance Costing (Memorial Site)

Note: Costing is based on memorandum from Lyn Fabricius, Environmental Health Advisor (May 5, 2008).

Bedrooms

- Semi-private rooms must be a minimum of 169 ft²
- To achieve this, the wall between 2 existing patient rooms will be demolished to create a semi-private and allow for expansion of washroom.
- Medical gas removals will be required (not to be re-installed)
- CCA, Cathlab, OR's and recovery rooms will be renovated to include bedrooms etc.
- Asbestos removals will be required as it is highly likely that the plastered walls contain asbestos

Washrooms

- Washroom is required in each bedroom
- Washrooms must allow for a wheelchair to fit in and the door have the ability to close.

Bathtub/Shower Rooms

- There should be a minimum of one bathtub and one shower for every 32 patients.
- The bathtub must have a mechanical lift or other approved device for safety purposes
- The tub/shower room must have a device to activate for staff communication and response system.
- The tub room must have adequate space around the tub to manoeuvre residents around safely.

Lounge/Activity Space

- Lounge space must be provided on each floor which encompasses 15 ft² per resident.
- Activity space must be provided on each floor which encompasses 6 ft² per resident.
- Each space can be combined provided there is 21 ft² per resident.

Dining Space

- There must be a minimum of 20 ft² of dedicated dining room space per resident.
- There must be server y space close to the dining room.

Clean/Soiled Utility Rooms

- Must meet infection control protocol.

Outdoor Area

- Must be secured.
- Must be fenced and surfaces must be barrier-free.

Safety Features

- Exterior doors leading into stairwells and doors leading to other areas should be equipped with door alarms and/or magnetic locks.
- Elevators may need to be equipped a security apparatus (wandering patient system)

Laundry Area

- Install a laundry area on each floor or contract out but ensure a 48 hour turn-around time.

Additional Safety Features (Assumed)

- Installation of sprinkler system through-out.
- Upgrade of existing fire alarm panel.

Costing

	5 th floor	4 th floor	3 rd floor	2 nd floor
Number of patient rooms	14 semi	19 semi	15 semi, 4 private	13 semi, 3 private
Bedrooms	\$84,000	\$114,000	\$114,000	\$96,000
Washrooms	\$70,000	\$95,000	\$95,000	\$80,000
Tub room	\$2,500	\$2,500	\$2,500	\$2,500
Shower room	\$2,500	\$2,500	\$2,500	\$2,500
Lounge space/activity space	\$5,000	\$5,000	\$5,000	\$5,000
Dining room	\$5,000	\$5,000	\$5,000	\$5,000
Servery Space	\$3,000	\$3,000	\$3,000	\$3,000
Utility room	\$6,000	\$6,000	\$6,000	\$6,000
Laundry Space	\$3,000	\$3,000	\$3,000	\$3,000
Safety Features	\$25,000	\$25,000	\$25,000	\$25,000
Patch/paint	\$25,000	\$35,000	\$35,000	\$25,000
Total	\$231,000	\$291,000	\$291,000	\$250,000

Additional Costs Compliance

Outdoor Area	\$20,000
Architectural fees (10%) includes building permit	\$106,000
Mechanical/Electrical Consultants (5%)	\$53,150
Additional Safety Concerns (sprinklers, fire alarm upgrade)	\$1,500,000
Total	\$1,679,150

Total Compliance Costing:- \$2,742,150

Building Upgrades: \$1,330,000

TOTAL COST: \$4,072,150

Appendix D

Operating Cost Per Bed

	<i>2007/2008 OCDM Cost per bed applying TCU rates (Annum)</i>	<i>% of Service Applicable to ALC</i>	<i>OCDM Adjusted Direct Cost per bed (Annum)</i>	<i>Cost per diem</i>
	1	2	3 (1 X 2)	4 (Col 3/365)
Direct Patient Care costs				
Nursing, Supplies, Drugs, Equipment	103,967	100.00%	103,967	285
Clinical Support Costs				
Ambulatory Costs - Emergency	1,218	100.00%	1,218	3
OR/Surgical Day Care	26,734	0.00%	0	0
Diagnostic and thereapeutic	58,082	25.00%	14,520	40
Total Clinical Support	86,034	81.71%	15,739	43
Nursing Admin and Food Services				
Nursing Admin	5,270	25.00%	1,318	4
Food Services	12,716	100.00%	12,716	35

	<i>2007/2008 OCDM Cost per bed applying TCU rates (Annum)</i>	<i>% of Service Applicable to ALC</i>	<i>OCDM Adjusted Direct Cost per bed (Annum)</i>	<i>Cost per diem</i>
Total Nursing Admin and Food Services	17,986	21.97%	14,034	38
Total Patient related cost prior to Co payments and Overhead costs (1a+2d+3c)	207,987	35.70%	133,739	366
Less: Average Co-pmt	-10,950	100.00%	-10,950	-30
Total Patient related costs net of co-payments	197,037		122,789	336
Overhead cost				
Education	1,403	100.00%	1,403	4
Administration and Support (Inl. Building Maint, Utilities, Housekeeping, other)	51,670	80.00%	41,336	113
Research	672	0.00%	0	0
Other	3,839	0.00%	0	0
Total Overhead Costs	57,585	25.78%	42,739	117
Estimated Total	\$254,621	34.99%	\$165,529	\$454

Appendix E

Equipment List

Equipment	Unit Price	Units	Total Cost
Beds and Mattress	\$5,625	100	\$562,500
Over bed tables	\$410	100	\$41,000
Bed side tables	\$336	100	\$33,600
Lifts	\$7,000	18	\$126,000
Stand to Lifts	\$5,500	6	\$33,000
Total			\$796,100

Appendix F

Revenues

	Option 1	Option 2	Option 3
	HRSRH Transitional Care Beds	Pioneer Manor Funding 56 Beds and SJHC up to 128 Beds Chelmsford LTC Funding Memorial Interim Bed Compliance	HRSRH Transitional Care Beds and Interim Bed Compliance Option
Total Solution Cost-36 Months	\$57,040,788	\$29,268,831	\$40,275,983

Revenues Sources Current	Period	Beds - Funded	Annualized Revenues	Period Revenues	Annualized Revenues	Period Revenues	Annualized Revenues	Period Revenues
1. Pioneer Manor Interim Funding	January 2010 to September 2010	56	\$2,800,280	\$2,100,210	\$2,800,280	\$2,100,210	\$2,800,280	\$2,100,210
2. Pioneer Manor Interim Funding	September 2010 - January 2013	16	\$800,080	\$1,866,853	\$800,080	\$1,866,853	\$800,080	\$1,866,853
3. SJ-Chelmsford	January 2010 to December 2010	128	\$6,400,640	\$6,400,640	\$6,400,640	\$6,400,640	\$6,400,640	\$6,400,640
4. Transitional Care Beds HRSRH	January 2010 to March 2010	24	\$2,500,000	\$833,333	\$2,500,000	\$833,333	\$2,500,000	\$833,333
5. Co-Payments	January 2010 to January 2013	100	\$1,325,534	\$3,976,602	\$0	\$0	\$1,325,534	\$1,988,301
Revenue Potential 36 Months				\$15,177,639		\$11,201,037		\$13,189,338
Net additional Revenue -36 months				\$41,863,149		\$18,067,795		\$27,086,600

1. Assumes that Pione

- All funding calculations are assumed at \$137 per day. It is assumed that the Pioneer Manor Interim Funding would be available to be used 56 Interim Beds for the period January 2010 to September 2010.
- It is assumed the funding for 16 Interim Beds would be available for the period from September 2010 to January 2013. Pioneer Manor currently operates 56 Interim beds at the Laurentian site and 24 Interim Beds at the Pioneer Manor site. Once the 64 bed are constructed they will only operate 64 Interim beds which are scheduled to become permanent leaving funding for 16 beds.
- St Joseph's has approval for 128 beds. It is assumed that this funding would be available for this period.
- The HRSRH has approval to operate 24 transitional care beds. This funding ends March 2010.
- Co-payments calculated on 100 beds at \$51.88

Appendix G

Capacity Options for Single Site Working Group

- Martha Auchinleck, Senior Director Performance, Contract & Allocation, NE-LHIN
- David McNeil, Vice President Clinical Program & Chief Nursing Officer, HRSRH
- Joe Pilon, Senior President, HRSRH
- Gwenne Roles, Director Facilities Management, HRSRH
- Paul St. George, Director Finance Department, HRSRH
- Brian Hanna, Manager Facilities Management, HRSRH
- Debbie Szymanski, Manager Clinical Utilization, HRSRH
- Andrea Lee, Director Continuing Care & Rehabilitation Program, HRSRH
- Randy Hotta, Administrator Pioneer Manor

Appendix H

Sudbury Alternative/ Appropriate Level of Care Community Steering Group

- Terry Tilleczek, North East LAIN
- Dr. Peter Zalan, HRSRH
- Dr. Jordi Cisa, HRSRH
- Dr. Jo-Anne Clarke, Regional Geriatric Centre
- Phil Kilbertus, North East LAIN
- Brenda Roseborough, North East LAIN
- Frankie Vitone, North East CCAC
- David McNeil, HRSRH
- Russ DeCou, Meals on Wheels (Sudbury) Inc.
- Catherine Matheson, City of Greater Sudbury
- Jim Gordon, Chair of the City of Greater Sudbury's Advisory Panel on Health Cluster Development
- Jo-Anne Palkovits, St. Joseph's Health Centre