CAPITAL REGIONAL DISTRICT

SUPPLEMENTARY STAFF REPORT TO THE HEALTH FACILITIES PLANNING COMMITTEE

MEETING OF WEDNESDAY, MAY 18, 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:

The last two months has seen the intermediate care upgrading funding application postponed until VIHA provided the Committee with the background Three Year Home and Community Care Plan. VIHA is unprepared to share the Plan so a set of seven questions was posed to them.

The main concern for Committee is the priority of upgrading of existing facilities over new residential care beds. The very important need to upgrade existing facilities is acknowledged. However with the associated loss of beds from the upgradings and various major problems related to the shortage of residential care beds, it is unclear why new residential care beds have a lower priority and are not being added.

The District's Assisted Living Review suggests new residential care beds are needed to reduce the number of people overstaying in hospitals, reduce the wait times for those waiting in the community, contend with population growth and reduce the risk that assisted living may not have as deep a potential to substitute for residential care as presumed.

Provincial and national supply measures are high level indicators but both show the Capital Region with fewer beds per capita.

In their written response VIHA implies that new residential care beds are not required for the South Island. The South Island has already seen the addition of 75 interim residential care beds, is looking to upgrade more intermediate care facilities and will rely on the 284 upcoming assisted living units and various complementary services (respite, adult day programs, community bathing) to meet future population needs.

VIHA points to a recent three month trend (January, February and March 2005) which saw significantly increased admissions to residential care, an average of 99 versus the previous 33 month average of 55, as evidence that its plan is working.

The last three months have moderated but not reversed the three year trend of increasing numbers of people waiting longer for residential care.

There were more people in hospital waiting placement (over 30 days) in 2004 than 2003. However the increase was only four people compared to an increase of 34 the previous year. The average wait period for hospital patients (placed in each 30 day reporting period) increased from 55 to 67 days, quite a bit lower than the previous year's (2002 to 2003) increase of 23 days.

There were also more community placements waiting over 30 days in 2004 over 2003, 101 versus 81 (25%), but again this a lower rate of increase than the previous year. In 2002 to 2003 the numbers increased from 47 to 81 (72%).

Only 20% of people waiting residential care are placed each month. The remaining 80% are carried over to be placed in the future. The aggregate average wait times for those placed within the reporting month and those carried over to eventual placement is a better measure of wait times. This information was not available for 2002/2003 but between 2003 and 2004 it increased from 82 days to 123 days (four months) for hospital patients and from 76 to 81 days (2.66 months) for community placements.

Increasing admissions are a function of either additional facilities (interim/permanent) or increasing vacancies in existing facilities.

VIHA advises that 75 interim residential care beds/clients have been brought on since late 2004. Also, since October 2004 there have been 71 assisted living units added. It is not clear whether the NBA wait list analysis covers assisted living placements. While the timing of the opening of the majority of these assisted living units is prior to the recent three month spike in residential care admissions, these openings may have had some impact.

A more likely explanation is a random unexplained higher death rate in residential care rates. Alternatively, it could be the first signs of a longer term trend declining average lengths of stay for the more complex care residents who have been admitted to residential care facilities over the last three years. The Assisted Living surveys also heard of increasing numbers of residential care admissions from people in crisis in the community. It is unlikely that a trend toward shorter lengths of stay in residential care facilities would have appeared so abruptly.

The last three months activity also shows that the number of people being placed and removed from the list exceeded new additions to the wait list by a sizeable margin (45). This is well above the full 2004/05 average of 25, last year's average of two (2), more people placed and removed from the list than added and two years ago when there were 15 more people added to the list than placed and removed each month.

It appears there are multiple causes behind the recent high rates of admissions. These include; 75 new (interim) residential care beds, possibly new assisted living, unexplained higher death rates in residential care and higher turnover (shorter lengths of stay) for the much frailer, medically complex residents who have been placed and retained in intermediate care facilities over the past three years.

These factors may continue to play out but this is not certain. The recent three month trend might persist or it could fall away. If the three month trend persists in terms of significantly more people placed and removed each month than are added to the wait list, then existing facilities might be able to handle most of the future emerging residential care needs and the requirement for new beds would be reduced. It will take another six months to confirm the current trend.

The question of the need for new beds in priority over renovations is more arguable in the context of the recent three month trend than it was in late 2004. In part the need for new beds has been recognized by VIHA in its acquisition of 75 (interim) residential care beds. Whether these beds are regularized is not known. VIHA indicate they are prepared to open a further 14 temporary beds at the Gorge Road site to offset the loss of the 16 beds associated with the upgrading application.

It will take time to assess whether VIHA's plan not to further increase residential care beds will work or whether it turns out that new residential care beds are required. In the meantime, the four subject intermediate care facilities definitely need to be upgraded. They now have 83% of their residents with complex care conditions compared to 51% in 2002. These improvements will help rectify the serious problems that inadequate buildings pose for them and their residents.

A more detailed report prepared prior to receipt of the VIHA responses is available for Committee members.

This analysis is only one element in understanding the workings of the residential care system, the larger Home and Community Care and the full health system. The more detailed report was forwarded to VIHA for their information.

<u>RECOMMENDATION</u>:

That the Committee recommends 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.

Jeremy Tate, Director
Health Facilities Planning

Comments of the Director of Finance:

Comments of the Acting Chief Administrative Officer: