Health Authority Investment of Revised Residential Care Client Rate Revenue

Summary Report for 2010/11 and 2011/12

Home, Community and Integrated Care Branch

Ministry of Health

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Overview

The Ministry of Health (the Ministry) implemented a revised client rate policy for publicly subsidized residential care services, beginning February 1, 2010, in order to:

- address the complex and challenging care needs of clients receiving residential care services;
- ensure residential care services remain sustainable and accessible to all British Columbians;
- develop and implement a more equitable client rate structure that reduces the burden on low-income seniors; and
- support ongoing improvements to the residential care system.

In 2010, the Ministry estimated that $53.70 million in incremental client rate revenue would be available for reinvestment once the revised client rate structure was fully implemented.[1] Health authorities were required to reinvest the incremental client rate revenue in the following priority investment options to improve the quality and consistency of care for residential care clients:

- 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;
- 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; and
- recruitment and retention initiatives.

These priority investment options, identified by the Home, Community and Integrated Care Council, were guided by the provincial Residential Care Staffing Framework (RCSF), an evidence-based framework developed to guide quality of care in residential care facilities. The additional priority investment option, mitigation of preferred accommodation charges, was approved by the Ministry in 2010/2011 (Year 1), to ensure equity in client charges by mitigating preferred accommodation fees.

Each health authority took a different approach to investment, based on their prior work and the unique issues in each region. As required by the Ministry, health authorities provided detailed plans for investment in the above priority areas; these were reviewed and approved by the Ministry. Health authorities were also required to provide the Ministry with financial, investment, service and staffing information reports regarding the incremental client rate revenues, and subsequent investments in residential care.

[1] Source: Analyses of Health Authority Investment of Revenues from Revised Residential Care Client Rates, Final Report, March 30, 2010

Purpose

Since policy implementation was over a two year period, from 2010/11 to 2011/12, this summary report provides the combined results for both years. The report presents the findings and recommendations of a formal evaluation and monitoring of the health authority investment of incremental client rate revenue in priority areas and its impact on resident care staffing and services to improve resident outcomes.

The summary report for 2010/11 (Year 1), Health Authority Investment of Revised Residential Care Client Rate Revenue 2010/2011 – Year 1 Analyses Report Summary is available on the Ministry website.

Methods

The Ministry conducted a formal monitoring and evaluation of the incremental client rate revenue reinvestment by health authorities for 2010/11 (Year 1) and 2011/12 (Year 2). Health authorities were required to submit a variety of data to the Ministry including an initial reinvestment plan, as well as financial, service and staffing information reports. The data collected focused on planning and reporting of inputs, outputs and process outcomes. In addition to these quantitative data analyses, key informant interviews were conducted by an independent consultant to assess processes and outcomes of implementation. These were reviewed by the independent consultants and Ministry staff. Data validation was limited to high level checks as detailed operational data was maintained and provided by health authorities. Since data from the Resident Assessment Instrument Minimum Data Set, Version 2.0 (RAI MDS 2.0)[2] was not available, analyses of client outcomes were not included as part of the evaluation.

A program logic model (see Appendix A) was developed that describes the target groups, activities, outputs, and outcomes and provides a graphical overview of the incremental client rate revenue reinvestment implementation. This logic model and other evaluation planning work were used to guide the current analyses and report.

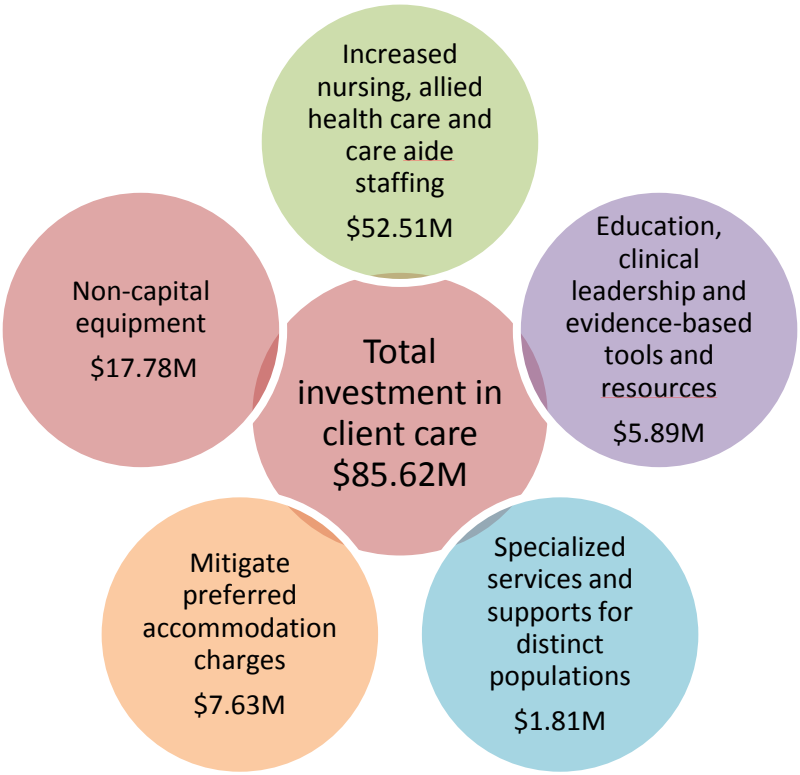
[2] The RAI MDS 2.0 is a provincially mandated assessment tool that enables a comprehensive, standardized evaluation of the needs, strengths, and preferences of all clients receiving publicly subsidized long-term residential care services in BC.

Key Findings Over 2010/11 (Year 1) and 2011/12 (Year 2)

All health authority plans, reports, investments and implementation were consistent with Ministry policy direction on the investment of revised residential care client rate revenue and related processes. The following key findings were supported by the analyses for 2010/11 and 2011/12.

A) Incremental Client Rate Revenue Investment Priorities

Over 2010/11 and 2011/12, the total reported incremental client rate revenue investment was $85.62 million across all health authorities. This was significantly higher than the Ministry's initial estimated increase in client rate revenue of $53.70 million.



Provincially, the majority of incremental client rate revenue was invested in increased nursing, allied health care and care aide staffing (61 percent), followed by non-capital equipment (21 percent) and mitigating preferred accommodation charges (9 percent).

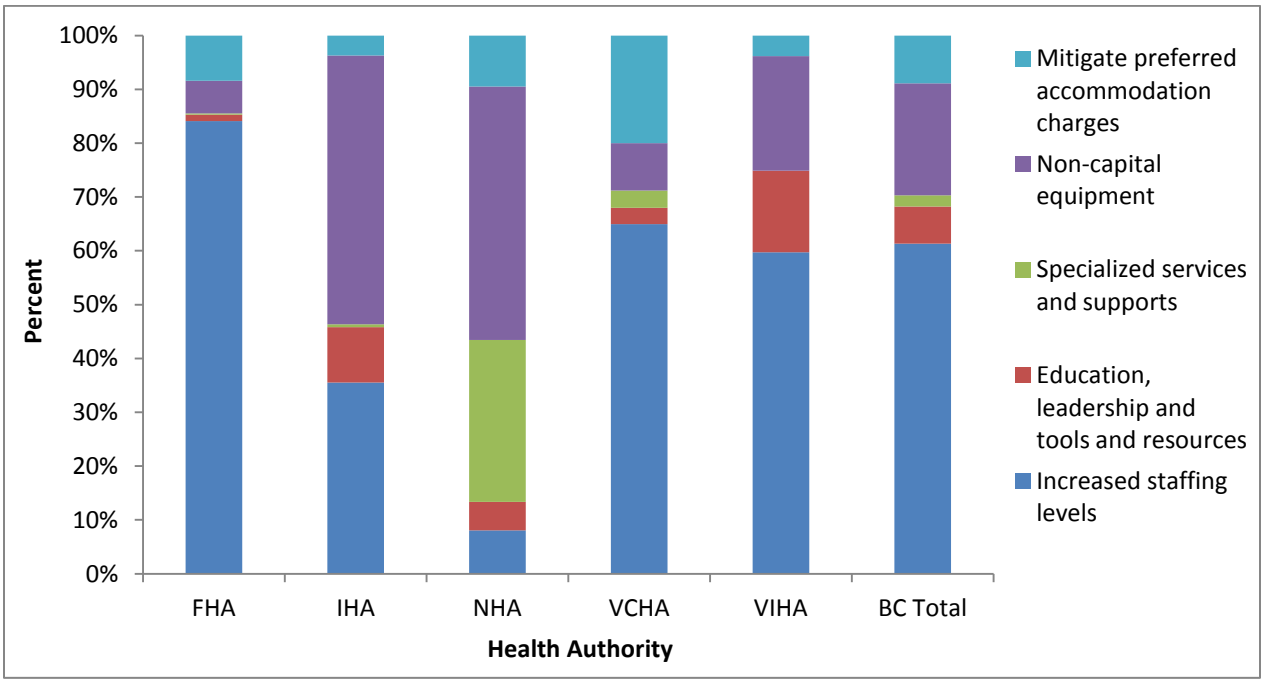
Of the total $85.62 million in incremental client rate revenue, the majority (76 percent) was invested in contracted residential care facilities. The remainder (24 percent) was invested in health authority owned and operated facilities. Table 1 presents the total investment across BC by priority investment area and facility type.

Table 1: Total Investments ($ Million) by Priority Area and Facility Type for 2010/11 and 2011/12, BC Total

Priority Investment Area	Owned and Operated Facilities	Contracted Facilities	Total
Increased nursing, allied health and care aide staffing levels	4.84	47.67	**52.51**
Education, clinical leadership and evidence-based tools and resources	3.32	2.56	**5.89**
Specialized services and supports for distinct populations	1.77	0.04	**1.81**
Non-capital equipment	8.10	9.68	**17.78**
Mitigate preferred accommodation charges	2.63	5.00	**7.63**
Total	**20.67**	**64.95**	**85.62**

As mentioned previously, each health authority took a different approach to investments based on its 2009/10 (Baseline Year) status, prior work and the unique issues in each region. FHA, VCHA, and VIHA invested the majority of their incremental client rate revenue in increasing nursing, allied health and care aide staffing levels while IHA and NHA invested the majority of their incremental client rate revenue in non-capital equipment such as beds and resident lifts. Figure 1 illustrates the proportion of investment by priority investment area and health authority.

Figure 1: Proportion of Investments by Priority Area and Health Authority for 2010/11 and 2011/12

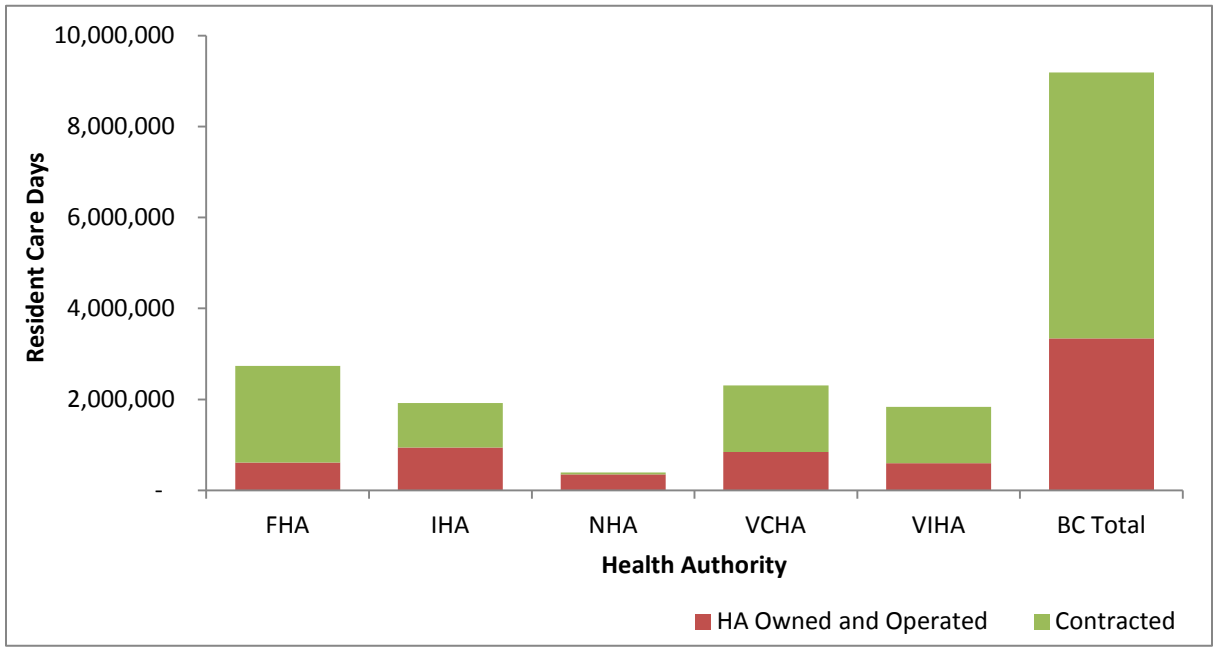


B) Direct Care and Allied Health Care Staffing Levels

The intent of the investment in nursing, allied health care and care aide staffing was to ensure an appropriate mix of staff is available in residential care facilities across BC to meet the needs of clients. This, in turn, will lead to positive client outcomes.

Provincially, there were 9.1 million resident care days provided in 2009/10.[3] This increased by approximately one percent to 9.2 million resident care days provided in 2011/12. Contracted facilities provided almost two thirds (64 percent) of the resident care days in BC. Figure 2 illustrates the total number of resident care days provided in 2001/12 (Year 2), by facility type and health authority.

Figure 2: Resident Care Days Provided in 2011/12, by Facility Type and Health Authority

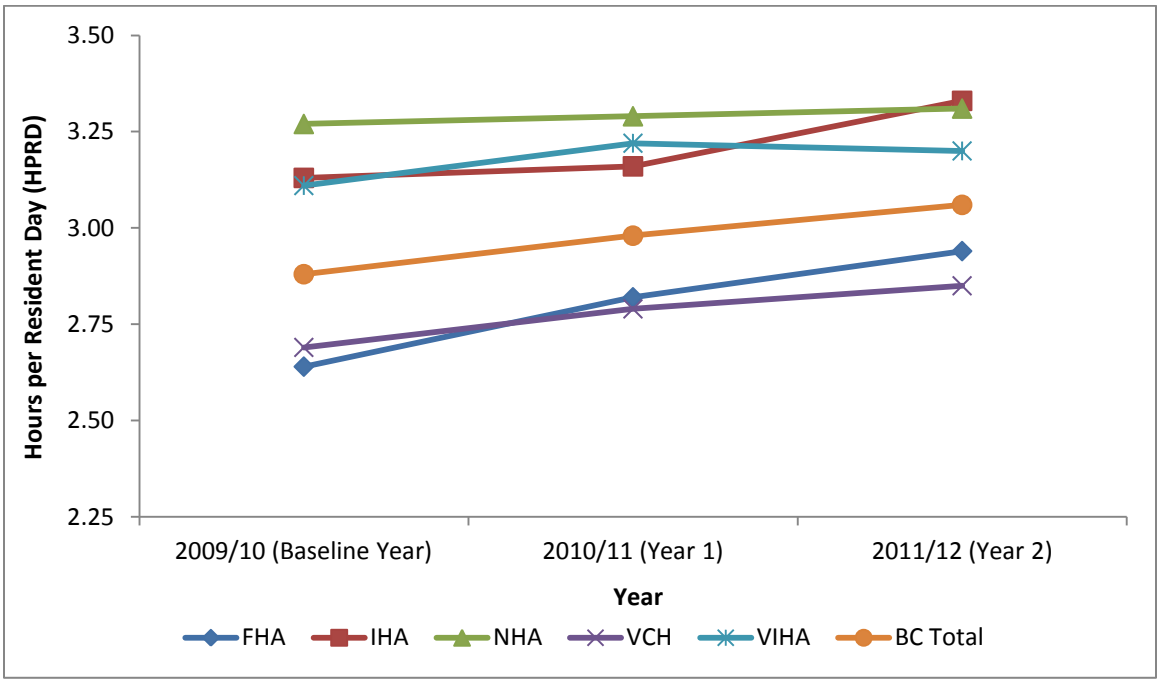


Changes in direct care (nursing and care aide) and allied health care staffing levels, measured in worked hours per resident day (HPRD) were examined provincially and by health authority, compared to 2009/10 (baseline). Staffing levels were reviewed in the Baseline Year and influenced health authority investment as all health authorities invested more heavily in contracted facilities where HPRD were lower than health authority owned and operated facilities over the baseline year.

The hours of direct care and allied health care provided to clients increased provincially from 2.88 HPRD in 2009/2010 to 3.06 HPRD in 2011/2012. All health authorities reported an increase in the average HPRD between 2009/10 and 2011/12. Figure 3 illustrates the average HPRD by facility type and health authority.

[3] Resident care days reflect the number of days clients are provided with residential care services.

Figure 3: Direct Care and Allied Health Care Worked Hours per Resident Day, by Facility Type and by Health Authority



When examined by facility type, the increase in direct care and allied health care HPRD was more significant in contracted facilities (from 2.65 HPRD in 2009/2010 to 2.93 HPRD in 2011/2012) than in health authority owned and operated facilities (from 3.27 HPRD in 2009/2010 to 3.30 HPRD in 2011/2012). The direct care and allied health care HPRD in health authority owned and operated facilities remained consistently higher than in contracted facilities except, in IHA. By the end of 2011/12, in IHA, the direct care and allied health care HPRD in contracted facilities was comparable to that in health authority owned and operated facilities. Table 2 presents the direct and allied health care worked HPRD by facility type and health authority.

Table 2: Direct and Allied Health Care Worked Hours per Resident Day (HPRD), by Facility Type and Health Authority

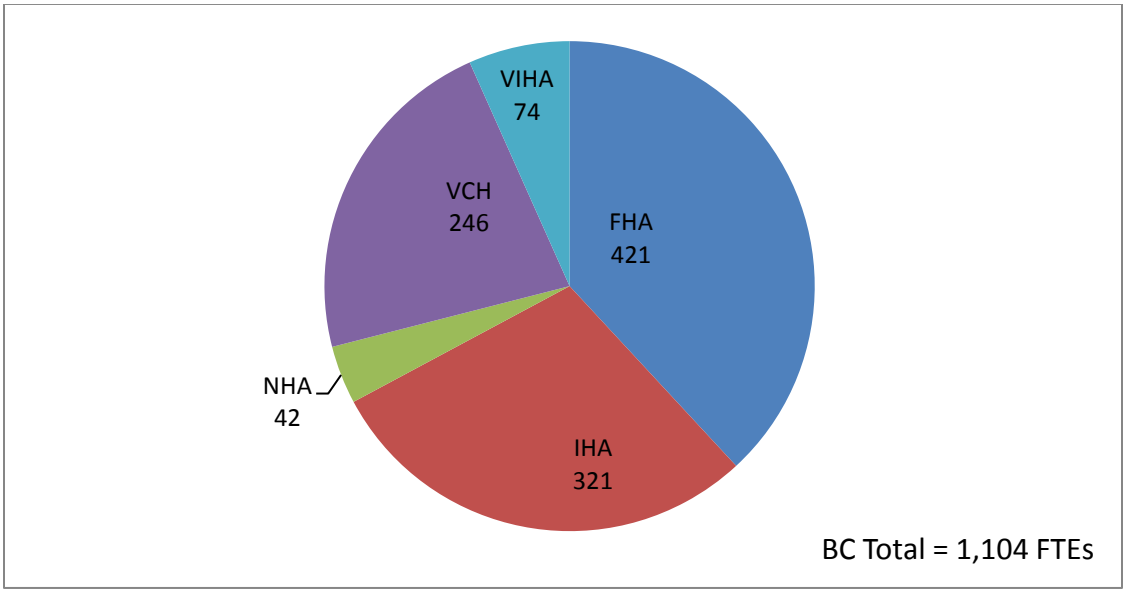
Health Authority	Facility Type	2009/10 (Baseline Year)	2010/11 (Year 1)	2011/12 (Year 2)
FHA	Owned and Operated	3.25	3.33	3.36
	Contracted	2.46	2.67	2.81
IHA	Owned and Operated	3.29	3.30	3.34
	Contracted	2.98	3.02	3.32
NHA	Owned and Operated	3.40	3.39	3.35
	Contracted	2.32	2.50	3.00
VCH	Owned and Operated	3.16	3.21	3.14
	Contracted	2.43	2.56	2.67
VIHA	Owned and Operated	3.32	3.38	3.37
	Contracted	3.01	3.13	3.12
Total	Owned and Operated	3.27	3.31	3.30
	Contracted	2.65	2.80	2.93

C) Increase in Direct Care and Allied Health Care Worked Hours and FTEs

In 2011/12, there were a total of 28.15 million direct care and allied health care worked hours across BC. This represents an additional 2.08 million worked hours compared to 2009/10. Provincially, direct care worked hours increased by four percent and allied health care worked hours increased by ten percent.

To evaluate the impact of the investment on the size of the residential care workforce, changes to the number of full-time worker equivalent (FTE) were estimated over the two years. Using 1,879 hours to reflect one direct care or allied health care FTE, there were an estimated 1,104 more FTEs across BC by the end of 2011/12. Of these, 932 were direct care FTEs and 172 were allied health care FTEs. Figure 4 illustrates the estimated number of additional direct care and allied health care FTEs in 2011/12 compared to 2009/10, by health authority.

Figure 4: Estimated Increases in Direct Care and Allied Health Care FTEs between 2009/10 and 2011/12, by Health Authority



D) Cost of Direct Care and Allied Health Care Worked Hours

As reported by the health authorities, the total cost of the worked hours of direct care and allied health care across BC was $984.69 million in 2009/2010. This increased to $1.02 billion in 2010/2011 and to $1.07 billion in 2011/2012.

E) Other Investment Priorities – Findings from the Management Implementation Summary

Each health authority provided a Management Implementation Summary documenting investments intended to improve client care and support consistent quality of care in residential care facilities across BC. The following are examples of investments reported by health authorities, by priority area.

Investment in Education, Clinical Leadership and Evidence-based Tools and Resources

- Education on skin/wound care, dementia care, prevention and management of aggressive behaviour, nurse leadership in residential care, and interdisciplinary team building.
- Addition of clinical leadership positions and quality review coordinator staff.
- Support for the use of the RAI MDS 2.0 assessment tool.

Investment in Specialized Services and Supports for Distinct Populations

- Addition of short-term staff to meet increased care needs for clients in exceptional circumstances.
- Creation of a health authority wide resource for populations requiring specific programming and staffing.

Investment in Non-Capital Equipment

- Purchase of equipment such as beds, mattresses, resident lifts, exit alarms, rehabilitation equipment, and vital sign medical equipment.

F) Findings from Key Informant Interviews

In 2010/11, 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.

In 2011/2012, key informant interviewees further discussed investment outcomes and implementation challenges as follows:

Staff Outcomes: At the staff level, outcomes described included increased staff knowledge and skills, positive feedback from staff, reduced staff illness/injury, optimal use of competencies and increased communication and team work

Quality of Care: Outcomes described included increased level of care, capacity to address special populations, improved continuity of care and improved admissions process

Clients and Families: At the client and family level, outcomes described included improved relationships with families, increased services to residents and reduced negative resident outcomes

Other Outcomes: Others included improved relationships with contracted facilities, increased transparency, fairness and consistency and increased focus on residential care

Implementation challenges: included recruitment and retention, shift scheduling, adjusting to the full scope of nursing practice, timelines, aging infrastructure, estimating revenues, addressing the needs of smaller communities, special populations, RAI implementation, and long term investment sustainability

Suggested improvements for implementation: included additional funding, more flexibility on how funds could be spent, more time and greater care in interpreting reported information.

Conclusions

Health authority plans, reports, investments and implementation were consistent with Ministry policy direction. The information provided by the health authorities allowed the Ministry to understand the progress being made by the health authorities in implementing specific initiatives. This enabled the Ministry to provide timely guidance where required, as well as to identify and build on health authority successes.

The actual incremental residential care client rate revenue investment was $85.62 million across BC over 2010/11 and 2011/12. This was significantly higher than the budgeted investment of $76.92 million as well as the initial estimated incremental client rate revenue of $53.70 million. The majority of investments (76 percent) were made in contracted residential care facilities while the remaining investments (24 percent) were made in health authority owned and operated facilities.

The large majority of investments (61 percent) were made in increased nursing, allied health and care aid staffing, followed by non-capital equipment (21 percent) and smaller investments in other approved areas. 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 mitigating preferred accommodation charges. Most health authorities invested in education, clinical leadership and evidence based tools and resources; specialized services and supports for distinct populations; and non-capital equipment.

Across BC, the direct care and allied health care worked hours per resident day increased from 2.88 HPRD in 2009/2010 to 3.06 HPRD in 2011/2012. By the end of 2011/2012 there were 2.074 million more direct care worked hours than there were in 2009/2010. Using 1,879 hours to reflect one direct care or allied health care full-time worker equivalent (FTE), in 2011/2012 there were 1,104 more FTEs across BC (932 direct care FTEs and 172 allied care FTEs) than there were in 2009/2010.

Qualitative data indicated that stakeholders felt that the implementation of the reinvestment of the residential care client rate revenue 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 BC.

Recommendations

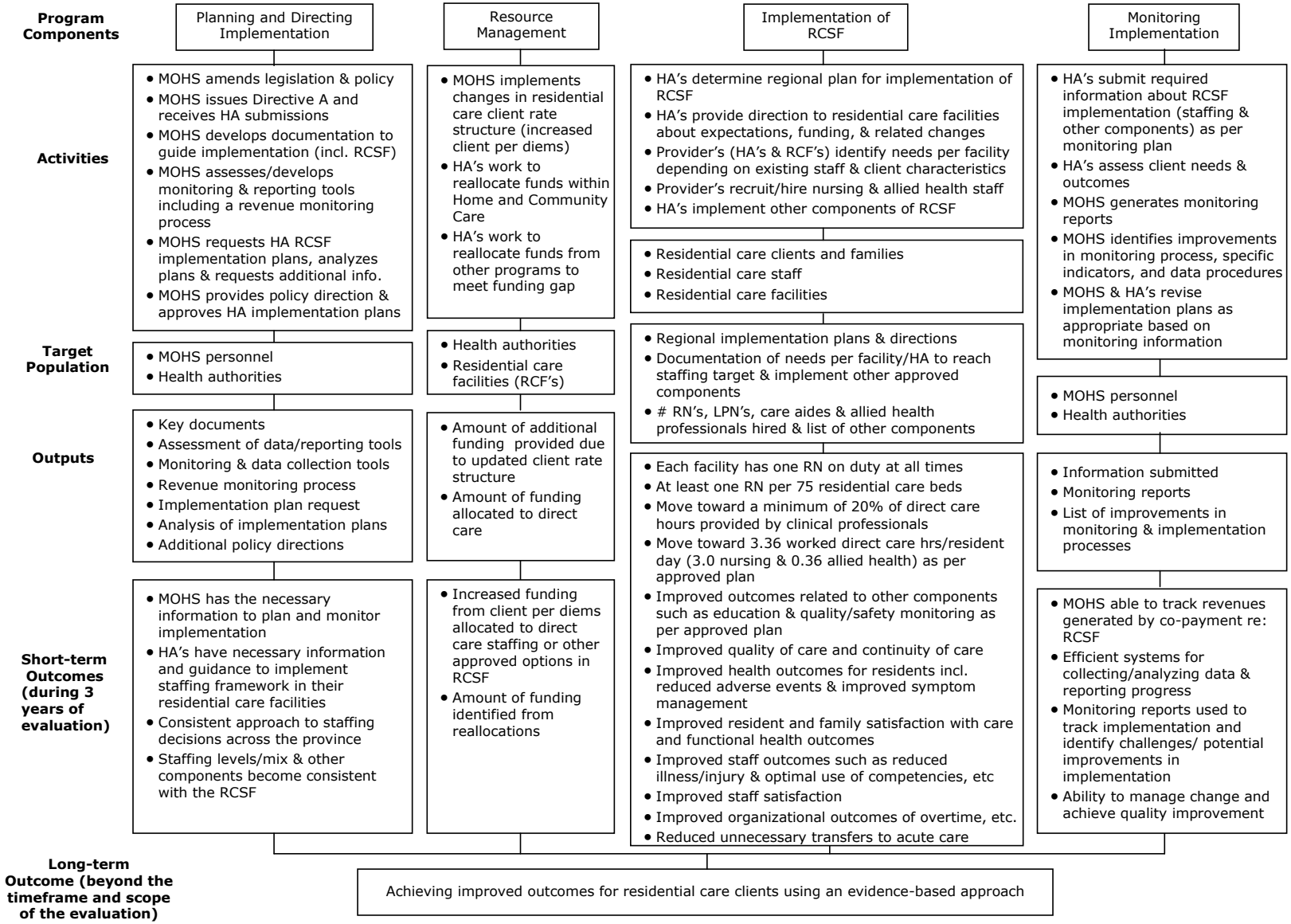
Based on the above findings, the recommendations focus on continued monitoring and evaluation of client outcomes, direct care worked hours and related investments. It is recommended that the Ministry:

- continue to monitor the direct care and allied health care staffing levels, worked hours, hours per resident day and related health authority investments;
- continue to validate health authority incremental client rate revenue based on actual client rate information provided by the health authorities; and
- analyze client specific RAI MDS 2.0 data to examine the impact of investments made on residential care client outcomes.

Appendix A:

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
• Residential care clients and families
• Residential care staff
• Residential care facilities
Target Population
• MOHS personnel
• Health authorities
• Health authorities
• Residential care facilities (RCF's)
• 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