Pre-Capital Submission Form (PCSF)

Proposing Health Service Provider (HSP) Information

Proposed Project Name:	West Durham (Ajax) Redevelopment Options	**For LHIN Use Proposal #:**	
HSP Name (Legal):	Rouge Valley Health System & The Scarborough Hospital	**For MOHLTC Use HCIS#:**	
Site Name, Address and Postal Code:	2867 Ellesmere Rd. Scarborough, ON M1E 4B9 & 3050 Lawrence Avenue East, Scarborough, Ontario, M1P-2V5	**LHIN:**	
Submission Date:	January 21st, 2014		

Facility Type– Please Select	
Public Hospitals (including own funds projects as per legislation)	☒
Community Health Centres	☐
Community-Based Mental Health Programs	☒
Community-Based Substance Abuse (Addiction) Programs	☒
Long-term Care Supportive Housing Providers (typically supporting programs for the frail elderly, acquired brain injury, physically disabled and HIV/AIDS)	☐

	HSP Primary Contact	**HSP Secondary Contact**
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HSP Approval:		
CEO/ED Name:	**Rik Ganderton & Robert Biron**	
CEO/ED Signature:		

Section 2 – Proposal Overview

Build Type Descriptions

Addition	☒	**Green field**	☒	**Infrastructure**	☒
Renovation	☒	**Remediation**	☐	**Leasehold Improvement**	☐
Brown field	☒	**Decommissioning**	☒	**Property acquisition**	☒
				Other	

Service Type Descriptions

Is this a proposal for a single or multi-service project?

Acute	☒	**ELDCAP**	☐	**Mental Health – Longer Term**	☐
Ambulatory	☒	**Emerg**	☒	**Rehab**	☒
CCC	☒	**Neonatal ICU**	☐	**Infrastructure**	☐
Adult Critical Care/ICU	☒	**Provincial Program**	☐	**Mental Health – Acute**	☐
Other Service Type	☐				
Support Service – Please Select					
Laboratory	☒	**CT**	☒	**Food Services**	☒
Pharmacy	☒	**Allied Disciplines**	☒	**Housekeeping**	☒
General DI	☒	**Counselling**	☒	**Maintenance**	☒
MRI	☒	**Staff Facilities**	☒	**Other**	☒

Completion Guideline: *It is expected that the response to Section 3 (Part A and Part B) will be completed in 15 regularly spaced pages.*

Section 3 - Proposal

PART A

Program/Service Proposal – LHIN Review

1. Provide a narrative description of the program/service need to be addressed by this initiative. Examples include, but are not limited to:

    a. Need for new program(s)/service(s).
    b. Need for expanded program(s)/service(s).
    c. Need for program redesign or integration.

The Central East LHIN's 2013-16 Integrated Health Services Plan takes its cue from the Ministry of Health and Long-Term Care's Action Plan for Health and the common objectives of Ontario's 14 LHINs. It is rooted in the CE LHIN's commitment to lead the creation of an integrated local health care system that delivers on better health for the community, better patient experience, and better value-for-money. Within the CE LHIN, east Scarborough is served by The Scarborough Hospital (TSH) and Rouge Valley Health System (RVHS). There are four primary sites associated with the two hospital corporations – TSH General; TSH Birchmount; RVHS Centenary which primarily serve Scarborough and RVHS Ajax which provides hospital services to West Durham residents.

The Central East Local Health Integration Network (Central East LHIN) Board passed a motion at its March 2013 meeting directing Rouge Valley Health System (RVHS) and The Scarborough Hospital (TSH) to participate in a Facilitated Integration process to design and implement a Scarborough Cluster hospital services delivery model – through integration of front-line services, back office functions, and leadership and/or governance – in order to improve client access to high quality services, create a readiness for future health system transformation and make the best use of the public's investment.

It is clear that each hospital has many strengths and both have introduced initiatives to strengthen their position and services within the health care system. Based on the current environment, understanding of the changing landscape and the current situation of the hospitals, the question being examined is whether or not the two hospital corporations are better positioned to provide sustainable and quality care to their communities as independent corporations or as a merged organization. Both RVHS and TSH recognize that, in order to support the plan for health care, they must continue to adapt to the growing needs of their communities, continue to explore integration opportunities and draw upon their previous integration experiences, including strategic alliances with primary care and other community partners. This is aligned to the broader vision for Ontario's health care transformation and to pursuing an integrated health system approach to delivering high-quality and responsive care for the Scarborough and west Durham communities. As a merged organization, long- term opportunities include:

- Centres of Excellence – Centres of Excellence provide more local access to a broader and deeper range of clinical expertise to our communities. Examples already exist for Cardiology and Nephrology and further development of these services is feasible. These services provide local access to world-class clinical care for our communities. Future opportunities could include (but are not limited to) Maternal Child, Oncology, Orthopaedics, Urology, Palliative Care and Post Acute Care.
- Development of Ambulatory Centres/Clinics – Growth or creation of new outpatient services; including multiple surgical outpatient clinics, as well as disease site clinics for Oncology provide better access to residents of Scarborough and west Durham.
- More effective integration with all sectors of the broader health care delivery system – these opportunities have strong potential for increasing the quality of care and the patient experience. For example, in the Mental Health program, by combining the Psychogeriatric Outreach Programs the relationship with long-term care homes could be simplified and more seamless care provided. Another example involves Palliative Care where a merged single hospital organization could standardize transitions with community providers to make them more seamless and less complex for patients and families.

RVHS and TSH have jointly completed a high level current state assessment of hospital facilities to assess the existing building infrastructure and its condition. Based on the FCI index (0.06) the RVHS Ajax-Pickering site ranks in the top 10% reflecting recent significant upgrades. However, this site is at maximum capacity and does not have the physical capacity to absorb further population growth, let alone repatriate a proportion of the almost 70% of the west Durham community who seek in-patient care and surgical services elsewhere. Demand for inpatient medical care has exceeded current RVAP ministry bed allotment and built physical capacity. Additional bed capacity is required in both the immediate and longer term to meet patient care demands. RVHS-Ajax:

- Is at capacity and unable to accommodate increasing workload;
- struggles to meet emerging contemporary planning standards in inpatient medical/surgical space and operating rooms to support many basic functions; and,
- extremely challenged to accommodate proper infection prevention and control practices.

Based on activity projections, current service delivery models and current hospital facility planning guidelines, the inpatient space and operating rooms would need to be significantly redeveloped in order to meet contemporary standards and address risk impacts to patient care. The two hospitals are further constrained due to very large working funds deficits. The ability to borrow is becoming more limited and any surpluses being generated are being used to replace equipment that is 2 or 3 times older than the Ontario average. While TSH/RVHS recognize that redevelopment of hospital facilities will be costly, this cannot be a barrier to moving forward. The Current State report has also not considered specific locations and/or a configuration of services. Consequently, TSH/RVHS seeks to complete the development of a Long Range Service Needs Assessment and Facilities Plan for delivery of services in Durham.

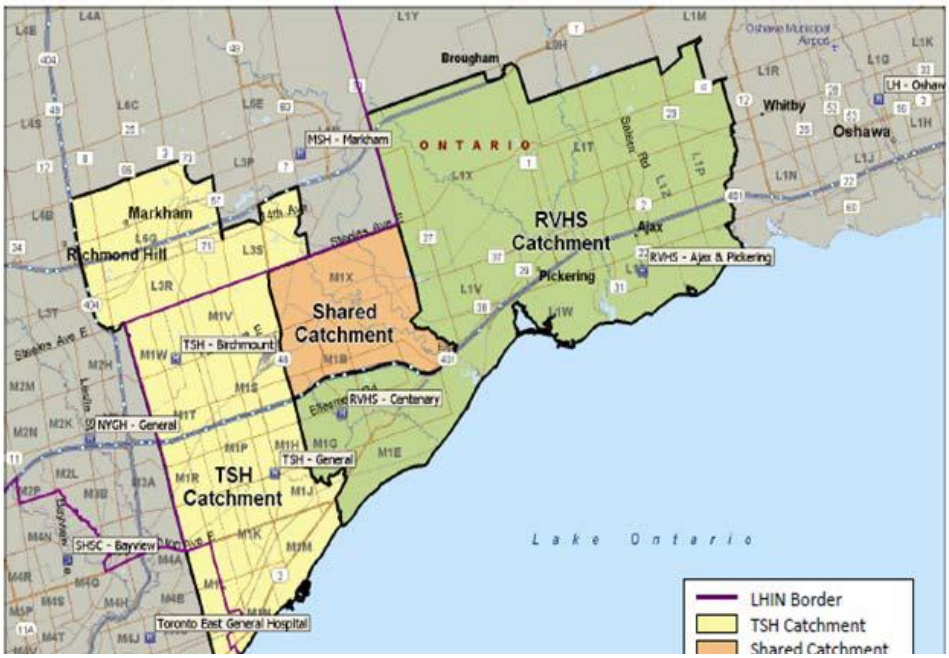
2. Provide a statistical description of the program/service need to be addressed by this initiative: This should include:

a. Demographic profile (current and projected population for 5, 10 and 20 years).
b. Utilization profile (current and projected demand for 5, 10 and 20 years).

RVHS and TSH are the results of previous integration efforts dating back to 1999. Since that time, the Scarborough and west Durham communities have grown and changed. West Durham represents 20% of the total Central East LHIN population. The communities served are among the fastest growing regions in the province.

- RVHS catchment area: 612,022
  - Ajax-Pickering: 9.8%; higher than Ontario average at 5.7%.

Both the RVHS and TSH communities are anticipating significant growth. The overall population growth in the Central East LHIN is forecasted to be 17% from 2011 to 2021 (Source: Ministry of Finance Population Projections by LHIN from C2011-2036, based on Census Survey data up to 2010). As the communities grow, inpatient cases are anticipated to grow by 13.3% over five years and 27.7% over 10 years. Over the next 10 years, percentage growth in cases will be the largest in specialized medical and surgical care such as vascular surgery, urology and cardiac care and the smallest in psychiatry, obstetrics and plastics. A summary of Key Facts for clinical profiles, market share growth, and population growth projections by patient clusters is attached.



In addition, The Central Pickering Development Plan provides a framework for the development of a combination of residential and non-residential uses in an area known as the Seaton Lands. It is anticipated that this development will accommodate an eventual population of 70,000 residents and is expected to generate 35,000 jobs. A December 17th , 2013 ruling by the Ontario Municipal Board has cleared the way for the Seaton community development to proceed. It is anticipated that construction will start later this year in north Pickering. Furthermore, the proposed Pickering Airport site is located immediately to the north of the Seaton employment lands. The Federal Government is currently conducting a due diligence review of the need for and

potential timing of the Pickering Airport. The Airport would act as a regional airport at first, replacing Buttonville and Oshawa airports and would potentially evolve to act as a reliever facility for Pearson which is anticipated to reach its planned capacity by 2018. These developments will put further stress on health care services provided in the region, especially North and West Durham.

3. Describe how this program(s)/service(s) need supports local health system integration and a unified system of care.

    a. MOHLTC – Provincial programs (e.g. Cardiac Care and Transplantation)
    b. LHIN – Integrated Health Services Plan, Clinical Services Plan, agreement with Provincial Agencies such as Cancer Care Ontario and Ontario Renal Network, as required
    c. HSP – Strategic Plan, Organizational Goals, Accountability Agreements

The Central East LHIN's 2013-16 Integrated Health Services Plan is rooted in the CE LHIN's commitment to lead the creation of an integrated local health care system that delivers on better health for the community, better patient experience, and better value-for-money. Using the framework of the four guiding principles – Collaboration, Accessibility, Sustainability and Excellence – significant opportunities and benefits have been identified by TSH/RVHS to improve care, access and value. Stakeholder input and the output of the Working Groups have provided concrete ideas that would benefit the communities of Scarborough and west Durham. These opportunities can be achieved by designing a strong, single hospital with a new brand and a shared vision. Together the two hospitals can position themselves to better respond to the needs of their communities, address fiscal challenges more effectively, and take advantage of the fast changing health care environment. A merged hospital would continue to provide regional programs; it would strengthen existing programs; and it could develop new or enhanced services for the community through Centres of Excellence, clinics and partnerships with other providers. The merger of the two organizations has the potential to create a hospital system that is positioned to succeed through the broader health system transformation, to deliver increased quality, access and range of services not currently available to the citizens of Scarborough and west Durham. Overall, the strength of this value proposition is not in the short-term, but rather in the longer-term in which the hospitals are able to position themselves to better serve their communities, create a shared vision for a transformed local health care system, address fiscal challenges together, and take advantage of the fast changing health care environment. The rationale for focusing on the merger option is to:

- Develop a long-term vision for hospital services for the Scarborough and West Durham communities;
- Develop a solution that has the potential to maintain access and maintain or improve quality while dealing with ongoing health system transformation and funding constraints;
- Develop a solution that will make the hospitals more competitive in response to government changes to the funding model;
- Ready the two hospital corporations for continuing health system transformation by developing a platform for better connecting with other sectors, such as primary care and community agencies;
- Ensure that separate governance and management structures would not be a barrier to identifying benefits as they have in the past; and,

- Overcome a history of limited collaboration between the two hospital corporations over the last 40 years.

4. What discussions have occurred and please describe what level of support has been received from other stakeholders with regard to this initiative? Other stakeholders may include:

    a. Internal staff, physicians and/or Board members
    b. Other HSPs
    c. Neighbouring LHINs
    d. Provincial agencies (e.g. Cancer Care Ontario)
    e. Service partners
    f. Community stakeholders [Local Health System Integration Act, Section 16 (6) Each health service provider shall engage the community of diverse persons and entities in the area where it provides health services when developing plans and setting priorities for the delivery of health services. 2006. c. 4, s. 16 (6)]

The Central East Local Health Integration Network (Central East LHIN) Board passed a motion at the March 2013 meeting directing Rouge Valley Health System (RVHS) and The Scarborough Hospital (TSH) to participate in a Facilitated Integration process to design and implement a Scarborough and west Durham hospital services delivery model – through integration of front-line services, back office functions, and leadership and/or governance structures – in order to improve client access to high quality services, create a readiness for future health system transformation and make the best use of the public's investment. The Central East LHIN took the lead in establishing the planning structure for the Facilitated Integration, an Integration Leadership Committee (ILC), to oversee the Facilitated Integration Planning activities. The ILC prepared and submitted a Planning Framework, key to which are the guiding vision and principles that were developed with full engagement and support by the ILC to guide the work of the two hospitals in the identification and evaluation of integration options.

The two hospitals have participated in a process to learn more about each other with a view to identifying opportunities where they have the potential to be stronger together. Fifteen groups made up of front line leaders, physicians, clinicians and administrators were established to look at the current state of 11 clinical programs and 4 back office areas and to generate integration ideas that would improve quality, access and care for the citizens of Scarborough and west Durham. The groups were tasked with soliciting input from key stakeholders to inform the completion of workbooks that identified over 40 potential integration opportunities with associated benefits, risks and mitigation strategies. In addition to the work of the clinical and back office Working Groups, an extensive stakeholder engagement process was undertaken to solicit input from community groups, staff and physicians, citizens of Scarborough and west Durham, politicians, and other stakeholders to explore the benefits and risks of a possible merger. Over 400 stakeholders provided direct input and were engaged over a three month period. Furthermore, some 16,000 persons participated in telephone town halls and there were more than 130,000 social media hits. The following is a summary of the internal and external stakeholder input:

- There are opportunities to provide better coordination of care and access through a single hospital organization.
- Improve opportunities to build on each hospital's strengths to create stronger local,

regional and provincial programs and position the hospital system as a strong player in other health system integrations and partnerships, such as with primary care, long-term care and other health and community service providers.

- Better opportunities to improve facilities together than independently – both hospital corporations require significant facility infrastructure renewal and expansion and as a united organization, will have a stronger voice with the province for capital investments.
- There are opportunities for financial savings through the elimination of duplication, such as back office services and management, as well as efficiency opportunities.
- Greater ability to attract more physician specialists for advanced care through a merged hospital corporation.
- Working together, instead of competing, the hospitals could increase their market share and repatriate patients travelling to other GTA hospitals.
- Scarborough and west Durham residents deserve a strong hospital system with a shared vision for the future, a competitive brand and one voice.
- The community is open to the idea of a merger – there is overall neutral to positive support for the merger.

Hospital services for the Durham area are provided by Lakeridge Health and Rouge Valley Health System. Pressures to the east are addressed by Lakeridge Health, to the west by RVHS, and to the north will have implications for both organizations. Hospitals in the Central East Local Health Integration Network have been working collaboratively (led by Lakeridge Health) to address the non-acute (Rehabilitation & Complex Continuing Care) health care needs of the Region. Discussions with the City of Pickering's Mayor's Office and Planning Department regarding addressing the needs of the Seaton Land development have been favourably received to date.

This Pre-Capital assumes a core set of facility-based hospital services in Durham that provides acute, emergency and ambulatory care services, complemented by an integrated continuum of services required to support emergency-driven services, patient flow and resident needs, e.g., primary care, complex continuing care, palliative and rehabilitation services, as integrated components would serve as broader input into the Long Range Service Needs Assessment and Facilities Plan for delivery of services in Durham. The nature of where and how these facility-based hospital services will be provided in the future will need to be determined through a collaborative process by relevant stakeholders including the MOHLTC and the CELHIN. This Pre-Capital does not fully or formally account for projected or forecasted needs identified by other hospital capital planning activities within the CELHIN. Currently, emerging priorities for Lakeridge Health include the following, but does not address acute bed capacity:

- Bowmanville Emergency , ICU, Operating Rooms
- Oshawa Diagnostic Services Building
- Port Perry Electricity and Service Model
- Whitby Hospital Regional CCC and Rehab

Consequently, the volume and nature of healthcare services required in the future to serve West Durham residents, including the need for emergency and inpatient services, would need to be provided at the RVHS-Ajax hospital facility and possibly an ambulatory care facility to service the needs of the planned Seaton development.

Future planning will need to consider other hospital and community health service planning in the CELHIN with a focus on creating a coordinated service base that includes west Durham

hospital services, and balances the needs across the CELHIN.

5. Describe any significant operational implications in terms of:

    a. Operating cost
    b. Staffing

TSH and RVHS are not able to describe the operating cost and staffing implications at this time. Operating costs and staffing implications will be identified during the Stage 1 Proposal planning process when additional detailed information will be available.

Both RVHS and TSH have a challenging financial starting point to manage going forward. To varying degrees, both organizations have weak balance sheets with constrained liquidity and cash flow. As a result, both have very limited financial means to replace aged equipment and buildings and to invest in improving services.

Under the HSFR, both hospitals have experienced near flat or negative funding, while having to address budget gaps driven by cost inflation, increasing patient volumes and patient complexity. While these gaps have been addressed for the 2013/14 fiscal year, the effort to balance the budget means that, in some cases, capital investments have been limited.

Based on these funding and budget pressures including inflation, population growth and increasing acuity, each hospital will need to continue to find ways to reduce costs. Overall:

- Both hospitals are facing flat or negative Provincial funding (similar to all hospitals) – combined with increasing patient volumes, complexity and a growing population.
- Both hospitals are facing inflation of 4-5% with flat revenue and a requirement to balance their budget.
- HSFR being rolled out by the provincial government is creating an increasingly competitive environment between hospitals for patients, funding, capital and health human resources. With the close proximity of hospital sites in Scarborough this competitiveness is not beneficial and could potentially drive negative impacts for patients.
- Both hospitals have tight balance sheets with constrained liquidity and cash flow although one at least has cash resources and has not drawn on its short-term borrowing facilities.
- Both hospitals have varying but constrained or limited financial means to replace aged equipment and buildings and to invest in improving services, although investments have been made over the last five years.

The two hospital corporations are running out of capacity to restructure services to improve efficiency. The next steps will have to include service reductions or eliminations. The Hospitals believe this can be avoided, minimized or deferred through the merger. RVHS and TSH will be stronger and more resilient together. Specifically, from a financial perspective, the estimated net cumulative operating savings impact is in the range of $7.6 million to $9.6 million by the end of year three. If a facility renewal were to occur, then the total potential benefits from operational efficiencies and economies of scale increases up to an estimated $41 million. This would need to be confirmed as part of detailed facility planning exercise.

One clear, but not necessarily directly quantifiable, benefit is that the combined organization would be of a size that could more easily withstand the impacts of funding reform and health system transformation, over the next few years, by adjusting services, programs and staffing such that services could be retained with possible reductions, but prevent service elimination. In essence, a larger organization (in fewer sites) is more able to adjust service delivery to maintain those services, compared to smaller, fragmented separate organizations.

6. Describe any alternative program/service solutions considered to address the need identified in Question 1 and 2 above. Examples may include:

    a. Integration opportunities.
    b. Program /service redesign opportunities.
    c. Alternative service delivery models.

Examples of integration in the existing service delivery model already exist for Cardiology and Nephrology and further development of these services is feasible. These services provide local access to world-class clinical care for our communities. Future opportunities could include Maternal Child, Oncology, Orthopaedics, Urology, Palliative Care and Post Acute Care. Development of Ambulatory Centres/Clinics provides the opportunity to grow or create new outpatient services; including multiple surgical outpatient clinics, as well as disease site clinics for Oncology providing better access to residents of Scarborough and west Durham. More effective integration with all sectors of the broader health care delivery system presents further strong potential for increasing the quality of care and the patient experience. For example, in the Mental Health program, by combining the Psychogeriatric Outreach Programs the relationship with long-term care homes could be simplified and more seamless care provided. Another example involves Palliative Care where a merged single hospital organization could standardize transitions with community providers to make them more seamless and less complex for patients and families.

How clinical services might be delivered differently in the future, factors driving the need for change and alternative service delivery models will be addressed in future stages of planning. The planning for hospital facilities presents an opportunity for ensuring both Ministry and CELHIN priorities are incorporated into the proposed service delivery model. Planning should focus on confirming unmet needs, the development of an integrated service delivery model and avoiding unnecessary duplication. Considerations to be addressed through the development of a Long Range Service Needs Assessment and Facilities Plan may include the planning for expansion and revitalization of the RVHS-Ajax hospital as well as the development of an ambulatory care centre to address the needs of the Seaton Lands development.

PART B

Development Concept – MOHLTC Review

7. What amount of space, based on space benchmarks, is required to meet the program need identified in Part A?

This will be developed during the next stage of planning. However, possible options for review in the next stage include:

- Option 1 – Expand the existing Rouge Valley Ajax Pickering campus to address bed requirements and surgical suite requirements; this project includes a new surgical suite, including same day surgery and post anaesthetic care units and a new central sterile reprocessing department. It will also introduce the capacity for the local delivery of minimally invasive surgery to the residents of West Durham. The surgical suite expansion is critical to keep pace with population growth and to accommodate increasing volume and complexity in areas such as cancer surgeries. Facility size to be in the 300-330 bed range. In addition, build a free standing urgent care/ambulatory care facility in Seaton which could provide up to 18 hour emergency care.
- Option 2 – build a single new full service acute facility in the 330 bed range in north-east Pickering.

In projecting future hospital service bed needs it is difficult to determine the clinical practice changes, technological innovations, or policy decisions that will change how services could be used in the future and its impact on bed requirements.

Both options assume further development of areas of specialization and elimination of unnecessary duplication. The following are Projected bed equivalents assuming:

- National average Length of Stay;
- Bed equivalents at 90% occupancy accounting only for population growth (Ministry of Finance);
- Projections stratified by <65 years old and > 65 years old; and,
- 2011/12 inpatient data.

Ajax	2011	5Yrs (2016)	10Yrs (2021)	15Yrs (2026)	20YRs (2031)	25Yrs (2036)
Acute	120	136	155	177	199	205
Post Acute (CCC/Rehab)	51	63	78	95	114	127
Mental Health						
Total	171	199	233	272	313	332

It is recognized that there are many emerging strategies (i.e. Ministry Action Plan, HSFR, Community Specialty Clinics, etc.) and changes in clinical practice that will likely impact (i.e. reduce) the final determination of bed requirements. Those impacts will be more fully explored and factored during the next phases of the capital planning and design.

8. Does the HSP have this space available to it now?

No existing space can be renovated to accommodate the additional beds and/or surgical suite capacity relative to contemporary planning guidelines. The proposed Ambulatory Care Centre will require land acquisition and new build in the Seaton Lands area.

9. Is it practical to renovate the existing space to meet the program need identified in Part A?

Options could include new facilities, redeveloped and expansion of existing sites and/or a combination of both. The Long Range Service Needs Assessment and Facilities Plan would allow the hospitals and community to determine the best option for future service delivery options and facility renewal in West Durham (Ajax). However, given the recent redevelopment at the Ajax site, expansion of the facilities will be essential and renovation of current space will be necessary to accommodate hospital-based services.

10. Does the HSP have physical support and operational support available to serve the existing space, (e.g. pharmacy, food services)?

This will be developed during the next stage of planning. Expansion of some or all support areas will be required.

11. Describe the proposed physical infrastructure changes required to support the program/service need identified in Part A. This may include:

    a. Renovation to existing infrastructure.
    b. Development of new infrastructure.
    c. Relationship to any other capital projects (approved or proposed).

To be detailed in the next stage of planning. Option 1 will require expansion of the facilities along with renovation of current space. Emerging projects at the RVAP site identified below will be impacted.

Strategy	2011/12	2013/14	2014	2015	2016	5 Yr. Plan
	Actual		Assumptions			
HIRF Funding (VFA Requirements)	$524,355	$429,214				$953,569
Capital Projects *(MOH Approval needed)*						
Surgical Suite/CPD/PACU (RVA)					$50,000,000	$50,000,000
60 Medical Beds (RVA)					$32,000,000	$32,000,000
Seaton Ambulatory (RVA)					$25,000,000	$25,000,000
Total					**$107M**	**$107M**

Generally speaking, it is anticipated that a new addition on the existing site will be required and will accommodate the additional beds as well as the surgical suite and associated services rebuild. The proposed urgent care/ambulatory care centre will be located in the Seaton area.

12. Describe the physical infrastructure deficiency related to the program(s)/service(s) need identified in Part A. This may include:

    a. General condition.
    b. Capacity to continue supporting program(s)/service(s) delivery.

The surgical suite requires extensive renovation and expansion to address numerous deficiencies and to provide sufficient space for the projected volume of surgical procedures. New operating theatres will provide state-of-the art facilities which will improve patient outcomes, promote wound healing and ensure a safer environment for patients and staff alike. Appropriate space for the following functions is completely lacking:

- specialized surgical procedures requiring advanced diagnostic equipment;
- case carts;
- supplies and equipment;
- family waiting; and,
- interview/consultations.

In addition, the surgical suite is below contemporary design and quality standards. For example, there is no central sterile corridor, clean and soiled materials are located in the same hallway and the patient waiting area does not support privacy. The proposed relocation of the surgical suite will also require relocation and the development of new space for central processing.

Inpatient acute units are currently:

- not configured for efficient clinical services;
- at capacity and provides limited flexibility for adopting new practices or accommodating increasing workload;
- not able to meet emerging contemporary planning standards, and has limited space to support many basic functions - single bed rooms range in size from 140 – 160 NSF and

ensuite 2-pc washrooms are 20-30 NSF; and,
- challenged to accommodate proper infection prevention and control practices.

Facility infrastructure upgrades (air exchanges, hand-washing sinks, medical gases, etc.) will be required to repurpose the existing space for acute bed use. In addition, right-sizing of exiting inpatient units to contemporary standards and to meet ICD guidelines dramatically reduces the number of beds in the existing footprint creating inefficient units.

13. Describe alternative infrastructure solutions considered.

Alternative infrastructure solutions will be considered during development of the Long Range Service Needs Assessment and Facilities Plan. However, two options are presented here for consideration.

14. Describe any development challenges expected, including:

    a. Site planning
    b. Phasing/decanting

Development challenges will be explored and addressed in progressive planning stages. However, no significant issues are expected from a site planning perspective since the proposed existing site area is currently vacant. Potential zoning issues will have to be addressed vis a vis potential height restrictions, set-backs, and parking requirements. Sanitary trunk capacity may be a significant issue relative to residential development nearby.

15. If physical infrastructure will be vacated, what is the intended use of the vacated space?

The potential future use of vacated facilities will be considered during development of the Long Range Service Needs Assessment and Facilities Plan.

16. Provide preliminary capital cost estimate (in current year dollars) noting any assumptions in projecting costs.

    While it is premature to document the initial preliminary cost estimate, a high level order of magnitude capital cost estimate was developed on Option 1 - Expand the existing Rouge Valley Ajax Pickering campus to address bed requirements and surgical suite requirements; this project includes a new surgical suite, including same day surgery and post anaesthetic care units and a new central sterile reprocessing department. Facility size to be in the 300-330 bed range. In addition, build a free standing urgent care/ambulatory care facility. However, the development of a Long Range Service Needs Assessment and Facilities Plan will better inform the implications of various service delivery model options including the quantitative costs (i.e., capital,

operational, transitional, etc.), the qualitative factors for considerations, as well, the specific scope of the project/request for capital approval.

Based on the following Table, it is assumed that a 300 bed facility would cost roughly $508M assuming roughly 2,300 sq. ft. per bed and roughly $736/sq. ft.

The construction of a roughly 90,000 sq. ft. ambulatory care centre under Option 1 is expected to be in the $25M ballpark excluding land acquisition costs.

Item	Cost	Assumptions (e.g., cost per sq. foot of renovation)
Construction Costs for space required for delivery of services (new construction or renovations)	$345,300,000	$500/sq. ft.
Any premium for renovations to existing conditions	$6,906,000	2%
Any premium for phasing and decanting	$6,906,000	2%
Any premium for land and/or building acquisition (for community-based agencies)	($25,000,000)	Ambulatory Care Centre $225/sq. ft assuming 90,000 Sq. Ft. Required $800,000/acre assuming 5 acres
Ancillary Costs	$80,109,600	23.2 %
Furniture and Equipment (including minor equipment)	$34,530,000	10%
Post Contract Contingency Allowance	$34,530,000	10%
Estimated Total Cost	$508,281,600	$736/sq./ft

Again it should be noted that the cost presented here is based on the current preliminary forecast need of 300 beds. Should fewer beds be required, based on the planning and design activities which take into account current government policy direction, the estimate would correspondingly be lower.

17. Is this project proposed to be:

Ministry cost shared	☒
Own Funds	☐

18. Explain how your HSP plans to provide for its share of the capital costs by identifying all proposed sources and amounts of funding, including any funding partners.

A comprehensive process will be used to identify the sources of funds including the potential for DBFM, alternate financing, partnering, fundraising by the Hospital's Foundation, etc.

If the HSP has supporting documentation that explains its development concept, please submit

Appendix: Key Facts

Clinical Profiles by Site

Table 1: Clinical Profile – Acute Inpatient

Organization	Rouge Valley Health System		The Scarborough Hospital		
Site	Centenary	Ajax	General	Birch-mount	Merged Volumes
Acute Inpatient Discharges	14,702	8,187	17,994	11,873	52,756
CE LHIN Resident % of Site Discharges	87%	98%	75%	68%	80%
Market Share of CE LHIN Residents Total Discharges	10%	6%	11%	7%	34%
Market Share of Scarborough Residents Total Discharges	20%	1%	27%	16%	65%
Market Share of Durham Resident Total Discharges	7%	16%	2%	1%	26%

Source: 2012/13 Intellihealth DAD

Table 2: Clinical Profile – Emergency Departments

Organization	Rouge Valley Health System		The Scarborough Hospital		
Site	Centenary	Ajax	General	Birch-mount	Merged Volumes
Emergency Visits	62,464	61,324	63,579	47,262	234,629
CE LHIN Resident % of Visits	93%	96%	85%	70%	87%
- Emergent & Potentially Life Threatening	15%	13%	24%	17%	17%
- Urgent & Potentially Serious	52%	47%	55%	57%	52%
- Less Urgent & Semi-Urgent	29%	35%	18%	24%	27%
Market Share of Scarborough Residents Total Visits	28%	1%	28%	17%	74%
Market Share of Durham Resident Total Visits	3%	24%	1%	0%	28%

Source: 2012/13 Intellihealth NACRS

Table 3: Clinical Profile – Specialty Ambulatory

Organization	Rouge Valley Health System		The Scarborough Hospital		
Site	Centenary	Ajax	General	Birch-mount	Merged Volumes
Day Surgery, Cardiac Cath Lab, Oncology & Renal Visits	31,694	9,630	118,081	17,023	176,428
Market Share of Scarborough Resident Day Surgery	24%	1%	23%	18%	66%
Market Share of Scarborough Resident Cath Lab	55%				55%
Market Share of Scarborough Resident Oncology	9%		30%	1%	40%
Market Share of Scarborough Resident Renal Dialysis			78%		78%
Market Share of Durham Resident Day Surgery	7%	15%	3%	2%	27%
Market Share of Durham Resident Cath Lab	67%				67%
Market Share of Durham Resident Oncology	6%		3%	0%	9%
Market Share of Durham Resident Dialysis			7%		7%

Source: 2012/13 Intellihealth NACRS

Table 4: Clinical Profile – Other Inpatient Programs

Organization	Rouge Valley Health System		The Scarborough Hospital		
Site	Centenary	Ajax	General	Birch-mount	Merged Volumes
Complex Continuing Care Discharges	12,488	8,767			21,255
CE LHIN Resident Share of CCC Days	95%	97%			96%
Site Share of CE LHIN Resident CCC Days	6%	5%			11%
Inpatient Rehabilitation Discharges	535	329		297	1,161
CE LHIN Market Share	11%	7%		5%	23%
Inpatient Mental Health Discharges CE	1,372			1,158	2,530
LHIN Resident % of Discharges Market	87%			76%	82%
Share of CE LHIN Mental Health Discharges	23%			17%	40%

Source: 2011/12 Intellihealth CCRS, OMHRS

Table 5: Summary of Clinical Sites Profiles

Summary of Clinical Site Profiles					
Organization	Rouge Valley Health System		The Scarborough Hospital		Merged Volumes
Site	Centenary	Ajax	General	Birchmount	
Acute Inpatient Discharges	14,702	8,187	17,994	11,873	52,756
CE LHIN Resident % of Site Discharges	87%	98%	75%	68%	80%
Market Share of CE LHIN Residents Total Discharges	10%	6%	11%	7%	34%
Market Share of Scarborough Residents Total Discharges	20%	1%	27%	16%	65%
Market Share of Durham Resident Discharges	7%	16%	2%	1%	26%
Emergency Visits	62,464	61,324	63,579	47,262	234,629
CE LHIN Resident % of Visits	93%	96%	85%	70%	87%
- Emergent & Potentially Life Threatening	15%	13%	24%	17%	17%
- Urgent & Potentially Serious	52%	47%	55%	57%	52%
- Less Urgent & Semi-Urgent	29%	35%	18%	24%	27%
Market Share of Scarborough Residents Total Visits	28%	1%	28%	17%	74%
Market Share of Durham Resident Total Visits	3%	24%	1%	0%	28%
Day Surgery, Cardiac Cath Lab, Oncology & Renal Visits	31,694	9,630	118,081	17,023	176,428
Market Share of Scarborough Resident Day Surgery Market	24%	1%	23%	18%	66%
Share of Scarborough Resident Cath Lab	55%				55%
Market Share of Scarborough Resident Oncology	9%		30%	1%	40%
Market Share of Scarborough Resident Renal Dialysis			78%		78%
Market Share of Durham Resident Day Surgery	7%	15%	3%	2%	27%
Market Share of Durham Resident Cath Lab	67%				67%
Market Share of Durham Resident Oncology	6%		3%	0%	9%
Market Share of Durham Resident Dialysis			7%		7%
Complex Continuing Care Discharges	12,488	8,767			21,255
CE LHIN Resident Share of CCC Days	95%	97%			96%
Site Share of CE LHIN Resident CCC Days	6%	5%			11%
Inpatient Rehabilitation Discharges	535	329	297		1,161
CE LHIN Market Share	11%	7%	5%		23%
Inpatient Mental Health Discharges	1,372			1,158	2,530
CE LHIN Resident % of Discharges	87%			76%	82%
Market Share of CE LHIN Mental Health Discharges	23%			17%	40%

Source: Acute Inpatient: 2012/13 Intellihealth Discharge Abstract Database (DAD); Emergency, Day Surgery and Ambulatory: 2012/13 Intellihealth National Ambulatory Care Reporting System (NACRS); Complex Continuing Care and Rehabilitation and Ontario Mental Health Reporting System: 2011/12 IntelliHealth.

Market Share and Patient Volumes

Table 6: Projected Market Share Growth of a Merged Organization

Patient Cluster Category	RVHS & TSH Inpatient Sites				Merged Volume
	Rouge Valley Health System		The Scarborough Hospital		
	Centenary	Ajax	General	Birchmount	
Separations					
Primary	6,256	4,610	7,609	5,014	23,489
Secondary	4,780	3,069	5,014	2,760	15,623
Tertiary	1,651	254	827	223	2,955
Quaternary	89	55	105	53	302
Market Share					
Primary	10%	7%	12%	8%	37%
Secondary	10%	6%	11%	6%	33%
Tertiary	15%	2%	7%	2%	26%
Quaternary	5%	3%	5%	3%	15%

Patient Cluster Category based on Hay Level of Care Methodology
Source: 2012/13 Intellihealth DAD

Table 7: Projected Inpatient Volume Growth for Central East LHIN

	Volume & Projection			Change from 2012	
Patient Cluster Category	2012/2013 (Actual)	2017 (Estimated)	2022 (Estimated)	2017	2022
Inpatient Cases	123,719	140,173	158,007	13.3%	27.7%
Emergency Visits	614,626	672,904	735,836	9.5%	19.7%
Day Surgery	140,850	159,355	179,310	13.1%	27.3%
Cardiac Cath Lab	6,336	7,374	8,543	16.4%	34.8%
Oncology	128,172	148,544	170,663	15.9%	33.2%
Renal Dialysis	146,699	169,330	195,381	15.4%	33.2%
CCC Assessments	3,026	3,576	4,188	18.2%	38.4%
Rehabilitation Episodes	4,356	5,122	6,021	17.6%	38.2%
Mental Health IP Episodes (Adult)	5,184	5,541	5,861	6.9%	13.1%

Source: 2012/13 Intellihealth DAD and NACRS, 2011/12 Intellihealth CCRS, OMHRS and NRS data, Ministry of Finance growth projections.

Table 8: Estimated Inpatient Volumes

CE LHIN: Estimated Inpatient Volumes in 2017 and 2022					
	Discharges			Change from 2012	
Patient Cluster Category	**2012/2013 (Actual)**	**2017 (Estimated)**	**2022 (Estimated)**	**2017**	**2022**
Cardiac Surgery	1,163	1,360	1,587	16.9%	36.5%
Cardiology	12,152	14,201	16,458	16.9%	35.4%
Dental/Oral Surgery	152	153	158	0.8%	3.7%
Endocrinology	2,056	2,315	2,614	12.6%	27.1%
Gastro/Hepatobiliary	8,378	9,553	10,832	14.0%	29.3%
General Surgery	9,310	10,458	11,720	12.3%	25.9%
Gynaecology	3,208	3,444	3,734	7.3%	16.4%
Haematology	2,311	2,605	2,931	12.7%	26.8%
Neonatology	17,310	19,063	21,116	10.1%	22.0%
Nephrology	1,176	1,372	1,591	16.6%	35.3%
Neurology	4,151	4,788	5,508	15.4%	32.7%
Neurosurgery	1,444	1,620	1,814	12.2%	25.6%
Non-Acute	4,314	5,066	5,883	17.4%	36.4%
Obstetrics	17,572	19,235	20,474	9.5%	16.5%
Ophthalmology	234	264	296	12.8%	26.5%
Orthopaedics	9,605	11,109	12,752	15.7%	32.8%
Other Internal Medicine	6,577	7,592	8,689	15.4%	32.1%
Other Reasons	1,636	1,897	2,186	15.9%	33.6%
Otolaryngology	2,897	3,209	3,555	10.8%	22.7%
Plastic Surgery	699	760	821	8.8%	17.4%
Psychiatry	1,445	1,473	1,586	2.0%	9.8%
Pulmonary	9,519	11,120	12,913	16.8%	35.7%
Thoracic Surgery	574	665	770	15.9%	34.2%
Urology	5,046	5,920	6,913	17.3%	37.0%
Vascular Surgery	790	930	1,103	17.7%	39.7%
Grand Total	**123,719**	**140,173**	**158,007**	**13.3%**	**27.7%**

NOTE: Growth projections are based on demographics alone. Current utilization rates are assumed to stay fixed.
Source: 2012/13 Intellihealth DAD and Ministry of Finance growth projections