2010/2011

Year 1

Ministry of Health
Home, Community and Integrated Care

Health Authority Investment of Revised Residential Care Client Rate Revenue 2010/2011 -Year 1 Analyses
Report Summary

ACKNOWLEDGEMENTS

This report was produced with the skilled assistance in framework development, analysis and stakeholder interviews by Robyn Kuropatwa and Paul Chaulk, independent consultants, and we are grateful for their expertise in the development of this report.

TABLE OF CONTENTS

RESIDENTIAL CARE CLIENT RATE REVENUE REINVESTMENTS – YEAR I ANALYSES

OVERVIEW

The care needs of clients in residential care (RC) facilities continue to grow more complex and challenging. Beginning in January 2010, the Home and Community Care residential care client rates policy changes were implemented. The intent of this policy was to ensure residential care remains sustainable and accessible to all British Columbians, to develop and implement a more equitable rate structure that reduces the burden on low-income seniors and to support ongoing improvements to the residential care system.

It was expected that health authorities would invest the incremental revenue accumulated due to changes in the residential care client rates, to improve the quality and consistency of care.

Health authority priority investment options defined by the provincial Home, Community and Integrated Care Council which were intended to improve resident outcomes included:

- Increased nursing, allied health and care aide staffing levels per resident day
- Education, clinical leadership and evidence based tools and resources to improve and sustain competencies of professional and non-professional care staff (including InterRAI)

- Specialized services and supports for distinct populations such as dementia, acquired brain injury, and palliative care
- Non capital equipment, such as specialized mattresses and rehabilitation supplies
- Recruitment and retention initiatives

These investments were guided by the provincial Residential Care Staffing Framework (RCSF), an evidence-based framework developed to guide quality care for Home and Community Care residential care facilities. The additional priority investment option of mitigation of preferred accommodation charges was approved by the MOH during Year 1, in order to address an issue of equity in client charges for all residential care clients.

Each health authority has taken a different approach to these investments based on their prior work and the unique issues in each region. As required by the Ministry of Health (MOH), health authorities have provided detailed plans for investment in the above areas, which were subsequently reviewed and approved by the MOH.

Health authorities also committed to provide the MOH with revenue, investment, service and staffing information reports related to the additional funds generated from the changes in residential rates and subsequent investments in residential care.

Report Purpose

This 2010/2011 Year 1 Analyses Report Summary and the supporting Technical Report present a snapshot of revenue, investment, service and staffing information related to the additional funds generated from the changes in residential rates as submitted by health authorities for April 1, 2010 to March 31, 2011. The quality and completeness of the material is verified; and limitations of the information presented are highlighted. The report assesses the alignment of these findings with the Ministry of Health Residential Care Client Rate Revenue Reinvestment policy direction. Finally, it also summarizes a series of qualitative interviews conducted with health authority and MOH representatives regarding Residential Care Client Rate Revenue Reinvestment Plan implementation.

Methods and Limitations

Over 2010/2011 to 2012/2013 the Ministry is undertaking formal monitoring and evaluation of the Health Authority Investment of Revised Residential Care Client Rate Revenue. Health Authorities have been required to submit a range of data to the Ministry including a Year 1 Detailed Reinvestment Plan, Quarterly RC Client Rate Revenue Monitoring Reports, Biannual HA Plan Staffing and Reporting and Management Report Updates. In addition a series of key informant interviews were conducted to assess processes and early outcomes of implementation. These HA reports were reviewed and analyzed by both the Ministry and independent consultants.

The key limitations of the Year 1 reports are that being the first year, only a partial view of implementation is presented, residential care client rate revenue needs to continue

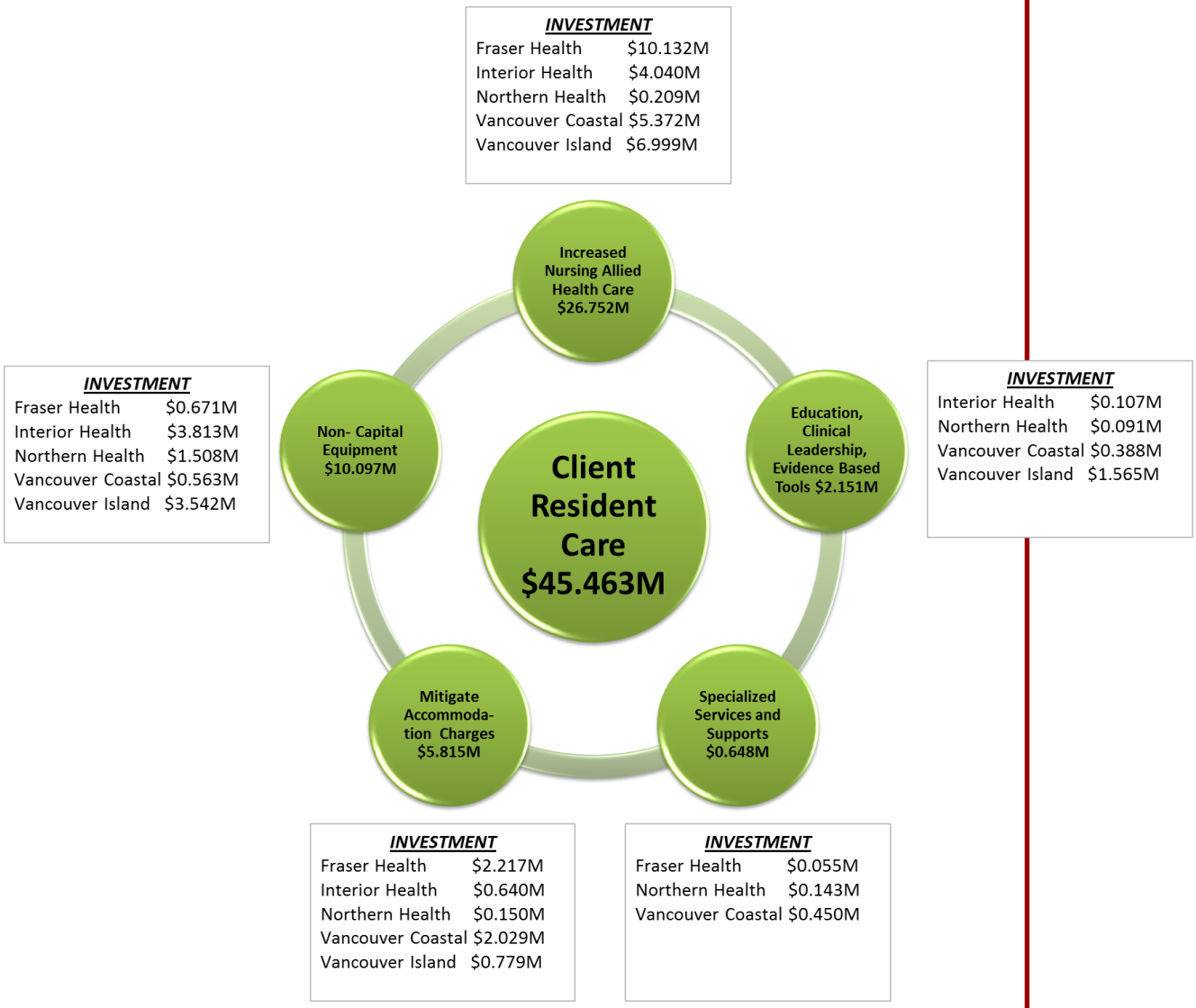
to be confirmed and that data validation has been limited to high level checks and triangulation for detailed residential care operations data is not available at the provincial level, but is maintained by health authorities.

KEY FINDINGS

Key findings supported by the Year 1 analyses are as follows.

Investment Priorities

Of the total $45.463 million investment expenditures across all HAs in 2010/2011:



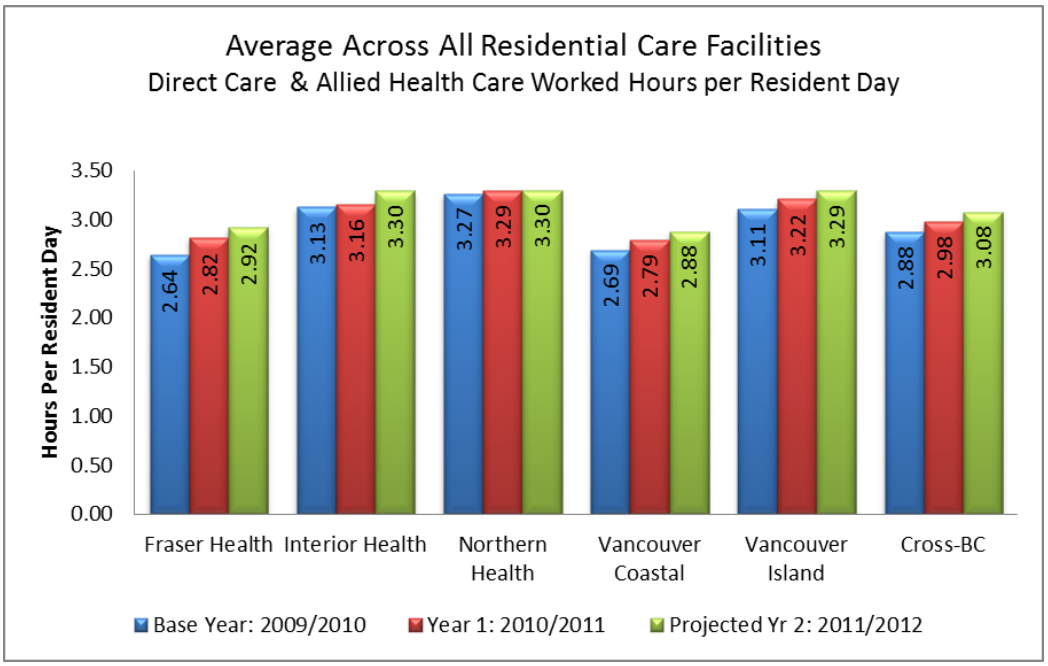
- The majority of the expenditures were related to priority investments in contracted residential care facilities with $34.119 million, the remaining $11.344 million were for investments in owned and operated facilities

- $26.752 million (58.8 percent) was invested in increased nursing, allied health and care aid staffing. Of this, $23.802 million was invested in contracted facilities
- $2.151 million (4.7 percent) was invested in education, clinical leadership evidence based tools with $1.092 for contracted and $1.059 million for owned and operated facilities
- $0.648 million (1.4 percent) was invested in specialized services and supports for distinct populations in owned and operated facilities
- $10.097 million (22.2 percent) was invested in non-capital equipment like specialized mattresses and rehabilitation supplies. Of this $5.780 million was to contracted facilities and $4.317 was to owned and operated
- $5.815 million (12.8 percent) was invested in mitigating preferred accommodation fees with $3.445 million for contracted facilities and $2.370 million for owned and operated

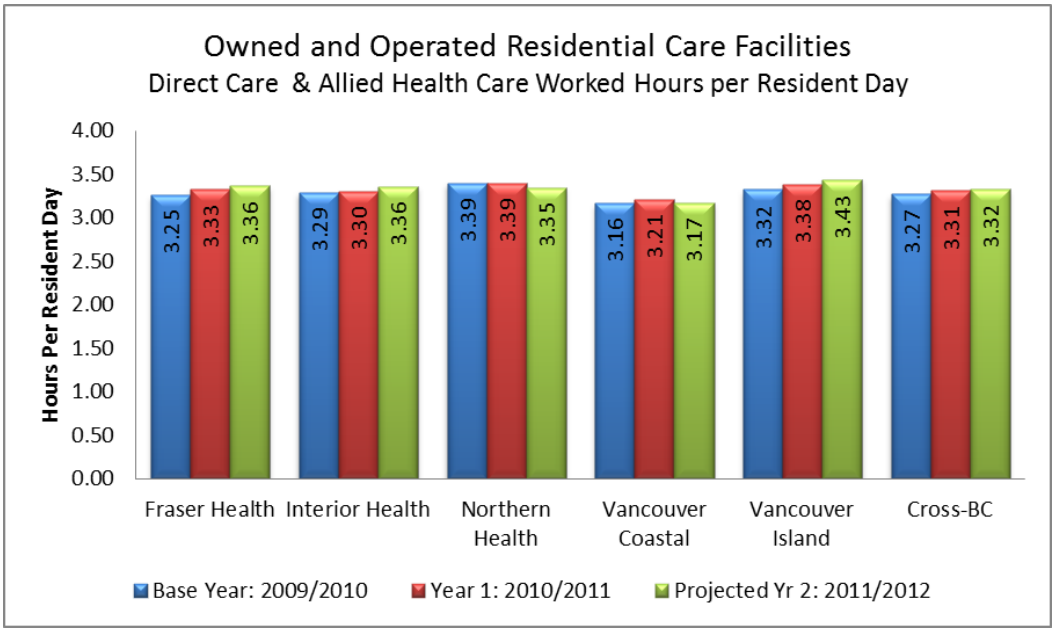
Direct Care and Allied Health Care Staffing Levels

Changes in direct care (nursing and care aide) and allied health care staffing levels were examined across all and by each health authority, as follows.

- Due to the changes implemented in direct care and allied health care worked hours in 2010/2011 the HPRD increased 3.7 percent across the province moving from 2.88 to 2.98 HPRD. When examined by facility type, the increase was more significant in contracted facilities where the HPRD increased by 5.4 percent from 2.65 to 2.80. Owned and operated facilities increased by 1.2 percent from 3.27 to 3.31 HPRD.




Contracted Residential Care Facilities
Direct Care & Allied Health Care Worked Hours per Resident Day
Hours Per Resident Day
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
2.46
2.67
2.79
2.98
3.02
3.24
2.32
2.50
2.94
2.43
2.56
2.72
3.01
3.13
3.23
2.65
2.80
2.94
Fraser Health
Interior Health
Northern Health
Vancouver Coastal
Vancouver Island
Cross-BC
Base Year: 2009/2010
Year 1: 2010/2011
Projected Yr 2: 2011/2012


Owned and Operated Residential Care Facilities
Direct Care & Allied Health Care Worked Hours per Resident Day
Hours Per Resident Day
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
3.25
3.33
3.36
3.29
3.30
3.36
3.39
3.39
3.35
3.16
3.21
3.17
3.32
3.38
3.43
3.27
3.31
3.32
Fraser Health
Interior Health
Northern Health
Vancouver Coastal
Vancouver Island
Cross-BC
Base Year: 2009/2010
Year 1: 2010/2011
Projected Yr 2: 2011/2012

- In Fraser Health, the total direct care plus allied health care worked HPRD increased by 6.7 percent from 2.64 to 2.82. The total worked HPRD increase in contracted facilities was 8.5 percent moving from 2.46 to 2.67 and owned and operated facilities increased 2.3 percent from 3.25 to 3.33.
- In Interior Health, the total direct care plus allied health care worked HPRD increased by 2.4 percent from 3.13 to 3.16. The total worked HPRD increase in contracted facilities was 1.5 percent moving from 2.98 to 3.02 and owned and operated facilities increased 0.4 percent from 3.29 to 3.30.
- In Northern Health, the total direct care plus allied health care worked HPRD increased by 0.8 percent from 3.27 to 3.29. The total worked HPRD increase in contracted facilities was 7.8 percent moving from 2.32 to 2.50 while owned and operated facilities remained the same as 2009/2010 at 3.39 HPRD.
- In Vancouver Coastal, the total direct care plus allied health care worked HPRD increased by 3.6 percent from 2.69 to 2.79. The total worked HPRD increase in contracted facilities was 5.2 percent moving from 2.43 to 2.56 and owned and operated facilities increased 1.4 percent from 3.16 to 3.21.
- In Vancouver Island, the total direct care plus allied health care worked HPRD increased by 3.4 percent from 3.11 to 3.22. The total worked HPRD increase in contracted facilities was 4.1 percent moving from 3.01 to 3.13 and owned and operated facilities increased 1.9 percent from 3.32 to 3.38.
- Due to direct care resource and staffing changes planned for 2011/2012 the projected HPRD is expected to increase a further 3.3 percent across the province increasing from an average HPRD of 2.98 to 3.08. As in Year 1, greater emphasis is being placed on contracted facilities where the HPRD is expected to increase 5.1 percent from 2.80 to 2.94. Owned and operated facility HPRD is expected to increase 1.2 percent from 3.31 to 3.32.
- When considering the change from the baseline 2009/2010 year, by the end of 2011/2012 the average HPRD is expected to have increased in:
    - Fraser Health from 2.64 to 2.92 HPRD
    - Vancouver Coastal from 2.69 to 2.88 HPRD
    - Vancouver Island from 3.11 to 3.29 HPRD
    - Interior Health from 3.13 to 3.30 HPRD
    - Northern Health from 3.27 to 3.30 HPRD
    - Across British Columbia from 2.88 to 3.08 HPRD

Year to Year Change in Worked Hours and Conversion to FTEs

Changes in care worked hours year to year were analyzed to determine the shift in FTEs from the base year 2009/2010.

At the end of 2010/2011, there were 916,889 more direct care and allied health care worked hours than in 2009/2010. Assuming 1,879 hours per FTE, there were 488 more care FTEs (437 direct care FTEs and 51 allied health care FTEs) across BC in 2010/2011 than there were in 2009/2010.

By the end of 2011/2012 it is projected there will be 1.977 million more direct care and allied health care worked hours than there were in 2009/2010. Assuming 1,879 hours per FTE this means there will be 1,053 more FTEs (854 direct care and 199 allied care FTEs) across BC than there were at the end of 2009/2010.

Cost of Worked Hours, Annual Change and Comparison to Client Rate Revenue Investment

Based on the data provided, the 2010/2011 increase in the direct care worked hours cost of $38.270 million is $11.510 million higher than the $26.752 million investments directly related to the residential care client rate revenue. Health authorities have advised that additional funds from their global budget were invested in residential care direct care and allied health care staffing.

Alignment with MOH Policy

Health authority plans, reporting and investments and implementation in 2010/2011 are consistent with MOH policy direction on investment of revised residential care client rate revenue and related processes.

Reporting

Health Authorities consistently completed and submitted the required investment plans and revenue, expenditure, and staffing reporting tools to the Ministry of Health.

Investment Plan Submissions

In all cases, the investments reported in the HA 2010/2011 Quarter 4 reports were consistent with the investment budget previously approved by the MOH and the Management Implementation Summary submitted for 2010/2011.

Client Rate Incremental Revenue

Across all HAs the reported incremental residential care client rate increase in revenue was $48.850 million in fiscal year 2010/2011. This was $7.334 million higher than the amount budgeted of $41.516 million.

Client Rate Revenue Expenditures

Across all HAs there was a $3.387 million difference between the $48.850 million incremental RC rate revenue received in 2010/2011 and the related expenditures of $45.463 million.

The reported revenue amount will be continue to be validated upon receipt of the actual client rate information through the Continuing Care Information Management System and the Minimum Reporting Requirements.

Key informant Interview Findings

Key informant interviewees described implementation challenges and supports and other outcomes of these investments as follows:

- Process outcomes: Included the collaborative approach used by health authorities to work with residential care facilities; increased fairness and consistency in staffing levels across the owned and operated and contracted facilities within health authorities; and increased consistency in staffing levels across the province that should lead to a more consistent resident experience and common expectations, regardless of location.
- Challenges to Implementation: Included the time required to work through staffing changes within the terms of existing collective agreements and provider contracts; difficulty recruiting specific health professionals; short timeline; difficulty demonstrating the impact of investments when a large amount of money results in a very small amount of direct care time per resident across the entire region; maintaining accountability for monies allocated to contracted sites; and difficulty completing the reporting templates.
- Supports to Implementation: Included the clarity and specificity of the Residential Care Staffing Framework; having a significant amount of funding available to invest; the directive from the Ministry to invest funding to improve care; and collaboration among health authorities.

CONCLUSIONS

The following conclusions may be made based on the Year 1 key findings:

- Health authority plans, reporting and investments and implementation in 2010/2011 are consistent with MOH policy direction
- There was a high level of health authority compliance with plans submissions and reporting requirements for the Residential Care Client Rate Revenue Reinvestment
- There was a total incremental residential care client rate increase in reported revenue of over $48.850 million across all health authorities in fiscal year 2010/2011. This was $7.334 million higher than the amount budgeted of $41.516 million

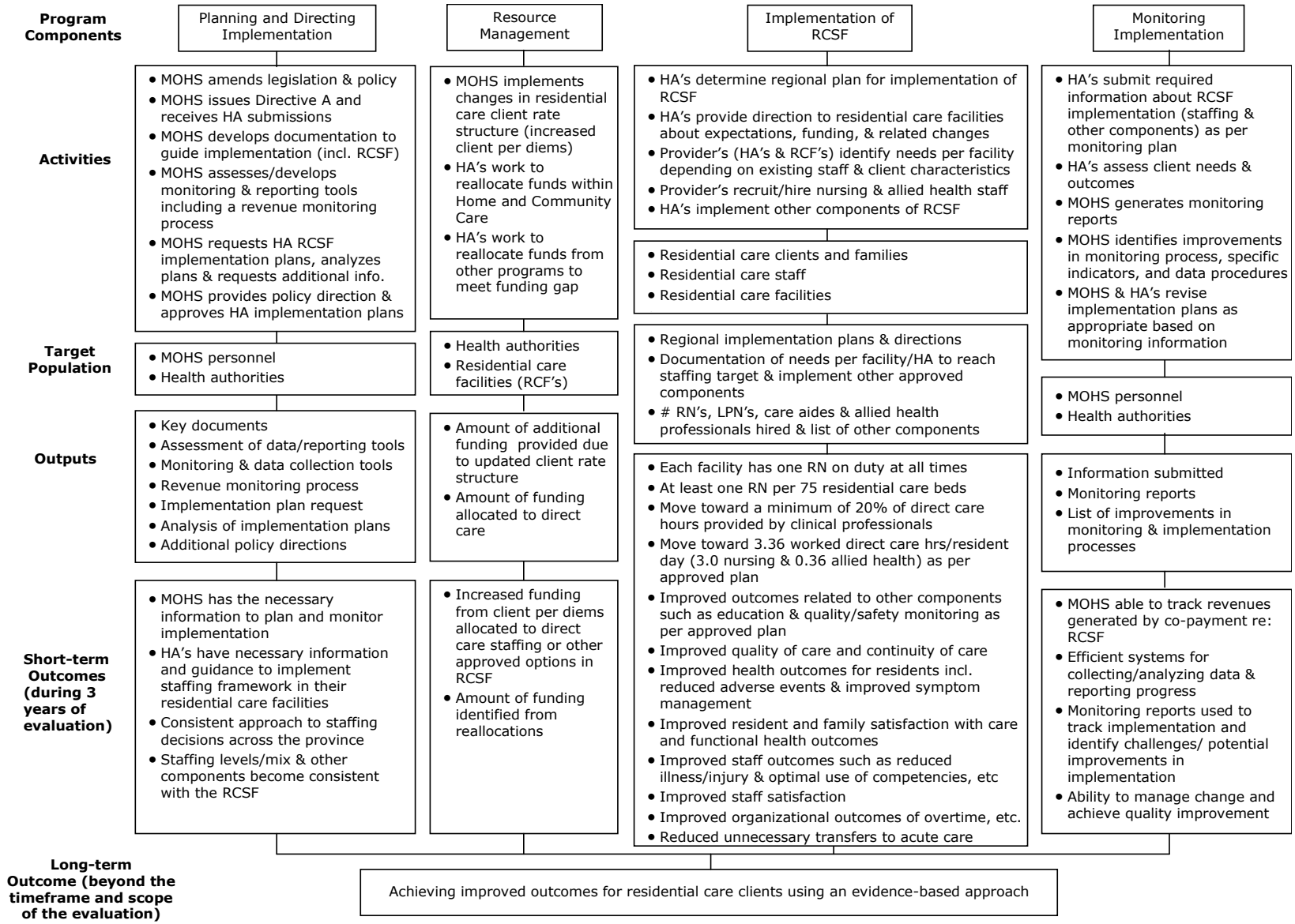
- There was a $3.387 million difference between the $48.850 million incremental RC rate revenue received in 2010/2011 and the related expenditures of $45.463 million
- The investment priorities varied across health authorities but all health authorities invested in increased nursing, allied health and care aid staffing levels, non-capital equipment and in mitigating preferred accommodation fees. Most health authorities invested in education, clinical leadership and evidence based tools and resources; specialized services and supports for distinct populations; and in non-capital equipment.
- The large majority (59 percent) of incremental client rate revenue was invested in increased nursing, allied health and care aid staffing levels followed by non-capital equipment (22 percent) and smaller investments in other approved areas.
- Across all health authorities, the total direct care plus allied health care worked HPRD increased by 3.7 percent from 2.88 to 2.98. Within this, contracted facilities increased 5.4 percent moving from 2.65 to 2.80 and owned and operated facilities increased 1.2 percent from 3.27 to 3.31
- At the end of 2010/2011, there were 917 thousand more direct care and allied health care worked hours than in 2009/2010. Assuming 1, 897 hours per FTE, this converts to 488 more care FTEs (437 direct care FTEs and 51 allied health care FTEs) across BC in 2010/2011 than there were in 2009/2010.
- By the end of 2011/2012 it is projected there will be 1.977 million more direct care and allied health care worked hours than there were in 2009/2010. This projection means there will be 1,053 more FTEs (854 direct care and 199 allied health care FTEs) across BC than there was at the end of 2009/2010.
- The implementation of the Residential Care Client Rate Revenue Reinvestment was seen to lead to other process outcomes such as a more collaborative approach of health authorities working with residential care facilities; increased fairness and consistency in staffing levels between owned and operated and contracted facilities within health authorities; and increased consistency in staffing levels across the province
- The information collected in Year 1 focused on planning and reporting of inputs, outputs and process outcomes. The more direct impact of these investments on specific facility or client outcomes were not captured

RECOMMENDATIONS

The following recommendations are based on Year 1 analyses of inputs, outputs and process outcomes from the HA Investment of Revised Residential Care Client Rate Revenue 2010/2011– Year 1. As such, they are focused on recommendations for continuing monitoring and evaluation of implementation into Year 2.

- Continue all existing monitoring and HA reporting for Year 2 of implementation of the Residential Care Client Rate Revenue Reinvestment Plan
- Require each HA to submit a written, narrative report at the mid-way and at the end of Year 2 summarizing actual investments and implementation
- Additional monitoring and evaluation activities for Year 2 should include:
    - Continue to validate HA client rate revenue based on actual client rate information provided by HAs through the Continuing Care Information Management System and the Minimum Reporting Requirements
    - Conduct qualitative interviews with both owned and operated and contracted facility managers to document the impact of investments on direct care provision
    - Further assess and document other (non-direct care) investments
    - Analyze client specific RAI data to examine the impact of investments made on residential care client outcomes

APPENDIX: RESIDENTIAL CARE STAFFING FRAMEWORK – PROGRAM LOGIC MODEL


Program Components
Planning and Directing Implementation
Resource Management
Implementation of RCSF
Monitoring Implementation
Activities
• MOHS amends legislation & policy
• MOHS issues Directive A and receives HA submissions
• MOHS develops documentation to guide implementation (incl. RCSF)
• MOHS assesses/develops monitoring & reporting tools including a revenue monitoring process
• MOHS requests HA RCSF implementation plans, analyzes plans & requests additional info.
• MOHS provides policy direction & approves HA implementation plans
• MOHS implements changes in residential care client rate structure (increased client per diems)
• HA's work to reallocate funds within Home and Community Care
• HA's work to reallocate funds from other programs to meet funding gap
• HA's determine regional plan for implementation of RCSF
• HA's provide direction to residential care facilities about expectations, funding, & related changes
• Provider's (HA's & RCF's) identify needs per facility depending on existing staff & client characteristics
• Provider's recruit/hire nursing & allied health staff
• HA's implement other components of RCSF
• HA's submit required information about RCSF implementation (staffing & other components) as per monitoring plan
• HA's assess client needs & outcomes
• MOHS generates monitoring reports
• MOHS identifies improvements in monitoring process, specific indicators, and data procedures
• MOHS & HA's revise implementation plans as appropriate based on monitoring information
Target Population
• MOHS personnel
• Health authorities
• Health authorities
• Residential care facilities (RCF's)
• Residential care clients and families
• Residential care staff
• Residential care facilities
• Regional implementation plans & directions
• Documentation of needs per facility/HA to reach staffing target & implement other approved components
• # RN's, LPN's, care aides & allied health professionals hired & list of other components
• MOHS personnel
• Health authorities
Outputs
• Key documents
• Assessment of data/reporting tools
• Monitoring & data collection tools
• Revenue monitoring process
• Implementation plan request
• Analysis of implementation plans
• Additional policy directions
• Amount of additional funding provided due to updated client rate structure
• Amount of funding allocated to direct care
• Each facility has one RN on duty at all times
• At least one RN per 75 residential care beds
• Move toward a minimum of 20% of direct care hours provided by clinical professionals
• Move toward 3.36 worked direct care hrs/resident day (3.0 nursing & 0.36 allied health) as per approved plan
• Improved outcomes related to other components such as education & quality/safety monitoring as per approved plan
• Improved quality of care and continuity of care
• Improved health outcomes for residents incl. reduced adverse events & improved symptom management
• Improved resident and family satisfaction with care and functional health outcomes
• Improved staff outcomes such as reduced illness/injury & optimal use of competencies, etc
• Improved staff satisfaction
• Improved organizational outcomes of overtime, etc.
• Reduced unnecessary transfers to acute care
• Information submitted
• Monitoring reports
• List of improvements in monitoring & implementation processes
Short-term Outcomes (during 3 years of evaluation)
• MOHS has the necessary information to plan and monitor implementation
• HA's have necessary information and guidance to implement staffing framework in their residential care facilities
• Consistent approach to staffing decisions across the province
• Staffing levels/mix & other components become consistent with the RCSF
• Increased funding from client per diems allocated to direct care staffing or other approved options in RCSF
• Amount of funding identified from reallocations
• MOHS able to track revenues generated by co-payment re: RCSF
• Efficient systems for collecting/analyzing data & reporting progress
• Monitoring reports used to track implementation and identify challenges/ potential improvements in implementation
• Ability to manage change and achieve quality improvement
Long-term Outcome (beyond the timeframe and scope of the evaluation)
Achieving improved outcomes for residential care clients using an evidence-based approach

RKL