LAKERIDGE HEALTH CORPORATION

WHITBY SITE STEERING COMMITTEE

Options Study

Central East Local Health Integration Network

April 24, 2008

TABLE OF CONTENTS

TABLE OF CONTENTS

EXECUTIVE SUMMARY

On July 2, 2007, an electrical fire at Lakeridge Health (LH) Whitby necessitated the evacuation of approximately 71 complex continuing care patients and the relocation/transfer of all other services to other hospital sites within and external to the Lakeridge Health system. Complex continuing care services were distributed to Lakeridge Health Bowmanville, Lakeridge Health Oshawa and the Rouge Valley Health System Centenary site, and dialysis and Day Hospital services were relocated to the LH Oshawa site. As a result of the temporary relocation and lack of appropriate physical space to accommodate the services, 16 complex continuing care services were removed from operation and dialysis capacity was reduced by five (5) stations (28 stations in operation compared to 33 pre-fire).

Although the surrounding hospitals, particularly the Rouge Valley Health System have responded to the situation, the temporary location of these services continues to place pressures on the hospital system.

Initial estimates suggested that the building might be ready for re-occupancy in November 2007 and work was completed to bring the building back to its status as of the date of the fire. However, Lakeridge Health was requested by Whitby Fire and Emergency Services to undertake a Life Safety Study review of the existing building and implement required renovations to comply with the "2007 Ontario Fire Code Retrofit Requirements for Health Care Facilities", prior to any re-occupancy.

The Life Safety Report was anticipated to be complete by late December 2007. LH anticipated that the hospital would require funds to comply with the outcomes of the report, once it was received and costs known. Prior to the Whitby fire, the Central East Local Health Integration Network (CE LHIN) had been in discussions with Lakeridge Health to assess the capital investments that may be necessary to continue to operate the building over the next 8-10 years.

Now faced with a capital investment resulting from the fire and the capital investments required to maintain the building for the next several years, the CE LHIN was concerned about the future use of this building. Lakeridge Health requested a steering committee be formed involving the LHIN to discuss what options the corporation ought to consider regarding the Whitby site.

In October of 2007, the CE LHIN Finance Committee supported the need for a steering committee to review options related to the Lakeridge Health Whitby site, which would be led and coordinated by the CE LHIN. Terms of Reference were developed and resources were put in place to undertake the study, with the first meeting being held on February 5, 2008.

A phased approach to the study was recommended with the first phase(s) concentrating on the identification, assessment and analysis of short term options followed by a subsequent phase that would review longer term options in relation to the CE LHIN, Lakeridge Health and the Whitby site.

However, upon further review of the key issues by the Steering Committee it was determined that the scope of the study needed to focus on options that would address the improvement of the physical and/or operating environment specifically related to:

1. The temporary dialysis stations (and related nephrology support services) operating on the 6th floor of the LH Oshawa site;
2. The 26 bed geriatric assessment and rehabilitation unit (GARU) at the Lakeridge Health Bowmanville site; and
3. The staffing challenges associated with the continued operation of the 20 complex continuing care beds on the Margaret Birch Wing at the RVHS-Centenary site.

Several options were developed and assessed (See Section 4 and Appendix B and C).

There was significant discussion by the Steering Committee concerning the Options. Through the assessment it became evident that several of the options clearly were not viable for a variety of reasons, namely:

- The extent of renovations required to improve the physical environment;
- The length of time required to implement the option;
- Associated costs, either individually or collectively;
- Negative service implications and/or impact; and
- The complexity of implementation; and the impact on long term planning.

Other influencing factors, in addition to the assessment criteria included:

- An inability of the options to fully address system capacity and bring bed numbers and dialysis stations to the pre-Whitby situation;
- Facilities within the CE LHIN are limited by space/system capacity;
- The necessity for the relocated services from the Whitby site to vacate their existing space as a result of redevelopment scenarios at the LH Oshawa and LH Bowmanville sites; and,
- The continuing impact of higher operational costs resulting from the Whitby fire.

In addition, although the focus of this phase of the study was to review specific short term solutions that would address the improvement of the physical and/or operating environment for complex continuing care located at the Bowmanville and Rouge Valley

– Centenary site) and the 21 temporary dialysis stations operating on the 6th floor of the LH Oshawa site, it was apparent that:

- Planning for the siting and sizing of services as a LHIN system is in the early development stages and short term solutions should have a defined time period, otherwise they could lead to longer term solutions that may not fit within a hospitals or the LHIN's service plan. Therefore, immediate solutions are required for the siting and operation of all the services previously located at the Lakeridge Health Whitby site from an operating and patient care perspective; and,
- The Whitby site, if re-opened, would provide a planning window of approximately 8 years in which to re-configure, as necessary, the scope and location of hospital based services within a LHIN system.

It was therefore recommended and supported by the majority of committee members:

1. That the relocation of the LH's Day Hospital to WMHC be pursued in order to help resolve some of LH's internal challenges related to the operation of Nephrology Services. This temporary relocation is estimated to be up to one year, as WMHC has considerable internal growth in their Master Plan and will require the space. (Note: This option is described under Dialysis Options, Item 4.2.5)
2. That Lakeridge Health and Rouge Valley proceed with steps that will involve the switch/transfer of the GARU unit from LH Bowmanville to the Centenary site and relocating the LH CCC unit at the RVHS-Centenary site to LH Bowmanville. As a result, the GARU unit at RVHS-Centenary should be increased from its present 20 beds to 28 beds, bringing some of LH's bed capacity back into the system.
3. To proceed with capital reinvestments and approvals necessary to re-open the Whitby site as soon as possible so that services displaced by the fire can be repatriated back to more favourable physical and operating environments. The process should be expedited with the Ministry of Health, to ensure that the scope of work is completed within the 12 month estimated timeline.

1. INTRODUCTION AND BACKGROUND

1.1 LAKERIDGE HEALTH WHITBY FIRE

Lakeridge Health (LH) is a community hospital system comprised of four (4) hospital sites within the Central East Local Health Integration Network. Lakeridge Health's sites include: Lakeridge Health Bowmanville, Lakeridge Health Oshawa, Lakeridge Health Port Perry and Lakeridge Health Whitby. Catchment area includes the Regional Municipality of Durham (Ajax, Pickering, Whitby, Oshawa, Clarington, Brock, Scugog and Uxbridge), with the primary catchment area comprised of the six municipalities situated from Whitby to Clarington and the northern portions of the Region.

Each of the hospital sites vary in size and scope of services offered. The Lakeridge Health Whitby Site (LH Whitby) provides a range of inpatient and outpatient services consisting of:

- Complex Continuing Care – Approximately 80 beds including complex continuing care and geriatric assessment and rehabilitation.
- Dialysis – Thirty three (33) dialysis stations, home dialysis and a kidney care clinic.
- Day Hospital – A 16-18 space multi-disciplinary rehabilitation service that provides specialized assessment and intervention in an ambulatory (outpatient) setting.

In addition to the above services, clinical support and administrative services are also located on-site to support patient care and the infrastructure of the hospital within the Lakeridge system, including:

- Pharmacy
- Site Administration (Administration, Infection Control, etc)
- LH WHITBY Foundation
- Materials Management
- Food Services
- Engineering/Facilities
- Volunteers

On July 2, 2007, an electrical fire at Lakeridge Health Whitby necessitated the evacuation of approximately 71 complex continuing care patients and the relocation/transfer of all other patient and support services to other hospital sites within and external to the Lakeridge Health system as follows:

Lakeridge Health Oshawa

- Complex Continuing Care – 10 beds
- Nephrology - 28 Dialysis stations (formerly 33 stations at LH Whitby), Kidney Care Clinic and Home Hemodialysis

Lakeridge Health Bowmanville

- Complex Continuing Care – 10 beds
- Geriatric Assessment and Rehabilitation – 26 beds

Rouge Valley Health System (Centenary Site)

- Complex Continuing Care – 20 beds

Initial estimates suggested that the LH Whitby site might be ready for re-occupancy in November 2007 following the clean-up work that was required to bring the building back to its status pre-fire. However, Lakeridge Health was requested by Whitby Fire and Emergency Services (letter dated August 30, 2007) to undertake a Life Safety Study of the existing building and implement required renovations to comply with the "2007 Ontario Fire Code Retrofit Requirements for Health Care Facilities", prior to any re-occupancy. The study was necessary to assess the fire protection measures required to achieve an acceptable level of fire safety in light of updated fire codes since the construction of Lakeridge Health Whitby in 1968.

The Life Safety Report was expected to be fully completed by late December 2007. In discussions with the CE LHIN, LH anticipated that the hospital would require funds to comply with the outcomes of the report, once costs were known.

The Whitby site had been under discussions between LH and the CE LHIN prior to the fire as a result of its capital investments that may be necessary to continue to operate the building over the next 8-10 years. The investments and state of the building have been well documented in previous studies, the most recent being the Business Case Report – Lakeridge Health Whitby (February 2006) conducted by Parkin Architects.

As a result of the Whitby fire and the reinvestment that would be required, the CE LHIN had concerns about the future uses of this building. Lakeridge Health requested that a steering committee be formed involving the CE LHIN to discuss what options LH ought to consider regarding the Whitby site.

In October of 2007, the CE LHIN Finance Committee supported the need for a steering committee to review options related to the Lakeridge Health Whitby site, to be led and coordinated by the CE LHIN. Terms of Reference were developed and resources were put in place to undertake the study. The first steering committee meeting was held on February 5, 2008.

1.2 PURPOSE OF THIS DOCUMENT

This document has several purposes:

i) It outlines the process, work and decisions reflected by the CE LHIN Whitby Site Steering Committee between February and April 2008.

ii) It documents the analysis and assessment of options that were considered by the Steering Committee to address the Lakeridge Health Whitby situation.

iii) It recommends a preferred option or option(s) resulting from the Steering Committee discussions.

1.3 METHODOLOGY AND PROCESS

A Steering Committee entitled the "Lakeridge Health Corporation: Whitby Site Steering Committee" was established as an advisory body to the Central East LHIN. Advice and recommendations of the Steering Committee were not to be binding to the CE LHIN and the acceptance of any recommendations remained the sole purview of the CE LHIN Board of Governors.

To assist in supporting the work of the steering committee, a project manager was hired to support the review and development of the options. The primary tasks of the Steering Committee were to:

- Consider short and long-term options on the Whitby site and resumption of operations, and
- Consider the cost of structural changes needed at the Whitby Site in relation to the LHIN and LH's desire to continue to deliver high quality services to patients previously receiving care from this site.

Membership on the Steering Committee included:

Derek Beckley	Chief Facilities & Development Officer, Lakeridge Health
Ritva Gallant	Team Lead, Finance, CE LHIN
Rik Ganderton,	CEO, Rouge Valley Health System
Deborah Hammons	CEO, CE LHIN – **(Chair)**
Chris Kooy	CNO & VP Clinical Services, Lakeridge Health
Nizar Ladak	Sr. Director, PCA, CE LHIN **(Mtg #1 only Chair)**
Brian Lemon	CEO, Lakeridge Health
James Meloche	Sr. Director, PICE, CE LHIN
Glenna Raymond	CEO, Whitby Mental Health Centre
Norman Rees	CFO, Lakeridge Health
Mike Yakamovich	Corporate Planner, Lakeridge Health Project Manager to the Steering Committee (secondment)

Other ad-hoc participants included:

Bill Colvin	Chief of Communications, Lakeridge Health
Katie Cronin-Wood	CE LHIN Communications Lead

The Steering Committee undertook its work between February 2008 and April 2008 over the course of three (3) meetings. Work of the committee involved:

- Review, discussion and approval of the terms of reference;
- Review and confirmation of the proposed study approach in light of key issues and other drivers;
- Presentation by Lakeridge Health outlining the issues and challenges associated with the temporary relocation of complex continuing care and dialysis services at Lakeridge Health and Rouge Valley sites;
- Review and evaluation of options using evaluation criteria; and
- Recommendation of a preferred option(s).

The development and documentation of the options by the Project Manager was accomplished through:

- Key informant interviews and meetings with Committee members and key program directors and management staff at each of the hospital sites in order to understand the current situation, key issues/considerations, options/space availability, sensitivities, system issues, and possible options;
- Site tours/visits to each hospital site to assess the physical space/operating environment of the relocated services and/or space availability to address these key issues (in particular of complex continuing care and dialysis services);
- Review of existing information and reports; and
- Obtaining order of magnitude costing information from the RVHS, LH and external companies, as appropriate.

1.4 SCOPE OF STUDY

Initially, the CE LHIN Finance Committee identified three options concerning the Lakeridge Health Whitby site:

1. Resume business as usual and identify the costs associated with returning and accommodating the 71 displaced patients since the fire;
2. Do not resume operations at the site and identify appropriate strategies to absorb the 71 displaced patients and the provision of dialysis services as well as considerations for alternate uses of the building and land;
3. A Hybrid option of the above two (2) options.

Based on the above, a phased approach to the study was recommended, with the first phase(s) concentrating on the identification, assessment and analysis of short term options followed by a subsequent phase that would review longer term options in relation to the CE LHIN, Lakeridge Health and the Whitby site.

However, upon review of the proposed study approach by the Steering Committee (February 5, 2008) and the key issues (see Section 2) , it was determined that the immediate scope of the study should focus on options that would address the improvement of the physical and/or operating environment specifically related to:

1. The temporary dialysis stations (and related nephrology support services) operating on the 6th floor of the LH Oshawa site;
2. The 26 bed geriatric assessment and rehabilitation unit (GARU) at the Lakeridge Health Bowmanville site; and
3. The staffing challenges associated with the continued operation of the 20 complex continuing care beds on the Margaret Birch Wing at the RVHS,- Centenary site.

The review of these options would then determine the necessity to proceed with a subsequent phase to review the longer term options, as initially proposed.

2. KEY ISSUES IDENTIFIED BY LAKERIDGE HEALTH

2.1 GENERAL INTERIM OPERATING ENVIRONMENTS

The following key issues were noted by LH at the first Steering Committee meeting on February 5, 2008 in order to bring context and background to the Whitby situation:

- The temporary facilities/locations established for the relocated services from the Whitby site are sub-optimal from a quality, operations and financial perspective.
- LH has encountered a severe bed capacity shortage and remains on Code Orange, given the fire situation.
- The ability to repatriate patients for the unforeseeable future is extremely limited.
- All LH sites are experiencing difficulties with backlogs. Elective/wait time surgery cancellations are real possibilities every day.
- Closure of the LH Whitby site is impacting nearby hospitals in the CE LHIN.
- Complex continuing care capacity has been reduced by 16 beds (64 operating down from 80) and is putting pressures on the system as a whole;
- Operating three 10 – 20 bed units is inefficient (10 complex continuing care beds units at LH Oshawa and LH Bowmanville and a 20 bed light care unit at RVHS – Centenary);
- The Day Hospital is overcrowded and unable to meet service demands;
- The Geriatric Assessment and Rehabilitation Unit (26 Beds) at the LH Bowmanville site:
  - Is placed on an old unit no longer used for inpatient care
  - Over-crowded conditions and small/inaccessible washrooms for patients
  - A marked increase in staff injuries
  - Patients have lost their dining rooms and recreation facilities.
  - The physical environment is affecting patients progress to recovery;
  - Rehabilitation has become next to impossible.
  - Bowmanville has lost its chapel to provide storage and overflow of Complex Continuing Care needs.
- Complex Continuing Care Unit (20 beds) - Rouge Valley-Centenary Site
  - Losing staff at the RVHS site due to staff dissatisfaction with travel and isolation from Lakeridge.
  - Operational costs for staff and family shuttles to the site.

  - Families are hesitant and/or refuse to move/transfer from LH to RVHS-Centenary

- Nephrology Services
  - The Renal Program is running five (5) less stations due to current location and space on 6A (old ICU) and Pod A (new ICU).
  - Working conditions are crowded and can be unsafe.
  - Reduced water pressure has necessitated longer dialysis cycles.
  - Quality and service to patients is being negatively affected.
  - The Kidney Care Clinic for pre-dialysis patients is overcrowded.
  - Biomedical Techs are working from closet size space in poor conditions. Preventative maintenance schedules are behind due to lack of space.

2.2 LAKERIDGE HEALTH WHITBY – CAPITAL

Based on a business case analysis in 2006, LH Whitby will require an estimated capital reinvestment of up to $14 million dollars over the next ten (10) years to maintain a suitable building infrastructure for the continued operation of the building. To date, approximately $1.2 million has been invested in renovations.

As requested by Whitby Fire and Emergency Services, Lakeridge retained an independent consultant (Randal Brown and Associates Ltd) to undertake a Life Safety Study which was completed during the fall of 2007. The final report, inclusive of the final comments from Whitby Fire and Emergency services was submitted to the LHIN on January 24, 2008. The report outlined the extent of renovations required prior to re-occupancy. Key renovations outlined must address containment, means of egress/suppression, fire alarm and detection, fire safety and fire protection and second floor dialysis smoke zones. A preliminary cost estimate for the scope of work wasestimated at $2,412,900 and taking 12 months to complete. This information, which was not available at the time the Steering Committee was initiated, became a major influencer on the scope of the study.

2.3 REDEVELOPMENT AT THE OSHAWA AND BOWMANVILLE SITES

Lakeridge Health reported the following issues related to the relocation of services from the Whitby site and their effect on redevelopment at the LH Oshawa and LH Bowmanville sites.

LH OSHAWA

- LH Oshawa – The LH Whitby hemodialysis program and day hospital are located in the first floor South Infill. There are plans to complete a 10,000 sq ft pharmacy renovation including moving the outpatient clinics from upper ground to the first

floor of South Infill. If the LH Whitby programs cannot be relocated, there will be significant impact on planned pharmacy program renovations.

- The 21 dialysis stations located on 6A will need to be vacated from this floor by July 2009 in order to allow Tender Package #5 to proceed.
- LH Bowmanville - The GARU which now occupies the first floor at LH Bowmanville was to be used as decanting space for patients from the second floor during the renovation project. If the geriatric program cannot be moved, second floor renovations will need to be phased in at an increased cost. In addition, if the GARU cannot be moved, the renovations to endoscopy will need to be phased, extending construction by approximately eight (8) months.

3. KEY ISSUES RESULTING FROM SITE TOURS AND KEY INFORMANT INTERVIEWS

The following major key issues were identified by the Project Manager as a result of key informant interviews and site visits at Lakeridge Health, Rouge Valley Health System and Whitby Mental Health Centre.

3.1 GENERAL

The availability of space to relocate LH Whitby's dialysis (from LH Oshawa site) and complex continuing care (GARU – LH Bowmanville site) within LH and to other hospital sites is significantly limited. In addition, space availability at RVHS or WMHS has compounding implications between LH/WMHC or LH/RVHS, related to costs, effect on existing services at the hospital, implementation considerations, approvals, and renovation considerations.

There are concerns related to whether short term solutions may lead to more permanent siting of services without consideration for the most appropriate sizing and siting of services at the LHIN level.

An open willingness of each of the hospitals to respond to the Whitby fire situation and assist in finding potential solutions/space has been remarkable, even though some of the options have an impact on existing operations and/or redevelopment plans. Many key informants within LH reported how well RVHS has responded in providing its assistance to accommodate the services and other operational challenges resulting from the Whitby situation.

3.2 NEPHROLOGY - LH OSHAWA

Twenty eight dialysis stations are operating at the Oshawa site which is down from the 33 stations pre-fire. The loss of five stations from the regional nephrology system is of concern to staff from a patient service perspective. Configuration of the temporary dialysis locations at the LH Oshawa site includes:

- 20 stations on floor 6A (the old ICU) consisting of 11 stations in Pod B and 9 stations in Pod C
- Eight (8) stations (Pod A) in the new ICU 8 stations (Pod A)

The Kidney Care Clinic and Home Hemodialysis are operating out of the South Infill space on the first floor, along with the relocated Day Hospital.

Issues related to the physical environment, safety, operations and care issues were verified as noted by LH at Steering Committee Mtg #1. Immediate issues to be addressed are related to plumbing and water for the 20 stations on 6A, inappropriate

space for the Biomedical Technician work area and finding a suitable location for the Home Hemodialysis Training Unit.
Prior to January 2008, LH developed several internal options to address the emergent issues (noted above) resulting from the relocation of dialysis at the LH Oshawa site. Order of magnitude costs ranged from $627,000 - $1.0 million, but subsequently these options were determined by LH's Management Executive Committee (MEC) that they were not practical given the timeframe to undertake the retrofit, costs, and the limited timeframe in which the space would be occupied (due to Tender Package #5). Therefore, alternative options to address the immediate urgencies were considered. They included:

- Finding alternative space for the Biomedical Tech Work area and Home Hemodialysis Training Unit by converting the old Nuclear Medicine Space (Upper Ground) at an estimated cost of $25, 000 with an estimated time of one month to complete.
- Continued operation of 6A (20 stations) on the short term by retrofitting plumbing and the sanitary piping system at an estimated cost of $145,000 with work to be phased in over a 4-5 week period.

3.3 GERIATRIC ASSESSMENT & REHABILITATION UNIT (26 BEDS) AND CCC UNIT (10 BEDS) - LH BOWMANVILLE

The physical environment and operating issues associated with GARU and CCC unit at LH Bowmanville were verified on the site visit. Issues for the GARU included:

- Cramped working conditions for all staff.
- Equipment/supplies in hallways – storage issues
- An activity area for CCC for LH Bowmanville patients has been given up to provide a temporary rehabilitation space for the GARU.
- Dining has temporarily been set up in the Chapel
- Physical space issues are leading to increased patient recovery time and therefore increased lengths of stay.

Issues related to the ten (10) bed CCC unit were similar. In addition, the operation of a 10 bed unit is inefficient from a staffing perspective.

3.4 CCC UNIT (10 BEDS) – 4 MAIN – LH OSHAWA

This unit occupies a wing on the medical unit of 4 Main at LH Oshawa, but does not operate as one unit. CCC staff and staff of the medical unit function independently which poses operational issues. Issues noted at this location were similar to the CCC unit at LH Bowmanville.

They included:

- Cramped working conditions for all staff.

- Equipment/supplies are in the hallways due to a lack of storage space.
- Operational inefficiencies.

3.5 CCC UNIT (20 BEDS) RVHS – CENTENARY - MARGARET BIRCH WING

As a former medical unit, the environment is suitable for complex continuing care from a physical perspective. There are some operational challenges related to patient flow when a CCC patient is compromised and requires acute care or emergency room support. Generally, the patient profile is comprised of lighter care patients, the majority of whom are waiting for LTC.

Continued staffing by LH is the major issue for the operation of this unit. LH has difficulty filling shifts as staff do not want to travel and many prefer to pick up shifts at other LH sites. Concerns were expressed in relation to potential closure of beds on the unit if the unit cannot be staffed appropriately or safety, subsequently leading more pressures on the capacity of the system. LH is experiencing higher operational costs in the operation of this unit due to overtime (resulting from difficulties in filling shifts) and the requirement to shuttle staff form the LH Whitby site to RVHS-Centenary.

3.6 PERCEPTIONS - WHITBY SITUATION

Discussions with several key informants noted:

- Decisions are taking too long.
- A sense of frustration amoung staff, patients, physicians on how long the "temporary" situation will continue and how long is temporary
- Perceptions that there are underlying politics not to re-open Whitby
- Continued higher operational costs and inefficiencies due to relocation (approximately $100,000 per month)

3.7 LAKERIDGE HEALTH DEVELOPMENT

In the long term the temporary situation/siting for the relocated services from the Whitby site cannot continue at the LH Oshawa or LH Bowmanville sites. The majority of the "Whitby" temporary locations must be vacated to allow for development initiatives at the LH Oshawa site and the LH Bowmanvillesite, specifically:

- All the Whitby services at the LH Oshawa site must be vacated by August 2009 to allow for Tender Package #5B to proceed and;
- The 26 bed GARU must be vacated at the LH Bowmanville site by January 2009 as this space is to be used for decanting purposes related to the redevelopment. Original construction plans must to be rescheduled and reflected in the Tender Package due for release April 2008.

If the "temporary locations" at the LH Oshawa and LH Bowmanville sites are not vacated by the specified dates outlined in the construction tender/documents, there will be significant cost implications to LH.

3.8 OTHER INFLUENCING FACTORS

Short term options to address the immediate issues related to the 20 dialysis stations on 6A at the LH Oshawa site, the GARU beds at LH Bowmanville and staffing issues related to the CCC beds cannot be dealt with in isolation of the other remaining service components that were relocated from the Whitby site as a whole (eg. all complex continuing care beds, dialysis services, Day Hospital, support services, etc) as well as other drivers, such as:

- The necessity to relocate all services to an alternative location or back to the Whitby site due to the redevelopment of the LH Oshawa and LH Bowmanville sites;
- Temporary relocation of services cannot continue indefinitely – a longer term solution is required;
- The proposed business case to replace the Whitby facility will take several years to work through the system;
- There should be a defined regional plan (eg. CE LHIN Clinical Services Plan) for the most appropriate sizing and siting of services throughout the Region; and
- The short term availability of space at Rouge Valley and Whitby Mental Health Centre for the temporary relocation of CCC and Dialysis is limited.
- Other factors related to costs, complexity, service impact, etc

4. OPTIONS CONSIDERED

4.1 INTRODUCTION

This section of the report summarizes the options considered by the Steering Committee in relation to the first phase of the study specific to:

1. The temporary dialysis stations (and related nephrology support services) operating on the 6th floor of the LH Oshawa site;
2. The 26 bed geriatric assessment and rehabilitation unit (GARU) at the Lakeridge Health Bowmanville site;
3. The staffing challenges associated with the continued operation of the 20 complex continuing care beds on the Margaret Birch Wing at the RVHS-Centenary site.

- Criteria used for the review of options; and
- The preferred option recommended by the Committee.

4.2 DIALYSIS OPTIONS

Several options were considered which are briefly summarized below. A full description of the options as well as the assessment in relation to key criteria can be found in Appendix B and C.

4.2.1 Option A: Maintain Dialysis on 6A at the LH Oshawa site

This option maintains twenty dialysis stations on 6A of the Oshawa site. There is a necessity to address ongoing plumbing issues (water and drainage) and risks associated with a disruption of services (eg. water leakage and water and drainage issues). An internal proposal/analysis completed by LH to reconfigure the waste drain system and install appropriate material for Reverse Osmosis supply and drain piping to each station is a component of this option.

4.2.2 Option B: Relocate to RVHS-Ajax or Other Locations – Trailers

The RVHS-Ajax has greenfield capacity to accommodate a temporary trailer setup for the provision of dialysis services. This option was not considered for the LH Oshawa site as there is no site capacity (by site allowance) to accommodate temporary trailers. Although, a trailer on the LH Oshawa site is being used by Redevelopment for office use, it is going to be used for alternative office capacity internal to LH. It is deemed neither suitable, nor allowable for patient service component as municipal approvals are currently for temporary office space.

4.2.3 Option C: Relocate to RHVS - Ajax – Ambulance Building and Bay

RVHS on the Ajax site has an Ambulance Building & Bay currently being renovated for outpatient mental health services. Configuration includes a variety of offices in the building and three group rooms in the ambulance bay proper. The Ambulance Bay lends itself to the provision of dialysis stations, providing the space can be opened up. Based on an estimate of 80 sf per station the bay could potentially accommodate ten (10) stations with space for circulation, supplies, etc. Construction/renovation would need to stop as soon as possible if this option was chosen and construction plans would change to retrofit the space for use as dialysis, rather than the current outpatient mental health.

4.2.4 Option D: RHVS - Ajax – Occupy Portion of Existing Maternal Child Wing

One half (½) of the Maternal Child wing at the RVHS Ajax site with adjacent access to the wing will potentially become available in 8 months. Upon initial assessment, this space would require a major renovation and would accommodate approximately 9 -10 dialysis stations.

4.2.5 Option E: Use of WMHC – Current LH Information Technology Space

LH leased approximately 4,400 gross square feet of space at WMHC for Information Technology which has since been relocated to the LH Corporate site. This space was a former activity/area unit with an open space configuration surrounded by several offices/meeting rooms, washrooms, kitchen and nursing station. The space was originally reviewed for dialysis stations. However, upon further assessment, it became apparent that this space may be more appropriate for the Day Hospital (currently relocated from Whitby to Oshawa) and therefore provide the potential capacity to solve internal dialysis pressures related to the relocation of Home Hemodialysis at the Oshawa site.

4.2.6 Option F: Lease Space – Alternative Community Based Locations

This option considers the leasing of appropriate building space in the community for dialysis satellite services.

4.3 GERIATRIC ASSESSMENT REHABILITATION UNIT OPTIONS

Two options were initially considered to solve the issues related to the GARU Unit at the LH Bowmanville site which are briefly summarized below. Throughout the process, a combined CCC Rouge Valley Centenary Site and LH Bowmanville GARU option was considered subsequently labelled as Option C. A full description of the options as well as the assessment in relation to key criteria can be found in Appendix B and C.

4.3.1 Option A: Status Quo – LH BOWMANVILLE Site

This option is status quo and maintains the 26 temporary GARU beds at the LH Bowmanville site. LH would need to make minor improvements where possible, although these are limited due to the physical layout and amount of space available.

4.3.2 Option B: Relocate to RVHS - Ajax – Current Mental Health Wing

A 20 bed mental health unit may potentially become available at the Ajax site due to the reconfiguration of mental health services within RVHS. Twenty beds would only be available if a four (4) bed Psychiatric Intensive Care Unit (PICU) was renovated. Without renovations to the PICU, the space could accommodate 16 beds (single rooms) for services such as the GARU (providing rehabilitation space could be provided) or typical complex continuing care.

4.3.3 Option C: Switch/Transfer Units - GARU Unit operates at Centenary & increases to 28 beds (from 20), CCC Unit operates from LH BOWMANVILLE site (operate 25-26 CCC beds)

This option involves the switching/transfer of the GARU unit from the LH Bowmanville site to the RVHS-Centenary site and relocating the CCC unit at the RVHS-Centenary site to LH Bowmanville. The GARU unit at RVHS-Centenary would be increased from its present 20 beds to 28 beds, bringing some of LH's bed capacity back into the system. To allow for eight (8) additional beds to become available on this unit, there is a willingness of RVHS to move its existing 8 bed operation out of this unit. Since the GARU has a rehabilitation focus, RVHS is prepared to offer full access to a rehabilitation gym on the floor immediately below.

4.4 CCC (20 BED) – ROUGE VALLEY-CENTENARY SITE

Two options were initially considered to solve the staffing issues related to the 20 bed CCC unit operated by LH at the Centenary site. Throughout the process, a combined CCC Rouge Valley-Centenary Site and LH Bowmanville GARU option was considered subsequently labelled as Option C. A full description of the options as well as the assessment in relation to key criteria can be found in Appendix B and C.

4.4.1 Option A: Status Quo – LH Continues to Operate

In this option, LH continues to operate the beds at the RVHS-Centenary site and deal with staffing challenges in the operation of the unit.

4.4.2 Option B: LH Transfers to RVHS to Operate (Short Term)

This option involves the transfers of operations of the unit from LH to RVHS for a defined period of time. Upon the conclusion of the agreement, the operation of the beds would be repatriated back to the LH hospital system.

4.4.3 Option C: Switch/Transfer Units - GARU Unit operates at RVHS-Centenary & increases to 28 beds (from 20), CCC Unit operates from LH Bowmanville site (operate 25-26 CCC beds)

See 4.3.3 for a description of this option.

4.5 ASSESSMENT CRITERIA

The assessment criteria used by the Committee in the discussion and evaluation of the options consisted of:

1. Physical Space/Environment

- The appropriateness of the physical space or environment in relation to the services proposed (or potential services that could be provided from this space).

2. Timing

- Estimated length of time before this option becomes available or in which space could become occupied. This includes reference to other time related drivers impacting on the use/non-use of the space.

3. Costs

- High level order of magnitude costs (where available) and/or other cost considerations, risks or impact associated with the option.

4. Service Implications

- Service impacts on the existing services and/or hospital(s).

5. Implementation Considerations/Complexity

- Implementation considerations or complexity related to the option.

6. Impact – Long Term Planning

- Considerations with respect to the impact on long term planning at the hospital(s) or at the system (CE LHIN) level.

4.6 ASSESSMENT SUMMARY

See Appendix B for a description and assessment of the options.

4.7 DESCRIPTION AND ASSESSMENT OF OPTIONS

See Appendix C for a summary of the options in relation to the assessment criteria.

4.8 PREFERRED OPTION(S)

There was significant discussion by the Steering Committee in relation to the Options. Through the assessment it became evident that several of the options clearly were not viable for a variety of reasons, namely:

- The extent of renovations required to improve the physical environment;
- The length of time required to implement the option;
- Associated costs, either individually or collectively;
- Negative service implications and/or impact;
- The complexity of implementation; and the impact on long term planning.

Other influencing factors, in addition to the assessment criteria included:

- An inability of the options to fully address system capacity and bring bed numbers and dialysis stations to the pre-Whitby situation;
- The CE LHIN being facility bound in the short term with respect to space/system capacity;
- The necessity for the relocated services from the Whitby site to vacate their existing spaces as a result of redevelopment scenarios at the LH Oshawa and LH Bowmanville sites; and
- The continuing impact of higher operational costs resulting from the Whitby fire.

In addition, although the focus of this phase of the study was to review specific short term solutions that would address the improvement of the physical and/or operating environment for complex continuing care (Bowmanville and Rouge Valley – Centenary) and the 21 temporary dialysis stations operating on the 6th floor of the LH Oshawa site, it was apparent that:

- Planning for the siting and sizing of services as a LHIN system is in the early development stages and short term solutions should have a defined time period, otherwise they could lead to longer term solutions that may not fit within a hospital or the CE LHIN's service plan. As a result, immediate solutions are required for the siting and operation of all the services previously located at the Lakeridge Health Whitby site from an operating and patient care perspective; and

- The Whitby site, if re-opened would provide a planning window of approximately 8 years in which to re-configure, as necessary, the scope and location of hospital based services within a LHIN system.

It was therefore recommended and supported by the majority of committee members:

1. That the relocation of the LH's Day Hospital to WMHC be pursued in order to help resolve some of LH's internal challenges related to the operation of Nephrology Services. This temporary relocation is estimated to be up to one year, as WMHC has considerable internal growth in their Master Plan and will require the space. (Note: This option was described under Item 4.2.5 as Option under the Dialysis Options)
2. That Lakeridge Health and Rouge Valley proceed with steps that will involve the switch/transfer of the GARU unit from LH Bowmanville to the RVHS-Centenary site and relocating the LH CCC unit at the RVHS-Centenary site to LH Bowmanville. As a result, the GARU unit at RVHS-Centenary should be increased from its present 20 beds to 28 beds, bringing some of LH's bed capacity back into the system.
3. To proceed with capital reinvestments and approvals necessary to re-open the Whitby site as soon as possible so that services displaced by the fire can be repatriated back to more favourable physical and operating environments. The process should be expedited with the Ministry of Health, to ensure that the scope of work is completed within the 12 month estimated timeline.

6. APPENDICES

This document contains the following Appendices:

Appendix A Terms of Reference

Appendix B Summary of Options

Appendix C Description and Assessment of Options

Appendix D Construction Costs - Replacement of Existing LH WHITBY Space

This document outlines a range of renovation and new construction costs to replace the existing space at the Whitby site. Two models are presented. Model 1 assumes the replacement of existing space at the Whitby site and Model 2 assumes the replacement of space using current planning standards. These models were generated at the request of the Steering Committee to help compare the costs of relocating the services at Whitby to other hospitals in comparison to the investment required as a result of the fire.

APPENDIX A

Terms of Reference

April 24, 2008

Appendix A

Lakeridge Health Corporation: Whitby Site Steering Committee

Terms of Reference

Purpose of the Steering Committee

The Central East Local Health Integration Network (CE LHIN) is seeking a focused review of options regarding the short and long-term future of the Whitby Site of Lakeridge Health Corporation.

The review was motivated by a recent set of events in July 2007 surrounding a fire that occurred at the site and resulted in 71 complex continuing care patients, outpatient dialysis services and other services (e.g. Day Hospital) having to be re-located and cared for elsewhere.

The purpose of the review is expected to support a cost-benefit analysis such that:

(a) the cost of structural changes needed at the Whitby Site building are balanced with
(b) the ability to continue to deliver high quality services care from this site.

Background

On July 2, 2007, Lakeridge Health Whitby declared a Code Green due to an electrical fire, leading to significant smoke and water damage to the facility, and resulting in the temporary closure of the facility and the evacuation of approximately 71 complex continuing care patients and the relocation of other services. It is anticipated that the facility will remain closed until February 2008 in order to return the facility to its former state to ensure the safety and quality of care for returning patients.

At this time, pressures to the flow of patients within the Oshawa site of Lakeridge Health Corporation continue to create difficulties for the hospital in terms of discharge planning. However, cooperation from neighbouring hospitals, namely Rouge Valley Health System along with other health service providers have resulted in the evacuated ofcomplex continuing care patients being served in alternative locations within and outside of the Lakeridge Health system. Escalating costs for repairing the building and additional capital renovation planned for the Whitby site have given rise to a series of questions/anecdotal observations listed below. **However, these anecdotal observations are exactly that and require additional due diligence to determine the impact to quality and patient access to services.**

- Costs for repairs and anticipated capital renovation for the Whitby site are high. Anecdotally, it is unclear whether a business case continues to support additional investment into what Lakeridge senior management have commonly referred to as an '*aging building needing considerable repair* and upkeep'

- New equipment for the facility and major structural improvements are needed and have been documented in previous operational planning submissions

- In the recent Peer Review report by Ken Deane, he indicated: "*Consolidation of clinical programs/services to realize greater operational efficiencies and economies of scale…there may be opportunities to leverage the current and future capacity at the Oshawa site.*" (page 27) suggests the consolidation of services offered at the Whitby site may alleviate financial and operational pressures faced by the Corporation

- Support for closing the site in favour of a new hospital has already been preliminarily tabled with the CE LHIN during a meeting with Lakeridge Board members, senior management and the CE LHIN Board and Senior Management Team that took place in May 2007

- Initial investigations for a new hospital for North Durham have begun through a local planning initiative sponsored by Lakeridge

- A CE LHIN-Lakeridge Health Corporation partnered analysis of the acuity levels of LH Whitby site patients could occur to determine whether other methods of service delivery could continue to meet patient needs and/or enhance quality of care through other avenues and whether the closure of the site would result in any disruptions to other services not governed by Lakeridge (e.g., York-Durham Aphasia Centre)

In light of these anecdotal observations and accompanied by a written request from Lakeridge Health Corporation's Board Chair to the CE LHIN Board Chair, a Steering Committee is being established to consider short and long-term options on the Whitby site and resumption of operations.

Structure

1. The Steering Committee is advisory to the Central East LHIN.
2. A Project Manager has been hired to conduct the review and examine options to be suggested by the Steering Committee.

3. The work of the Project Manager will build on analysis and work done to date by the Lakeridge Health Corporation and incorporate analysis undertaken at the request of the Steering Committee.
4. The absence of the CE LHIN Clinical Services Plan will be accommodated through input from the CE LHIN and related planning partners.
5. The steering committee will be formed and chaired by the CE LHIN. It will meet monthly during the review period. Membership will be comprised of the following representatives:
    - Lakeridge Health - 3
    - CE LHIN – 3
    - Rouge Valley Health System – 1
    - Whitby Mental Health Centre – 1
    - MoHLTC Capital Branch – 1

6. The Project Manager will provide regular progress reports to the Senior Director, Performance, Contracts and Allocations who will also serve as the key contact on issues requiring clarification.

Principles

- It is anticipated that the review will be a collaborative, supportive effort between the hospital and CE LHIN given its origins stemmed from a request by Lakeridge Health Corporation. However, the advice and recommendations of the Steering Committee are not binding to the CE LHIN and the acceptance of these recommendations remains the sole purview of the CE LHIN Board of Directors.

Scope of the Review

A series of high level options were identified by the CE LHIN Board Finance Committee at their October 25, 2007 meeting. These options were subsequently shared with the Project Manager engaged to undertake this review with a request to develop the approach and scope of the review more fully for presentation to the Steering Committee at its first meeting. It is anticipated that the endorsement of these options will form the basis for a workplan and deliverables for this project.

Timeframe

It is expected that a final report will be completed by March 31, 2008.

Communications

The Chair of the Steering Committee will be the sole spokesperson for Lakeridge Health and CE LHIN during this review process.

Distribution of the final report on the CE LHIN's website will occur and the content remains at the discretion of the CE LHIN Board of Directors.

APPENDIX B

Summary of Options

TABLE I – Summary of Dialysis Options

Criteria & Considerations	Option A Maintain Dialysis 6A	Option B RVHS-Ajax or Other Locations – Trailers	Option C RVHS-Ajax – Ambulance Building & Bay	Option D RVHS-Ajax – Maternal Child Wing	Option E WMHC – Current I.T. Space	Option F Lease Space – Alternative Community Based Locations
Physical Space/Environment					Appropriate for Day Hospital	Up to 33 stations
No change	✓	-	-	-	✓	-
Improves	-	✓	✓ (9 stations only)	✓ (Potential to)	✓ (O.T Kitchen)	✓ (Potential)
No (or minimal) Renovation	-	-	-	-	✓	-
Minor Renovation	✓	-	✓	-	-	-
Major Renovation	-	-	-	✓	-	✓
Timing						
Less than 1 month	-	-	-	-	✓	-
1 – 2 months	✓	-	✓	-	-	-
3 – 6 months	-	✓	-	-	-	-
6 months +	-	-	-	✓	-	✓
Costs (High Level Estimate)						
Capital Renovation (hard construction)	$145,000	$2,960,000	$390,000 - $780,000	$865,800 - $1,082,250	Not required – Day Hospital	$1.589,000 - $3,178,000
Additional capital costs	-	✓	✓	✓	-	✓
Additional Operating Impact	✓ Minor	✓	✓	✓	✓ Minor	✓

Criteria & Considerations	Option A Maintain Dialysis 6A	Option B RVHS-Ajax or Other Locations – Trailers	Option C RVHS-Ajax – Ambulance Building & Bay	Option D RVHS-Ajax – Maternal Child Wing	Option E WMHC – Current I.T. Space	Option F Lease Space – Alternative Community Based Locations
Service Implications						
Minor Impact/Issues	✓	-	-	-	✓	-
Major Impact/Issues	-	✓	✓	✓	-	✓
Implementation Considerations/Complexity						
Straightforward	✓	-	-	-	✓	-
Multifaceted/Complex	-	✓	✓	✓	-	✓
Impact – Long Term Planning						
Impact on Service Planning	No impact	Multi-site	Multi-site	Multi-site	No impact	Multi-site
Increase capacity to pre-LHW Fire	-	-	-	-	-	-

TABLE II –Summary of CCC/GARU Options

Criteria & Considerations	Geriatric Assessment & Rehabilitation Unit (26 beds)		Complex Continuing Care – 20 Beds – Rouge Valley Centenary		Combined Option
	Option A Status Quo – LH Bowmanville Site	**Option B** RVHS-AJax – Current Mental Health Wing	**Option A** LHC Continues to Operate	**Option B** LHC Transfers to RVHS to Operate (Short Term)	**Option C (New)** Switch/Transfer Units – GARU Operates at RVHS-Centenary (increases to 28 beds) – CCC operates at LH Bowmanville site
Physical Space/Environment					
No change	✓	-	✓	✓	-
Improves	-	✓	-	-	✓
No (or minimal) Renovation	✓	-	✓	✓	✓
Minor Renovation	-	-	-	-	-
Major Renovation	-	✓ (PICU only)	-	-	-
Timing					
Less than 1 month	-	-	-	-	✓
1 – 2 months	-	-	-	✓	-
3 – 6 months	-	✓	-	-	-
6 months +	-	-	-	-	-
Costs (High Level Estimate)	-	PICU Conversion	-	-	-
Capital Renovation (hard construction)	-	$400,000 - $800,00 (minor) $800,000 - $1M (major)	-	-	-

Criteria & Considerations	Geriatric Assessment & Rehabilitation Unit (26 beds)		Complex Continuing Care – 20 Beds – Rouge Valley Centenary		Combined Option
	Option A Status Quo – LH Bowmanville Site	**Option B** RVHS-AJax – Current Mental Health Wing	**Option A** LHC Continues to Operate	**Option B** LHC Transfers to RVHS to Operate (Short Term)	**Option C (New)** Switch/Transfer Units – GARU Operates at RVHS-Centenary (increases to 28 beds) – CCC operates at LH Bowmanville site
Additional capital costs	-	✓	-	-	-
Additional Operating Impact	-	✓	-	-	✓ One time for transfer of units
Service Implications					
Minor Impact/Issues	**Status Quo**	✓	-	-	✓
Major Impact/Issues	-	-	✓ (Staffing)	✓	-
Implementation Considerations/Complexity					
Straightforward	✓	-	✓	-	✓
Multifaceted/Complex	-	✓	-	✓	✓
Impact – Long Term Planning					
Impact on Service Planning	No impact	Multi-site	No impact	No impact	No impact
Increase capacity to pre-LH Whitby Fire	-	-	-	-	Increases slightly

APPENDIX C

Description and Assessment of Options

Option	Dialysis	Geriatric Assessment and Rehabilitation Unit (26 Beds)	Complex Continuing Care (20) Beds – Rouge Valley - Centenary
A	Maintain Dialysis 6A – LH OSHAWA	Status Quo – LH Bowmanville Site	Status Quo – LHC Continues to Operate
B	RHVS-Ajax or Other Locations - Trailers	RVHS-Ajax – Current Mental Health Wing	LHC Transfers to RVHS to Operate – Short Term
C	RHVS-Ajax – Ambulance Building and Bay	Switch/Transfer Units - GARU Unit operates at RVHS-Centenary & increases to 28 beds (from 20), CCC Unit operates from LH Bowmanville site (operate 25-26 CCC beds)	
D	RHVS-Ajax – Occupy Portion of Existing Maternal Child Wing		
E	Use of WMHC – Current LHC Information Technology Space		
F	Lease Space – Alternative Community Based Locations		

Headings/Criteria	Description
Description	Brief description of the option.
Physical Space/Environment	The appropriateness of the physical space or environment in relation to the services proposed (or potential services that could be provided from this space).
Timing	Estimated length of time before this option becomes available or in which space could become occupied. Includes reference to other time related drivers impacting on the use/non-use of the space.
Costs	High level order of magnitude costs (where available) and/or other cost considerations, risks or impact associated with the option.
Service Implications	High level service impacts on the hospital(s).
Implementation Considerations/ Complexity	High level implementation considerations or complexity related to the option.
Impact – Long Term Planning	Considerations with respect to the impact on long term planning at the hospital(s) or at the system (CE LHIN) level.

DIALYSIS SERVICES

OPTION A MAINTAIN DIALYSIS – 6A - LH OSHAWA	OPTION B RVHS-AJAX OR OTHER LOCATIONS - TRAILERS	OPTION C RVHS-AJAX – AMBULANCE BUILDING & BAY
Description ➢ Maintain dialysis services on 6A - 20 stations ➢ Necessity to address ongoing plumbing issues (water and drainage) and risks associated with a disruption of services (water leakage on floors – potential for code brown, – water and drainage issues) ➢ Internal proposal/analysis has been completed by LHC to reconfigure waste drain system and install appropriate material for RO supply and drain piping to each station	➢ RVHS - Ajax site has greenfield capacity to accommodate a temporary trailer setup for the provision of dialysis services. ➢ LH Oshawa has no site capacity (by site allowance) to accommodate temporary trailers. ➢ Current "development" trailer on the LH Oshawa site is being vacated but being re-occupied for other office capacity internal to LHC. Not suitable, nor allowable for patient service components. Municipal approval is currently for office space – temporary.	➢ Ambulance Building & Bay (3,900 gsf) is currently being renovated for outpatient mental health services. Configuration includes a variety of offices in the building and 3 group rooms in the ambulance bay proper. ➢ Ambulance bay (estimated at 1130 dgsf) lends itself to the provision of dialysis stations, providing the space can be opened up (currently being renovated into 3 rooms). Based on 80 sf per station – achievable stations is approximately 10 stations (800 sf). Remaining space for circulation, supplies, etc. ➢ Construction would need to stop ASAP if chosen as an option and construction plans changed to fit up the space for use as dialysis, rather than the current outpatient mental health.

OPTION A MAINTAIN DIALYSIS – 6A - LH OSHAWA	OPTION B RVHS-AJAX OR OTHER LOCATIONS - TRAILERS	OPTION C RVHS-AJAX – AMBULANCE BUILDING & BAY
Physical Space/Environment ➢ If proposal proceeds the physical environment will be improved substantially through the elimination of water seepage, trip hazards, hoses over sinks, etc. Will help to improve clutter in treatment cubicles. ➢ Maintains clinical infrastructure and support by maintaining on an acute site ➢ Physical environment remains less than ideal for patients and nursing staff, but could continue for a defined period of time with improvement of water and plumbing issues, as identified.	➢ Trailers have previously been used for dialysis services – several years ago on the Oshawa site. Trailer capacity required for at least 20 stations (and associated support areas) if transferring all stations from 6A – LH Oshawa. ➢ Trailers are less than ideal from a physical environment. Previous issues cited with trailers include air quality, infection control, appropriate of piping/waste systems. ➢ Will need to define specific space and functional requirements to determine trailer sizing and number of stations. ➢ Parking is available at Ajax.	➢ Providing construction does not proceed too far, this space has potential to be renovated for dialysis as it is currently shelled in space. ➢ Immediate parking available. ➢ Drop off area in front of the ambulance bay. ➢ Building is at grade level and easy to access.
Timing ➢ Upon approval, work is estimated at 4 -6 weeks to be completed in small phases. ➢ Some disruption to patients.	➢ Requires further analysis to confirm timing. ➢ Estimate up to 3 months to implement considering site approval and municipal approvals, trailer fit up, transfer of equipment, staffing considerations, communication.	➢ Two (2) – three (3) months to refit/renovate upon decision to stop the current renovation taking place. ➢ Timing may be influenced by other approvals required (MoH) due to change in use/functions and corresponding impact on RVHS services and redevelopment plans.

OPTION A MAINTAIN DIALYSIS – 6A - LH OSHAWA	OPTION B RVHS-AJAX OR OTHER LOCATIONS - TRAILERS	OPTION C RVHS-AJAX – AMBULANCE BUILDING & BAY
Costs ➢ Estimated budget $145K to undertake renovations to improve water supply and drainage. ➢ Costs associated with service disruption (non-quantifiable).	➢ Trailers - If siting trailer at RVHS will require trailer rental and fit up, costs for water, hydro, etc (from RVHS). May also require Reverse Osmosis water system. ➢ High level cost estimate for 21 station dialysis trailer is $2,960,000 plus taxes based on modular trailer quote provided by external company. Price excludes installation, landscaping, granular base, connection of sewer and water. ➢ Quote based on an estimate of 11,000 gross square feet.	➢ Construction contract changes (would need to be quantified). ➢ Fit up and renovation to the existing space for dialysis. ➢ High level renovation cost estimate ranging from $390,000 to $780,000 based on the following assumptions: – Minor renovation at $100 - $200 sf (hard costs) at 3,900 gsf of existing ambulance bay.

OPTION A MAINTAIN DIALYSIS – 6A - LH OSHAWA	OPTION B RVHS-AJAX OR OTHER LOCATIONS - TRAILERS	OPTION C RVHS-AJAX – AMBULANCE BUILDING & BAY
Service Implications ➢ Addresses the immediate risk and safety issues in the operation of this unit ➢ Maintains current 28 stations in operation as a result of the LHW fire (5 stations lost). Does not address loss of 5 stations and related services post-fire. ➢ May be required to review station capacity and/or operational hours/services within existing temporary locations to accommodate loss of 5 stations and service capacity. ➢ Interim operational and service issues associated with space will continue until dialysis is returned to a suitable physical location/environment. ➢ Maintains acute clinical support and infrastructure – temporary relocation has had some advantages in being sited in an acute hospital site.	➢ Will require on-site hospital clinical support. Arrangements with RVHS would need to be worked out. Patients may need to be pre-screened in order to determine the most appropriate site that will be able to meet their clinical needs (eg. lesser risk patients may need to be sent to the satellite as opposed to the hospital located dialysis) ➢ Consider LHC physician coverage/travel, etc in operational planning of this option. ➢ Operational and clinical issues/considerations in the multi-siting services or satellites – staff, supplies, etc. Presently, there is clinical comfort level and operational economies in consolidation at one site. ➢ Services for patients become multi-sited and may not be sited according to best geographical fit for service within the Region.	➢ Service implications and development at Ajax are compounded. ➢ If ambulance bay was used for dialysis – outpatient mental health is affected as it was to occupy this space. Outpatient mental health would likely remain in its current location at the Ajax site. ➢ Loss of outpatient program from its proposed space. May be community perceptions related to the loss of outpatient mental health services for dialysis. ➢ RVHS would lose 3 beds in PICU as a result of outpatient mental health remaining in its current location based on RVHS's reconfiguration of mental health services. ➢ Operational and clinical issues/considerations in the multi-siting services or satellites – staff, supplies, etc.

OPTION A MAINTAIN DIALYSIS – 6A - LH OSHAWA	OPTION B RVHS-AJAX OR OTHER LOCATIONS - TRAILERS	OPTION C RVHS-AJAX – AMBULANCE BUILDING & BAY
Implementation Considerations/Complexity ➢ Minor to mid complexity involving the removal of patients for short periods of time, core drilling walls/floors, fabrication of new pipe fittings, replacement of rubber hoses, paint/patch, asbestos abatement (as req'd)	➢ Transfer of dialysis equipment and related equipment to trailers. ➢ Anticipated impact to operational costs due to multisite staffing, etc. ➢ HR implications involving relocation of staff to an alternate site outside of LHC's infrastructure. May need to shuttle staff to RVHS-Ajax site (as per current arrangements at RVHS-Centenary site – CCC) ➢ Municipal approvals required for siting of trailers. ➢ Parking is available ➢ Clear Memorandums or Agreements with RVHS – clinical support, lease arrangements (water, hydro, etc)	➢ Minor functional planning work to determine appropriateness of existing office layouts for services and support to be provided. ➢ Immediate decisions required if spaces is going to be retrofitted for a different purpose - construction is currently in process. ➢ If going to use space for dialysis - need to stop construction immediately to convert bay to open space for dialysis stations. ➢ May likely require approvals from the MOH as the change in scope will impact other services within RVHS – will need to verify

OPTION A MAINTAIN DIALYSIS – 6A - LH OSHAWA	OPTION B RVHS-AJAX OR OTHER LOCATIONS - TRAILERS	OPTION C RVHS-AJAX – AMBULANCE BUILDING & BAY
Impact – Long Term Planning ➢ Short term solution only to address the existing situation. ➢ Proper space/environment is required to return the services to an operational level. ➢ Does not provide any capacity for service growth and the siting/sizing of nephrology services within the LHC Regional system (previous planning identified a base of 70 stations – 40 at LH Oshawa and 33 at LH Whitby, with potential for future satellite) or the Regional LHIN level. ➢ Space can only be occupied until August 2009 (to be confirmed) - 8 months of starting TP#5B. Space needs to be vacated by this time. Relocation of space/services to other appropriate environments will be required to maintain existing stations within the system, exclusive of growth projections to 70 stations by 2011.	➢ Services for patients become multi-sited (although short term) throughout the CE LHIN in the in the absence of a long term CE LHIN CSP. ➢ Rouge Valley has not included any long term siting of dialysis services within its clinical services plan or development scenarios.	➢ Short term solution only to address the existing situation. ➢ Services for patients become multi-sited (although short term) throughout the CE LHIN in the in the absence of a long term CE LHIN CSP. ➢ Does not provide any capacity for service growth and the siting/sizing of nephrology services within the LHC Regional system (estimated at 70 stations for 2011) or at the Regional LHIN level. ➢ Complicates and affects RVHS services and development – may have compounding effects in terms of costs, services.

OPTION D RVHS-AJAX – OCCUPY PORTION OF EXISTING MATERNAL CHILD WING	OPTION E USE OF WMHC – CURRENT LHC INFORMATION TECHNOLOGY SPACE (I.T.)	OPTION F LEASE SPACE - ALTERNATIVE COMMUNITY BASED LOCATIONS
Description ➢ One half (½) of Maternal Child wing with adjacent access to the wing will potentially become available in 8 months. Upon initial assessment, space would require a major renovation and would only accommodate 9-10 stations.	➢ LHC currently leases I.T. space at WMHC. Space to be vacated within the next 1-2 months and I.T. services relocated to 2nd floor – Champlain site. ➢ Space was a former activity/area unit. Configuration includes an open space comprised of workstations, several offices/meeting rooms, washrooms, kitchen, nursing station (fishbowl). ➢ Total space estimated at 4,400 gsf. ➢ Central core area could be opened up through the elimination of workstations - approximately 1,000 nsf. ➢ Although reviewed for dialysis, this space offers significant potential for Day Hospital space. ➢ Further assessment (subsequent to Steering Committee Meeting #2), suggests that this space could immediately accommodate LHC's Day Hospital and would require no renovation (essentially a "move-in")	➢ Lease appropriate building space in community for dialysis satellite services.

OPTION D RVHS-AJAX – OCCUPY PORTION OF EXISTING MATERNAL CHILD WING	OPTION E USE OF WMHC – CURRENT LHC INFORMATION TECHNOLOGY SPACE (I.T.)	OPTION F LEASE SPACE - ALTERNATIVE COMMUNITY BASED LOCATIONS
Physical Space/Environment ➢ Major renovations would be required to open up this area in order to provide a suitable dialysis environment.	➢ Offers potential for 9-10 dialysis stations (720 - 800 sf) within central core area based on 80 sf per station – Remaining space for circulation, supplies, etc ➢ Upon further review, the space is extremely suitable to Day Hospital environment with minimal changes. Space requirements of the existing day hospital at the LHW site and this site are similar. If considered for this purpose, it may relieve internal space pressures within the LH Oshawa site and provide additional internal alternatives for solving dialysis services/pressures at LH Oshawa. ➢ Good ground floor access.	➢ Will need to define specific space and functional requirements to determine sizing and/or availability of alternative locations within the community. ➢ Building would be renovated to accommodate service and functional aspects for dialysis services.

OPTION D RVHS-AJAX – OCCUPY PORTION OF EXISTING MATERNAL CHILD WING	OPTION E USE OF WMHC – CURRENT LHC INFORMATION TECHNOLOGY SPACE (I.T.)	OPTION F LEASE SPACE - ALTERNATIVE COMMUNITY BASED LOCATIONS
Timing ➢ A decision to vacate would need to be made by the end of this year – April/May 2008. ➢ 8 months minimum prior to a move-in, following renovations/physical changes to the unit.	➢ Estimate 1 month for relocation of Day Hospital if this option was internally feasible for LHC. ➢ Space is currently vacant (vacated at end of March) ➢ Secondary assessment (April 2008) indicates that the space is most suitable for a Day Hospital as opposed to Dialysis due as it has a better fit with WMHC and requires no renovation. . ➢ If option is chosen to relocate Day Hospital this could be an immediate move-in, as the space is now vacated.	➢ Requires further analysis to confirm timing. ➢ Could be several months to find suitable locations for lease and to renovate space for dialysis purposes.

OPTION D RVHS-AJAX – OCCUPY PORTION OF EXISTING MATERNAL CHILD WING	OPTION E USE OF WMHC – CURRENT LHC INFORMATION TECHNOLOGY SPACE (I.T.)	OPTION F LEASE SPACE - ALTERNATIVE COMMUNITY BASED LOCATIONS
Costs ➢ Significant costs in renovations for 9-10 stations, particularly if only for the short term. ➢ High level renovation cost estimate ranging from $865,800 to $1,082,250 based on the following assumptions: – 378 sf per station x 9 stations (3402 sf) – 103 sf per station for clinical support (927 sf) – Major renovation at $200 - $250 sf (hard costs) for 4329 sf.	➢ Moving costs for transfer of equipment, set-up, etc. ➢ Minimal costs for Day Hospital – mainly transfer of equipment and minor setup. Space is essentially “move in”.	➢ Leased space (buildings within community). Typical lease costs average $20 sf, plus costs of fit-up to services being provided. Buildings typically have to be returned to their previous state, once vacated. ➢ Moving costs for transfer of equipment, set-up, etc. ➢ High level lease cost estimated at $317,800 per annum ➢ High level renovation cost ranges from $1,589,000 - $3,178,000 ➢ Assumptions: – $20 per sf for lease costs – Using 15,890 cgsf (existing LHW area for Dialysis stations and support – Minor renovation at $100 - $200 per sf

OPTION D RVHS-AJAX – OCCUPY PORTION OF EXISTING MATERNAL CHILD WING	OPTION E USE OF WMHC – CURRENT LHC INFORMATION TECHNOLOGY SPACE (I.T.)	OPTION F LEASE SPACE - ALTERNATIVE COMMUNITY BASED LOCATIONS
Service Implications ➢ RVHS will be required to relocate services. ➢ Service implications and development at Ajax are compounded	➢ No on-site hospital based clinical support. Patients may need to be pre-screened in order to determine the most appropriate site that will be able to meet their clinical needs (eg. lesser risk patients may need to be sent to the satellite as opposed to the hospital located dialysis) ➢ Consider LHC physician coverage/travel. ➢ Transfer of dialysis equipment and related equipment. ➢ Anticipated impact to operational costs due to multisite staffing, etc. ➢ HR implications involving relocation of staff to an alternate site outside of LHC's infrastructure, although would not need to shuttle staff due to adjacency to LH Whitby site. ➢ Parking immediately available. ➢ Clear Memorandums /Agreements with WMHC – clinical support, lease arrangements (water, hydro, etc) ➢ Discussions would need to take place with Handi-Transit if Day Hospital is being relocated to ensure transportation will be provided.	➢ No on-site hospital based clinical support. Patients may need to be pre-screened in order to determine the most appropriate site that will be able to meet their clinical needs (eg. lesser risk patients may need to be sent to the satellite as opposed to the hospital located dialysis) ➢ Consider LHC physician coverage/travel. ➢ Operational issues/considerations in the siting of staff and services between multiple sites. Presently, there is clinical comfort level and operational economies in consolidation at one site. ➢ Services for patients become multi-sited and may not be the most appropriate geographical siting if this turns into a longer term solution.

OPTION D RVHS-AJAX – OCCUPY PORTION OF EXISTING MATERNAL CHILD WING	OPTION E USE OF WMHC – CURRENT LHC INFORMATION TECHNOLOGY SPACE (I.T.)	OPTION F LEASE SPACE - ALTERNATIVE COMMUNITY BASED LOCATIONS
Implementation Considerations/Complexity Substantially complex with respect to relocation of services from this wing, renovations, construction documents, etc.	➢ WMHC to consider "best fit" within their facility/complex based on current services provided. May be more appropriate to accommodate Day Hospital program as opposed to dialysis services.	➢ Satellite services should be established in context of a longer term CE LHIN CSP. Otherwise, if on a short term basis, may be false expectations established with the community. ➢ Choice of available sites may not be the most appropriate from a long term satellite siting perspective.
Impact – Long Term Planning ➢ Rouge Valley has not included any long term siting of dialysis services within its clinical services plan or development scenarios. ➢ Assumed that this would be a short term solution only, until Whitby situation is resolved and/or sizing and siting of Dialysis services is determined at the CE LHIN level.	➢ Services for dialysis patients become multi-sited (although short term) throughout the LHIN in the in the absence of a long term CE LHIN CSP.	➢ Satellite services should be established in context of a longer term CE LHIN CSP. Otherwise, on a short term basis there may be false expectations established with the community. ➢ Choice of available sites may not be the most appropriate from a long term satellite siting perspective.

Geriatric Rehabilitation & Assessment Unit – GARU (26 beds) – LHC – Bowmanville

OPTION A STATUS QUO - LH BOWMANVILLE SITE	OPTION B RVHS-AJAX - CURRENT MENTAL HEALTH WING	OPTION C (NEW) SWITCH/TRANSFER GARU AND CCC UNITS BETWEEN RVHS-CENTENARY AND LH BOWMANVILLE
Description ➢ Maintain temporary GARU beds at the LH Bowmanville site ➢ Make minor improvements where possible (there may be some opportunities for LH to revisit the ability to free-up additional space on the unit in order to improve conditions)	➢ A 20 bed mental health unit may potentially become available at the Ajax site due to the reconfiguration of mental health services within the RVHS. ➢ Current space contains a 4 bed Psychiatric Intensive Care Unit (PICU) inclusive of the 20 beds. ➢ Unit is self contained – soiled/clean utility rooms, dining room, bedroom spaces, shower, gases, etc. ➢ Without physical changes to the PICU – it is likely that the space could immediately accommodate an immediate 16 beds (single rooms) for services such as the GARU.	➢ This option involves the switching/transfer of the GARU unit to the Centenary site and relocating the CCC unit at the Centenary site to LH Bowmanville ➢ The GARU unit at Centenary would be increased from its present 20 beds to 28 beds, bringing some of LHC's bed capacity back into the system. To allow for 8 additional beds to become available on this unit, there is a willingness of RVHS to move its existing 8 bed operation out of this unit. ➢ Since the GARU has a rehabilitation focus, RVHS is prepared to offer full access to a rehabilitation gym on the floor immediately below.

OPTION A STATUS QUO - LH BOWMANVILLE SITE	OPTION B RVHS-AJAX - CURRENT MENTAL HEALTH WING	OPTION C (NEW) SWITCH/TRANSFER GARU AND CCC UNITS BETWEEN RVHS-CENTENARY AND LH BOWMANVILLE
Physical Space/Environment ➢ The physical environment, as is, will not change due to the physical setup and space restrictions of the unit.	➢ As a former mental health unit, the space is well suited to GARU and/or CCC. The immediate space requires little renovation and once vacant becomes a "walk in unit" for other services requiring bedroom accommodation, dining, etc. ➢ There is potential to bring the bed complement to 20 beds +/- by renovating the PICU and converting it to 4 bedroom spaces. Renovations could likely occur during occupancy of the unit, but would require further investigation. ➢ Note: Upon further assessment (post Steering Committee Mtg #2), this unit would only be suitable for CCC and would require renovation to the PICU space in order to provide rehabilitation space for a GARU. ➢ Physical space/configuration of this unit is a substantial improvement in comparison to the temporary location at LHB.	➢ The unit is currently operating as a CCC unit and provides an appropriate environment for GARU on the condition that there is access to rehabilitation space (which RHVS could be made available). ➢ The entire unit would be operate as a self contained single unit (by LHC) rather than its current configuration of a split unit (20 beds LHC and 8 beds RVHS). ➢ Similarly, the LH Bowmanville site could provide a CCC program in the short-term, although the issues related with the physical environment would remain). Bed complement at the LH Bowmanville site would remain at 25-26 beds, but now for CCC.

OPTION A STATUS QUO - LH BOWMANVILLE SITE	OPTION B RVHS-AJAX - CURRENT MENTAL HEALTH WING	OPTION C (NEW) SWITCH/TRANSFER GARU AND CCC UNITS BETWEEN RVHS-CENTENARY AND LH BOWMANVILLE
Timing ➢ Occupancy of GARU at the LH Bowmanville site can only continue until January 2009 at which time the space must be vacated due to redevelopment. Alternative locations of a permanent or longer term nature must therefore be considered within LHC or externally.	➢ Timing is dependent on RVHS's plans to reconfigure mental health services within the RVHS. ➢ Unit potentially available as early as May 2008 with ability to accommodate 16 CCC beds. ➢ An additional 2 -3 months are likely required if renovations are done to the PICU to bring the bed complement to 20 beds and provide rehabilitation space for any type of GARU services.	➢ A unit-unit switch could likely be accomplished within one month. ➢ The free up of 8 additional beds on the Margaret Birch Wing by RVHS (which could also be done post move, if implementation is problematic for RVHS). Therefore the unit could operate at 20 beds or 28 beds (post move), providing RVHS is able to create additional capacity on the unit.

OPTION A STATUS QUO - LH BOWMANVILLE SITE	OPTION B RVHS-AJAX - CURRENT MENTAL HEALTH WING	OPTION C (NEW) SWITCH/TRANSFER GARU AND CCC UNITS BETWEEN RVHS-CENTENARY AND LH BOWMANVILLE
Costs ➢ Any additional expenses related to the operation of the unit will continue. ➢ There are unquantifiable costs associated with the potential for staff injuries due to the physical environment. ➢ There is potential for substantial costs to LHC if the space is not vacated as outlined in the redevelopment schedule and tender package signoff.	➢ Lease costs for the unit, as appropriate or defined between RVHS and LHC. ➢ Costs associated with renovation to the PICU. ➢ High level renovation costs to convert PICU to rehabilitation/patient space ranges from $400,000 - $800,000 (minor renovation) to $800,000 - $1,000,000 (major renovation) ➢ Assumptions: – Minor renovation at $100 - $200 per sf – Major renovation at $200 - $250 per sf – PICU space estimated at 4,000 cgsf ➢ Transfer of related equipment, furniture, etc from LH Bowmanville.	➢ No renovation costs ➢ One time costs will be incurred for the patient transfer and any related equipment transfer between the sites. A relocation firm that is experienced in these types of moves may be most appropriate from a logistical perspective.

OPTION A STATUS QUO - LH BOWMANVILLE SITE	OPTION B RVHS-AJAX - CURRENT MENTAL HEALTH WING	OPTION C (NEW) SWITCH/TRANSFER GARU AND CCC UNITS BETWEEN RVHS-CENTENARY AND LH BOWMANVILLE
Service Implications ➢ Service implications are well outlined in the 1st meeting by LHC at Mtg #1, such as cramped working conditions, inadequate areas for patients (rehabilitation, dining, social activities) ➢ Perception that quality of care is being compromised, depression for some patients, length of stay being compromised.	➢ Transfer of GARU patients to RVHS. ➢ Clear Memorandums or Agreements with RVHS, as appropriate – clinical support, lease arrangements, food, defined period of arrangement, etc. ➢ Improved physical environment for patients and staff with potential for improved patient outcomes.	➢ Allows LHC to take the "appropriate" type of CCC client as there will be more control at the LH Bowmanville site. Currently, there are inappropriate CCC clients being accepted at the RVHS-Centenary site (eg. most being lighter care and appropriate for LTC) due to staffing/operational challenges by LHC in operating this unit. ➢ The current issues/challenges associated with staffing the existing CCC unit at RVHS-Centenary will be resolved. LHC believes that the GARU are extremely dedicated to this unit and will follow the patient unit, if it is relocated to RVHS-Centenary. ➢ If RVHS is able to accommodate LHC in the operation of 8 additional beds on the unit (Centenary site), system capacity will be enhanced by 8 beds (the system has been reduced by 20 CCC beds as a result of the fire at Whitby). System capacity is brought to at total of 74 CCC/GARU beds (previously 80 prior to the fire) comprised of 28 GARU (RVHS), 26 CCC (LH Bowmanville) and 20 beds at LH Oshawa. ➢ Increased system capacity may help with internal pressures within the LHC system.

OPTION A STATUS QUO - LH BOWMANVILLE SITE	OPTION B RVHS-AJAX - CURRENT MENTAL HEALTH WING	OPTION C (NEW) SWITCH/TRANSFER GARU AND CCC UNITS BETWEEN RVHS-CENTENARY AND LH BOWMANVILLE
Implementation Considerations/Complexity ➢ Clarity is required around how long the current situation is expected to continue.	➢ CE LHIN and/or MoH approvals, as appropriate. ➢ Renovations, as determined.	➢ Several issues requiring further internal discussions could lead to complexity and would need to be resolved prior to proceeding as an option. They include: – Patient Safety – The ability of LHC to manage acutely ill patients at RVHS and transfer back to ER. This puts RVHS staffing an unsafe situation (hence the current situation in the management of lighter care CCC patients at RHVS by LHC). Arrangements/support with RVHS would require further discussion. – Staff leaving – There is potential that staff may leave (unknown) if there are no timelines or indication as to the status of Whitby site. – Requirement for medical consultation and follow-up at LH Oshawa – operational and cost issue for LHC. ➢ Minor implementation related to an actual physical transfer of patients involving: – Coordination of the transfer of patients and related equipment between sites – The free up of 8 additional beds on the Margaret Birch Wing by RVHS (which could also be done post move, if implementation is problematic for RVHS). – Communications – staff, patients, etc

OPTION A STATUS QUO - LH BOWMANVILLE SITE	OPTION B RVHS-AJAX - CURRENT MENTAL HEALTH WING	OPTION C (NEW) SWITCH/TRANSFER GARU AND CCC UNITS BETWEEN RVHS-CENTENARY AND LH BOWMANVILLE
Impact – Long Term Planning ➢ Absence of a CE LHIN CSP with respect to the sizing and siting of rehabilitation and complex continuing care services.	➢ Expectation that siting of LHC's GARU would not be on the Rouge site permanently. ➢ Expectation that GARU would be repatriated to an appropriate location within the LHC system. ➢ Absence of a CE LHIN CSP with respect to the sizing and siting of rehabilitation and complex continuing care services.	➢ Expectation that siting of LHC's GARU would not be on the RVHS-Centenary site permanently. Clarity on return to the LH Whitby site required prior to possible implementation. ➢ Expectation that GARU would be repatriated to an appropriate location within the LHC system. ➢ Absence of a CE LHIN CSP with respect to the sizing and siting of rehabilitation and complex continuing care services. ➢ No allowance for system capacity to be bought up to pre-fire level (eg. 80 CCC beds)

Complex Continuing Care Beds – (20 beds) – RVHS Centenary Site

OPTION A STATUS QUO - LHC CONTINUES TO OPERATE	OPTION B LHC TRANSFERS TO RVHS TO OPERATE - SHORT TERM	OPTION C (NEW) SWITCH/TRANSFER GARU AND CCC UNITS BETWEEN RVHS-CENTENARY AND LH BOWMANVILLE
Description ➢ LHC continues to operate the beds and deal with staffing challenges in the operation of the unit.	➢ LHC transfers the operation of the unit to RVHS for a defined period of time at which time the operation of the beds are repatriated back to the LHC hospital system.	➢ See "Option C" described under Geriatric Rehabilitation & Assessment Unit – GARU (26 beds) – LH Bowmanville on the previous pages.
Physical Space/Environment ➢ There are no issues with the current physical environment with the exception of securing the unit for dementia patients who wander off of the unit (there is no wanderguard system in place)	➢ There are no issues with the current physical environment with the exception of securing the unit for dementia patients who wander off of the unit (there is no wanderguard system in place).	➢ As above

OPTION A STATUS QUO - LHC CONTINUES TO OPERATE	OPTION B LHC TRANSFERS TO RVHS TO OPERATE - SHORT TERM	OPTION C (NEW) SWITCH/TRANSFER GARU AND CCC UNITS BETWEEN RVHS-CENTENARY AND LH BOWMANVILLE
Timing ➢ There is a perceived fear that the staffing situation will become more difficult and this may place LHC in a risk situation whereby the beds will not be able to be staffed safely, particularly as scheduling is developed for the summer months. This may lead to the unnecessary closure of beds as a result of this situation. ➢ In conjunction with the Unions, there may be opportunities to develop workable solutions to solve the staffing issue, providing that there are decisions on how long the services will continue to be temporarily located on the RVHS site. ➢ Staff scheduling is done 8 weeks in advance	➢ Discussions between RVHS/LHC and other parties related to the development of the "straw dog" with respect to legal implications, operating budget transfer, HR implications/plan could start immediately. ➢ Clarity is still required with respect to whether this is a short term solution (and for how long) or a solution of a permanent nature. ➢ Staff scheduling is done 8 weeks in advance ➢ 3 months plus to work out contractual obligations and issues associated with RVHS, LHC and CE LHIN	➢ See "Option C" described under Geriatric Rehabilitation & Assessment Unit – GARU (26 beds) – LH Bowmanville on the previous pages.
Costs ➢ Additional operating costs by LHC in the operation of this unit will continue until the situation is resolved.	➢ Costs associated with HR implications.	➢ See above.

OPTION A STATUS QUO - LHC CONTINUES TO OPERATE	OPTION B LHC TRANSFERS TO RVHS TO OPERATE - SHORT TERM	OPTION C (NEW) SWITCH/TRANSFER GARU AND CCC UNITS BETWEEN RVHS-CENTENARY AND LH BOWMANVILLE
Service and Other Implications ➢ There will be a loss of service (short or long term) if beds are closed due to unsafe situations. ➢ Closure of any CCC beds will likely compound the ALC situation being faced by hospitals within the system.	➢ Significant HR implications due to the layoff of staff. Other solutions (early retirement, etc) would be offered prior to layoff. Bumping would occur through LHC organization and take several months. If beds were repatriated back to LHC subsequent to this, LHC would then be faced with the rehiring of staff. ➢ Negotiation and transfer of operating budget to RVHS.	➢ See "Option C" described under Geriatric Rehabilitation & Assessment Unit – GARU (26 beds) – LHC – Bowmanville on the previous pages.
Impact – Long Term Planning ➢ Absence of a CE LHIN CSP with respect to the sizing and siting of complex continuing care services.	➢ Absence of a CE LHIN CSP with respect to the sizing and siting of complex continuing care services ➢ Expectation that siting of CCC services would not be permanent. Perceived loss of CCC services by the LHC community. ➢ Expectation that CCC would be eventually be repatriated to an appropriate location within the LHC system.	➢ See above.

APPENDIX D

Construction Costs – Replacement of Existing LHW Space

Central East LHIN

Lakeridge Health Corporation: Whitby Site Steering Committee

Scenario #1 - Construction Costs - Direct Replacement of Existing LH Whitby Space

Program/Service	# Beds Units	Existing Area (LH Whitby) cgsf	sf/bed, sf/station	Minor Renovation - Hard Costs per sf		Major Renovation - Hard Costs per sf		New Construction - Hard costs per sf	
				Low $100	High $200	Low $200	High $250	Low $350	High $425
Dialysis (33 stations)									
Hemodialysis Unit	33	12,489	378	$1,248,900	$2,497,800	$2,497,800	$3,122,250	$4,371,150	$5,307,825
Dialysis Program (Clinic & Program)	33	3,401	103	$340,100	$680,200	$680,200	$850,250	$1,190,350	$1,445,425
Subtotal				*$1,589,000*	*$3,178,000*	*$3,178,000*	*$3,972,500*	*$5,561,500*	*$6,753,250*
Complex Continuing Care - 53 beds									
Inpatient Unit	53	16,441	310	$1,644,100	$3,288,200	$3,288,200	$4,110,250	$5,754,350	$6,987,425
Program Admin & Associated Functions		1,772	33	$177,200	$354,400	$354,400	$443,000	$620,200	$753,100
Subtotal				*$1,821,300*	*$3,642,600*	*$3,642,600*	*$4,553,250*	*$6,374,550*	*$7,740,525*
Geriatric Rehabilitation - 32 beds									
Inpatient Unit	32	13,143	411	$1,314,300	$2,628,600	$2,628,600	$3,285,750	$4,600,050	$5,585,775
Program Admin & Associated Functions		1,772	55	$177,200	$354,400	$354,400	$443,000	$620,200	$753,100
Subtotal				*$1,491,500*	*$2,983,000*	*$2,983,000*	*$3,728,750*	*$5,220,250*	*$6,338,875*
Day Hospital - 16 spaces									
Day Hospital	16	4,925	308	$492,500	$985,000	$985,000	$1,231,250	$1,723,750	$2,093,125
Subtotal				*$492,500*	*$985,000*	*$985,000*	*$1,231,250*	*$1,723,750*	*$2,093,125*
Total				**$5,394,300**	**$10,788,600**	**$10,788,600**	**$13,485,750**	**$18,880,050**	**$22,925,775**

Scenario #2 - Construction Costs - Typical Space Planning Benchmarks

Program/Service	Beds/ Stations	Future Area cgsf	sf/bed, sf/station Note 1	Minor Renovation - Hard Costs per sf		Major Renovation - Hard Costs per sf		New Construction - Hard costs per sf	
				Low $100	High $200	Low $200	High $250	Low $350	High $425
Dialysis (33 stations)									
Hemodialysis Unit	33	17,754	538	$1,775,400	$3,550,800	$3,550,800	$4,438,500	$6,213,900	$7,545,450
Dialysis Program (Clinic & Program)	33	4,026	122	$402,600	$805,200	$805,200	$1,006,500	$1,409,100	$1,711,050
Subtotal				*$2,178,000*	*$4,356,000*	*$4,356,000*	*$5,445,000*	*$7,623,000*	*$9,256,500*
Complex Continuing Care - 40 beds									
Inpatient Unit	40	26,480	662	$2,648,000	$5,296,000	$5,296,000	$6,620,000	$9,268,000	$11,254,000
Program Admin & Associated Functions		incl above	incl above	incl above	incl above	incl above	incl above	incl above	incl above
Subtotal				*$2,648,000*	*$5,296,000*	*$5,296,000*	*$6,620,000*	*$9,268,000*	*$11,254,000*
Geriatric Rehabilitation - 40 beds									
Inpatient Unit	40	26,480	662	$2,648,000	$5,296,000	$5,296,000	$6,620,000	$9,268,000	$9,268,000
Program Admin & Associated Functions		incl above	incl above	incl above	incl above	incl above	incl above	incl above	
Subtotal				*$2,648,000*	*$5,296,000*	*$5,296,000*	*$6,620,000*	*$9,268,000*	*$9,268,000*
Day Hospital - 16 spaces									
Day Hospital	16	4,928	308	$492,800	$985,600	$985,600	$1,232,000	$1,724,800	$1,724,800
Subtotal				*$492,800*	*$985,600*	*$985,600*	*$1,232,000*	*$1,724,800*	*$1,724,800*
Total				**$15,933,600**	**$31,867,200**	**$31,867,200**	**$39,834,000**	**$55,767,600**	**$63,006,600**

Notes (Scenario 1 & 2):

1. Renovation costs per square foot reflect fit out rates, exclusive of other allowances and ancillary costs (typically 23.5% above hard construction costs)
2. Renovation rates and new construction costs are in current dollars. Renovation rate range (low - high) provided by RVHS.
3. New construction rates reflect fit-out, M&E infrastructure and shell allowance but exclude site allowance.
4. New construction costs provided by RVHS are consistent with reference materials provided by LHC (Hanscomb) indicating an average construction rate of $363 per sf for ambulatory based programs and $343 per sf for complex continuing care, exclusive of building gross and plant space.
5. Costs do not include other potential space implications required to support the program infrastructure such as clinical support, administrative and other areas, plant operations and maintenance, etc.