Letter from Parliamentary Secretary Darryl Plecas

As Parliamentary Secretary for Seniors to the Minister of Health, ensuring high quality patient-centred care for seniors is a priority for both myself and our government. I also know that ensuring our seniors receive the best care we can provide is a priority for our service providers, their staff, families of seniors and seniors themselves. I know that because I have had the privilege of visiting many of our senior’s care facilities around the province, and I have had the opportunity to meet and talk directly with seniors and seniors’ groups, service providers, unions, associations and service groups to learn about the issues that matter most to them. All of these groups have truly helped me to identify strengths and challenges in the existing health system and opportunities to enhance quality of life for seniors in residential care facilities throughout British Columbia. Most significantly, their dedication, compassion and deep sense of concern has made my learning more about seniors care more heartfelt. They are truly inspirational.

I have also had the pleasure of working with the seniors advocate and Ministry of Health staff to examine the current state of residential care service delivery in B.C., with a focus on quality of care (including outcomes), staffing levels and funding. I have learned much from that work about the complexity in trying to establish what ought to be, and can be, an appropriate number of funded care hours for any one care facility. Indeed, as the findings of this review indicate that, in addition to staffing levels and staffing mix, there are multiple factors that contribute to quality of care, quality of life and resident outcomes. For example, meals, recreational activities, and opportunities for socialization are just some of the other ways that a resident’s experience can be enriched, and we need to be attentive to these considerations as we continue with our efforts to get our funding and staffing models right.

We have learned a great deal through this review process and I am confident that moving forward with the actions in this report will help our province to meet current and future population needs for residential care services and improve the lives of seniors living in residential care.

Dr. Darryl Plecas
Parliamentary Secretary for Seniors to the Minister of Health
Acknowledgements

I would like to acknowledge and thank the following committees and organizations for their contributions to this report:

- B.C. Ministry of Health – Primary and Community Care Policy Division; Finance and Corporate Services Division; Health Sector Information, Analysis and Reporting Division; and, Health Sector Workforce Division
- Office of the Seniors Advocate
- Regional Health Authorities
- BC Care Providers Association
- Denominational Health Association
- Canadian Institute for Health Information
- Hospital Employees' Union
- Ontario Ministry of Health and Long Term Care
- Alberta Health and Wellness
- Alberta Health Services
- RKL Health Informatics
Executive Summary

A number of events in B.C., culminating in the posting of the Office of the Seniors Advocate’s 2016 Residential Care Facilities Quick Facts Directory, which indicated that 81% of facilities were operating below 3.36 direct care worked hours per resident day, have brought to light concerns about the progress in implementing the Ministry of Health staffing guideline in residential care facilities, and the impact on quality of care and residents.

Health Minister Terry Lake asked Parliamentary Secretary Darryl Plecas to work with Seniors Advocate Isobel Mackenzie and ministry staff to examine three core areas – quality of care, (including outcomes), staffing levels and funding in residential care facilities and report back to him. The intent was to determine what, if any, changes need to be made in the residential care system to ensure consistency, transparency and accountability across the province in meeting resident’s needs, sustainability and alignment with the ministry’s focus on patient-centered care in the community.

In 2008, the ministry’s new provincial residential care staffing framework (described in Appendix C), was developed in response to growing concerns about the availability of appropriately educated, competent staff to adequately meet the complex care needs of clients in residential care, as well as the appropriate mix of professional and non-professional staff to meet these needs. The framework included a stated philosophy of care and describes the intended relationship between resident care needs, and staff leadership and direct care. The resulting staffing model was predicated on the basis that direct care hours align with the needs of the resident and are determined through a comprehensive assessment process involving the resident, their family and staff.

After considering the research findings, as well as current staffing levels within B.C., it was agreed in 2009 that a target be established where total direct care staffing levels for each health authority was to average 3.36 hours per resident day, comprised of 3.0 worked hours of nursing care (includes care aides) and 0.36 worked hours of allied health services. At that time, the cost of achieving this level was estimated at about $215 million of new incremental annual funding, which was about 14% of total reported expenditures of $1,525.6 million.¹

¹ 2008/09 reported expenditures for residential care, prepared by Regional Grants and Decision Support, Ministry of Health.
Implementation of the framework was funded using incremental revenue generated by changes to the residential care client rate structure, where clients pay up to 80% of their after-tax income (subject to minimum and maximum rates), which took effect Feb. 1, 2010. The ministry estimated that $53.7 million in incremental annual client revenue would be available for reinvestment once the revised rate structure was fully implemented. By 2011/12, health authorities reported a total of $85.62 million being re-invested into residential care due to the changes, of which $52.51 million was invested in increasing nursing, allied health and care aide staffing levels (leaving a gap of about $129 million needed to reach the 2009 estimated amount of $215 million). Health authorities have maintained that level of investment and reported small growth in the subsequent years, with $87.96 million being invested in 2014/15.

Provincially, hours per resident day improved from a baseline of 2.88 in 2009 to 3.06 in 2011/12 and 3.11 as of January 2016. Although some facilities have achieved 3.36 hours per resident day, no health authority has achieved the desired average set by the province.

As part of this review, the ministry conducted a literature search, as well as a jurisdictional review with Alberta and Ontario to look at current evidence/best practices for staffing hours and funding.

The jurisdictional review showed that both Alberta and Ontario have standard province-wide residential care funding models. However, when components of these models are examined, there are similarities and differences in the models and how they address staffing in their residential care facilities. For example, Alberta includes paid hours worked per resident day in their formula while Ontario does not factor hours per resident day into their calculations. Both jurisdictions consider client case mix index, a measure of resource intensity based on the client’s needs, and have quality improvement outcome measures in their funding formulas.

The recent literature search findings showed that nursing staff affects the quality of care in facilities. Staffing stability is associated with better patient outcomes while staffing instability is associated with poorer patient outcomes. While there was no consistent evidence for a relationship between higher staffing levels and improved quality of care indicators, other articles reviewed indicated that, in general, staffing levels were predictors of care quality and increased staffing levels could improve care and resulted in better outcomes or decreased risk. Increased staffing was found to be a common intervention to improving quality of care and outcomes. However, it was noted that the effectiveness of minimum staffing standards is unknown and that staffing should also be allocated according to particular resident needs.

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2 For existing clients, 50% of the client rate increase was applied Feb. 1, 2010 and the remainder was applied on Jan. 1, 2011.
Quality of care and safety of residents living in residential care facilities are absolute priorities for government. The ministry needs to ensure that services delivered by the health authorities in owned-and-operated facilities, as well as by contracted service providers, meet patients’ needs, are aligned with its focus on patient-centred care in the community, and are sustainable. Although the literature is inconclusive about the effectiveness of defined minimum staffing standards, the ministry believes that achieving a minimum 3.36 hours per resident day average by health authority is required for safe, quality care in most facilities. It is recognized that some special populations, such as younger adults with behavioural and cognitive issues or small facilities in rural areas, would require specific consideration.

The seniors advocate has suggested that all facilities could be brought to a minimum average of 3.36 hours per resident day by health authority through the investment of $83.5 million based on $30/hour for care aides (assuming all the added staff are made up of care aides).\(^4\) Using the current staffing framework and current labour costs provided by the Health Employers Association of B.C., the ministry calculates it could cost upwards of $113.7 million for an increase of 1,511 FTEs (includes 886.7 care aides) to meet a standard of an average of 3.36 hours per resident day by health authority. Even if new funding could be made available, the likelihood of increasing to 3.36 hours per resident day within a short timeframe is unlikely, given the challenges with the supply of health human resources required.

Achieving an average of 3.36 hours per resident day by health authority would best be supported by a standard funding and monitoring approach. The funding approach should incorporate variables that impact staffing level and mix such as changes in workload resulting from residents moving into and departing from facilities, and changing resident needs over time. This could be done in conjunction with defining a small number of province-wide priority quality of care initiatives.

The actions set out in the following table are grouped into one of three categories (funding and staffing, quality of care and accountability), and will be carried out in collaboration with the Office of the Seniors Advocate, other provincial ministries (e.g. ministries of Advanced Education and Jobs, Tourism and Industry), health authorities, industry partners and other stakeholders. The table includes the next steps required to move forward:

\(^4\) 2015 labour costs provided by the Health Employers Association of B.C. cite $34.27/hour on average for care aides, and includes wages, premiums and benefits (source is data reported in the Health Sector Compensation Information System). Using this higher average cost, the estimate would increase to $95.3 million.
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<tr>
<th>Category</th>
<th>Action</th>
<th>Proposed Timeline</th>
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<tbody>
<tr>
<td>Funding and Staffing</td>
<td>1. Finalize a report, in collaboration with the Canadian Institute for Health Information, to better understand the demand for home health, assisted living and residential care services (including the different profiles of clients using RAI assessment and service episode data) given the changes taking place in the home and community care system, and to inform required changes to existing residential care service models.</td>
<td>May 2017</td>
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<td>2. Confirm the definition of direct care hours per resident day.</td>
<td>July 2017</td>
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<td>3. Establish a baseline for: hours per resident day, client case mix, other identified residential care costs.</td>
<td>September 2017</td>
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<td>4. Work with health authorities and industry to create and implement an interim targeted process that would increase hours per resident day for areas with identified gaps until a costing review has been completed and the funding model has been updated to incorporate client complexity.</td>
<td>October 2017</td>
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<td>5. Move towards a province-wide standard residential care funding model, with a lens to incorporate resident complexity (using RUGs and case mix index from RAI assessments), quality of care and flexibility.</td>
<td>January 2018</td>
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<td>6. Complete an analysis of percentage of casual and part-time positions that can potentially be converted to regular full-time positions in residential care facilities.</td>
<td>June 2017</td>
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<td>7. Develop an interim strategy to address immediate high-priority vacancies in residential care facilities.</td>
<td>June 2017</td>
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<td>8. Develop a health human resources plan to ensure supply of staff will meet the needs of the residential care sector. The plan will include targeted recruitment activities and seat-planning in post-secondary programs.</td>
<td>November 2017</td>
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<td>Category</td>
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<td>Quality of Care</td>
<td>1. Prioritize key quality of care initiatives in residential care and facilitate a coordinated approach that promotes consistency and standardization, yet allows for flexibility given varying needs across facilities.</td>
<td>April 2018</td>
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<td>2. Bring into force Part 3 (care facility admission) of the <em>Health Care (Consent) and Care Facility (Admission)</em> Act to protect vulnerable adults. This work will include revising the residential care admission policy to be more person and family-centred.</td>
<td>April 2018</td>
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<td>3. Develop and implement palliative and dementia care policy including requirements and targets for staff education.</td>
<td>April 2018</td>
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<td>Accountability</td>
<td>1. Incorporate the requirement to increase hours per resident day through annual bi-lateral agreements between the Ministry and health authorities.</td>
<td>April 2017</td>
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<td>2. Monitor health authority progress on achieving the 3.36 hours per resident day and produce annual reports for Leadership Council.</td>
<td>April 2018</td>
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<td>3. Develop and implement a policy to mandate accreditation for all residential care facilities.</td>
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<td>4. Develop and implement performance measures that support quality of care and quality of life outcomes using outputs from RAI assessment and survey data including quality indicators.</td>
<td>April 2018</td>
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<td>5. Develop and implement a process and policy for monitoring, reporting and evaluation processes related to resident need, funding, service delivery and operations, building on experience from other provinces such as Alberta and Ontario to assess whether quality, funding and staffing policies and goals are being achieved.</td>
<td>April 2019</td>
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Introduction

In B.C., care and support are available from both publicly subsidized and private-pay providers for people having difficulty coping with activities of daily living because of health-related problems or a life-threatening illness. Publicly subsidized home and community care services in B.C. provide a range of health-care and support services for people who have acute, chronic, palliative or rehabilitative health-care needs. People receiving home and community care services may have a short-term need due to an episode of illness, surgery or specialized treatment, or a long-term need as a result of a chronic condition or life limiting illness.

Although home and community care services are provided to adults of all ages, the majority of clients are seniors. More information about B.C.’s publicly subsidized home and community care services is available at www.gov.bc.ca/hcc.

Residential care services are part of the continuum of care in B.C., and include both long-term and short-term services (see Appendix A). Long-term residential care services provide 24-hour professional supervision and care in a protective, supportive environment for people who have complex care needs and can no longer be cared for in their own homes or in an assisted living residence. Short-term residential care services include respite care, convalescent care and residential hospice care. Supportive and compassionate care is provided with the goal of preserving an individual’s comfort, dignity and quality of life as their needs change, and to offer ongoing support for family and friends.

Similar services can also be purchased by individuals privately from a service provider, where aspects of service provision are agreed to by both parties. In these cases, government does not provide any financial assistance to individuals or service providers for the service. This report deals only with publicly subsidized residential care services.

Why are we doing this?

Moving into a residential care facility is a significant life change event for a person, their family and friends. There can be a lot of uncertainty and stress experienced during the transition period, and once in a residential care facility, residents and families alike want to be reassured that the services provided will meet not only the resident's care needs, but their emotional, psychological, social and spiritual needs as well, along with upholding their autonomy and dignity to the greatest degree possible.
Staffing levels and staffing mix are two key components that contribute to both quality of care and quality of life for residents, as well as improved resident outcomes. However, there are other components that can be just as important such as the programs offered in each facility, facility design, training and education for staff, availability of technology, models of care delivery, and organizational culture and leadership.

B.C. has had a staffing target of an average of 3.36 hours per resident day by health authority since 2009, which means that some facilities may have lower levels and some may have higher levels within a given health authority. However, no one health authority has yet reached the goal of an average of 3.36 hours per resident day.

A number of events in B.C., culminating in the posting of the Office of the Seniors Advocate’s 2016 Residential Care Facilities Quick Facts Directory, which indicated that 81% of facilities were operating below 3.36 worked hours per resident day, have brought to light concerns about the ministry’s staffing guideline in residential care facilities. The ministry has stated previously that 3.36 hours is a starting point for planning decisions that health authorities should be working toward, and that direct care hours are dependent on the individual’s needs and are determined through a comprehensive assessment process involving the client, their family and staff. The ministry wants care providers to deliver high quality care at whatever level is most appropriate for an individual client. The average number of care hours and staffing mix in each facility will depend on the resident population in that facility.

Health Minister Terry Lake asked Parliamentary Secretary Darryl Plecas to work with Seniors Advocate Isobel Mackenzie and ministry staff to examine quality of care, staffing levels and funding and report back to him. The review is timely – providing services for medically complex and/or frail seniors (including dementia) is one of government’s five strategic priorities in health care. Additionally, changes to the Community Care and Assisted Living Act are anticipated to increase the proportion of clients with complex care needs residing in residential care facilities.

The purpose of this review is to examine the current state of residential care service delivery in B.C., with a focus on quality of care (including outcomes, staffing levels and funding), and to determine what, if any, changes need to be made in the residential care system. These changes will ensure consistency, transparency and accountability across the province in meeting residents' needs, in remaining sustainable and in aligning with the ministry's focus on patient-centred care in the community.
The current state analysis included a document review, key/expert interviews with industry contacts and health authority staff, a literature search, a staffing model review, a health authority current state questionnaire and a jurisdictional scan with Alberta and Ontario to look at current evidence/best practices for staffing hours and funding (see Appendix F).

**Background**

**How is residential care provided now?**

*Access to Services*

In B.C., anyone can access publicly subsidized residential care services regardless of income, provided they meet the eligibility criteria set out by the province in the Home and Community Care Policy Manual. All clients are assessed by a health authority professional to determine their care needs, using the interRAI Home Care Assessment instrument. If they are found eligible, they are offered a bed in a facility based on the urgency of their care needs and other factors such as their facility preference, clinical care needs, appropriateness of the facility, availability of caregivers and community supports, and potential risk from abuse, neglect or self-neglect in their present living situation arising from ability of the client and/or their caregiver to manage their health and daily living needs.

Health authorities try to accommodate individual needs and move clients into a facility that is their first choice. However, as the goal is to find a residential care facility that meets the care needs for a person at risk as quickly as possible, sometimes an individual is not placed in the facility that is their first choice. In these situations, health authorities facilitate a transfer to the client’s preferred facility at a later date.

*Provision of Residential Care Services*

Currently in B.C., there are approximately 27,760 subsidized residential care beds in 335 regulated facilities. The facilities are owned and operated either by health authorities, not-for-profit organizations, or for-profit companies. These care facilities are regulated under two different statutes – the *Hospital Act* (102 facilities or 31% of all publicly subsidized facilities) and the *Community Care and Assisted Living Act* (231 facilities or 69% of all publicly subsidized facilities). In addition, these acts also govern over 3,300 non-publicly subsidized (private-pay) beds, some of which are located in the same facilities as publicly subsidized beds. In 2015/16,

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5 [www.gov.bc.ca/hccpolicymanual](http://www.gov.bc.ca/hccpolicymanual)
6 Ministry of Health Home & Community Care Bed Inventory – September 2016.
7 Ministry of Health bed inventory, March 2016.
health authorities reported spending over $1.8 billion on residential care services, an increase of just over 18% since 2009/10, and 60% since 2001.\(^8\)

The *Continuing Care Act* and the Home and Community Care Policy Manual set out what services must be provided by health authorities and contracted service providers, and how fees will be charged. Residential care clients pay a monthly client rate of up to 80% of their after-tax income towards their housing and hospitality services subject to a minimum monthly client rate of $1,104.70 and a maximum monthly client rate of $3,240.00 (as of Jan. 1, 2017). However, the estimated actual cost of residential care as reported by the seniors advocate is close to $7,000 per month.\(^9\) Health authorities cover the costs of care (e.g., nursing/care aides) in all publicly subsidized residential care facilities and residents receive coverage for most of their prescription medication, routine medical supplies and equipment, and some over the counter drugs.

For the most part, it is expected that publicly subsidized residential care facilities are able to provide services that can meet the needs of clients with complex care needs. This has not always been the case, which will be explained in the section, *Historical Context*.

Residential care residents live in a room, sometimes with one or more people, and have either a private or shared washroom. Meals are provided in a common dining area (some facilities have several such areas) and access in and out of the facility is secured and monitored. Some facilities have special units for residents with severe dementia that include an additional level of security, sometimes referred to as secure care units. Once a client has moved into a residential care facility, facility staff assess clients with the interRAI Minimum Data Set 2.0 assessment instrument. An individualized care plan is developed within two weeks of admission and re-assessed 90 days after admission and quarterly thereafter.

Clinical data from these assessments, which are completed electronically, generates other useful information for clinicians, facility managers and decision makers such as: clinical assessment protocols (used to determine areas of further assessment and develop a client’s care plan); outcome scales (a series of outcome measures that assist clinicians to understand the characteristics of a client’s health status); quality indicators (used to monitor quality of specific areas of clinical practice in a particular facility and can be used for comparison across facilities, health authorities and provinces) and resource utilization groups or RUGs (a case mix classification to categorize clients into groups based on similarity of resource use).

Average length of stay in residential care facilities in B.C. has either remained fairly constant or increased over the past five years across the five regional health authorities, contrary to

\(^8\) 2015/16 actual expenditures are taken from health authority service plans for 2016/17 – 2018/19.

anecdotal reports from health authorities and operators. For all of B.C., there was a 17.6% increase from 705 days in 2009/10 to 829 days in 2014/15, and a 4.7% increase from 2013/14 (791 days) to 2014/15.10

**Who lives in Residential Care Facilities?**

Currently, over one-sixth of B.C.’s population is over 65 years old.11 The number of seniors is expected to rise from approximately 853,000 in 2016 to an estimated 1.47 million over the next 20 years.12 It is important to realize that, while it is mainly seniors who live in residential care facilities, most seniors will not require residential care services. The total number of people who received services in 2015/16 was over 40,000, which represents less than 1% of B.C.’s total population, 4.4% of the seniors’ population (those aged 65+) and 9.1% of the population over 75.13

Residential care facilities are home not only to seniors, but also to people with physical disabilities, acquired brain injuries or chronic conditions such as multiple sclerosis who cannot be cared for without access to an array of services, particularly unscheduled care provided by regulated professionals such as nurses.

In 2015 there were 28,156 resident assessments completed using the interRAI Minimum Data Set 2.0 resident assessment instrument.14 Based on the information from these assessments, we can ascertain that the majority of the residents are frail and have complex care needs. For example, the assessments found 93% of residential care clients had some level of cognitive impairment, and 66% had moderate or higher cognitive impairment; 65% had a diagnosis of dementia; 93% had some level of impairment with their ability to perform activities of daily living while 73% required moderate to significant assistance; 69% had bladder incontinence and 47% had bowel incontinence; just over 21% had suffered a cerebral vascular accident and 12% had congestive heart failure. 55% of residents had some indication of frailty and health instability, and 10% had a higher level of medical complexity and were at serious risk of decline.

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10 2016_0387 Home and Community Care Residential Care Average Length of Stay at Discharge.
12 Ibid.
14 B.C. interRAI Minimum Data Set 2.0 and interRAI Home Care data, 2015.
How has residential care changed over the years?

**Historical Context**

In 2002, the government implemented a Home and Community Care Redesign Strategy to address seniors’ and people with disabilities’ need for more independent housing and care options that would allow them to remain in the community for as long as possible. A key component of this redesign was the government’s commitment to make 5,000 net new residential care beds, assisted living units, and supportive housing units with home support available by December 2008. The 5,000 beds target was met in June 2008, with the majority of new beds/units built and operated by contracted for-profit and not-for-profit service providers.

As part of this redesign strategy, significant changes were made to the residential care system in the province to ensure sustainability and quality care. The provincial access policy was changed to one of priority based on urgency and need, rather than chronology. The criteria for access was amended to focus on clients with higher care needs and all facilities were expected to be able to provide care to clients with complex care needs rather than just extended care hospitals, private hospitals and what were known as "multi-level care" facilities.

**2008 Provincial Residential Care Staffing Framework**

**Implementation of the Provincial Residential Care Staffing Framework**

As a result of the changes described above, there was a significant shift in the care needs of clients living in care facilities. From 2002 on, concern grew about the availability of appropriately educated, competent staff to adequately meet the complex care needs of residential care clients, as well as the appropriate mix of professional and non-professional staff to meet client care needs. In 2007, the Ministry of Health and health authority representatives started work to develop a draft provincial staffing framework to:

- provide an evidence-based staffing framework for facilities;
- support the provision of quality services and care to facility residents;
- improve the health outcomes of facility residents; and
- support a consistent approach to making staffing decisions in all provincial facilities.

The literature review conducted in 2008 clearly identified that facility staffing decisions should be made based on evidence-based staffing frameworks that incorporate variables that positively affect resident and staff outcomes (Appendix B). It was noted that establishing provincial averages for direct care staffing levels and professional staff mix should only be one component of the staffing framework. Organizational structures, managerial practices, work environment and culture, education and experience of staff, clinical leadership, and resident needs all impact resident and staff outcomes.
It is also known that other factors such as facility design influence how well care can be provided to residents with complex care needs, including dementia.

Based upon best practice evidence, the final framework components included philosophy of care, resident care needs, structure (staff level and mix, structures to support care, leadership, culture and climate), process, outcomes and evaluation (see Appendix C).

After considering the research findings, as well as current staffing levels within B.C., it was agreed in 2009 that total direct care staffing levels for each health authority was to average 3.36 hours per resident day, comprised of 3.0 worked hours of nursing care (includes care aides) and 0.36 worked hours of allied health services. In order to meet the goal of a consistent approach to making staffing decisions in facilities across the province, the framework identified the number of registered nurses, licensed practical nurses and care aides based upon facility size and identified that no less than 20% of the direct care hours should be professional care (registered and licensed practical nurses) and that each facility was to have at least one registered nurse on duty at all times (see Appendix D).

On Feb. 27, 2009, the Minister of Health Services released a directive regarding Home and Community Care Quality and Performance Monitoring (see Appendix E). The directive covered four deliverables and outlined six objectives, including:

*Achievement of average standard staffing levels, in worked hours per resident per day for direct care (Registered Nurse, Licensed Practical Nurse, Residential Care Attendant) and for clinical support services (Rehabilitation, Social Work, Activity and Pastoral Care) in residential care facilities.*

Health authorities were asked at that time to estimate the cost of implementing the framework of 3.36 direct care worked hours per resident day and determined the annual incremental cost to be about $215 million. Implementing the other components of the framework (leadership, culture and physician oversight to support care) was estimated at an additional $175 million annually. Initial implementation of the framework was to be funded using incremental revenue generated by rate changes to the residential care client rate structure, which took effect Feb. 1, 2010. The ministry estimated that $53.7 million in annual incremental revenue would be available for reinvestment once the revised rate structure was fully implemented. Therefore, it was recognized that the changes to the residential care client rate structure would fund only a portion of the costs required to achieve the 3.36 hours per resident day component of the framework.
**Reinvestment Results**

One of the commitments that government made when it introduced the new client rate structure, which was based on the principle that people should pay what they could afford toward the cost of their accommodation (housing and hospitality services), was to ensure that health authorities used the incremental revenue resulting from the rate changes to increase direct care staffing levels. Individual health authorities were allowed to direct some of the reinvestment funding to other priority investment options that would improve care, such as staff education, specialized services and non-capital equipment, if their staffing levels were sufficiently high enough already to start with and if approved by the ministry. Interior Health, Island Health and Northern Health all had staffing levels above 3.0 hours per resident day when this process started. Vancouver Coastal Health and Fraser Health had levels below 3.0 hours per resident day. The latter two health authorities were required to direct almost all of their incremental revenue to increasing staffing levels.

In collaboration with an independent consultant and health authorities, the ministry developed and implemented a formal monitoring evaluation framework for the residential care rate reinvestment which spanned from 2010/11 to 2011/12.

Health authorities were required to submit a range of data to the ministry, including an initial detailed reinvestment plan, quarterly residential care client rate revenue monitoring reports and biannual health authority plan staffing, and reporting and management report updates. These health authority reports were reviewed and analyzed by both the ministry and independent consultants. In addition to analyses of these data, a series of informant interviews were conducted to assess processes and outcomes of implementation. While in both years the information available reflected inputs, outputs and process outcomes, the data required to be able to identify and reflect client (e.g., interRAI data) and staff outcomes were not available.

As mentioned above, the rate reinvestment was estimated to generate $53.7 million of additional funds over the initial two years. However, health authorities reported the total annual incremental residential care client rate revenue investment was $85.62 million after two years.\[^{15}\] Each health authority was required to submit reinvestment plans, which were vetted and in some cases adjusted, then approved by the ministry. The majority of the expenditures ($64.95 million) were related to priority investments in contracted residential care facilities.

\[^{15}\] B.C. Ministry of Health (May 2013). *Health Authority Investment of Revised Residential Care Client Rate Revenue: Summary Report for 2010/11 and 2011/12.*
The remaining $20.67 million was for investments in owned and operated facilities. The funds were distributed as follows across the five areas described below:

1. $52.51 million (61%) was invested in increased nursing, allied health and care aide staffing. These funds were primarily invested in contracted facilities with $47.67 million invested and the remaining $4.84 million going to health authority owned and operated facilities.
2. Education, clinical leadership evidence-based tools investments of $5.89 million (6.9 %) were distributed across health authority owned and operated facilities ($3.32 million) and contracted facilities ($2.56 million).
3. Specialized services and supports for distinct population’s investments in owned and operated and contracted facilities were $1.81 million (2.1%).
4. Non-capital equipment investments of $17.78 million (20.8%) were distributed across contracted facilities ($9.68 million) and owned and operated facilities ($8.1 million). Health authority documentation provided shows equipment purchased included items such as beds, mattresses, resident lifts, bed and chair exit alarms and vital sign equipment.
5. Mitigating Preferred Accommodation Fees accounted for $7.63 million (8.9%) of the total invested, with $2.63 million being for owned and operated and $5 million for contracted facilities.

Changes in direct care worked hours per resident day were analyzed to determine the shift in full time equivalent positions (FTEs). From 2009/10 to 2011/12, there was an increase of 1,104 FTEs across the province. These included 932 direct care FTEs and 172 allied care FTEs.

With the $52.51 million investment in increased nursing, allied health and care aide staffing, by the end of 2011/12 the average hours per resident day increased from the baseline 2009/10 hours per resident day in:

- Fraser Health – from 2.64 to 2.94 hours per resident day
- Vancouver Coastal Health – from 2.69 to 2.85 hours per resident day
- Vancouver Island Health – from 3.11 to 3.20 hours per resident day
- Interior Health – from 3.13 to 3.33 hours per resident day
- Northern Health – from 3.27 to 3.31 hours per resident day
- **Across British Columbia – from 2.88 to 3.06 hours per resident day**

After two years of intensive monitoring and evaluation, it was determined by ministry executive that this level of monitoring at the facility level was challenging to sustain for the ministry, health authorities and facility operators. Much of the reporting was manual, carried out at the facility level, and also involved health authority staff in both the program and financial areas.
A decision was made to instead communicate to health authorities a requirement to continue to invest the incremental fee revenues from the revised client rate structure to increase care hours and move towards full implementation of the staffing framework. Through funding letters to the health authorities in 2012/13, 2013/14, 2014/15, 2015/16 and 2016/17, the ministry has directed health authorities to sustain this investment. Health authorities have been able to maintain the annual incremental investment in resident direct care hours in subsequent years, along with having small growth over and above the $85.62 million. As of 2014/15, the health authorities reported the annual incremental investment had reached $87.96 million.

The figure below shows the change in client rate revenue reinvestment from 2009/10 to 2014/15. In 2009/10, it was estimated that $215 million was required to fully achieve the 3.36 hours per resident day. Over 2009/10 to 2014/15, the client rate revenue reinvestment reached $87.96 million. In 2016, based on current staffing levels and costs, it is estimated an annual additional $113.7 million is required to fully achieve the 3.36 hours per resident day average for each health authority, with an increase of 1,511 FTEs (includes 886.7 care aides).
It is important to note that the total amount of the client rate revenue reinvestment has not been all directed to increasing staffing. Health authorities have directed some of those additional funds to the other priority investment options (staff education, specialized services and non-capital equipment). Nevertheless, hours per resident day have improved provincially from a baseline of 2.88 in 2009 to 3.06 in 2011/2012 and 3.11 as of January 2016. Although some facilities have achieved 3.36 hours per resident day, no health authority has achieved the desired average set by the province.

The following table shows hours per resident day in both owned and operated and contracted facilities as of March 2016, and as reported by the health authorities. Owned and operated facilities tend to have higher direct care hours. Only two health authorities (Fraser Health and Northern Health) have achieved the average 3.36 hours in owned and operated facilities. Fraser Health and Vancouver Coastal Health have the lowest hours per resident day in contracted facilities (2.86 and 2.81 respectively).

### Residential Care Beds and Ownership and Direct Care Hours per Resident Day – March 2016 as reported by health authorities

<table>
<thead>
<tr>
<th>Health Authority</th>
<th>Owned/Operated</th>
<th>Contracted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraser Health</td>
<td>1,870</td>
<td>6,233</td>
<td>8,103</td>
</tr>
<tr>
<td>Ownership%</td>
<td>23%</td>
<td>77%</td>
<td>100%</td>
</tr>
<tr>
<td>Hours per Resident Day (average)</td>
<td>3.59</td>
<td>2.86</td>
<td></td>
</tr>
<tr>
<td>Interior Health</td>
<td>2,548</td>
<td>3,014</td>
<td>5,562</td>
</tr>
<tr>
<td>Ownership%</td>
<td>46%</td>
<td>54%</td>
<td>100%</td>
</tr>
<tr>
<td>Hours per Resident Day (average)</td>
<td>3.22</td>
<td>3.15</td>
<td></td>
</tr>
<tr>
<td>Island Health</td>
<td>1,713</td>
<td>3,721</td>
<td>5,434</td>
</tr>
<tr>
<td>Ownership%</td>
<td>32%</td>
<td>68%</td>
<td>100%</td>
</tr>
<tr>
<td>Hours per Resident Day (average)</td>
<td>3.16</td>
<td>3.12</td>
<td></td>
</tr>
<tr>
<td>Northern Health</td>
<td>1,031</td>
<td>138</td>
<td>1,169</td>
</tr>
<tr>
<td>Ownership%</td>
<td>88%</td>
<td>12%</td>
<td>100%</td>
</tr>
<tr>
<td>Hours per Resident Day (average)</td>
<td>3.36</td>
<td>3.10</td>
<td></td>
</tr>
<tr>
<td>Vancouver Coastal Health</td>
<td>2,532</td>
<td>4,258</td>
<td>6,790</td>
</tr>
<tr>
<td>Ownership%</td>
<td>37%</td>
<td>63%</td>
<td>100%</td>
</tr>
<tr>
<td>Hours per Resident Day (average)</td>
<td>3.14</td>
<td>2.81</td>
<td></td>
</tr>
<tr>
<td>Total Beds</td>
<td>9,694</td>
<td>17,364</td>
<td>27,058</td>
</tr>
<tr>
<td>Ownership %</td>
<td>36%</td>
<td>64%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Source:** Health authority combined hours per resident day submissions. June 2016. Regional Grants and Decision Support, Ministry of Health.

**Notes:** Fraser Health excludes hospice. Interior Health excludes hospice and family care home beds. Island Health excludes family care home beds. Northern Health excludes 10 hospice and two family care home beds. Vancouver Coastal Health excludes temporary and hospice beds.

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2016 Literature Review

As B.C.’s staffing framework was based upon evidence compiled in 2007/08, the ministry conducted an extensive literature scan to identify any new evidence that would support a set level of hours per resident day. The 2007/08 review (see Appendix C for a summary) identified only three studies from the U.S.A. that provided recommendations for a range of total nursing staff levels needed for quality care, between 3.20 and 3.93 worked hours per resident day. A 2016 article references a study done in 2001 by the U.S. Centres for Medicaid and Medicare Services that cites 4.1 worked hours per resident day as a minimum target, and which was later confirmed in a 2004 observational study and in a reanalysis by Abt Associates in 2011. A further article from the U.S.A. found that beyond 4.1 hours per resident day there was no further benefit of additional staffing with respect to quality.

The 2016 literature scan involved a PubMed search for long-term care in conjunction with budget, quality and staffing. The search terms for long-term care included “long term care,” “nursing home” and “residential care” (with qualifiers of “frail” or “elderly”). A total of 3,246 unique articles were identified, of which 2,581 were for quality, 630 were for staffing and 240 were for budget. As 3,246 abstracts were too numerous to be reviewed in a short period of time, the scan was limited to abstracts of articles published between 2013 and 2016, plus a handful of abstracts before 2013. The final literature scan includes 181 papers, a short summary of which is provided below.

Similar to the 2007/08 finding, the 2016 literature review findings identified that facility staffing decisions should be made based on evidence-based staffing frameworks that incorporate variables that positively affect resident and staff outcomes. Other articles reviewed indicated that in general, staffing levels were predictors of care quality, and that increased staffing levels could improve care and resulted in better outcomes or decreased severity of deficiencies.

The more recent findings showed that nursing staff affects the quality of care in facilities and that staffing stability is associated with better patient outcomes while staffing instability is associated with poorer patient outcomes. Staffing challenges that negatively affect quality include director of nursing turnover, staff turnover, changes in staffing pattern (e.g., decrease in staffing levels or change in staffing mix), high levels of absenteeism and limited time available to train staff.

While increased staffing was a common intervention to improving quality of care and outcomes, it has been noted that the effectiveness of minimum staffing standards is unknown and that staffing should also be allocated according to particular resident needs.

**Changes to the Community Care and Assisted Living Act**

Government introduced amendments to the *Community Care and Assisted Living Act* in March 2016 to offer more flexibility and choice and to achieve a more person-centered approach for seniors in assisted living residences, while at the same time increasing protections. Bill 16, *Community Care and Assisted Living Amendment Act*, received Royal Assent by the Lieutenant Governor on May 19, 2016, and responds to concerns identified over the past several years in reports published by the ombudsperson, the seniors advocate and the B.C. Law Institute.

The changes mean that seniors may be able to remain in assisted living longer, and, if their care needs change, may not have to move into a residential care facility as early as they would have had to previously, or not at all. It is not yet known what the full impact of these changes will be to the residential care sector, but some have suggested that the proportion of higher needs clients will increase in care facilities, which will impact staffing. Whether or not the demand for residential care beds will decline is uncertain, as the growth in the proportion of people aged 75+ continues to significantly outpace the growth in new beds across the province. The ministry has plans to engage in predictive modeling that may assist in helping to answer some of these questions.

**How does residential care in B.C. compare to other Canadian jurisdictions?**

Residential care services provided in B.C. are fairly similar to services provided in other jurisdictions across Canada. Home and community care services are not governed under the *Canada Health Act*, but instead are regulated by each province or territory. There are probably more similarities between the services provided than differences. The clients who live in these facilities have similar care needs across the country.

As both Alberta and Ontario are often provinces referenced by our industry partners, as well as by unions, the ministry wanted to understand how B.C. compared to them in relation to population and expenditures on home and community care. In 2015, Ontario had the largest number of citizens aged 75+ at 0.974 million, B.C. was second largest at 0.354 million, followed by Alberta at 0.205 million.\(^{19}\) When annual spending made in residential care was examined between the three provinces, B.C.’s overall spending in 2014/15 ($1.8 billion) was higher than

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\(^{19}\) Statistics Canada, Table 051-0001 Estimates of population, by age group and sex for July 1, Canada, provinces and territories [www5.statcan.gc.ca/cansim](http://www5.statcan.gc.ca/cansim).
Alberta’s reported spending ($1.43 billion) but lower than Ontario’s ($3.9 billion). When distributed across all people 75 years and older, at $5,085 per person, B.C. spent more than Ontario ($4,003 per person) and less than Alberta ($6,976 per person). Both Alberta and Ontario have also announced increased funding over the next 3-5 years.

Alberta and Ontario both have province-wide funding models for residential care. However, their approaches have similarities and differences as set out below:

- **Ontario’s model is outcome-based and does not include hours per resident day** (the Province has been lobbied by the Canadian Union of Public Employees for a legislated minimum average of four hours of nursing and personal care per resident per day in residential care facilities).
- **In Ontario, there are four funding envelopes** (Nursing and Personal Care, Program and Support Services, Raw Food, Other Accommodation) and full funding is based upon an annual occupancy of 97%. If occupancy rates drop below 97%, the service provider is funded at actual occupancy.
- **Ontario service providers receive funding in their nursing and personal care envelope based on the assessed needs of their residents determined annually using RUGs (places clients into groups based on similarity of resource use) and the related Case Mix Index score based on the Resident Assessment Instrument assessments.**
- **According to Ontario’s posted information, operators of residential care facilities in Ontario cannot make a profit on the provision of nursing and personal care, program and support services (e.g., therapeutic services, pastoral care, staff training) or raw food. The only envelope in which they can retain surplus funding is “other accommodation.” Financial accountability is more stringent in the residential care sector than in any other sector within the health-care system in Ontario.**
- **Residential care facilities in Ontario are guided by the Local Health Integration Network Service Accountability agreement and the Long Term Cares Home Act. Residential care facilities are required to complete audited annual reports on their revenue and expenses in all envelopes. Any unspent funding in the specific areas is returned to government through a reconciliation process.**

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22 B.C. Ministry of Health received information about Alberta and Ontario through interviews and materials provided by both provinces.
In 2009 Alberta Health Services adopted a patient/care-based funding model, with the key objective of aligning incentives within the health system so that the most appropriate services are delivered for the most efficient funding levels. Alberta Health Services identifies that patient/care-based funding is:

- An output based allocation method that classifies residents/patients by clinical acuity and resource use to enable consistent and appropriate funding. The model provides funding based on care provided to residents/patients, recognizing needs and complexities as opposed to funding a specific type of bed.

Alberta has incorporated the Resident Assessment Instrument Case Mix Index measure directly into its funding model, with the intent to reflect different resident complexity levels. The Case Mix Index is multiplied by the number of resident days to calculate a facility’s "weighted resident days," which is the main determinant of variable patient/care-based funding for a facility.

Alberta talks about two measures – 3.02 worked hours or 3.67 paid hours.

The key objective of Alberta’s model is to align incentives within the health system so that the most appropriate services are delivered for the most efficient funding levels. Alberta has stated a number of accountabilities that each provider must meet.

**How is residential care funded and what is the model?**

There is no agreed-upon province-wide standard funding methodology in B.C. for residential care services. Most health authorities report having a standard funding model, which is used annually to allocate annual increases to address cost changes such as increased wages due to collective agreements and other cost pressures. It is not clear whether these models also attempt to address variation in facility-base funding across facilities, which has existed historically and is reflected by the variation in direct care hours per resident day. Health authorities have indicated they have been making efforts to bring up the funding levels for the lowest funded providers.

In 2006, the ministry held an industry forum on residential care to discuss a number of topics, including moving toward a standardized residential care service agreement and the possible use of performance metrics in determining funding and overall funding levels.

As B.C. has moved to a regionalized health-care system, the Province no longer funds service providers directly, as it did prior to 1997. The ministry allocates funding to each health authority annually using a number of methodologies including targeted funding, consideration of past historical base funding and its Population Needs Based Funding model. This model is a funding methodology to determine how to divide a pre-determined pool of funds fairly and
equitably between the five regional health authorities. The model has a number of elements or inputs, which include population growth and demographics, expected use of services, complexity, remoteness and the inter-regional patient flows. The health authority then decides, based on its annual service plan, how to allocate the funding to various services and programs described as sectors, including the acute sector (e.g., services provided through hospitals), population health and wellness, mental health and substance use, residential care and community care. Within the community care sector, the five regional health authorities determine the amount of funding to be directed toward services such as home support, adult day programs, assisted living and residential care.

Within the residential care sector, health authorities are both the funder and owner/operator of their own residential care facilities, and the funder of contracted for-profit and not-for-profit residential care providers. When considering residential care facility operations, the following standard cost categories exist across all facilities:

- Wages for direct care costs (hours provided by registered nurses, licensed practical nurses, and care aides are based upon a staff to resident ratio that factors in facility size. Funding for allied health staff is based on a block of time, dependent on the type of health care provided);
- Wages for supports (administration, office staff, dietary, housekeeping, laundry, facility maintenance, education, support labour funding);
- Non-wage costs (food costs, dietary supplies, housekeeping, laundry, administrative supplies, insurance, professional fees);
- Property operating costs (utilities and maintenance);
- Capital costs – rent/lease (property taxes, mortgage [interest and principal], building reserve, equipment reserve, rent/lease);
- Other add-on’s or adjustments (facility size [less than 75 or 51 beds], pharmacy labour and drug costs in sites that operate under the Hospital Act, additional staff requirements).

While standard cost categories are similar, each health authority currently use different methods for determining priorities and assigning funds to residential care providers. As well, there is a range of approaches taken to monitor how these funds are implemented and the impact on direct care hours per resident day within each facility.

As with many other public services, government expects a public-private partnership approach to be used to develop new capacity for residential care beds. Health authorities are mandated by the ministry to plan for services that will meet the needs of their residents. When they decide that new beds are required in a given community, they engage in a competitive process
to procure those beds and then enter into a contract with the service provider to provide the necessary services and programs. One health authority has reported the cost of construction for one new residential care bed to be about $190,000. Operating funding for new beds comes from the health authority's annual funding allocation from the ministry.

While there is a lot of activity around the province in planning and development of new beds, many of those will be replacing older sites that can no longer adequately meet the needs of today’s residents. For 2016/17, there are about 500 new beds that will open, and many more are planned for 2017/18 and 2018/19. Health authorities recognize how critical it is to either renovate or replace their older bed stock with improved facility design, including single rooms with a private washroom and shower, walking loops and smaller dining areas. Better design has a significant positive impact on the ability of service providers to care for residents, especially those with dementia as well as younger adults with behavioural and cognitive challenges.

**Concerns and Issues: What we heard**

As mentioned previously, there are a number of challenges and issues regarding the provision of residential care services in B.C., in particular related to staffing levels. Residents and their families, the public, media, the ombudsperson, the seniors advocate, individual service providers, industry associations and others have raised these concerns previously.

**Ombudsperson**

On Feb. 14, 2012 the ombudsperson released *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*. This comprehensive and in depth report included 143 findings and made 176 recommendations. Of these, recommendation 123 and 124 spoke specifically about new client rate reinvestment and meeting the guideline of providing 3.36 direct care hours per resident day.

Recommendation 123: The Ministry of Health provide further and more detailed public information on how the additional revenue generated by the new residential care rate structure is being spent and what improvements to care have resulted in each facility.

Recommendation 124: The Ministry of Health, together with Interior, Fraser, Vancouver Coastal and Vancouver Island health authorities ensure that each health authority, at a minimum, meets the ministry’s guideline of providing 3.36 daily care hours by 2014/15.

Since 2012, the Ministry of Health has been actively addressing the recommendations from this report and has provided regular updates to the Office of the Ombudsperson, including the purpose of and findings from this review.
Seniors Advocate

Several reports released by the Office of the Seniors Advocate, including their reports on placement, drugs and therapy (April 2015), housing (May 2015) and resident to resident aggression (June 2016), have highlighted concerns about residential care such as the proportion of “light care needs” clients living in care facilities that could be living in assisted living or at home, the need for more private rooms and staffing levels. With the publishing of the Residential Care Facilities Quick Facts Directory in March of 2016, which includes a variety of information about each care facility, many questions were asked about the variation in the staffing levels between facilities and about the ministry’s role in monitoring them. Ministry staff have been working with staff from the Office of the Seniors Advocate to better understand their data analysis and the concerns expressed in their reports.

As mentioned earlier, the seniors advocate has suggested that all facilities could be brought to a minimum average of 3.36 hours per resident day by health authority through the investment of $83.5 million based on $30/hour for care aides (assuming all added staff are care aides).23

Health Authorities

As part of this review process, the ministry asked health authorities a series of questions related to quality, staffing levels and budget. One question asked was, “Is the client rate reinvestment achieving identified outcomes?” Four health authorities answered the question and indicated that intended outcomes were achieved. Island Health prefaced the answer by affirming that “no one investment (staffing, education, equipment) is solely responsible for improving care and client outcomes.”

- In Interior Health, there were improvements in nine of the ten interRAI quality indicators ranging from 8% to 36%. There was no change in one of the indicators (worsened pain).
- In Island Health, there were improvements in wound care, pain reduction and the reduced use of restraints.
- In Northern Health, there was an increase in hours per resident day levels to 2.8 hours and 3.5 hours in residential care facilities and designated special care units respectively.
- In Vancouver Coastal Health, there was an increase in hours per resident day levels across all owned and operated as well as contracted facilities.

An unintended consequence highlighted by Interior Health was that the principle of standardization resulted in higher workload costs at individual facilities when residents with high complex needs were admitted.

23 2015 labour costs provided by the Health Employers Association of B.C. cite $34.27/hour on average for care aides, and includes wages, premiums and benefits (source is data reported in the Health Sector Compensation Information System). Using this higher average cost, the estimate would increase to $95.3 million.
Health authorities concerns included:

- Lack of clarity on contracted site operating costs;
- Provincial policies are being implemented without additional funding (e.g., basic wheelchairs);
- Cost of collective agreement negotiations; and
- Generous entitlements for vacation and sick leave in collective agreements.

**Industry Associations**

In addition to discussions with operators while visiting facilities, a conference call was held with members from the B.C. Care Providers Association, the Denominational Health Association and the B.C. Seniors Living Association. Discussion points included: 1) what was working well in the existing system; 2) what innovations would assist in improving care; and, 3) if government could only make one change, what would have the greatest impact?

Concerns included:

- The majority of interviewees identified the need to increase funding for hours per resident day. Many noted that the complexity of clients is changing and that additional funding is not typically provided to address increased care requirements.
- There is a lack of consistency between health authorities in approaches to service provision including funding, staffing, training, policies and procedures, which impact contracted service providers that operate in more than one health authority.
- Direct care hours are defined differently – both within the same health authority and across health authorities.
- Funding is not keeping up with inflation/labour costs in negotiated collective agreements.
- Policies are being implemented without additional funding (e.g., basic wheelchairs).
- Challenges attracting and retaining staff.
- Wanting to operate as a campus of care, but policies can intervene (e.g., first appropriate bed).
- The lack of job readiness of new health-care graduates.
- “Rich” vacation and sick leave entitlements and impacts on staffing.
- Timing of notification on budget and unclear how annual lifts are calculated. Providing an interim budget was identified as a best practice.
- Cost of capital to increase private sector investment and residential care development.
- Inconsistent interpretation of regulations and licensing.
Affiliates indicated challenges with being competitive with the for-profit providers in the request for proposal process for new beds as they have to pay union rates, the same as health authority owned and operated facilities.

In addition to consultation with the industry associations, it is important to note that in May 2016, the B.C. Care Providers Association issued two White Papers that explain the concerns of care providers and outline 32 options for review and consideration. Sixteen options are related to funding and 16 to new care models and innovation.24 In January 2017, the B.C. Care Providers issued their final report, *Strengthening Seniors Care: A Made-in-BC-Roadmap*. While the papers and final report do not focus solely on residential care services, they offer food for thought in several areas that have been touched on in this report.

Finally, the ministry has heard concerns expressed about how the client rate structure for residential care services is not aligned with other home and community care services where the client rate is based on an individual's income. For clients receiving either home support or assisted living services, the maximum rate a client would pay (if their income is high enough to warrant being charged the maximum rate) is the full cost of the service, which means those individuals would be paying about the same amount as if they were to seek services from the private-pay sector. However, this is not the case for residential care services. Currently, the maximum rate is capped well below the actual cost of delivering the service.

**Rethinking the Foundation**

At the beginning of this report, three key areas were identified for examination – quality of care, staffing levels and funding – to determine what, if any, changes need to be made in the residential care system to ensure consistency, transparency and accountability across the province in meeting residents' needs, in remaining sustainable and in aligning with the ministry's focus on patient-centred care in the community. Based on all the information collected to date, it seems evident that action is required in a number of areas and on a number of levels.

**Quality of Care**

B.C. is now in a position to take advantage of the effort that has been invested in years past in implementing the interRAI Minimum Data Set 2.0 assessment instrument and to learn from the information generated from the clinical data to improve care. While most facilities are already

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using such information to monitor quality, there are opportunities for the ministry to take a leadership role in working collaboratively with service providers, including health authorities, to develop province-wide goals and focussed quality initiatives. Focusing on resident outcomes could be a key element in a new approach moving forward. Recent research indicates there are 13 main clinical areas to monitor.\textsuperscript{25} B.C. could also look to Ontario to explore how they have incorporated monitoring of outcomes into their overall accountability mechanisms for care providers.

Health authorities have identified a number of quality of care initiatives being pursued, but there are few of these that are consistent across health authorities or the province. A co-ordinated approach would benefit all.

\textit{Quality of Life}

Quality of life is another important factor that needs to be included in any quality improvement work. For those seniors who experience increasingly complex medical health care needs and/or frailty, it is critical that they have access to well-coordinated and integrated services. However, many of the medical conditions experienced by seniors are more about how they live with their conditions, with a focus on quality of life, rather than cure; and, in some instances, particularly in terms of frailty, are linked to the realities of an aging body.\textsuperscript{26} People living and managing daily with complex chronic medical conditions, or experiencing frailty, are increasingly dependent on others to maintain their health and well-being, and want more than medical care. They want:

- As much freedom from the impact of their medical conditions as possible;
- To retain as much function as possible to engage in their community, with continued autonomy to shape their own life and story; and
- To be able to take part in meaningful activities, maintain social and family connections, and enjoy the here and now and the everyday pleasures of living.

Both the Office of the Seniors Advocate, in their April 2015 report \textit{Placement, Drugs and Therapy... We Can Do Better}, and the BC Care Providers Association, in their 2017 report \textit{Strengthening Seniors Care: A Made-in-BC-Roadmap}, identify the importance of increased access to programs provided by allied health professionals such as recreational therapy, physical therapy and occupational therapy, as a means to achieving quality of life expectations. The seniors advocate is currently engaged in a province-wide quality of life survey of residents and their most frequent visitor in residential care facilities, using the \textit{interRAI Self-Report}.


\textsuperscript{26} See Atul Gawande’s \textit{Being Mortal} (2014)
Nursing Home Quality Of Life Survey, with results expected within the 2016/17 fiscal year. This work offers another opportunity for learning more about what is important to residents and their families and could offer insight into how care providers could recognize and address the things that give joy and meaning in the day of a resident.

**Staffing Levels and Staffing Mix**

There are some basic actions that could take place that may resolve some issues, such as working with health authorities and service providers to confirm the definition of direct care hours per resident day as the standard across the province, and to collect supporting information. While this may seem challenging, consistency was maintained in the definition for over two years while the ministry was working closely with the health authorities monitoring and evaluating the impact of the residential care rate reinvestment. In addition, based on the review to date, the ministry’s position is that it is appropriate to continue with B.C.’s original target of an average of 3.36 hours per resident day, at a minimum, by health authority. Work also needs to be done to explore if this standard should be revised to better reflect changing resident needs.

There will always be exceptions and variations may be necessary in some circumstances. For example, special populations, such as younger adults with behavioural and cognitive challenges, may require a different staffing mix with less nursing care time and more time from allied health workers. Facilities in rural settings may have different needs as well that must be accommodated.

**Funding**

There are a number of factors that would support consideration of moving toward a province-wide funding model for residential care facilities. The B.C. Care Providers Association has included this as an option in its white papers, and cited the models from both Ontario and Alberta. B.C. has been in discussions with both provinces and both seem willing to assist. The ministry, working in collaboration with the health authorities and service providers, could develop a made-in B.C. version of a comprehensive funding and monitoring model that incorporates variation in resident needs, promotes the principles of transparency and consistency, and aligns resources to meet not only the physical care needs of residents, but their emotional, social, psychological and spiritual care needs as well. As suggested by the B.C. Care Providers Association, funding model components could include client case mix and other cost categories. Building on this, the Province could explore a number of funding envelopes similar to what Ontario has established.

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B.C. may want to consider the key objectives of Alberta’s patient/care-based funding model, which include:

- Achieve equity in funding allocation by focusing on the equitable access and quality of services for residents with similar needs.
- Support consistency in access to care, standards of care, and the amounts paid for care for residents with similar care needs.
- Provide transparent, predictable funding consistent with the quantity, complexity and quality of the services needed by residents.
- Enhance funding predictability for residents, operators, decision-makers and other stakeholders.
- Provide incentives for improving efficiency and quality in long term care service delivery.

**Accountability**

Accountability is a key foundational element as well when trying to ensure quality care is provided to residents of care facilities. Again, the province may want to look to Alberta and Ontario in the way they have structured their reporting, monitoring and evaluation processes related to resident need, funding, service delivery and operations across the residential care sector, which happen at the facility level. Accreditation is another mechanism for accountability and ensuring quality of care. As most facilities are accredited through a recognized accrediting body currently, B.C. may want to standardize the requirements for accreditation.

**Way Forward**

The Province is fully committed to ensuring the needs of residential care clients are met in a caring, holistic manner that respects their dignity and autonomy, and results in better client outcomes and promotes quality of life. Within the context of the current fiscal situation, challenges exist that influence how this work may move forward, including the estimated $113.7 million annual cost needed to fund a standard average of 3.36 hours per resident day, at a minimum, by health authority and how to recruit the additional 1,511 FTEs needed. While there is still much more work to be done, this review offers many avenues for further exploration and analysis.

**Next Steps**

Achieving a standard cross-province average of 3.36 hours per resident day (at a minimum) by health authority would best be supported by a standard funding and monitoring approach. The funding approach should incorporate variables that impact staffing level and mix such as
changes in workload resulting from residents moving into and departing from facilities, and changing resident needs over time. This work could be done in conjunction with defining a small number of province-wide priority quality of care initiatives.

The actions set out in the following table are grouped into one of three categories (funding and staffing, quality of care and accountability), and will be carried out in collaboration with the Office of the Seniors Advocate, other provincial ministries (e.g. ministries of Advanced Education and Jobs, Tourism and Industry), health authorities, industry partners and other stakeholders. The table includes the next steps required to move forward:

<table>
<thead>
<tr>
<th>Category</th>
<th>Action</th>
<th>Proposed Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding and Staffing</td>
<td>1. Finalize a report, in collaboration with the Canadian Institute for Health Information, to better understand the demand for home health, assisted living and residential care services (including the different profiles of clients using RAI assessment and service episode data) given the changes taking place in the home and community care system, and to inform required changes to existing residential care service models.</td>
<td>May 2017</td>
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<td></td>
<td>2. Confirm the definition of direct care hours per resident day.</td>
<td>July 2017</td>
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<td>3. Establish a baseline for: hours per resident day, client case mix, other identified residential care costs.</td>
<td>September 2017</td>
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<td>4. Work with health authorities and industry to create and implement an interim targeted process that would increase hours per resident day for areas with identified gaps until a costing review has been completed and the funding model has been updated to incorporate client complexity.</td>
<td>October 2017</td>
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<td></td>
<td>5. Move towards a province-wide standard residential care funding model, with a lens to incorporate resident complexity (using RUGs and case mix index from RAI assessments), quality of care and flexibility.</td>
<td>January 2018</td>
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<td>6. Complete an analysis of percentage of casual and part-time positions that can potentially be converted to regular full-time positions in residential care facilities.</td>
<td>June 2017</td>
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<td>7. Develop an interim strategy to address immediate high-priority vacancies in residential care facilities.</td>
<td>June 2017</td>
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<td>8. Develop a health human resources plan to ensure supply of staff will meet the needs of the residential care sector. The plan will include targeted recruitment activities and seat-planning in post-secondary programs.</td>
<td>November 2017</td>
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<tr>
<td>Category</td>
<td>Action</td>
<td>Proposed Timeline</td>
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<tr>
<td>Quality of Care</td>
<td>1. Prioritize key quality of care initiatives in residential care and facilitate a coordinated approach that promotes consistency and standardization, yet allows for flexibility given varying needs across facilities.</td>
<td>April 2018</td>
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<td></td>
<td>2. Bring into force Part 3 (care facility admission) of the <em>Health Care (Consent) and Care Facility (Admission) Act</em> to protect vulnerable adults. This work will include revising the residential care admission policy to be more person and family-centred.</td>
<td>April 2018</td>
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<td>3. Develop and implement palliative and dementia care policy including requirements and targets for staff education.</td>
<td>April 2018</td>
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<tr>
<td>Accountability</td>
<td>1. Incorporate the requirement to increase hours per resident day through annual bi-lateral agreements between the Ministry and health authorities.</td>
<td>April 2017</td>
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<td>2. Monitor health authority progress on achieving the 3.36 hours per resident day and produce annual reports for Leadership Council.</td>
<td>April 2018</td>
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<td>3. Develop and implement a policy to mandate accreditation for all residential care facilities.</td>
<td>April 2018</td>
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<td>4. Develop and implement performance measures that support quality of care and quality of life outcomes using outputs from RAI assessment and survey data including quality indicators.</td>
<td>April 2018</td>
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<td></td>
<td>5. Develop and implement a process and policy for monitoring, reporting and evaluation processes related to resident need, funding, service delivery and operations, building on experience from other provinces such as Alberta and Ontario to assess whether quality, funding and staffing policies and goals are being achieved.</td>
<td>April 2019</td>
</tr>
</tbody>
</table>
**Appendix A: B.C. Residential Care Program Overview**

**B.C. Residential Care Logic Model**

<table>
<thead>
<tr>
<th>Purpose</th>
<th>To provide residential care services for those who can no longer be supported in their home and to support residents and their family nearing the end of their life in a residential care facility</th>
</tr>
</thead>
</table>
| Inputs (Resources) | • Ministry of Health (MoH) funding, which is distributed and managed via the five regional Health Authorities (HAs)
• In kind resources from MoH, HAs, other government bodies, associations, RC facility operators, not for profit groups
• Fees paid by residents and their families
• Funds raised by volunteer groups associated with specific Residential Care facilities |

### Components

| Legislation, Policy, Standards and Communication |
| Assessment of Eligibility, Care Planning and Service Delivery |
| Quality, Safety, Licensing, Monitoring and Reporting |

| Key Activities |
| • MoH develops & updates legislation, (CC Act, Hospital Act) policy (HCC Policy Manual), eligibility, standards, staffing and funding models & reporting req. |
| • MoH develops Residents’ Bill of Rights incl. commitment to care; rights to health, rights to transparency & accountability |
| • MoH consults to gather input into legislation, policy, bill of rights, etc. |
| • MoH maintains worker registry |
| • Minister appoints a director of licensing as the steward for all HA Community Care Facility Licensing |
| • MoH communicates legislation, policy and other info to residents, families, public and RC program |
| • MoH/HA plans to meet current & future population RC service needs |
| • HA plan for new/maintain existing and manage RC services across HA |
| • HA case manager assesses person, eligibility to RC, facility & client rate |
| • HA prioritizes access to services in owned/operated & contracted facil. |
| • Facility direct care staff develop care plan with resident, physician, family, etc. to identify resident’s abilities, preferences, needs, supports |
| • Facilities provide accommodation, meals, health care, assistance with ADLs, social/recreational activities & supervision to meet resident needs |
| • HA case manager & health profess. review resident needs & make care and placement changes as needed |
| • Family physicians provide clinical and care oversight, med. review. |
| • Family and Resident Councils engage residents to improve quality |
| • HAs provide/contract RC services |
| • HAs issue licenses and conduct inspections to ensure facilities follow rules & provide safe care |
| • Licensed/Regulated facilities follow RC Reg’s & Standards of Practice & implement & monitor to ensure quality of care |
| • Patients/family discuss concerns with facility and make a formal complaint if not resolved |
| • HAs investigate any complaints and MoH/HAs post summary inspection reports on websites |
| • RC facility operators complete accreditation as required by HA |
| • MoH work with HAs to establish Performance Management frameworks & reports |

| Target Group(s) |
| • Health Authorities |
| • RC facility operators |
| • Residents, family & general public |
| • Residents and family members |
| • RC facility operators |
| • Residents, family & gen. public |
| • All RC stakeholders |

| Key Outputs |
| • Legislation, policy manual, staffing & funding models, Resident Bill of Rights, worker registry, plans, etc. |
| • HA RC Plans, assessment reports, prioritized placements, care plans and plan revisions, services |
| • HA Plans, RAI measures, contracts, licenses, inspection, complaint, accred. reports, etc. |

| Short-term Outcomes |
| • Residents are able to enter or transfer to the facility they prefer, which has the necessary supports |
| • Residents receive housing & a range of other services that meet their health, daily living & other needs |
| • Family and friends of residents receive ongoing support |
| • Care is provided in a safe manner to preserve residents’ comfort, dignity and quality of life as their needs change |
| • Inspections promote adherence to rules & standards of practice and promote safe delivery of care |
| • Patient and family complaints are addressed & support RC improve. |
| • Accreditation leads to ongoing quality improvement based on best practices across Canada |
| • Performance management supports care quality improvement |

| Long-term Outcomes |
| • Delivery of high quality, resident-centred residential care to British Columbians in every region of BC |

*Primary content source: http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care*
Appendix B: Summary of 2008 Research Findings

The following material is a summary of a review of the most recent and relevant research into residential care staffing practices (2008), which was undertaken to inform the development of an evidence-based staffing framework for residential care facilities. The review consisted of research pertaining to direct care nursing providers and allied health staff, leadership and education-related structures, and non-direct care services.

- Canadian researchers and professional organizations support the need for a broad focus on the factors impacting staff and resident outcomes, and reject the legislated focus on staffing ratios and hours of care adopted in some jurisdictions in the United States.
- Research in all jurisdictions emphasizes the complexity of making staffing decisions. Staffing decisions should be made following consideration of many variables and once made, they should be evaluated to ensure the level and mix of staff result in positive resident and staff outcomes.
- Research supports the development of staffing frameworks that are evidence-based and help those making staffing decisions to consider all important variables. An effective staffing plan requires an understanding of the complexity involved in matching human resources to resident needs, and appropriately skilled individuals to develop these plans.
- Staff mix is just one factor impacting resident outcomes and staff job satisfaction. Organizational structures, managerial practices, the work environment and culture, education and experience of staff, clinical leadership, and resident needs and complexity all have an impact on resident outcomes and staff satisfaction and turnover.
- Research in all jurisdictions consistently shows that higher levels of all types of staffing lead to better resident outcomes. Most research studies specify the levels of staffing required to avoid specific adverse events or improve specific quality of care outcomes. Only three US studies address total nursing staff levels needed for quality care in residential facilities; the recommended range is between 3.9 and 4.8 paid hours per resident day.
- Research suggests the higher the proportion of professional staff, particularly registered nurses, the better the quality of care as evidenced by resident and staff outcomes.
- Decisions about registered nurse and licensed practical nurses staff mix must consider their core competencies, the acuity and complexity of resident care needs, and the availability of supports such as other health-care staff.
- Some evidence supports the need for a shift in the way that organizations view cost. The emphasis should be on the cost of outputs, such as nurse absenteeism and the results of poor quality care, rather than the cost of inputs such as nurse to resident ratios and nurse skill level.
Appendix C: 2008 Staffing Framework Principles and Components

The following material is taken from 2008 planning documents that describe the framework to support residential care evidence-based staffing practice decisions and quality of care.

Framework Principles:
1. The delivery of safe, competent care is based on having the appropriate number and mix of multidisciplinary staff and the competencies required to provide the care.
2. Sufficient nursing competencies are required to address the highly complex, unpredictable care needs of residents in care and to avoid situations where subtle changes in status that are treatable are not identified until irreversible damage has occurred.
3. Sufficient allied health staff (regulated and non-regulated) are required as part of the multidisciplinary team to improve the functional status of residents and augment the direct care nursing staff.
4. All staff work to full scope of practice.
5. While cost efficiency is an essential element, achieving good resident outcomes through an evidence-based approach is central to making staffing decisions.
6. An evidence-based approach to staffing and resident outcome evaluation requires inclusion of structure and process indicators, not only staffing levels and mix.

Description of the Framework Components

Philosophy of Care
The philosophy of care specifies the values and beliefs about residents and care, and guides how resident care needs are identified, how staff resources are determined and how staff is organized to provide care.

Resident Care Needs
Staffing decisions must be based on a clear understanding of the unique needs of residents which in turn creates the demand for care by a multidisciplinary team. This includes resident characteristics such as age and sex, as well as common physical, social, emotional and cognitive problems; common acute and chronic medical diagnoses; admissions and discharges/deaths; end of life care; functional status; ethnicity; family relationships and the care required to meet basic human needs. Care needs vary in complexity, variability and acuity, thus affecting the amount of time required to meet them. Staffing levels, staff mix and care processes should be developed based on care needs, including at a minimum an RAI MDS 2.0 assessment.
Structure
Structure encompasses a broad range of variables that influence care processes and outcomes. They are divided into the following three categories:

1. **Staff level and mix** – Resident care needs is one factor that must be used to determine the level, mix and type of disciplines needed to provide care. Staff mix, staffing levels, multidisciplinary team members, full-time versus part-time status, competencies, education, experience and workload are other factors that must be considered before making staffing decisions. Access to primary care (physician or nurse practitioner) influences staff capacity to meet resident needs.

2. **Structures to support care** – There are many structure variables identified in the literature that impact care processes and outcomes. Examples include room size, physical layout of a site, the needs of specialized client populations, availability of technology, availability of clerical and support staff, unit geography/layout, availability of equipment and supplies, model of care delivery, contingency plans and availability of clinical practice guidelines. These must be considered in addition to resident care needs when making decisions about staffing levels and staff mix.

3. **Leadership, culture and climate to support care** – Organizational culture and climate, management strategies, communication, control, autonomy, span of control and governance are all variables that must be considered at the unit and facility levels when making staffing decisions, as these factors influence both care processes and staff and resident outcomes.

Process
Process pertains to activities undertaken by staff when delivering care, such as assessing residents; resident and family education; therapeutic communication; activities aimed at improving functional, physical and cognitive status; monitoring resident status; discipline specific and inter-professional practice; symptom management and avoiding predictable adverse events. Process examines actual services or activities provided to, or on behalf of, clients and is influenced by structure and resident care needs. Often clinical practice guidelines form the basis on which indicators are defined and monitored.
Outcomes
Outcomes are the relationships between structure, process and resident care needs that determine resident, staff and system outcomes. Outcomes are commonly separated into three areas: resident, staff and organization.

- Resident outcomes can be grouped as adverse events, symptom management, resident satisfaction with care and functional health outcomes (physical, social, and cognitive functioning, mental health and self-care ability).
- Staff outcomes include staff illness and injury, retention, turnover, autonomy, optimal use of competencies and job satisfaction.
- Organization outcomes include overtime, absenteeism, sustainable costs, continuity of care and recruitment.

Evaluation
Evaluation involves:

- identifying indicators that reflect good care and positive health outcomes for residents;
- identifying indicators that reflect a culture and climate that retains staff;
- developing efficient systems for collecting and analysing data, and reporting progress; and,
- developing processes to manage change and achieve quality improvement.

The following diagram identifies the framework components that are essential to support evidence-based staffing decisions and are more likely to result in high quality, safe resident care and increased staff job satisfaction. It also identifies the contextual factors that have the potential to affect all components of the model. These factors include resources [such as financial, human, primary care (physician and nursing practitioner), physical plant, equipment and supplies], health needs of residents, and legislation, policy and standards. They also include a quality improvement process that seeks to meet residents' needs and expectations, and is achieved through a structured process that selectively identifies and improves all aspects of care and services on an ongoing basis.
2008 staffing framework components to support evidence-based staffing decisions:

Comprehensive Understanding of Health Needs of Residents

PHILOSOPHY OF CARE

RESIDENT CARE NEEDS

Level & Mix of Interprofessional & Unregulated Staff to Provide Care

Structure to Support Care

Leadership & Culture to Support Care

Care provided by multidisciplinary team

Outcomes - Resident - Provider - System

EVALUATION

Quality Improvement

Legislation, Policy & Standards

Resources

STRUCTURE

PROCESS

OUTCOME
Appendix D: 2008 Costing Assumptions – Assignment of Direct and Allied Health-Care Staff

The following information is taken from the 2008 Ministry of Health Costing Assumptions for the Proposed Staffing Framework for Residential Care Facilities. At that time, the Residential Care Standing Committee developed, as part of the costing assumptions, detailed staffing levels and staff mix to ensure consistency in costing the first phase of implementation of the framework.

The staffing levels and mix set out below are evidence-based. However, they are not indicative of actual staffing patterns to be used in each facility. Facilities will have the flexibility to develop their own staffing levels and mix, with the exception that they must at least one registered nurse for every 75 beds.

Direct Care

The total is 3.36 worked hours of care made up of direct and allied health care staff.

- Includes registered nurses, licensed practical nurses and care aides.
- *Registered nurses*: Should be one registered nurse 24 hours/day, seven days/week as set out in the table below.

<table>
<thead>
<tr>
<th>Number of Beds</th>
<th>Number of Registered Nurses 24/7</th>
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<tbody>
<tr>
<td>0 – 75</td>
<td>1</td>
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<tr>
<td>76 – 150</td>
<td>2</td>
</tr>
<tr>
<td>151 – 225</td>
<td>3</td>
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<tr>
<td>226 - 300</td>
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- *Licensed practical nurses*: Should be one licensed practical nurse for every 25 residents on day and evening shifts, none for the night shift in facilities with 75 beds or less, and one for the night shift in facilities with more than 75 beds, as set out in the table below.

<table>
<thead>
<tr>
<th>Number of Beds</th>
<th>Number of Licensed Practical Nurses 24/7</th>
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<tr>
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<td>Days</td>
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<td>0 – 25</td>
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<td>26 – 50</td>
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<td>51 – 75</td>
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<td>151 – 175</td>
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<td>201 – 225</td>
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<td>226 – 250</td>
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<td>251 – 275</td>
<td>11</td>
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<td>276 - 300</td>
<td>12</td>
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</tbody>
</table>
- **Care aides**: Should be one care aide for every six residents on day shifts, and one care aide for every eight residents on evening shifts – one to 37 residents on nights.

- Each resident should get 3.0 worked hours of direct care per day.

- Not less than 20 – 25% of the direct care hours should be professional (registered and licensed practical nurses) care.

- In a 75 bed facility, each resident would receive daily:
  - 19 minutes of registered nurse care (10%) based on a DC1 at the top step.
  - 57 minutes of licensed practical nurse care (32%) based on a PC11 at the top step.
  - 104 minutes of care from care aides (58%) based on a PC3 at the top step.

- In a 25 bed facility, each resident would receive daily:
  - 58 minutes of registered nurse care (32%).
  - 122 minutes of care from care aides (68%).

**Allied Health Care**

- Includes occupational therapists, physiotherapists, social workers, dietitians, recreational therapists, and activity workers.

- Each resident should get 0.36 worked hours (22 minutes) of allied health care per day based on a seven day work week comprised of:
  - 7 minutes of professional care based on an occupational therapist at the top step (equivalent to 8.8 hours/day for all residents in a 75 bed facility).
  - 15 minutes of care from activity workers based on a PC13 at the top step (equivalent to 18.75 hours/day for all residents in a 75 bed facility).

- Current occupational therapy/physiotherapy staffing levels would not be reduced if a facility has more than the target seven minutes/resident/day professional staffing level.

**Benefits**

- Includes sick, vacation, severance and shift differential - cost at 26%

- Relief factor is 26% based on 100% backfill
Appendix E: 2009 Ministerial Directive

On Feb. 27, 2009, the Minister of Health Services issued a ministerial directive to the health authority board chairs re: Home and Community Care Quality and Performance Monitoring, pursuant to the 2008/09 government letters of expectations. The directive included the following home and community care deliverables for health authorities:

A: Quality and Consistency – Assisted Living and Residential Care Services

B: Quality and Consistency – Home Health Services

C: Access to Information on Home and Community Care Services

D. Access to a Continuum of Home and Community Care Services

E. Minimum Reporting Requirements

Directive A included six areas related to assisted living and residential care including staffing, education, facility conditions and capital investments, quality and safety monitoring protocols, contract management process, and a monitoring and inspection process for extended care hospitals and private hospitals under the Hospital Act.

A.1, which focussed on staffing, stated:

Achievement of average standard staffing levels, in worked hours per resident per day for direct care (Registered Nurse, Licensed Practical Nurse, Residential Care Attendant) and for clinical support services (Rehabilitation, Social Work, Activity and Pastoral Care) in residential care facilities. (This is the initial focus of the implementation and evaluation.)
Appendix F: Current State Analysis Methodology

Working closely with Ministry of Health and the Office of the Seniors Advocate, the residential care environmental scan included:

- **Key/Expert Interviews**: Semi-structured interviews were held with industry contacts, health authority staff and jurisdictional contacts in Alberta and Ontario to examine/discuss various aspects of residential care.

- **Document Acquisition and Review**: Numerous documents were gathered and reviewed in the course of the project. These included legislation, standards, policy, consultant reports, internal communications, draft materials, statistical summaries and other sources.

- **Health Authority Current State Questionnaire**: Each health authority provided a written response to the ministry. The results were analyzed and overview of the findings is presented in this report. The topics addressed include:
  - Ensuring quality of care for residential care clients;
  - Identifying/supporting staffing care models that enable quality and safe care;
  - Budgeted residential care funding; and
  - New models and innovation.

- **Literature Review**: A PubMed search was conducted for long-term care in conjunction with budget, quality and staffing. The search terms for long-term care included “long term care,” “nursing home” and “residential care” (with qualifiers of “frail” or “elderly”). Of the 3,246 abstracts identified, 181 were selected and reviewed.

- **Data Analyses**: Data was provided by the ministry and the Office of the Seniors Advocate. The data was analyzed using primarily descriptive statistical approaches to address a range of questions.

- **Application of the Residential Care Staffing Framework Staffing Model**: The model was reviewed, applied to current state data and projected staffing requirements were estimated.