CAPITAL REGIONAL DISTRICT

STAFF REPORT TO THE HEALTH FACILITIES PLANNING COMMITTEE

MEETING OF WEDNESDAY, APRIL 20, 2005

SUBJECT:

Request by the Vancouver Island Health Authority (VIHA) to cost share in capital upgrading to four intermediate care facilities. Bylaw No. 342, "Capital Regional Hospital District Capital Bylaw No. 135, 2005.

BACKGROUND:

At the March Committee VIHA's application for $3.366 M toward the cost of upgrading six intermediate care facilities, four projects and two feasibility reviews, was approved-in-principle. There were a few missing elements in the proposal requiring further review. These included:

- Project scope and cost details.
- Budget/Requisition Implications.
- VIHA's updated Home and Community Care Renewal Plan.

The District's Assisted Living Review, presented to Committee in February, provides the background to this request. With the advent of assisted living in 2002, residential care facilities (including the intermediate care facilities included in this proposal) predictably experienced changes in their occupancy. Incoming residents had much higher levels of physical and cognitive disability and a higher proportion of residents were coming straight from hospital. These facilities lacked many of the design features required to support the new complex care residents, all with high degrees of physical and/or cognitive conditions. Also the buildings in question were on average 30 years old and at a point in their life cycle where they require major renovations to achieve their full asset life.

The need for these renovations is obvious and as in the March report, staff can support the funding application. However, there are some concerns.

The first concern is the relative benefit to the larger health system from this type of proposal compared to other potential funding options.

The four upgrading projects in question will involve a net loss of approximately 16 beds which will further aggravate the shortage of residential care beds. The current large numbers of people overstaying in hospital waiting for residential care bed which also contributes to overcrowding in emergency departments will not be alleviated by this proposal. The preferred funding, from the District's perspective, would be applied to new residential care beds. We are advised by VIHA that new residential care bed funding is unavailable, leaving these upgrading projects as the only available way of making improvements to long term care facilities.

A second concern is the absence of any plan dealing with the future make-up of the programs and services for chronically disabled elderly and adult persons in the region. Requests to VIHA for their Home and Community Care Plan including the one submitted at the closed session of the VIHA Board on March 23, 2005 have been denied. The last request was denied due to changes needing to be made prior to its incorporation in their overall Integration Plan for the VIHA May board meeting. The absence of a draft

Plan prevents a review of the relative priority of new beds versus existing bed upgradings and the supporting rationale. District staff may not have an adequate understanding of the issue and the Plan may allow reconsideration.

The Plan would also be expected to have a capital component. The capital component would cover both assisted living and residential care. It would include projections and how these projections would be obtained through renovation of exiting facilities, replacement of outdated facilities and new construction and their distribution throughout the Region, year by year.

THE PROJECT PROPOSAL:

Since the March meeting VIHA has withdrawn the funding request for the two feasibility studies (Sunset Lodge and Central Care Home) and reallocated the $500,000 to the four projects.

The renovations proposed for the four facilities identified in Attachment 1 include:

- installing ceiling mounted resident lifts for resident and staff safety;
- upgrading the handicapped accessibility of bathroom;
- where possible, increase the size and layout of resident rooms;
- creating small, self-contained clusters of resident rooms to support dementia care; and,
- upgrading infrastructure systems such as fire alarms and nurse call systems.

The work will improve the ability of the buildings to meet the care needs of complex care clients and provide a better quality of environment for residents and staff at these facilities. These upgrades will not however, bring the buildings to full compliance with complex care standards.

The four facilities in question have not been reviewed in the context of their cost to renovate and upgrade to fully meet current standards versus their replacement. VIHA has determined that with modest funding these facilities can be adapted and suitably accommodate complex care residents and that replacement options are neither financially or strategically possible.

Again while these upgradings will improve the quality for residents and staff they will also likely entail a net loss of beds. Old facilities invariably have smaller rooms and common areas than today's standards. Upgrading to increase resident accessibility and dementia suitable environments mainly within the existing building envelope invariably means a loss of beds. The loss of beds from these four projects is estimated at 16 or 7% of existing beds[1].

Of the four facilities in the proposal, three have undertaken a project scope and cost analysis and are ready to begin the final planning stage prior to construction tendering. The fourth facility requires further scope and cost definition before being ready to proceed to final design and tendering. VIHA realizes that the District's funding will not be increased if the scope or costs for these projects unexpectedly increases.

[1] *Beckley Farm Lodge (-6 beds); Luther Court (-8 beds); Rest Haven Lodge (-2 beds) = 16 beds. Depending upon budget constraints, an addition to Rest Haven Lodge may be possible for a net gain at that facility of 10 beds.*

CAPITAL FINANCING AND BUDGET/REQUSITION IMPLICATIONS

The capital funding sources for these projects are outlined in Table 1.

Table 1: Capital Funding Sources and Amounts	
Home & Community Care Transition Funding	$1,049,000
Federal Base Funding – through VIHA for home and community care upgrading	$4,000,000
Sub-total (60%)	**$5,049,000**
Request to CRHD (40%)	$3,366,000
Total (100%)	**$8,415,000**

The projects in this request were not included in the Regional Hospital District Three/Five Year Capital Plan. Three acute care projects[2] included in the Capital Plan are not proceeding at the pace expected. This creates cash flow room in the budgets for 2005 and 2006 for which these complex care upgrading projects can absorb.

All of the work defined in the request is betterment type and would be funded through a capital borrowing bylaw. The estimated impact debt service cost of $3.366M borrowed over 10 years is an additional $2.95 per 2005 average assessed residential value[3].

From a total debt service perspective, adding these projects would increase the total debt service level with the greatest impact in year 2008 from $86.76 to $89.23 – an increase of $2.47 for that year. The peak debt year would remain unchanged at 2008. Table 2 outlines the incremental increase in total debt servicing costs.

Table 2: Existing & Estimated Debt Servicing Difference
- Cost per Average 2005 Residential Assessment ($349,156)

	2005	**2006**	**2007**	**2008 (Peak Debt)**	**2009**	**2010**
Apr 2005	$75.83	$82.58	$87.38	$89.23	$84.86	$82.24
Less Nov 2004	$75.06	$82.23	$86.16	$86.76	$82.28	$79.17
Difference	**+ $0.77**	**+ $0.35**	**+ $1.22**	**+ $2.47**	**+ $2.58**	**+ $3.07**

Amounts before Section 20(3) and Grants-in-lieu.
Nov 2004 figures based on 2004 Aver Residential Assessment ($290,237)

[2] *Royal Jubilee Hospital – planning for replacement Inpatient Facility & Royal 1 and Bay Pavilion refit; Victoria General Hospital – planning for Emergency, Day Surgery and Maternity Renovations.*
[3] *2005 Average Assessed Residential Value = $349,156. Additional cost per $100,000 residential value = $0.84.*

CONCLUSION:

The upgrading of these four intermediate care facilities to enable them to better support the more complex, higher disability residents is needed. The four facilities are close to thirty years old and were designed for personal and low intermediate care people, not the extended care and high intermediate care people who now live there.

While this type of upgrading is necessary and important we are unconvinced that it represents the highest priority for capital funding in the long term care sector. With the current large and growing numbers of people waiting residential care placement in hospital and these inappropriately occupied hospital beds contributing to emergency department overcrowding, the situation suggests a need for a higher priority for new residential care beds. However, VIHA advises that there is no operating funding for new beds which precludes this option. This leaves the four upgrading projects as the only means to affect change to the residential care system.

Also of concern is the unavailability of the recently updated Home and Community Care Plan, presented to the closed session of the VIHA Board meeting. Staff has been requesting a copy of the Plan since January and was officially denied it two weeks ago on the basis that changes were being made prior to its release in late May. Without seeing this Plan staff is unable to assess either the Health Authority's direction or its rationale for their higher priority for upgrading existing beds over creating new beds. In terms of the current adverse impacts of the shortage of residential care on the larger health system (mainly hospitals) and the general population, it is difficult to understand why existing facility upgradings take priority. We suspect that there is no operating funding for new residential care beds leaving upgrading of existing facilities (and the loss of another 16 beds) as the only potential to move the system forward. Also missing is a capital plan for the long term care (residential care and assisted living) sector including unit projections and a program of major renovations, replacements and net new units.

Approval of these projects can be accommodated within the cash flow projections of the current Five Year Capital Plan however it will increase the total debt servicing cost by $2.47 per 2005 Average Assessed residential value in the peak year of 2008.[4]

These projects appear to be the only possible application of capital funds to improve the residential care sector and the absence of District cost sharing would likely reduce the number of projects from four to two. In view of the benefits created by these projects staff recommends approval of the application but express serious reservations over VIHA's withholding relevant background information (the Home and Community Care Plan) and the absence of a capital plan for the long term care sector.

[4] *From $86.76 to $89.23 in 2008.*

RECOMMENDATIONS:

That the Committee recommend that the Capital Regional Hospital District Board grant:

1. Approval of $3,366,000 towards the upgrading of four former intermediate care facilities.

2. Approval of Bylaw No. 342, "Capital Regional Hospital District Capital Bylaw No. 135, 2005" for $3,366,000, for the District share of 40% of the capital cost of upgrading four intermediate care facilities with a financing term of 10 years.

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Comments of the Director of Finance:

Comments of the Executive Director: