Deloitte.

Newfoundland Labrador

Government of Newfoundland and Labrador: Department of Health and Community Services

Long-Term Care and Community Support Services Funding Models – Final Report

February 2020

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Long Term Care (LTC) and Community Support Services (CSS) play an essential role within the Newfoundland and Labrador (NL) health system and are increasingly becoming a focal point of clinical service delivery as the Province simultaneously strives for better health, better care, and better value. The Department of Health and Community Services (HCS, the Department) and the four Regional Health Authorities (RHAs) partner with third-party service providers for an array of supports that constitute approximately $350 million in annual program expenditures. However, the current methods of funding third-party services do not consistently reflect the level or quality of care provided, the attainment of clinical outcomes, and, are not informed by a structured and robust rate-setting methodology.

Given the materiality of program expenditures and concurrent efforts to renew policy, redefine Levels of Care, establish service-level agreements (SLAs) and build capacity in LTC CSS, the Department engaged Deloitte to undertake a comprehensive review of funding arrangements for third-party service providers. This report details the findings of the review, with the policy-makers and program staff at the Department and RHAs as the intended audience.

The scope of this report to the Steering Committee includes:

- A comprehensive inventory of services in the LTC CSS system that utilize third-party service providers.
- A literature review and jurisdictional scan to identify leading practices that inform the development of new funding models.
- Outcomes of stakeholder engagement with the RHAs, LTC CSS service providers, and service provider associations across the province.
- Identification of the factors, indicators, and analytics which should be considered in funding model development for community-based programs.
- Recommended funding models for community-based programs in alignment with the Department's long term vision, reflecting the level of care provided and with appropriate differential rates to meet population needs, including:
  - Provincial Home Support Program (PHSP);
  - Bookkeepers for Self-Managed Care (SMC) PHSP clients;
  - Personal Care Homes (PCHs);
  - Live-In and Live-Out Supervisors;
  - Management Fees for Residential Arrangements for Complex Clients;
  - Residential Respite provided by Alternate Family Care (AFC) Homes; and,
  - Supplemental Benefits.

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- Funding model recommendations for new programs and service offerings delivered through third-party service providers including;
  - Residential End of Life Hospice Care;
  - Adult Day Programming; and,
  - Non-Traditional Types of Care in PCHs (including: residential respite, residential rehabilitation, and dementia care).
- An implementation plan for introducing funding models including analysis of the anticipated impacts, expected service provider reactions, and, a change management plan to address anticipated barriers to change.

Current Services Inventory

Third-party service providers deliver the following LTC CSS programs and services:

- The Provincial Home Support Program (PHSP) provides in-home personal care, homemaking, and, respite services to approximately 8,400 seniors and persons living with disabilities totaling $214M in annual program expenditures for FY2017/18. Eligible services within the PHSP are provided by 33 agency providers or under Self-Managed Care (SMC) arrangements (including paid family caregivers) and are reimbursed on a per hour basis. The current funding model for agency care is based upon on the direct costs of Home Support Workers (HSWs) with a 2.9% allowance for administrative expenses. Funding for SMC is based upon the provincial minimum wage, and those clients may avail of separately funded bookkeeping services to assist in managing administration.
  - There are over 80 bookkeeping service providers who support SMC clients. Bookkeepers are paid a bi-weekly amount scaled to the number of HSWs engaged in the provision of care services.
  - Clients with complex care and support needs within the PHSP may also avail of Live-in or Live-out Supervisors who assist with the coordination of services. Live-Out Supervisors are funded on a per hour basis and Live-In Supervisors receive an annualized salary that is commensurate to experience and are reimbursed for 50% of the expenses associated with living with the client (e.g., rent, utilities). There are approximately 80 clients being cared for by Live-in and Live-out supervisors amounting to annual program expenditures of $6.2M.
- Personal Care Homes (PCHs) are a residential care option for seniors and adults with disabilities with needs, per the existing clinical assessment framework, categorized as Level I, II, II Enhanced Care or III (awaiting placement in LTC). There are 84 PCHs operating in the province, varying in size from 5 to 100 beds, which provided $42M of subsidized care to approximately 2,700 clients in FY2017/18. PCHs are funded in a per diem basis for board and lodging with differential rates for clients with Enhanced Care or Level III needs. PCHs are also eligible for reimbursement for medical and family travel, the associated wait and escort time, as well in some cases, subsidies to support small or isolated homes.

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- Residential Arrangements for Complex Clients are currently established when no other service option is available or appropriate for an adult with an intellectual disability. Historically, Individualized Living Arrangements (ILA) were chosen as a planned arrangement; however, the popularity of this type of arrangement has decreased since it's introduction in the 1990's. There are currently 133 clients living in ILAs and Shared Living Arrangements (SLA). Funding for residential arrangements for Complex Clients is individualized based on specific client needs, service plan parameters, and the monthly costs of service provision. Total program expenditures for ILAs and SLAs were $2.9M for FY2017/18 (excluding direct home support hours) and are significant on a per-client basis compared to other LTC CSS programs. Management Fees for Residential Arrangements for Complex Clients are paid to providers of clients in ILAs and SLAs – these fees represented 18% ($531,190) of program expenditures for FY2017/18.

- Residential Respite is the provision of substitute caregiving, offered to caregivers of adults with disabilities currently accessing home support or other benefits from LTC CSS. Separate funding rates are in place for weekend respite, extended weekends, weekday overnight, and vacation respite. AFC providers are entitled to 54 days per year of respite care. AFC homes provided 13,731 respite days totaling $1.1M in program expenditures in FY2017/18.

- The Province also funds a range of supplemental benefits to clients availing of LTC CSS programs including home therapy support, behavioural aides, behavioral management specialists, foot care, bloodwork, and, supplementary benefits.

Literature Review & Jurisdictional Scan

Review of relevant literature identified the range of policy options within which to categorize current funding methods for LTC CSS programs and services and to frame future model development. While relevant literature lacks a standardized and industry accepted taxonomy of funding approaches in the health sector, the research identified the following discrete reimbursement methodologies that may be customized or combined to fund health programs and services:

- Historical: Lump sum payments based on historically agreed upon amounts.
- Per Diem: Payments based on the days of services provided where the scope and volume of services delivered per day are pre-defined.
- Activity-Based Funding (ABF): Payments based on the volume of services delivered with no differentiation for case or client complexity.
- Complexity Adjusted ABF: Payments based on the volume of services delivered, with funding rates adjusted for client complexity and caseload composition;
- Capitation: Payments made to a provider to meet client needs for a defined period based on the probability of client accessing health services;
- Bundled Payments: Payments that are shared among multiple providers to provide a pre-defined bundle of services to a client; and,
- Pay-for-Performance (P4P): Payment/Penalty is applied based on provider's performance on pre-defined metrics.

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Innovative practices in funding service providers have historically tended to originate in acute care and primary care settings. Many jurisdictions have struggled to implement or are in the process of implementing progressively more innovative funding models into continuing and LTC settings.

In NL, historical payments are used for several of the supplemental benefits and for small home subsidies paid to PCHs. Per Diems are the dominant reimbursement methodology used for residential-based care options such as LTC facilities and PCHs in NL and other jurisdictions. Activity-Based Funding is the primary reimbursement methodology used in programs where the driver of volume is hours of care (e.g., agency and self-managed home supports, and live-out supervisors in NL). Examples of capitation include fixed bookkeeper fees and salaries paid to Live-in supervisors. Applications of bundled payments and P4P schemes are limited in the continuing care and community services sector. Examples of P4P schemes identified in literature include: the Quality and Outcomes Framework in the UK, the former Quality Incentives Funding program in Alberta, and various individualized performance-based contracts.

A review of healthcare funding models used in acute, primary, and continuing care in other countries revealed that complexity adjusted ABF is utilized more frequently in international jurisdictions compared to Canadian jurisdictions. P4P is also more widely adopted outside of Canada. However, there are limited long standing implementations and subsequent assessments of outcomes for complexity adjusted ABF, capitation, bundled payments, and P4P schemes in long-term or continuing care settings.

Review of relevant programs in comparator jurisdictions also identified other areas of interest for the Department, including individualized funding programs and competitively-bid contracts for service providers. The following factors are not classified as reimbursement methodologies according to the taxonomy described previously, but rather as rate-setting mechanisms for providers.

- In many provinces, individualized funding was simply the equivalent of SMC home support with funding allocated based on prescribed hours of care as per clinical care plans. For the purpose of this report, individualized funding is defined as a historical, lump sum payment which can be freely allocated to any services, equipment, and supplies desired by the client or administrator. The Personal Allowance available to LTC CSS clients is an example of individualized funding according to this definition.
- Additionally, the competitive bidding process used by service providers to secure a contract with the government will not be considered as a reimbursement methodology per se, but rather a market-determined rate setting mechanism.

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Stakeholder Insights

Consultations were held with key stakeholders on current funding models, cost pressures, and to obtain insights and feedback on potential funding approaches in future.

- Providers generally want to do the right thing by their clients and provide quality care. All parties consulted believe providers should be fairly compensated for the work they do.
- An online survey of service provider revealed that 63% of respondents are dissatisfied with current funding rates for LTC CSS services; 47% of home support agencies are dissatisfied with funding rates compared to 88% of personal care home respondents.
- Direct consultations with the RHAs, service providers, and service provider associations revealed that in general, funding rates are not always reflective of levels of client complexity, funding issues are often entangled with issues associated with operating and staffing for providers, and both service providers and RHAs believe that a higher level of oversight and accountability would resolve some system-wide challenges.
- There is a high level of dissatisfaction across providers, particularly in the personal care home and home support provider communities, that will need to be addressed by the Department when implementing the proposed Levels of Care framework, and with the final funding formulas. Careful consideration will need to be given to change management, the level of business acumen within the provider community, and managing expectations for those providers who do not operate at maximum efficiency today and may struggle to operate at even higher levels of quality and effectiveness.
- P4P may be challenging to implement and to obtain provider support.

Key Factors for Funding Model Development

Outlined below are the three key rate components that can be built into a funding model. How the rate components are combined in the model is dependent on a program's attributes as well as the attributes of its service providers.

- Base funding is associated with meeting assessed client needs according to defined levels of care, as well as provincial operational and service-level expectations.
- Differential funding is associated with addressing exceptional requirements that vary significantly from typical levels of care and service delivery expectations (e.g., regional service delivery).
- Incentive funding is associated with exceeding performance indicators, innovating service delivery, and, improving client and system-wide outcomes beyond service-level expectations.

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Particular program attributes and characteristics may make certain rate components applicable to different programs. Likewise, service and provider attributes also determine the appropriateness of a reimbursement methodology for the program's funding model. Key factors that influence the selection of reimbursement methodologies for in-scope programs are presented below and were used to determine the funding model and rate recommendations.

The key attributes to determine the appropriate methodology for **base funding** include: the need and burden of program oversight, the maturity of client needs assessment and care planning, complexity of client needs, variability of service volume, risk sharing and transfer, co-delivery between service providers, scope of service, and clinical authority.

- The key determinant for **differential funding** is a population need that varies significantly from the typical levels of care and service delivery expectations; the intent of differential funding is not to compensate for system or service provider inefficiency.
- The key attributes to determine the appropriateness of **incentive funding** (i.e., pay-for-performance) include: criticality to clinical outcomes, maturity of program performance management framework, funding adequacy, and service provider maturity.

Funding Model Recommendations

A key decision made by the Steering Committee early in the review was to develop a set of guiding principles for development of new funding models for community-based care. These guiding principles leveraged Deloitte's research into leading practices from other jurisdictions, and reflect the Department's long-term vision, including its desire to recognize and incentivize desirable provider behaviour and service quality, and to gain effectiveness and efficiency in its administration of service provision.

In practice, these principles allowed the Steering Committee to avoid unnecessary 'customization' of individual program areas and for specific client needs. In many cases, aggregate client data demonstrated that a significant proportion of the sector's client base would benefit from a service, even if they are not in receipt of it today. A key example of this were the services included in the base rates for PCHs, such as general mobility equipment, footcare and supplies which have historically been funded on an individual client basis, however analysis shows that these items are required by at least 80% of PCH clients.

Guiding Principles:

The Steering Committee identified the following principles to guide funding model development:

1. Funding models need to be **objective** in how funding is allocated.
2. Funding methodologies need to be **structured, consistent** and **defensible**.
3. Funding models need to reflect the **needs** of the **client** and **populations.**
4. Models must provide the **base funding** required to **maintain** the **provision of services.**
5. Where possible, funding models should be **streamlined** and **simplified**.
6. Where appropriate, funding models should reflect **provider performance** and client outcomes.

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Similarly, the guiding principles permitted the development of differential rates for population health factors and challenging client circumstances (e.g., dementia care) which may require a provider to increase service levels beyond what could reasonably be expected based on the needs of the general population. Deloitte's assumptions and recommended inclusions for each base rate are itemized within the body of this report.

Other key design decisions made by the Steering Committee include:

- To permit all current providers the opportunity to continue providing care and avoid disadvantaging existing providers for reasons of location or size, while supporting the Department's expectations to improve care to the community;
- To stage implementation in alignment with other policy renewal efforts currently being implemented by HCS;
- To ensure fairness and equity across all providers in a given program area by confirming a standard implementation approach for all programs; and,
- To leverage the Department's recent engagement of the home support sector by introducing the new funding model into this sector, before initiating change management efforts in other sectors.

These, along with other key design decisions described in later sections of this document, were developed in coordination with the Steering Committee and used to form the basis of Deloitte's funding model recommendations.

The analysis completed for this work suggests that within existing funding mechanisms, and going forward, some degree of change is required. Some of the rate calculations go beyond incremental increases; instead, they are aligned with the preferred long-term vision of HCS and the desire for greater provider accountability and quality of service. For that reason, some significant changes are proposed that reflect increased expectations of providers for the quality of service and inclusions of ancillary services and equipment in base rates.

Provincial Home Support Program

The recommended funding model for home support agencies is a complexity adjusted activity-based approach that directly ties funding rates to the Province's proposed LoC framework. Under this proposed model, agency service providers will receive funding based on average monthly caseloads, to meet clients' holistic support needs per level of care (e.g., $864 per month for low complexity Level B – Low to Moderate clients and $11,931 for clients with complex needs). If implemented, this would be a change from an unsophisticated per hour reimbursement rate to a funding model that is intended to improve client centricity, incentivize service-providers to meet clients' holistic needs, to improve funding alignment to the complexity of support needs, and, to streamline and simplify the reimbursement process substantially. Funding for agency-based providers will be expected to increase to reflect changes in the PHSP operational standards, a wider scope of services, and, increased service-provider responsibility and autonomy.

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Additionally, given the implementation of home support agency service-level agreements (SLAs) and the Province's commitment to quality improvement through accreditation and the implementation of new technology enablers, agency funding will also feature a P4P framework. Following stabilization of SLAs and the supporting performance management processes, home support agencies will be able to attain incentive payments of up to 10% of their annual PHSP subsidies. The proposed P4P framework is intended to provide direct financial incentives for agencies to exceed the Province's service-level expectations and to deliver measurable client outcomes.

While it is recommended that the PHSP transitions to a complexity-adjusted activity based funding approach, this changes could take a number of years to implement. Deloitte recommends an 'interim' funding model during this implementation period which reflects the additional costs associated with the SLAs and Operational standards based on the hourly activity based funding (ABF) model currently in place.

The SMC service delivery option within the PHSP is designed to empower clients to manage their own care needs to meet population needs that cannot be feasibly met by agency-based providers. SMC is more prevalent in rural communities that lack the scale for a home support agency. As such, no differential rates have been developed for the PHSP. Funding for SMC clients will continue to be proportional to the clinically assessed hours of support needs per individual client. However, to better reflect the nature of supports provided to SMC clients, separate rates for Personal Care and Homemaking services are recommended and will be consistent with prevailing labor market rates for those competencies.

It is recommended that Bookkeepers of SMC clients will continue to be funded per client they support. In this model, funding rates will continue to scale proportionally to the number of employed HSWs but are expected to increase to reflect better the responsibilities bookkeepers assume on behalf of SMC clients.

Personal Care Homes

While it is recommended that PCHs will continue to be funded on a per diem basis for each publicly subsidized client in residence, future reimbursement rates will be subject to significant change to align to the Province's proposed Levels of Care framework and the renewal of operational standards. Base funding for PCH will include direct care and program costs consistent with client support needs and expected staffing ratios, indirect staffing support costs, dietetic services, facilities and administrative expenses, and, array of other services that are currently reimbursed separately (i.e., medical travel, foot care, safety and accessibility equipment, and, medical supplies). The bundling of these ancillary services based on expected utilization rates is intended to incentivize service provider cost management and to simplify the reimbursement process. The design of the future PCH funding model seeks to improve the alignment of funding to client care needs, improve client centricity, and, incentivize the acceptance of complex referrals. The model's design also reflects the Department's vision of expanding the types of services offered by PCHs, In order to meet the changing needs of clients and fill gaps in service delivery within community settings.

The nature of these changes makes it difficult to compare current and recommended PCH per diem rates directly. However, in general, recommended funding for current Level I residents in PCHs will be slightly reduced while funding rates for Level II and Enhanced Care residents will be increased to reflect the complexity of care needs and expected staffing levels.

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The Department currently provides differential funding to small and isolated PCHs to help maintain the availability of services, particularly in rural areas of the province. Current funding mechanisms lack standardization from a policy standpoint and do not necessarily reflect demonstrated population need. In the future, the Small and Isolated Home Grants could be replaced with temporary funding supports that are directly tied to capacity, vacancy, and, performance criteria. Furthermore, our recommendations include continuing to provide differential funding for Level III residents awaiting LTC placement. Additional funding should also be introduced to supplement the staffing costs tied to the enhanced supervision required during Adult Protection Act (APA) investigations.

Consistent with the Department's objective to improve access to community-based services, incremental per diem funding is also recommended for clients availing of expanded PCH services, including adult day programming and short-term rehabilitation services. Furthermore, the Department and RHAs also seek to enhance supports for residential dementia care, hospice, and, palliative care services delivered within PCHs or in standalone facilities (e.g., dementia care, hospice). However, policies and programming for those services are not yet sufficiently defined to establish appropriate reimbursement rates.

At this stage, it is not recommended that the Province pursue a P4P incentive framework for PCHs, but may do so in the future with the maturation of operational standards and the development and implementation of SLAs.

Supplemental Benefits

As part of the funding models project, Deloitte reviewed the reimbursement rates supplemental benefits provided as financial assistance to clients of LTC CSS. In particular, supplemental benefits include top-ups provided in addition to funding from the Department of Advanced Education, Skills and Labour (AESL) for mortgage, rent, fuel, utility, electricity, and telecommunications services for clients residing in an independent living unit. All Board & Lodging Benefits were not considered in this review.

Currently, all supplemental benefits are paid as actuals but Deloitte was asked to analyze historical rates for regional differences and compare to market rates for similar services. After reviewing the rates, we propose the following recommendations for consideration:

- A cap for rent top-ups based on regional market rates should be implemented to control costs for clients in regions where there is sufficient availability of appropriate rental options. Clients in regions with limited rental options or exceptional residential requirements should be continue to be funded on an individualized basis, as determined in conjunction by the Department and RHAs.
- Given the low volume of clients receiving mortgage top-ups, we recommend continuing to fund these benefits on an individualized basis.

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- Based on regional differences and utilization levels, Deloitte recommend the Province consider combining the Fuel/Electricity and Fuel Top-Up benefits and setting a soft-limit across the province. Based on the inconsistency in the distribution of home energy benefits (in particular, noting that Central Health does not currently pay fuel top-ups), we recommend the Department align the policy for home energy top-ups across the RHAs before setting a cap rate.
- Due to very low utilization, telecommunication services should continue to be funded on an individualized basis.

These changes to Supplemental Benefits are intended to simplify and streamline payments, improve the robustness of rates, and, to strengthen the fair and consistent application of eligibility criteria across the province.

Residential Care (non-PCH)

While the PHSP and PCH Program represent the majority of LTC CSS programming from an expenditure and caseload volume standpoint, residential care options such as ILAs, SLAs, AFC, and Live-In Supervisors play an important role in supporting clients with complex needs. The development of detailed funding models and rate schedules for the PHSP and PCHs demonstrates a significant dependency on a well-defined scope of services and supporting operating standards. However, the policies and programming that are central to these residential care arrangements will be subject to a comprehensive review by the Department and RHAs in the near-term. As such, the Steering Committee opted to defer detailed funding model development for these programs and services until the completion of the wider program review and advancement of policy. When appropriate, funding models for non-PCH residential care options should ideally be developed consistent with the guiding principles, stakeholder input, and, analysis methods applied within this report.

Implementation Plan

A key underlying issue with impact on the implementation of Deloitte's recommendations is that HCS is currently developing a new Levels of Care framework. Additionally, there are concurrent analytical activities underway which may inform the finalization of HCS' policy decisions. These activities are in progress at time of writing this report, and have not been completed. However, sufficient work has been done by the Department to date which have allowed for high-level implementation planning.

In general, introduction of any new government policy including new funding formulas must be executed carefully with appropriate consideration of the potential impact on current and future clients, service providers, and the population at large. It must also be done in consideration of the broader social, political and economic context within which the policy framework has been developed.

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Deloitte recommends a staged implementation strategy which recognizes the Department's wider strategic goals and a reasonable timeline for execution. Our recommended strategy reflects that there is already considerable work being done in the Home Support sector to engage and support community-based providers. As the Department and RHAs introduces the new Levels of Care framework, links between service levels and client complexity will become clearer. As Government implements Service Level Agreements for home support agencies that will require agencies to achieve certain service standards including responsiveness, greater client choice will be enabled (e.g., self-managed care) particularly in rural and remote communities where gaps in service availability and service quality have been observed. For these reasons, Deloitte proposes that:

1. Implementation of new funding formulas for community-based care should be paced with initiatives taking place in the Home Support sector.

2. Implementation of new funding formulas for community-based care (outside of the Home Support sector) should be executed on a timeline acceptable to the Department, in keeping with existing initiatives that are currently in development (e.g., analysis of residential care options, proposed Levels of Care for Personal Care Homes, population-based needs assessment for Personal Care Homes sector).

3. That the Department and RHAs consider adopting an 'interim re-assessment date' for implementation of the recommended funding models for Personal Care Homes, such that all residents of each PCH are re-assessed in a short period of time. While it may present a challenge to select the order in which PCHs would be re-assessed, it would allow each PCH operator to be moved off the existing funding model and onto the new funding model, and avoid the need for both RHA and individual PCHs to run both sets of client accounting processes for a longer period of time

The implementation of any new government program including funding models should be done carefully, ensuring that communication with service providers and the broader community is clear. The large number of new initiatives underway presents the risk of change saturation, necessitating the careful application of change management. As such, it is important that expectations are well-understood, and that channels are established to provide effective two-way feedback to allow for continuous improvement and avoidance of unintended consequences. For those reasons, it is also recommended that:

1. Industry/sector specific operator associations are engaged in discussion on the impact and opportunities presented by adoption of the new funding models. We believe there is a significant opportunity for industry associations to provide important support and value to their members in ways such as improved purchasing power, general business advice/assistance, quality improvement, or procurement/contracting support for members. It would also be helpful if associations were appropriately supportive of long-term quality improvement measures (e.g., accreditation processes) given that the Department is moving in this direction today.

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2. Further analysis is undertaken by the Department and RHAs with regard to internal resource capacity, administrative and financial process improvement. It is expected that administrative and financial resource capacity within the RHAs will be significantly increased over time, provided efforts are focused on how to simplify, streamline and improve the RHA's own processes for administration of bundled billing for providers.

3. Consideration be given to engaging external public relations and communications support, including the launch of a provincial public awareness campaign focused on how program changes may (or may not) impact clients, and also educate clients & families about increasing service expectations of their service providers. Such a campaign would typically leverage multiple channels of communication, including but not limited to newspapers, television, radio, online media). This type of communications vehicle would allow HCS/RHAs to convey the right messages quickly and broadly to ensure that existing clients, families and other community-based stakeholders fully appreciate the service improvements that are expected, and allow the Department to manage any concerns arising from these stakeholders.

4. Formal program management, project management, and change management support are engaged by the Department to assist internal resources in planning, supporting and reinforcing the implementation of new funding models, and other concurrently running programs that may create change anxieties across all stakeholders (e.g., RHAs, providers, clients). There is much good work underway by the Department/RHAs. Many of the changes to policy and program are being welcomed by service providers. Some may be met with hesitation or fears. Both perspectives should be expected and should be considered useful as HCS/RHAs move forward in their combined efforts to undertake policy reform. However, it should also be considered that the likelihood of success will increase significantly if formal change support is engaged by the Department and RHAs.

In particular, the value of a formal change management framework cannot be understated. Such a model will assist HCS to support RHA program staff, providers and other stakeholders as they move along the continuum of change from 'Awareness' through to 'Action'. While there are numerous change management approaches, the Prosci ADKAR model is well-known and generally an effective way of structuring a change program. HCS is encouraged to leverage any change management approach that it may be familiar with or have staff with technical change expertise.

It is also important to assist the Department and RHAs in planning and managing the transition between old and new funding models (e.g., assistance with administrative process change, tightly managing scope creep, implementation costs, ensuring benefits are measured).

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Concluding Remarks

The analyses and recommendations laid out in this report set forward an ambitious long-term vision for the future ways of funding third-party providers of LTC and CSS services. This vision seeks to more closely align service provider funding with the needs of clients and populations in a manner consistent with concurrent changes to policies and programming. Implementation of the new funding models for LTC and CSS services will not be easy or quick, but will be necessary for both the Province and service providers to strengthen community-based services and to build the capacity required by the citizens of Newfoundland and Labrador.

Introduction

Background Context

In November 2018, Deloitte was engaged by the Department to review and develop funding models to guide reimbursement rates to third-party service providers for services offered under Long Term Care and Community Support Services (LTC CSS). The development of the funding models encompassed all the programs within LTC CSS which utilize third party service providers, including home support services, personal care homes and various other programs.

Third-party service providers play an important role in the provision of Long Term Care and Community Support Services (LTC CSS) within Newfoundland and Labrador, accounting for approximately 50% of the expenditures within the system.

While factors such as consumer price index increases, wages/rates for privately provided services, minimum wage rates and operating margins are all currently considered by the Government when setting rates for third party providers, there is no rigorous methodology or structured funding model in place.

The development of funding models aligns with the Department's efforts to implement improvements in service delivery within the LTC CSS system, which includes a focus on quality of care and clinical outcomes. This involves the development of a new levels of care framework, which will result in more clearly defined care levels. These improvements are part of the goals and priorities outlined in the strategic plan of the Department such as:

- Increased access to community-based home support and care services;
- Increased use of personal care homes for respite and restorative care;
- Improved patient/client satisfaction with community-based services; and,
- Achieving more efficient health care spending through modernizing and streamlining the delivery of services.

'It is anticipated the number of individuals (in NL) over age 65 will increase to 30 per cent, making the need for effective community supports even more urgent'

- HCS Strategic Plan, 2017-2020

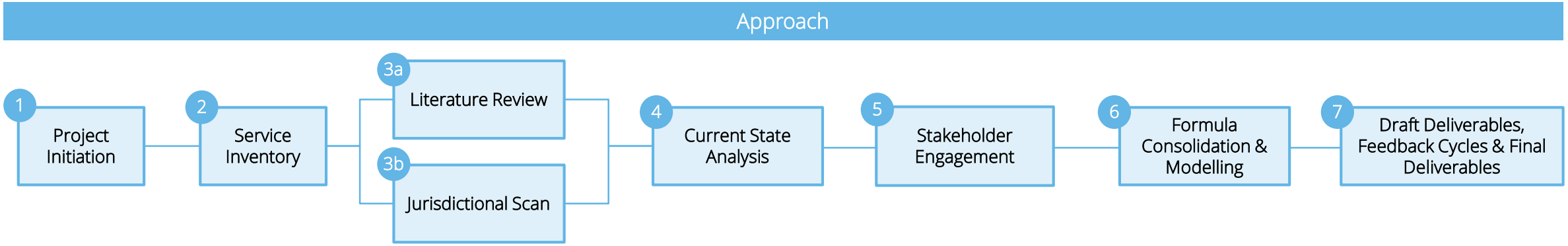
Background Context

A structured and consistent funding model with traceability to the levels of care framework that is being developed concurrently is a key enabler for the Department's goal of achieving a higher quality of care and better value in the healthcare system through supports within the community. With the oldest median age in the country, the complexity of Newfoundland and Labrador's LTC CSS client population is rising; as such, the quality of care delivered by service providers also needs to be elevated. The potential implementation of incentive payments for provider performance and client outcomes was a key consideration within this engagement.

The development of funding models aimed to create models of reimbursement which reflect the varying and increasing complexity of clients within LTC CSS and provide HCS with a solid foundation for continued improvements in service delivery.

In completing the review, key elements of the approach included:

- The development of guiding principles which informed the philosophy and design principles of the funding models.
- An inventory of LTC CSS programs which utilize third-party service providers.
- Research into leading practices, reimbursement methodologies, and funding models in other jurisdictions. This research included a review of publicly available research, literature, policies as well as consultations with jurisdictional contacts and subject matter advisors.
- Engagement with LTC CSS service providers and service provider associations across NL through both direct consultations and an online survey.
- The development of quantitative models used to generate rates for in-scope programs; including initial projections on the cost to HCS.
- Analysis of findings and development of rate recommendations supported by implementation considerations.



Scope & Governance

Deloitte's funding model development encompassed all LTC CSS programs contracting third-party providers; oversight for the engagement was provided by a Steering Committee.

Project Scope

Within the scope of this project were all LTC CSS programs that currently contract third-party providers to deliver services. This included:

- Provincial Home Support Program (PHSP);
- Bookkeepers;
- Live-In and Live-Out Supervisors;
- Personal Care Homes (PCHs);
- Management Fees for Residential Arrangements for Complex Clients;
- Residential Respite provided by AFC Homes; and,
- Supplemental Benefits.

HCS is also exploring the introduction of new program and service offerings through third-party service providers, this includes:

- Residential End of Life Hospice Care;
- Adult Day Programming; and,
- Non-Traditional Types of Care in PCHs (including: residential respite, residential rehabilitation, and dementia care).

Steering Committee Oversight

Throughout this engagement, a Steering Committee comprised of representatives from the Department and the Regional Health Authorities (RHAs) provided guidance, oversight, and feedback. The members of the Steering Committee and their roles are listed below:

Name	Department/RHA	Role
Annette Bridgeman	Health and Community Services	Director, Regional Services
Deena Waddleton	Health and Community Services	Manager of Community Health Planning, Regional Services
Pam Barnes	Health and Community Services	Health Consultant, Regional Services
Paul Greene	Health and Community Services	Departmental Controller, Financial Services
Janice Dalton	Eastern Health	Regional Director, Community Support Program
Melvin Layden	Eastern Health	Regional Director, Long Term Care
Joanne Halfyard	Eastern Health	Regional Manager, Community Support/Personal Care Home Programs
Keith Parsons	Central Health	Regional Director, Community Support Services
Tammy Priddle	Western Health	Regional Director, Community Support Services
Greg White	Western Health	Client Financial Services Manager
Beverly Woodward	Labrador-Grenfell Health	Regional Manager for Community Supports, SAP and Rehab Services

Current Services Inventory

Overview of LTC CSS Programs and Services

Long-term Care and Community Support Services (LTC CSS) are delivered to seniors, and adults and children with disabilities by the four Regional Health Authorities (RHAs) and a multitude of third-party service providers.

LTC CSS programs and services are delivered to over 20,000 seniors, and adults and children with disabilities by the four RHAs and many third-party service providers. Approximately 50% of LTC CSS expenditures are incurred by the RHAs to deliver long-term care, with the majority of the remainder allocated to third-party service providers.

$700M is spent annually on LTC & CSS services in NL
- RHAs provides LTC to approximately 2,900 residents;
- 50% of program expenditures are allocated to third-party service providers for the PHSP, PCH, and other LTC CSS programs and services.

Program Statistics for FY2018:

Provincial Home Support Program (PHSP)

- $214M in annual program expenditures
- 8,359 seniors and persons with disabilities
  - 3,459 of those clients self-manage care

Personal Care Homes (PCH)

- $41.9M in annual program expenditures
- 3,337 residents at September 30, 2018

Other Programs[1]

- Expenditures for Special Child Welfare Allowance were $4.6M for 260 clients
- Expenditures were $2.9M for 133 Individualized and Shared Living Arrangement clients; Management fees paid to these providers were $531,190 in 2018
- Expenditures for Live-in and Live-out supervisors was $6.2M for approximately 80 clients
- AFC Homes provided 13,731 respite days/nights and amounted to $1.1M in total program expenditures

[1]Some of these other program expenditures may also be included within the PHSP expenditures

Overview of LTC CSS Programs and Services

Below are the current LTC CSS programs that are offered by third-party providers. The services under these programs are currently compensated using varying reimbursement methodologies.

Program	Service	Reimbursement Methodology
Personal Care Home Program	Board & Lodging	**Per Diem:** Payment is fixed at a daily cost; scope of services (lodging, number of meals, etc.) provided is fixed.
	Personal care	**Per Diem:** Payment is fixed for a pre-defined volume of personal care hours according the PCH Operating Standards.
	Transportation	**Activity-Based Funding:** Payment is variable and scales based on the number of kilometers travelled and the waiting time.
	Other Care Services	**Activity-Based Funding:** Payment is fixed for the provision of one specific service.
	Short-term Respite	**Per Diem:** Payment is fixed at a daily cost; scope of services (lodging, number of meals, etc.) provided is fixed.
Home Support Program	Home Support Worker (Agency)	**Activity-Based Funding:** Payment is variable and scales to the volume of services required (e.g., hours of care accessed).
	Home Support Worker (Self-managed)	
	Bookkeeping Services	**Capitation:** Payment is fixed, while the number of hours of bookkeeping (within bi-weekly period) is variable.
	Live-in Supervisors	**Capitation:** Payment is fixed but the services that a Live-in supervisors may vary week on week based on the needs of the client.
	Live-out Supervisor	**Activity-Based Funding:** Payment is variable and scales to the volume of services required (e.g., hours of care accessed).
Residential Respite Program	Regular Weekend Respite (2 nights)	**Per Diem:** Payment is fixed for a certain number of days, some of the services within respite (e.g., board, lodging) are fixed in volume, while some services (e.g., care hours, day shifts) can be variable. Services with a fixed volume are per diem, while services with a variable component are capitated.
	Extended Weekend (3 nights)	
	Daily Overnight (up to 2 nights)	
	Vacation Respite	

Overview of LTC CSS Programs and Services

Below are the current LTC CSS programs that are offered by third-party providers. The services under these programs are currently compensated using varying reimbursement methodologies.

Program	Service	Reimbursement Methodology
Management Fees for Complex Residential Arrangements	Individualized and Shared Living Arrangements	**Various:** Contracts are individualized. In most cases, providers submit a proposal based on the provider's fee schedule and contract terms. In some cases, providers have a block funding agreement with the RHA for an ILA or SLA with up to 3 clients.
Community Behavioral Services	Behavioural Aide	**Activity-Based Funding:** Payment is variable and scales to the volume of services required (e.g., hours of care accessed).
Autism Services	Home Therapist	**Activity-Based Funding:** Payment is variable and scales to the volume of services required (e.g., hours of care accessed).
Foot-care Program	Foot-care services	**Activity-Based Funding:** Payment is variable and scales to the volume of services required (e.g., number of Foot-care Services).
Supplemental Benefits	Top-ups for Board and Lodging, Rent/Mortgage, and Fuel/Utility	**Historical, Per Diem, and Activity-Based Funding:** Payment is based on historical lump-sum amounts (e.g., B&L Top-up) or payment is variable and scales to the volume of services required, generally according to actuals (e.g., fuel/utility, rent/mortgage).
Special Child Welfare Allowance	Various	**Various:** Contracts are individualized and paid directly to the parents or guardians of the child.

New Program Initiatives

These programs are not currently offered in NL by third-party service providers.

Program	Service	Reimbursement Methodology
New Program Initiatives	Adult Day Programs	**TBD:** Adult Day Programs are not currently offered by third-party providers in NL.
	Restorative Rehabilitation	**TBD:** Restorative Rehabilitation Services are not currently offered by third-party providers in NL.
	Residential Hospice and Palliative Care	**TBD:** Residential Hospice and Palliative Care Services are not currently offered by third-party providers in NL.
PCH New Program Initiatives	Dementia Care Services	**TBD:** Dedicated Dementia Care Services are not currently offered in PCHs.

Current Services: Provincial Home Support Program

The PHSP is offered through third-party agencies and home support workers hired by self-managed clients. Agencies receive additional funding to compensate for deductions and administration expenses.

Home Support Program

Description:

Home support services enable seniors and adults with disabilities that require support with Activities of Daily Living (ADL) to remain independent and continue living in their own home or independent living unit. Home supports are not available to clients who currently reside in LTC, PCH, Community Care Home, or Assisted Living facility. Residents of Co-operative apartments are eligible for home support services; however, funding for those services is included in the annual grant paid to the Co-op Board.

Clients:

Clients are children, seniors and adults with disabilities who require support with Activities of Daily Living and/or Instrumental Activities of Daily Living. Care needs range from low to very complex clients with multiple disabilities. Hours of care are determined through a clinical assessment completed by social workers and Community Health Nurses (CHNS) employed by the RHA.

Providers:

Clients accessing home support services may choose between Home Support Agencies (where available) or Self-Managed Care when hiring support workers. Agencies are private operators which employ, coordinate and supervise workers; some of these Agencies are unionized. In a self-managed care arrangement, clients or family members are responsible to act as employer for independent care workers. Alternatively, clients can choose to apply for funding for a Paid Family Caregiver.

Services:

- Personal Care Services
  - Cleaning, hygiene services, positioning and transferring locations
- Homemaking Services
  - Housecleaning, laundry, meal prep, and feeding
- Respite Care
- Supports for Community Living
  - Emotional/physical supports
  - Personal development
  - Interpersonal relationships & Social inclusion
- Delegation of Nursing Function (medical care and medication administration)
- Transportation (Community Access Funding)

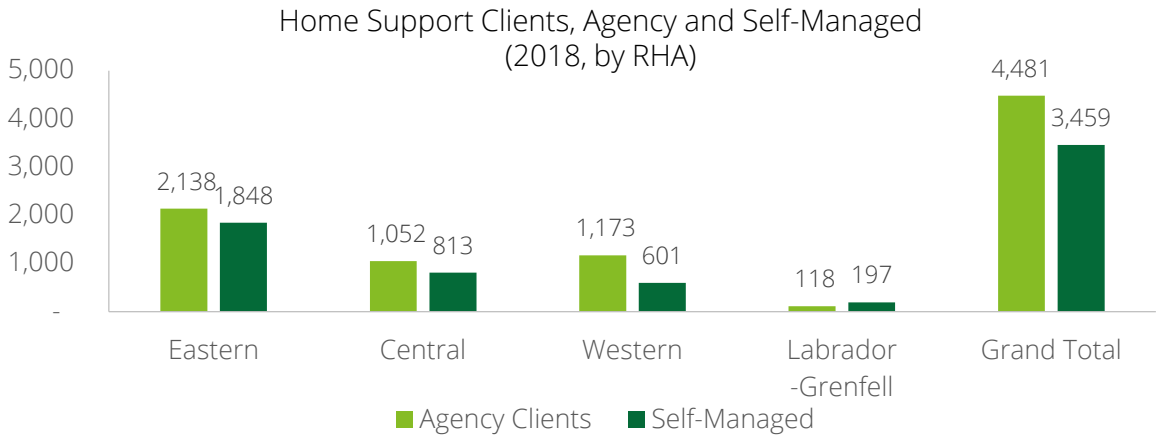
Below services are available to PHSP clients but are not funded through PHSP program

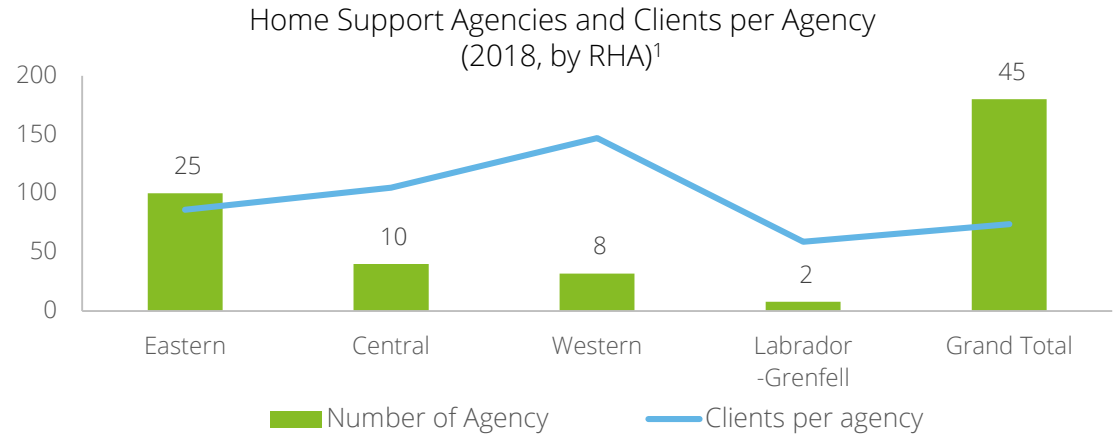
- Home Therapist (funded separately)
- Behavioral Aide (funded separately)
- Foot-care (funded separately)
- Bookkeeping services (funded separately)

	Service	Program Funding Rates	Monthly Ceiling	Reimbursement Methodology
Self Managed Care	Home Support Worker	$15.55/hour + deductions	Seniors: $3,650/month Disabilities: $5,220/month	Activity-Based Funding: Payment is variable and scales to the volume of services required (e.g., hours of care accessed)
Paid Family Caregiver	Family Home Support	$15.55/hour + deductions	Bookkeeping services are on top of the ceiling (included on following slide)	Activity-Based Funding: Same as above.
Agency	Home Support Worker + Administration	$23.43/hour + 0.67/hour		Activity-Based Funding: Same as above.

Current Services: Provincial Home Support Program

The PHSP primarily focused on subsidies for seniors and persons with disabilities with $214M (excluding Mental Health and Addictions) in annual program expenditures.





[1]Includes branches of the same agencies, there are 33 standalone agencies in the province

As of November 2018[2]:

- Home support agencies and self-managed workers provided home support services to 7,940 seniors and adults with disabilities across the province.
- 56% of clients receive care from a home support agency while the remaining 44% access care through self-managed care workers.
- 66% of agency clients received home support from an agency with greater than 166 subsidized clients.
- Small agencies (< 26 subsidized clients) provide care for only 9.4% of all subsidized agency clients.

Source: RHA Data (As of November 2018)

Program Expenditures	FY2018 Actuals	Percent of Total
Home Support Subsidies (Seniors)	90,941,786	42.4%
Home Support Subsidies (Adults w/Disabilities)	119,361,304	55.7%
Children w/Disabilities (SCWA)	2,736,307	1.3%
Home First	729,381	0.3%
Home Support Program – Acute	144,439	0.1%
Home Support Program – End of Life	423,246	0.2%
Total expenditures	**214,336,463**	**100.0%**

Source: GNL HCS Program Expenditures, 2018

[2]All numbers are exclusive of private pay clients

Current Services: Provincial Home Support Program

Self-managed clients may elect to hire a bookkeeper to provide payroll and administrative support.

Bookkeeping Services

Description:

Funding for bookkeepers is made available to subsidized clients who are self-managing their care needs. Bookkeepers support clients by helping them manage payroll activities for the workers employed by their clients.

Clients:

Clients are seniors and adults with disabilities who choose to manage their own care.

Providers:

Bookkeepers can be an organization or a self-employed individual. Currently, there are no qualifications or training standards required to be a bookkeeper for a client.

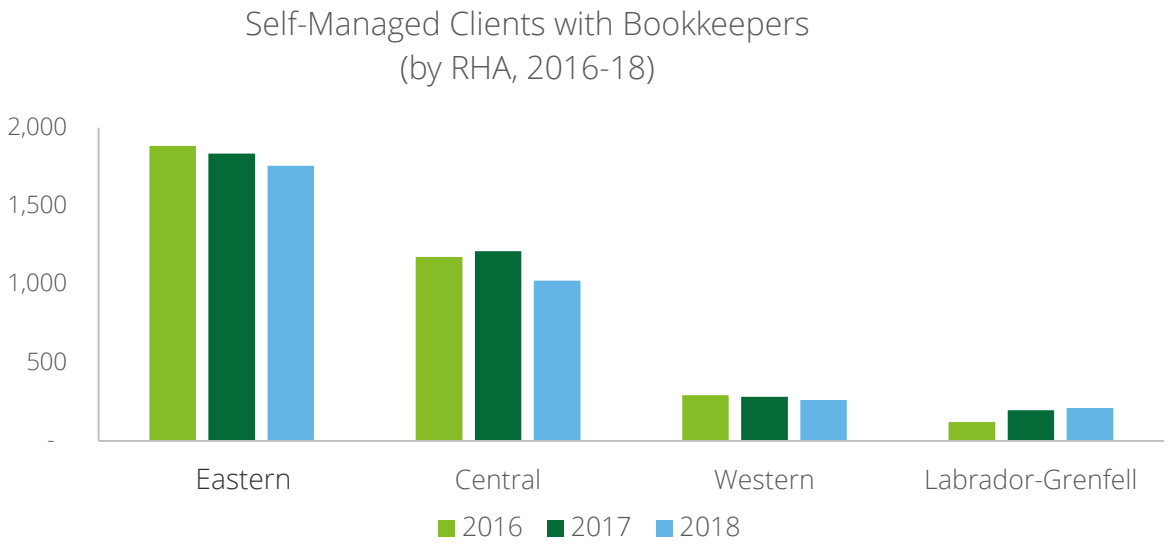
Services:

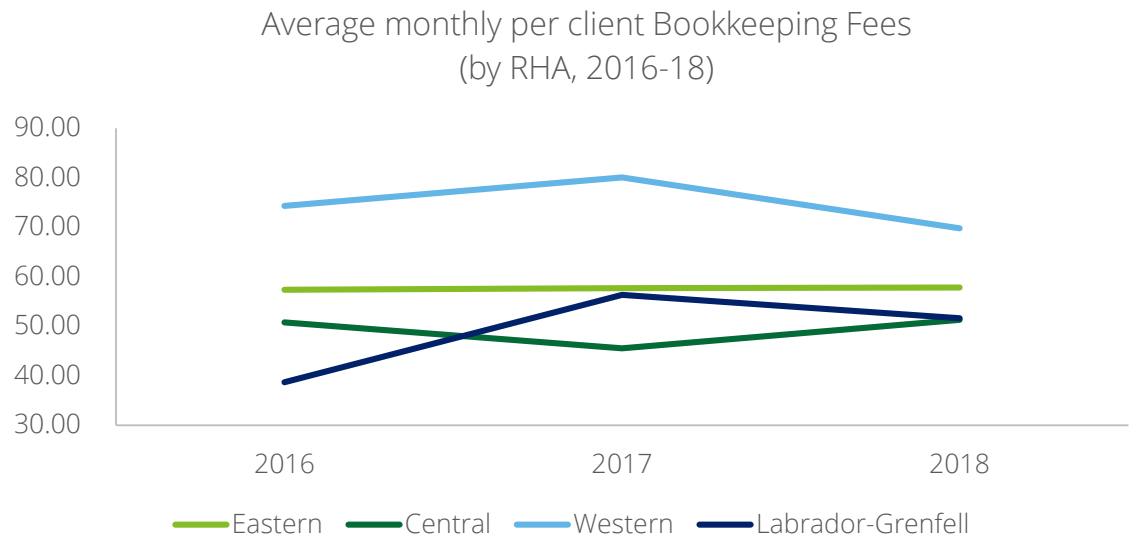
- Bookkeeping
  - Issuing employee pay cheques on a regular basis
  - Issuing T-4's and records of employment for employees
  - Maintaining payroll records, identifying gross earnings and mandatory deductions
  - Making monthly remittances to Canada Revenue Agency as per its requirements
  - Providing copies of monthly remittance verification to the above individual
  - Preparing financial reports as requested
  - Work with client to pay the co-pay

Service	Number of HS Workers	Monthly Ceiling	Reimbursement Methodology
Bookkeeping	1-2 Workers	$25.00 bi-weekly + HST	**Capitation:** Payment is fixed, while the number of hours of bookkeeping (within bi-weekly period) is variable.
	3 Workers	$30.00 bi-weekly + HST	**Capitation:** Same as above.
	4 Workers	$35.00 bi-weekly + HST	**Capitation:** Same as above.
	5+ Workers	$40.00 bi-weekly + HST	**Capitation:** Same as above.

Current Services: Provincial Home Support Program

Bookkeeping services are provided to approximately 94% of all self-managed clients.





Bookkeeping services are provided to roughly 3,250 self-managed clients across the province by over 80 professional bookkeepers; the number of non-professional bookkeepers is unknown. Annual program expenditures in 2018 totaled $2.2M, or $56/month per client.

Current Services: Provincial Home Support Program

Live-in and Live-out supervisors are compensated differently despite providing a similar level of support for seniors and adults with disabilities.

Live-in and Live-out Supervisors (part of Home Support Program)

Description:

A Live-in or Live-out Supervisor may be engaged to assist with home support coordination for clients; while also providing Home Support services.

Clients:

Clients are seniors and adults with disabilities who require support with Activities of Daily Living and/or Instrumental Activities of Daily Living. Clients generally have very complex care needs and may require more than one home support worker at any given time. Hours of care are determined through a clinical assessment completed by home support coordinators and clinicians employed by the RHA.

Providers:

Clients accessing home support services may choose to hire a Live-in or Live-out Supervisor to coordinate the scheduling and supervision of other care workers within the home. Live-in supervisors share a residence with the client.

Services:

- Board and Lodging (Shared Living Arrangement)
- Care coordination
  - Scheduling and supervising HS workers
- Administration
  - Paying bills and scheduling home maintenance
- Personal Care Services
- Homemaking Services
- Respite Care
- Supports for Community Living (Behavioural Aid)
- Delegation of Nursing Function (medical care and medicine administration)

Service	Program Funding Rates	Reimbursement Methodology
Live-In Supervisor	Salary Steps (proposed April 1, 2018) • **Salary Step 1:** $59,050 • **Salary Step 2:** $61,273 • **Salary Step 3:** $63,496 • Salary calculated based on estimated number of hours of service (96 hours per week) and minimum wage • Salary increases on a 3-step scale commensurate with years of experience • Rate is set by province **Live-in Supervisors share 50% of living expenses with the client (e.g., rent, utilities)**	**Capitation:** Payment is fixed but the services that a Live-in supervisors may vary week-on-week based on the needs of the client.
Live-Out Supervisor	**Self-Managed Rate + $1** $16.55/hour • Rate is set by RHAs	**Activity-Based Funding:** Payment is variable and scales to the volume of services required (e.g., hours of care accessed)

Current Services: Personal Care Homes

Personal Care Homes are compensated using a per diem rate to provide care for Level I, Level II, Enhanced Care, and Level III (Awaiting LTC) residents.

Personal Care Home Program

Description:

Personal Care Homes are residential settings providing care and accommodations for seniors and adults who require support with Activities of Daily Living (ADL).

Community Care Homes are a residential living arrangement for adults with mental health and addictions issues. Similar to personal care homes, residents require support with ADLs and IADLs. Community Care Homes only operate in Eastern Health and use the same reimbursement rates as PCHs.

Clients:

Clients are seniors and adults that have low care needs but require assistance with Activities of Daily Living. Resident needs are categorized as Level I, Level II, Enhanced Care, and Level III (awaiting LTC placement).

Providers:

Personal Care Homes are run primarily by private, for-profit organizations operated by large, corporate operators with up to 100 permanent beds, mid-range operators with 30-60 beds or small operators with a handful of residents. PCHs are licensed by the RHAs and are required to comply with regulations and operational standards.

Services:

- Board & Lodging
  - Rent
  - Housekeeping
  - Laundry
  - Various amenities (e.g., recreation, telephone, internet)
  - Food Service
- Travel (distance, wait time, escort)
- Respite Care
- Care Needs
  - Assistance with medication administration
  - Assistance with Activities of Daily Living
  - Assistance with personal care as outlined in care plan
  - Appropriate supervision consistent with needs of the Resident
- Social and Recreational Services

- Foot-care (service available to PCH residents but not funded through PCH program)
- Bloodwork (sub service provider)

Services	Program Funding Rates	Reimbursement Methodology
Board & Lodging	Board and Lodging (B&L) $2,375/month (Level I & II) $3,430/month (Enh. Care) $1,135/month (Supplemental rate for Level III awaiting LTC placement)	Per Diem: Payment is fixed at a daily cost; scope of services (lodging, number of meals) provided is fixed.
Personal care	Covers: Lodging, Food Service, Personal Care Cost differentials Small Home Subsidy: $2,000/month Isolation grant: Varies	Per Diem: Payment is fixed for a pre-defined volume of personal care hours according the PCH Operating Standards.
Transportation	Waiting and Escort Time $13/hour (up to 12 hours each) Travel/Family Transport/Taxi $0.55 km/$0.30 km/Actual	Activity-Based Funding: Payment is variable and scales based on the number of kilometers travelled and the waiting time.
Other Services Available to PCH residents	Bloodwork $25-40 (varies)	Activity-Based Funding: Payment is fixed for the provision of one unit of service.

Proposed Services: Personal Care Homes

HCS has identified the potential expansion of the following programs areas into PCHs (or other care facilities provided by private operators) as a strategic priority for the province.

Expansion of Services in PCHs

Dementia Care Services (in PCH)

Description:

Dementia Care Services may be offered to residents of Personal Care Homes in moderate stages of dementia. Services will include additional monitoring and security for ambulatory residents.

Adult Day Program

Description:

Adult Day Programs may be offered to residents of PCH and the community to support individuals with care needs during the day who live in community. Depending on the level of complexity of the client, additional nursing functions and personal care supports may be provided.

End-of-Life and Palliative Care

Description:

Residential end-of-life and palliative care may be offered to current PCH (or other residential care option) residents with chronic illness and at end-of-life.

Restorative Rehabilitation

Description:

Following hospitalization, clients are eligible to receive a period of convalescence (up to 30 days in a calendar year) to convalesce prior to returning to their primary residence.

RN/LPN/Rehab (OT, PT, etc.) services are currently provided to PCHs through the Health Authority. No additional resources are provided to allow additional staffing for the PCH. It has historically been the responsibility of the PCH to provide appropriate staffing to match the client level of care.

The Department may expand rehabilitative care through out PCHs and expand the service providers scope of services.

Service	Program Funding Rates	Reimbursement Methodology
Dementia Care Services	N/A	**TBD:** Dedicated Dementia Care Services are not currently offered in PCHs.
Adult Day Program	N/A	**TBD:** Dedicated Adult Day Programs are not currently offered in PCHs.
End-of-Life and Palliative Care	N/A	**TBD:** Dedicated End-of-Life and Palliative Care Services are not currently offered in PCHs.
Restorative Rehabilitation	N/A	**TBD:** Restorative Rehabilitation is not currently offered in PCHs.

Proposed Services: Personal Care Homes

HCS has identified the potential expansion of the following programs areas into PCHs (or other care facilities provided by private operators) as a strategic priority for the province.

New Residential Care Programs

Residential Hospice Care

Description:

In additional to developing strategies for providing end-of-life care and palliative care services at-home and in existing PCHs, the Department is also exploring piloting hospice care in a dedicated facility for clients at end-of-life or with chronic illness.

Dementia Care Homes (Dedicated Residential Facilities)

Description:

In additional to developing strategies for providing dementia care services at-home and in existing PCHs, the Department may also consider piloting dementia care services in a dedicated facility for clients with moderate to advanced stages of dementia. The facilities may include infrastructural features such as Wander Guard, secure outdoor space, and a structure designed for continuous movement. Services may include additional monitoring and security for ambulatory residents.

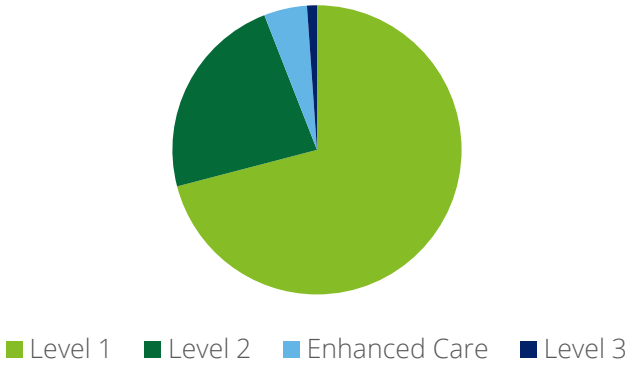
At the time of this report's writing, offering dementia care in a dedicated facility (outside of PCHs) is not being considered as one of the Department's strategic priorities.

Service	Program Funding Rates	Reimbursement Methodology
Residential Hospice Care	N/A	**TBD:** Residential Hospice Care facilities do not exist.
Dementia Care Homes (Dedicated Residential Facilities)	N/A	**TBD:** Dementia Care Homes do not currently exist.

Current Services: Personal Care Homes

Personal Care Homes represent approximately 12% of the total third-party spend for LTC CSS and provide care for seniors. Breakdowns of PCH residents by level of care and annual expenditures are provided below.

Breakdown of PCH Residents by Level of Care



As of September 2018:

- There were 3,337 PCH residents throughout NL
- 83% of PCH residents receive subsidies
- There were 84 PCH homes ranging in size from 6 beds to 100; 50% of all PCHs are 45 beds or less
- There are a total of 4,065 beds available for occupancy across the province; 2,016 in EH, 1,145 in CH, 766 in WH, and 138 LGH
- Average vacancy rates are 17.9% across the province, LGH has the lowest vacancy rate at 7.2% and CH has the highest rate at 19.4%
- There are 728 vacant beds across the province; 352 in EH, 222 in CH, 144 in WH, and 10 in LGH

Source: RHA Data (Q3/18)

Program Expenditures (all RHAs)	Claims	FY2018 Actuals	Percent of Total
Total Board and Lodging Expenditures	63,304	36,458,948	87.1%
Personal Allowance	4,179	342,506	0.8%
Short Term Respite Allowance	245	162,306	0.4%
Other Residential expenses	*Unknown*	1,033,516	2.5%
Travel expenses	39,011	1,693,953	4.0%
Other expenditures	*Unknown*	53,292	0.1%
Supplies	*Unknown*	713	0.0%
Medical and Surgical Supplies	*Unknown*	920,079	2.2%
Foot care	23,380	410,811	1.0%
Blood work	4,258	119,163	0.3%
Differentials			
Isolation Grants	5	258,460	0.6%
Small Home Subsidy Program	13	387,510	0.9%
Other Grants	*Unknown*	17,291	0.0%
Total Program and Resident Expenditures		**41,863,931**	100%

Source: GNL HCS Program Expenditures (2018), CRMS Data

Current Services: Residential Respite

Residential Respite is provided in Alternate Family Care (AFC) homes to adults and seniors with intellectual disabilities. Rates vary depending on the length and timing of respite.

Residential Respite Program (AFC Homes)

Description:

Residential respite care is the provision of substitute caregiving in a residential setting to relieve and support primary caregivers temporarily. Residential respite may be offered in an Alternative Family Care (AFC) Home to adults with intellectual disabilities who require support, with care being provided in a family setting.

Clients:

Clients are adults with intellectual disabilities.

Providers:

Providers of residential respite are generally Alternative Family Care (AFC) homes. AFC homes provide room and board, supervision and personal and social support.

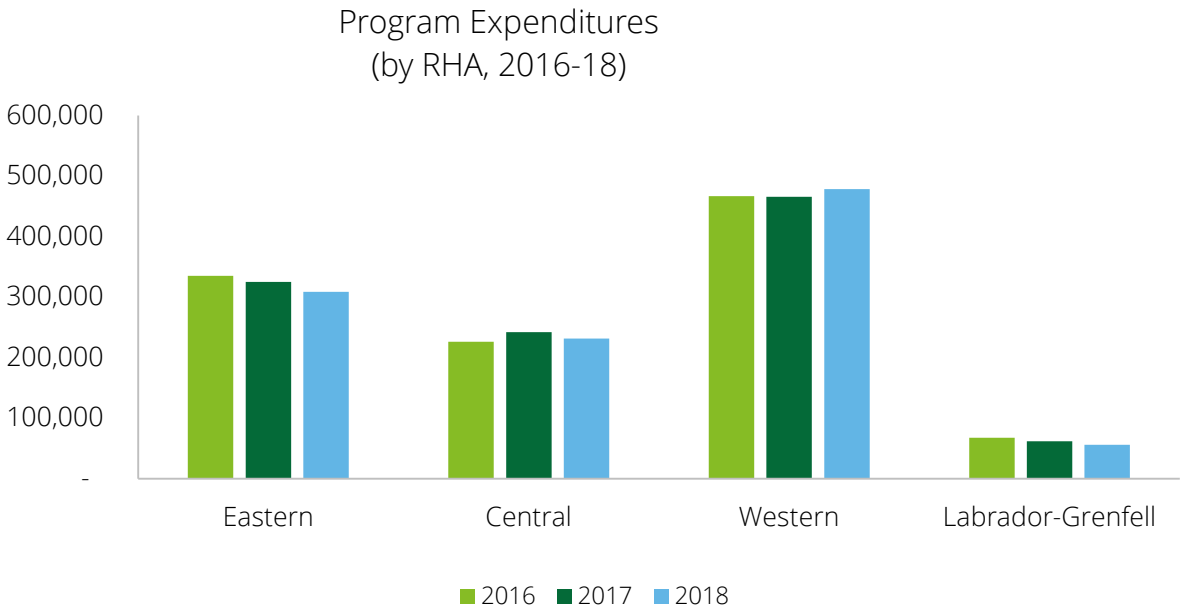
Services:

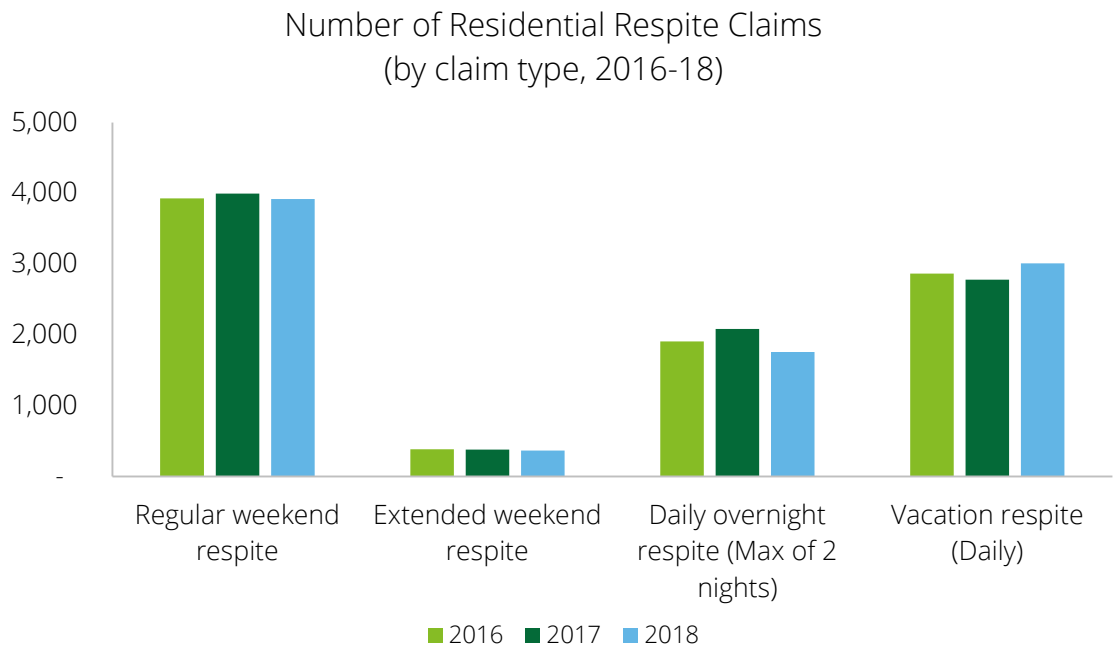
- Board & Lodging
  - Rent
  - Housekeeping
  - Laundry
  - Various amenities (e.g., recreation, telephone, internet)
- Meal Preparation
- Care Needs
- Social and Recreational Services

Service	Program Funding Rates	Reimbursement Methodology
Regular Weekend Respite (2 nights)	$190/weekend	**Per Diem & Capitation:** Payment is fixed for a certain number of days, some of the services within respite (e.g., board, lodging) are fixed in volume, while some services (e.g., care hours) can be variable. Services with a fixed volume are Per Diem, while services with a variable component are capitated.
Extended Weekend (3 nights)	$251/weekend	**Per Diem & Capitation:** Same as above.
Daily Overnight (up to 2 nights)	$51/night	**Per Diem & Capitation:** Same as above.
Vacation Respite	$45.37/day	**Per Diem & Capitation:** Same as above.

Current Services: Residential Respite

Alternate Family Care (AFC) homes provided 13,731 respite days/nights and amounted to $1.1M in total program expenditures in 2018.





Residential respite for adults with intellectual disabilities is provided in AFC Homes. Extended weekend respite is the most underutilized claim type due to limited availability of AFC Homes willing to provide respite.

As of July 2019, there are 348 AFC[1] Homes operating in NL (EH: 234, CH: 54, WH: 49, LGH: 21); however, not all AFC Homes currently provide residential respite and some providers travel over 200km return to accommodate clients for respite periods.

Source: 1 - RHA Data collected by the Department (July 2019)

Current Services: Residential Arrangements for Complex Clients

Residential arrangements for complex clients are funded by the RHAs on an individualized basis with little standardization between cases.

Residential Arrangements for Complex Clients

Description:

Residential Arrangements for Complex Clients are established when no other service option is available or appropriate for an adult with an intellectual disability who meets home support criteria and is unable to reside with their natural family. Residential arrangements can be Individualized Living Arrangements (ILAs) or Shared Living Arrangements (SLA); an ILA will have a single client in the residence, while SLAs have more than one. Residential Arrangements are not available to clients who currently reside in a LTC facility, PCH, Community Care Home, Co-operative apartments, or Assisted Living facility.

Clients:

Clients are seniors, and adults and children with disabilities who require significant support with Activities of Daily Living and/or Instrumental Activities of Daily Living. Clients generally have very complex care needs and may require more than one home support worker at any given time. Hours of care are determined through a clinical assessment completed by home support coordinators and clinicians employed by the RHA.

Providers:

Clients accessing home support services may choose to hire a home support worker from an agency.

Services:

- Board and Lodging
- Care coordination
  - Scheduling and supervising HS workers
- Administration
  - Paying bills and scheduling home maintenance
- Personal Care Services
- Homemaking Services
- Respite Care
- Supports for Community Living
- Delegation of Nursing Function (medical care and medicine administration)

Service	Program Funding Rates	Reimbursement Methodology
Residential Arrangements	Individual Contract Contracts vary based on the needs of the client(s).	Various: Contracts are individualized. In most cases, providers submit a proposal based on the provider's fee schedule and contract terms. In some cases, providers have a block funding agreement with the RHA for an ILA or SLA with up to 3 clients.

Current Services: Residential Arrangements for Complex Clients

Management fees for residential arrangements for complex clients are funded by the RHAs on an individualized basis with little standardization between cases.

Management Fees for Complex Residential Arrangements

Program Management fees are paid to providers of clients in Individualized and Shared Living Arrangements (ILAs and SLAs) – these fees represented 18% ($531,190) of program expenditures for the 126 clients in individualized living arrangements. The majority of funding allocated for ILAs and SLAs are facility expenses and community access expenses for clients (42.8% and 34.5%, respectively). Direct client care expenses for these clients are included under the PHSP budget for adults with disabilities.

FY2017/18 Program Expenditures for ILAs and SLAs

ILA/SLA Expenditures	FY2017/18	As a Percent
Facility Expenses	$ 1,010,380	42.8%
Community Access	$ 999,515	34.5%
Program Management Fees	**$ 531,190**	**18.4%**
Other Resident Care Expenses	$ 308,975	13.1%
Miscellaneous Expenses	$ 32,166	1.4%
Dietetics	$ 11,947	0.5%
Grand Total	**2,894,172**	**100%**

Source: CRMS Data, 2018

Current Services: Special Child Welfare Allowance (SCWA)

SCWA is offered to children with disabilities who require additional supports.

Special Child Welfare Allowance (SCWA)

Description:

The Special Child Welfare Allowance (SCWA) program is intended to help families offset some of the costs of additional services/supports incurred in supporting children with developmental and/or physical disabilities in the family home. The program provides financial assistance for families that care for a child with a disability at home.

Clients:

Clients are families who are caring for a child with development and/or physical disabilities at home.

Providers:

Various providers, depending on the services accessed by the family.

Services:

- Transportation to appointments/activities which are disability related
- Special equipment/apparatus/supplies
- Home Support

Service	Program Funding Rates	Reimbursement Methodology
Various: (Including but not limited to) • Home Support • Transportation • Medication • Special Equipment	Home Support: Disabilities celling applies to SCWA recipients: $5,220/month Medical Travel: $0.30/km Other rates depend on the costs of services	Various: Dependent on the nature of the services accessed.

FY2018/17 Program Expenditures for Special Child Welfare Allowance

Special Child Welfare Allowance	FY2017/18	As a Percent
Home Support	4,190,979	91.4%
Transportation	230,249	5.0%
Payroll Administration Fees	74,402	1.6%
Community Access	48,001	1.0%
Respite	20,563	0.4%
Miscellaneous	8,302	0.2%
Dental	7,363	0.2%
Uninsured Medical Service	3,486	0.1%
Minor Repair/Equipment (e.g., Bed)	2,901	0.1%
Special Diet	53	0.0%
Grand Total	4,586,299	100%

Medical Transportation Claims

SCWA Medical Transportation claims covered approximately 260,000 km for 111 clients, and total medical transportation expenditures amounted to $230,248 in FY2017/18. Overall expenditures for SCWA were $4.6M for 260 clients.

Current Services: Home Therapy & Behavioural Supports

Home Therapy and Behavioural Support can be availed by a multitude of clients currently accessing supports from LTC CSS.

Autism Services Program – Home Therapist

Home Therapy can be availed by children with an Autism Spectrum Disorder under the age of 9 (end of Grade 3). Home Therapists are expected to have post-secondary education with preference given to candidates with post-secondary training in psychology or a related field.

Services:

- Home Therapy (i.e., hands-on behaviour intervention and skills development)

Community Behavioral Services Program – Behavioral Management Specialist & Behavioural Aide

Description:

Persons with intellectual disabilities may receive support (via referral) from Behavioral Management Specialists and Behavioural Aides. Behavioral Management Specialists develop and oversee behaviour management plans, which the Behavioural Aides implement. Both roles are required to have higher education training in Psychology.

Services:

- Supports for Community Living

Service	Program Funding Rates	Reimbursement Methodology
Home Therapy	$17.13/hour + source deductions	Activity-Based Funding: Payment is variable and scales to the volume of services required (e.g., hours of care accessed).
Behavioral Aide	$17.13/hour + source deductions	Activity-Based Funding: Payment is variable and scales to the volume of services required (e.g., hours of care accessed).

Current Services: Foot Care

Foot Care can be availed by a multitude of clients currently accessing supports from LTC CSS.

Foot Care Program

Description:

Individuals 65 years of age and older, who are residents in a personal care home or in receipt of subsidized home supports, are eligible for advanced foot care services.

Services:

- Foot care

Service	Program Funding Rates	Reimbursement Methodology
Foot care	$40 per session, up to 8 sessions per year	Activity-Based Funding: Payment is variable and scales to the volume of services required (e.g., foot care services accessed).

Current Services: Supplemental Benefits

Supplemental benefits are in place to provide additional financial support to a variety of LTC CSS clients.

Supplemental Benefits

Description:

Supplemental Benefits are primarily offered to adults and children with intellectual disabilities (and primary caregivers) on the basis of financial or clinical need to assist with Activities of Daily Living to remain independent and living in their own home or independent living unit.

Central Health Authority currently only pays the Fuel and Utilities top-up to clients in an ILA; however, the other RHAs have paid supplemental benefits for other programs as well.

Clients:

Clients are seniors and adults or children with disabilities that require support with Activities of Daily Living and/or Instrumental Activities of Daily Living. Care needs range from low to very complex clients with multiple disabilities.

Providers:

Supplemental benefits are paid out to assist with living expenses of clients living in their own home or independent living unit.

In-Scope Supplemental Benefits:

- Mortgage/Rent Top-Ups
- Fuel and Electricity
- Fuel and Electricity Top-Up

Out-of-Scope Supplemental Benefits:

- Personal Allowance
- Board & Lodging (B/L Relative)
- Board & Lodging (B/L Non-Relative)
- Board & Lodging (AFC Homes Top-Up)

In-Scope Program/Service Not In-Scope Program/Service

Service	Program Funding Rates	Reimbursement Methodology
Personal Allowance	$150/month	**Historical:** Lump sum payment to client.
Mortgage Top-Up	Actual less AESL Portion AESL Portion: $372/month	**ABF:** Payment is variable and scales to the volume of services required, according to actuals.
Rent Top-Up	Actual less AESL Portion AESL Portion: $372/month	Same as above.
Fuel and Electricity	Actual	Same as above.
Fuel and Electricity Top-Up	Actual less AESL Portion AESL Portion: $71/month	Same as above.
B&L (Relative) Top-Up	**Top-up**: up to $362/month AESL Portion: $323/month	**Per diem:** Payment is fixed at a daily cost; scope of services (lodging, number of meals, etc.) provided is fixed
B&L (Non-Relative) Top-Up	**Top-up:** $362/month AESL Portion: $534/month	Same as above.
B&L AFC Homes	**Top-up:** up to $384/month **RHA Portion:** $462-$485/month AESL Portion: $507-$534/month	Same as above.

Literature Review & Jurisdictional Scan

Literature Review & Jurisdictional Scan

Deloitte's research took a wide-lens approach to identify innovations and thought leadership in funding model development and leveraged a deep understanding of the current state of community-support services in GNL HCS.

Research Scope

Deloitte's research gathered data and information from Canadian provinces along with several other countries. Additional research relating to leading practices and innovative programs was used to supplement the jurisdiction-specific findings. The purpose of the research was two-fold:

1. Develop a comprehensive inventory of reimbursement methodologies used in long term care, community support services, and other areas of healthcare in Canada and internationally.

2. Understand the current state of reimbursement methodologies used to fund in-scope programs and services offered to seniors and adults with disabilities across Canada.

Research Methodology

The research comprised the following elements:

- Desk-top research on in-scope programs in Canada and across other jurisdictions;
- Review of literature on funding models used in healthcare (e.g., secondary research, industry reports);
- Interviews with government and service providers in select Canadian provinces, including: British Columbia, Alberta, Ontario, New Brunswick, and Nova Scotia; and,
- Interviews with subject matter experts.

Research Findings

The research identified the following key insights:

- Seven distinct reimbursement methodologies emerged from across the healthcare landscape that can be used separately or in combination to form a funding model.
- Utilization of reimbursement methodologies is relatively limited for in-scope programs and services in Newfoundland and Labrador and other Canadian provinces.
- In general, the landscape of programs and service providers is quite fragmented across the country. Policy and operating changes may need to take place before the harmonization of rates and funding models.
- Innovative practices in funding service providers have historically tended to originate in acute care and primary care settings. Many jurisdictions have struggled to implement or are in the process of implementing innovative funding models into continuing and long-term care settings.

The pages that follow explain the seven distinct reimbursement methodologies, and findings from Canadian and international jurisdictions. Detailed findings from the jurisdictional research are included in Appendix A.

Reimbursement Methodologies

Reimbursement Methodologies

Review of relevant literature identified reimbursement methodologies for third-party service providers of community-based programs and services.

Provision Based Reimbursement Methodologies – Methodologies used to reimburse providers for the provision of services.

Methodology	Definition
Historical	Under a historical reimbursement methodology, a lump sum is provided based on a historically agreed upon value. Adjustments may be made to reflect changes in the cost of living and population growth.
Per Diem	Under a Per Diem methodology, the service provider is paid a rate for each day of service that they provide to a client. The volume of services to be provided for each day of service is pre-defined according to client needs
Activity-Based Funding (ABF)	Under an ABF methodology, providers are compensated for the volume of services delivered. The complexity of patients is not considered as part of the assessment. ABF may also be referred to as volume-based funding or service-based funding.
Complexity Adjusted ABF	Under a complexity adjusted Activity-Based funding methodology, providers are compensated for the **volume** of services delivered, taking into account **cost differentials** such as the complexity of the patient.
Capitation	Under a capitation methodology, service providers are paid a fixed fee for each client they provide services to over a given period of time. Recipients of the fee are obligated to meet the needs of the client, regardless of the volume of service they need. As such in a capitation model, the volume of services is not a fixed value.
Bundled Payments	Under a bundled payments methodology, **multiple** service providers are paid a fee for providing a **predefined bundle of services** to the client. The recipients of funding will be required to provide services to the client for a given time, as defined by the services within the bundle. The fee or 'budget' is **shared** between the service providers, incenting them to coordinate services and minimize costs, as all surplus is shared out between the service providers within the bundle.

Performance Incentive – *Methodologies that are used to reward providers or penalize providers based on their performance.*

Methodology	Definition
Pay-for-Performance (P4P)	Under a Pay-for-Performance (P4P) methodology, providers are compensated for **achieving pre-specified objectives**, such as thresholds of quality or performance metrics, or **penalized** for failing to meet a **minimum level of quality or safety**. P4P schemes may be implemented as a 'top-up' to a base level of funding determined from an alternative methodology, such as ABF. P4P may also be referred to as outcomes-based.

Reimbursement Methodologies: Historical

Definition: Lump sum payment based on historically agreed upon amounts (i.e., global funding).

Model: Historical

Overview: Under a historical reimbursement methodology, a lump sum is provided based on a historically agreed upon value. Adjustments may be made to reflect changes in the cost of living and population growth; however, once provided, the value of funding does not scale based on the volume of services provided and complexity of client needs.

Use in Other Jurisdictions: Historical funding was the dominant methodology used in publically-funded health care settings in the past. However, following the rise of activity-based and pay-for-performance funding in healthcare, historical funding is often considered a legacy model with limited applicability in modern care settings.

Historical funding was traditionally used to fund hospitals and other acute care and primary care settings through global budgets that allocated funding based on the previous year's operating expenditures. The Ministère de la Santé et des Services Sociaux in Québec funds operators using historical funding amounts. Many publically operated long-term care facilities in Canada also use this methodology.

In Newfoundland, funding provided for Small Home Subsidies for PCHs is a fixed amount determined in 2011 that was not subsequently updated to reflect cost of living increases or volume or complexity of clients.

Rate Setting Methodology (Example):

- Establish historical value of funding
- Estimate changes in cost of living
- Estimate changes in population demographics

Inputs Required:

- Historical reimbursement values
- CPI historical and predictions
- Population trends

Example Application:

- **Travel Reimbursement =** Travel budget (previous year) * inflation rate * changes in population rate

Advantages	Disadvantages
Extremely easy to implement and maintain.	Fails to incentivize performance and efficiency.
	Lacks responsiveness to changes in the funding environment (e.g., scope of services delivered, innovation, etc.)
	Unsuitable for expenses that vary unpredictably.
	Providers are generally reimbursed regardless of outcomes attainment.

When is Historical Appropriate?

- When there was rigor in the original setting of rates.
- When existing service providers appear satisfied with the rates.
- When new service providers are willing to deliver services at historical rates.

Reimbursement Methodologies: Per Diem

Definition: Payment based on days of service provided; volume of service provided each day is pre-defined.

Model: Per Diem

Overview: Under a Per Diem methodology, the service provider is paid a rate for each day of service that they provide to a client. The volume of services to be provided for each day of service is pre-defined according to client needs

Use in Other Jurisdictions: Per Diem funding is used most frequently in post-acute and continuing care settings where utilization is measured in days.

Research into other jurisdictions revealed that per diems are most commonly used in programs with a residential arrangement, including personal care homes and long-term care facilities.

In NL, personal care homes are funded with a per diem for Level I and II clients; however, there are complexity adjustments for residents classified as Enhanced Care and Level III (awaiting LTC placement).

Given the ongoing nature of continuing care supports, complexity-adjusted per diems are dependent on well-defined and standardized measures of levels of care for clients. In jurisdictions where complexity-adjustments are not employed, service level agreements or contracts between the health authority and third-party provider include terms to prevent risk-selection (e.g., mandatory referral acceptance, financial penalties for vacancies).

As examples, nursing homes in NS and NB are penalized for vacant beds, and home support agencies in Ontario must meet 97% to 98% referral acceptance rates to contract with the Local Health Integration Networks (LHINs).

Rate Setting Methodology (Example):

- Identify key services (costs) based on stakeholder engagement
- Define the parameters (volume, scope) of services to be covered under Per Diem rate
- Estimate the daily cost of key services
- Set per diem rates based on key costs and defined volume & scope of services

Inputs Required:

- Key services (costs)
- Estimated daily volume of services accessed by clients
- Daily cost of services accessed by clients
- Estimated number of clients

Example Application:

- **Travel Reimbursement (One day) =** Per Diem rate for travel for Level 1 clients * number of Level 1 clients

Advantages	Disadvantages
Encourages service providers to manage daily expenses for the given scope of services.	May encourage service providers to preferentially accept low complexity referrals.
Service volume tracking and payments are relatively simple.	Rates will need to be periodically reviewed to ensure alignment to the cost of service delivery and service level expectations.
Funding is relatively easy to forecast based on provider capacity and service utilization rates.	Providers are generally reimbursed regardless of outcomes attainment.

When is Per Diem Appropriate?

- When the scope of services is well defined.
- When programs and services are accessed regularly and in predictable volumes.
- There is a history of payments, thus service provider costs are reasonably well known.
- When tracking individual units of service (e.g., meals provided) is difficult or administratively burdensome.

Reimbursement Methodologies: Activity-Based Funding (ABF)

Definition: Payment based on the volume of service delivered; no consideration given to client complexity.

Model: Activity-Based Funding (ABF)

Overview: Under an ABF methodology, providers are compensated for the volume of services delivered. The complexity of patients is not considered as part of the assessment. ABF may also be referred to as volume-based funding or service-based funding.

Use in Other Jurisdictions: ABF is a common practice in clinical settings and the primary reimbursement methodology for physicians (i.e., Fee For Service). ABF is also prevalent outside of Canada and is the dominant funding methodology used in other countries, such as the U.S., UK, France, Germany, Finland, and others. However, most applications have been implemented in primary and acute care settings and have not been widely-utilized for continuing and LTC settings.

ABF can be targeted to address specific policy objectives. ABF can reduce waitlists by incentivizing volume of services delivered and removing funding caps associated with a historical funding methodology, such as global budgeting. ABF can be used to minimize costs by setting rates below the current average cost of service delivery.

Our jurisdictional scan revealed that ABF is the dominant reimbursement methodology in agency and self-managed home supports, driven by hours of care from a clinically-assessed care plan.

Rate Setting Methodology (Example):

Identify key services based on stakeholder engagement and existing case-mix/diagnostic related groups (DRGs) methodology

- Estimate the cost of key services
- Estimate the volume of services to be delivered
- Set ABF rates for a given unit of service (i.e., hours of service)

Inputs Required:

- Key services (by cost) for each program/case-mix
- Cost of delivering key services
- Utilization rates of key services
- Estimated client volumes

Example Application:

- **Travel Reimbursement =** Travel rate (per km) * Number of kilometers traveled by all clients

Advantages	Disadvantages
Directly ties payment to standardized services being provided	Rates are undifferentiated on the cost of services for different types of client complexities.
Service volume tracking and payments are relatively simple.	Providers with costs above the reimbursement rate for a service will lose money.
Funding is relatively easy to forecast based on provider capacity and service utilization rates.	Rates will need to be reviewed periodically to ensure alignment to the cost of service delivery and service level expectations.
	Providers are generally reimbursed regardless of outcomes attainment.

When is Activity-Based Funding Appropriate?

- When clients and their care needs are relatively homogenous.
- When discrete care needs can be accurately identified and interventions planned.
- Programs where there is high variability in volume of services accessed.

Reimbursement Methodologies: Complexity Adjusted Activity-Based Funding (ABF)

Definition: Payment based on the volume of service delivered; rates adjust based on client complexity.

Model: Complexity Adjusted Activity-Based Funding (ABF)

Overview: Under a complexity adjusted Activity-Based funding methodology, providers are compensated for the volume of services delivered, taking into account cost differentials such as the complexity of the patient.

Use in Other Jurisdictions: Similar to ABF, Complexity Adjusted ABF models are increasingly used across health care settings in other countries.

Alberta uses a complexity adjusted ABF model, called Patient/Care-Based Funding, for LTC facilities which classifies patients by clinical acuity (RUG groups) and funds according to staffing intensity to meet the needs of the client case-mix. Alberta Health is also in the process of implementing this funding model into their designated supportive living facilities (PCH equivalent).

Ontario has also implemented a complexity adjusted ABF for LTC which uses RAI Maple Scores to assess client complexity and funds according to client hours of care.

Many other countries have funded LTC using complexity adjusted ABF, including Australia (Case-Mix Adjusted Funding), the U.S. (Medicare Access and CHIP Reauthorization Act of 2015), and the UK.

Rate Setting Methodology (Example):

Identify key services based on stakeholder engagement and existing case-mix/diagnostic related groups (DRGs) methodology

- Estimate the cost of key services for different levels of care/cases/DRGs
- Estimate the volume of services to be delivered by levels of care/cases/DRGs
- Set ABF rates for a given unit of service (i.e., hours of service) based on specific levels of care/cases/DRG

Inputs Required:

- Key services (by cost) for each program/case-mix
- Cost of delivering key services by different client demographics (estimate)
- Utilization rates of key services by different client demographics (estimate)
- Estimated client volumes by different demographics

Example Application:

- **Travel Reimbursement =** Travel rate (per km) for a Level I client * Number of kilometers travelled by Level I clients

Advantages	Disadvantages
Accounts for variability in client complexity and case mix to drive the efficient allocation of funding.	Rate design is complex; it requires quality population and client level data, a detailed understanding of risk factors, and analytics capabilities.
Directly ties payment to services being provided.	Rates will need to be reviewed periodically to ensure alignment to the cost of service delivery and service level expectations.
Once rates are set, service volume tracking and payments are relatively simple.	Providers are generally reimbursed regardless of outcomes attainment.
Funding is relatively easy to forecast based on provider capacity and service utilization rates.	

When is Complexity Adjusted Activity-Based Funding (ABF) Appropriate?

- When clients and their care needs are relatively diverse.
- When needs assessment and care planning processes can effectively differentiate case complexity and client risk factors.

Reimbursement Methodologies: Capitation

Definition: Payment made to provider to meet client needs for a defined period of time; based on probability of client accessing the service.

Model: Capitation

Overview: Under a capitation methodology, service providers are paid a **fixed fee** for each client they provide services to over a **given period** of time. Recipients of the fee are obligated to meet the needs of the client, regardless of the volume of service they need. As such in a capitation model, the volume of services is not a fixed value. Service providers benefit if fewer hours of service are required than was originally estimated.

Use in Other Jurisdictions: Capitation models have been implemented primarily in primary care settings as a replacement to Fee-for-Service (FFS) models to remove the incentive for physicians to over-service clients to increase volumes. As opposed to remunerating for the unit of service delivered, physicians are compensated per head.

A basic form of capitation is a family doctor who is paid a fixed salary to serve a group of patients with varying volumes and types of care needs.

Given the pre-defined scope of services (i.e., care plan hours) specified in most continuing care settings, there have been limited applications of capitation observed in our literature review and jurisdictional scan.

In NL, the salary of Live-in supervisors is closest to the true definition of capitation as the supervisor is ultimately responsible for the full-time care of a particular client.

Rate Setting Methodology (Example):

IdeIdentify key services based on stakeholder engagement

- Estimate the utilization rate of services based on different **levels of care/case mixes/DRGs**
- Estimate the number of clients with different **levels of care/case mixes/DRGs**
- Set capitation rates based on key costs and estimated usage

Inputs Required:

- Key services (by cost) for each program
- Utilization rates of key services by different client demographics (estimate)
- Cost of delivering key services by different client demographics (estimate)
- Estimated client volumes by different demographics

Example Application:

- **Travel Reimbursement =** Capitation Travel Rate for Level I clients * Number of Level I clients

Capitation rate reflects the typical number of kilometers travelled by a Level I client, and the cost of transporting a Level I client.

Advantages	Disadvantages
The risk of service utilization deviating from expected rates (either positively or negatively) is borne by providers. Providers are incentivized to improve quality and attain clinical outcomes	Rate design is complex; it requires quality population and client level data, a detailed understanding of risk factors, and analytics capabilities.
Discourages the provision of unnecessary services.	Potentially administrative burdensome to monitor and identify under-utilization of services.
Global funding is predictable for both payers and providers.	Providers are generally reimbursed regardless of outcomes attainment. Accountability for determining appropriateness of services resides with the provider. However, capitation agreements can include provisions to mitigate under-utilization of services.
Capitation agreements can include performance hold-backs tied to provider and program performance	

When is Capitation Appropriate?

- When payers seek to shift financial risk to service providers.
- When eligible services are well defined and aligned to expected client needs.
- When providers possess the clinical competencies and authority to determine needs, formulate care plans and make appropriate referrals for services (e.g., primary care physicians)

Reimbursement Methodologies: Bundled Payments

Definition: Payment that is shared between multiple providers to provision a bundle of services to the client.

Model: Bundled Payments

Overview: Under a bundled payments methodology, **multiple** service providers are paid a fee for providing **a predefined bundle of services** to the client. The recipients of funding will be required to provide services to the client for a given time, as defined by the services within the bundle. The fee or 'budget' is **shared** between the service providers, incenting them to coordinate services and minimize costs, as all surplus is shared out between the service providers within the bundle.

Use in Other Jurisdictions: Bundled payments have been used in a variety of settings as a method to encourage coordination and continuity of care between service providers. Given that funding is attached to a particular episode of care, and providers are expected to deliver all aspects of that care for a fixed rate, providers are forced to coordinate to minimize costs.

Successful examples include the Acute Care Episode and ProvenCare programs in the U.S. which provided clear pathways and engaged physicians to coordinate internally. Many successful implementations of this model are in acute care settings, where episodes of care are relatively short and clearly defined.

The Netherlands also implemented a bundled payments model to provide continuous care to clients with a specific diagnosis, such as: diabetes, chronic pulmonary diseases, and vascular risk management.

Limited applications of a truly bundled, all-inclusive approach have been observed for the in-scope programs and services. The Program of All-Inclusive Care for the Elderly (PACE) is an integrated care model which currently serves over 38,000 participants in 32 states. The PACE model requires service providers to coordinate care to ensure the client's care needs are met.

Rate Setting Methodology (Example):

Identify key services provided through service providers that can be bundled together.

- Identify the cost of key service bundles by levels of care/cases/DRGs
- Estimate the volume of bundles to be provided by levels of care/cases/DRGs

Example Application:

- **Bundle Reimbursement** = Bundle rate * Number of bundle initiations

Bundle rate can be calculated for a particular client complexity. This would take into account the cost of services.

Inputs Required:

- Key services (by cost) that can be bundled together
- Utilization rates of key services by different client demographics (estimate)
- Cost of delivering key services by different client demographics (estimate)
- Estimated demand for bundles

Advantages	Disadvantages
Incentivizes coordination across multiple service providers.	Difficulty defining discrete episodes of care for chronic conditions.
Providers are incentivized to improve quality and attain clinical outcomes.	Potentially administrative burdensome to monitor and identify under-utilization of services.
Discourages the provision of unnecessary services.	Rate design is complex; it requires quality population and client level data, a detailed understanding of risk factors, and analytics capabilities.
Funding is predictable for both payers and providers.	

When are Bundled Payments Appropriate?

- When payers seek to improve coordination across multiple providers, commonly across the continuum, in meeting the care needs of a client.
- When client care needs are episodic.
- When care pathways are well defined and client needs are relatively predictable.

Reimbursement Methodologies: Pay-for-Performance

Definition: Payment/Penalty is applied based on provider's performance on pre-defined metrics.

Model: Pay-for-Performance

Overview: Under a Pay-for-Performance (P4P) methodology, providers are compensated for **achieving pre-specified objectives**, such as thresholds of quality or performance metrics, or **penalized** for failing to meet a **minimum level of quality or safety**. P4P schemes may be implemented as a 'top-up' to a base level of funding determined from an alternative methodology, such as ABF. P4P may also be referred to as outcomes-based.

Use in Other Jurisdictions:

As jurisdictions have matured performance measurement for service providers, funding models which link provider performance and client outcomes to funding have emerged.

The Quality and Outcomes Framework (QOF) in the UK was implemented in 2004 and remains the world's largest and longest-running P4P scheme. This funding model is a voluntary scheme that allows service providers to access an additional top-up for meeting a set of pre-defined quality indicators. QOF has 77 distinct indicators focused on clinical and biomedical dimensions of care. Sixty-eight (68) indicators are related to objectives of LTC.

Norway piloted the Quality Based Financing model in 2014 to motivate overall quality and patient safety in acute care. Norway's National Quality Indicator system consists of 100 indicators, 33 of which are used in QBF.

Alberta piloted and subsequently discontinued their P4P scheme (Quality Incentives Funding) due to low uptake by LTC service providers. The incentive was structured as a top-up using RAI 2.0 Quality Indicators for long-term care. However, providers were eligible to earn up to only 0.2% of their operating budget, which providers did not view as worth the administrative burden.

The use of penalties and claw-backs have also been implemented as a form of P4P funding. For example, residential care facilities in NS and NB have financial penalties for vacancy rates. Home support agencies that contracted with the Local Health Integration Networks (LHINs) in Ontario are penalized if their referral acceptance rate falls below 97% to 98%.

An additional example of a P4P scheme with financial incentives and penalties is the contracted agreement between Extra-Mural/Ambulance New Brunswick and Medavie to provide home healthcare to New Brunswick residents of all ages. Through this contract, Medavie can earn up to $1.8M annually in incentives for achieving and exceeding targets for five key performance indicators (KPIs). Medavie is also subject to penalties for failing to meet baseline requirements for the previously mentioned indicators.

Reimbursement Methodologies: Pay-for-Performance

Definition: Payment/Penalty is applied based on provider's performance on pre-defined metrics.

Rate Setting Methodology (Example):

Determine global budget for incentive payments without affecting core/base funding

- Identify quality indicators of care/performance (may be negative or positive indicators, i.e. falls in the last 30 days, percentage of clients offered smoking cessation support, respectively)
- Determine incentive (or penalty) for achieving (or failing to achieve) objectives
- Estimate achievement of objectives/incidences (for example, estimated number of falls in last 30 days) based on regional/national benchmarks

Example Application:

- **Travel Penalty =** Penalty for failing to transport client to appointment * Number of incidences
- **Travel Incentive =** Top-up for transporting client to X number of appointments * Number of incidences

Inputs Required:

- Global budget for incentives
- Quality indicators
- Estimate of incidences and/or regional/national benchmarks

Advantages	Disadvantages
Direct financial incentive to provider performance.	Funding is relatively less predictable for both payers and providers.
Provides a mechanism for payers to shape providers' behavior and objectives.	Potential for service providers to 'game the system' if there is an overdependence on self-reported data.
Can be applied to augment base rate mechanisms that lack appropriate incentives or as a standalone model.	Inappropriate quality indicators may incentivize undesirable outcomes.
	Complex to design, implement and sustain.

When is P4P Appropriate?

- Programs will mature performance management frameworks and enabling technologies, processes, and organizational capabilities.
- Programs where provider performance has a material effect on client outcomes.
- Where there's variability in quality across service providers.

Jurisdictional Comparison

Key Insights from Canadian & International Jurisdictions

While Canadian provinces predominantly rely on per diem and ABF to reimburse third party service providers, International jurisdictions apply a wider range of reimbursement methodologies.

Insights from the Canadian Provinces

- Most Canadian provinces use simple reimbursement methodologies, such as per diem and activity-based rates.
- Few provinces use a standardized formula or harmonized rates to remunerate service providers.
- Most programs don't differentiate rates for different services within a single program (e.g., food, nursing) with the exception of Ontario's LTC funding formula.
- Most provinces have programs in place which prioritize keeping seniors and individual with disabilities living independently within their own homes for as long as possible.
- Performance based pay is not commonly used across Canada. Exceptions include: penalties and claw backs built into service provider contracts, British Columbia's ARQ Model, and the discontinued 'Quality Incentives Funding' pilot in Alberta.

Insights from International Jurisdictions

- Activity-based funding (ABF) and complexity adjusted ABF models are used more extensively in acute care globally (also referred to as acuity-based funding in a clinical setting).
- Examples of implementations of complexity adjusted ABF in long-term care and community support settings are limited but it has been identified as a priority in many jurisdictions.
- There are limited applications of Pay-for-Performance (P4P) in long-term care and community supports; however, systems such as the UK's Quality and Outcomes Framework have been implemented system-wide.

Funding Model Adoption by Program & Jurisdiction

Frequency of Reimbursement Methodologies employed in LTC CSS in Canadian provinces (by program)

Newfoundland & Labrador

Program	Home Support			Residential Arrangements			Other Programs		
	Agency	**Self-Managed**	**Bookkeepers**	**Personal Care Homes**	**Residential Arrangement for Complex Clients**	**Live-In/Live-Out Supervisors**	**Residential Respite**	**Adult Day Programs**	**Hospice**
Reimbursement Methodology	ABF	ABF	Capitation	Per Diem/ ABF	Various	Capitation/ABF	Per Diem	N/A	N/A

Canadian Province Jurisdictional Scan

Program	Home Support			Residential Arrangements			Other Programs	
	Agency	Self-Managed	Bookkeepers & Admin	Long-term care and Nursing Homes	Personal Care Homes	Residential Arrangement for Complex Clients	Respite	Adult Day Programs
Historical (Lump sum)	-	-	-	-	-	-	-	-
Per Diem	2	2	-	6	9	2	5	3
Activity Based Funding (ABF)	6	6	1	-	1	1	3	2
Complexity Adjusted ABF	-	-	-	2	-	-	-	-
Capitation	-	-	2	-	-	-	-	-
Bundled	-	-	-	-	-	-	-	-
Pay-for-Performance (P4P)	-	-	-	-	-	-	-	-
Unknown or N/A	*2*	*2*	*7*	*2*	-	-	*2*	*5*

Jurisdictional Insights: Home Supports

Funding models for agency managed home care are still primarily driven by hours of care in most jurisdictions.

Provincial Home Support Program – Agency Managed

Home Supports in other provinces are predominantly funded based on hours of care. The delivery model of home supports range across the provinces; for example, in regions of Alberta where there is sufficient market demand, home supports are delivered by third-party private providers that contract with Alberta Health Services, whereas in certain rural regions AHS provides home care directly. Therefore, the reimbursement methodologies employed in different regions vary depending on the delivery model.

Ontario recently went through a process of rate harmonization for home support workers (personal service workers) across all LHINs to set the current $35.09/hour rate. Home support agencies in Ontario had previously contracted with the LHINs through a competitive bidding process for a certain amount of hours; however, rates were harmonized following a 2010 report by the Auditor General that noted 'significant difference in rates paid to service providers for similar services'.

Overall, the market for home support agencies is generally much more consolidated in the rest of the country compared to Newfoundland and Labrador – agencies in NL are generally smaller and more localized than the inter-provincial providers such as ParaMed and VON operating in other markets. There is currently only one out-of-province home support provider operating in Newfoundland and Labrador (Bayshore HealthCare).

There are a few applications of pay-for-performance funding for home supports in other jurisdictions which primarily consist of prudent contract management with the use of claw-back provisions and penalties for metrics such as referral acceptance. For example, contracts with Community Care Access Centres (CCACs) in Ontario require service providers to accept 97% to 98% of client referrals, regardless of client complexity.

Rates for Agency Managed Care in Comparator Jurisdictions

Jurisdiction	RM	Rate
BC	Per diem	Varies by contract
AB	ABF	Varies by contract
ON	ABF	$35.09/hr bill rate
QC	ABF	Up to $15.44 ($4/hour fixed + $11.44/hour variable)
NB	ABF	$19.25/hour bill rate ($13.80 hourly wage)
NS	ABF	Varies by contract
NL	ABF	$23.43/hour + 0.67/hour

Source(s): Consultations with Government and/or Service Providers in BC, AB, ON, NS, NB; BC Health Authorities Website; BC Ministry of Health Website; Alberta Health Website; Ontario Government Website; Home Care Ontario Website; Government of Quebec Website; NS Department of Health and Wellness; Statistics Canada

Jurisdictional Insights: Home Supports

Most self-managed home care programs are established to provide personal care to clients in remote and isolated geographies. Funding models for self-managed care are still driven by hours of care.

Provincial Home Support Program – Self-Managed Care and Bookkeeping

Most other provinces in Canada offer self-managed care equivalent programs for both seniors and adults with disabilities. As seen in the table to the right, activity-based funding is the most prevalent reimbursement methodology with hourly rates ranging from $11.25 (NB) to $31.00 (BC). Saskatchewan and Nova Scotia both use per diem reimbursement methodologies built on hours of care in individualized care plans. None of the provinces included in our review had differentiated rates for service types (i.e., homemaking, personal care, respite, etc.) for self-managed home supports. Alberta was the only program identified which allows clients to allocate funding towards professional health services (i.e., registered nursing or therapies).

Funding is provided for bookkeeping and administrative support for clients using the self-managed home support model in most provinces. In Alberta, funding for administrative support is provided as a percentage of the monthly funding amount. Manitoba has established the Independent Living Resource Centre (ILRC) which acts as a bridging agent to provide administrative support for recipients of the self-managed and family care option.

Individualized Funding Programs in Other Jurisdictions

Individualized Funding Programs in various provinces were also considered as part of the review. In many provinces, 'individualized funding' programs were merely the equivalent of self-managed home support with funding allocated based on prescribed hours of care as per clinical care plans (e.g., British Columbia, Choices for Support in Independent Living (CSIL); Saskatchewan, Individualized Funding Program). Some programs allowed more flexibility for clients to allocate monthly funding towards professional health services or medical and/or mobility equipment. Notably, Alberta's Individualized Funding Program allows client administrators to allocate funding across four areas of support, Community Living Supports, Employment Supports, Community Access Supports, and Specialized Community Supports. Manitoba's Individualized Funding Program offered by Autism Services for children under 6 with an ASD diagnosis allows for funding to be allocated towards specialty equipment and coaching/training courses for parents (in addition to funding for personal care workers).

Rates for Self-Managed Care in Comparator Jurisdictions

Jurisdiction	RM	Rate
BC	ABF	$31.00/hour
AB	ABF	$13.35/hour (non-professional PCAs) $16.43/hour (LPNs)
SK	ABF	Variable, based on care plan
MB	ABF	$16.01/hour
ON	Per diem	Unknown
NB	ABF	$11.25/hour ($2,150/month ceiling)
NS	Per diem	$3,780.29/month ($18.36/hour)
NL	ABF	$15.55/hour ($3,650/month ceiling for seniors, $5,220/month for adults with disabilities)

Rates for Bookkeepers in Comparator Jurisdictions

Jurisdiction	RM	Rate
AB	ABF	Up to 12% of self-managed monthly funding
NS	Capitation	Up to $100/month
NL	Capitation	$25 – $40 bi-weekly

Source(s): Consultations with Government in BC, AB, ON, NS, BC Health Authorities Website; BC Ministry of Health Website; Alberta Health Website; Saskatchewan Government Website, Manitoba Government Website, Independent Living Resource Centre Website (MB), Ontario Government Website; Home Care Ontario Website; NS Department of Health and Wellness; Statistics Canada

Jurisdictional Insights: Personal Care Homes

Service delivery models for personal care home equivalents vary from province to province; however, funding is allocated as a per diem in most cases.

Government Subsidized Personal Care Homes and Nursing Homes

The terminology, service delivery model, and levels of client care for residential care homes in other provinces are quite divergent.

Personal care home equivalents in other provinces are referred to as residential care homes, designated supportive living arrangements, and special care homes. Nursing homes are comparable to LTC in NL (outside the scope of this project); however, insights from the jurisdictional scan are included when relevant. Residents include seniors and adults with disabilities with a range of care needs and complexities. Service offerings include shared accommodation with minimal support for instrumental activities of daily living (IADL, e.g., housework, cooking, cleaning, etc.), support for activities of daily living (ADL, i.e., personal care needs such as bathing, dressing, and grooming), adult day programming, residential respite, and palliative, hospice, and end-of-life care.

Given the aforementioned variety of programs, it is unsurprising that government subsidized rates vary significantly between facility types and provinces. However, personal care home equivalents not funded through a competitive bidding process are usually compensated using per diems. Services included in the per diem rates vary and additional services are often funded on an ABF basis.

Consultations with Nova Scotia's Department of Health and Wellness revealed that the funding model for personal care home equivalents, residential care facilities, consists of two separate reimbursement methodologies, called envelopes. The protected envelope includes funding solely for personal care needs of clients and is tied directly to hours of care for residents. The second envelope is allocated through a competitive bidding/Request for Proposal (RFP) process to cover start-up, operating, and non-direct care expenses. New Brunswick's funding model for special care homes, community residences, generalist care, and nursing homes is based on the funding approach used in NS. NB special care homes are permitted to surcharge residents above the subsidized rates.

PCHs in NL are permitted to take on private-pay clients to fill vacancies. Nursing homes in NS and NB (comparable to LTC in NL) can only accept subsidized residents but are subsequently subject to penalties for empty beds.

Rates for Personal Care Home equivalents in Comparator Jurisdictions

Jurisdiction	RM	Rate
BC	Per diem*	$1,000/month – $1,524/month dependent on occupancy
AB	Per diem	Varies
SK	Per diem*	$1,086/month (Standard resident charge as at July 1, 2017) $21.50/month for personal hygiene items
MB	Per diem*	$37.90 – $88.50/day dependent on occupancy
NB	Per diem*	$2,567.17/month (Special Care Home) $3,746.42/month (Level 3) $4,701.20/month (Level 4) $4,106.25/month (Generalist Care) $135/month (Comfort and Clothing Amount)
NS	Per diem*	$107.75/day (Nursing homes) $64/day (Residential Care Facility)
NL	Per diem	$2,375/month (Level I & II) $3,430/month (Enhanced Care)

*Only reflects the subsidized portion of the rate

Source(s): Consultations with Government in BC, AB, ON, NS, BC Health Authorities Website; BC Ministry of Health Website; Alberta Health Website; Saskatchewan Government Website, Manitoba Government Website,, Ontario Government Website; NS Department of Health and Wellness Website; Statistics Canada

Jurisdictional Insights: Other Programs & Services

The development of Adult Day and Residential Respite programs are an increasing priority in many jurisdictions; however, reimbursement methodologies and rates vary according to the service delivery model and target client population.

Subsidized Adult Day Programming

Given aging demographics and increased client complexity in many parts of Canada, the prevalence of adult programming has increased to accommodate seniors and adults with disabilities who require assistance with day-to-day activities. In alignment with the Department's strategic priorities, several provinces (e.g., British Columbia, Alberta, Ontario, Nova Scotia), offer day programs to support the personal and clinical care needs of clients awaiting placements in long term care facilities. Client complexities and levels of care vary across the programs. Additionally, given the national rise of home supports for clients and resulting isolation of seniors and persons with disabilities, there is a perceived increased need for communal social and recreational activities for this population. Adult day programs are offered in part in long term care facilities or personal care homes and also in purpose-built facilities. For example, adult day programs and residential respite are offered together in a designated facility in Hamilton, Ontario.

A review of select adult day programs offered in nursing homes in NS revealed that the market rates for private clients range from $26-$29/day.

Per diem is the most frequent reimbursement methodology for adult programs in Canada. However, third-party MSAAs (Multi Sector Service Accountability Agreements) for home support with the LHINs in Ontario bundle in a certain amount of day program attendance days and respite bed days.

Residential Respite Programs

Similar to adult day programming, residential respite programs are growing in popularity across the provinces. Residential respite is typically offered by publically operated LTC homes or other residential facilities and funded using a per diem reimbursement methodology based on the per bed day rate for the facility. However, in some cases residential respite may be provided in a dedicated facility and combined with other programming such as adult day programs.

The implementation of both Adult Day Programs and Residential Respite is seen as an increasingly important policy objective in many jurisdictions to provide respite to informal and formal caregivers for seniors and adults with disabilities.

Rates for Adult Day Programs in Comparator Jurisdictions

Jurisdiction	RM	Rate
BC	Per diem	$10/day
ON	ABF	Varies based on contract
NB	Per diem	$50/day subsidy (client co-pays $10/day)
PE	Per diem	$6/day
NS	ABF	$26-$29/day (private rate)
NL	N/A[1]	N/A[1]

Notes:: 1 - Adult day programs are currently offered in a select number of LTC care facilities in NL; however, subsidized adult day programs are not currently offered through PCHs.

Source(s): Consultations with Government and/or Service Providers in BC, AB, ON, NB, NS, BC Health Authorities Website; BC Ministry of Health Website; Alberta Health Website; Ontario Government Website; NB Department of Health Website; PEI Government Website; NS Department of Health and Wellness Website; Statistics Canada

Jurisdictional Insights: Other Programs & Services

There are limited examples of structured funding models for complex residential and hospice care arrangements to draw insights from.

Complex Residential Arrangements

Programs supporting care for adults with complex care needs are quite fragmented across the country and fall within a varying mandate at a provincial level. Funding for these programs is often based on individualized care plans and funded at cost. For example, in some provinces, clients are still housed in smaller group homes with 2 to 3 residents or supported in 1-on-1 living arrangements. In general, programs are offered to clients with dual-diagnosis who have limited informal care networks to support their care. Funding may be offered through separate funding envelopes at a provincial level, for example, housing supports may be funded separately from personal care supports for these clients.

Residential End of Life Hospice and Palliative Care

End of Life, Hospice and Palliative care options are offered in most provinces to clients in their primary residence, or on a temporary basis in a residential care or long-term care facility. Hospice care offered in long-term care and residential care facilities is typically funded as a per diem rate. As an example, British Columbia offers end of life care in short-term residential care facilities for $37.10/day.

Consultations with BC, AB, and NS revealed that shifting palliative and hospice care away from acute care and long-term care settings and into the community is a common policy objective in many provinces. However, determining the appropriate approach to funding hospice and palliative care in non-traditional settings is still under development.

Source(s): Consultations with Government in BC, AB, ON, NS, BC Health Authorities Website; BC Ministry of Health Website; Alberta Health Website; Saskatchewan Government Website, Manitoba Government Website, Independent Living Resource Centre Website (MB), Ontario Government Website; Home Care Ontario Website; Government of Quebec Website; NS Department of Health and Wellness; Statistics Canada

Key Factors for Funding Model Development

Strategic Health System Intent

Strategic Health System Intent

The 'Triple Aim' framework provided guiding philosophies for both the Department of Health and Community Services' Strategic Plan and Deloitte's work in developing funding models.

Newfoundland & Labrador's Health System Strategy

A key consideration within Deloitte's work was ensuring that the development of funding models aligned with the guiding framework behind HCS's strategic plan. The 2017-2020 plan was governed by the Triple Aim concept, which ties health reform with three 'interconnected and inseparable dimensions':

- Improving population health
- Enhancing the patient and provider experiences of care
- Creating better value for health care expenditures

Guided by the Triple Aim framework, HCS has identified the increased use of community supports and services as a means to achieving a higher quality of care and better value within the wider health system.

To enable this, HCS requires a model which **objectively** and **consistently** allocates funding based on the varying and increasing acuity of clients accessing community support services. The funding model must also reflect the **needs** and **characteristics** of the population; ensuring the continuation of **service provision**. Finally, where appropriate the funding model should encourage better value in healthcare expenditures; **simplifying** the existing processes and rewarding outstanding **performance and client outcomes**.

Taking into consideration the three elements of the Triple Aim framework, Deloitte crafted guiding principles with Steering Committee input which informed the development of the funding models.

Guiding Principles:

1. Funding models need to be objective in how funding is allocated.
2. Funding methodologies need to be structured, consistent and defensible.
3. Funding models need to reflect the needs of the client and populations.
4. Models must provide the base funding required to maintain the provision of services.
5. Where possible, funding models should be streamlined and simplified.
6. Where appropriate, funding models should reflect provider performance and client outcomes.

Stakeholder Insights

Stakeholder Engagement Approach

Deloitte's stakeholder engagement process included direct consultations with HCS, RHA experts, service-providers, and service-provider associations, and a confidential online survey for service-providers.

Summary of Stakeholder Consultations – Approach

Consultation with key stakeholders on current funding models, cost pressures, and to obtain insights and feedback on potential funding approaches in future, were important parts of this engagement. Stakeholder groups were identified to be:

- Government, namely the Department of Health and Community Services, and the four Regional Health Authorities operating in the Province;
- Community-based service providers that deliver care in the confirmed in-scope program areas, and which are operating in both urban and rural areas; and
- Industry associations, primarily those representing home support agencies and personal care homes.

A comprehensive engagement process was designed to capture stakeholder feedback, insights and promote discussion in a constructive and meaningful way. Consultations were intended to solicit provider views on the current funding model, to understand key cost pressures and challenges inherent in the current funding approach. A secondary objective was to provide initial awareness and change management with providers, in anticipation of HCS' plan to implement a new Levels of Care framework and tie provider performance to funding.

Formal consultations included:

1. Meetings with internal HCS and Regional Health Authority experts (11). The Steering Committee assisted Deloitte in identifying relevant internal experts and program managers in each of the four RHAs.
    - Eleven (11) internal experts were interviewed by the project team to understand HCS/RHA perspectives on the current funding model, and to provide a historical perspective on how pay rates and fee schedules were calculated. Internal experts also identified areas of concern and pointed to potential improvements in the funding formulas for the in-scope programs.

Stakeholders consulted in this review

Target group	Consultations completed
Government 'internal' experts – HCS & RHAs	11
Service providers for in-scope program areas	26 confidential one to one discussions; 50 responses to online survey
Industry associations	3

Stakeholder Engagement Approach

Deloitte's stakeholder engagement process included direct consultations with HCS, RHA experts, service-providers, and service-provider associations, and a confidential online survey for service-providers.

Approach (cont'd)

2. Direct one-to-one telephone interviews with select service providers (25). Direct consultation of a relatively small number of service providers was planned (originally expected to be 16 service providers representing the in-scope program areas). The number of direct telephone consultations was later broadened to 25 telephone interviews with service providers.

   Although contact information was provided by the RHAs and HCS, Deloitte selected potential interviewees and distributed requests for interview by email. For some providers, only telephone numbers were available. In these cases, Deloitte phoned and left voicemail messages. A representative cross-section of providers were selected based on in-scope program, provider size, client mix, geography (e.g., urban versus remote/rural), and other funding factors (e.g., recipients of isolation grants or small home subsidies).

   It must be noted that the level of participation by service providers invited for interview was quite poor. Over 80% of contacts did not respond at all to telephone messages, email invitations, or did not show to scheduled interview slots. At least five providers were 'no shows'. As a result, a larger than expected number of contacts was necessary to obtain the minimum level of participation.

3. In-person meetings with key industry associations (3). The Deloitte team was approached by one of the two province's personal care home associations, asking to provide a written submission 'on behalf of all members'[1]. Deloitte agreed to accept a written response. Additionally, it was agreed with the Steering Committee that in-person meetings with Deloitte would be offered to both personal care home associations, as well as the home support association. All three associations accepted the opportunity to meet with Deloitte.

4. Confidential online survey (total 50 completed surveys). A confidential online survey was designed with the key objective to maximize participation from as many community-based providers as possible across the province. The survey was designed to allow all providers – from bookkeepers to home support workers, to large personal care home operators – to provide feedback. The survey invited respondents to provide qualitative and quantitative feedback on financial challenges, costs of doing business, client and staffing mix, and other factors. It also invited participants to comment freely on any factors they felt was important or wished to be considered.

   The survey was initially launched for a three-week period from December 21, 2018 until January 14, 2019. To assist in capturing provider interest, it was agreed that the RHAs would distribute the access link by email with a request to complete the online survey. The RHAs were also requested to issue reminders. It was later confirmed that some providers in one of the RHAs had not received the survey link. The survey was then reopened for an additional one-week period, closing January 23, 2019. All consultations were conducted between November 14, 2018 and January 30, 2019. The following pages outline the feedback and results of those consultations.

[1]At time of writing, a written submission has not yet been received from this association (Quality Living Alliance).

Stakeholder Insights: RHAs

RHA consultations revealed a desire for funding models to be tied to levels of care, increasing client complexity, and operating standards for third-party service providers.

Feedback and comments from RHA Consultations

A summary of concerns expressed by the RHA (internal subject matter experts):

- Community-based care in context of population needs and provider expectations. Universally, RHA representatives commented on the changing nature and landscape of client complexities around the province. They cited increasing prevalence of dementia and other chronic disease as being a key driver of health care costs in general.
- Representatives also commented in general about the evolving expectations of service providers and the changing nature of the health care system in general. While it was universally acknowledged that historically, Government has not set out very high expectations of service providers and has been generous with the financial support provided to them, there are realities of today's provincial economics that make this untenable going forward. They also acknowledge that modernization of community-based care practices and assurance of quality are increasingly the focus of Government. As a result, expectations of service providers are increasing (e.g., education, training, operating standards, tying funding to performance, funding incentives for quality or accreditation).
- Provider responsiveness to market demand and population needs. Several RHA representatives perceive that there are several personal care homes and home support agencies which are not financially sustainable without supplementary funding, and which are underutilized by the local population. RHAs also expressed concerns about a 'huge number' of new PCH homes (several of 100-bed size) currently being built or proposed by private providers. Historically, there has been minimal consultation or engagement with the providers to assist in placing homes in desirable geographies or to serve unique client populations (e.g., dementia). At this time, providers perform their own market research to submit as part of the licensing process. RHA representatives commented that government has no opportunity or jurisdiction to influence the location or focus of new PCH homes, yet they express frustration about the expectation to support homes that have insufficient demand.
- Provider readiness for increased accountabilities. RHA representatives feel that some providers struggle to understand and meet current operating standards set out by the province. Moving to new operating standards may be difficult for them. A number of RHA representatives expressed concern that some operators may not be successful. Some discussions included reflection on whether Government has any responsibility to those providers, or to providers in geographies where clients may be left without services if the provider were to close.
- Rural staffing concerns. Some providers in rural/remote areas struggle to retain staff and maintain profitability (e.g., several RHAs reported known cases of owners not drawing a salary) but are perceived by the RHAs as not being sufficiently 'business-minded' or innovative enough to adjust their staffing and scheduling practices. Some providers are believed to be innovative in how they recruit, contract and engage staff over time, but even those are known to struggle in some geographies such as Labrador.

Please note that the statements above are based on direct quotes that are illustrative of emergent themes, these do not necessarily represent the view of the RHA/ all RHA employees

Stakeholder Insights: RHAs

RHA consultations revealed a desire for funding models to be tied to levels of care, increasing client complexity, and operating standards for third-party service providers.

- Funding levels and gaps. RHA managers report that there is very little 'science' behind the current rates of pay (e.g., hourly pay rates for home support or Alternative Family Care; per diem rates for PCHs). Incremental increases have occurred over the years, however, these are also not sufficiently defensible.
  - *Competitiveness and fairness of current rates.* Funding levels across the board for community-based services are considered low by most RHA managers. Most believe that home support work is (at best) paid at a somewhat fair rate. It is considered by some to be a 'good job' compared to other employment options available in smaller communities. However, for more remote communities and in particular, Labrador, home support pay levels are perceived to be falling considerably short of market rates (e.g., local fish plant or hydroelectric power company) and as a result, recruiting in these communities is challenging. Current rates of pay are not perceived as competitive with better paying opportunities (e.g., unionized factory work) or what may be perceived by jobseekers as less 'heavy' and difficult work).
  - *Paid travel for home support workers*. A significant concern from most stakeholders to this review including RHA managers was related to the inability to cover home support worker's travel time nor mileage. For this reason, workers are often required to put in several extra unpaid hours to make up a day's paid work.
  - *Ceilings.* Client service 'ceilings' are generally considered 'too low', particularly because they have not been scaled with wage rate increases. As a result, clients can access fewer hours.[1]
  - *Per diem rates for Personal Care Homes.* Universally, RHA representatives did not agree with the current approach to fund Level I and Level II clients at the same per diem rate. They also generally did not feel that the Enhanced Care supplement provided enough coverage for the additional staffing required to receive such funds for more complex clients[2]. Also related to PCH:
    - *Staffing concerns.* RHA managers expressed concern about the staffing requirements as outlined in the current standards. In particular, ratios should be smoothed across PCHs of all sizes to ensure that adequate staff are present at all times of the day to ensure appropriate, safe, and quality care for all residents.
    - *Equipment and supplies gaps*. At this time, the standards do not require PCH operators to provide equipment that RHA representatives feel would be reasonable given that the business is focused on serving seniors and other people with mobility and general care needs. For example, PCH operators are not currently required to provide raised toilet seats or transport wheelchairs. Instead, PCH operators request extra funding for many items from the RHA under the Special Assistance Program (SAP). Historically, RHAs have also provided general supplies and cleaning products to PCH operators such as bleach and gloves. These practices are not perceived as appropriate or necessary today and are perceived as the provider's responsibility.

[1] Since 2011, ceilings are adjusted each time there is a rate increase to ensure the maximum monthly hours available to a client is maintained when a rate increase occurs.
[2] Funding provided for Enhanced Care and Level III is based on hours as outlined in policy.

Please note that the statements above are based on direct quotes that are illustrative of emergent themes, these do not necessarily represent the view of the RHA/ all RHA employees

Stakeholder Insights: RHAs

RHA consultations revealed a desire for funding models to be tied to levels of care, increasing client complexity, and operating standards for third-party service providers.

  - *Education/training.* At this time, PCH owners/operators are not required to have any formal training or education, with the exception of basic first aid training, to operate a PCH. While there is no clear approach that should be required of operators, there is general agreement that operators and staff should understand how to address increasingly common client needs such as dementia, aggression or behavioural management. Furthermore, RHA managers report that jobseekers in home support or personal care home work may not have the interest or ability to travel from remote geographies for specialized training and further exacerbates staffing concerns if mandatory training is considered in future. First Aid training for workers is another gap identified by RHAs.

- *Fee proposal evaluation.* RHA representatives also expressed concern and confusion about what are perceived as 'extremely high' management fee proposals for complex clients. They also feel they have no way to assess or evaluate proposals. As a result, most are approved as presented.

- *Inconsistencies across RHAs*. A small number of inconsistencies in supplemental benefit policy were identified, including rent and lodging top-ups which vary depending on geographic area. Also, some RHAs pay utilities in addition to a rent top-up, whereas others do not pay for these items (e.g., Central).

- Restrictive policies. Some RHA representatives felt program funding is sometimes too restrictive. Examples included caregiver respite funding, which is available from time to time but requires that the client leave the home, or that the caregiver physically leave the home and leave the care of the client to another person. Both options are disruptive and undesirable to some families and may not be what the caregiver perceives as true respite or relief – however no other options are available. Greater flexibility for families should be considered. Another example given was related to complex clients in individualized residential arrangements that cost tens of thousands of dollars monthly, because there is insufficient flexibility within the Community Supports Program to assist them in ways that would be more appropriate for them.

- Oversight and accountability. RHA stakeholders believe that they have minimal or inadequate resources to oversee home support bookkeepers in the community. In one RHA there are 22 social workers on staff, but they are largely tied up with investigating allegations of abuse, conducting client intake and assessments, responding to provider queries, etc. Although oversight of the administration of public funds is very important, the resources are simply stretched too thin. Provider accountability concerns expressed by RHAs also included:

  - Accreditation uncertainty. While most RHA managers view accreditation as a good thing, some (particularly those in very remote and rural areas) voiced concern about whether local providers are 'realistically' and 'efficiently' able to prepare for and achieve accreditation status. Concerns were expressed about the degree to which some providers may not have strong leadership capability, literacy, numeracy and other skillsets required for accreditation.

Please note that the statements above are based on direct quotes that are illustrative of emergent themes, these do not necessarily represent the view of the RHA/ all RHA employees

Stakeholder Insights: RHAs

RHA consultations revealed a desire for funding models to be tied to levels of care, increasing client complexity, and operating standards for third-party service providers.

- Administrative headaches (e.g., timesheet submissions, quarterly review/audit process for PCHs). RHAs express frustration and do not see significant benefit to several administrative processes. Most administrative processes are paper-intensive and equally burdensome to RHAs and providers. They comment that technology would be an improvement, but policy also needs to change.
- Inconsistency in quality of care across providers and difficulty in holding providers accountable. They express some frustration in being unable to hold providers accountable to the provincial operating standards, especially when operators have historically struggled to meet increasing quality standards. Instead they feel they are continuing to pay providers at the same rates, even when quality of care is variable.
- 'Cherry-picking' of clients by service providers. Providers are perceived as selecting the least complex clients and in some cases requesting re-assessments that are unnecessary or unwarranted, as a means to transfer a complex client out of their facility. Reports were given of clients being dropped off at urgent care by providers refusing to take them back.

- Self-managed care. Self-managed home care received mixed reviews from RHA managers. They express concern that there is virtually no oversight by the RHA under the current structure, resulting in higher risk for both worker and client. One RHA representative indicated that when self-managed care works, 'it is more a result of luck than by design'.
  - Multiple examples were given of former agency workers that were dismissed for cause by the agency, only to be hired by clients under self-managed care. Anecdotal examples of poor conduct by workers, and clients having to 'make do' with workers refusing to perform tasks or work certain schedules, because there is no management or RHA oversight of the worker.
  - Some examples were also given of workers feeling unsafe in client homes. However, clients can purchase more hours using self-managed care than they can with agency delivered care making it an attractive option for some individuals that feel they need more hours of support.
  - RHA managers also acknowledge that self-managed care will be a good option particularly for those in remote areas, especially when new technology and other anticipated improvements come to fruition.

Please note that the statements above are based on direct quotes that are illustrative of emergent themes, these do not necessarily represent the view of the RHA/ all RHA employees

Stakeholder Insights: Service Providers

Stakeholder engagement with service providers consisted of direct consultations with 26 service providers and three industry associations and a confidential survey with 50 respondents; however, initial service provider response-rates were less than anticipated.

Feedback and comments from One-to-One Service Provider Consultations (25 telephone interviews), Industry association consultations (3), and consultations with internal program leads (2 telephone interviews)

- Surprisingly, service providers were not as eager to meet on the topic of funding as one might have expected. Private telephone interviews were offered as a way for providers to get their point of view across with regard to funding levels, operating realities, cost pressures, gaps in funding, or inefficiencies in the broader system.
- The review team initially planned to secure ~16 interviews, however, responsiveness to the team's initial interview requests was not high. Despite repeated contacts, and broadening the pool of potential interviewees, the level of engagement by service providers across the province was far less than expected, and required a significant level of effort to engage providers in meaningful discussion.
- The impact of this weak responsivity was a concern for the provider survey, which was initially viewed as an opportunity to capture broad stakeholder views and feedback. To minimize the risk of poor participation in the survey, and to ensure adequate consultation was performed, it was decided by the Steering Committee that the number of stakeholder interviews would be increased so that there were no fewer than 2 providers for each in-scope program area.
- As part of this process, the review team also met with three industry associations:
  - Quality Living Alliance for Seniors (PCH)
  - Personal Care Home Association of NL
  - Home Care Association of NL

- A total of 25 interviews were completed with providers in the in-scope program areas, as outlined in the table below. A summary of provider feedback, comments and concerns are outlined in the following pages.
- Interviews were also completed with internal program leads for new program initiatives identified by the Department, including: adult day programming and end-of-life and palliative care.

Target Stakeholder	Contacted	Completed Interviews
Home Support (agency only)	33	7
Personal Care Home	54	4
Bookkeepers	18	3
Live-in/Live-out Supervisors	13	5
Providers of Complex Residential Arrangements	6	3
AFC Care Providers	8	3
Adult Day Program (WH LTC)	1	1
End-of-Life Care (WH LTC)	1	1
Total	**134**	**27**

Stakeholder Insights: Service Providers

What we heard from **home support agencies.**

Operating Model

- The home care agency market in NL is dominated by a few large agencies catering to a significant volume of clients and smaller owner/operator models catering to complex clients and more remote areas.
- Larger home support agencies acknowledge that it is a 'volume business' and wonder how small providers can earn a profit given all the 'hidden' costs of doing business and inefficiencies in the current model.
- The two largest HS Agencies in the province have over 700 home support workers on their staff. They have a long operating history in the province (greater than 20 years). In general, larger agencies have different operating models:
  - One head office which provides centralized strategy, financial support, payroll and administration for all home care workers. Workers are attached to small satellite offices to run day-to-day operations with local oversight.
  - Agencies that have offices in several communities or RHAs, which have critical mass but which operate independently of other offices.
- The current approach by Government is that clients select their own home support agencies, based on availability, geography, reputation and informal word-of-mouth. There is no official matching of clients and agencies, nor are there RFP processes that would grant or guarantee a minimum case load to agencies.
- High worker turnover and increasing demand for home care due to aging demographics has created a market where there is a shortage of home care workers.
- Use of technology appears to be minimal, although there is variation across providers. The introduction of technology (e.g., service tracking) has been a cause of concern for some agencies, these concerns include: cost of software & hardware, phone/internet coverage, client access to technology, and training.
- Several of the larger HS Agencies have received, or are in the process of receiving, accreditation from Accreditation Canada. Providers expressed frustration with the cost of gaining accreditation; including the direct survey expenses and the cost of meeting (and maintaining) accreditation standards. One agency hired a contractor to lead the accreditation process within the organization, as the task was too onerous to do 'off the side of the desk'.
- Transporting home support clients is not currently a requirement of agencies; one provider expressed concern that introducing this service will raise vehicle insurance costs for their agency.

Please note that the statements above are based on direct quotes that are illustrative of emergent themes

Stakeholder Insights: Service Providers

What we heard from **home support agencies.**

Staffing

- Staffing models typically include roles for management, administration, and unlicensed home care workers. Larger and more sophisticated agencies report that they have nursing staff and/or professional staff (e.g., occupational or physical therapists, home therapists) on staff as well.
- There are no 'typical' home support workers. Qualifications for workers range from first year nursing students looking for summer work, to adults and seniors with families looking to get out of the house for a few hours a week.
  - Providers expressed concern that there is such significant administrative burden and delays when hiring new support workers, such as background and reference checks. It can often mean delays in providing client care. They also report that they have high standards and are concerned that staff they dismiss can be hired by a client privately under the self-managed care model.
  - Tenure of staff ranges from a few months to 15 to 20 years in some cases. Providers view home support work as increasingly 'heavy' and difficult work. While some examples of long-term support relationships exist, turnover is generally very high. An example was turnover as high as 38% in one region of the province, as reported by one agency.
- Most home support agencies operate in a unionized environment; wages and benefits for workers are defined in collective agreements between the unions and agencies.
- Home support providers acknowledge that client travel, particularly those working in communities outside of urban areas is a significant challenge for workers:
  - Operators and workers are dissatisfied with the current model, which does not provide workers with compensation for travel to or from client homes in any way (time, gas reimbursement nor kilometers).
  - Clients with low-care needs may only need care in 1 hour increments, which lead to undesirable split-shifts and additional unpaid travel for care workers; some collective agreements stipulate that workers can refuse shifts that are less than three hours. Providers report that these short and split shifts have recently become more prevalent.
  - Unpaid travel time and expenses create significant recruiting and retention challenges for operators.
- Several of the larger home care agencies have developed their own training modules for workers (often similar to material covered in a standard PCA program). Basic skills that workers are expected to offer include: First aid, lifting techniques, hand washing, personal protective equipment (PPE) training, hazard avoidance and abuse protection. Advanced skills are more difficult to obtain in workers, and must be trained 'on the job', such as designated nursing functions and medication administration, and care techniques for clients with Dementia and Alzheimer's.
- Providers report that educational levels, literacy and numeracy of support workers varies greatly. In some communities, literacy rates are very low which providers believe limit the ability of the agency to increase the level of care they can provide.
- While the use of technology is generally limited in home support settings (some exceptions exist), there are believed to be technological literacy issues within small agency providers and care workers.

Please note that the statements above are based on direct quotes that are illustrative of emergent themes

Stakeholder Insights: Service Providers

What we heard from **home support agencies.**

Client Needs

- Clients are living at home for longer, which in turn increases the complexities of services provided by home care agencies:
  - Clients are now living at home for much longer with chronic health conditions, open wounds, advanced Alzheimer's and dementia, bariatric needs, mental health issues, or are using oxygen support, ventilators, or have catheters. Home support workers are doing more than homemaking and providing personal support.
  - There are now true health and medical needs being managed at home. Providers struggle with how best to manage these needs.
- Clients may live in very rural and remote areas, and have no way to access medical support or specialist appointments in urban centers.
- Abusive clients and clients with other complex needs leads to emotional strain on employees and higher turnover.
  - Providers express general concern that clients using self-managed care are not overseen by any management and that workers are 'on their own' in the home. They recognize that there is increased risk for clients to be abused by workers. Technology improvements would benefit these populations significantly.[1]

Reimbursement

- Providers feel strongly that hourly rates paid by the RHAs are not appropriate compensation for the level of care being provided at this time, and that a single rate of pay is inappropriate. They believe client complexity should be reflected in the rate of pay.
- Wages being paid to home workers are not always competitive with other industries. Qualified nursing staff can be compensated at a higher rate at medical clinics or hospitals. Providers also report their frustrations that those individuals who seek home care workers may prefer to take jobs in other industries (e.g., local fish plant, seasonal tourism, Tim Horton's etc.), which are viewed as being at least 'easier' on the worker, and are likely to be considerably more financially lucrative.
- Some providers believe that the hours of care required by the care plan are often insufficient to meet the needs of clients. One agency indicated that the majority of his staff will work unpaid hours in excess of hours compensated as per the client's care plan.
- Travel to and from client site or transportation of clients to appointments or social activities is not compensated under the current funding arrangements.
  - In some cases, worker travels 40km each way for 4 hours of work.
  - At best, informal arrangements between clients and care workers arise.
  - At worst, clients do not have access to the appropriate quality and volume of care.
- Providers have also expressed dissatisfaction with the timeliness of payments; one owner claims that they took $30,000 out of their own account to meet payroll.
- Some providers believe that the lack of reimbursement for overtime is contributing to scheduling challenges; requiring the agencies to split long shifts. Some agencies claim that they are 'eating into their margins' to provide overtime pay.

[1]Please note that RHAs meet with and assess clients periodically throughout the year

Please note that the statements above are based on direct quotes that are illustrative of emergent themes

Stakeholder Insights: Service Providers

What we heard from SMC **bookkeepers.**

Operating Model and Staffing

- Bookkeeping services may be offered by professional accounting businesses, family/friends of client, or the client themselves. Clients are not required to hire bookkeepers with any formal training or qualifications
- Bookkeepers may take on a large volume of clients (for example, one bookkeeper interviewed has approximately 100 clients). The level of financial responsibility is significant.
  - One bookkeeper has $3M of payroll flowing through her in a given year and remittances of over $400K going to CRA.
  - Workers may submit time sheets to bookkeepers via email, fax, cellphone picture, or dropped off at the bookkeepers door.
  - Bookkeepers receive a direct deposit or cheque from the RHA and are responsible to distribute appropriate payment to the care workers. Payments might be e-transferred or mailed as a cheque to workers.
- Bookkeepers also assist clients with coordinating co-pay to workers (may be received as e-transfer, cheque, money order from bank, or, in some cases, cash).
- Process required by the RHA is still primarily paper based. While many bookkeepers are technologically savvy and could batch process the timesheets, they are still required to fax and then drop off or mail paper timesheets to the RHA for processing. For bookkeepers with a high volume of clients, they may have to fax upwards of 100-150 timesheets (2 workers per time sheet) to the RHA on a bi-weekly basis.
  - This process is viewed as extremely inefficient on both ends, for both the bookkeeper and the RHA.

Funding

- Bookkeepers are very dissatisfied with the level of compensation and feel that they are woefully underpaid for the level of work they do.
  - There are significant activities being performed in order to set up the client as an employer and manage their financial needs, that are not compensated separately and are included in the $25-$40 compensation per client every two weeks.
- However, they tend to accept the work because it may lead to referrals or follow-on work for the worker, such as tax returns. Some also report that they view it as performing a 'community service'.
- One provider commented: *"I'd rather have the funding than not have it, but, honestly in some cases the compensation isn't worth the time and effort."*
- Bookkeepers provided mixed responses when asked whether the number of care workers per client affects the time and effort required to meet the needs of self-managed care clients; this may be attributable to variations between the HSW turnover rates of different clients. Clients with more workers and a high turnover may require more effort to support.
- Timeliness and speed of reimbursement is another challenge – one bookkeeper claimed that they had to loan money from their personal account in order to pay HSWs on time.

Clients

- Clients may have multiple employees on payroll.
- Clients with cognitive impairments may not have the ability to communicate/correspond appropriately with RHA, home care workers, and bookkeeper – a responsibility which may fall to the bookkeeper if family is not involved.
  - Delays in financial assessment, social worker authorization, and contact with bookkeeper may lead to delays in the receipt and payment of funding to home support workers.
  - Self-managed care is a large burden for client or family; client is responsible for hiring, hours/scheduling, timesheets and managing paid time off and sick leave.

Please note that the statements above are based on direct quotes that are illustrative of emergent themes

Stakeholder Insights: Service Providers

What we heard from **personal care homes.**

Operating Model

- Personal Care Home (PCH) providers recognize there is a range of operating models in place for PCHs in NL:
  - 'Mom and Pop' shops may be owner-operated out of a home or with very few clients (e.g., 10);
    - Some of these homes struggle to manage with so few clients, which may have varying levels of complexity.
    - Many providers recognize that smaller homes may have a difficult time meeting operational standards and retaining good staff.
    - Some expressed a view that Government has a role to play in supporting PCHs in rural areas. They believe that if Government wants to avail of PCH beds in certain areas of the Province, they should be "reserved" to ensure the home stays afloat (whether or not there is a client in the bed). They do not necessarily have a business perspective or see that PCH should be located where there is a business need.
  - Larger PCHs are typically owned by a corporate entity with province-wide or nation-wide operations;
    - These homes are typically in higher demand by clients with lower care needs due to location, architecture, and age of facility.
    - The facility/building is typically owned by a real estate arm of the corporate entity and leased to the personal care operator.

Funding

- PCHs express significant concern that the per diem rates paid for Level I and II residents are the same. The subsidized rate is all-inclusive of rent and personal care services, even if the resident pays out of pocket for an upgrade to a private room or suite. Their view is that the subsidy is overall too low for the level of care required, even for Level I residents, and most certainly for Level II residents.
- PCHs admit to sometimes using private paying clients, or those that wish to upgrade, to 'subsidize' the home's operation in other ways. Private-pay clients pay a separate rate for rent and personal care; i.e., 'everything costs you model' (government does not limit the rents that a provider can charge).
- Residents are sometimes recommended for reassessment at a higher level, such as for 2-person care or transfers. In the meantime, the PCH must self-fund the staffing and other expenses required to meet that client's needs. This increases the financial and staffing pressures on the home.
- PCHs do not currently receive any additional funding to support the increased staffing requirement for residents who have made allegations through the Adult Protection Act (APAs).

Please note that the statements above are based on direct quotes that are illustrative of emergent themes

Stakeholder Insights: Service Providers

What we heard from **personal care homes.**

Staffing

- PCHs tend to leverage one of two standard models of staffing:
  - 'Universal workers': Usually present in smaller homes; universal workers perform all functions within a PCH (including: personal care, cooking and serving, housekeeping, and designated nursing functions); or,
  - Larger homes usually have some division of labour which assigns regular duties for each worker, e.g., laundry, housekeeping, culinary, Personal Care Attendants (PCAs), and LPNs.
- Demand for employees is very high – recruiting is a consistent and ongoing process for PCHs in most regions.
  - In particular, culinary staff and LPNs are in demand due to their transferability of skills to other work-environments.
- Background checks and documentation required by operational standards may lead to a 2-4 week lag in staffing and compensation.

Clients

- Overall client complexities are believed by PCH operators to be increasing dramatically. They report that in years past, most residents would have had Level I needs, but now are Level II and Enhanced Care. They report that Level II and Enhanced Care residents may require up 10 times more time with particular activities (e.g., bathing) than Level I residents.
- Dementia care and chronic illnesses are two areas that PCHs are seeing increasing levels of need. They do not always feel prepared to manage the care of individuals with these complexities. They also report that their staff need more training, but there is no funding for staff education nor for the operational 'backfilling' required when staff are offsite for professional development.
- Some PCHs report that RHA caseworkers have frequently and 'disingenuously' referred new residents to them as Level I which then present with, what the PCHs perceive to be, Level II or Enhanced Care needs. An example was given of a married couple that had been assessed as Level I's, but upon acceptance, the operator believed the residents should have been assessed as Level II or Enhanced Care. Due to a significant backlog of reassessments for caseworkers there was a time lag of several months before the residents were reassessed and the PCH felt obligated to increase staffing (without additional funding) to meet the clients' care needs until the reassessment took place.
- Some PCHs have expressed concern that clients' needs may be underreported as a strategy to increase the referral acceptance rate into PCHs (the assumption being that PCHs are more willing/able to accept clients with lower needs).

Please note that the statements above are based on direct quotes that are illustrative of emergent themes

Stakeholder Insights: Service Providers

What we heard from **live in/live out supervisors** and **other service providers for individuals with complex needs.**

Funding

- **Low per diem wages and inflexible expense policies.** Smaller, independent providers (e.g., AFC, respite, live in/out supervisors) feel their per diem rates are very low given the client complexities, level of care being provided and the fact that they have full-time responsibility for their client.
  - Universally, these providers expressed affection for their clients and acknowledged very long working relationships (e.g., over decades). They report that the clients have become well-known to their spouses and children, and acknowledge that it can be difficult to keep an appropriate professional distance with the client.
  - They also report that their clients have very significant challenges, from behavioral issues, to global developmental delay, to chronic and life-threatening health conditions – in some cases, clients have multiple complexities. They note that their clients are often in their homes because they are so complex or have no family involvement and as a result, cannot be cared for in other environments.
  - Some providers report feelings of isolation and being overwhelmed by their responsibilities, which are compounded by the fact that they do not feel adequately compensated. They believe they are 'subsidizing' government, for example, by accepting an hourly wage that is far lower than minimum wage, as well as by using their personal vehicles to transport clients to/from leisure activities (often during their own family time), or by supplementing the client's monthly personal allowance with gifts and 'extras'. This unique personal relationship between the provider and client tends to mean that providers will provide a service even when they are not reimbursed (e.g., long distance trips over the Christmas holidays that will be unpaid by the RHA because maximum mileage has been exceeded for the month).
  - One live-in supervisor emphasized the unique challenges associated with living together with clients. The supervisor would typically be under-slept as the clients would require care throughout the night. In the previous year, the supervisor was unable to take a vacation as there were insufficient staff to cover their shifts. Live-in supervisors often commented that funding seemed inadequate for the level of care provided and only provided care due the length of their service and family-like closeness of their relationship with the client.
  - AFC Homes commented that the funding for residential respite is inadequate to cover the administrative tasks and burden of rehoming clients for a few days or weekend; this, they believe, has lead to a shortage of residential respite options for primary caregivers of complex clients.
  - AFC Homes and other respite providers generally feel supported by RHA and have good relationships with professionals and managers. They report that they have regular oversight (e.g., monthly visits) by social workers and are often asked to do additional work such as take on new clients when there is an urgent need, or to provide respite.
- Given that they run very small homes with few clients, AFC Homes, respite providers, and live in/out supervisors generally reported feeling pressures related to cost of living including increases on food and utilities more acutely. They believe that providers should have small allowances for client 'extras' or unusual circumstances.

Please note that the statements above are based on direct quotes that are illustrative of emergent themes

Stakeholder Insights: Service Providers

What we heard from **adult day program providers** and **end-of-life and hospice providers.**

Adult day program providers

- Adult day programs are currently offered in LTC facilities in Stephenville Crossing and Saint Luke's in St. John's. There are approximately 114 long-term care beds in the facility at Stephenville Crossing and 14 adult day spaces available 4 days a week for residents of the surrounding communities. There is an additional program located in Port-aux-Basques; there are 30 beds in the LTC facility with 10 adult day spaces available 3 days a week for clients from the community.
- Program managers have indicated that their programs are more appropriate for adults seeking socialization. In fact, they confirmed that adults with greater acuity are typically screened out as managers believe that clients with higher levels of care cannot be supported under the current adult day program construct (e.g., require assistance with toileting, behaviours). However, the Department intends to provide support to clients with personal care needs in future adult day programs.
- Funding for adult day programs comes out of budget for LTC providers. The Stephenville Crossing program has access to the LTC facility's bus which is used for transporting clients to and from the facility each day.
- The current staffing model at Stephenville Crossing is structured around 1 LPN and 1 PCA, but is undergoing change to reflect the program's current focus on social and recreation activities. The new model will engage a recreational coordinator instead of the LPN. The provider does not believe this model is essential, citing increased use of home supports in the community for personal care.
- Providers are driving towards combining staffing and programming for adult day clients and recreational services in LTC facilities.
- Providers *do not* believe LTC facilities are the most appropriate venue for this programming as lower-acuity seniors and adults with disabilities may associate a stigma with a LTC facility.

Hospice and end-of-life care providers

- While hospice, end-of-life, and palliative care options are offered to clients in the community, in hospitals, and in LTC facilities, a well-defined hospice care program has not been developed for PCH operators or in dedicated residential facilities. The Department is currently exploring the expansion of PCHs to include hospice care services.
- Clients are currently able to access up to 8 weeks of community-based end-of-life care from home support workers and community health nurses in the province.
  - Given the increased involvement of family at the end of life, there is generally more unpaid caregiver support for housekeeping and delegation of nursing functions (administration of subcutaneous injections).
  - Home Support workers are engaged to deliver personal care hours for clients (end-of-life clients are generally not eligible for homemaking supports).
- 8 designated palliative care beds are also available at Western Memorial Regional Hospital in Corner Brook and Miller Centre in St. John's; however, these beds are not reserved for end-of-life or palliative patients and thus are often occupied by acute care patients.
  - Residential hospice beds have been identified as a community need in different regions of the province.

Please note that the statements above are based on direct quotes that are illustrative of emergent themes

Survey Results: Demographics (Survey Questions 1- 4)

As at the close of the survey (January 23rd) we have received 50 complete responses (29%) out of 175 surveys issued*

The majority of respondents were owners and senior managers of Home Support agencies and Personal Care Homes

Survey responses by service provider type and role

Service Provider	Owner	Senior Mgmt.	Bookkeeper	Other
Home Support Agency	13	5	-	2**
Personal Care Home	12	5	-	-
Bookkeeper	-	-	8	-
Live-in/out Supervisor	-	2	-	-
Residential Respite	-	-	-	1
Other	1	1	-	-
Total	**26**	**13**	**8**	**3**

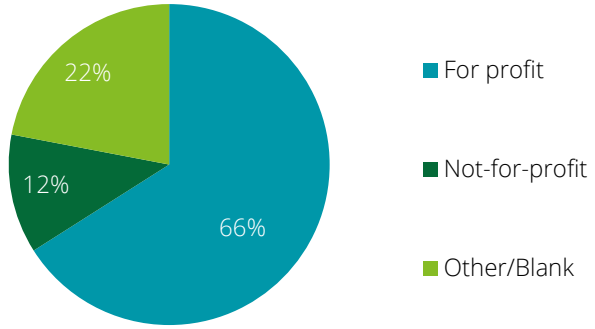
*The survey deadline was extended to the 23rd of January, to allow Personal Care Homes in Central Region more time to respond

**One respondent is a Respite/ABA Therapist worker, the other respondent is a service coordinator

***Note that some respondents operate in more than one RHA

****N refers to the number of respondents

The majority of respondents are for-profit organizations



N = 50****

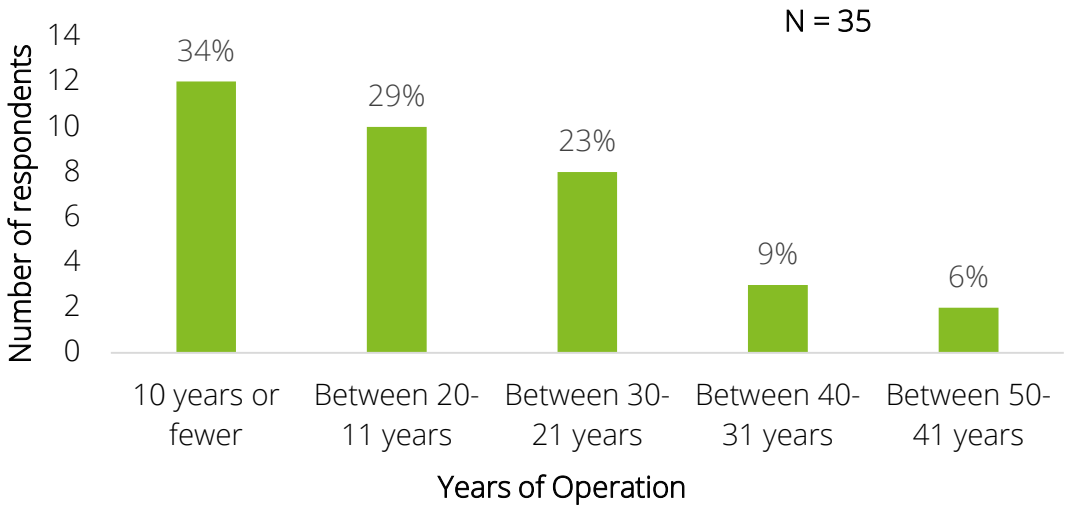
Geographical distribution of responses generally reflect the distribution of service providers across the Province

Region	Surveys Issued	Responses Received***	Response Rate
EH	95	21	22%
CH	34	17	50%
WH	33	18	55%
LGH	13	3	23%

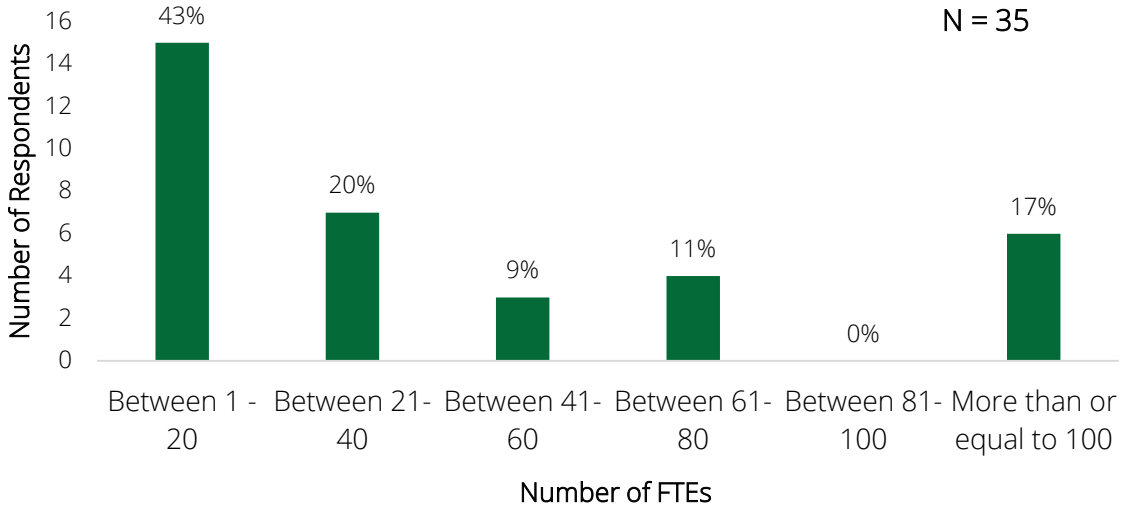
Survey Results: Demographics (Survey Questions 5 – 7)

We received responses from providers of varying sizes and tenure.

Service Provider Years of Operation



Number of FTEs in Organization (Annual Basis)



The majority of service providers (63%) have been in operation for less than 20 years.

- On average, respondents (all service provider types) have been in operation for 18 years (N=35)
- On average, home support agency respondents have been in operation for 22 years (N=17)
- On average, Personal Care Home respondents have been in operation for 17 years (N=13)

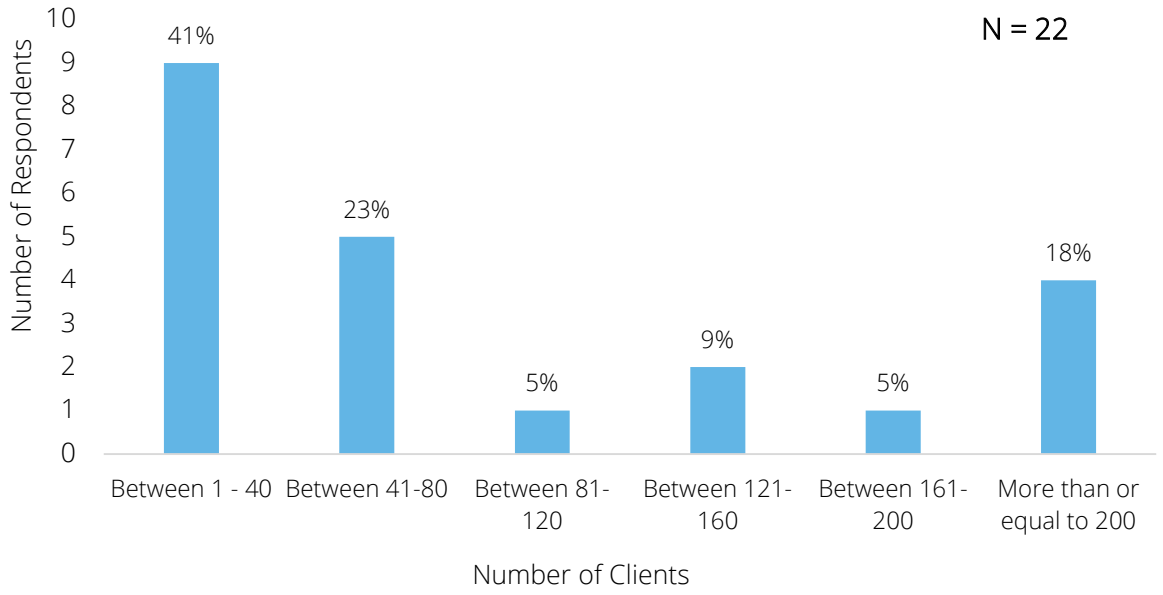
The majority of service providers (63%) employ fewer than or equal to 40 FTEs.

- On average, respondents (all service provider types) employ 67 FTEs on an annual basis. On average, 88% of these FTEs are front line care workers (N=35)
- On average, home support agency respondents employ 94 FTEs on an annual basis. On average, 97% of these FTEs are front line care workers (N=17)
- On average, PCH respondents employ 19 FTEs on an annual basis. On average, 74% of these FTEs are front line care workers (N=13)

Survey Results: Demographics (Survey Questions 8 – 12)

We received responses from providers of varying sizes and tenure.

Number of Clients Served (In an average month)



N = 22

Note: Data excludes PCH providers

The majority of service providers (64%) serve fewer than 80 clients per month

- On average, each HS Agency serves 119 clients in a typical month; the average number of HS hours delivered in a month is 13,715 hours (N=17)

PCH – Number of Clients Served (In an average month)

Level of Care	Average Number of Clients per agency by LoC
Level I	32
Level II	15
Enhanced Care	2
Level III	1

N = 14

The majority of the PCH clients are either Level I or Level II

- On average, each PCH serves 49 clients in a typical month (N=14)

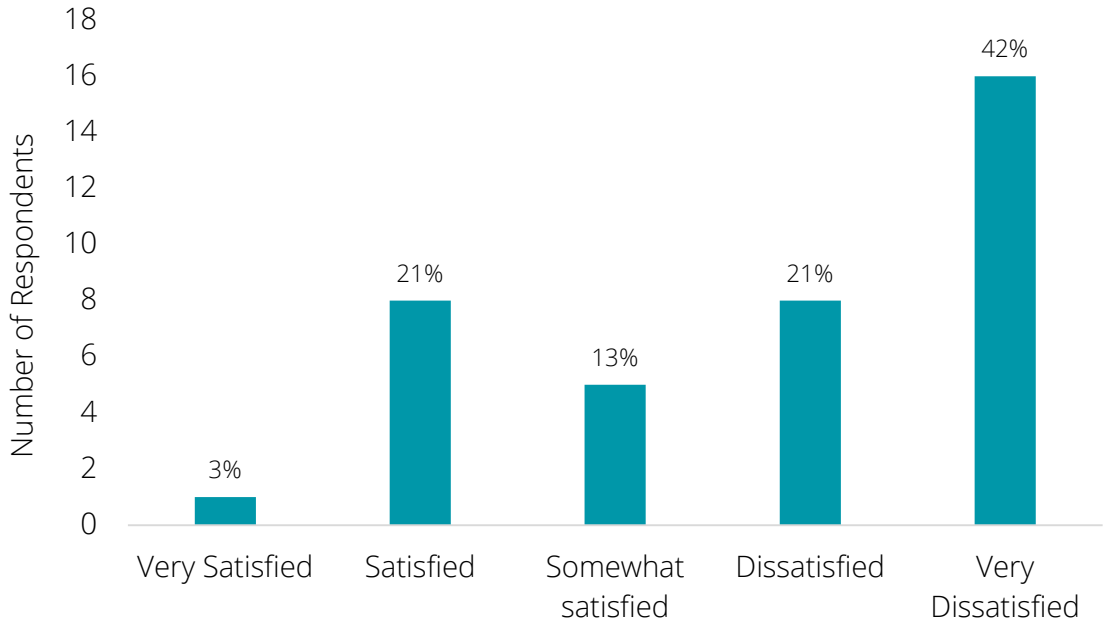
Survey Results: Provider Satisfaction (Survey Question 13)

Over half of respondents (63%) expressed dissatisfaction with current funding rates for LTC CSS services.

Question 13: How satisfied are you with current funding rates and the way the rates are currently being calculated?

Satisfaction with current rates (All providers)

N = 35



47% of Home Support respondents were very dissatisfied or dissatisfied with the current funding rates compared to **88% of Personal Care Home** respondents

Service Providers were asked to provide written comments on current funding rates; key themes from the responses are detailed below:

Home Support Agencies:

- Current **operating margins are too small**, failing to reflect the cost of operating an agency

"Home support rates provide little profit margin to allow a business to operate in a way that supports employees and superior client care."

"Very small profit margin. What we have to pay in wages is fairly close to what I get paid per hour."

"There needs to be further funding for training."

"Rates should be calculated based on varying levels of care. There should be tiered rates based on client care needs and competencies necessary to complete the work. The rates do not take into account all mandatory employee related costs or overhead costs associated with running a business."

Personal Care Homes:

- Current rates **don't reflect the needs** of the client; funding for Level II and Enhanced Care clients is insufficient to meet their needs

"The rates are good to care for a Level I; however, for a 'high' Level II, Enhanced Care and Level III, the funding is not enough."

"Need to see increase for the business and client."

"Rates are not high enough to offer competitive salaries to entice trained individuals."

"Special needs clients need more specific and intensive care on a daily basis."

Survey Results: Funding Challenges & Cost Pressures (Survey Question 14)

Service Providers were asked to explain the key funding challenges and cost pressures they faced; key themes from the responses are listed below.

Question 14: What are the key funding challenges and cost pressures faced by you/your organization?

Home Support Agencies	Personal Care Home	Other

• Some providers are finding it difficult to **sustain the costs** associated with meeting **Service Levels** and **Accreditation**; examples include: clinical expertise, training and reporting requirements
"Ongoing training is very costly, further funding is required to maintain our high standard."
"In recent years, plus the upcoming SLA requirements, the administrative overhead and cost have significantly increased and our current funding model has not reflected such operating increases."
	• Some providers are struggling to offer **competitive wages**; they are unable to hire workers with qualifications to support clients with **higher needs**. However, the **complexity of PCH residents** continue to **increase**.
	"In order to be competitive and to attract quality and qualified workers we need more income to raise wages."
	"Complexity of client diets have changed and require more attention and higher cost to provide. Clients who are able, require a higher activity level, (but there is) no extra funding for recreation. Resident Care Manager is required by the governing agency to complete more paperwork/forms, this adds to the cost of staffing."
		• **Live-in/Live out** supervisors listed the following cost pressures
		  • Cost of Benefits (e.g., SL/OT/WHSCC)
		  • Cost of client supplies
		"The government cut back on client supplies they have provided in the past and (are) only giving them $150 a month which the client has to pay for themselves."
		"The key challenges are SL/OT/WHSCC costs which are difficult to predict."

• Some providers are encountering difficulty in **providing benefits** to their workers; examples include statutory holidays, overtime and sick leave *"Insurance, extra-statutory holidays, bereavement leave, sick leave, vacation pay, orientation of new employees"*	• Some providers felt that **rates are reviewed** and **adjusted infrequently**; costs (e.g., electricity, heating, groceries) are increasing faster than the rates *"Wages, taxes, transportation, heating, electricity, food and supplies continue to rise and yet subsidies have not been increased for two years"*	
• *Some providers are experiencing **delays in payment**; one provider claimed they had to take out an overdraft to sustain their business* *"Not receiving Service Authorizations in a timely manner for new clients and expired authorizations. I have been waiting 6 weeks now for expired service authorizations on 4 clients; 3 billing periods with unfunded shifts."*[3]	• Some providers were dissatisfied that **Government subsidies** for **Level I clients** are no longer available *"Funding for Level I clients is no longer available. This is a huge problem because seniors who are a Level I cannot pay their own way, therefore cannot enter a PCH"* [2]	

[1] Rates last increased September 2017.
[2] Funding for clients with Level I care needs is available.
[3] *Reported by a service provider in CHA.*

Survey Results: Funding Model Design (Survey Questions 15 – 16)

Service Providers were asked to provide input into the design of the funding model.

Question 15: Below we identify a number of factors that other jurisdictions consider when developing funding models for community-based services.

How important is it for NL to consider each factor in its funding decisions for community-based services?

Consideration N = 39	Rating *(e.g., 1 is not important and 5 is extremely important)*
Quality of care provided	4.6
Provider performance	4.5
Cost of services	4.4
Complexity of client needs	4.4
Client outcomes	4.3
Providers' ability to meet population needs	4.3
Innovative ways to deliver services	4.2

Results suggest that all considerations are important to service providers in the design of NL's funding model.

Question 16: Are there any funding models or practices from other provinces that you would like NL to consider?

Personal Care Homes:

- **Freeze** on new **PCH licenses**; issue licenses only when there is a proven need

"We would like to see a freeze on PCH licenses. Other provinces have used an 'as needed' based approach to issuing PCH licensing."

- Allow PCHs to care for **Levels III & Level IV** clients

"I believe giving private operators Level III & IV clients along with dementia [clients] etc., will save the Government an immense amount of money annually if the proper funding was given."

- Review **Ontario's** model as an example, for funding homes that support individuals with **persistent mental health needs**

"Ministry of Health in Ontario is worthy of study. Home for those with persistent and various mental health issues are funded more specifically to meet these needs than those of a regular personal care home."

Home Support Agency:

- **Tiered funding** based on **Levels of Care**

"There should be tiered funding aligned with the Level of Care."

- Assigning cases/hours to agencies based on **geographies**

"NL should consider assigning cases to agencies based on geographic regions."

- **Guaranteed hours/caseloads** for HS Agencies

"Ontario provides service providers with budgeted hours for the upcoming year so the service provider can ensure they have adequate resources and business models in place to accommodate."

- Give providers **more flexibility**; consider weekly care plans/funding rather than daily plans

"Provide Agencies with small grants to provide enough flexibility to offer clients a few hours per week without too much red tape."

Survey Results: Funding Model Design (Survey Question 17)

Service Providers were asked to elaborate on the impact (to their organization) of making client complexities a significant factor in service provider compensation; key themes from the responses are listed below.

Question 17: HCS is considering making client complexities a more significant factor in service provider compensation, how would that impact your organization?

Home Support Agencies	Personal Care Home	Other
• Most providers responded **favorably**; funding for client complexities will allow providers to pay for **training**, **education** and additional **nursing** staff/hours *"This would positively impact the organization if done correctly, as we would be better situated to provide care to clients and proper training to employees to provide an enhanced level of care'* *"Greatly (Impact), some clients need more care than others and they are not receiving it because every client is under the same model"*	• Some providers responded **favorably** to the suggestion; respondents confirmed that **client complexities** are **increasing** and expressed the need to employ more **qualified staff** *"Compensation would increase and enable me to employ qualified support services for the clients."*	• **Providers of Residential Respite (AFC Homes)** and **Live-in/Live-Out supervisors** responded favorably; citing that their **clients' needs** are especially **high** *"We support the individuals with the most complex needs therefore this would assist us."* *"Great impact. Some of my clients are high maintenance."*

• Some providers expressed **reservations** based on a number of considerations:
  • Reclassification of **union** workers
  • **Management challenges** in paying workers different rates
"This could provide advantages and disadvantage …easier to recruit workers to work with complex clients, however, other workers with clients of a lesser complexity may not be pleased to know their co workers are receiving an increased rate of pay."
	• One respondent expressed the view that the **current Levels of Care** don't' reflect all of their **clients' needs**; as Level II clients may have different care needs (e.g., Colostomy care, catheter care, 15 minute checks)
	"Considering all the care a client needs, not just the level of care, should be a factor when determining the rate. For example, level 2 clients can have varying care needs which make them level 2. Some of their care needs take more time to complete than others. Colostomy care, catheter care, 15-min checks, etc. require more staffing and should be reflected in the rate."	

• One respondent believes that complexity should be reflected in a **monthly stipend**, not an increase in **hourly rates** *"The preferred method for consideration would be agencies that receive approval to accept complex clients would receive a monthly stipend as opposed to just an hourly increase for particular clients."*	• One respondent felt that HCS needs to **improve monitoring and oversight** of client complexities and needs *"In order to successfully do this, HCS would need more staff monitoring the clients that are in each PCH. Considering the staffing issues we currently have with community care nurses, etc. I fail to see how they would be able to do this considering their current staffing levels."*	

Survey Results: Funding Model Design (Survey Question 18)

Service Providers were asked to elaborate on the impact (to their organization) of making provider performance a significant factor in service provider compensation; key themes from the responses are listed below.

Question 18: HCS is considering making provider performance a more significant factor in service provider compensation, how would that impact your organization?

Home Support Agencies	Personal Care Home
• Some providers responded **favorably**; respondents claimed that they are prepared for performance based funding, saying that it's **"fair"** to reimburse agencies for **exceeding expectations** *"We have long advocated that provider performance should be considered in compensation and in how services are procured. This would be a positive development, especially for accredited agencies."* *"Our organization is well poised to provide reports to support our performance. Organizations should be prepared to provide an array of services that meet client needs and our agency is prepared to meet those expectations."*	• Some providers expressed that the **current standards** are **onerous** and are not **measured correctly/consistently** between RHAs; respondents were **wary** of linking performance to compensation until these issues are addressed *"Significantly, especially with implementation of the current standards. Some standards, especially staffing, can be unrealistic to achieve and puts homes in non-compliance. Also, the standards are reviewed by the regional health authority front line workers who at times enforce standards differently from other regional boards. Sometimes even different among different workers … Provider performance is important but cannot become a significant factor until the Dept. of Health and the Regional Health Authorities fix these problems so that all homes and long term care facilities operate under the same conditions."*
• Some providers expressed skepticism over the necessity of **performance based funding**; citing **Service Level Agreements** and **competition** as sufficient pressures to maintain provider performance *"I don't think this is necessary. We are governed by Eastern Health now and if all our standards are met why would we need a performance assessment done?"*	• Some providers were concerned that **regional differences** (especially in rural NL) would make it **impossible** to measure performance **fairly** *"This is not possible in many areas of NL. Rural NL has more challenges as the more urban centers can avail of more services provided by the communities."*
• Some providers would prefer more information on **criteria/markers** for performance based funding before making a judgement *"Without knowing what the criteria or markers are, it's impossible to know what impact it would have."*	• Some providers **don't believe** this will **impact their home**; one respondent claimed that they are already providing the "best of care" *"Should not impact (our organization) at all being that we offer the very best of care."*

Survey Results: Funding Model Design (Survey Question 19)

Service Providers were asked to elaborate on the impact (to their organization) of making client outcomes a significant factor in service provider compensation; key themes from the responses are listed below.

Question 19: HCS is considering making client outcomes a more significant factor in service provider compensation, how would that impact your organization?

Home Support Agencies	Personal Care Home	Other
• Some providers responded **favorably**; respondents saw client outcomes as the ultimate goal of the agency *"Our agency prides itself on ensuring all responsibilities are met and clients needs are addressed. It is extremely important that our clients maintain their health or improve where possible. If the client outcomes can be measured accurately our agency would score very well and additional compensation would allow us to maintain this."*	• Some providers responded **favorably** to the suggestion; respondents had the view that their homes are **already focused** on **client outcomes** *"Client outcomes are a very important factor in long term care. In developing a care plan, the outcome is to provide the best care to clients, ultimately enhancing their quality of life, [and] allowing them to maintain their independence. Client-specific outcomes should be considered in the rate formula."*	• One **Live-in/Live-out supervisor** reacted positively to the suggestion; the respondent supported a more client focused approach *"We are open to same – this supports a client focused approach."*
• Some providers were concerned that focusing on client outcomes would raise the **cost of operations**; respondents indicated that **client needs** are becoming **more complex**, and require **more nursing care** *"Again extra workload – would need more office staff, more frequent client visits to make sure client needs are being meet."*	• Some providers expressed reservations; respondents claimed that **outcomes** are dependent on **individual clients**; different clients will react differently to the same treatment/care *"Not all individuals are going to do better once they move into a Personal Care Home. This doesn't mean that they are not getting the absolute best possible care. They may just not respond to the care the same as another client."*	
• Some providers were worried that client outcome tracking **won't reflect** the individual **medical needs/challenges** of certain clients; particularly clients that have **behavioral problems** *"What is the criteria for the outcome? As some clients have a greater amount of care and history of illness, the outcome for these clients would not be the same as clients with those with fewer medical problems."* *"Some clients will not comply which makes it unfair as the worker would work harder to get the client to do what needs to be done."*		

Survey Results: Funding Model Design (Survey Question 20)

Service Providers were asked to provide suggestions for improving the rates or current model of funding; key suggestions are listed below.

Question 20: Please share any ideas you have to improve the rates or model of funding

Home Support Agencies

- Using the Levels of Care framework, differentiate home support rates based on client complexities

"Rates should be aligned with level of care framework. Funding models should eventually incorporate a more integrated care model so that an array of services could be provided to a client, preferably in place or in home. There needs to be caution as to the impact that fewer hours (one to two hour shifts) will have on the cost of delivering service …"

- Ensure that rates reflect the cost of having **more clients** with **shorter (i.e., 1 to 2 hour) shifts**

"There needs to be caution as to the impact that fewer hours (one to two hour shifts) will have on the cost of delivering service. While on one hand fewer hours may be approved for clients (and therefore 'save' money for the RHAs), the cost of scheduling, onboarding and overall servicing of clients is more costly to providers when there are more clients but fewer hours. This needs to be considered in the funding model."

- Ensure that rate reflect mandatory **employment related costs** (e.g., training, overtime, statutory holidays)

"Tiered levels of funding and care incorporating mandatory employment related costs into rates include a cost recovery for training provided to employees…"

- Review **client care plans** more frequently to ensure that they match **client needs**

"I feel each client should be assessed by their needs and how many hours they get. Some clients get more hours than they need, while other clients do not get as many hours. They need to fit their needs. Also, a better system for issuing the funding approvals to get them before they are expired."

Survey Results: Funding Model Design (Survey Question 20)

Service Providers were asked to provide suggestions for improving the rates or current model of funding; key suggestions are listed below.

Question 20: Please share any ideas you have to improve the rates or model of funding

Home Support Agencies

- Provide **financial incentives** for **accreditation**

"…there should be a financial incentives for agencies who have third party accreditation"

- Explore **alternative funding models**:
  - Provide small grants to HS agencies to deliver care to **seniors** receiving **guaranteed income supplements**; provide minimal home support **without** bringing the client into the PHSP program
  - Provide small grants to HS agencies for **emergency/unplanned care needs**; include payment for **mileage** if possible

"We have a program that allows seniors who are in receipt of their guaranteed income supplement to have 6 to 8 hours per week for home making and personal care or respite. This allows individuals to have minimal support and remain in their own home without going on the provincial program and easy access to a needed service."

"Giving agencies small grants to be more flexible with emergency hours and getting employees to help out at the last minute. Also helping pay for employee kilometers if needed to travel for those emergency hours.

- Maintain funding based on **hours of home support** delivered

"Keep hourly funding"

Survey Results: Funding Model Design (Survey Question 20)

Service Providers were asked to provide suggestions for improving the rates or current model of funding; key suggestions are listed below.

Question 20: Please share any ideas you have to improve the rates or model of funding

Personal Care Home

- Ensure that the rates for **higher levels of care** (e.g., Level III, Enhanced Care) are reflective of the **increased needs** of the clients

"PCHs, although privately-owned, should have a standard pay rate for staff. Rates for Level III (awaiting placement at LTC) do not meet the needs of the clients. Rates between Level II and Enhanced care do not meet the needs of the Enhanced care client."

- Review **client needs** (Level of Care) and **funding rates** more **frequently**; ensure that rates are reflective of **increasing costs**

"The majority of our residents require care, when a resident's care need changes, they should be accessed and extra funding put in place."

- **Reinstate funding subsidies** for **Level I** clients; all seniors should be allowed to receive subsidized care at PCHs[1]

"Bring back funding subsidies for Level I seniors."

- **Tie rates** for Personal Care Homes to the cost of care of **other Long Term Care providers**, such as Home Care or LTC facilities

"Rates that PCHs receive should be directly tied to the same rates as any other LTC provider. For example PCHs should be compensated at the same level as Home Care and government run LTC facilities."

- One respondent felt that the PCH program was **not a good fit** for their **home**, due to the fact that they deliver care to individuals with **serious** and **persistent mental health issues**

"Separate (providers that service clients with) serious and persistent mental health (issues) from PCH homes"

[1] Subsidies for clients with Level I care needs is available.

Survey Results: Funding Model Design (Survey Question 20)

Service Providers were asked to provide suggestions for improving the rates or current model of funding; key suggestions are listed below.

Question 20: Please share any ideas you have to improve the rates or model of funding

Other

- Residential Respite (AFC Home) – Increase the rate of reimbursement to reflect challenging working conditions; including long hours, sickness, behavioral issues, and paper work.

"Respite workers got a raise. We as AFC providers do not receive any extra funding. Some days [there are] long hours with clients, doctors appointments, sickness, behavioural issues, paper work."

- Live-in and Live-out supervisors – Explore alternative delivery models:
  - Accommodate multiple (up to 3) clients within one home; allow house purchases to enable service providers to develop floor plans for this delivery model. Unused space in the house can be repurposed for rental income.
  - Promote social enterprise.

- Live-in and Live-out supervisors – Recognize the cost of renovations and modifications

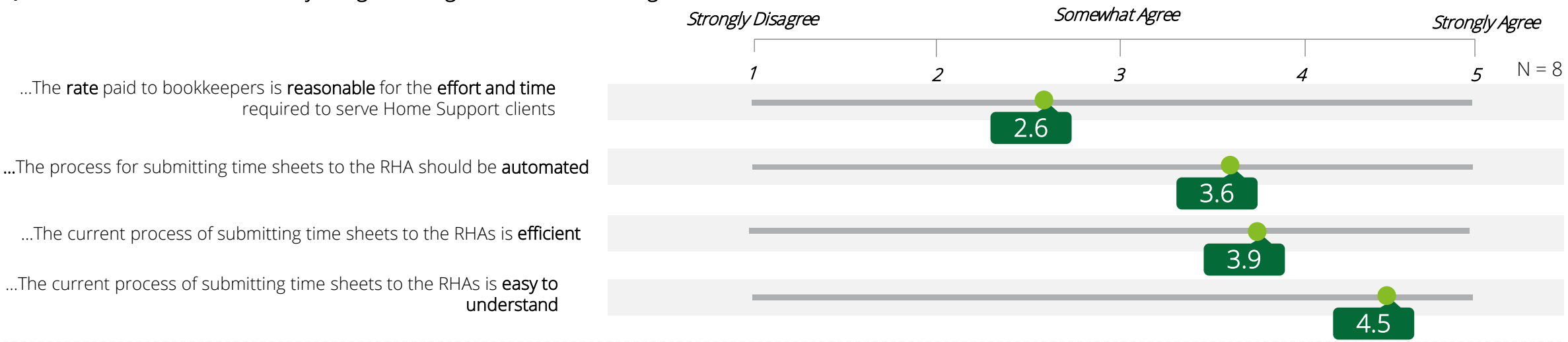
"Set up placements (at the beginning) to accommodate multiple clients (up to 3 individuals).

- Allow for house purchases so service providers can develop floor plans that promote safety and care for more than one individual – most rentals cannot safely provide support for additional residents.
- Recognize that the cost of renovations, modifications, rent and damage repair are actually less cost effective than rent.
- Promote social enterprise.
- Shared services – i.e., purchase a house (rent the basement/side apartment to the public or use the apartment as an emergency shelter unit) for rental income."

Survey Results: Bookkeepers (Survey Questions 24 & 25)

Bookkeepers were asked to respond to the following statements.

Question 24: To what extent do you agree/disagree with the following statements:



Question 25: What comments do you have with regards to how you are currently being funded?

- Many bookkeepers **responded positively** to the current system

"Works good."

- Some bookkeepers highlighted receiving **time sheets** from clients in a timely manner as a challenge; some providers have to **remind or assist clients** in completing **time sheets**

"I feel funding is provided in a very timely manner. My problem is ensuring the time sheets are received from my clients/workers in a timely manner so they can be sent to be processed."

- Some bookkeepers indicated a **delay** in receiving **funding** from the RHAs, respondents are currently **fronting payroll** in order to ensure workers receive **payments on time**

"The only thing I have some issues with is having to wait so long (in time) for the service authorizations to be put in, so therefore I have to be waiting on funds for clients. However I still have to issue cheques to the employees who worked for these clients as it is mandatory by the department of labour laws."

Stakeholder Consultation: Overall Conclusions

The consultation exercise surfaced important lessons and insights that will assist in design and implementation of funding changes in future

Conclusions from stakeholder consultation activities

- Overall, the participation rate for the provider survey was reasonable (29%), and good engagement was ultimately achieved through one-to-one interviews of service providers. While we would always like to see very strong rates of participation, we believe this level of engagement is appropriate and representative of the population of service providers that needed to be engaged in this review process.
- Providers generally want to do the right thing by their clients and provide quality care. Both RHAs and providers feel providers should be fairly compensated for the work they do.
- Providers and RHAs are in agreement that funding is generally low for some programs (e.g., bookkeepers). Personal care home providers have the strongest view that they are underpaid for the level of care provided, although home support agencies are also very dissatisfied with the current rate of pay.
- Providers and RHAs are also in agreement that funding should scale commensurate with client complexities. They want to ensure however that the full range of clients needs are taken into account (not only the physical needs), particularly in home support and PCH environments.
- However, there is varying levels of provider readiness and openness to changes in the current funding model:
  - A small number of providers have developed a proven business model that can be costed accurately, scaled, and replicated as needed (e.g., home support and nursing, management fees for complex needs). Others are working a shift in the business model and have begun to add new professional disciplines to accommodate future demand (This is unfortunately not the norm).
  - Most providers were not able to discuss with any degree of granularity their costs of doing business, identify new ways of working that could create efficiencies. These providers believe improved care lies solely in additional staff.
  - Some providers clearly expect government to “buy beds” even when they are not utilized in order to ensure that PCH homes remain open and available for use by local residents. There will be a significant change management effort needed for these providers.

Stakeholder Consultation: Overall Conclusions

The consultation exercise has surfaced important lessons and insights that will assist in design and implementation of funding changes in future

- Clearly there is a high level of dissatisfaction across providers, particularly in the personal care home and home support provider communities, that will need to be addressed by Government when moving forward with the future Levels of Care framework, and with the final funding formulas. Consideration will need to be given to change management needs, the level of business acumen available within the provider community, and managing expectations for those providers that do not operate efficiently today and may struggle to operate at even higher levels of quality and effectiveness.

- Pay for performance may also be challenging to implement or to obtain provider support for. Some providers believe that if they meet the standards, there is no need for performance appraisal. As such, they would need to hire additional office staff for the administrative burden that would come with this effort.

- While some new programs are emerging in areas of interest to HCS such as adult day programming, there are differing philosophies and intentions within Government and RHAs with regard to the level of care that can be supported within those programs. Some adult day programs are based on a social model and limit access to those adults who need the least support throughout the day, despite the fact that adults living in the community may require escalating levels of support, and that caregivers may view such programs as being vital sources of respite. Government should be careful to align funding for such programs with the future Levels of Care framework to ensure that funding is proportional to the level of support required.

Summary of Key Factors for Base, Differential & Incentive Funding

Key Factors for Base, Differential & Incentive Funding

Deloitte's jurisdictional scan and literature review identified key client, population and system considerations for funding model development.

Outlined below are three key rate components which can be built into a funding model; how the rate components are included in the model is dependent on a **program's attributes** and the attributes of its **service providers.**

- Strategic Health System Intent
- Literature Review Insights
- Jurisdictional Scan Insights
- RHA Input
- Service Provider Input

Differential funding associated with addressing *exceptional requirements* that vary significantly from typical levels of care and service delivery expectations (e.g., regional service delivery).

Base funding associated with meeting assessed client needs according to *defined levels of care* and provincial service level expectations.

Incentive funding associated with exceeding performance indicators, innovating service delivery, and, *improving client and system-wide outcomes* beyond service level expectations.

Key Factors for Base Funding

Numerous factors spanning program and service provider attributes need to be considered in establishing appropriate mechanisms for base funding.

Base funding is associated with meeting assessed client needs according to ***defined levels of care*** and provincial service level expectations. This is the portion of funding intended to reimburse a service provider for the **typical expenses** incurred in the delivery of service and provide a **set operating margin.** All in-scope LTCS CSS programs were required to have a base rate to ensure the continued provision of services. Listed below are the program/service attributes and service provider attributes that were taken into consideration when selecting the reimbursement methodology for each program's base rate.

Program/Service Attribute Service Provider Attribute

Need and Burden of Program Oversight

The reimbursement of programs and services is influenced by the need for program oversight (as influenced by the volume of program expenditures). Programs requiring more oversight may require the tracking and reimbursement of individual service units (e.g., ABF) and more frequent reviews. Stakeholder consultations with the RHAs have identified that the current processes are administratively burdensome, this consideration must also be taken into account when selecting a reimbursement methodology.

Maturity of Client Needs Assessment & Care Planning

Clearly defined care plans, care pathways, and, clinical assessments that effectively differentiate case complexity are key element for several sophisticated models (e.g., Complexity Adjusted ABF). The Department is in the process of developing new LoC frameworks, once implemented, this can form a clearly defined basis for differentiating case complexities, increasing the programs' suitability to complexity adjusted funding.

Complexity of Client Needs

The extent to which client needs impacts the cost or volume of services delivered will influence the need for complexity adjustments. Consultations with Service Providers support this observation. For example, Personal Care Home providers have identified the challenges of providing services to Level II clients who receive no additional funding despite their increased care needs.

Variability of Service Volume

Programs and services that vary greatly in service volumes (between individual clients or time periods) may require a different type of reimbursement than programs with a relatively static utilization and/or service volume. Reimbursement methodologies which track service volume (e.g., ABF) are more appropriate for programs with a high degree of service volume variability.

Key Factors for Base Funding

Numerous factors spanning program and service provider attributes need to be considered in establishing appropriate mechanisms for base funding.

Program/Service Attribute Service Provider Attribute

Risk Sharing & Transfer

The potential to shift or share risks within a program/service between service provider, clients and Government also influences the choice of reimbursement methodology. The jurisdictional research and review of literature have identified the trend of shifting financial risks from the payer (Government) to the provider. This is achieved by moving away from volume driven reimbursement (e.g., ABF), to fixed payments for the provision of services (e.g., Per-Diem). This encourages providers to manage expenses and prevent the overutilization of services.

Co-delivery between Service Providers

To apply bundled payments as a reimbursement methodology, service providers must be (or have the potential to be) co-delivering services (or a continuum of services) to a single client. One example from Deloitte's literature review are hip replacement surgeries, where the cost of surgery and follow on care (usually delivered by multiple providers) are bundled into a single payment

Service Provider Scope of Services

Outcomes-based funding models are typically more reliant on providers with a scope of services that is sufficient to holistically meet client needs.

Clinical Authority

To apply a capitation style reimbursement methodology, the service provider must have the authority to prescribe additional services on behalf of the client (e.g., general physician prescribing diagnostic imaging).

Key Factors for Differential Funding

Considerations for differential funding vary by program and populations served.

Unique/Exceptional Client Requirements

Differential funding should be provided for exceptional client requirements to the extent that the cost required to meet clients' needs is so great that it is not reasonable to expect service providers to deliver service without additional funding. While operational challenges may contribute to increased cost for service providers, the intent of differential funding is not to compensate for inefficiency.

Program/Service Attribute Service Provider Attribute

Unique/Exceptional Client Requirements

Differential funding should be provided for exceptional client requirements to the extent that the cost required to meet clients' needs is so great that it is not reasonable to expect service providers to deliver service without additional funding. While operational challenges may contribute to increased cost for service providers, the intent of differential funding is not to compensate for inefficiency.

Current Funding Differentials	Additional Funding Differentials
• Isolation • Travel • Small Providers • Enhanced care • Clients awaiting transfer to LTC • Supplemental Benefits	• Availability and appropriateness of other care options for client • Involvement of family/unpaid caregivers • Regional delivery constraints • Unique client conditions requiring additional resources

Key Factors for Incentive Funding

Incentive funding and Pay-for-Performance component can be included as a top-up to base and differential rates.

Incentive funding is associated with exceeding performance indicators, innovating service delivery, and, ***improving client and system-wide outcomes*** beyond service level expectations. Providers are compensated for achieving pre-specified objectives, such as thresholds of quality or performance metrics, or penalized for failing to meet a minimum level of quality or safety. Listed below are the program/service attributes and service provider attributes that were taken into consideration when deciding whether a program was suitable for incentive funding.

Program/Service Attribute Service Provider Attribute

Criticality to Clinical Outcomes

Outcome and incentive funding should ideally align with attaining wider health system objectives (e.g., demand for long-term care placement, reduction in in-patient ALC, population health, and wellbeing, etc.). For example, the New Brunswick EM Contract with Medavie includes KPIs that influence incentive payments; these KPIs linked closely to overall health objectives such as reducing emergency department visits, improving patient experience and decreasing referral times.

Maturity of Program Performance Management Framework

In addition to clear operational standards and service level expectations, outcomes-based funding is dependent on effective and efficient performance management processes, systems, and organizational capabilities.

Funding Adequacy

In general, service provider margins must be sufficient to sustain financial penalties without compromising their ability to meet client needs. Conversely, the program must be able to sustain paying incentives that reflect the additional effort and achievement of service providers. One jurisdiction that Deloitte interviewed had previously attempted to introduce P4P to Long Term Care providers; the scheme failed because the payments were too low to incent service providers to improve their performance..

Service Provider Maturity

The ability of service providers to meet and exceed service level expectations and capacity for change are key considerations in pursuing outcomes-based funding.

Funding Model Recommendations

Funding Model Recommendations

Overview of recommended funding models

The following sections provide an overview of the recommended funding models for each in-scope program area, along with an explanation of the detailed analysis and calculations.

Included in the recommended funding recommendations for each in-scope program area are:

- Monthly Base Rate recommendations for services under the existing Levels of Care framework, and the draft future Levels of Care framework which is currently being developed by HCS.
- Rate differentials which may be applied on top of monthly base rates, where applicable and in alignment with HCS policy, protocols and approval processes.
- Rates for new initiatives expected to be rolled out by HCS/RHAs, both assuming that applicable licensing and HCS approvals have been granted.

Deloitte has also provided a framework for the development of performance incentives, which is described within the PHSP section.

In-scope program areas

Home Support

- Agency
- Self-Managed Care
- Bookkeepers

Personal Care Homes

- New initiatives being considered by the Department:
    - Residential End of Life Hospice Care
    - Adult Day Programming

Supplemental Benefits

Residential Care (non-PCH)

- Residential Respite (Alternative Family Care Homes)
- Management Fees for Complex Clients
- Non-Traditional types of care in Personal Care Homes (e.g. residential rehabilitation, dementia care)

Provincial Home Support Program

PHSP Funding Recommendations

Home Support – Overview

Home Support - Overview

Personal home support services have been available for a long period of time around Newfoundland and Labrador. Such services provide assistance with personal care, homemaking, and other related services, all of which support individuals to remain in their homes for much longer than they would otherwise be able to do so. Deloitte has prepared funding recommendations for home support agencies, self-managed care and bookkeepers providing support to self-managed care clients. For further information on the nature of these services, please refer to the current service inventory.

Home Support – Agency Rates - Funding Model Selection

In general, home support agencies have provided similar services as those provided privately by support workers under the self-managed care model. Deloitte assessed the current state of agency-provided home support services[1] along with the Department's desire for quality improvements and oversight, greater efficiency and effectiveness of care, and the desire to more appropriately compensate providers for the services provided. The analysis shows that a shift to *complexity adjusted activity-based funding approach* is appropriate.

Going forward, it is recommended that home support agencies are funded on a *complexity adjusted activity-based funding approach*– that is, it is recommended that agencies are compensated at a monthly rate based on the size and complexity of their caseload. There are three distinct advantages to this model:

- Client Centricity: Funding by client caseload will reward service providers for thinking holistically about client needs; agencies will have the incentive to realize efficiencies in how they deliver services to their client population. The focus on individual clients can also form the foundation for funding client outcomes within the home support program.
- Alignment to Client Complexity: Once implemented, the future Levels of Care framework will lead to clearly defined care plans, pathways and clinical assessments that effectively differentiate case complexity. Monthly rates scale objectively based on the framework; providing a defensible and consistent basis for the allocation of funding. The Department can also choose to adjust the Operating margins for each Level of Care to incent agencies, reflecting the additional cost and uncertainty in supporting more complex clients. Through this reimbursement methodology, base funding can reflect the complexity of the client, a key factor in funding model selection.
- Streamlining & Simplification: Funding will be simplified to client case volumes rather than hours of services provided, reducing the administrative burden on both RHAs and home support agencies as funding is delinked from service verification; this reflects Deloitte's consideration of the need and burden of program oversight, one of the key factors in base funding. By managing the case volume and mix of each agency, the RHAs can ensure that each provider receives the base funding needed to maintain the provision of services. Fluctuations between the expected and actual utilization of home support services is expected to be mitigated by both the large volume and diversification of agencies' client population; this is anticipated to reduce the overall variability of service volume.

[1] Consultations with home support providers have surfaced concerns about lack of compensation for time/vehicle use between home support visits, the wage differential between agency and self-managed worker pay rates, and the fact that agency home support was paid at the same rate ($24.10 per hour), regardless of the complexity of the client's care requirements. Lastly a key concern for both providers and clients was that the 'ceiling' for maximum funding for home support clients was too low, which tended to drive clients to self-managed care in order to access more hours than through agencies.

PHSP Funding Recommendations

Home Support – Agency Base Rates

Home Support – Agency Base Rates – Components

A shift to a *complexity adjusted activity-based funding approach* means that instead of being paid on a pure hourly basis for services rendered, it is recommended that agencies are paid a consolidated monthly base rate which is adjusted to align with the complexity of client care being provided and their expected monthly utilization of home support services. The base rates has been calculated based on seven (7) components, as outlined below.

Analysis of the components of the agency base rate further illustrates HCS' movement toward increasing quality of care and professionalism of the sector. Readers will note that Nursing and Quality Assurance, as well as Accreditation Costs, are now featured in the base rate calculation. This inclusion will ensure agencies are funded to provide the right care, based on the requirements outlined in the service level agreements and operating standards.

Monthly Base Rate Components – Agencies

Home Support Services:

Direct costs associated with the provision of home support services

Mileage:

Cost of home support workers traveling to and from client homes

Supplies:

Cost of supplies expended in the provision of home support (e.g., gloves).

Administration & Other

Indirect costs related to business and administration activities. Including the direct cost of accreditation

Nursing & Quality Assurance

Nursing staff wages required to meet service levels

Facility Expense

Costs related to the operation and maintenance of the agency's office

Technology

Cost associated with investing and maintaining technology assets. Notably, this includes the cost of an integrated cloud-based home health care SaaS platform that will be common across all agencies and self-managed Care

PHSP Funding Recommendations

Home Support – Agency Base Rates

Home Support – Agency Base Rates – Calculation Methodology

The calculation methodology for each of the seven base rate components takes into consideration at least one or more of the following approaches to calculate an objective and defensible rate:

- Directly tied to Levels of Care, Operating Standards and Service Level Agreements: Where applicable, funding was directly tied to the expected utilization of services and the service requirements as outlined by the future Levels of Care framework, Operating Standards and Service Level Agreements.
    - Reimbursement for Home Support Services are calculated based on the expected utilization of home support services (homemaking, personal care) for a given level of client complexity as defined by the proposed Levels of Care framework; historical home support data was used to determine the average hours and types of home support services accessed by each Level of Care. Agencies will be reimbursed on a monthly basis in accordance to the size and complexity of their caseload
    - Various components included in the Nursing & Quality Assurance, Technology and Administration & Other expenses are included in the base rate in accordance to the requirements outlined in the Operating Standards and Service Level Agreements
    - It is anticipated that changes to the Provincial Home Support Program (notably the Operating Standards and Service Level Agreements) could decrease the number of operators within the home support sector. Deloitte made an illustrative assumption regarding the potential number of operators in NL's Home Support market (see Appendix C for further details)
- Fair market value for equivalent costs & services: In the case of expenses that are common across the home support industry, Deloitte performed desktop research and consulted a number of operators from a variety of jurisdictions. Key sources of data include operators in Newfoundland & Labrador, Nova Scotia and New Brunswick, as well as industry data from Statistics Canada. These comparable costs were used to form the foundation of a defensible market rate for the base rate components listed below:
    - Home Support Services
        - Differentials between wage rates for personal care and homemaking were estimated based on desktop research on rates in other jurisdictions
    - Facility Expenses
        - Rent expenses were calculated using market studies of commercial properties in NL
    - Administration and Other Expenses
        - Staffing ratios for support staff (e.g., schedulers, recruiters and management) were estimated based on consultations with agencies in NL, NS and NB. The wage rates were estimated based on comparable wages at the RHAs and desktop research into collective agreements.
        - Expenses are inclusive of training costs for Home Support workers, reflecting HCS's efforts in developing a robust education strategy.
    - Nursing and Quality Assurance
    - Supplies
    - Operating Margin

PHSP Funding Recommendations

Home Support – Agency Base Rates

Home Support – Agency Base Rates

The shift to a *monthly, per client reimbursement* for agencies will mean greater opportunities for provider efficiency, predictability of funding, and other desirable factors for providers. Key considerations for the new funding approach for agency care acknowledge that client variability is high for home support clients. Specifically, the recommended funding approach acknowledges that:

- Care hours should rise with the level of complexity. A client's level of care and support needs will be based on formal assessment by the RHAs and set out in a client's Care Plan.
- Administrative efforts should also rise with the level of complexity, and have been calculated to scale based on the care required;
- Mileage between the agency and client homes should be reflected in the calculation, and proportional to hours of care accessed by the client;
- The cost of nursing oversight, facilities, technology and supplies should be distributed across the client base. These expenses also scale to the hours of client care, as provider resources will be disproportionately tied to clients with higher levels of complexity. This mechanism distributes fixed costs (e.g., facilities and technology) across care hours provided by an agency, rather than individual clients; as this is an activity based model, reimbursement is tied to the volume of service delivered (expected monthly hours of service by LoC)
- An operating margin has been factored into the calculation. Deloitte recommends a 5%, margin for the Department's consideration, this primarily reflects industry data from Statistics Canada and is corroborated through consultations with agencies in Atlantic Canada. The inclusion of an operating margin is a net new addition for home support agency funding. HCS recognizes that the majority of agency operators are from the private sector and thus the need to incorporate a profit margin and a 'cushion' for variability in business expenses.

  At present, Deloitte is recommending the same operating margin for all Levels of Care, as agencies will already be remunerated at a higher rate for more complex clients (reflecting higher service utilization), it is currently uncertain whether differentiated margins are required to enable the rapid placement of complex clients into the community. Should this need arise, the Department can make necessary adjustments to the funding model.

Deloitte worked with HCS / RHAs to understand clinical requirements and to develop underlying assumptions related to staffing, management, and overhead costs. Such calculations that are factored into the base rate components and described in detail in Appendix C. The table below summarizes the costs and total base rates for each of the Levels of Care in the new HCS policy framework:

	Monthly Base rate components – Agencies											
	Home support services	Admin and other	Mileage	Nursing and Quality Assurance	Facilities Expense	Technology	Supplies	Subtotal	Operating Margin	Recommended Monthly Base Rate	Avg. Personal Care Hours (Per Client, Per Month)	Avg. Home Making Hours (Per Client, Per Month)
Level B – Low to Moderate	$700	$88	$21	$6	$4	$4	$2	$823	5%	$864	12.4	22.5
Level C – Moderate	$1,711	$213	$47	$14	$9	$9	$6	$2,008	5%	$2,108	36.1	48.5
Level D – Moderate to High	$2,971	$364	$73	$23	$15	$15	$15	$3,476	5%	$3,650	88.8	55.7
Level E – High	$4,203	$510	$95	$32	$21	$21	$24	$4,906	5%	$5,151	143.2	59.6
Level F - Complex	$9,788	$1,181	$161	$75	$48	$48	$61	$11,363	5%	$11,931	365.6	103.5

PHSP Funding Recommendations

Home Support – Agency Base Rates

Home Support – Agency Base Rates

While it is recommended that the home support program transition to a complexity-adjusted activity based funding approach, this change could take a number of years to fully implement. During this transition period, service providers will require an 'interim' funding model to reflect the additional costs associated with the Service Level Agreement and the Operational Standards. Deloitte is recommending an interim funding model based on the hourly activity based funding (ABF) model currently in place; with updates to reflect the cost of various base rate components that were previously outlined. The base rate components are largely the same as the assumptions in the proposed model (see Appendix C), but adjusted to reflect a cost per hour of home support delivered. Two notable differences between the assumptions for the interim model and proposed future model are:

- **Hourly rate of home support services:** In the interim, it is assumed that the hourly rate of home support services remain at the collective agreement rate of $16.55/hr
- **Accreditation costs:** In the interim, the Department can consider directly covering the cost of accreditation. For the purposes of the interim model, Deloitte has made the illustrative assumption that Accreditation costs will be reimbursed by the department (with agencies that receive accreditation), thus the cost is not reflected in the model.

Current Model

- Activity Based Funding
- Hourly rate of home support services is $16.55
- Cost of Accreditation not included in rate

Interim Model

- Activity Based Funding
- Hourly rate of home support services is $16.55
- Updated to reflect costs associated with Service Level Agreement and Operational Standards
- Cost of Accreditation not included in rate

Future Model

- Complexity-Adjusted Activity Based Funding
- Payments are based on the expected monthly utilization of services (as determined by a client's Level of Care)
- Includes costs associated with Service Level Agreement and Operational Standards
- Cost of Accreditation is included in the rate

Hourly base rate components – Agencies (Interim)

	Home support services	Administration and other	Mileage	Nursing and Quality Assurance	Facilities Expense	Technology	Supplies	Subtotal	Operating Margin	Recommended Hourly Base Rate	Current Hourly Rate
Hourly Rate	$20.35	$2.51	$0.50	$0.16	$0.10	$0.10	$0.09	$23.82	5%	$25.01	$24.10

PHSP Funding Recommendations

Home Support – Agency Base Rates

Home Support – Agency Differential Rates

Deloitte is not recommending the widespread use of differential rates for PHSP agencies. While there will certainly be PHSP clients requiring care in rural regions, it is anticipated that self-managed care (as opposed to agency based home support) will be a more accessible, efficient and effective care option in those scenarios. The rationale for differential rates is to support clients with exceptional needs/requirements that would limit access to services if no additional funding is provided; the availability of self-managed care ensures that clients living in remote areas continue to have reasonable access to care. However, cost of living differences experienced in Labrador are significant and warrant separate consideration. Consistent with multiple public sector collective agreements, the Province should consider a Labrador Allowance in recognition of the labor force challenges faced by agencies in Labrador. Detailed analysis of applicable wage differences are provided within Appendix C.

Home Support – Agency P4P Incentives

Part of the Department's long-term vision for LTC CSS is to incent greater innovation and performance in community-based service providers. Different models of incentive or reward-based funding have been explored by jurisdictions in Canada, however, as described in earlier sections of this report, there are few examples to date where funding has been tied directly to provider performance.

To assist the Department in moving toward this long-term goal, Deloitte developed different demonstrative pay for performance (P4P) frameworks that could be used to incent providers in programs such as Home Support. The PHSP is recommended to be the first program to implement a P4P framework because of the planned introduction of Key Performance Indicators (KPIs) as part of the new service level agreement; as such, the PHSP is likely to be the first program to have sufficient 'baseline' performance data to use as the foundation for a pay for performance framework.

Deloitte is recommending that the Department considers a 'Scoring System' performance payment framework when implementing P4P in the PHSP. Under this model, achieving targets for Key Performance Indicators will contribute 'points' to an individual agency. Achieving a given number of points within a set time frame (e.g., one year) will enable an agency to claim an incentive payment. The points allocated to each KPI can be weighted based on the Department's priorities. The benefits of a 'Scoring System' performance payment framework are:

- Holistic view of performance metrics: As all KPIs contribute to the same payment, providers are encouraged to consider all metrics holistically, rather than picking the metrics that can be achieved more easily
- Mechanism to implement penalties: Penalties can be implemented within the scoring system for certain metrics, enabling the Department to penalize certain behaviours without affecting an agency's base funding
- Alignment to Audit Process: If incentives are distributed on an annual basis, the payment schedule would align to the Department's audit/review process

For a more detailed comparison of Performance Payment models, please see Appendix H.

PHSP Funding Recommendations

Home Support – Agency Base Rates

Home Support – Agency P4P Incentives

The KPIs listed below are performance indicators that are being implemented as part of the new service level agreements in PHSP. These KPIs were used as the foundation of the **demonstrative performance management framework**; the data collected from these metrics may form the 'baseline' performance data required to implement incentive payments. Implementing a performance management framework without "baseline" data runs the risk of having too many or two few agencies achieving performance targets and receiving incentive payments. **The indicators below and the P4P framework detailed in subsequent pages are purely demonstrative and may differ from the future performance payment model.**

Note that, 'attainment of accreditation', the last of the listed KPIs is not from the performance management framework but was included due to the Department's focus on the attainment of external accreditation among home support agencies.

Indicator	Goal	Target	Standard	Frequency of report/review
Percentage of service requests accepted by the Service Provider.	To decrease time for supportive services to be put in place	95% of service requests issued by the RHA will be accepted by the Service Provider	98% of service requests issued by the RHA will be accepted by the Service Provider	Quarterly/Annually
Percentage of clients who received first service visit within the time frame indicated in the service request.	To ensure clients receive timely access to support	90% of clients will receive their first service visit within the time frame indicated in the service request.	95% of clients will receive their first service visit within the time frame indicated in the service request.	Quarterly/Annually
Percentage of episodes of missed care.	To ensure clients receive timely access to care	The percentage of episodes of missed care shall not be greater than 2%.	The percentage of episodes of missed care shall not be greater than 1.5%.	Quarterly/Annually
Percentage of Service Provider Progress Reports that have been submitted.	To ensure a client's Service Plan is implemented	90% of Service Provider Progress Reports will be submitted at month's end.	95% of Service Provider Progress Reports due will be submitted at month's end.	Monthly/Quarterly
Percentage of instances where there are inconsistencies in the Confirmation of Service Provision and/or Service Billing Invoices have been delayed or have had an error.	To ensure appropriate financial management	No greater than 5% of submissions have inconsistencies	No greater than 2% of submissions have inconsistencies	Quarterly/Annually
Attainment of accreditation within a defined time period	To encourage agencies to gain accreditation status	Targets and standards can relate to the timing for attaining accreditation. Agencies that are accredited earlier may receive a larger incentive		Annually/Annually

PHSP Funding Recommendations

Home Support – Agency Base Rates

Home Support – Agency P4P Incentives

Deloitte generated a number of assumptions that were used to create the example performance payment framework:

- A key assumption of the development of performance frameworks is that the size of potential performance payments are scaled based on the number of home support hours delivered by Home Support Agencies. That is, the achievement of the same indicator by a very small agency and a very large agency would generate performance payments of different value. For the purposes of demonstration only, three levels of provider service volume ('bands') were established:
    - Band 1 for agencies delivering more than 30,000 hours of subsidized care each month;
    - Band 2 for agencies delivering between 10,000 and 30,000 hours of subsidized care per month; and
    - Band 3 for agencies delivering less than 10,000 hours of subsidized care each month.
- It was assumed that key performance indicators would only be tied to performance incentives, not penalties
- For the purposes of discussion, a total annual budget for performance incentives would be limited to $10 million per year.
- Given current market changes in other jurisdictions, it was assumed that the number of agencies in the Province will decrease to 20 home support agencies.

The following table outlines how performance payments might be allocated, based on these assumptions:

Distribution of HS Agencies by hours of home support delivered per month:

Band	Hours of Subsidized Home Support (Monthly)	Number of Agencies	Maximum Annual Payment per Agency
1	More than 30,000 hours	5	$750k per annum
2	Between 10,000 and 30,000 hours	10	$500k per annum
3	Less than 10,000 hours	5	$250k per annum

PHSP Funding Recommendations

Home Support – Agency Base Rates

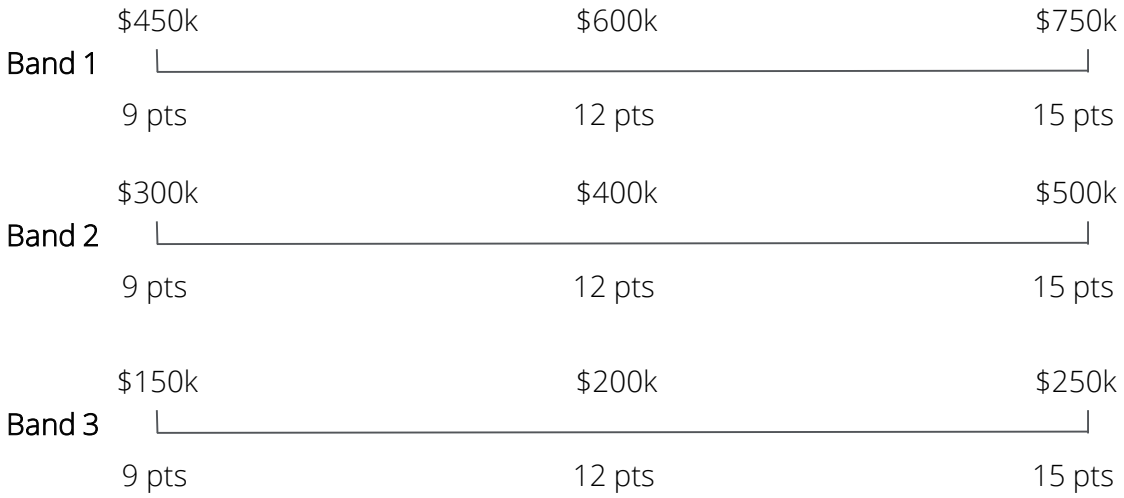
Home Support – Agency P4P Incentives

Using the outlined assumptions and the aforementioned KPIs, Deloitte developed a demonstrative performance payment framework based on the Scoring System model. Each indicator contributes to a maximum of 15 points, which are then weighted based on the relative importance of each indicator to the Department. The scores for each indicator are tallied annually and incentives are allocated to successful agencies based on the incentive payment schedule.

The highest an agency can score is 15 points, as such, this score corresponds to the full funding amount of 750k per agency, per annum. Both the scoring (Steps) and the payment schedule are demonstrative and should be informed by historical 'base line performance'.

Through observing the distribution of agency performance against the KPIs, scoring and payment should be calibrated to incent the metrics where performance improvements are most necessary. Weighting of KPIs can be calibrated based on historical performance and policy direction

Example Incentive Payment Schedule – All incentives are paid out annually



Example Performance Payment Framework

KPI	Weight	Score (Steps)		
		Step 1 (5 points)	Step 2 (10 points)	Step 3 (15 points)
Referral Acceptance Rate	40%	95% of referrals accepted	96.5% of referrals accepted	98% of referrals accepted
Client Satisfaction	30%	90% of clients are satisfied	95% of clients are satisfied	100% of clients are satisfied
Accreditation Status	10%	Accreditation received in Y3+*	Accreditation received in Y2*	Accreditation received in Y1*
Episodes of Missed Care	10%	The percentage of episodes of missed care is less than 2%	The percentage of episodes of missed care is less than 1.75%	The percentage of episodes of missed care is less than 1.5%.
Billing Errors	10%	Less than 5% of submissions have inconsistencies	Less than 3.5% of submissions have inconsistencies	Less than 2% of submissions have inconsistencies

*Years since launch of performance incentive framework

PHSP Funding Recommendations

Home Support – Self-Managed Care & Bookkeepers

Home Support – Self-Managed Care & Bookkeepers – Funding Model Selection

Self Managed Care

Going forward, self-managed home support (as envisioned by HCS and assuming the implementation of the recommendations in this report) will provide clients with greater choice and control of their care than in the past. The analysis done by Deloitte indicates that changes to the funding approach for the home support program will also benefit the workers that provide home support to self-managed care clients.

The recommended option for funding self-managed care is a complexity-adjusted activity based model; instead of being paid on a pure hourly basis regardless of the type of work being done, home support work under the self-managed care option would be compensated at a rate that more accurately reflects the nature of support being provided. There are distinct advantages to this model:

- Alignment to Client Complexity. Part of the strategy underlying the funding changes to the Provincial Home Support program is to compensate work of different complexities at different rates of pay, this is a core consideration when selecting the model for base funding. Some clients may primarily need homemaking support (e.g. making meals, light housekeeping) whereas other may need assistance with personal care (e.g. bathing, dressing). Other clients may need a combination of both types of services. By adjusting the base rate for each of these services, the model will reflect the different complexities of client needs
- Responsiveness to Service Volumes. Because self-managed care workers lack the client caseload and diversification of a home support agency, it is recommended that the self-managed care option continues to be funded on an hourly basis (as opposed to case volume). This reflects the expected variability of hours delivered from client to client, one of the key factors for consideration when selecting a funding model

Bookkeepers

It is recommended that bookkeepers continue to be reimbursed biweekly, as calculated based on a bookkeeper's client caseload and the expected utilization of bookkeeping services (as determined by the number of home support workers a client employs). There are distinct advantages to this model:

- Responsiveness to Service Volumes. Consultations with providers indicated that the high turnover of home support workers is one of the key challenges encountered by bookkeepers, and one of the main drivers of variability in provider effort. Clients that employ more home support workers are more likely to experience worker turnover; by adjusting the base rate to reflect the number of workers, the model will capture the variability of service volume
- Need and Burden of Program Oversight. A bi-weekly reimbursement model based on client caseload reduces both the frequency of payments and the administrative burden associated with tracking the hours of service delivered

PHSP Funding Recommendations

Home Support – Self-Managed Care & Bookkeepers

Home Support – Self-Managed Care & Bookkeepers Base Rate – Components

The recommended shift to a *complexity-adjusted activity-based* funding model for self-managed care means that different home support services (i.e., personal care and homemaking) have different base rates to reflect their different complexities. The base rates for both self-managed care and bookkeepers has been calculated based on the components, as outlined in the table below.

Self-managed care has considerably fewer base rate components than home support agencies. This reflects the realities of the two modes of service delivery, wherein self-managed care is delivered by individual workers, whilst agencies are an organization with administration, mileage, nursing, facility and technology expenses. This difference also reflects the fact that agencies are required to meet operating standards and service levels that are not required for SMC workers.

The funding recommendations are made with the assumption that SMC workers will provide required supplies (excluding supplies included as part of the SAP). However, if the Department chooses to provide supplies to clients/workers directly, this reimbursement component can be excluded.

Respite care and Behavioral Supports are also provided by Self Managed Care workers. Respite care "packages" are a combination of various home support services including homemaking and personal care. As such, it is recommended that respite hours be categorized under these services (based on client needs) and reimbursed at the relevant rate. Furthermore, Deloitte recommends that HCS consider the analysis from this report to inform further study on the reimbursement rate for Behavioral Support provided by SMC workers; this rate can be implemented at a later date.

Hourly Base Rate Components – Self-Managed Care	
Home Support Services: Direct costs associated with the provision of home support services. Two types of home support services are provided: Personal Care and Homemaking, which are payable at different rates.	**Bookkeeping** Cost of hiring a bookkeeper to support a self-managed care client
Supplies: Cost of supplies expended in the provision of personal care services (e.g., gloves).	

Home Support – Self-Managed Care & Bookkeepers Base Rate – Methodology

Self-Managed Care:

The calculation methodology for the two base rate components in the SMC model follow the same methodologies as outlined for home support agencies. The key difference being that home support services are calculated as an hourly rate in the SMC model, as opposed to the monthly expected utilization in the agency model

Bookkeepers:

Deloitte utilized an internal bookkeeping pricing tool and consultations with a Deloitte bookkeeper to estimate the expected monthly effort (hour per month) to support clients employing varying numbers of home support workers; this analysis was corroborated by consultations with bookkeepers and bookkeeper responses to the service provider survey. A combination of desktop research, stakeholder consultations and Deloitte's rates were used to estimate the market rate for bookkeeping services in Newfoundland & Labrador

PHSP Funding Recommendations

Home Support – Self-Managed Care & Bookkeepers

Home Support – Self-Managed Care & Bookkeepers Base Rate

The shift towards a *complexity adjusted activity-based* funding model for self-managed care workers will mean that funding is representative of the varying levels of complexity between clients. The recommended funding approach for bookkeepers and self-managed care workers acknowledges the realities of the industry. Key considerations of the recommended funding approach include:

- **The harmonization of wage rates between self-managed care and home support workers.** The wage rates for both types of workers have been harmonized, reflecting the fact that self-managed care and agency workers are providing the same services to clients
- **The inclusion of benefits in the home support services rate.** Benefits (reflecting EI, CPP and Vacation) are included in the home support services rate for self-managed care workers
- **The assumption that supplies are clinical in nature, and are not required for homemaking services.** As with PHSP agency assumptions, it is assumed that supplies (notably gloves) are only consumed regularly in the provision of personal care services.
- **Bookkeeping assumptions are based on the current processes and technology.** Stakeholder consultations have identified inefficiencies in the current process and technologies in place between the RHAs and the bookkeepers. Improvements in technology and processes for submitting claims may significantly reduce the effort (hours per task) and potentially the volume of bookkeeping services required.

Appendix C contains all detailed assumptions, data sources and calculations for each of these recommendations.

The table below outlines the underlying rate components for each type of home support and for bookkeeping services:

Service Type	Hourly Rate	Home Support Rate Components		Bookkeeping Rate Components (per client)	
		Home Support Services (inclusive of benefits)	Supplies	Number of HS Workers	Rate (biweekly)
Personal Care	$ 19.43*	$ 19.27	$ 0.17	1	$ 26.07
				2	$ 40.88
				3	$ 55.70
Homemaking	$ 17.60	$ 17.60	-	4	$ 70.52
				5	$ 85.34

*Note that some rates may not total due to rounding

PHSP Funding Recommendations

Home Support – Self-Managed Care & Bookkeepers / Behavioral Supports

Home Support – Self-Managed Care & Bookkeepers Differential Rate

Deloitte is not recommending the use of differential rates for either self-managed care or bookkeepers. Neither services have clients with unique/exceptional requirements to the extent that the cost required to meet their needs would preclude service providers from delivering services without additional funding. While there are certainly self-managed care clients in rural areas, it is expected that they will receive services from home support workers living in the same region. In the case of bookkeeping, service providers do not have to be physically accessible in the same manner as home support workers, enabling them to deliver services remotely. The recommended base funding approaches for both self-managed care workers and bookkeepers are also expected to reflect different client complexities.

Home Support – Self-Managed Care & Bookkeepers Performance Incentives

Incentive funding for self-managed care and bookkeepers is not recommended at the current time for the reasons outlined below:

- Lack of Program Performance Management Framework: A successful pay-for-performance (P4P) framework is dependent on an established underlying performance management and measurement system. As the process and system for tracking and monitoring the performance metrics for self-managed care workers and bookkeepers have not been established, there is not yet sufficient baseline data to develop a performance management framework for either service.
- Administrative Burden: Self-managed care is delivered by independent home support workers; the effort required to track, assess and reward the performance of individual workers would put a considerable administrative burden on the department and the RHAs.
- Ongoing Changes to the Administrative and Technological Process: Conversely, the process and technology for delivering bookkeeping services for self-managed clients are currently being updated. Until those improvements have been implemented, it is unclear whether a P4P framework will be required for bookkeepers.

Other Programs – Behavioral Supports

While not part of the Home Support program, services from Home Therapists and Behavioral Aides can also be accessed by clients at home. These services are availed by clients with intellectual disabilities and are delivered by individuals with post secondary education (preferably in the field of psychology). To ensure that there is alignment between funding and client complexity, Deloitte utilized GNL's job class profiles and the NAPE General Service Pay Grid (CG Hourly Rate) to identify the appropriate reimbursement rate for Home therapist and Behavioral aides given their skills, experience and education requirements. Appendix C contains the detailed results of Deloitte's analysis.

PHSP Funding Recommendations

Home Support – System Impact

Home Support – Impact on Program Expenditures

Within the development of funding models, the potential impact to program/system expenditure is an important consideration. However, additional inputs will be required before an analysis of the potential impacts to overall program expenditures can be completed. The dependent inputs are as follows:

- Levels of Care Mapping: The Department and the RHAs are in the process of mapping clients to a proposed Levels of Care framework. Until this process is complete, it is unclear how many clients would fall under each level and the expected service utilization at each Level of Care. This input is required to project the client caseload, case-mix and service volume, all of which are key inputs into the program expenditures for both the agency and self-managed care models.

- Ongoing Efforts to Address Over-Servicing: The Department recognizes that there is currently an over-servicing of clients within the Health and Community Services Programs. To address this, HCS has been working to ensure that clients are receiving the appropriate services in accordance to their needs. These ongoing efforts may affect both the volume and types of services being delivered, thus potentially impacting program expenditures for the PHSP.

- Potential Cost Efficiencies from new Operating Standards and Service Level Agreements: The recommended funding models reflect the additional costs associated with meeting the new Service Level Agreements and Operating Standards within the PHSP. Whilst this may incur a cost for the program, there are potential cost efficiencies that may be realized. For example, investments in Home Health technology may reduce the administrative burden for both the RHAs and providers. Until these potential benefits are realized, it is difficult to assess the financial impact of the new Service Level Agreements and Operating Standards.

- Policy and Process Changes: The interdependencies within the system, means that any changes to existing policies and processes can lead to 'knock-on' effects on the system. For example, changes to financial assessment processes and other policies may have impact on the volume of clients receiving services within the PHSP, which in turn, would affect the program's expenditures.

Once these dependent inputs have been addressed, the Department should conduct an analysis of the potential impacts of the new funding models on PHSP expenditure.

Personal Care Homes

Personal Care Home Funding Recommendations

Personal Care Homes – Funding Model Selection for Base Rate

As outlined in the Current Service Inventory and Stakeholder Engagement sections of this report, Deloitte's research and analysis demonstrated that historical funding rates of Personal Care Homes were not calculated using a defensible, consistent methodology reflective of levels of care. The funding model did not provide sufficient clarity and transparency, nor did it reward operators for increasing quality of care and professionalism over time. The value of the historical per diem rates also did not provide sufficient value to providers that are in most cases, operating a private business to serve clients in the community.

Going forward, it is recommended that PCH operators continue to be reimbursed using a *monthly per diem*, however, the base rate should be *complexity adjusted* by Level of Care to reflect the increasing care needs for each respective Level of Care, the monthly per diem could also incorporate rates for highly-utilized services or supplies in PCH (such as foot care, medical travel, medical outbreak and incontinence supplies) to incentivize providers to control costs and reduce the administrative burden on the RHAs, and finally, the monthly rate should build in differentiated operating margins by Level of Care to incentivize operator to accept clients with more complex needs. The key advantages of this model are detailed below.

- Alignment to Client Complexity: Monthly rates scale objectively based on the proposed Levels of Care framework; providing a defensible and consistent basis for the allocation of funding. Operating margins can be adjusted for each Level of Care to incent homes to support more complex clients.
- Client Centricity: Bundling in frequently-utilized services will reward service providers for thinking holistically about client needs; homes will have the incentive to realize efficiencies in how they deliver services to their resident population.
- Streamlining & Simplification: Building in rate components such as foot care, medical travel, medical outbreak and incontinence supplies, and safety and accessibility equipment will reduce the administrative burden on the RHAs.

At time of writing, the new Levels of Care framework remain under development. Even when implementation begins, a period of transition may be expected during which time some PCHs are likely to continue operating under the existing approach. In general, Deloitte recommends the following for adoption in the near term:

- That monthly base rate funding is increased to reflect client complexity. Deloitte recommends changes to the current PCH funding rate structure as outlined in the table on the next page, which represent an 3.0% increase on average from current levels (see Appendix D for total cost analysis of current and proposed funding levels for each program area).
- That the range and nature of services provided within the PCH base rate structure, should be increased. Deloitte recommends that the nature of the services included in PCH base rates should also be increased to increase client access to services and to provide higher quality care to PCH residents.

Personal Care Home Funding Recommendations

Personal Care Homes – Monthly Base Rates

Part of Deloitte's work was to examine the financial records of selected PCH providers, government funding policy, and financial statements from similar providers in other jurisdictions, with a view to describing the core components of monthly base rate funding. After consultation with the Steering Committee, it was agreed that the following ten components would be recommended for inclusion in the monthly base rate for PCHs.

Base Rate Components			
Resident Care		Facility Operations	
	**Direct Care and Program Support.** Costs of direct care staff and program costs directly associated with the provision of care services.		**Facility Expense.** Costs related to the operation and maintenance of the personal care home.
	**Supporting Services.** Costs such as salaries and benefits for administrative and other staff not directly associated with the provision of resident care.		**Insurance Expense.** Cost of applicable commercial, property, and vehicle insurance.
	**Dietetic Services.** Cost of quality meal and dietary provisions for residents.		**Administration, Training, and Other.** Cost of administration costs, training, and other indirect costs related to business.
	**Medical Travel.** Cost of travel to from client medical appointments, or as required for health/medical related services (e.g., to obtain bloodwork).		**Safety and Accessibility Equipment.** Costs of essential equipment for a resident-friendly environment.
	**Foot Care.** Cost of directly providing or arranging to provide foot care services.		**Medical and Incontinence Supplies.** Costs of highly utilized incontinence, medical and outbreak supplies.

Personal Care Home Funding Recommendations

Personal Care Homes – Calculation Methodology for Base Rate

The calculation methodology for each of the ten base rate components takes into consideration at least one or more of the following approaches to calculate an objective and defensible rate.

- Directly tied to Levels of Care and Operating Standards: For service volumes that are explicitly outlined in the proposed Levels of Care or Operating Standards and determined according to a clinical need, funding should be calculated according to those service levels.
    - Direct Care and Program Support is calculated according to this methodology using the daily direct care hours required for Level I, II, Enhanced Care, and III residents. Funded hours of care will only change with changes in the levels of care framework and operating standards. For existing operating standards, Level I and II residents are entitled to 2.0 hours of direct and indirect care per day, Enhanced Care residents are entitled to 3.5 hours, and Level III's are entitled up to 3.9 hours. Indirect support hours are assumed to represent approximately 0.5 hours per day for all Levels.
        - Under the proposed Levels of Care Framework, direct daily hours of care for Level B – Low to Moderate, Level C – Moderate, Level D – Moderate to High, and Level E – High may change in relation to new operating standards; however, at the time of this report's writing, these details are yet to be determined.
    - Certain components included in the Safety and Accessibility Equipment, Medical and Incontinence Supplies, and Administration, Training and Other rates are calculated according to specific requirements outlined in the operating standards.
- Fair market value for equivalent services: For services that are offered in the private sector, or offered by comparable operators in other jurisdictions, detailed analysis of rates paid for select services in Nova Scotia, New Brunswick, and select PCH operators in Newfoundland and Labrador and desk-top research was completed by Deloitte to determine a defensible market rate for the following components.
    - Dietetic Services, Facility Expense, Insurance Expense, and Administration, Training, and Other components were all calculated using select comparator financials in NS, NB, and NL of various sizes (ranging from 17 to 190[1] beds) in various regions to capture potential deviances in operating costs. Components were adjusted for cost of living differences between regions and Consumer Price Index (CPI) inflation rates where applicable.
    - Supporting services are calculated as a percentage of direct care salaries and expenses from comparator organizations.
    - Operating margins are built in to incentivize operators to deliver services and accept complex clients. The jurisdictional scan revealed that operating margins for PCH equivalent facilities range from 1.3% to 41.5%. The weighted[2] average operating margin from jurisdictional comparators from across Canada, 9.6%, was used in the base rate for the funding model for Level II residents, which can be adjusted up or down for each level to incentivize acceptance of clients.
    - Select supplies, equipment, and training costs were determined using desk-top research.

[1] By definition, PCHs in NL cannot exceed 100 beds. All figures from comparator jurisdictions were analyzed on a per bed basis to adjust for variances in facility sizes.
[2] Weighted according to revenue to reflect differences in scale. Figures for residential care facilities across Canada from Statistics Canada.

Personal Care Home Funding Recommendations

Personal Care Homes – Calculation Methodology for Base Rate

- Standard rates based on utilization of services, supplies, or equipment: As a general rule, services used frequently by the majority of residents (within 5 percentage points of 50% overall utilization or higher) were built into the monthly rate based on the average volume of claims in a month.
    - Medical travel was claimed by 59% of PCH residents in FY2017/18. 80% of medical travel claims were below 215km and are built in to the base rate as a fixed monthly amount. All monthly claims in excess of 215km are considered exceptional medical travel, it is recommended that these claims are individualized to meet clinically-assessed needs.
    - Foot care was claimed by 56% of PCH residents on average 5.2 times per year in FY2017/18.
    - Safety and Accessibility equipment required to provide a safe and accessible living environment for seniors were built into the base rate according to their useful life and ratio of equipment to resident. For example, equipment included in this rate includes highly-utilized, general use walkers, canes, wheel chairs, raised toilet seats, and other common equipment.
    - Incontinence supplies were claimed by 46% of PCH residents, and included a variety of products including soaker pads, pull-ups, light protection pads, bariatric briefs, and other products used by incontinent residents. A weighted average including the cost of the individual supplies, and the average number of packages claimed by residents was used to calculate the monthly rate.

A detailed description of the base rate component calculation methodologies, assumptions, analysis, and data sources are provided in Appendix D. All historical data provided by the Department are based on the existing Levels of Care framework (Level I, II, Enhanced Care, and III); however, following the reassessment of LTC CSS clients, implementation of the proposed Levels of Care framework, and PCH operating standards, the key inputs and assumptions included in the base rate should be revisited.

Personal Care Home Funding Recommendations

Personal Care Homes – Monthly Base Rates

The base rate calculations also include a new amount for operating margin (%). Historically, a 3% 'vacancy rate adjustment' was included in the Board & Lodging rate for all levels of care.

- Deloitte recommends an operating margin be included to reward providers for serving clients with higher levels of complexity. A weighted average operating margin of 9.6% was calculated based on 14 Atlantic Canadian comparators.
- 3%, 10% and 12% operating margins have been included in the recommended base rates for the three levels of care.
    - The Level I margin of 3% is based on the 'vacancy rate adjustment' margin historically included in the Board & Lodging rate for a similar rationale and to differentiate the Level I and II monthly base rate.
    - 10% for Level II is included according to the comparator operating margin.
    - An incremental margin of 2% points was added to the Level II rate for the Enhanced Care rate to incentivize acceptance of more complex clients.
- While the actual value of the operating margin remains at the discretion of HCS to confirm, an incremental amount (equivalent to 1-5% of the subtotaled base components) is included to ensure that providers' profit is reflected, and to reward providers for serving clients with higher levels of complexity.

Personal Care Home Funding Recommendations

Personal Care Homes – Monthly Base Rates

The table below describes the funding levels for each of the ten components of Deloitte's monthly base rate recommendations.

Existing Levels of Care – Recommended Monthly Base Rates:

	Base rate components – Personal Care Homes										Subtotal	Operating Margin (%) (formerly vacancy adj.)	Recommended Monthly Base Rate[1]
	Direct care & program costs	Support Services	Dietetic Services	Medical Travel	Foot Care	Facility Expenses	Insurance	Admin, Training, Other	Safety and Access. Equip	Medical and Incont. Supplies			
Level I	$872	$250	$250	$18	$10	$731	$28	$125	$17	$30	$2,332	3%	$2,402
Level II	$872	$250	$250	$21	$10	$731	$28	$125	$17	$30	$2,335	10%	$2,558
Enhanced Care	$1,745	$250	$250	$21	$10	$731	$28	$125	$60	$30	$3,250	12%	$3,626

Under the existing Levels of Care:

- Direct care and program costs are the same for Level I and Level II; funding for direct care of Enhanced Care clients have declined by $182/month to adjust for differences in the historical calculation of overtime and payroll deductions.
- Medical travel costs assessed as a percentage of total utilization across PCHs have been included at a rate of $18 for Level I, and $21 for each of Level II and Enhanced Care.
- Foot care for PCH residents was historically funded on an individualized basis to a sub-service provider at a rate of $40 per claim for up to 8 claims per client per year. Foot care is now included at a rate of $10/month for all levels.
- The monthly rate now includes an amount for employee training costs and fees in Administration, Training, and Other. The historical Board & Lodging rate did not include funding for training costs.
- Safety and Accessibility equipment were previously funded on an individualized basis through the Special Assistance Program (SAP). The monthly PCH rate now includes $17 each for Level I and II, and $60 for Enhanced Care based on common-use equipment. Specialized and custom equipment should continue to be funded through the SAP.
- Medical and Incontinence supplies were historically billed funded on a per client basis through the SAP. Medical and Incontinence supplies are now included at a rate of $30.
- Level III clients (not shown here) are assumed to have the same base rate components as Enhanced Care clients, with the new differential rate for 'Awaiting LTC placement' applied to compensate for additional direct care hours.

[1] For comparison, current PCH base funding rates are $2,375/month for Levels I and II; $3,430/month for Enhanced Care; $1,135/month supplemental rate for Level III awaiting LTC placement (total of $3,510/month when added to Level I and II Board and Lodging rate). Current funding covers lodging, food service, personal care only.

Personal Care Home Funding Recommendations

Personal Care Homes – Monthly Base Rates

The tables below outline the recommended monthly base rates for PCH operators under the existing Levels of Care:

Program	Service	Rate Recommendations – Existing Levels of Care			
		Level I	Level II	Enhanced Care	Level III [1]
Proposed Funding	Base Rate	$2,402/client per month	$2,558/client per month	$3,626/client per month	$3,885/client per month
Current Funding	Board & Lodging Rate	$2,375/client per month	$2,375/client per month	$3,430/client per month	$3,512/client per month

It may be tempting to directly compare funding levels between the current funding formula, and Deloitte's funding recommendations. Readers of this report are reminded that in the past, PCH operators were reimbursed over and above the monthly base rate for some services, which are now recommended for inclusion in monthly base rate amounts. A comparative analysis for current and recommended funding levels is located in Appendix D.

Under the proposed Levels of Care framework, funding for Level I, II, Enhanced Care, and III residents will approximately map to Level B – Low to Moderate, Level C – Moderate, Level D – Moderate to High, and Level E – High. However, daily direct hours of care for PCH residents are to be confirmed in future operating standards. As such, monthly base rates are subject to change following confirmation of direct care hours by level.

System Impact of Monthly Base Rate Recommendations

Estimates are based on the PCH resident count as of September 2018 and assume that the portion of private-pay clients and the co-pay portion of funding remains constant; however, any changes to the underlying assumptions used to calculate estimated impacts are subject to change and forecasts should be updated as new information becomes available. Additionally, any changes to financial or clinical eligibility criteria for these programs would impact estimates for overall program expenditures. Following the introduction of the proposed Levels of Care framework, the financial impacts of these recommendations are also subject to adjustment.

The estimated combined impact of the proposed changes on the monthly base rates for the existing Levels of Care (including Level III clients) is estimated to represent a modest increase of 1.9%, or roughly $756,000[2] for provincial spending on Personal Care Homes, before the inclusion of new differential funding amounts and new program offerings in PCHs.

[1] As part of the consultation process during this work, HCS confirmed that Level III clients may be funded at Enhanced Care rate + differential rate for 'Awaiting LTC Placement' as defined in the following section
2 Figures are calculated based on September 2018 occupancy figures for PCHs.

Personal Care Home Funding Recommendations

Personal Care Homes – Differential Rates

It is also acknowledged that certain PCH residents or populations present exceptional requirements that vary significantly from typical levels of care and service delivery expectations. As such, it is recommended that differential funding be provided to operators to ensure that clients receive high-quality, appropriate care to meet their unique needs. In particular, through Deloitte's analysis and consultations with various stakeholders (including both RHAs and operators), the following circumstances for which differential funding would be appropriate have been identified.

- Differential rates are recommended to address temporary costs associated with increased client care and/or supervisory requirements (in alignment with appropriate HCS policy, protocols and approvals). Specifically:
    - For those Level III clients that are cared for in PCH environments but which have been identified to be Awaiting a LTC Placement, funding could be provided to meet the additional daily direct hours of care;
    - There are a small number of cases annually where resident abuse is investigated under the Adult Protection Act ('APA'). During the investigation period, there is an expectation of additional supervision which is not currently covered by the RHAs. At present, PCH providers must absorb costs related to APA investigations. Those clients for whom an accusation of abuse or similar is under investigation of the Adult Protection Act ('APA'), funding could be provided to meet the Enhanced Supervision requirements;
- It is recommended that existing subsidy programs are discontinued, and replaced with new differential rates to support established *population need* or other factor (see Appendix E). There are a small number of Personal Care Homes which provide services in geographic areas that have an established population need, but are otherwise unable to meet the required staffing requirement, may be subject to high operating costs, or which have higher-than-average vacancy rates but which are deemed to be 'essential' to the community at large.
    - Definition of Population Need: For a given region or client population, there are insufficient third-party or RHA service providers to provide the appropriate level of care, quality of care, and care setting for a particular client population (where no alternative exists).
    - Population Need Funding should support PCHs in regions that do not have a sufficient population base to support a 'to scale' PCH operation but there is still a proven need for PCH services (e.g., population need funding should correct market failures). In particular, we note that population need *should not* compensate: small homes operating in over-saturated markets where there is not a proven need for services, homes with vacancies that have refused referrals from the RHAs, or homes that take on residents that could be placed in an alternative, lower-cost, more-appropriate care setting.
    - A comparison analysis of historical and proposed base rate changes and staffing requirements outlined in the operating standards revealed that there is a persistent funding gap due to staffing ratio requirements for PCHs with less than 18 residents (according to requirements for indirect and direct staffing hours). Once a PCH reaches 29 residents, the funding gaps are completely eliminated.

Personal Care Home Funding Recommendations

Personal Care Homes – Differential Rates

- Also, following stakeholder consultations, it was revealed that for certain small operators, if the number of residents in the home temporarily falls below a certain level (despite 100% acceptance of referrals from RHAs) that home would no longer be able to cover their fixed costs. In such a case, the operator would either be required to pay out-of-pocket to keep their doors opens for that period or be forced to close their doors. Analysis completed by Deloitte on select PCH financials ranging from 17 to 22 beds revealed that the break even number of residents to cover the fixed cost portion of expenses is 10 to 11 residents, corresponding to a vacancy rate of approximately 36% to 47%.
- Some additional financial subsidies (i.e., small home subsidy, isolation grant) are available to support some of these operators today, however Deloitte's analysis demonstrates that there is a need to refresh the underlying policy and eligibility criteria for these subsidy programs. Regardless, Deloitte acknowledges that there will continue to be a need to support a small number of PCH operators in providing vital services to specific geographies, or specific client groups.

A detailed list of recommended eligibility conditions and supporting analysis for these funding differentials are included in Appendix D. We also note that differential rates should be made available under the current and proposed Levels of Care framework.

Personal Care Home Funding Recommendations

Personal Care Homes – Calculation Methodology for Differential Rates

The recommended differentials and the respective calculation approach are outlined in brief below.

- Awaiting LTC Placement: It is recommended that residents currently classified as Level III (awaiting LTC placement) should continue to receive supplemental funding for the enhanced staffing required to meet clinical care needs.
    - As per provincial policy, homes are required to provide 3.4 direct daily care hours (assuming 0.5 indirect care hours) to Level III residents, which should be funded on an incremental basis on top of the Enhanced Care rate. Including adjustments for statutory holidays and overtime, Level III's require an additional 12 hours of care per month above and beyond the hours provided for Enhanced Care residents. Medical Equipment for Level IIIs was determined to be equivalent to the required equipment for Enhanced Care. Additional nursing supports should continue to be provided by the RHAs.
- Enhanced Supervision for Adult Protection Act ('APA') Investigations: During an APA investigation, it is recommended that PCHs receive additional compensation for the increased monitoring and supervision of clients.
    - According to discussions with RHAs and analysis by Deloitte, on average there is an additional 3 hours per day of supervision required for APA investigations for an average of 3 days per claim (but may range any where from 1 to 60 days in certain cases). Funding should be provided as a daily rate to supplement additional staffing requirements.
- Population Need Funding: In lieu of Isolation Grants and Small Home Subsidies, funding should be directly tied to serving a proven population need, according to capacity, vacancy, and performance criteria. Our recommendations include introducing a Small Home Staffing Differential Funding and Temporary Per Bed Fixed Cost Subsidy for PCHs with less than 24 beds who meet certain criteria.
    - For a number of small PCHs which would otherwise be unable to meet the required staffing requirement, a $2,500 / month Staffing Differential payment per PCH is recommended. This rate is calculated assuming a median monthly shortfall of 183 indirect staffing hours (actual shortfall ranges from 61 to 425 hours per month, depending on the number of residents) funded at the minimum wage rate adjusted for payroll deductions.
    - For PCHs serving a proven population need (measured based on historical occupancy and referral acceptance), a Temporary Per Bed Fixed Cost subsidy of $900 / month per vacant bed up to the equivalent of 50% occupancy to support PCHs that have temporarily fallen below an occupancy rate sufficient to cover fixed operating costs. The recommended $900 is inclusive of Facility Expenses, Insurance, Safety and Accessibility Equipment, and Administration, Training, and Other.
    - Detailed eligibility criteria and analysis are included in Appendix E.

Personal Care Home Funding Recommendations

Personal Care Homes – Differential Rates

The following table outlines the recommended differential rates to be applied under both current and proposed Levels of Care framework[1]:

Program	Service	Rate Recommendations – Current or proposed LoC	
Personal Care Home – Current or New LOC	Differential Rates	Awaiting LTC Placement	$260/client per month (on top of Enhanced Care or Level D – Moderate to High rate)
		Adult Protection Act (APA) Enhanced Supervision	$56/client per day
		Staffing Differential for Small PCH	$2,500/PCH per month
		Temporary Per Bed Fixed Cost Subsidy	$900/bed per month

The system impact of the revised Awaiting LTC Placement differential are included in the proceeding section on base rates.

At the time of writing, there is insufficient data on the volume and length of APA investigations in PCHs to accurately assume the system wide impact. However, given the total volume of APA investigations across the province was only 60 across all of LTC CSS for FY2017/18, Deloitte does not anticipate the introduction of this differential will result in a significant increase in program expenditures going forward. However, the average volume of claims and potential financial impact should be fully explored by the Department prior to implementation.

[1] Detailed calculation methodologies, inputs, assumptions, and estimated impacts on program expenditures for PCH differentials are fully described in Appendix E.

Personal Care Home Funding Recommendations

Personal Care Homes – New Strategic Initiatives

Ongoing work by HCS/RHAs involves the development of new program initiatives to better meet the care requirements of the community. While there is still ongoing policy renewal work underway to finalize the care hours and training requirements for some of these new programs, in general, it has been determined that the following programs are developed for delivery by qualified Personal Care Home providers. Four new program initiatives have been explored for this work:

- Community-based adult day programs that provide a safe, supportive and social environment for adults or seniors from the community and/or support the personal care needs of clients living in community that would otherwise be placed in a PCH or LTC facility full-time;
- Temporary short-term rehabilitative and/or respite services for adults that are expected to return to their homes following recovery from illness or injury;
- Specific programs and environments are constructed by qualified PCH providers to provide Residential Moderate to Advanced Dementia Care, and/or Residential End of Life & Hospice Services.

It is recommended that funding models to be delivered by Personal Care Homes use a similar methodology as monthly base rate funding for PCH, regardless of whether the provider is an existing PCH or a standalone operator. Outlined below are the recommended reimbursement methodologies and calculation approaches for the new strategic initiatives.

- Adult day programs are not currently offered in personal care homes; however, if an adult-day program is developed for private operators to serve subsidized clients, rates can be calculated using the daily rate components for PCHs.
    - Fixed costs such as Supporting Salaries, and all the Facility Operations-related rate components can be prorated to reflect the length of the day program out of 24 hours.
    - Direct Care and Program Support, and Dietetic Services can be adjusted to reflect the volume of services delivered relative to a full-time PCH resident. For example, determining the number of daily direct care hours for a full-time Level I compared to a Level I only attending adult day programs. Dietetic services should be adjusted to reflect the number of meals and snacks relative to full-time residents. The rate schedule presented on the following page is calculated assuming direct daily hours are scaled as 8 program-hours out of 24, and dietetic services assumes 1 meal and 2 snacks (compared to 3 meals and 2 snacks offered to full time residents).
    - Medical Travel and Foot Care are currently excluded from the daily rate; however, should the Department wish to include these components following future policy changes, they should be included based on the expected utilization of services by adult day program attendees.
- Restorative Rehabilitation services should be calculated as a daily rate based on the PCH base rate. Funding should be incrementally increased to compensate for additional care hours, OT/PT services, or supplies and equipment required to be provided by the PCH.
- Residential dementia care, end-of-life or hospice care, and other non-traditional types of residential care to be offered either in a PCH or as a standalone should be built on top of the PCH base rate. Incremental funding should be provided for enhanced infrastructure requirements (for example, leading practices for dementia care services often incorporate features such as continuous movement floor plans, secure outdoor spaces, and Wander Guard as part of the facility), increased staffing and training requirements, and additional equipment or supplies required to be provided by the operator.

Personal Care Home Funding Recommendations

Personal Care Homes – New Strategic Initiatives

Given there is still ongoing policy work to finalize the clinical and financial eligibility, hours of care, and training requirements for new initiatives, final funding recommendations are subject to change. The following table outlines illustrative rates for these four new programs, applied according to the existing Levels of Care framework. Appendix D provides details of each component and assumptions for each of the recommended rates:

Program	Service	Rate Recommendations – Existing LOC			
Personal Care Homes – New Initiatives	Adult Day Programming	Level I	Level II	Enhanced Care	Level III
		$27/client per day	$29/client per day	$40/client per day	$43/client per day
	Restorative Rehabilitation in PCHs	Hours/training requirements unavailable at time of writing			
	Residential Dementia Care	Hours/training requirements unavailable at time of writing			
	Residential End-of-Life and Hospice Care	Hours/training requirements unavailable at time of writing			

Following a successful pilot of the aforementioned new initiatives, a detailed analysis of the potential financial impact of implementation should be completed prior to rolling these programs out system-wide.

Supplemental Benefits

Supplemental Benefits Funding Recommendations

Supplemental benefits are paid to clients of LTC CSS that meet financial eligibility criteria and demonstrate a need for additional financial assistance. Benefits include monthly top-ups for rent and mortgage payments, home energy costs, and telecommunications services. All supplemental benefits included in the scope of this review are currently paid based on actuals. Where possible, Deloitte recommends setting a cap for supplemental benefits based on a defensible market rate for equivalent services or the average historical claim amount, according to the criteria outlined below.

- Clarity and Consistency in Policy Application: Setting a fair cap for benefits on a provincial or regional basis is dependent on consistent application and policy directives for the particular benefits across RHAs. For example, for fuel top-ups, which are not currently compensated by Central Health, we do not recommend setting a cap unless policy directives are aligned across all RHAs.
- Utilization and Materiality of Claims: Further to the above, and similar to the rationale applied when determining what base rate components to include in the PHSP and PCH funding models, a fixed cap rate should only be set for highly-utilized benefits and/or benefits that represent a material percentage of program expenditures. For this reason, mortgage top-ups and telecommunications benefits should continue to be funded on an individualized basis.
- Volatility and Responsiveness of Prices: Cap amounts should be considered carefully when market rates for a particular benefit type are particularly volatile or can be manipulated by service providers. For example, rental rates for apartments are sensitive to regional economic conditions and subject to adjustment by landlords.

Analysis was completed to determine the utilization, distribution, and average cost of historical claims compared to defensible market rates for similar services. Following analysis, it was determined the types of available supplemental benefits should be consistent across RHAs before an objective, defensible, and equitable cap for benefit amounts could be determined. Our recommendations for each supplemental benefit type are outlined below.

- Accommodation: We recommend that a cap be set for rental top-ups based on the median adjusted average rent published by the Canadian Mortgage and Housing Corporation (CMHC). Caps should be adjusted for regions that materially exceed the median (currently, rental rates in St. John's are the only exception) to reflect regional differences in rental rates. Given the low volume and specialized nature of clients receiving mortgage top-ups, we recommend continuing to fund these benefits on an individualized basis if mortgage holders can demonstrate they are an equivalent or lower-cost alternative to other accommodation, or if the living arrangement is deemed to be the most appropriate for the client's needs.
- Home Energy: Based on regional differences and inconsistency in the distribution of home energy benefits (in particular, we note that Central Health does not currently pay fuel top-ups), we recommend the Department align the policy for home energy top-ups across the RHAs before setting a cap rate.
- Telecommunications: Due to the immateriality and low-volume of telecommunication claims, we recommend continuing to fund telecommunications services on an individualized basis.

Appendix F contains the detailed results of Deloitte's analysis.

Residential Care (non-PCH)

Residential Care (non-PCH) Funding Recommendations

Residential community-based care options outside of PCHs such as ILAs, SLAs, AFC, and Live-In Supervisors[1] play an important role in supporting clients with the most complex needs. Current funding for these care arrangements is often highly individualized to clients' needs and developed through close collaboration between the RHAs and third-party service providers. Furthermore, they commonly involve policy exceptions and detailed evaluation of alternative placement options by the RHAs.

Policy advancement for residential care options, particularly for those clients with highly complex needs, is an ongoing priority for the Department. A comprehensive review of Residential Care is currently planned to holistically consider population needs, to clarify the scope of services delivered within the community as well as the role of third-party service providers.

As demonstrated by the prior sections detailing recommendations for the PHSP and PCHs and in the table on the right, funding model development is highly dependent on:

- The scope of service and the level of care needs to be supported by third-party providers;
- Operational standards; and,
- Service-level expectations.

Clarity on these elements is critical for the selection of appropriate reimbursement methodologies and the development of detailed funding formulae and rates. With these considerations in mind, Deloitte recommends deferral of detailed funding model development for these programs and services until the completion of the wider program review and the renewal of supporting policy. When appropriate, funding models for non-PCH residential care options should be developed consistent with the guiding principles, stakeholder input, key factors for funding model selection, and, the analysis methods applied within this report.

[1] While not strictly a residential care option, Live-Out supervisors are considered alongside Live-In supervisors for the purposes of funding model development.

	LTC CSS Policy Element	
Illustrative Funding Model Dependencies	Operating Standards	Proposed Levels of Care Framework
PHSP Agency Base Rate Components		
Home Support Services	✓	✓
Nursing & Quality Assurance	✓	✓
Administration (Training)	✓	✓
Administration (Staffing)	✓	
Facility Expense (Insurance)	✓	
Accreditation	✓	
Technology	✓	
PCH Base Rate Components		
Direct Care and Program Support	✓	✓
Supporting Salaries	✓	
Facility Expense	✓	✓
Safety and Accessibility Equipment	✓	✓
Insurance	✓	
Medical and Incontinence Supplies	✓	✓
Administration, Training, and Other	✓	

Implementation Plan

Overview of Funding Model Implementation

Conceptual implementation approach and key implementation recommendations.

In the implementation of any new policy or program, Government may consider one of several conceptual approaches:

- *'Big bang' implementation,* in which new funding models are implemented across all in-scope programs at the same time;
- *Phased implementation,* in which the new funding models are implemented sequentially or in phases, depending on pre-defined criteria such as stakeholder readiness or perhaps geography; or
- *Hybrid implementation,* in which implementation is done in a sequence determined by the resolution of the underlying dependencies such as status of policy renewal efforts, stakeholder readiness and technology availability.

The following general recommendations are made to assist in planning the successful implementation of funding models:

1. Inclusion of a Pilot Phase for Personal Care Homes and Home Support Agency funding models

An option for consideration is the concept of 'pilot project' or 'demonstration project'. A pilot project is recommended for situations where the approach being implemented is substantively different than the current approach, or net new for the Government. In these cases, a pilot would allow Government to effectively inform, communicate and educate providers on the new approach, obtain their feedback and insights on its effectiveness for supporting quality service delivery, and to ensure the new funding approach supports service provision with appropriate quality and expected outcomes. Given these criteria:

- Deloitte recommends a demonstration project or pilot for Personal Care Homes. While the newly recommended monthly base rate for PCH will be tied to client complexity and inclusive of new services, it is still similar to the monthly base rate reimbursement approach currently in place for this sector. For that reason, monthly base rates do not represent a net new approach for this sector.

  However Deloitte believes there is merit to validating the underlying assumptions of the base rate calculation, obtaining provider feedback and gauging readiness for the higher level of service delivery expectations that rolled out in this sector. It is recommended that a limited demonstration project is conducted for PCH.

  Government may also wish to consider a formal procurement vehicle (such as an Expression of Interest or Request for Proposal process). Typically, selection of pilot group members is done through a defensible and transparent process (e.g. based on factors such as geography, size / scale, business maturity, client base, accreditation status, or other criteria desirable to HCS).

- Deloitte recommends a demonstration project for Home Support Agencies. Deloitte believes the recommended funding model (e.g. a monthly per diem rate tied to client complexity) is substantively different than the activity-based hourly funding that exists today. It has not existed in the Province for home support services in the past. For this reason, it is desirable for Government to validate the effectiveness of the base rate funding for Home Support Agencies, and specifically the underlying assumptions on which base rate components were calculated. A full pilot project would also allow Government to monitor intended and unintended outcomes and to perform any adjustments necessary before rolling it out to the broader HS agency population.

In either case, only the pilot group should be provided with advance education and information on the recommended funding model and the methods used for program evaluation. This group will confidently assist Government in validation of the model and its assumptions over a reasonable, pre-determined period of time (e.g. one year period). During this time, the pilot groups would be evaluated on an ongoing basis, using a range of performance indicators. Baseline data will be required on performance indicators such as those already developed by the Department (e.g. responsiveness), as well as financial indicators.

Members of both pilot groups must be committed to mutual transparency, and willing to fully disclose financial and other information to the Department. Likewise, it is incumbent on the Department to ensure that pilot group members have meaningful engagement during the pilot, with reasonable opportunities to provide feedback and input on the new model.

2. Uncoupling funding models from inter-dependent and concurrent LTC CSS policy reform efforts

There has been considerable work done by HCS and the RHAs to update LTC CSS policy, and introduce new mechanisms for improving quality of care. An example of this effort is the recent review of the Provincial Home Support Program[1] that produced an array of recommendations for adoption by the Department and RHAs. HCS is also developing a new Levels of Care framework that tie client complexity to the care required for that individual. Both of these efforts have led to HCS and the RHAs undertaking a range of appropriate follow-up activities which will allow for these Levels of Care to 'come to life' in terms of operating standards for providers, and re-assess clients to establish their care requirements under the new framework. Government also intends to clarify and establish service delivery expectations by implementing Service Level Agreements between RHAs and home support agencies, and implement technology solutions that will facilitate the validation of home support visit schedules and assist in overseeing care delivery. These efforts are incredibly necessary, and will pave the way to greater accountability and transparency for both Government and service providers.

The challenge is that, at time of writing, some of these efforts are still in progress. And, beyond the activities currently underway, there will be even more effort required to fully roll-out policy changes (such as redesigning new clinical, administrative and other processes) or to fully realize their benefits (such as training / supporting workers and adopting the new technologies). While funding models are not necessarily linked to these efforts, we are convinced that it would be ineffective and risky to begin implementation of any funding model before these efforts are sufficiently close to conclusion.

[1] A list of HCS/RHA policy reform efforts related to LTC CSS are illustrated on pg. 143.

Overview of Funding Model Implementation

Conceptual implementation approach & key implementation recommendations

While the approach to assessing and developing new funding models across LTC CSS was the right decision in order to provide consistency of approach and the standardization of process and policy, at this time, there are many moving parts within the Department and RHAs. There is also considerable variation in the maturity and readiness of some sectors to implement funding models. For example, policy renewal efforts in home support have been underway for some time, whereas policy renewal in PCH are more recent. It is also possible that operators themselves are more or less ready for change in some sectors, than in others.

- Deloitte recommends that funding models are now uncoupled from the Department-wide point of view, such that implementation is done on a program-by-program basis. This recognizes the interdependencies of the policy reform efforts, assumes variability in the level of readiness of some sectors to adopt the recommended funding model, and allows implementation to be paced as key milestones are reached within each program.

3. Enhancing stakeholder capacity for change

Implementation of any program or policy component must take into account the broader environmental, social, economic or political factors that may influence positively or negatively how stakeholders perceive and are able to adapt to the new way of working.

In those LTC CSS programs impacted by the funding models recommendations in this document, there are already numerous initiatives underway that will compel both RHA staff and providers to absorb, react, adjust to, and monitor the new way of working within their respective organizations. Stakeholders in the RHAs may express fears about what some of these new policies mean for their workload, for their long-term employment horizon, for the ultimate accountability and responsibility for care decisions, or for the quality of care to the end-user clients. Providers may have fears about what these changes mean for their day to day operations, their long-term business profitability, or have concerns about the impact of these changes on their ability to acquire and retain staff. Clients may not be clear on what is changing and why, and may have fears about their ability to access care in the future.

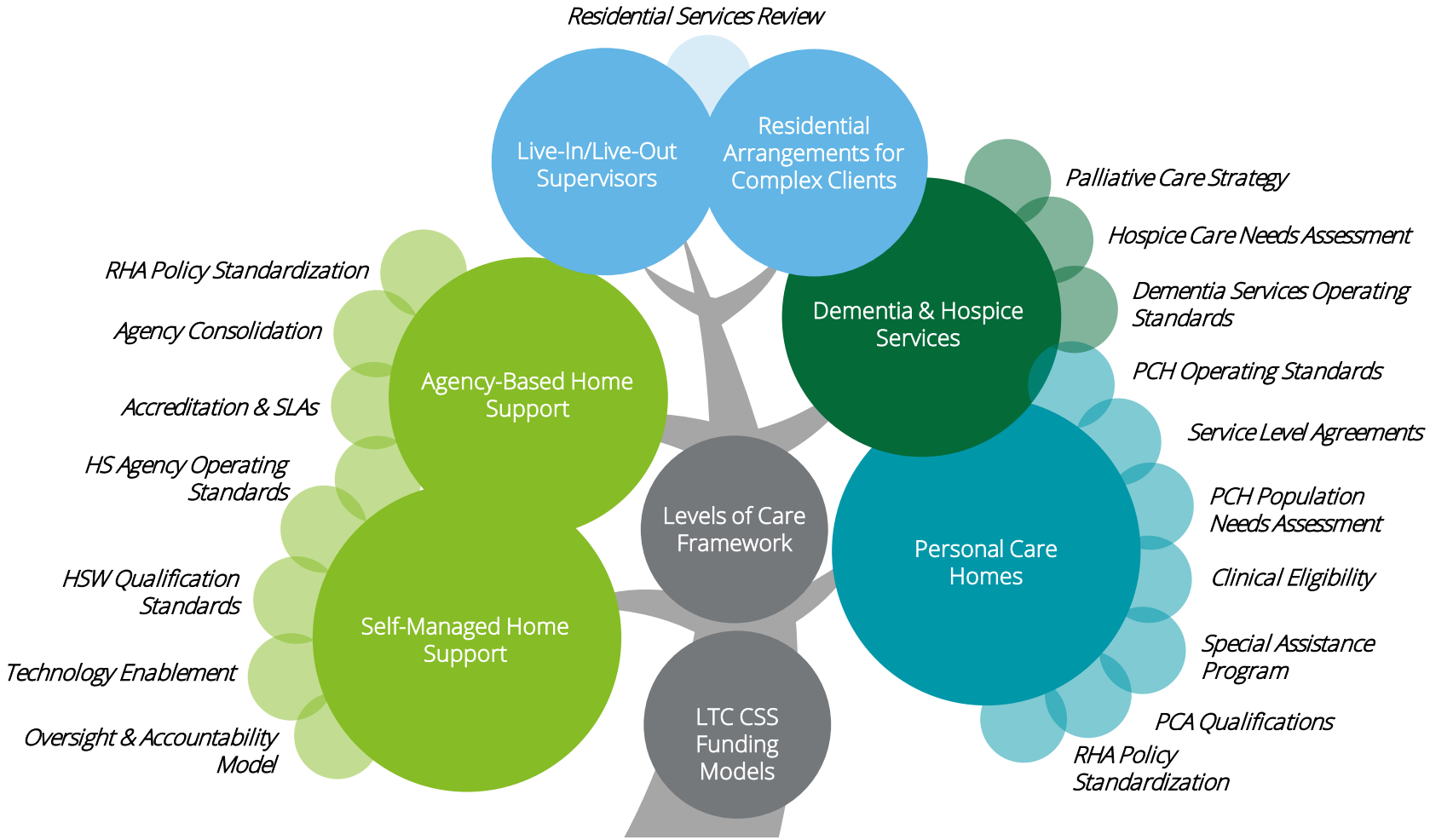
Funding models represent yet one more change that must be appropriately communicated, understood, absorbed, and adapted to by stakeholders in the RHAs and in each sector. Not only does the actual policy represent change, but the act of implementing funding model will also represent disruption and change (given all of the potential for confusion around client re-assessments, staffing changes, client billing process changes, etc. that will no doubt occur to some degree). Some stakeholders will have less capacity for change, and may become resistant or negative and impede the efforts of the Department to make progress. It will be very important for Government to support and assist RHA resources and providers in increasing their capacity for change.

- Deloitte recommends that the Department identify and prioritize administrative activities that will minimize disruption and improve change acceptance by providers. For example, for existing residents within the same PCH provider, there may be a benefit to establishing 'special assessment' dates that allows for rapid reassessment of all residents in a PCH against the proposed Levels of Care framework in order move one provider to the new funding model, versus having PCH providers wait for all residents to be re-assessed on their normal reassessment date. The normal reassessment process could take a full year for some residents, during which time both provider and RHA counterparts would require two sets of billing and account billing processes to run concurrently until all residents have been moved over.

LTC CSS Program Renewal Context

HCS and the RHAs have a large number of concurrent policy reform efforts; managing these effectively will affect how easily stakeholders understand, absorb and adapt to changes

- The illustration (right) provides a snapshot of initiatives and program renewal efforts that are underway within HCS and the RHAs at time of writing.
- While it is not unusual for Government to engage in a wide range of initiatives within any given Department at any given time, the current range of actions undertaken by the Department and RHAs tend to affect the same sectors, groups of stakeholders, RHA program staff. Many of these initiatives also require significant change management to be successful.
- Such magnitude of change may prove difficult for RHA resources and service providers to absorb.
- To improve the success of funding model implementation, Deloitte recommends some core guiding principles to form the basis of its strategy. These are described on the next page.



Overview of Funding Model Implementation: Guiding Principles for Success

Implementation guiding principles have been developed from leading practices in program management and project implementation to assist in planning, execution, monitoring and evaluation of the implementation activities for the recommended funding models.

1 Planning & Alignment

- Develop an integrated program view of all policy renewal activities in LTC CSS programs, and align to HCS Strategic Aim and other objectives.
- With 'funding model' as a work-stream within each LTC CSS program, conduct integrated implementation plan and change management.
- Use standard planning tools, processes, 'gates' and templates

2 Top Down, Bottom Up

- Engage senior leadership to champion change from top down
- Leverage front-line resources including provider financial staff to co-design solutions and processes. For example, consulting with provider subject matter experts to redesign more streamlined information sharing processes and procedures, or assisting to establish administrative deadlines

3 Program Governance

- Ensure all programs report into a common governance structure
- Ensure program governance structure has sufficient visibility, authority and accountability to implement and effect change in a timely manner

4 Client-centricity

- Identify universe of events and adverse effects that may impact clients
- In the event of dispute or delay in implementation, client needs should always take priority

5 Heterogeneity of Providers

- Avoid 'one size fits all' approach; assume greater degrees of provider variance within programs (e.g., size, geography, business maturity, readiness for change)
- Develop supports to enable providers of varying capacity to enable their long-term success (without compromising the Department's target outcomes)

6 Internal Capacity

- Assess internal RHA resource capacity, design new workflows, admin processes
- Consider developing a centre of excellence to share technical expertise in areas of program management, change management, process redesign

7 Quick Wins

- Identify creative ways for providers to see positive benefits, early in the implementation.
- Consider engaging provider resources to assist in identifying quick wins

8 Flexibility & simplicity

- Minimize disruption and the impact of change on individual providers.
- Where necessary, program policy (e.g., client assessment dates) should be made flexible and/or simplified to enable a provider to 'switch over' more quickly

9 Communications & Change management

- Develop key messages and cascade of communications for each stage of implementation; Ensure program is supported by communications expertise
- Consider launching a public awareness campaign (e.g., external agency)

10 Dedicated Resources

- Avoid temptation to assign internal resources to implementation program as part-time or 'off the side of their desk'
- Reserve implementation budget to support program management and other implementation activities

Overview of Funding Model Implementation: Intended and Unintended Outcomes

While there is momentum and importance in proceeding with implementation of new funding models for LTC CSS, HCS should expect (and plan for) a range of unintended outcomes as part of its risk mitigation and management processes

Intended Outcomes

- Increased alignment of LTC CSS funding and HCS strategic objectives
- Simplified, defensible rate structures across programs
- Consistency of funding policies and processes across RHAs
- Improved oversight of care delivery and focus on client outcomes
- Improved provider accountability for quality of service and cost management
- Increased clarity of roles or providers and RHAs
- Greater financial transparency and control:
  - Tighter financial management and predictability of care costs for RHAs
  - Greater financial transparency over HCS/RHA program spending
  - Greater control over cost of client care across programs
- Once process improvements have been performed:
  - Reduced administrative burden on RHA and provider resources
  - Increased capacity of RHA and provider resources
- Improved ability for HCS/RHAs to reward desirable provider behaviour and/or high quality client care

Unintended Outcomes

- Negative reaction and/or stakeholder confusion:
  - Political pressures from some stakeholder groups/providers
  - Mixed messages between providers, front-line workers and clients about funding changes
  - Surge in client re-assessments – leading to frustration / negative impact on RHAs and providers
- Increased provider attrition:
  - Unable to meet new operating standards and provider expectations, some may close or no longer be profitable in their current structure
  - Decreasing number of SMC clients looking for bookkeeper support – business impact on bookkeepers
- Incenting the wrong behavior:
  - Providers may seek out ways to cut costs to improve profit, particularly on lower-acuity clients.
  - Increased requests for reassessment/appeal of clients to higher levels of need
  - Attempts to 'game' the system, or collect on unbillable expenses in another way, as seen in other jurisdictions
- Decreased number of providers. Market consolidation may lead to domination of HS services by a smaller than expected number of large providers.
- Increased staffing challenges:
  - Pressure to unionize
  - Difficulty staffing shorter HS shifts
  - Attrition of PCH workers to perceived 'easier' HS working conditions
  - Potential difficulty of providers in obtaining qualified staff for higher LoC clients.
  - Front-line worker concerns/resistance to technology requirements

Overview of Funding Model Implementation: Order of Operations

Implementation on a program-by-program basis is recommended; each implementation should follow a similar order of operations (see detailed implementation plans in Appendix G)

Dependencies have been identified in the concurrent policy renewal efforts that may impact the successful implementation of funding models (e.g. finalization of the Levels of Care framework applied to PCH, or refreshing of clinical requirements for PHSP; public consultations; rollout of Service Agreements for HS agencies). Analyze other dependencies from the perspective of **people** (e.g., RHA social workers), **process** (e.g., public consultations, RHA admin processes) and **technology** (e.g., CRMS, HS visit validation software tool). Pay for performance concepts as presented for HS sector are dependent on the RHAs having the right technology and processes to capture / track performance metrics. HCS/RHAs should also assess the impact of new funding models on total spending, and prepare a timeline for resolving policy, people, process and technology dependencies.

In the context of the broader HCS strategic aims, and concurrent policy renewal efforts, it is recommended that HCS/ RHAs develop integrated implementation plans for funding models in each program, that take into account and effectively manage the other activities that impact the implementation of funding models. Develop a resource management plan including external resources if necessary. Consider the timing and procurement requirements for obtaining contractors. HCS/RHAs should be particularly sensitive to pacing and support for providers who may also be absorbing change resulting from other efforts.

Implementation can create stress, particularly for any stakeholders who may not be fully 'on board' with changes, or who lack the skills, knowledge or business maturity to adapt successfully. Consideration is being given as to how to assist providers with the introduction of funding models, such as the possibility of cost-sharing certain provider expenses. Other supports would be helpful with particular emphasis on communications to build 'the case for change' and assist in understanding the 'why' behind the changes. It will also be equally important to support RHA program and financial staff in increasing readiness for change, and facilitating expected process/policy changes impacting providers. Where possible, engage providers in developing reasonable timelines and assessing readiness.

Implementation should be done on a program-by-program basis, using common steps, stages and tools. A formal program management structure is recommended, with appropriate governance, senior leadership involvement, and day to day project leadership. Dedicated change management and communications support is invaluable, including for engaging with providers and clients that may struggle with the changes.

A pilot program is recommended (e.g. home support, PCH) for at least a one year period. HCS may then wish to make adjustments to the funding models, and/or to leverage pilot providers to assist in peer-to-peer learning, and develop a network of change champions.

Barriers to Change

With such an ambitious vision for the future of LTC CSS funding in the province, it is critical to understand barriers to implementation of new funding models, and to establish appropriate mitigating strategies

Barrier to Change	Stakeholder	Mitigation Strategies
Limited financial resources to assist in implementing funding models	HCS / RHAs	• Establish mechanisms that enable savings gained from operational efficiencies within RHAs to be reinvested in other initiatives to support implementation of funding models in other programs. • Avoid unpleasant surprises by assessing the impact of funding model implementation on total spending, developing detailed implementation budgets, and a realistic resource management plan, prior to initiation of funding model implementation. • Explore alternative resourcing models to secure required expertise, including professional project management and senior change experts to lead change management and communications activities – both of which will ensure implementation is done on time, minimizing costly delays, negative reaction, and disruption.
Limited data on which to base quality measures and performance incentives	HCS / RHAs	• Establish common technology application, data collection processes and methods to be used by RHAs and providers. • Using existing performance metrics (e.g. HS provider responsiveness, acceptance rate), capture current state information for one year period. Confirm initial quality measures appropriate for all program areas. • Once a baseline data has been captured, reassess appropriateness of KPIs and assess provider performance. Set performance expectations and incentive rates accordingly. • Consider adding a requirement for provider financial transparency (e.g. submission of financial statements) as part of policy renewal efforts.
Need to develop new clinical, quality, oversight, administrative and financial policies, processes and protocols	RHAs	• Identify and prioritize the streamlining of bottleneck processes (e.g. client re-assessment). Remove unnecessary administrative obstacles and explore efficiency opportunities related to timely provider pay which were identified as creating frustration or preventing other areas of implementation from moving forward. • Consider ways to limit 'churn' and disruption, for example, to limit the number of client re-assessment requests or appeals permitted per year. • Engage RHA staff, physicians and leaders in identifying and prioritizing key policy renewal / people / process / technology dependencies. Focus on those that are 'mission critical' (such as client reassessments) and defer those that can have a temporary 'workaround' to avoid overwhelming RHA staff. • Ramp up internal resources to develop new oversight / monitoring requirements, timelines and protocols to support the successful implementation of funding models. • Consider external contract staff from the private sector, or engage third-party supplier to assist in developing and implementing monitoring and oversight processes.

Barriers to Change

With such an ambitious vision for the future of LTC CSS funding in the province, it is critical to understand barriers to implementation of new funding models, and to establish appropriate mitigating strategies

Barrier to Change	Stakeholder	Mitigation Strategies
Disengagement / resistance / change fatigue from multiple policy changes	RHAs	• Clearly communicate and reinforce 'the case for change' at all levels so that RHA staff, physicians and other RHA leaders speak confidently and have the right information when communicating with clients and providers. • Provide meaningful support (e.g. education, training) and communications before, during and after change occurs. Ensure RHA resources are acknowledged and supported through the change process. • Monitor RHA resources for signs of serious distress and refer to appropriate mental health resources.
Limited RHA resource capacity to assist in implementing funding models	RHAs	• Prioritize RHA capacity assessment activities to ensure that current and future workloads are well-understood and benefits can be realized. • Identify potential process bottlenecks (such as where 'surge' requirements may exceed resource capacity), which will create stress, unnecessary delays and further confusion. • Simplify administrative processes and policy to the extent possible. For example, consider accepting digital signatures or digitized documents where currently paper copies are required and create admin headaches. • Consider external or contract staff to assist RHA staff in managing 'surge' requirements, for example, by engaging third-party supplier to perform specific tasks.
Realigning care delivery / provider resources to meet population needs across geographies	RHAs	• Using population needs assessment for PCHs, explore options for market-based licensing of new homes. Engage potential / new operators in discussion about population needs, new rate structures and care delivery expectations. • Consider incenting providers to move operations or open branches in underserved geographies.
Lack of technology systems that adequately support community-based programs and care across the continuum	HCS / RHAs	• Prioritize implementation of PHSP review recommendations that focus on integrated clinical information and case management systems. • Reassess alternatives to maintaining CRMS as the primary system for community-based programs and services.

Barriers to Change

With such an ambitious vision for the future of LTC CSS funding in the province, it is critical to understand barriers to implementation of new funding models, and to establish appropriate mitigating strategies

Barrier to Change	Stakeholder	Mitigation Strategies
Stakeholder alignment and buy-in to new funding models	Providers	• Undertake a process of stakeholder engagement and public consultation if possible to further refine and validate the funding models. • Commit to piloting new funding models in HS and PCH sectors, at a minimum of one-year period. Engage pilot providers in meaningful discussion to obtain feedback and insights on rate components and key assumptions, particularly around new services embedded in PCH base rates (e.g., foot care and medical transportation) • Commit to a process of rate review and adjustment every five to seven years, maximum. • Utilize a formal change management strategy (such as the ADKAR model on p. 151) and engage dedicated resources to support implementation of the funding model in each program area.
Fragmentation of Home Support market and inability to meet caseload requirements	Providers	• The proposed funding model for HS Agencies is reliant on having sufficient caseload to meet fixed costs and managing the variance between individual care plans and the calculated average hours. • Consider hosting roundtable discussions with industry association and key providers to identify impacts of future market consolidation and implementation of funding models. • Consider delaying the broader implementation of the new funding model until changes to LoC and Home Support service levels agreements are finalized and implemented.
Varying levels of business / operational expertise required to adapt successfully to new funding models	Providers	• Consider hosting roundtable discussions with industry association and key providers to identify opportunities and impacts of new funding model. • Enlist industry associations to assist in supporting business and operating needs of provider members (e.g. group purchasing power, business advice, financial expertise and technology assistance). Also engage associations in co-developing and delivering operator education, training and support tools. • Secure adequate change resources for providers to support implementation of funding models. Ensure communications reflect the needs, fears and insights from the point of view of providers, their staff and their clients. Support with appropriate education and user-directed training materials.

Barriers to Change

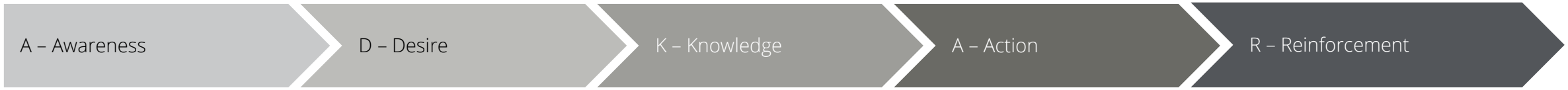
With such an ambitious vision for the future of LTC CSS funding in the province, it is critical to understand barriers to implementation of new funding models, and to establish appropriate mitigating strategies

Barrier to Change	Stakeholder	Mitigation Strategies
Negative provider reactions / confusion / resistance / active disruption	Providers	• Utilize a formal change management strategy for each program area, and embed into implementation planning. • Engage dedicated change specialists to assist in assessing provider readiness, and developing key communications messages addressing specific fears or reactions. • Identify quick wins, and identify areas where providers can be involved in planning and change efforts. • Develop a network of trusted, provider-based 'change champions' to become deeply involved in understanding the new funding model, its benefits, and will be willing to assist in supporting change on a peer-to-peer level.
Existing unions / collective bargaining agreements	Providers	• Consider engaging unions in consultation related to upcoming transformational changes. For example: ➢ Formally engaging unions in consultation about the potential impact of two-tier wage rates (e.g. Homemaking and Personal Care). ➢ Emphasizing that proposed rate changes represent compensation increases for most Home Support Workers.
Concerns about service availability or closures in small / remote communities	Clients	• Consider a 'matching service' for SMC clients and workers in remote / limited geographies . • Explore alternative means to deliver care to remote communities, for example, through video technology (e.g. Facetime) with appropriate nursing supervision. • Consider utilizing strong providers with operations in proximate communities to assist in overseeing client care, or providing specialized training and support for self-managed workers and clients to ensure consistent quality of care. • Consider financial assistance for clients with a proven need to move to another geography where they would be better served for their unique needs.
Client confusion and/or active client resistance	Clients (PCH/HS)	• Ensure PCH/HS clients and their families are a stakeholder group included in communications / change management. Communications / change efforts should be focused on "assisting clients to understand the case for change, and what it means for them". • Consider a public awareness campaign prior to implementation to ensure that broad messages about quality and care improvements are well-understood. Enlist external communications expertise to assist in getting out ahead of negative reactions. • Establish internal HCS/RHA communications protocol and designated 'go to' team to assist in supporting clients one to one in the event that political pressures or media attention are incurred.

Overview of Funding Model Implementation: Change Management

An example of one of the most powerful models to understanding change management, is the Prosci™ ADKAR model, which identifies five main steps to managing change a the individual and organizational or system level. ADKAR is defined as A – Awareness; D – Desire, K- Knowledge; A – Action; R – Reinforcement.

Applied to policy reform, ADKAR may assist Government and stakeholder groups to assess, plan and reinforce change, and ultimately to be successful in implementing the new funding models. The five-step process is plotted below, along with the key questions to be answered in each step:



- What is working and not working today in community-based care?
- What is the cause of the problem?
- What are the risks of not changing, and what are the options?
- Where are stakeholders in their level of awareness about the need to change?

- What do stakeholders need to know, in order to support the change?
- What fears do they have?
- What does Government need to know in order to manage the change?
- How can stakeholders participate and provide feedback as the change is implemented?

- Specifically how do stakeholders need to change in order to be successful in future?
- How does Government need to change or support stakeholders to be successful?
- Consider:
  - New knowledge
  - New competencies and capabilities
  - New technical skills
  - Improved processes
  - Redeployed resources
  - Other supports

- How will the change be implemented?
- What results or outcomes are desirable?
- How will success be measured?

- How can Government and stakeholders build a culture of change – together?
- Are there champions that can assist?
- How does Government sustain the change?

Concluding Remarks

Concluding Remarks

Private third-party service providers play an integral role in the Province's LTC CSS programs. The Department, RHAs, clients, and, their families all rely upon the provision of high-quality services in the community that delivers tangible outcomes. Moreover, productive, collaborative, and, mutually beneficial relationships between the public and private sectors will be essential for Newfoundland and Labrador to effect sustainable change within its health care system and to meet the challenges of a disproportionately aging population, to match the availability of services to population needs, and, to improve the overall quality and cost-effectiveness of care.

The analyses and recommendations laid out in this report set forward an ambitious long-term vision for the future ways of funding third-party providers of LTC and CSS services. This vision seeks to more closely align service provider funding with the:

- Modernization of policy and processes for the uniform and transparent client needs assessment, care planning, and, placement in the most appropriate setting,
- Modernization of operating standards for private third-party service providers and the implementation of new service-level agreements and performance management requirements; and,
- Expansion of services available in the community to include respite and restorative care, enhanced dementia services, hospice, and, palliative care.

The recommended funding methods represent a structured, consistent, defensible, and, objective way of allocating resources to meet the care needs of clients and populations. Further, they strive to provide the base funding necessary to maintain service provision while concurrently streamlining and simplifying the reimbursement process to enable the redeployment of resources to direct care activities. Finally, the new ways of funding empower service providers to take an elevated role in holistically meeting the needs of clients and provide direct financial incentives for attaining service quality excellence and making an increased contribution to the wider provincial health system.

Implementation of the new funding models for LTC and CSS services will not be easy or quick, but will be necessary for both the Province and service providers to strengthen community-based services and to build the capacity required by the citizens of Newfoundland and Labrador.

Appendices

Appendix A: Detailed Jurisdictional Scan

Jurisdictional Scan – British Columbia

BC has developed delivery-model innovations in providing long-term care in an urban setting.

Topic	Details		
System Strategic Goals	• Integrate primary and home/community care as described in *Primary and Community Care in BC: A Strategic Policy Framework (2015)* • Develop a plan to align BC's home support delivery with best practices, including a review of the funding needed to increase staffing level, teamwork and training, increase number of resources to support community health workers, as per *Living Up to the Promise: Addressing the High Cost of Underfunding and Fragmentation in BC's Home Support System*		
Care Options	**Fully-Subsidized**	**Co-pay**	**Private-pay**
Relevant Services	• Community Nursing • Community Rehabilitation • BC Palliative Care Benefits Program (Home support)	• Home Support • Choice in Supports for Independent Living (CSIL) • Caregiver Respite • End-of-Life Care • Assisted Living • Group Homes • Family Care Homes • Short-Term Residential Care • Long-Term Residential Care	• Adult Day Services
Needs assessment process	**Care Needs** • Care needs are solely assessed by health care professional in the RHA (Home care)	**Financial Needs** N/A	
Performance measurement metrics	N/A		
Innovative Funding Models in LTC & CSS (including cost differentials for small/rural providers)	• Accountability, Responsiveness and Quality for Clients Model of Home Support (ARQ Model) in Vancouver modelled after Norwegian cluster-care model for high-density buildings and neighborhoods – P4P Model consisting of a Hourly Base rate + Performance top-up		
Other innovations in funding	• Implemented a form of activity-based funding (patient-focused funding) in 2010 for acute care hospitals • St Paul's Hospital HUB healthcare model in Canada for Mental Health and Addictions		

Jurisdiction Snapshot	BC
Population (2017, 000's)	4,817.16
Pop. Density (2011, per square km)	4.8
Population senior (2017, %)	18.3
Population adults w/disabilities (%)	10.8
Seniors in home care or residential care (2016, %)	55.4
Percentage falls (2016, seniors)	23.1
Percentage hospitalized within 90 days (2016, seniors)	17.9
Percentage ER visits within 90 days (2016, seniors)	11.7
Percentage home health aides (2016, seniors)	62.9

Funding and Expenditures	BC
Per capita healthcare spending	$ 6,597
Healthcare expenditure on seniors (2016, %)	41.6
Publically funded healthcare expenditure (2016, %)	70.5

Source: Health Authorities Website, Ministry of Health Website, University of British Columbia Website, Spinal Cord Injury BC, Statistics Canada

Jurisdictional Scan – British Columbia

Funding models in BC are still primarily per diem and ABF based, with the exception of pilots in service-delivery.

Relevant Program	Payer	Description	Service Providers	Reimbursement Method	Funding Formula
Community Nursing	Public	Short-term basis; acute, chronic, palliative, or rehabilitative support; provided where client currently resides.	Licensed nursing professionals (RHA)	Unknown	Fully-subsidized + cost for equipment items
Community Rehabilitation	Public	Short-term basis; acute, chronic, palliative, or rehabilitative support; provided where client currently resides.	Licensed physical therapist or occupational therapist (RHA)	Unknown	Fully-subsidized + cost for equipment items
BC Palliative Care Benefits Program (Home support)	Public	Direct care services to end-of-life clients who require assistance with Activities of Daily Living; delivered in client home.	Unknown	Unknown	Unknown
Home Support	Co-Pay	Direct care services to clients who require assistance with Activities of Daily Living; delivered in client home.	Community health workers	Per diem	Varies by contract
Choice in Supports for Independent Living (CSIL)	Co-Pay	CSIL Employers receive funding to purchase their own home support. Phase 1: Client manages all hours Phase 2: Client support group manage	Community health workers Bookkeepers	ABF	Fixed number of care hours * pre-determined hourly rate ($31.00 as of April 1, 2018)
Caregiver Respite	Co-Pay	Temporary relief for unpaid caregivers; delivered at-home, community day programs, short-term residential care facility.	Community health workers	ABF	Unknown
End-of-Life Care	Co-Pay	Comfort, quality of life, respect for personal health care treatment decisions, support for the family, and psychological, cultural and spiritual concerns for dying people.	Licensed nurses and community health workers	Per diem	$37.10/day – subsidy based on financial need
Assisted Living	Co-Pay	Housing, hospitality services and personal care services with adults with disabilities who can live independently; client lives in complex.	Community health workers	Per diem + ABF for extra	$1,000.80 per month for single-dwelling and $1,524.40 per month for couples + FFS for extras
Group Homes	Private	Non-licensed congregate housing for clients with disabilities.	Primarily non-profit societies	ABF	Clients share costs of living (rent, food, utilities, etc)

Source: Health Authorities Website, Ministry of Health Website, University of British Columbia Website, Spinal Cord Injury BC, Statistics Canada

Jurisdictional Scan – British Columbia

Funding models in BC are still primarily per diem and ABF based, with the exception of pilots in service-delivery.

Relevant Program	Payer	Description	Service Providers	Reimbursement Method	Funding Formula
Family Care Homes	Co-Pay	Provided in a single family residence to clients with complex care needs (up to 2 clients per home).	Community health workers	Per diem	Minimum monthly rate: $1,130.60 + annual adjustment based on Old Age Security/Guaranteed Income Supplement Maximum monthly rate: $3,278 + annual adjustment for CPI Up to 80% of after-tax income or if income < $19,500/year it is calculated as (after tax income – $3,900)/12
Short-Term Residential Care	Co-Pay	Respite care, convalescent care, or residential hospice care for up to 3 months.	Community health workers	Per diem	$37.10/day in 2018, minimum monthly rate for long-term residential care services by 12 months and dividing by 365 days.
Long-Term Residential Care	Co-Pay	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.	Third-party providers: Licensed nursing professionals (RHA) + Community health workers	Per diem	Minimum monthly rate: $1,130.60 + annual adjustment based on Old Age Security/Guaranteed Income Supplement Maximum monthly rate: $3,278 + annual adjustment for CPI Up to 80% of after-tax income or if income < $19,500/year it is calculated as (after tax income – $3,900)/12
Adult day services	Private	For seniors and adults with disabilities; 1-2 days per week; supportive group programs and activities; usually provided within a residential care facility.	Residential care facility	Per diem	Rate charged for supplies, transportation and meals cannot exceed $10.00 per day for client.

Source: Health Authorities Website, Ministry of Health Website, University of British Columbia Website, Spinal Cord Injury BC, Statistics Canada

Jurisdictional Scan – Alberta

Alberta is one of the fastest aging populations in Canada.

Topic	Details		
System Strategic Goals	• Keep people living independently within their own home for as long as possible • *Alberta Dementia Strategy and Action Plan, December 2017* – Position Alberta as a leader in Dementia care and research – Ensure Alberta has a trained and supported workforce to provide Dementia care and services – Implement a comprehensive measurement, monitoring, and report framework to guide implementation		
Care Options	**Fully-Subsidized**	**Co-pay**	**Private-pay**
Relevant Services	• Long-term care accommodation • Designated Supportive Living • Home care	• Long-term care accommodation* • Designated Supportive Living*	• Supportive Living (Lodge, Assisted Living, Group Home)
Needs assessment process	**Care Needs:** N/A	**Financial Needs:** N/A	
Performance measurement metrics	9 CIHI LTC Quality Indicators (RAI-MDS 2.0)		
Innovative Funding Models in LTC & CSS (including cost differentials for small/rural providers)	• LTC – Implemented a ABF funding methodology for LTC in 2009 (Patient/Case-based Funding) that includes an optional Quality Incentive funding top-up linked to quality indicators/criteria identified by CIHI (P4P)		
Other innovations in funding	• Building Communities of Care program to ensure LTC spaces are built where they are needed (not-for-profit operators, housing management bodies, and Indigenous communities/organizations)		
Other notes	• 45,500 occupants in supportive living and LTC • 14,140 occupants across 174 LTC facilities (only 145 were complaint with LTC Accommodation Stds) • 31,380 occupants across 801 supportive living accommodations (group homes, lodges, and assisted living) (only 737 were compliant) • 42,000 Albertans with dementia (2016)		

Jurisdiction Snapshot	AB
Population (2017, 000's)	4,286.13
Pop. Density (2011, per square km)	5.7
Population senior (2017, %)	12.4
Population adults w/disabilities (%)	9.4
Seniors in home care or residential care (2016, %)	56.8
Percentage falls (2016, seniors)	22.9
Percentage hospitalized within 90 days (2016, seniors)	25.9
Percentage ER visits within 90 days (2016, seniors)	14.3
Percentage home health aides (2016, seniors)	74.2

Funding and Expenditures	AB
Per capita healthcare spending	$ 7,552
Healthcare expenditure on seniors (2016, %)	36.6
Publically funded healthcare expenditure (2016, %)	72.3

Source: Alberta Health Website, Statistics Canada

Jurisdictional Scan – Alberta

Complexity Adjusted ABF was implemented successfully in LTC and is being rolled out to designated supportive living.

Relevant Program	Payer	Description	Service Providers	Reimbursement Method	Funding Formula
Long-term care accommodation	Public or co-pay	Nursing home with care and accommodation services for people with complex health needs (Long-Term Care Accommodation Standards and the Continuing Care Health Service Standards)	Alberta Health Services (AHS), Private, and Voluntary	Complexity Adjusted ABF + P4P Top-up	Complexity Adjusted ABF methodology using RAI CMIs (case mix indexes).
Designated Supportive Living (DSL)	Public (AHS operated only) or private	24 hour a day personal care and health support services for clients requiring a higher level of care than other supportive living arrangements. DSL 3, DSL 4, and DSL 4-D	AHS, Private for-profit and non-profit	Per diem	In the process of transitioning to model used in LTC – Complexity Adjusted ABF using RAI CMIs (case mix indexes). Rate varies by contract.
(DSL) Assisted Living	Public (AHS operated only) or private	Provides supportive living (SL) to more than 10 people	AHS, Private for-profit and non-profit	Per diem	Set by operator; subject to a monthly cap and adjusted according to Alberta CPI
(DSL) Group Home	Public (AHS operated only) or private	Provides supportive living to 4 to 10 people	AHS, Private for-profit and non-profit	Per diem	Set by operator; subject to a monthly cap and adjusted according to Alberta CPI
(DSL) Lodge	Public (AHS operated only) or private	Supportive living accommodation under the Alberta Housing Act	AHS, Private for-profit and non-profit	Per diem	Set by operator; subject to a monthly cap and adjusted according to Alberta CPI
Home care	Public	Professional and personal care services provided to resident in-home to support independent living for as long as possible	Professional care givers and personal care workers – for profit and AHS	ABF	Hourly rate, number of hours dependent on care plan. Rate varies by contract.
Self-managed home care (SMC)	Public	Personal care, home support, respite care for clients who wish to manage their own allocated funding. Year long contract set according to unmet care needs (AHS Provincial Home Care Service Guidelines) and re-evaluated annually. Client/family responsible for managing employees.	Can hire anyone	ABF	Max amount of funding month varies by region (determined by different regional authorities) Non-professional service providers receive $13.35 per hour and licensed practical nurses receive $16.43 per hour.
Individualized Funding Program	Public	Allocation of individualized funding is determined by the client.	Can hire anyone	Unknown	Unknown

Source: Alberta Health Website, Statistics Canada

Jurisdictional Scan – Saskatchewan

Capacity and access to care for Saskatchewan's indigenous population is a system priority.

Topic	Details		
System Strategic Goals	• Build capacity to deliver culturally-appropriate home care and health care services to Aboriginal people and reduce barriers to access health care services		
Care Options	**Fully-Subsidized**	**Co-pay**	**Private-pay**
Relevant Services	• Resident Directed Care • Convalescence • Palliative Care	• Long Term Care (Special Care Homes) • Community Day Program • Respite (Planned and Emergency) • Re-enablement Programs	• Retirement Home
Needs assessment process	**Care Needs** • N/A	**Financial Needs** • N/A	
Performance measurement metrics	• Conducted a regional survey of resident and family experience in LTC. Categories included: Experience, Communication, Care Provision, Food and Mealtime Experience, Home Environment and Services, Activities Experience, and Overall Rating		
Innovative Funding Models in LTC & CSS (including cost differentials for small/rural providers)	• N/A		
Other innovations in funding	• N/A		

Jurisdiction Snapshot	SK
Population (2017, 000's)	1,163.93
Pop. Density (2011, per square km)	1.8
Population senior (2017, %)	15
Population adults w/disabilities (%)	10.6
Seniors in home care or residential care (2016, %)	75.8
Percentage falls (2016, seniors)	24.8
Percentage hospitalized within 90 days (2016, seniors)	26.7
Percentage ER visits within 90 days (2016, seniors)	15.1
Percentage home health aides (2016, seniors)	46.6

Funding and Expenditures	SK
Per capita healthcare spending	$ 6,931
Healthcare expenditure on seniors (2016, %)	40.9
Publically funded healthcare expenditure (2016, %)	76

Source: Saskatchewan Government Website, Saskatchewan Pension Plan Website, Statistics Canada

Jurisdictional Scan – Saskatchewan

Available information indicates Saskatchewan's primary reimbursement methodology is per diem.

Relevant Program	Payer	Description	Service Providers	Reimbursement Method	Funding Formula
Retirement Home	Private	Multi-residence housing facility that provides accommodation and services such as meals and cleaning for older people	Private operators	N/A	Monthly fee ranging from $1,500-$5,500 for private rooms
Special Care Homes	Co-pay	Residential long term care facilities that provide 24-hour professional nursing care and supervision for people who have complex care needs	Public, for-profit, non-profits	Per diem	Fees set provincially; Income test: standard resident charge ($1,086 at July 1, 2017) plus 57.5% of the portion of their income between $1,413 and $4,200; $21.50/month for personal hygiene items
Respite Care (Planned and Emergency)	Co-pay	Respite care provides temporary relief to families or other primary care providers.	Special care homes	Per diem	Standard fee + cost of transportation to and from (Emergency only) + Cost of medicines
Adult Day Programs	Co-pay	Maintain and increase your ability to perform Activities of Daily Living	Special care homes	Per diem	Unknown
Convalescence	Public	Period of additional recovery time following surgery or serious illness, usually following a stay in hospital	Special care homes	Unknown	Unknown
Palliative care	Public	Active, compassionate care to people in the final stages of a serious, incurable disease, when a cure or prolongation of life is no longer the objective	Special care homes	Unknown	Unknown
Individualized Funding Program	Public	Available to individuals with long term care needs who are eligible for home support services.	Home support workers	ABF	Amount of funding is based on an individual assessment which is conducted by a member of the Home Care assessment team (no cap). Variable rate based on contract with providers.
Personal Care Homes	Co-pay	Provide lodging, meals, and assistance with, or supervision of the Activities of Daily Living.	Privately-owned and operated; licensed by government	N/A	Rates set by operator; Personal Care Home Benefit is available to eligible lower-income seniors living in personal care homes

Source: Saskatchewan Government Website, Saskatchewan Pension Plan Website, Statistics Canada

Jurisdictional Scan – Manitoba

Manitoba has prioritized number of falls and critical incident reporting as methods to improve health care outcomes.

Topic	Details		
System Strategic Goals	• Make fall prevention a priority *(Manitoba's Falls Prevention Plan and Framework* (2015-2020)) • *Aging in Place* strategy • *Strategy for Alzheimer Disease and Related Dementias* in Manitoba was released in 2002 and addressed nine strategic areas (including enhancing rural support and access to specialists)		
Care Options	**Fully-Subsidized**	**Co-pay**	**Private-pay**
Relevant Services	• Home Care Services • Self-managed Care	• Personal Care Services • Home support • Health care • Respite Care in the Home • Respite Care in Alternate Settings • Supplies and Equipment • Volunteer Services • Community Housing with Support Options	• Adult Day Programs
Needs assessment process	**Care Needs** • Case coordinator will work with the client/caregiver to complete a multidimensional assessment to identify client needs, current supports in place and risk factors for client safety • Care plans are reviewed on a regularly scheduled basis by the Case Coordinator		**Financial Needs** • Financial need is typically assessed based on last year's CRA after-tax income of client and their spouse (if applicable)
Performance measurement metrics	• Number of falls • In 2006, legislation was introduced for mandatory no-blame **critical incident reporting** across the health system to support a culture of learning and openness • Community Health Assessment measures the health status of the population for a given health authority		
Innovative Funding Models in LTC & CSS (including cost differentials for small/rural providers)	• Primary Caregiver Tax Credit – a $1,400/year refundable tax credit awarded to unpaid primary care providers of adults and seniors with disabilities or life-threatening illness • Personal Care Home Grant of up to $2,000/year paid to RNs, RN(EP)s, RPNs, and LPNs to work in PCHs in Manitoba to reduce nursing vacancies and maintain continuity of care for clients		
Other innovations in funding			
Other Notes	• 5,700 people receive LTC in Winnipeg • Number of residents awaiting placement in PCH has decreased from 321 to 133 (2014-2018) in WRHA (Winnipeg RHA) for the week ended November 27		

Jurisdiction Snapshot	MB
Population (2017, 000's)	1,338.11
Pop. Density (2011, per square km)	2.2
Population senior (2017, %)	15.2
Population adults w/disabilities (%)	11.1
Seniors in home care or residential care (2016, %)	58
Percentage falls (2016, seniors)	20.3
Percentage hospitalized within 90 days (2016, seniors)	14.8
Percentage ER visits within 90 days (2016, seniors)	8.1
Percentage home health aides (2016, seniors)	71

Funding and Expenditures	MB
Per capita healthcare spending	$ 7,354
Healthcare expenditure on seniors (2016, %)	44.4
Publically funded healthcare expenditure (2016, %)	74.3

Source: Government of Manitoba Website, Independent Living Resource Centre Website, Support Services for Older Adults Website, Winnipeg Free Press Website, Comfort Life, Statistics Canada

Jurisdictional Scan – Manitoba

Relevant Program	Payer	Description	Service Providers	Reimbursement Method	Funding Formula
Manitoba Home Care Program	Public (If client can demonstrate care need)	Home Care Programs help people remain independent for as long as possible; oldest, most comprehensive, province-wide, universal home care program in Canada.	Non-professional care workers	ABF	Financial need is determined based on the previous years tax assessment from the CRA.
Self and Family Managed Care	Public (If client can demonstrate care need)	May be used in combo with Home Care Program. Peer Support Group in place for managers	Non-professional care workers (Independent or Agency)	Per diem	Client need is assessed from a formal application to the RHA. Self/Family Managers are expected to use monies to employ staff or an agency to meet needs. Payroll company can be hired to assist with employer obligations. Rate is $16.01/hour.
Transitional Care Environment	Public	Relatively new program in Manitoba (circa 2017). May be used in combo with Home Care Program. Intermediary care between acute care in a hospital and return home.	RHA	Unknown	Unknown
Priority Home	Public	New program to provide intensive home care to clients on a temporary basis (up to 90 days).	Mix of private providers (support workers) and RHA employees (RNs and OT)	Unknown	Unknown
Independent Living Resource Centre (ILRC) as an Agent	Same as Self and Family Managed	ILRC acts as a bridging agent to fulfill specific administrative and employee-related roles for self and family managed care.	ILRC	Same as Self and Family Managed	Same as Self and Family Managed
Long Term Programs	Co-pay	Greater than 60 days	Private LTC residences	Per diem	Monthly fee ranges from $54 (subsidized) to $1,650 for a basic unit. Rates include rent and other services including 2-3 meals per day.
Short Term Programs	Co-pay	Less than 60 days	Unknown	Unknown	Unknown
Personal Care Home Services	Co-pay	PCHs are subject to the PCH Standards and reviewed every 2 years.	Non-professional care workers	Per diem	Rates range between $37.90 – $88.50 a day. Differential rates are set for single seniors and couples. Subsidy of rates depends on financial need.

Source: Government of Manitoba Website, Independent Living Resource Centre Website, Support Services for Older Adults Website, Winnipeg Free Press Website, Comfort Life, Statistics Canada

Jurisdictional Scan – Manitoba

Relevant Program	Payer	Description	Service Providers	Reimbursement Method	Funding Formula
Respite Care	Same as Home Care	Temporary care to provide a break for primary caregivers (in-home)	Non-professional care workers (agencies or independents)	Same as Home Care	Unknown.
Respite care in personal care homes	Co-pay	Temporary care to provide a break for primary caregivers (in a PCH). Normal length of stay is two weeks.	PCHs	Per diem	Rates are set as a subsidized daily fee.
Supportive Housing	Co-pay	Supportive housing is a transitionary arrangement for seniors who can no longer manage to live on their own but do not require the level of support provided in a PCH. Supportive housing provides personal support services and homemaking in a permanent congregate residential setting. Supervision is provided 24/7.	Private residential facilities	Per diem	Rates are set based on a fixed level of services delivered per day. Rent: $1,200 – $2,600/month (includes household expenses and food) Phone/cable: $85 Insurance: $10 Disability Tax Credit and Primary Caregiver Tax Credit available to off set costs.
Residential Care Facilities	Co-pay	Residential Care Facilities are government-licensed premises in which accommodation, care and supervision are provided to adults who require care due to a developmental disability, mental disorder or because of frailty or cognitive impairment related to aging.	Foster homes, and private and agency managed facilities.	Per diem	Rates range between $37.90 – $88.50 a day. Differential rates are set for single seniors and couples. Subsidy of rates depends on financial need.
Adult Day Programs	Private	Community based program to provide social stimulation to individuals and respite for caregivers.	Unknown	Per diem	Unknown
Life Lease	Private	Communal living arrangement for individual or couple over 55 wo need assistance with home maintenance (snow removal, yard maintenance, etc).	Private building operators.	ABF	Tenants are charged an entrance fee + monthly rate based on market-driven rent rates.
Rent Assist	Co-pay	Subsidy available to assist low-income Manitobans with private market rent. (Available to residents of nursing homes and residential care facility).	Any housing or unit which receives housing benefits or subsidy (including nursing home, residential care facilities, etc.)	Per diem	Rent Assist will subsidize up to 75% of the Median Market Rent (established by the Canada Mortgage and Housing Corporation and reflects the midpoint between highest and lowest amount) according to household size.

Source: Government of Manitoba Website, Independent Living Resource Centre Website, Support Services for Older Adults Website, Winnipeg Free Press Website, Comfort Life, Statistics Canada

Jurisdictional Scan – Ontario

Source: Government of Manitoba Website, Independent Living Resource Centre Website, Support Services for Older Adults Website, Winnipeg Free Press Website, Comfort Life, Statistics Canada

Topic	Details		
System Strategic Goals	• Transform home and community care to introduce greater consistency in care, a better understanding of the services available, more support for caregivers and better access to the right care for those who need it most as per *Patients First: A Roadmap to Strengthen Home and Community Care (2015)* • Stabilize sector funding to ensure more equitable, evidence-based and predictable funding decisions that support better patient care as per *Making Way for Change: Transforming Home and Community Care (2014)*		
Care Options	**Fully-Subsidized**	**Co-pay**	**Private-pay**
Relevant Services	• Temporary respite care	• Home care • Long term care	• Retirement homes
Needs assessment process	**Care Needs** • RAI MDS-MDS 2.0 used as the primary clinical assessment and outcome monitoring tool to set client care plans • Clients must be reassessed annually	**Financial Needs** • Net income assessment is based on CRA income tax filings.	
Performance measurement metrics	• Health Quality Ontario (HQO) established 12 indicators to measure performance in LTC.		
Innovative Funding Models in LTC & CSS (including cost differentials for small/rural providers)	• Ontario Ministry of Health & Long-term Care implemented a funding methodology that includes ABF and per diem (capitation) components based on Level-of-Care across 4 funding envelopes (Nursing and Personal Care, Program and Support Services, Raw Food, and Other Accommodation)		
Other innovations in funding	• Ontario launched a bundled care model in September 2015 for short-term care at home after leaving hospital and intends to expand the program to cover 60% of hip and knee replacement surgeries in 2018/19		
Other Notes	• Hospitals receive 54 percent of their funding through global budgets, 40 percent based on HBAM and six percent based on clinical quality groupings. Clinical quality groupings are an risk-adjusted FFS methodology. • As of 2014/15 70% of CCAC clients are considered complex (compared to less than 40% 5 years prior).		

Jurisdiction Snapshot	ON
Population (2017, 000's)	14,193.38
Pop. Density (2011, per square km)	14.1
Population senior (2017, %)	16.7
Population adults w/disabilities (%)	11.4
Seniors in home care or residential care (2016, %)	78.1
Percentage falls (2016, seniors)	24.6
Percentage hospitalized within 90 days (2016, seniors)	21.8
Percentage ER visits within 90 days (2016, seniors)	12.4
Percentage home health aides (2016, seniors)	76.9

Funding and Expenditures	ON
Per capita healthcare spending	$ 6,584
Healthcare expenditure on seniors (2016, %)	45.6
Publically funded healthcare expenditure (2016, %)	66.1

Source: Ontario Government Website, Home Care Ontario Website, Statistics Canada

Jurisdictional Scan – Ontario

Relevant Program	Payer	Description	Service Providers	Reimbursement Method	Funding Formula
Homecare	Public and Co-pay	Allows seniors and adults with disabilities to live independently, either at home or in an independent living unit.	Local Health Integration Networks arrange all government-funded services for people living at home	ABF	$39.05 bill rate for HS Agencies. Home care rate was recently harmonized by the Ministry of Health.
Long term care	Co-pay	Live-in facilities for seniors and adults with disabilities who require help with most or all Activities of Daily Living (ADLs) and access to 24 hour/day nursing and personal care.	Private operators	Complexity Adjusted ABF	Per diem funding based on Level of Care: (NPC + PSS + RF + OA) – Resident Co-Payment Revenue = LOC Per Diem Funding The LOC per diem funding consists of four funding components, referred to as envelopes. Specifically: Nursing and Personal Care (NPC), Program and Support Services (PSS), Raw Food (RF), Other Accommodation (OA) Uses RUG-III case mix classifications.
Temporary respite care	Public	Temporary care to provide a break for primary caregivers (in-home).	LHIN	Per diem	LHIN assessment used to determine number of hours available. Rate unknown. Rates
Retirement Homes	Private	Allow seniors with low care needs to live independently with some assistance with ADLs.	Private operators	Per diem	$1,500 to $6,000 per month.
Adults days programs	Co-pay	Provide structured and supervised in a group setting for seniors and adults with disabilities.	Community organizations	ABF	Varies based on contract with provider. Generally provided through a home support contract along with residential respite services.
Transportation services	Co-pay	Unknown	Community organizations	Unknown	Unknown
Community hospice services	Co-pay	Unknown	Community organizations	Unknown	Unknown
Residential hospices	Co-pay	Unknown	Community organizations	Unknown	Unknown
Family-managed home care	Co-pay	Unknown	Local Health Integration Networks arrange all government-funded services for people living at home	Unknown	Unknown

Source: Ontario Government Website, Home Care Ontario Website, Statistics Canada

Jurisdictional Scan – Quebec

Topic	Details		
System Strategic Goals	• Active aging strategic plan released in 2018, identified 5 priority areas to assist seniors to live independently (85 measures identified in the plan target social engagement, intergenerational solidarity, home care services, housing, transportation, security and access to government)		
Care Options	Fully-Subsidized	Co-pay	Private-pay
Relevant Services	• Adult day program • Home care (some services) • Long term care center (CHSLD)	• Home care (some services)	• Retirement Homes
Needs assessment process	Care Needs • Local Community Service Centers (CLSC) will conduct an assessment through a social worker or nurse (assessing physical & mental capabilities)	Financial Needs • Annual income tax returns used to assess home support assistance • Income/asset test for CHSLD takes into account liquidity, assets, and revenue; assessment conducted by Health Insurance Board of Quebec	
Performance measurement metrics	• N/A		
Innovative Funding Models in LTC & CSS (including cost differentials for small/rural providers)	• Combination of Global Budget and Population-based funding		
Other innovations in funding	• Families being charged for home support services receive a cost differential based on the number of minors in the immediate family; having more minors reduces the cost of the service to the recipient		
Other Notes	• N/A		

Jurisdiction Snapshot	QC
Population (2017, 000's)	8,394.03
Pop. Density (2011, per square km)	5.8
Population senior (2017, %)	18.5
Population adults w/disabilities (%)	6.7
Seniors in home care or residential care (2016, %)	N/A
Percentage falls (2016, seniors)	N/A
Percentage hospitalized within 90 days (2016, seniors)	N/A
Percentage ER visits within 90 days (2016, seniors)	N/A
Percentage home health aides (2016, seniors)	N/A

Funding and Expenditures	QC
Per capita healthcare spending	$ 6,749
Healthcare expenditure on seniors (2016, %)	50.1
Publically funded healthcare expenditure (2016, %)	69.8

Source: Quebec Government Website, Sun-life Website, Statistics Canada

Jurisdictional Scan – Quebec

Relevant Program	Payer	Description	Service Providers	Reimbursement Method	Funding Formula
Long term care centre (CHSLD)	Co-pay (If client can demonstrate need)	Multi-resident housing facility that provides support for individual who have lost functional or psychosocial independence. For individuals who have nursing needs that can't be met through home care	Public & Licensed Private	Per Diem	The Ministry of Health and Social services set daily and monthly rates based on the type of accommodation (e.g., private room). No details provide as to how the rates are derived
Retirement Homes	Private	Multi-resident housing facility that provides accommodations and homemaking services for older people	Private Operators	N/A	Private operators set fees, no regulation around how prices are set. Residents can pay monthly or purchase a room (like a condominium)
Home Care (Including respite services)	Public & Co-pay	Home Care Programs help people remain independent for as long as possible	Home support workers	ABF	Government will subsidize up to $15.44/hour ($4/hour base rate + up to $11.44/hour variable component based on market rate of services). All services are free for clients, except for housekeeping, meal delivery, home repairs and required equipment. These costs are paid at the rate set by the home support provider Financial assistance is available based on the outcome of financial assessments.
Adults day programs	Public	Adult day programs provide a safe group setting during the day for dependent adults/seniors within a particular community. Nutritious meals are usually provided.	Public and Private (non-profit and for-profit) operators	N/A	Clients are not charged for adult day care services

Source: Quebec Government Website, Sun-life Website, Statistics Canada

Jurisdictional Scan – New Brunswick

Topic	Details		
System Strategic Goals	• New Brunswick's Long-Term Care Strategy was last updated in 2008. The strategy revolves around five major themes: Informal Caregivers, Formal Caregivers, Affordability and Sustainability, Qualify of Delivery and Quality of Care. 12 goals were identified under these five themes, focusing on improvements such as increasing the quality of assessments and training.		
Care Options	Fully-Subsidized	Co-pay	Private-pay
Relevant Services		• Nursing Homes • Relief Care • Home Support services • Special care homes • Adult Day Programming	• Retirement Homes
Needs assessment process	Care Need • Staff from the Department will conduct the assessment of long term health care and social needs.	Financial Need • Assessment conducted by the Department of Social Development • Client net income is used to determine the size of the co-payment	
Performance measurement metrics	N/A		
Innovative Funding Models in LTC & CSS (including cost differentials for small/rural providers)	N/A		
Other innovations in funding	N/A		
Other Notes	• Long-term care has four levels of care differentiating between different levels of cognitive and physical dependence • All Home Support workers working for Home Support Agencies are trained and certified		

Jurisdiction Snapshot	NB
Population (2017, 000's)	759.66
Pop. Density (2011, per square km)	10.5
Population senior (2017, %)	20.1
Population adults w/disabilities (%)	12.3
Seniors in home care or residential care (2016, %)	N/A
Percentage falls (2016, seniors)	N/A
Percentage hospitalized within 90 days (2016, seniors)	N/A
Percentage ER visits within 90 days (2016, seniors)	N/A
Percentage home health aides (2016, seniors)	N/A

Funding and Expenditures	NB
Per capita healthcare spending	$ 6,935
Healthcare expenditure on seniors (2016, %)	50.3
Publically funded healthcare expenditure (2016, %)	70.1

Source: New Brunswick Government Website, New Brunswick Home Support Association Website, Sun-life Website, Statistics Canada

Jurisdictional Scan – New Brunswick

Relevant Program	Payer	Description	Service Providers	Reimbursement Method	Funding Formula
Nursing Homes	Co-pay	Nursing home services multi-resident facilities for individuals who are medically stable and who need nursing care. Services in nursing homes emphasize the resident's physical, social and psychological independence. These services include resident care, resident support, plant and maintenance and general administration.	Public	Per Diem	Government sets the fee for the nursing homes which includes room & board, as well as required supervision. Residents in receipt of provincial assistance can receive a personal allowance for clothing and personal items. Funding is based on a nursing home formula which calculates the number of staff required based on the predicted or defined (depending on type of service) volume of services and hours delivered. Varies per home.
Special Care Home, Community Residence, Generalist Care, Memory Care	Co-pay	Residential care facilities; funding and placement options vary based on the residents' level of care, age, and behavior.	Private Operators	Per Diem	Funding is calculated as a per diem, and varies on a per-home basis. Operators may apply an additional surcharge for non-clinical services or features.
Retirement Homes	Private	Multi-resident housing facility that provides accommodations and homemaking services for older people	Private Operators	N/A	Private operators set fees, no regulation around how prices are set.
Relief Care	Co-pay	Relief care provides temporary relief to families or other primary care providers.	Nursing Homes	Per Diem	Relief care funding is provided to nursing home operators on a Per Diem basis.
Home Support Services	Co-pay	Home Care Programs which help people remain independent for as long as possible	Home support workers	ABF	Bill rate is $19.25/hour. Amount of funding is based on an individual assessment which is conducted by a Care Coordinator. Assessment takes into consideration the size of the family. Home support workers are not compensated for their travel time, but they can claim mileage.
Self-Managed Home Supports	Co-pay	Self-managed home support programs.	Self-managed workers	ABF	Rate is $11.25/hour subject to a monthly ceiling of $2,150.
Adult Day Programming	Co-pay	Adult day programs provide a safe group setting during the day for dependent adults/seniors within a particular community. Nutritious meals are usually provided.	Public or Private Operators	Per Diem	Government subsidizes the cost of $50 per day, clients copay an amount of $10 per day

Source: New Brunswick Government Website, New Brunswick Home Support Association Website, Sun-life Website, Statistics Canada

Jurisdictional Scan – PEI

Topic	Details		
System Strategic Goals	Strategic 'pillars' were outlined in 2009 Healthy Aging strategy. The 5 pillars include: • Manor replacement • Palliative Home Care Drug Pilot Project • Enhanced Home Care • Extended & Improved Long-term Care • Transitional Care		
Care Options	Fully-Subsidized	Co-pay	Private-pay
Relevant Services	• Home Care	• Long-term care nursing homes • Respite Care • Adult Day Programming	• Retirement homes
Needs assessment process	Care Need: • Care needs are assessed by a care coordinator	Financial Need: • Income test assessment based on the applicant's net income as reported on their Income Tax and Benefit return	
Performance measurement metrics	N/A		
Innovative Funding Models in LTC & CSS (including cost differentials for small/rural providers)	N/A		
Other innovations in funding	N/A		
Other Notes			

Jurisdiction Snapshot	PEI
Population (2017, 000's)	152.02
Pop. Density (2011, per square km)	5.8
Population senior (2017, %)	19
Population adults w/disabilities (%)	11.8
Seniors in home care or residential care (2016, %)	N/A
Percentage falls (2016, seniors)	N/A
Percentage hospitalized within 90 days (2016, seniors)	N/A
Percentage ER visits within 90 days (2016, seniors)	N/A
Percentage home health aides (2016, seniors)	N/A

Funding and Expenditures	PEI
Per capita healthcare spending	$ 6,824
Healthcare expenditure on seniors (2016, %)	51.4
Publically funded healthcare expenditure (2016, %)	73.8

Source: PEI Government Website, Sun-life Website, Statistics Canada

Jurisdictional Scan – PEI

Relevant Program	Payer	Description	Service Providers	Reimbursement Method	Funding Formula
Community Care Homes	Co-pay (If client can demonstrate need)	Multi-resident housing facility that provides support for individual who have lost functional or psychosocial independence. Nursing care is generally not provided within community care, although some private facilities may be licensed to provide both community care and nursing.	Public & Private	Per Diem	The Department of Health sets the fees of nursing homes, including room and board Private Community Care homes can set their own rates for long-term care
Long-term care nursing homes	Co-pay (If client can demonstrate need)	Multi-resident housing facility that provides support for individual who have lost functional or psychosocial independence. For individuals who have nursing needs that can't be met through home care	Public & Private	Per Diem	The Department of Health sets the fees of nursing homes, including room and board, and care hours. Private nursing homes can set their own rates for long-term care
Respite Care	Co-pay	Respite care provides temporary relief to families or other primary care providers.	Long-term care nursing homes	Per Diem	Relief care funding is provided to nursing home operators on a Per Diem basis.
Retirement homes	Private	Multi-resident housing facility that provides accommodations and homemaking services for older people	Private Operators	N/A	Private operators set fees, no regulation around how prices are set.
Home Care	Public	Home Care Programs which help people remain independent for as long as possible	Home support workers	N/A	Home care is fully funded by the Government in PEI.
Adult Day Programming	Co-pay	Adult day programs provide a safe group setting during the day for dependent adults/seniors within a particular community. Nutritious meals are usually provided	Public or Private Operators	Per diem	Client pays up to $6/day. Adult day programming is not means tested, Government pays a portion of the programming cost of all recipients. Transportation is not covered.

Source: PEI Department of Health Website

Jurisdictional Scan – Nova Scotia

Topic	Details		
System Strategic Goals	• Access to Primary Health Care • Access to Orthopedic Surgeries • Access to Mental Health & Addictions Supports • Continuing Care	• Digital Health—One Person One Record, MyHealthNS • QEII Redevelopment & IWK Emergency Department	
Care Options	Fully-Subsidized	Co-pay	Private-pay
Relevant Services	• Supportive Care • Self-managed care • Caregiver Benefit	• Residential Care Facilities • Nursing Homes • Respite Care • Palliative Care • Home care	• Retirement Homes
Needs assessment process	Care Needs • Care coordinators provide assessments of client needs	Financial Needs Various including: • Caregiver benefits – caregiver financial needs are assessed based on 'Net Income' as identified on the federal income tax return • Home Support – Determined based on net household income and family size by a Continuing Care Assessor	
Performance measurement metrics	• Home Support service providers are required to submit nine key performance indicators (e.g., service response time, delivered hours) to the Department of Health and Wellness. These are not currently linked to performance based funding.		
Innovative Funding Models in LTC & CSS (including cost differentials for small/rural providers)	• N/A		
Other innovations in funding	• Families being charged for home support services receive a cost differential based on the number of minors in the immediate family; having more minors reduces the cost of the service to the recipient.		
Other Notes			

Jurisdiction Snapshot	NS
Population (2017, 000's)	953.87
Pop. Density (2011, per square km)	17.4
Population senior (2017, %)	19.8
Population adults w/disabilities (%)	14.2
Seniors in home care or residential care (2016, %)	N/A
Percentage falls (2016, seniors)	N/A
Percentage hospitalized within 90 days (2016, seniors)	N/A
Percentage ER visits within 90 days (2016, seniors)	N/A
Percentage home health aides (2016, seniors)	N/A

Funding and Expenditures	NS
Per capita healthcare spending	$ 7,173
Healthcare expenditure on seniors (2016, %)	49.9
Publically funded healthcare expenditure (2016, %)	71.2

Source: NS Department of Health Website, Sun-life Website, Statistics Canada

Jurisdictional Scan – Nova Scotia

Relevant Program	Payer	Description	Service Providers	Reimbursement Method	Funding Formula
Nursing Homes	Co-pay	Multi-resident housing facility that provides support for individual who have difficulty performing everyday tasks, such as dressing, bathing and toileting. For individuals who have nursing needs that can't be met through home care	N/A	Per Diem	The Department of Health and Wellness reviews the detailed budgets of each long term care facility on an annual basis and individually sets a "facility per diem rate" that covers both "health care costs" and 'accommodation costs'. • Nursing Homes: $107.75 per day • Residential Care Facility: $64 per day • Adult day programs also included
Residential Care Facilities	Co-pay	Multi-resident housing facility that provides support for individual who have difficulty performing everyday tasks, such as dressing, bathing and toileting. For individuals who don't need a nursing home but have needs that can't be meet at home	N/A	Per Diem	
Retirement Homes	Private	Multi-resident housing facility that provides accommodations and homemaking services for older people	Private Operators	N/A	Private operators set fees, no regulation around how prices are set. Residents can pay monthly or purchase a room (like a condominium).
Respite Care (Planned and Emergency)	Co-pay	Respite care provides temporary relief to families or other primary care providers.	Long Term Care Facilities	N/A	Maximum Old Age Security and Guaranteed Income Supplement pension for the preceding tax year less the annual 'Minimum Retained Income' divided by 365 days.
Palliative care	Public	Active, compassionate care to people in the final stages of a serious, incurable disease, when a cure or prolongation of life is no longer the objective	Home support worker	N/A	N/A
Supportive Care	Public	Available to individuals with cognitive impairments	Home support workers	N/A	Recipient receives $500 per month.
Self-Managed Care	Public	Available to individuals with long term care needs who wish to coordinate their own care	Home support workers	N/A	Monthly service maximum of $3,780.29 (205 hours per month). Hourly funding rate for self-managed care is $18.36.
Home Care	Co-pay	Home Care Programs help people remain independent for as long as possible	Home support workers	ABF	Amount of funding is based on an individual assessment which is conducted by a Care Coordinator. Assessment takes into consideration the size of the family. Rate for home support workers is set via Government agreements with agencies. NS HS workers receive 'availability pay' of $0.27 for each hour they work; accounting for travel and time between shifts. Workers also receive an evening premium for services performed outside of working hours, and are reimbursed for mileage.
Caregiver Benefit	Public	Available to individuals who provide 20 or more hours of assistance per week	Family/Friend Caregiver	Historical	Caregiver receives $400 per month.

Source: NS Department of Health Website, Sun-life Website, Statistics Canada

Funding Model Considerations

Below is a selection of some of the unique funding models and service-delivery innovations we've seen in other Canadian provinces.

Accountability, Responsiveness and Quality for Clients Model of Home Support (ARQ Model)	*Vancouver, British Columbia:* Modelled after the Norwegian clustered-care model of home support for high-density buildings in urban neighborhoods, the ARQ model incorporates components of complexity adjusted ABF and P4P.
St. Paul's Hospital Mental Health and Addictions HUB	*Vancouver, British Columbia:* The HUB is an innovative, centralized resource for mental health and addictions clients in BC. The HUB takes a 'wraparound' approach to care that brings services together in one judgement free location.
Patient/Case-based Funding	*Alberta:* One of the few province-wide complexity adjusted ABF funding models in long-term care in Canada. System uses RAI CMIs (case mix indexes) and RAI-MDS 2.0 LTC Quality Indicators. They are in the process of rolling this model out to PCHs (Designated Supportive Living).
Building Communities of Care	*Alberta:* Building Communities of Care is a funding program designed to incentivize continuing care providers to build/add new spaces in communities where they are most needed, such as indigenous communities and populations with complex care needs.
Individualized Funding Program	*Alberta:* Client is paid a lump-sum amount which they can allocate to purchase care needs and other supplies/equipment at their own discretion.
Personal Care Home Grant	*Manitoba:* RNs, RN(EP)s, RPNs, and LPNs can apply for an annual grant of $2,000 to work in PCHs in rural and underserved communities to reduce nursing vacancies and maintain continuity of care for clients.
Availability Pay	*Nova Scotia:* Home support workers in NS receive an availability pay of $0.27 an hour to account for travel and slack time between shifts. Workers also receive an evening premium for services performed outside of working hours, and are reimbursed for mileage.

Funding Model Considerations

Canadian provinces' existing reimbursement methods, namely per diem and activity-based funding rates, are struggling to address population health needs and improve client outcomes.

Outcomes:
- NL has one of the highest percentages hospitalized within 90 days.
- BC and MB have the lowest documented hospitalization rates in Canada.
- Either MDS 2.0 or RAI-HC assessments are used in BC, AB, ON, NL, and YK.

Accessibility:
- The proportion of the population aged 65 and over in NL is comparable to other jurisdictions with higher rates of seniors in home care or residential care arrangements; however, NL has one the lowest documented population of seniors accessing residential care or home care services.
- Relevant population demographics in NL are most similar to BC, ON, and the Maritime provinces (NS, NB, and PE).

Cost Effectiveness:
- While faced with similar demographic challenges to NL, per capita healthcare spending and the proportion of healthcare spending on the senior population are lower in both BC and ON.

Funding models:
- Per Diem and ABF are the dominant reimbursement methodology for LTC and home support services in Canada.
- BC and ON are the only jurisdictions with Pay-for-Performance schemes in place.

Legend	National Average	NL	BC	AB	SK	MB	ON	QC	NB	PE	NS
Population Seniors (2017, %)	N/A	19.8%	18.3%	12.4%	15.0%	15.2%	16.7%	18.5%	20.1%	19.8%	19.0%
Population adults with Disabilities (2017, %)	N/A	11.4%	10.8%	9.4%	10.6%	11.1%	11.4%	6.7%	12.3%	14.2%	11.8%
Per Capita Healthcare Spending ($)	$6,839	$7,443	$6,597	$7,552	$6,931	$7,354	$6,584	$6,749	$6,935	$7,173	$6,824
Healthcare Expenditures on Seniors (2016, %)	44.8%	49.0%	41.6%	36.6%	40.9%	44.4%	45.6%	50.1%	50.3%	49.9%	51.4%
Seniors in home care or residential care (2016, %)	N/A	22.2%	55.4%	56.8%	75.8%	58.0%	78.1%	N/A	N/A	N/A	N/A
Percentage hospitalized within 90 days (2016, Seniors)	N/A	26.3%	17.9%	25.9%	26.7%	14.8%	21.8%	N/A	N/A	N/A	N/A

Sources: CIHI, Statistics Canada

Jurisdictional Scan – International

Jurisdiction	LTC&CSS Reimbursement Methodology(ies)	Description of Reimbursement Methodology	Other innovations in healthcare funding models
USA	Per diem, Complexity Adjusted ABF, P4P	The USA has implemented a range of different healthcare funding models (including bundled care, ABF, QoF, ACOs, etc) across a variety of care settings (from long-term care to acute care).	• Bundled payments in acute care hospitals • Pay-for-performance using the OASIS quality standards – Quality Payment Program (QPP) to reimburse Medicare clinicians. Goals of QPP include: improve population health, improve quality of care and to lower costs to the Medicare program • Population global gap in the State of Maryland (all-payer state) – Rate set based on population – Exemption from feds on Medicare/Medicaid • Disruption in healthcare sector comes primarily from the delivery side (technology, pharma distribution, etc)
United Kingdom	P4P	The Quality and Outcomes Framework (QOF) was implemented in 2004 and remains the world's largest active pay-for-performance system in primary care • Additional funding is paid out to providers for measuring and achieving pre-determined quality indicators • QOF indicators tend to be focused on clinical/biomedical dimensions of care – 68/77 indicators related to LTC objectives • Research has since shown that QOF was associated with modest increases in health outcomes for LTC recipients	• QOF is a voluntary program that spans all healthcare services in the UK • Research into QOF has shown that there may not be significant improvements in quality of care associated with implementing the scheme
Australia	Complexity Adjusted ABF, P4P, Bundled Payment (Pilot)	• Uses the Aged Care Funding Instrument to assess the relative needs of the residents, allocates funding based on three categories: Activities of Daily Living, Behavior, and Complex Health Care. – A 12-question assessment is conducted by professionals to determine the appropriate funding level – Scores are used to assign a High, Medium, or Low needs level which determines funding • Incentive payments for admitting residents and renovating/building new facilities	• Complexity Adjusted ABF in acute care settings, ambulatory services • Complexity Adjusted ABF classifications piloted in mental health (not used for funding) • In primary care settings, Australia uses separate definitions/codes for small regional and remote hospital types which are funded differently from large, urban hospitals – with fee modifiers or guaranteed levels of funding • July 2017, Australia launched a pilot bundled payment program called 'health care homes' for patients with multiple chronic conditions and complex needs

Source: Accountable Health Communities, British Journal of General Practice-The role of the Quality and Outcomes framework in the care of long-term conditions, Australasian Psychiatry – Activity-based funding: implications for mental health services and consultation-liaison psychiatry

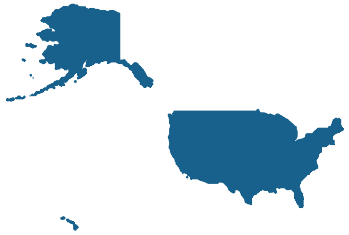
Jurisdictional Scan – International

Jurisdiction	LTC&CSS Reimbursement Methodology(ies)	Description of Reimbursement Methodology	Other innovations in healthcare funding models
New Zealand	ABF	• Four levels of care (rest home, dementia, continuing care, and psychogeriatric) • Budget is uncapped and uses a bed-day to measure units of service • Adjustments made for geographic location of facility • NZ is in the process of a review of their Funding Models for Aged Residential Care (ARC)	• Complexity Adjusted ABF classifications piloted in mental health (not used for funding) • New Model recently (2012/13) implemented in NZ to improve care for disabled people – Choice in Community Living (CiCL): Focus on increasing independence through 3 core values: control (to select staff and budget), choice (to decide where to live, to choose daily activities), and flexible funding (to use to achieve personal goals, develop living skills, and purchase equipment that decreases care burden) – Enhanced Individualized Funding (EIF): enabling disabled people to decide how they will use their funding allocation to purchase disability supports, products, services and/or arrangements that meet three criteria set out in the Purchasing Guidelines produced by the Ministry
Norway	N/A	• Traditional/historical methodology for LTC • Scandinavian countries have not been leaders in funding model development for LTC	• P4P scheme, Quality Based Financing, implemented in 2014 as a pilot to motivate overall quality and patient safety – Norway's National Quality Indicator System is comprised of 100 indicators, 33 of which are used in QBF – As of January 2016, QBF cost about NOK 500 million, or around 0.5% of the health regions budget

Source: Evalue research – Demonstrating changes to disability support, Norwegian Directorate of health – Quality Based Financing in Norway

Jurisdictional Scan – International

A scan of funding models used in acute-care, long-term care and community services in international jurisdictions has identified a range of examples to draw insights and ideas from.



USA

Reimbursement Methodologies for LTC:

Per diem, Complexity Adjusted ABF, P4P

Funding models in the U.S. range from state to state and generally attempt to minimize costs to the system.

- Has implemented a range of different healthcare funding models (including bundled care, ABF, QoF, ACOs, etc) across a variety of care settings (from long-term care to acute care).

Australia

Reimbursement Methodologies for LTC:

Complexity Adjusted ABF, P4P, Bundled (Pilot)

Australia uses the Aged Care Funding Instrument to allocate funding based on client needs including a bonus/subsidy for rural providers.

- A 12-question assessment is conducted by professionals to determine the appropriate funding level.

Similar population considerations to Canada (remote/rural population, aboriginal populations, aging populations).

United Kingdom

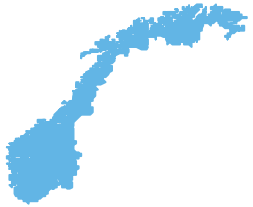
Reimbursement Methodologies for LTC:

P4P

Quality and Outcomes Framework (QOF) was implemented in 2004 and remains the world's largest active pay-for-performance system in primary care.

- QOF indicators tend to be focused on clinical/biomedical dimensions of care – 68/77 indicators related to LTC objectives.

Research has since shown that QOF was associated with modest increases in health outcomes for LTC recipients.



Norway

Reimbursement Methodologies for Acute Care:

P4P (Pilot)

P4P scheme, Quality Based Financing, implemented in 2014 as a pilot to motivate overall quality and patient safety in acute care.

- Norway's National Quality Indicator System is comprised of 100 indicators, 33 of which are used in QBF.

As of January 2016, QBF cost about NOK 500 million, or around 0.5% of the health regions budget.

New Zealand

Reimbursement Methodologies LTC:

*RM Currently under review

NZ is in the process reviewing of their Funding Models for Aged Residential Care (ARC).

Recently implemented the 'New Model' in 2013/14 for care for adults with disabilities, including the implementation of 'Enhanced Individualized Funding' which encourages greater independence for adults living with disabilities.

Appendix B: Further Stakeholder Insights

Stakeholder Consultations: Challenges Identified

RHA and Service Provider consultations shed light on current challenges, due in part to the way they are funded.

Funding is contributing to **operational** and **policy challenges**	• Recruitment is difficult at current rates • Operational costs (e.g., travel, split shifts) are not reflected in current rates
Funding is **not** always **fair**	• Client complexities are not always reflected in current rates • Regional accessibility of care are not always reflected in current rates
Funding is **inflexible**	• Home Support ceilings are not keeping pace with costs[1] • Providers can't be reimbursed on a timely basis when care needs change
Funding is **complex**	• Paying different rates for different services may have unintended consequences (e.g., travel rates for PCHs) • Clients do not understand how funding works
Funding promotes the **status quo**	• Providers are not incented nor given the flexibility to innovate in their operations (e.g., recruitment and retention in remote environments) • Providers are not incented to improve their quality of care or efficiency

[1] Since 2011, ceilings are adjusted each time there is a rate increase to ensure the maximum monthly hours available to a client is maintained when a rate increase occurs.

Stakeholder Consultations: Challenges Identified

RHA and Service Provider consultations shed light on current challenges, in part due to the ways which they are funded.

Substantially related to current models of funding

Multi-dimensional program challenge

Challenges	What we heard from stakeholders...
Insufficient increases to the Home Support ceiling rate is reducing the number of hours a client can access.	• *"The HS ceilings aren't increasing with wage rates, and what's more, when a adult with disabilities turns 65, they no longer have access to the same ceiling."* [1] • Completing paperwork to maintain or increase ceiling rates or levels of funding can be an administrative burden for clients and care workers with varying levels of literacy.
Inability to compensate staff for travel is directly inhibiting access to care for remote clients.	• *"Some HS workers need to travel over 40km each way to access clients."* • Clients are unable access to care due to low-population density and difficulties in attracting staff in rural regions.
Funding mechanism for Home Support is inflexible; workers are working hours that are not being compensated.	• *"90% of workers are going above-and-beyond what is required in the care plan."* • Care plans are seen as inflexible and difficult to update as clients needs change and evolve.
Rates for Bookkeepers are not commensurate with actual hours worked.	• *"In some cases the compensation [for bookkeeping services] isn't worth the time and effort."* • Lack of technology infrastructure and burdensome administrative process of setting up clients with the CRA and submitting timesheets requires hours above and beyond what the rate covers.
Rates for Personal Care Homes and Home Support are not in line with client complexities.	• *"In some homes they are only doing light housekeeping and putting the kettle on, and in other homes the client can't even get themselves out of bed by themselves."* • The rate applied to Level I and Level II clients in PCHs should be different. • HS client needs range in complexity depending on the care plan.
Personal Care Homes and Home Support are challenges in recruitment and retention; potentially due to rates being perceived as uncompetitive with other industries.	• *"We'd like to take everyone who calls, but we don't have enough staff."* • Recruiting and retaining staff is challenging in both rural and urban areas due to labour-market dynamics in Newfoundland and Labrador. • Lack of access to training may leave staff feeling unprepared to perform duties.

[1] Since 2011, ceilings are adjusted each time there is a rate increase to ensure the maximum monthly hours available to a client is maintained when a rate increase occurs.

Appendix C: PHSP Detailed Analysis & Assumptions

Appendix C: Home Support – Agencies: Calculations and Assumptions

Home Support Services

Calculation Methodology

Monthly home support service rates for each Level of Care were calculated by multiplying the average hours (per month) accessed by each level, with the hourly rate for Home Support services.

Key Assumptions and Inputs

- Average hours of Personal Care and Home Making per month by Level of Care
- Wage rate for Personal Care and Homemaking (as determined by HCS policy)
- Benefits as a percentage of home support wage

Funding formula

$$\textbf{\textit{Monthly Home Support Service Rate}} = \left((\textit{Average monthly hours of Homemaking} * \textit{Wage rate for Homemaking}\right)$$

Calculations

HCS supplied a database of Home Support clients with monthly approved hours of care (divided by homemaking, personal care and respite). Each client was assigned to a level of care based on the total monthly approved amounts. Respite hours were divided between personal care and home making based on the mix of personal care and homemaking hours accessed at each level of care. Deloitte included a mechanism to factor in community inclusion services, at present the number of hours delivered for this service is assumed to be zero

Home Support Hours by Levels of Care (Monthly)

All figures are on a monthly basis

Level of Care	Personal Care Hours	Homemaking Hours	Respite Hours	Respite Hours (PC)	Respite Hours (HM)	Community Inclusion	Total PC Hours	Total HM Hours	Community Inclusion
Level B – Low to Moderate	10	19	6	2	4	0	12.4	22.5	0
Level C – Moderate	31	42	12	5	7	0	36.1	48.5	0
Level D – Moderate to High	68	43	34	21	13	0	88.8	55.7	0
Level E – High	91	38	73	52	22	0	143.2	59.6	0
Level F – Complex	116	33	320	249	71	0	365.6	103.5	0

Data Sources: Data provided by HCS – Hours of Home Support accessed per month per client; Draft Levels of Care framework

Appendix C: Home Support – Agencies: Calculations and Assumptions

Home Support Services

Home Support Worker Wages (Agencies)

Calculation Methodology

Using the collective agreement rate as the starting point, Deloitte applied the wage differentials between housekeeping and support workers (in Ontario) to generate rates for Personal Care and Homemaking

Assumptions

Worker Wages in Comparator Jurisdictions[2]

Province	Designations	Hourly Rate	Differential	Applied to NL CA Rate
ON	Housekeeping	$ 11.63	95.45%	$ 15.80
	Private Care	$ 12.74	104.55%	$ 17.30
MB	Support Worker I	$ 14.21	92.88%	$ 15.37
	Support Worker II	$ 16.39	107.12%	$ 17.73
BC	Housekeeper	$ 16.10	91.84%	$ 15.20
	Support Worker 1	$ 18.96	108.16%	$ 17.90
NL[1]	Homemaker (NAPE)	$ 19.98	98.21%	$ 16.25
	Personal Care Attendant (NAPE)	$ 20.71	101.79%	$ 16.85

[1] NAPE Job Class profiles for homemakers are Personal Care Attendants are provided as a comparison to the differential between homemaking and personal care. Deloitte notes that these job profiles do not directly match NL's home support services

[2] Differentials are calculated using the following formula:
Lower Differential = Lower Hourly Rate/ (Median between Upper and Lower Rates) **Upper Differential** = Upper Hourly Rate/ (Median between Upper and Lower Rates)

Home Support Worker Benefits & Overtime (Agencies)

Calculation Methodology

Deloitte calculated the benefits payments for Home Support agencies based on data provided by a NL agency. Data from agencies in other provinces was used as a comparison

Assumptions

- Benefits are **23% of Wages.** Includes: EI, CPP, WHSCC, Vacation, Sick days, Stat Holiday, HAPSET, Payroll Processing

Work Benefits & Overtime – Comparator Agencies in Other Jurisdictions

Metric	NL Agency #1	NB Agency #1*	NS Agency #1
Benefits as % of Wages	23%	12%	33%

Data Sources: Collective agreements from other jurisdictions; GNL – Job Class Profiles/Wage Scales; Interviews with Home Support Agencies

*Excludes vacations, sick days and HAPSET

Appendix C: Home Support – Agencies: Calculations and Assumptions

Administration & Other

Calculation Methodology	Key Assumptions and Inputs
The methodology for calculating administration and other expenses differ depending on whether the cost is fixed or variable. Variable costs are those that increase or decrease depending on the volume of services delivered by the agency. Fixed costs are those that do not increase or decrease with the volume of services.	• Average hours of Personal Care and Home Making per month by Level of Care • Wage rate for Personal Care and Homemaking (as determined by HCS policy) • Benefits as a percentage of home support wage • Overtime as a percentage of home support wage

	Variable Cost		Fixed Cost	
Funding formula	$\boldsymbol{Variable\ Cost(Monthly)} =$ *Cost per hour of Home Support delivered * Average monthly hours of home support (by Level of Care)*		$\boldsymbol{Fixed\ Cost(Monthly)} =$ *(Fixed Cost/Average monthly hours of home support per agency) * Average monthly hours of home support (by LoC) * (1-% of home support agency expenses attributable to private pay clients)*	

Assumptions	The variable cost for each hour of home support delivered was calculated using data from NL agencies and comparators in other provinces. Hourly costs were multiplied by the average number of home support hours accessed at each level of care.	Variable costs are deemed to include:
		• Non-wage expenses:
		  • Advertising
		  • Office & Misc.
		  • Training
		  • Vehicle Operating
		  • General/Business/Professional Fees
		• Staffing cost for: Scheduler, Payroll staff and Recruiter/HR staff
			Fixed costs were calculated using data from NL agencies and comparators in other provinces.
			Fixed costs were divided by the average number of hours a HS agency is expected to deliver. The resultant cost per hour was applied to the expected hours of care (per month) for each level of care. A "discount" was applied to reflect the percentage of fixed costs shared with the Private Pay portion of Home Support agencies' business
				Fixed costs are deemed to include:
				• Staffing cost for Management staff
				• Accreditation Expenses
				• Municipal Taxes
				• Interest/Banking/Accounting Expenses
				• Percentage of Home Support agency expenses attributable to private pay clients

Data Sources: Interviews with Home Support agencies, Desk Research, Information from RHAs

Appendix C: Home Support – Agencies: Calculations and Assumptions

Administration & Other – Non-wage expenses

Variable Costs

Calculation Methodology

Deloitte calculated the cost of non-wage variable expenses based on information provided by a NL agency; data was compared to an agency in NB.

Assumptions

Administration & Other Expenses (Excluding Wages)

Expenses	Cost per Hour of Home Support	Example Monthly Cost (HS Agency -10,000 hours per month)	Example Annual Cost (HS Agency – 10,000 hours per month)
Advertising	$0.11	$1,100	$13,200
Office & Misc.	$0.08	$800	$9,600
Training	$0.07	$700	$8,400
Vehicle Operating	$0.05	$500	$6,000
General/Business/Professional Fees	$0.05	$500	$6,000

Comparative Data

Comparator Agencies – Administration & Other Expenses (Excluding Wages) – Cost Per Hour

Expenses	NL Agency #1*	NB Agency #1
Advertising	$0.11	$0.02***
Office & Misc.	$0.08	$0.05
Training	$0.07	$0.04
Vehicle Operating	$0.05	N/A
General/Business/Professional Fees	$0.05	$0.13**

Data Sources: Interviews with Home Support agencies
*Reflects an agency with multiple offices. Deloitte excluded travel and meal expenditure arising from meetings and travel between branch offices (~$2,033 per month)
** Includes vehicle operating expenses
***Some advertising expenses (e.g., meeting expense, vehicle operating expense) may be excluded from this figure

Appendix C: Home Support – Agencies: Calculations and Assumptions

Administration & Other – Support Staff Salaries

Variable Costs

Support Staffing – Staffing Ratios

Calculation Methodology

Deloitte calculated the staffing ratios based on the number of staff and the monthly hours of home support delivered by agencies in NL, NS and NB.

Assumptions

Designations	Number of HS Hours per FTE (Monthly)	Example (HS Agency - 10,000 hours per month)
Scheduler	5,000	2.0 FTEs
Payroll	10,000	1.0 FTEs
Recruiter/HR	10,000	1.0 FTEs

Data Sources

Monthly Home Support Hours per Support Staff FTE

Designations	NL Agency #1	NL Agency #2	NS Agency #1	NS Agency #2	NB Agency #1
Scheduler	5,000	2,333	4,000	2,400	~9,000*
Payroll	10,000	7,000	Not Provided	2,400	9,000
Recruiter/HR	10,000	Not Provided	Not Provided	Not Provided	~9,000**

Support Staff – Salaries

Deloitte calculated the support staff wages based on data from a NL home support agency and equivalent RHA wages in NL.

Roles	Annual Salary	Monthly Salary	Est. Hourly Rate (40 hours per week)
Scheduler	$50,400	$4,200	$26.25
Payroll	$50,400	$4,200	$26.25
Recruiter/HR	$56,400	$4,700	$29.38

Comparative Support Staff Salaries

Role	Source	Designations	Monthly Salary****	Est. Annual Salary
Scheduler	NL***	Scheduler	$ 4,200	$ 50,400
	NL RHA	Clerk	$ 4,149	$ 49,788
	BC	Scheduler 1	$ 4,695	$ 56,340
	BC	Scheduler 2	$ 4,904	$ 58,848
	SK	HC Scheduler	$ 4,605	$ 55,260
Payroll	NL***	Payroll	$ 4,200	$ 50,400
	NL RHA	Payroll Clerk 1	$ 3,858	$ 46,296
	NL RHA	Payroll Clerk 3	$ 4,425	$ 53,100
	SK	Payroll Clerk	$ 4,275	$ 51,300
Recruiter/HR	NL***	Recruiter/HR	$ 4,700	$ 56,400
	NL RHA	Staffing Specialist	$ 5,908	$ 70,896
	NL RHA	HR Consultant	$ 6,803	$ 81,636

Data Sources: Interviews with Home Support agencies; Desk Research; Information from RHAs

*Two individuals share this responsibility but both have other functions within the organization

** One individuals has this responsibility but performs other functions within the organization

***NL Home Support Agency

****BC and SK rates are based on rates from Collective Agreements. Rates have been increased by 23% to reflect the estimated benefits payments of Home Support Agencies in NL

Appendix C: Home Support – Agencies: Calculations and Assumptions

Administration & Other – Home Support Agency Caseload Sizes

Variable Costs

Calculation Methodology

It is important that funding reflects the expected client caseload (per agency). Currently, Newfoundland & Labrador's home support agency market is fragmented relative to other jurisdictions, with a lower population to agency ratio relative to other Canadian provinces. Applying the national median ratio of population to the # of HS agencies, against NL's population, suggests that the province should have 15 HS agencies. Given these considerations, it can be reasonably assumed that the number of HS agencies will fall between 15 and 33 (the current number of HS agencies in NL). For calculation purposes, Deloitte made the illustrative assumption that 20 home support agencies will operate in the province.

The total number of home support hours (per month) delivered by agencies was divided by the assumed number of agencies to approximate the number of monthly hours per agency.

Assumptions

Long-term Market Size and Caseload Sizes

Assumed number of Home Support Agencies	15 – 33	→	Monthly hours of subsidized home support per agency	25,831
Illustrative number of Home Support Agencies	20			
Average number of subsidized clients per agency	197			

Comparative Analysis

Monthly Home Support Hours per FTE****

Data*	NL	NS	NB	ON	BC	SK	MB	QC	Median***
# of HS Agencies**	33	36	47	301	160	34	28	70	47
Population	528,817	953,869	759,655	14,193,384	4,817,160	1,163,925	1,338,109	8,394,034	
Ratio of population to # of HS Agencies	16,025	26,496	16,163	47,154	30,107	34,233	47,790	119,915	34,233
Number of NL Agencies (Median)	15 *Calculated by applying the median ratio of population to # of HS agencies against Newfoundland & Labrador's population*								

Data Sources: Desk research

*Data from Statistics Canada

**Excludes micro agencies with only 1-4 employees

*** Excludes NL

****Excludes Alberta, Home Support in rural areas within AB are delivered publicly

Appendix C: Home Support – Agencies: Calculations and Assumptions

Administration & Other – Management Costs

Fixed Costs

Calculation Methodology

Management staff excludes staff that perform scheduling, payroll, HR and nursing related activities. Management staff typically perform a directorship role within the organization and oversee the operations.
The number of management staff is derived from consultations with HS agencies in NL, NS and NB. The salaries are estimated by subtracting wages for other support staff (e.g., schedulers, payroll)

Assumptions

Estimated monthly hours of home support per agency	25,831
Number of Management staff FTEs	2
Average monthly salary per Management FTE	$6,600
Average annual salary per Management FTE	$79,200

Comparative Analysis

Monthly Home Support Hours per FTE

Data	NL Agency #1	NL Agency #2	NL Agency #3	NL Agency #4	NS Agency #1	NB Agency #1
Average hours of Home Support delivered (monthly)	30,000	7,000	3,000	3,000	2,400	9,000
Number of Management Staff FTEs	8	3	1	1	1	1
Est. average monthly salary per FTE*	$6,600	N/A	N/A	N/A	$6,012	N/A

Data sources: Interviews with Home Support agencies; Desk Research; Information from RHAs

Appendix C: Home Support – Agencies: Calculations and Assumptions

Administration & Other – Other Components

	Fixed Costs		
	Fixed Costs attributable to Private Pay	Administration & Other (Excluding Wages) – Fixed Costs	Accreditation Costs
Calculation Methodology	A portion of each Home Support Agency's fixed costs are attributable to private pay clients, this percentage was deducted from the reimbursement rates	Deloitte calculated the cost of fixed Administration & Other expenses based on information provided by a NL agency; data was compared to an agency in NB and industry data from Statistics Canada.	Deloitte calculated the cost of Accreditation based on information from Accreditation Canada.
Assumptions/Research			
Estimated Cost	Percentage (%) of fixed costs attributable to private pay clients*** **20%**		
	Data sources: Data from HCS	Data sources: Interviews with Home Support agencies; Desk Research	Data sources: Accreditation Canada

Expenses	NL Agency #1	NB Agency #1	NAICS – StatsCan**
Municipal Taxes	$234	N/A	N/A
Interest/Banking/Accounting	$450*	$519	$817

	Monthly Expense***
Municipal Taxes	$ 234
Interest/Banking/Accounting	$ 450

Number of Survey Days per Accreditation Cycle (4 years)	4.25 days
Accreditation Fee (% of Annual Revenue)	0.01%
Monthly Cost of Accreditation (Survey Only)	$ 227

*Data based on an example HS Agency provided by the NL agency

** Statistics Canada Industry Data (Homecare in NL)

*** Applies to all fixed costs, including municipal taxes, interest/banking/accounting costs and the costs of accreditation (survey only)

Appendix C: Home Support – Agencies: Calculations and Assumptions

Mileage

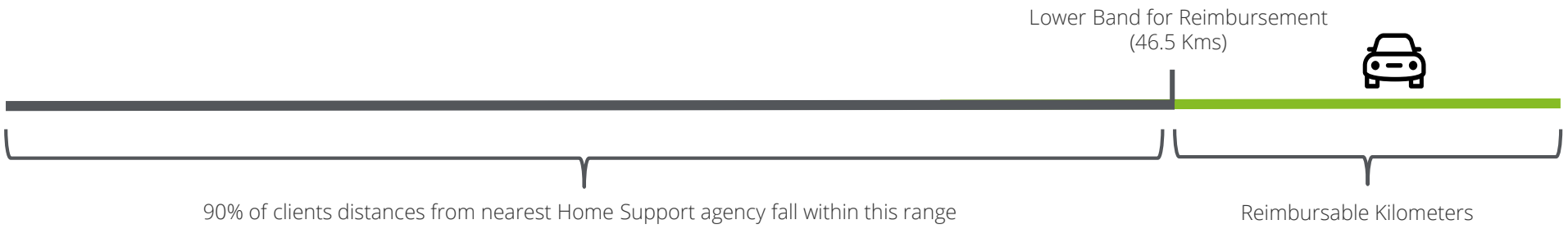
Calculation Methodology	Key Assumptions and Inputs
Mileage was approximated based on the distance from clients' homes to the nearest home support agency. The cost of mileage would be reimbursed once it exceeded a minimum amount, based on distances in excess of 90% of clients' distances from nearest home support agency (~46.5kms). The estimated number of mileage reimbursements per month was calculated based on the expected frequency of travel reimbursements multiplied by the approximate number of shifts (per month) by level of care. The monthly mileage reimbursement is based on the estimated number of reimbursements multiplied by the average reimbursable kilometers	• Average number and lengths of shifts by Level of Care • Lower band for reimbursements • Rate of reimbursement per kilometer • Frequency of travel reimbursements • Average distance travelled above lower band for reimbursements • Standard deviation of distance travelled

Funding formula

Mileage **(*Monthly*)** = (Average number of kilometers above lower band) * (Estimated number of travel reimbursements per month) * (Rate of reimbursement per kilometer)

Calculations

Reimbursable mileage



Data Sources: Data provided by HCS – Hours of Home Support accessed per month per client; Draft Levels of Care framework

Appendix C: Home Support – Agencies: Calculations and Assumptions

Mileage

Calculation Methodology

Deloitte calculated the mean and standard deviation for the distances between home support agency clients in CRMS pay and the nearest home support agency. These values were used to determine the lower band for reimbursements (Distance above 90% of client distance from nearest home support agency) and the average distance travelled above the lower band. The number of travel reimbursements (per month) was calculated for each Level of Care by multiplying the estimated number of monthly home support shifts by the frequency of travel reimbursements.

Assumptions

Mileage

Lower band for reimbursement	46.5 Km
Frequency of Travel Reimbursement	10%
Rate of Reimbursement (Per Kilometer)	$ 0.55
Average Reimbursement Distance (One way)	22.4 Km
Average Reimbursement Distance (Round trip)	44.9 Km
Average Reimbursement Amount	$ 24.69

New LoC	Average Shift Length	Average # of Shifts (Monthly)	Average # of Travel Reimbursements (Monthly)	Average distance reimbursed (Monthly)
Level B – Low to Moderate	4.0	9	0.8	38 Km
Level C – Moderate	4.3	19	1.9	85 Km
Level D – Moderate to High	4.8	30	3.0	133 Km
Level E – High	5.2	39	3.8	172 Km
Level F – Complex	7.0	67	6.5	293 Km

Comparative Analysis

Current NL Home Support Client Statistics

Average distance between client and nearest home support agency	15.5 Km
Standard deviation of distance between CRMS clients and nearest home support agencies	18.9 Km
Lower band for reimbursement (includes 90% of client distances from home support agency)	46.5 Km
Percentage of clients above lower band for reimbursement	10%
Average number of kilometers in excess of 46.5 Km	22.45 Km

Data Sources: CRMS Data; Desk research

Appendix C: Home Support – Agencies: Calculations and Assumptions

Supplies Expense

Calculation Methodology

Based on consultations with home support agencies, the main supplies consumed in the delivery of home care are gloves, aprons and gowns. Supplies expenses per hour of home support was calculated using data provided by home support agency in NS. This cost was validated against the retail cost (market rates) of home support supplies.

Key Assumptions and Inputs

- Cost of Supplies consumed per hour of home support
- Average hours of home support (monthly) delivered by level of care

Funding formula

$$\boldsymbol{Supplies\ Cost\ per\ Month} = (Average\ hours\ of\ home\ support\ (monthly) by\ level\ of\ care) * (Cost\ of\ supplies\ per\ hour\ of\ home\ support) Supplies\ Expense\ (Monthly)$$

Comparative Data

Comparative Data on Supplies

Data	NS Agency #1
Supplies Cost per Month	$ 417
Supplies Cost per hour of care delivered	$ 0.17
Supplies include:	Gloves, Disposable Gowns & Aprons

Market Research	
Average Cost of Gloves (1 pair)	$ 0.20
Average Cost of Disposable Aprons (Individual)	$ 0.11

Assumptions

	Hourly Expense
Cost of Supplies per hour of home support	$0.17

Data Sources: Interviews with Home Support agencies; Desk Research

Appendix C: Home Support – Agencies: Calculations and Assumptions

Nursing & Quality Assurance

Calculation Methodology

The monthly cost of nursing & quality assurance are calculated by multiplying the average ratio of nursing hours to home support hours, with the average number of home support hours (monthly) by level of care. This estimates the total number of nursing hours (monthly) by level of care, which is multiplied by the hourly wage for nurses.

Key Assumptions and Inputs

- Ratio of nursing hours to home support hours
- Hourly wage for nurses
- Average hours of home support be level of care

Funding formula

$$\textbf{\textit{Nursing Expenses per Month}} = (Ratio\ of\ nursing\ hours\ to\ home\ support\ hours) * (Average\ hours\ of\ home\ support\ by\ level\ of\ care) * (Hourly\ wage\ for\ nurses)$$

Comparative Data

Nursing Staffing Ratios

Deloitte calculated the ratio of nursing hours to HS hours based on nursing staff ratios provided by agencies in NL, NS and NB

Nursing Wages

Deloitte calculated the cost of nursing wages based on data provided from the RHAs, market research and interviews with other jurisdictions

Comparative Data

	NL Agency #1	NS Agency #1	NB Agency #1
Ratio of nursing hours to HS hours	0.004x	0.067x	0.004x

	NL Agency #1	NB Agency #1	RHA: Nurse I	RHA: Nurse IC	Market Research
Nursing hourly wages	$75	$35	$38	$41	$33

Assumptions

Ratio of Nursing Hours to HS hours 0.004x

i.e., there is **one nursing hour** for every **250 HS hours** delivered

Hourly Wage	$40
Est. Annual Salary (1 FTE) (40 hours per week)	$83,200

Data Sources: Interviews with Home Support agencies; Jurisdictional Research

Appendix C: Home Support – Agencies: Calculations and Assumptions

Facility Expenses

Calculation Methodology

The monthly cost of facility expenses was calculated using data from agencies in NL, NB and NS, as well as industry data from Statistics Canada. Facility expenses are all considered fixed costs, as such, they were divided by the average number of hours a typical HS agency is expected to deliver. The resultant cost per hour was applied to the expected hours of care (per month) for each level of care. A "discount" was applied to account for the percentage of technology expenses attributable to private pay clients.

Key Assumptions and Inputs

- Rent
  - Rental Rate
  - Offices per agency
  - Average size of office
- Insurance
- Utilities
- Estimated number of HS hours delivered per HS agency (Monthly)
- Percentage (%) of Home Support agency expenses attributable to private pay clients

Funding formula

$$\textbf{\textit{Facility Expenses (Monthly)}} =$$
$$(\textit{Facility Expenses/Average monthly hours of Home Support per agency}) * \textit{Average monthly hours of home support (by Level of Care)} * (1 - \textit{\% of home support agency expenses attributable to private pay clients})$$

Comparative Data

Rent/Amortization

Deloitte determined the average office net rental rate in St. John's to be $18.42 per sq. ft (annually). Using CMHC research into the average monthly rents for two person bedrooms, Deloitte estimated that St. John's rental rates are approximately 25% higher than an average of rates from 10 other regions within the Province. The average St. John's office net rental rate was adjusted by this premium to an estimated $13.82 per sq. ft (annually). This rental rate was applied to an estimated size and number of offices, currently assumed to be one office at 1,500 sq. ft

Assumptions	Data
Offices per Agency	1
Size of Office	1,500 sq ft.
Average Net Rent	$ 13.82
Monthly Rent Expense	$ 1,727

Comparative Data

Monthly Expenses Facility Expenses	Estimated – Turner Drake & CMHC	NL Agency #1*	NB Agency #1	NS Agency #1	NAICS – StatsCan***
Rent/Amortization	$ 1,727	$ 1,985	$ 571**	$ 1,167****	$ 1,658

Data Sources: Desk Research – Canadian Mortgage and Housing Corporation, Turner Drake; Consultations with HS Agencies; Data from HCS
*Averaged between five offices (Average Square Footage is 1,150 sq. ft per office)
** Amortization of a purchased building
*** Statistics Canada Industry Data (Homecare in NL)
****Includes utilities

Appendix C: Home Support – Agencies: Calculations and Assumptions

Facility Expenses

Calculation Methodology

The monthly cost of facility expenses was calculated using data from agencies in NL, NB and NS, as well as industry data from Statistics Canada. Facilities expenses are all considered fixed costs, as such, they were divided by the average number of hours a typical HS agency is expected to deliver. The resultant cost per hour was applied to the expected hours of care (per month) for each level of care. A "discount" was applied to account for the percentage of facility expenses attributable to private pay clients.

Key Assumptions and Inputs

- Rent
  - Rental Rate
  - Offices per agency
  - Average size of office
- Insurance
- Utilities
- Estimated number of HS hours delivered per HS agency (Monthly)
- Percentage (%) of Home Support agency expenses attributable to private pay clients

Funding formula

$$\textbf{\textit{Facility Expenses (Monthly)}} =$$

*(Facility Expenses/Average monthly hours of Home Support per agency) * Average monthly hours of home support (by Level of Care) * (1-% of home support agency expenses attributable to private pay clients)*

Comparative Data

Rent/Amortization

Deloitte calculated the monthly cost of each facility expense based on data from agencies in NL, NS and NB, as well as industry information from Statistics Canada. In cases where an agency operates more than one office, facility expense are averaged between the number of offices.

Assumptions	Data
Insurance	$ 800
Utilities	$ 775

Comparative Data

Non-rent Expenses	NL Agency #1*	NB Agency #1	NS Agency #1	NAICS – StatsCan***
Insurance.	$ 801	$ 227	$ 350	$ 383
Utilities	$ 775	$ 429	N/A	$ 1,083

Data Sources: Desk Research – Canadian Mortgage and Housing Corporation, Turner Drake; Consultations with HS Agencies; Data from HCS

Appendix C: Home Support – Agencies: Calculations and Assumptions

Technology Expense

Calculation Methodology	Key Assumptions and Inputs
The monthly cost of technology expenses was calculated using data from agencies in NL and NS. Technology expenses are considered fixed costs, as such, they were divided by the average number of hours a typical HS agency is expected to deliver. The resultant cost per hour was applied to the expected hours of care (per month) for each level of care. A "discount" was applied to account for the percentage of technology expenses attributable to private pay clients.	• Technology expenses • Percentage (%) of Home Support agency expenses attributable to private pay clients • Percentage (%) of technology expenses to be shared

Funding formula

$$\textbf{\textit{Technology Expenses (Monthly)}} =$$

*(Technology Expenses/Average monthly hours of Home Support per agency) * Average monthly hours of home support (by Level of Care) * (1-% of home support agency expenses attributable to private pay clients) * (% of Technology Expenses to be shared)*

Comparative Data

Deloitte calculated the monthly cost of technology expenditures based on data provided by NL and NS home support agencies. In the future state of the Home Support program, technology costs may be shared between agencies and the RHAs to strengthen purchasing power. Because the details of this arrangement have not been determined, the percentage of technology expenses expected to be shared is set at 0%

Assumptions	Monthly Expense
Technology	$ 3,284
% of Technology expense to be shared with other organizations	0%

Comparative Data

	NL Agency #1	NS Agency #1
Technology	$ 3,284*	$ 1,167**

*Technology Costs Include

- $77.67 per month– expense reporting software.
- $300 per month – Human resource management software.
- $2,609 per month – Home Health Care Software (incl. clinical documentation, back office functionality, client and family portals, remote patient monitoring and mobile care worker functionality)
- $275.93 per month – Accounting software.
- $21.79 per month – Website hosting service

**Technology Costs Include:

- $600 per month – Cell Phone plans
- $567 per month – Scheduling Software

Data Sources: Interviews with Home Support agencies

Appendix C: Home Support – Agencies: Labrador Differential

Deloitte utilized the Labrador Allowance as outlined in the Labrador Benefits Agreement to identify a differential rate for Home Support workers working in Labrador

The Labrador Benefits Agreement is an agreement between various Provincial agencies (incl. the LG RHA) and various labor unions (incl. CUPE, Registered Nurses' Union). The agreement secures an allowance for union employees (and dependents), reflecting the cost of living in and traveling to/from the region. The size of the allowance differs based on the employee's community, with more rural communities receiving a larger allowance.

Deloitte pro-rated the annual allowances to an estimated hourly rate (see assumptions below). Applying these allowances to the current hourly agency ($16.55/hr) results in an increase ranging from 12.1% to 14.4%

Assumptions:

- 48 Working Weeks per annum (Includes 4 weeks of paid leave & public holidays)
- 40 Working Hours per Week

Group	Locations		Labrador Allowance (annual)[1]	Labrador Allowance (hourly est.)	% Increase over PHSP agency union rate ($16.55)
Group 1	• Happy Valley/ Goose Bay • North West River • Sheshatshiu	• Wabush • Labrador City • Churchill Falls	$3,850	$2.01	12.1%
Group 2	• Red Bay • L'Anse au Loup • L'Anse au Clair • Forteau • Pinware • West St. Modest • Mud Lake	• Cartwright • Mary's Harbor • Port Hope Simpson • St Lewis • Charlottetown • Lodge Bay • Paradise River	$4,364	$2.27	13.7%
Group 3	• Rigolet • William's Harbour • Norman's Bay • Black Tickle • Pinset's Arm • Makkovik	• Makkovik • Postville • Hopedale • Davis Inlet/ Natuashish Nain	$4,573	$2.38	14.4%

[1]Includes both the Labrador Allowance and Travel Allowance (Allowance for recipients to travel outside of Labrador)

Appendix C: Home Support – Self-Managed Care: Calculations and Assumptions

Home Support Services

Calculation Methodology

Hourly home support service rates are calculated by multiplying the rate for each type of home support service by the benefits rate for Self Managed Care

Key Assumptions and Inputs

- Wage rate for Personal Care and Homemaking
- Benefits as a percentage of home support wage

Funding formula

$$\textbf{\textit{Home Support Service Rate}} = \textit{Rate for Home Support Service (Personal Care or Homemaking)} * (1 + \textit{Benefits as a \% of home support wage})$$

Calculation

Home Support Worker Wages

Using the collective agreement rate in NL as the starting point ($16.55), Deloitte applied the wage differentials between housekeeping and support workers (Ontario) to generate rates for Personal Care and Homemaking

Home Support Worker Benefits (SMC)

Deloitte utilized the benefits rate currently being offered by the Department for Self Managed Care workers, noting that not all benefits offered by a home support agency may be available to an SMC worker.

Comparative Data

Province	Designations	Hourly Rate	Differential	Applied to NL CA Rate
MB	Support Worker I	$ 14.21	93%	$ 15.37
	Support Worker II	$ 16.39	107%	$ 17.73
BC	Housekeeper	$ 16.10	92%	$ 15.20
	Support Worker 1	$ 18.96	108%	$ 17.90
ON	Housekeeping	$ 11.63	95%	$ 15.80
	Private Care	$ 12.74	105%	$ 17.30
NL	Homemaker	$ 19.98	98%	$ 16.25
	Personal Care Attendant	$ 20.71	102%	$ 16.85

Benefits are **11.37% of Wages.**

Includes: EI + CPP + Vacation Pay

- Data Sources: Collective agreements from other jurisdictions; GNL – Job Class Profiles/Wage Scales; Data from HCS

Appendix C: Home Support – Self-Managed Care: Calculations and Assumptions

Supplies Expense

Calculation Methodology

Based on consultations with home support agencies, the main supplies consumed in the delivery of home care are gloves, aprons and gowns. Supplies expenses per hour of home support was calculated using data provided by home support agency in Nova Scotia. This cost was validated against the retail cost of home support supplies

The funding recommendations are made with the assumption that SMC workers will provide required supplies (excluding supplies included as part of the SAP). However, if the department chooses to provide supplies to clients/workers directly, this reimbursement component can be excluded.

Key Assumptions and Inputs

- Cost of Supplies consumed per hour of home support

Funding formula

Supplies Expense *= Cost of supplies per hour of home support*

Comparative Data

Home Support Worker Wages

Data	NS Agency #1
Supplies Cost per Month	$ 417
Supplies Cost per hour of care delivered	$ 0.17
Supplies include:	Gloves, Disposable Gowns & Aprons

Market Research	
Average Cost of Gloves (1 pair)	$ 0.20
Average Cost of Disposable Aprons (Individual)	$ 0.11

Assumptions

	Hourly Expense
Cost of Supplies per hour of home support	$0.17

Data Sources: Interviews with Home Support agencies; Desk Research

Appendix C: Bookkeepers: Calculations and Assumptions

Bookkeeping Expense

Calculation Methodology

The effort required to deliver services to a typical self-managed home support client (in hours per month) was calculated using Deloitte's pricing tool for bookkeeping services and through consultations with a Deloitte bookkeeper. The estimated hours scale to the number of home support workers employed by the client (to a maximum of 5).
The market rate of bookkeeping services (per hour) was applied by Deloitte to estimate the bi-weekly bookkeeper reimbursement

Key Assumptions and Inputs

- Hourly rate of bookkeeping services
- Estimated hours of bookkeeping per month, per client

Bookkeeping Rates	
Hourly Bookkeeping Rate	$ 45

Funding formula

Bookkeeper Expense (Biweekly)=

*((Average hours of bookkeeping per month, per client) * (hourly rate of bookkeeping services))/2*

Comparative Data

Comparative Data on Bookkeeping

Deloitte Bookkeeping Pricing Tool – Estimation of Bookkeeping Hours Required by Level					
Number of HSWs employed by Client	1	2	3	4	5
Tasks (Hours per Month, per Client)					
Employee Payroll	0.22	0.44	0.66	0.88	1.10
Issuing T-4s	0.03	0.05	0.08	0.10	0.13
Employee Management (Onboarding/Termination)	0.41	0.83	1.24	1.65	2.06
Remittances	0.5	0.5	0.5	0.5	0.5
Estimated Hours of Bookkeeping per Month, per Client	**1.16**	**1.82**	**2.48**	**3.13**	**3.79**

	Deloitte	NL Bookkeeper	Internet Source #1	Internet Source #2
Hourly Bookkeeping Rate	$50	$60–$80	$30–$90	$25–$80

Stakeholder Consultations	
Number of Respondents	8 (6 survey, 2 phone consults)
Average hours of bookkeeping per month, per HS client	2.03 hours

Data Sources: Deloitte Bookkeeping Pricing Tool; Deloitte Bookkeeper; Interviews with NL Bookkeepers; HCS Service Provider survey; Desk Research

Appendix C: Other Programs – Behavioural Aides/Home Therapist

Behavioural Aide/Home Therapist

Calculation Methodology	Key Assumptions and Inputs
Deloitte used GNL's job class profiles to identify the skills, experience and education required for Home Therapists & Behavioural Aides. Each job class profile corresponded to an hourly wage rate based on the NAPE General Service Pay Grid (CG Hourly Rate). By assessing the skills, experience and education required for the two roles, Deloitte assigned a CG Hourly Rate for Home Therapist and Behavioral Aides ($25.18). Deloitte approximated the differential between Home Support workers and Behavioural Aides/Home Therapists using the Homemaker CG Hourly Rate and the Personal Care Attendant (PCA) CG Hourly Rate (Reflecting the spectrum of a HSW's roles) as the upper band and lower bands in relation to the CG rate for Home Therapists and Behavioral Aides. The differentials were applied to the collective agreement rate ($16.55) to estimate the range of hourly rates for Behavioural Aides/Home Therapists	• Government of Newfoundland and Labrador "Job Class profiles for Homemakers and PCAs • Newfoundland & Labrador Association of Public and Private Employees (NAPE) General Service Pay Grid • Collective Agreement Rate ($16.55)

Home Therapist/Behavioural Rate ($25.18 – Assigned CG Hourly Rate)

Band	Differential (Home Therapist Rate/Comp. Rate)	Estimated Hourly Rate (Applied to Collective Agreement Rate)
Upper band (Homemaker) ($19.98 per hour)	26.0%*	$20.85 per hour
Median	**23.8%**	**$20.49 per hour**
Lower band (PCA) ($20.71 per hour)	21.6%**	$20.12 per hour

*Calculated as Assigned CG Hourly Rate ($25.18)/ Homemaker Rate ($19.98)

**Calculated as Assigned CG Hourly Rate ($25.18)/ PCA Rate ($20.71)

Appendix D: PCH Detailed Analysis & Assumptions

Appendix D: Estimated Impact of Recommended PCH Rate Changes on Expenditures

Comparison of current

A comparison of the proposed rate changes for PCH was done on current spending of GNL HCS. The proposed base rate increases present an increase in monthly spending of 1.1% for Level I residents, 7.6% for Level IIs, 5.7% for Enhanced Care residents, and 10.7% for Level IIIs (rate is calculated including the Level II Awaiting LTC Differential). The combined impact of the proposed changes on the monthly base rates for the existing Levels of Care (including Level III residents awaiting LTC placement) represents a modest increase of 1.9%, or roughly $756,000 for provincial spending on Personal Care Homes, before the inclusion of new differential funding amounts and new program offerings in PCHs.

The future levels of care Level B – Low to Moderate, Level C – Moderate, Level D – Moderate to High are expected to map to Levels I, II, and Enhanced Care.

Levels of Care (Current)	Current Rate	Recommended Rate (Existing LoC)	Delta (%)
Level 1	$2,375	$2,402	+1.1%
Level 2	$2,375	$2,558	+7.6%
Enhanced Care	$3,430	$3,626	+5.7%
Level III (incl. Awaiting LTC Differential)	$3,510	$3,885	+10.7%

Total annual direct program expenditure (Current Rates): **$39.6M**

Estimated total annual expenditure (Proposed Rates – Existing LOC): **$40.3M*** (+1.9%)

*Estimated total expenditures assumes that the percent of subsidized clients (82.6% as of September 2018) and co-pay portion (average of $1,338/month for FY2017/18) will remain constant.

Appendix D: PCH Level I Rate Reconciliation

Component by component comparison of the proposed Level I Base Rate to the historical Board & Lodging Rate for Level I's and II's.

	Existing Rate	Proposed Base Rate	Delta (%)
	Level I	Level I	
Direct Care and Program Support	872	872	0.0%
Supporting Salaries	284	250	-11.9%
Dietetic Services	239	250	+4.7%
Medical Travel ★	Variable	18	N/A
Foot care ★	Variable	10	N/A
Facility Expense	690	731	+6.0%
Insurance	164[1]	28	N/A
Administration, Training, and Other ★	74	125	+68.8%
Safety and Accessibility Equipment ★	Variable	17	N/A
Medical and Incontinence Supplies ★	N/A	30	N/A
Base Rate (before Adjustments)	**$2,323**	**$2,332**	**+0.4%**
3% Operating Margin (Vacancy adjustment)	53	70	31.8%
Contingency Rate *(Excluded from this comparison)*	N/A	0	N/A
Base Rate	**$2,375**	**$2,402**	**+1.1%**
Base Rate (before building in Medical Travel, Foot Care, Equipment, Medical and Outbreak Supplies, Incontinence Supplies, Training, and Contingency Rate)	**$2,323**	**$2,208[2]**	**-5.0%**

★ Includes net new components not in historical per diem for PCH

Notes: 1 - Includes amount for Vehicle Insurance
2 - Includes: $872.36 for Direct Care and Program Support, $250.00 for Supporting Salaries, $250.10 for Dietetic Services, $731.24 for Facility Expenses, $28.11 for Insurance, and $75.77 for Office Expenses/General Supplies/Other/Accountant (included in Administration, Training, and Other)

Appendix D: PCH Level 1 Rate Reconciliation: Detailed Component Comparison

Detailed Component Comparison

Facility Expense Breakdown (for Level I Base Rate)

	Existing Rate	Proposed Rate	Delta (%)
Facility Expense	**$690**	**$731**	**+6.0%**
Rent expenses	$371	$412	+10.8%
Repair, renovation, and maintenance	$159	$157	-1.6%
Utilities (including telecommunications)	$159	$163*	+2.4%

*Adjusted for NL Consumer Price Index: Energy

Medical and Incontinence Supplies

	Existing Rate	Proposed Rate	Delta (%)
Medical and Incontinence Supplies	**-**	**$30**	**N/A**
Incontinence supplies	-	$9	N/A
Medical and Outbreak Supplies	-	$21	N/A

Administration, Training, and Other

	Existing Rate	Proposed Rate	Delta (%)
Supplies, Administration, and Other	**$74**	**$125**	**+68.8%**
Office Expenses, General Supplies, Accounting fees and Other	$74	$76	+2.0%
Training	-	$50*	N/A

*Based on training costs for new hires and recurring training costs, employee turnover rate, and average number of FTEs per Resident

Appendix D: Definitions – Personal Care Homes

Monthly base rate components defined – Resident care

Ten components are proposed for inclusion in the base rate for PCH, under the current/existing Levels of Care framework, and under the new LOC framework. The inclusion of any components not previously included in the historical Board & Lodging is dependent on policy renewal. The following definitions have been applied for Resident Care components:

Rate Component	Description	Calculation Methodology	Base rate inclusions
1. Direct Care and Program Support[1]	Direct care costs including staffing and other care and program costs directly associated with the provision of care services.	Based on the hours of care specified in the PCH Operational Standards and the hourly wage paid to Personal Care Workers.	All expenses incurred in the direct care of residents
2. Supporting Services[2]	Costs such as salaries and benefits for administrative and non-direct care staff.	Calculated as a percentage of direct care salaries and wages, using the median of comparator organizations in NS, NB.	Inclusive of kitchen staff, administrative staff, and other indirect staff as per the Operational Standards
3. Dietetic Services[3]	Expenses for meal and dietary provisions for residents	Calculated as the median of comparator organizations in NL, NS, and NB and adjusted for the Consumer Price Index for Food Costs in NL.	All food and kitchen supplies required for meal preparation.
4. Medical Travel[4]	Cost of travel to and from client medical appointments and other necessary travel.	Calculated using the average kilometers travelled per claim, number of claims per month, and the average per km rate for travel. Average wait time and escort fees are included as a monthly rate based on utilization.	Fuel costs, vehicle depreciation, and wait/escort times. *Not previously included in historical per diem calculation.*
5. Foot Care[5]	Costs of foot care services provided directly by the PCH or on/offsite by a third-party.	Calculated using the average number of claims per month (utilization rate) and the historical foot care rate in NL.	All costs associated with the provision of foot care services. *Not previously included in historical per diem calculation.*

1. Source: Operational Standards; Levels of Care Framework
2. Source: Nursing Home and PCH Comparators in NS and NB
3. Source: Long-term Care Homes in NL; Nursing Home and PCH Comparators in NS and NB
4. Source: CRMS and RHA Data (2016–2018); CRA Mileage Rate
5. Source: CRMS and RHA Data (2016–2018); Desk top research
6. Source: Long-term Care Homes in NL; Nursing Home and PCH Comparators in NS and NB
7. Operational Standards; RHA Clinical Expertise; RHA Expenditures (2016–18); Lawton's Home Health (Western); Desk-top research
8. Select PCH Financials; Isolation Grant Recipient Financials; Commercial Insurance Providers
9. Source: Long-term Care Homes in NL; Nursing Home and PCH Comparators in NS and NB; CRMS and RHA Data

Appendix D: Definitions – Personal Care Homes

Monthly base rate components defined – Facility Operations expenses

Ten components are proposed for inclusion in the base rate for PCH, under the current/existing Levels of Care framework, and under the new LOC framework. The inclusion of any components not previously included in the historical Board & Lodging is dependent on policy renewal. The following definitions have been applied for Resident Care components:

Rate Component	Description	Calculation Methodology	Base rate inclusions
6. Facility Expenses	Expenses related to the operation of a PCH, including maintenance, cleaning and laundry.	Calculated as the median of comparator organizations in NL, NS, and NB.	Rent/mortgage, utilities, general household expenses, housekeeping, laundry services, repair and maintenance, yard care.
7. Insurance	Applicable commercial, property, and vehicle insurance.	Calculated as the median of comparator organizations in NL, NS, and NB for insurance for an average sized PCH.	All types of insurance required to operate a PCH to standards.
8. Administration, Training, and Other	Cost of administration, training, and other indirect costs related to business.	Training costs are calculated according to per FTE historical costs for select PCHs and adjusted for recurring training, and employee turnover. Administration, management, office supplies, and other indirect costs are the historical funding amount adjusted for inflation.	Includes training costs, administration, management, office supplies, and other indirect costs. *Training not previously included in historical per diem calculation.*
9. Safety and Accessibility Equipment	Costs of essential equipment for a resident-friendly environment	Calculated as the average cost and useful life of equipment required as per Personal Care Home Operational Standards.	General medical and safety equipment required to ensure a safe and accessible living environment for PCH residents. Individualized equipment will continue to be accessed through the Special Assistance Program (SAP). *Not previously included in historical per diem calculation.*
10. Medical and Incontinence Supplies	Costs of highly utilized incontinence, medical and outbreak supplies.	Calculated according to historical utilization and cost of relevant supplies in NL.	All clinical and health care supplies necessary to contain the spread of diseases and promote resident safety and quality of care. *Not previously included in historical per diem calculation.*

6 Source: Long-term Care Homes in NL; Nursing Home and PCH Comparators in NS and NB
7 Source: Operational Standards; RHA Clinical Expertise; RHA Expenditures (2016–18); Lawton's Home Health (Western); Desk-top research
8 Source: Select PCH Financials; Isolation Grant Recipient Financials; Commercial Insurance Providers
9 Source: Long-term Care Homes in NL; Nursing Home and PCH Comparators in NS and NB; CRMS and RHA Data

Appendix D: Personal Care Homes: Assumptions

Direct Care and Program Support

Calculation Methodology

Direct Care and Program Support is calculated according to the hours of care specified in the PCH Operational Standards and the hourly wage paid to Personal Care Workers.

Key Assumptions and Inputs

- Direct hours of care as per the PCH Operating Standards
- Wage rate for Personal Care Workers
- Overtime rate, statutory holidays, and payroll deductions

Funding formula

$$\textbf{\textit{Monthly Direct Care Rate}} = \big((PCW\ direct\ care\ hours + Statutory\ Holiday\ Hours\ at\ overtime\ rate) * (PCW\ wage\ rate\ * (1 + Payroll\ deductions\ as\ a\ percentage\ of\ PCW\ wage\ rate))\big)$$

Assumptions

Comparative Data on Bookkeeping

Current PCH Operating Standards	Level I	Level II	Enhanced Care	Level III
Daily Direct Care Hours	1.5	1.5	3	3.4
Monthly Care Hours	45.6	45.6	91.3	103.4
Monthly Care Hours (incl. OT for stat holidays)	46.8	46.8	93.5	106.0

Wage rate	
Personal Care Rate	$15.55/hour
Other Staffing Assumptions:	
Paid Statutory Holidays	6 days/year
Overtime (OT) Rate	1.5x
Payroll deductions (incl. CPP and EI)	20%

Source: PCH Operating Standards
Source: Levels of Care Framework

Appendix D: Personal Care Homes: Assumptions

Supporting Services

Calculation Methodology	Key Assumptions and Inputs
Supporting Services is calculated as a percentage of direct care salaries and wages, using the median of comparator organizations in NS, NB.	• Wages and salaries for supporting services as a percentage of direct care salaries/wages • It is assumed that Supporting Services do not increase/decrease with client complexity.

Funding formula

$$\textbf{\textit{Monthly Supporting Services Rate}} = \left((Monthly\ Direct\ Care\ Rate\ for\ Level\ I\ Clients) * (Wages\ and\ Salaries\ for\ Supporting\ Services\ as\ a\ percentage\ of\ direct\ care\ funding)\right)$$

Assumptions

% of Direct Care	
% Supporting Services	29%

Included Roles:

Supporting Services is assumed to include:
- Management salaries and administrative salaries
- Kitchen staff wages
- Housekeeping staff wages
- Facilities management wages
- All and any other staff required to operate the PCH according to applicable Operating Standards

Comparator jurisdictions (obtained from financial statements)

Province	N (Sample Size)	Median	Min	Max
NB	7	26%	19%	30%
NS	1	36%	-	-
NL (LTC)	8	31%	15%	42%

Median	29%
Average	28%
Std Dev	+/-6.8%

Appendix D: Personal Care Homes: Assumptions

Dietetic Services

Calculation Methodology	Key Assumptions and Inputs
Dietetic Services is calculated as the median monthly, per-client cost of food and kitchen supplies, based on comparator organizations in NL, NS, and NB, and adjusted for the Consumer Price Index for Food in NL.	• Median cost per meal/snack in comparator jurisdictions • NL Cost of Living (Food) Index • Cost of Living Food Index for comparator jurisdictions.

Funding formula

$$\textbf{Monthly Dietetic Services Rate} = \left(\frac{(Comparator\ Median\ Monthly\ Food\ Costs\ per\ client)}{Comparator\ Cost\ of\ Living\ (Food)\ Index} * (NL\ Cost\ of\ Living\ (Food)\ Index)\right)$$

Assumptions

Monthly Per-Client Cost of Food and Kitchen Supplies for Comparator Homes (Base Year)

Province	N	CPI (Food) as of Nov/18	Median	Min	Max
NB	7	151.4	$168	$154	$237
NS	1	149.0	$268	-	-
NL (PCH)[1]	7	145.1	$286	$242	$529

Median Monthly Dietetics Services Cost (Sample of 8 NB & NS Homes, Base Year)	$172
Consumer Price Index (Food) as of Nov/18	145.10
Monthly Dietetics Services Cost (in Nov/18 Dollars)	$250

[1] Financial Information from Isolation Grant Recipients included for comparison purposes only – not included in the Dietetics Services Rate

Appendix D: Personal Care Homes: Assumptions

Medical Travel

Calculation Methodology	Key Assumptions and Inputs
Medical Travel and Transportation is calculated based on the percentage of clients accessing travel, the average kilometers travelled per claim, number of months per year with a travel claim, and the average per km rate for travel. Includes fuel costs, vehicle depreciation and wait/escort times. Average wait time and escort fees are included as a monthly rate based on utilization.	• Average kilometers per travel claim (for Level I and Level II) • Utilization (Average number of travel claims per client/month) • Per km travel rate ($); Escort hourly wage rate ($) • Average wait and escort time per client **Excludes** exceptional travel claims (greater than 215km per month) for clients accessing regular medical treatments and appointments.

Funding formula

$$\textbf{Monthly Medical Travel Rate}$$

$$=(\textit{Percentage of Clients Accessing Medical Travel} * (\textit{Average number of months per year with travel claim}) / 12 \text{ months in a year} * \textit{Number of KM per Claim (for Level I and Level II)} * \textit{Per KM Travel Rate}) + (\textit{Average Wait Time per client per month} * \textit{Hourly Wage for Escort Fees})$$

Assumptions

Average kms per Claim		Mileage Rate		Wait times and escort fees	
Level I Average KM per Claim	63km	Mileage rate	$0.55/km	Average Monthly Wait Time per Client	0.47 hours
Level II Average KM per Claim	80km	**Utilization**		Escort Fee Hourly Wage	$13.00/hour
Exceptional Travel Boundary	215km	% Total Clients Accessing Travel	59%		
% normal (non-exceptional) travel claims	80%	Average number of months per year with travel claim	6.8 months/year	Estimated Monthly Medical Travel Rate (rounded)	$18/month (Level I)
Sources: FY2017/18 CRMS Data for Medical Transportation Claims for PCH Residents; FY2016–18 RHA Data on Transportation and Escort/Wait Time Claims; CRA Mileage Rate		Source: 2018 CRA Automobile Allowance Rate Source: FY2017/18 CRMS Data		Source: FY2017/18 RHA Data, Historical Hourly Rate for Escort Wage	

Appendix D: Personal Care Homes: Assumptions

Foot Care

Calculation Methodology	Key Assumptions and Inputs
Foot care is calculated based on the average number of months with claims per client, the percent of total residents accessing foot care, and the historical foot care rate in NL.	• Historical Foot Care rate ($) • Foot Care claims per year for residents accessing services • Percentage of PCH Residents accessing foot care

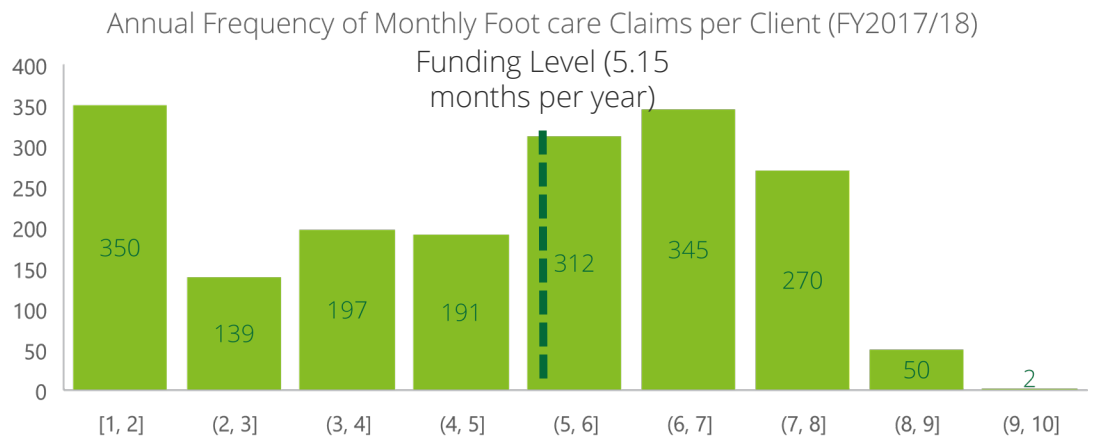
Funding formula

$$\textbf{Monthly Foot Care Rate} = Percent\ of\ Residents\ accessing\ Foot\ Care * \frac{Average\ Number\ of\ Months\ with\ claims}{12} * Foot\ Care\ Rate$$

Assumptions

Foot Care Rate	$40/claim
Average Number Months with Claims for Foot Care Clients	5.15 months per year
Percent of Total Residents accessing foot care	55.6%

Sources: FY2017/18 CRMS Data for Foot Care Claims for PCH Residents; desk-top research on market rates for foot care



Appendix D: Personal Care Homes: Assumptions

Facility Expense

Calculation Methodology

Facility Expense is calculated as the median per bed expenses from comparator organizations in NL, NS, and NB. Facility expense is defined to include rent/mortgage expenses, property tax, repairs, and renovation and maintenance. Utilities and telecommunications costs are calculated as the historical funding amount adjusted for inflation.

Key Assumptions and Inputs

- Median facility expenses in comparator jurisdictions
- Historical Funding Amount for Utilities and Telecommunications
- Market rate adjustment factors for NL Rental Rates and Cost of Living

Funding formula

$$\textbf{Monthly Facility Expense Rate} = \left(\frac{Comparator\ Rental\ Expenses + Comparator\ Repair, renovation, and\ maintenance\ Expense + Historical\ Utilities\ and\ telecommunications\ funding}{(1 + Inflation\ Rate)} *\right)$$

Assumptions

Adj. Average Rent – CMHC

Average semi-private accommodation* in NL ranges from $258 – $387/month based on double occupancy

Monthly Per Bed Facility Expense for Comparator Homes

	Min	Max	Std Dev	Median/Rate
Rent	$155	$2,210	$867	$412
Repair, renovation and maintenance	$111	$239	$48	$157
Utilities and telecommunications	= $159 * [1 + (NL CPI Energy Index Jan 2019/July 2017)]			$163
Total Facility Expense Rate:				**$731**

Monthly Per Bed Rental Expense for Comparator Homes

Province	N	Median	Min	Max	Std Dev
NB	7	$421	$363	$2,210	$868
NS	1	$155	-	-	-
Monthly Per Bed Repair, Renovation, & Maintenance Expense for Comparator Homes					
NB	7	$155	$111	$239	$44
NS	1	$227	-	-	-
Monthly Per Bed Cost of Utilities and telecommunications for Comparator Homes					
NB	7	$214	$148	$300	+/- $53
NS	1	$543	-	-	-
NL (PCH)*	7	$92	$63	$140	+/- $29

Median	$157
Avg	$166
Std Dev	+/- $48

Sources: Comparator financial statements from other jurisdictions; Canada Mortgage and Housing Corporation Rental Rates; Statistics Canada, NL CPI Index

Appendix D: Personal Care Homes: Assumptions

Insurance Expense

Calculation Methodology

Calculated as the median of comparator organizations in NL, NS, and NB for insurance for an average sized PCH. Insurance is defined as:

- Commercial Fire and Property
- Environmental Liability
- General Commercial Liability
- Crime
- Cyber Security
- Director and Officers
- Employers Liability
- Auto and Vehicle
- Coverage for Oxygen Use
- Coverage to Transport Clients

Key Assumptions and Inputs

- Median Insurance expenses in comparator jurisdictions
- Median Insurance expenses for select PCHs
- Market rates for applicable Insurance types

Funding formula

$$\textbf{\textit{Monthly Insurance Rate}} = (Median\ Comparator\ Insurance\ Costs)/(Number\ of\ PCH\ Beds\ in\ Average\ Facility)$$

Assumptions

Monthly Per Bed Insurance Expenses for Select PCHs

Homes	N =	Beds	Total Annual Insurance	Median Per Bed Monthly Insurance	Median Target Per Bed Monthly Insurance (Average of 67 Beds)
NB	7	50–190	$4,653–$32,681	$18	$19
NS	4	N/A–100	$31,986–$62,673	$27	$59
NL Large PCHs	2	100	$12,314–$17,500	$34	$14
NL Small PCHs*	7	17–20	$4,683–$22,220		
Average Number of PCH Beds	67 beds				
Median Target Per Bed Monthly Insurance	**$28**				

Sources: Comparator financial statements from other jurisdictions; Insurance rates for select PCHs in NL

* Sample consists of FY16 and FY17 financials from 4 Isolation Grant recipients

Appendix D: Personal Care Homes: Assumptions

Administration, Training, and Other

Calculation Methodology

- Office Expenses, General Supplies, Accounting fees and Other is calculated as the historical funding amount paid to PCH (adjusted for inflation)
- Training is based on the training costs for PCWs incurred by select PCHs in NL and comparator jurisdictions.

Key Assumptions and Inputs

- Median general and other expenses in comparator jurisdictions
- Inflation rate adjustment for NL
- Training costs in comparator jurisdictions and select PCHs in NL

Funding formula

Administration, Training, and Other = GNL HCS Base Year Administration and other expenses * CPI Inflation Rate + Training Costs

Training Costs = Monthly Fixed Costs per PCH/Average number of beds + [(Training for New FTEs, including hours of training at the hourly wage rate, and additional fees)/12 months/(1 − Average Turnover Ratio of Staff) + (Recurring Training Costs, including fees and hours of training at the hourly wage rate)]/Average Ratio of FTEs to Residents/12 months

Assumptions

Assumptions for Administration and Other Expenses

Historical Administration and Other Expense	$74
Inflation Rate (CPI)	2.0%
Adjusted Administration and Other Expense	$76

Training Assumptions

Divisors for Training Costs	Rate
Ratio of Residents to FTEs	1.61
Average Residents per PCH	67

Training Assumptions (cont'd)

Annual Training Costs	500
Monthly fixed costs per resident	$0.62

New Staff Training	Rate
Frequency (per year)	1
Hours of Training	24
PCA Wage Rate (incl. CPP and EI)	18.66
Total wages for training	447.84
Monthly new FTE training costs per resident	41.27

Training Assumptions (cont'd)

Recurring training costs	Rate
Hours of training (annual)	8
Total wages for recurring training per FTE	149.28
Monthly training costs per Resident	7.73
Total Monthly Training Costs per Resident	$49.62

Sources: PCH Operational Standards; HCS Historical rate paid for Office Expenses, General Supplies, Accounting fees and Other; Statistics Canada CPI Rate;

Appendix D: Personal Care Homes: Assumptions

Safety and Accessibility Equipment

Calculation Methodology	Key Assumptions and Inputs
Safety and Accessibility Equipment is calculated as the average cost and useful life of equipment required as per Personal Care Home Operational Standards.	• List of Safety and Accessibility Equipment • Cost of Equipment • Estimated Useful Life of Equipment (i.e., depreciation rate) • Ratio of Residents to Unit of Equipment

Funding formula	$$\boldsymbol{Monthly\ Safety\ and\ Accessibility\ Equipment} = \left(\frac{Average\ Cost\ of\ Equipment}{Useful\ Life\ (in\ Years)} * Ratio\ of\ Units\ per\ Client\right)/(12\ months) * (1+HST)$$
Assumptions	Equipment required to ensure a safe and accessible living environment for PCH residents. Only equipment required by the majority of residents will be included in the base rate, all other individualized equipment must be accessed through the Special Assistance Program (SAP). A detailed listing of base equipment (by Level of Care) and equipment included in differential or individualized funding is provided on the following slide.

Sources: PCH Operational Standards; RHA Clinical Expertise; Special Assistance Program Expenditures for Enhanced Care Clients (2018); Equipment Costs provided by Lawton's Home Health (Western Region); CRA Capital Equipment Depreciation Rates according to CCA Class; Desk-top research

Appendix D: Personal Care Homes: Assumptions

Safety and Accessibility Equipment

Base Equipment (Level I and Level II)

- Bed rails
- Furniture Risers (4 pack)
- Grab bars and hand rails
- Raised toilet seats
- Anti-slip mats
- Commodes
- Bed Pans
- Bathroom Safety Shower Chair
- Wheelchair shower seat
- Sliding board
- Transfer belt
- General use canes, walkers, transport wheel chairs – excludes individualized and specialized equipment currently accessed through the SAP program
- Appropriate fire safety equipment

Enhanced Care and Level III

- Hospital bed
- Mattress
- Stand Up Patient Lifts
- Over bed tables

Palliative and Hospice Equipment

- Hospital bed
- Pressure redistribution mattresses
- Over bed tables
- Oxygen supplies

Individualized Equipment

The listing below is not comprehensive of all possible individualized equipment:

- SAP Equipment
- Nutritional Supplements
- Personal medication and medication administration equipment
- Bed bug remediation (funded on a per-case basis)
- Low bed
- Bed bolsters/wedges
- Bed extender
- Lift out chair

Appendix D: Personal Care Homes: Assumptions

Safety and Accessibility Equipment

Level I and II Equipment	Units	Cost	CCA Class	Useful Life (Years)*	Ratio of Clients to Unit	Monthly Amount (Purchase)
Base Equipment						
Bed rails	per client	$ 71.32	Class 12	1	1	$ 5.94
Furniture Risers (4 pack)	PCH	$ 11.99	Class 12	1	1	$ 1.00
Grab bars and hand rails	PCH	$ 37.99	Class 12	1	10	$ 0.32
Raised toilet seats	PCH	$ 40.00	Class 12	1	10	$ 0.33
Anti-slip mats	PCH	$ 7.98	Class 12	1	10	$ 0.07
Commodes	PCH	$ 47.03	Class 12	1	10	$ 0.39
Bed Pans	PCH	$ 8.52	Class 12	1	10	$ 0.07
Bathroom Safety Shower Chair	PCH	$ 47.29	Class 12	1	10	$ 0.39
Wheelchair shower seat	PCH	$ 117.99	Class 12	1	10	$ 0.98
Sliding board	PCH	$ 54.00	Class 12	1	10	$ 0.45
Transfer belt	PCH	$ 68.64	Class 12	1	10	$ 0.57
General use canes, walkers, wheel chairs						
Cane	PCH	$ 31.29	Class 12	1	10	$ 0.26
Indoor Walkers	PCH	$ 51.99	Class 12	1	10	$ 0.43
Transport wheelchair	PCH	$ 209.99	Class 12	1	10	$ 1.75
Appropriate fire safety equipment						
ABC Type Fire Extinguisher	PCH	$ 55.95	Class 12	1	10	$ 0.47
Strobe Light	PCH	$ 123.00	Class 12	1	10	$ 1.03
Total Monthly Base Equipment Cost						$ 14.46
					Rounded Up	$ 15.00

Sources: PCH Operational Standards; RHA Clinical Expertise; Special Assistance Program Expenditures for Enhanced Care Clients (2018); Equipment Costs provided by Lawton's Home Health (Western Region); CRA Capital Equipment Depreciation Rates according to CCA Class; Desk-top research

Appendix D: Personal Care Homes: Assumptions

Safety and Accessibility Equipment

Additional Enhanced Care and Level III Equipment	Units	Cost	CCA Class	Useful Life (Years)*	Ratio of Clients to Unit	Monthly Amount (Purchase)
Enhanced Care and Level III						
Hospital bed (new)	Per client	$ 798.65	Class 8	5	1	$ 13.31
Hospital bed (recycled)	Per client	$ 334.47	Class 8	5	1	$ 5.57
Hospital bed (average)	Per client	$ 566.56	Class 8	5	1	$ 9.44
Mattress	Per client	$ 476.65	Class 8	5	1	$ 7.94
Stand Up Patient Lifts	Per client	$ 1,590.00	Class 8	5	1	$ 26.50
Over bed tables	Per client	$ 88.99	Class 12	1	1	$ 7.42
Total Monthly Enhanced Care & Level III Equipment Cost						$ 51.30
					Rounded Up	$ 52.00

Sources: PCH Operational Standards; RHA Clinical Expertise; Special Assistance Program Expenditures for Enhanced Care Clients (2018); Equipment Costs provided by Lawton's Home Health (Western Region); CRA Capital Equipment Depreciation Rates according to CCA Class; Desk-top research

Appendix D: Personal Care Homes: Assumptions

Safety and Accessibility Equipment

	Units	Cost	CCA Class	Useful Life (Years)*	Ratio of Clients to Unit	Monthly Amount (Purchase)
Palliative and Hospice Care Equipment						
Hospital bed (average)	Per client	$ 566.56	Class 8	5	1	$ 9.44
Pressure redistribution mattresses	Per client	$ 476.65	Class 8	5	1	$ 7.94
Over bed tables	Per client	$ 100.43	Class 12	1	1	$ 8.37
Total Monthly Hospice Care Equipment Cost						$ 25.76
					Rounded Up	**$ 26.00**

Sources: PCH Operational Standards; RHA Clinical Expertise; Special Assistance Program Expenditures for Enhanced Care Clients (2018); Equipment Costs provided by Lawton's Home Health (Western Region); CRA Capital Equipment Depreciation Rates according to CCA Class; Desk-top research

Appendix D: Personal Care Homes: Assumptions

Medical and Incontinence Supplies

Calculation Methodology	Key Assumptions and Inputs
Costs of highly utilized incontinence, medical and outbreak supplies.	• List of Medical and Outbreak Supplies • FY2016–18 Personal Care Homes Expenditures for Supplies • Discount percent (Reserve for exceptional medical supplies) • CRMS Claims for Incontinence Supplies

Funding formula	Medical Incontinence Supplies = (Weighted Average Monthly Claim for Incontinence Supplies * Percent of Total Residents accessing incontinence supplies) + (Average Medical and Outbreak Supplies per Resident * (1 – Percent reserve for exceptional medical supplies)
Assumptions	Incontinence Supplies includes ***all*** incontinence supplies required to provide appropriate care to PCH residents. The rate is calculated based on the average cost and utilization of all incontinence supplies. Medical and Outbreak Supplies includes all frequently utilized clinical supplies required to operate a PCH to standards. The rate is calculated based on average historical expenditures for Medical and Surgical Supplies. A 10% discount was applied to the historical average to incentivize cost reduction and allow the RHAs to maintain a reserve to fund exceptional medical supplies needs on an individualized basis.

Sources: 2017/18 CRMS Claims for Incontinence Supplies

Appendix D: Personal Care Homes: Assumptions

Medical and Incontinence Supplies

Assumptions

Incontinence Supplies include:

- Soaker pads
- Mesh pants
- Bariatric briefs
- Light protection pads
- Pull ups
- Briefs

GNL HCS – Personal Care Homes Incontinence Supplies Expenditures

Weighted Average Monthly Claim for Incontinence Supplies	$19/month
Percent of Total Residents accessing incontinence supplies	46%
Monthly Incontinence Supplies	$9

Medical and Outbreak Supplies include:

- Disinfectants (i.e., Javex)
- Colostomy supplies
- Catheter supplies: leg bags, overnight bags, catheters, catheter trays, saline, 10 cc syringes, catheter secures, bag straps, etc.
- Urostomy supplies
- Gloves
- Dressing supplies
- Urinals
- Sharps
- Medicine cups
- Outbreak supplies: gowns, gloves, masks

GNL HCS – Personal Care Homes Medical and Outbreak Supplies Expenditures

	FY16	FY17	FY18
Average Monthly Medical Supplies Costs per PCH Resident	$25	$24	$23
90% of Average Monthly Medical Supplies	$22	$22	$21

Sources: 2017/18 CRMS Claims for Incontinence Supplies; FY2016–18 Personal Care Homes Expenditures

Appendix D: Personal Care Homes: Assumptions

Overview of calculation approach for differential funding

Awaiting LTC Placement	Additional Direct Care Hours
Adult Protection Act (APA) Enhanced Supervision	Additional Hours
Staffing Differential for Small PCH	Additional Indirect Staffing Hours
Temporary Per Bed Fixed Cost Subsidy	Monthly Per Bed Fixed Costs (PCH Base Rate)
Daily Respite	Daily PCH Base Rate

Appendix D: Personal Care Homes - Differential Funding: Assumptions

Awaiting LTC Placement

Calculation Methodology

Level III Clients awaiting placement in a long-term care facility will be funded based on a rate built on top of the PCH Enhanced Care Rate. Funding is calculated according to the additional personal care hours plus the applicable operating margin.

Key Assumptions and Inputs

- Additional hours of direct care (on top of Enhanced Care hours)
- Wage rate for PCWs and payroll deductions
- Additional equipment *(same equipment as Enhanced Care)*

Funding formula

$$Monthly\ Awaiting\ LTC\ Placement\ Rate = Additional\ Personal\ Care\ Hours * PCA\ Hourly\ Wage\ (incl.\ benefits) * Operating\ Margin\ for\ Level\ II\ Enhanced\ Clients$$

Assumptions

Monthly Awaiting LTC Placement Rate (incl. Enhanced Care Rate)
$3,885/client per month

= **Enhanced Care Rate** $3,626/client per month + **Awaiting LTC Rate** $260/client per month

Awaiting LTC Assumptions	
Additional Monthly PCA Care Hours (incl. stat days OT)	12.47
PCA Wage Rate (Benefits Included)	$18.66
Additional PCA direct care	$232.63
Operating Margin for Enhanced Care	12%
Awaiting LTC Differential Rate	**$260**

Sources: PCH Operating Standards, PCH Base Rate Components

Appendix D: Personal Care Homes - Differential Funding: Assumptions

Adult Protection Act (APA) Enhanced Supervision

Calculation Methodology	Key Assumptions and Inputs
Additional staffing hours may be required in a PCH for supervision during an APA investigation.	• Additional staffing hours to supervise APA clients • Hourly wage for PCA & payroll deduction assumptions

Funding formula

$$\text{Daily APA Enhanced Supervision Funding} = \text{PCA Rate (incl. benefits)} * \text{Additional Supervision hours per day}$$

Assumptions

Wage Rate Assumption	
Personal Care Rate (benefits included)	$18.66/hour

Other Staffing Assumptions	
Average Days	3 days
Range of Days	1 – 60 days
Additional staffing hours per day	3 hours

Past APA Investigations (FY2017/18)	
Total number	61/year

Proposed APA Enhanced Supervision rate	
Daily rate	$56

Sources: Consultations with RHAs; PCH Operational Standards

Appendix D: Personal Care Homes - Differential Funding: Assumptions

Staffing Differential for Small Homes

Calculation Methodology

Calculated using the median monthly shortfall of required staffing hours relative to funded hours, as per operating standards for PCH with less than 24 beds, and the hourly wage for indirect care staffing (minimum wage in NL).

Key Assumptions and Inputs

- Monthly number of hours (shortfall)
- Hourly wage for indirect staffing hours (minimum wage in NL) & payroll deduction assumptions

Funding formula

$$\text{Staffing Differential per PCH} = \text{Indirect Staffing Hourly Rate (incl. benefits)} * \text{Monthly Shortfall of Indirect Staffing Hours}$$

Assumptions

Wage Rate Assumption	
Minimum wage in NL (As of April 1, 2019)	$11.40/hour
Minimum wage in NL (benefits included)	$13.68/hour
Monthly Staffing Shortfall (for PCHs with less than 24 residents)	
Median Hours per Month	183 hour
Range of Hours (PCH with 5 – 24 residents)	61 – 425 hours

Monthly Staffing Differential Amount (Proposed)	
Staffing Differential	$2,503.44/month
Rounded Staffing Differential	$2,500/month

Sources: PCH Operational Standards

Appendix D: Personal Care Homes - Differential Funding: Assumptions

Temporary Per Bed Fixed Cost Subsidy

Calculation Methodology

Calculated as the total of fixed cost rate components from the PCH base rate. PCHs with less than 24 beds are eligible to receive funding up to the equivalent of 50% occupancy above current residency if they meet the eligibility conditions.

Key Assumptions and Inputs

- Base rate components for fixed costs based on the PCH monthly base rate
- Number of beds above current occupancy up to the equivalent of 50% occupancy (per case basis)

Funding formula

$$Temporary\ Per\ Bed\ Fixed\ Cost\ Subsidy = Facility\ Expenses + Safety\ and\ Accessibility\ Equipment + Insurance + Adminsitration, Training, and\ Other$$

Assumptions

Temporary Fixed Cost Subsidy	
Facility Expense	$731
Safety and Accessibility Equipment	$17
Insurance	$28
Administration, Training, and Other	$125
Total Fixed Costs	$902
Total Fixed Costs (Rounded)	**$900**

Sources: PCH Base Rate Assumptions

Appendix D: Personal Care Homes - Differential Funding: Assumptions

Daily Respite Rates

Calculation Methodology	Key Assumptions and Inputs
Daily Respite are per diems calculated as a prorated amount according to the PCH Base Rate, inclusive of operating margin.	• PCH Funding Model rates and assumptions • No additional equipment is required • Additional RN/LPN/OT staffing is provided by the RHA

Funding formula

$$Daily\ Respite\ Rate = PCH\ Monthly\ Rate\ (by\ Level\ of\ Care) * \frac{12\ months}{365\ days}$$

Assumptions

Level I	Level II	Enhanced Care	Level III
$79/day	$84/day	$119/day	$128/day

Sources: PCH Base Rate calculations

Appendix D: Personal Care Homes - Differential Funding: Assumptions

Overview of calculation methodology for new program initiatives

Adult Day Programming	Pro-rated Daily PCH Base Rate
Restorative Rehabilitation	Daily PCH Base Rate + Additional Personal and Clinical Hours + Equipment + Training
Advanced Dementia Care Services	Monthly PCH Rate + Hours + Additional Infrastructure + Equipment + Training
Residential End-of-Life and Hospice Care	Monthly PCH Rate + Hours + Equipment + Training

Appendix D: Personal Care Homes - Differential Funding: Assumptions

Adult Day Programming

Calculation Methodology

Adult Day Programming is a per diem calculated as a prorated amount according to the hours of daily programming and included services. Operating Margins for each respective level are included. As policy develops, the appropriate components for inclusion in the rate will be determined and quantified.

At the time of this report's writing, adult day programs are not subsidized in PCHs.

Key Assumptions and Inputs

- PCH Funding Model rate components and assumptions
- Daily program hours
- Number of meals and snacks
- Operating margin and contingency rate

Funding formula

$$Daily\ Adult\ Day\ Programming = ((Direct\ Care\ Rate + Supporting\ Salaries\ Rate + Facility\ Expense + Insurance +$$

Assumptions

- Adult day programming is assumed to be part of the PCH program. The funding approach is assumed to be similar, in that, the adult day program will have a monthly base rate that is comprised of the same components as the PCH monthly base rate[1], with the following exceptions:
- Direct Care and Program Support and Supporting Services was calculated as a percent of the PCH rate assuming an 8-hour/day program. Alternatively, rate could be funded based on a specified number of care hours.
- All facility related rate components were calculated as a percent of the PCH rate assuming an 8-hour/day program.
- Dietetic Services was calculated (based on number of meals and snacks) as a percent of the PCH Dietetic Services rate. The rate assumes 1 meal and 2 snacks per 8-hour programming day (compared to 3 meals and 2 snacks for full-time residents).
- Medical Travel and Foot Care are excluded from the Adult Day Programming rate.

Level I	Level II	Enhanced Care
$27/day	$29/day	$40/day

[1] Resident care components of the monthly base rate for PCH (as outlined in this Appendix): Direct Care and Program Support; Supporting Services; Dietetic Services; Medical Travel; Foot Care. Facility Operations components include: Facility Expense; Safety and Accessibility Equipment; Insurance Expense; Administration Supplies and Other.

Sources: PCH Base Rate calculations

Appendix D: Personal Care Homes - Differential Funding: Assumptions

Daily Restorative Rehabilitation Rates

Calculation Methodology	Key Assumptions and Inputs
Restorative Rehabilitation Rates should be calculated using the daily respite rate (inclusive of operating margin) plus daily rates for additional personal care hours, clinical care, training, and equipment provided by the PCH. As policy develops, the appropriate components for inclusion in the rate will be determined and quantified. At the time of this report's writing, restorative rehabilitation is not provided by PCH operators.	• PCH Funding Model rates and assumptions • Additional personal care hours provided by the PCH • Additional clinical care hours provided by the PCH (including RN/LPN/OT) • Additional equipment, and medical and incontinence supplies provided by PCH

Funding formula	$Daily\ Respite\ Rate = PCH\ Monthly\ Rate\ (by\ Level\ of\ Care) * \frac{12\ months}{365\ days} + Additional\ Daily\ Funding\ for\ personal\ care\ hours,\ clinical\ care\ hours,\ equipment,\ and\ medical\ and\ incontinence\ supplies\ provided\ by\ PCH$
Assumptions	Level I: $79/day (Respite Rate) + TBD Level II: $84/day (Respite Rate) + TBD Enhanced Care: $119/day (Respite Rate) + TBD Level III: $128/day (Respite Rate) + TBD

Sources: PCH Base Rate calculations

Appendix D: Personal Care Homes – New Initiatives: Calculations and Assumptions

Residential Moderate Dementia Care

Calculation Methodology

Residential Moderate Dementia Care should be built on top of the base funding amount for personal care homes. This rate would be applicable both as a differential for PCHs or as a base rate for a standalone moderate dementia care facility.
Monthly rate based on the PCH Base Rates for each Level of Care plus Residential Security, Alternate Infrastructure, and Increased Staffing and Qualifications. Additional training costs calculated using the same calculation methodology as PCH training.
At the time of this report's writing, residential moderate dementia care is not provided by PCH operators.

Key Assumptions and Inputs

- List and cost of additional resident security features
- Additional security hours for residents
- Hourly wage for security and monitoring + payroll deductions
- Alternate Infrastructure Costs from comparator facilities
- Hourly wage and hours for nursing
- Training costs for supporting dementia care patients

Funding formula

PCH Base Rate + Resident Security = Additional hours of monitoring * hourly wage (incl. deductions) + Alternate Infrastructure = Comparator Additional infrastructure and Facility Costs + Increased Staffing and Qualifications = Nursing Hours * Nursing wages + Dementia Training Costs

Assumptions

Differential Rate Component	Calculation Methodology	Recommended rate:
Resident Security	Residents with dementia require additional monitoring and security features, such as Wander Guard.	TBD
Alternate Infrastructure	Leading research in dementia care recommend certain infrastructure features, such as smaller home size, single/ground floor facility, and a physical layout designed for continuous movement.	TBD
Increased Staffing and Qualifications	Additional training to provide direct care and counselling for dementia care residents and family.	TBD

[1] Resident care components of the monthly base rate for PCH (as outlined on p. 11): Direct Care and Program Support; Supporting Services; Dietetic Services; Medical Travel; Foot Care. Facility Operations components include: Facility Expense; Safety and Accessibility Equipment; Insurance Expense; Administration Supplies and Other.
Sources: PCH Base Calculations

Appendix D: Personal Care Homes – New Initiatives: Calculations and Assumptions

Residential Hospice and End-of-Life Care

Calculation Methodology	Key Assumptions and Inputs
Monthly rate should be added to PCH monthly base rate. Calculation is based on the PCH Base Rates for each Level of Care, plus: • **Supplementary Direct Care and Nursing:** Direct costs associated with any additional staffing and nursing care for palliative and end-of-life clients. • **Additional Equipment and Supplies**: Equipment and supplies specific to palliative clients. • **Training (e.g., LEAP)**: Additional training to support palliative residents and family. At the time of this report's writing, residential hospice and end-of life care is not provided by PCH operators.	As described on following pages.

Funding formula
(details on next 3 pages)

PCH Base Rate + Supplementary Direct Care and Nursing + Additional Equipment + Training (e.g., LEAP) = Calculations as described on following pages

Assumptions

Differential Rate Component	Calculation Methodology	
Supplementary Direct Care & Nursing	Reimbursed based on additional monthly personal care hours and enhanced nursing care (including specialist palliative care nursing), to be defined in future Operating Standards.	• TBD
Additional Equipment & Supplies	Reimbursed based on the approved list of additional equipment and supplies for all palliative care clients.	• $26[1]
Training (e.g., LEAP)	Additional costs associated with training care workers in LEAP Palliative Care methodologies.	• TBD

1 Does not currently capture monthly costs of oxygen supplies for palliative and hospice clients.
Sources: Western Health Palliative Approach to Care; Desk-top Research (BC and UK Palliative Care); Comparators in NB and NS

Appendix D: Personal Care Homes – New Initiatives: Calculations and Assumptions

Residential Hospice and End-of-Life Care

Components	
Supplementary Direct Care and Nursing	TBD
Additional Equipment and Medical Supplies	$9
Training Expense	$21
Total Hospice and Palliative Care	TBD

Calculation Methodology

Supplementary Direct Care and Nursing is calculated according to the additional hours of personal care and nursing care to be provided by the PCH (or Hospice Provider), as required by HCS/RHA policy.

Calculation Methodology

- Direct hours of care as per Operating Standards for Residential Hospice patients (Not available at time of writing)
- Wage rate for Personal Care Workers
- Overtime rate, statutory holidays, and payroll benefits
- Additional nursing hours and qualifications (if provided by the PCH)
- Wage rate for nurse (RN, LPN)

Assumptions

$$\textbf{\textit{Monthly Supplementary Direct Care and Nursing Rate}} = \left(\begin{array}{c} (PCW\ direct\ care\ hours + Statutory\ Holiday\ Hours\ at\ overtime\ rate) \\ * \left(PCW\ wage\ rate\ * (1 + Payroll\ deductions\ as\ a\ percentage\ of\ PCW\ wage\ rate)\right) \\ + (Nursing\ hours\ * Nurse\ wage\ rate) \end{array} \right)$$

Sources: Operating Standards for Residential Hospice patients (Not available at time of writing)

Appendix D: Personal Care Homes – New Initiatives: Calculations and Assumptions

Residential Hospice and End-of-Life Care

Components	
Supplementary Direct Care and Nursing	TBD
Additional Equipment and Medical Supplies	$9
Training Expense	$21
Total Hospice and Palliative Care	**TBD**

Calculation Methodology

Additional Equipment and Supplies is calculated based on the average cost and useful life of equipment required as per PCH Operational Standards for end-of-life patients and the cost of supplies for dedicated palliative care facilities in comparator jurisdictions. *Equipment for Residential Hospice is assumed to include: Hospital beds; Pressure redistribution mattresses; Over bed tables; Oxygen supplies, which are required to ensure a safe and accessible living environment for end-of-life residents.* Only equipment required by the majority of end-of-life residents will be included in the differential rate, all other individualized equipment must be accessed through the Special Assistance Program (SAP).

Key Assumptions and Inputs

- List of Safety and Accessibility Equipment
- Cost of Equipment
- Estimated Useful Life of Equipment (i.e., depreciation rate)
- Ratio of Residents to Unit of Equipment

Funding formula

$$\textbf{Monthly Additional Equipment} = \left(\frac{Average\ Cost\ of\ Equipment}{Useful\ Life\ (in\ Years)} * Ratio\ of\ Units\ per\ Client\right)/(12\ months)$$

Sources: PCH and/or Residential Hospice Operational Standards; RHA Clinical Expertise; Special Assistance Program Expenditures for Enhanced Care Clients (2018); Equipment Costs provided by Lawton's Home Health (Western Region); CRA Capital Equipment Depreciation Rates according to CCA Class; Desk-top research

Appendix D: Personal Care Homes – New Initiatives: Calculations and Assumptions

Residential Hospice and End-of-Life Care

Components	
Supplementary Direct Care and Nursing	TBD
Additional Equipment and Medical Supplies	$9
Training Expense	$21
Total Hospice and Palliative Care	TBD

Calculation Methodology

- Training Expense is calculated based on comparator organizations in other provinces, select PCHs in NL and market rates for training. Training for hospice may include: LEAP Mini (1-day introductory palliative care course); Other training for palliative care **(TBD)**

Key Assumptions and Inputs

- Median training expenses in comparator jurisdictions
- Market rates for relevant training programs (e.g., LEAP)
- Paid training hours and hourly wage for PSW
- Ratio of trained staff to palliative residents
- Frequency of Training renewal/churn

Training Costs for LEAP Mini (per person)	$95-$550
Paid Training Hours (LEAP Mini)	8.5 hours
Ratio of trained staff to Residents	TBD
Frequency of training renewal	TBD

Comparator Monthly Per Bed Training Expenses for Select Residential Hospice Facilities

Province	Beds	Total Annual Training	Per Bed Monthly Training
NS	10	$3,360	$28
NB	10	$5,648 – $7,000	$47 – $58

Funding formula

$$\textit{Monthly Training Expense} = \textit{Comparator Training Costs}$$

Data Sources: Comparator financial statements from other jurisdictions; Cost of training for relevant programs

Appendix D.2: PCH Differentials – Population Need Analysis

Appendix D.2: Philosophy of Population Need Differential Funding

Prior to embarking on an exploration of funding alternatives for the PCH Population Need Differential Funding, the following criteria were outlined to define "Population Need".

- Population Need: For a given region or client population, there are insufficient third-party or RHA service providers to provide the appropriate level of care, quality of care, and care setting for a particular client population (where no alternative exists).
- Population Need Funding should support PCHs in regions that do not have a sufficient population base to support a "to scale" PCH operation but there is still a proven need for PCH services (e.g., population need funding should correct market failures).
- Population need funding should not compensate:
  - Small homes operating in over-saturated markets (measured with vacancy rates)
  - Homes that risk select low complexity clients (measured based on referral acceptance)
  - Homes that are staffed inefficiently (measured based on staffing ratio)
  - PCHs that take on residents that could be placed in an alternative lower-cost, appropriate care setting
- Population need funding should be agnostic of risk premiums for high borrowing costs or mortgage payments.
- As per the guiding principles of this project, population need funding amounts should be simple to calculate and administer.

Appendix D.2: Current State of Isolation Grants and Small Home Subsidies

Keeping in mind the definition of population need outlined on the previous pages and the ultimate goal of Population Need Differential Funding, here is how additional funding is currently being provided to small and rural/remote providers:

- In their current form, Isolation Grants and Small Home Subsidies are compensating homes for:
  - Operating below scale
    - Homes must spread fixed costs over a smaller client case load
    - Most isolation grant recipients have a much higher ratio of Level I's to more-complex clients
- Operating at high vacancy
  - As of September 2018, isolation grant recipients are operating at 30% vacancy or higher
  - Average vacancy of isolation grant recipients is 51%
  - Average vacancy of small homes (< 22 beds) is only 22.7%
- Comparing costs to the current Level I rate build-up, the main cost differentials are:
  - Direct and supporting salaries – median of $1,468 per client vs. $1,156 for Level I monthly rate
  - Dietetic Services (groceries and kitchen supplies) – median of $416 per client vs. $239 for Level I monthly rate

Appendix D.2: Current State of Isolation Grants and Small Home Subsidies

Outlined below are the current eligibility criteria and funding formulas for the Small Home Subsidy and Isolation Grants.

Small Home Subsidy Amount = $2,000/month per home

Small Home Subsidies were paid to 13 PCHs in FY2017/18 serving 156 subsidized clients. Total subsidy expenditures amounted to $387,510 for FY2017/18.

Eligibility Criteria for Small Home Subsidy:

- Average of 15 residents during the previous fiscal year

Isolation Grant Formula = Actuals – Monthly Subsidy Rate

Actual Isolation Grant amounts ranged from $49,320 to $104,856 for FY2017/18 for 5 PCHs serving a total of 47 subsidized clients. Total grant expenditures amounted to $258,460 for FY2017/18.

Eligibility Criteria for Isolation Grants:

- Home is 50km from the nearest PCH
- Annual occupancy is 15 or fewer residents
- Able to demonstrate difficulties in maintaining financial viability (based on comparison of actual expenditures to the monthly subsidy rate)

Appendix D.2: Personal Care Homes: Small Home Subsidies

Small PCH 13 is an example of a PCH that serves a proven population need. Small Home Subsidy Expenditures of $387,510 supported care for 156 subsidized residents across the province in 2018.

Small Home Subsidy Recipients	Full Occupancy	Vacancy Rate	Percent of Clients Level	Staffing ratio (1:X)[1]
Small PCH 1	8	25.0%	75.0%	0.3
Small PCH 2	15	13.3%	61.5%	1.3
Small PCH 3	19	36.8%	100.0%	1.7
Small PCH 4	15	20.0%	100.0%	1.5
Small PCH 5	19	0.0%	64.7%	2.4
Small PCH 6	22	27.3%	68.8%	1.5
Small PCH 7	29	41.4%	100.0%	2.1
Small PCH 8	21	42.9%	100.0%	1.1
Small PCH 9	24	66.7%	85.7%	1.3
Small PCH 10	20	30.0%	85.7%	2.0
Small PCH 11	6	0.0%	100.0%	-
Small PCH 12	14	0.0%	85.7%	-
Small PCH 13	20	5.0%	52.6%	2.4
Provincial Averages for Small Home Subsidy Recipients	**18**	**23.7%**	**81.4%**	**1.6**

Notes: [1] Staffing ratio calculated as the average number of FTE divided by number of occupied beds

Source: PCH Database September 2018

Appendix D.2: Personal Care Homes: Isolation Grants

Vacancy rates of PCHs receiving isolation grants significantly exceed the provincial average of 17.9%; however, PCHs serving clients requiring higher levels of care may support population need despite over capacity. Isolation Grants of $258,460 supported care for only 47 subsidized residents across the province in 2018.

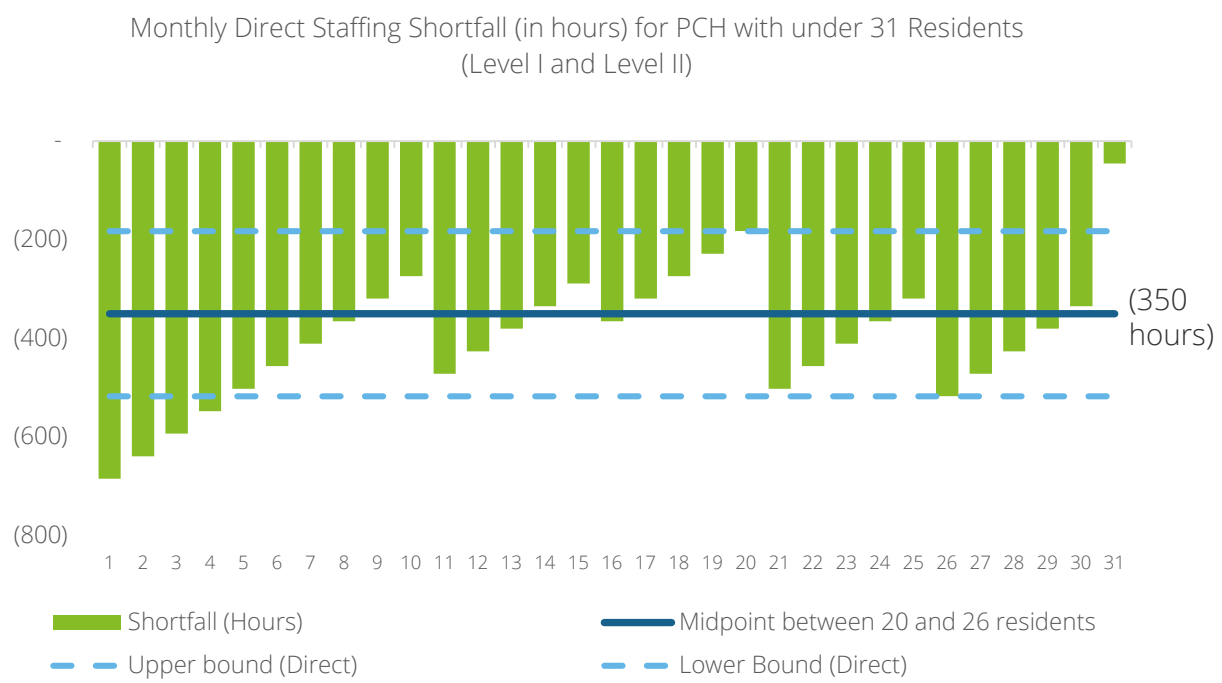
Isolation Grant Recipients	Full Occupancy	Vacancy Rate	Percent of Clients Level I	Staffing ratio (1:X)[1]
Isolation Grant PCH 1	22	54.5%	55.6%	1.4
Isolation Grant PCH 2	20	40.0%	25.0%	2.0
Isolation Grant PCH 3	17	41.2%	60.0%	1.4
Isolation Grant PCH 4	18	58.8%	81.3%	-
Isolation Grant PCH 5	16	87.5%	100.0%	-
Isolation Grant PCH 6	20	30.0%	78.6%	-
Provincial Averages for Isolation Grant Recipients	**19**	**50.6%**	**57.4%**	**1.6**

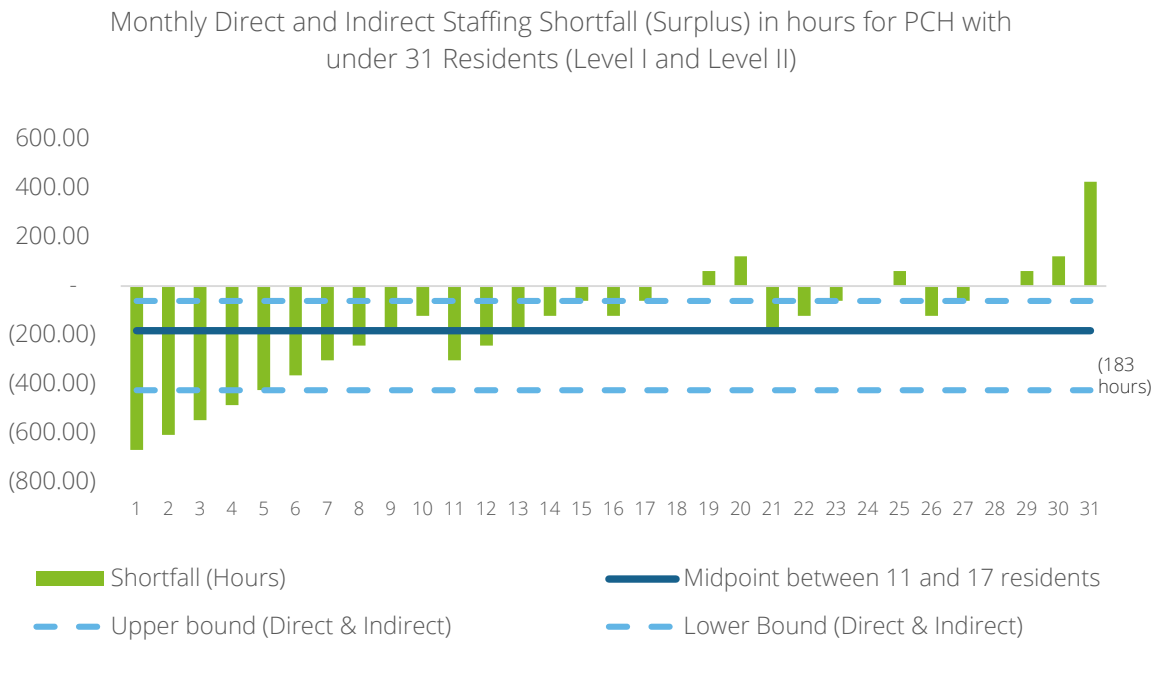
Notes: [1] Staffing ratio calculated as the average number of FTE divided by number of occupied beds

Source: PCH Database September 2018

Appendix D.2: Staffing Ratios for Small Personal Care Homes

There is a persistent funding gap under the current staffing model for PCH with less than 18 residents.





The graphs presented above show the monthly shortfall (surplus) between the hours required to be staffed (as per operating standards staffing ratios) and the hours funded on a per-client basis for Level I and Level II residents. In the graph shown to the top left, funded hours of direct care fall significantly short of hours according to PCH operating standards. To the top right, where PCHs are allowed to include all staff in the staffing ratio (2.0 cumulative hours of direct and indirect care per Resident per day), the gap between direct and indirect staffing is significantly reduced. There is a persistent funding gap under the current staffing model for PCHs with less than 18 residents.

Appendix D.2: Breakeven Fixed Costs for Small PCHs

Breakeven Analysis for fixed costs was completed based on a sample of PCH financials

Fixed Cost Breakeven Number of Residents in Small PCHs* (17–22 beds)

Breakeven	Median	Average	Min	Max
Number of Residents	11	10	4	18
Vacancy	36%	47%	11%	82%

N = 7 *Sample consists of FY16 and FY17 financials from 4 Isolation Grant recipients

Assumptions:

Monthly Base Rate Funding for Fixed Costs* $900

*Fixed Costs include Facility Expense, Insurance, and Administration, Supplies, and Other

As shown in the table above, the number of residents required to break even on fixed costs (based on proposed base rates for fixed costs from the PCH Funding Model) ranges from 4 to 18. The median and average number of residents are 11 and 10, respectively.

Based on the full occupancy number of beds, breakeven vacancy ranges from 11% to 82%. The median and average breakeven vacancies are 36% and 47%, respectively.

Appendix D.2: Population Need Funding Conditions

Based on the analysis presented in the previous slides, our recommendation consists of eliminating the isolation grants and small home subsidies in their current form and implementing a monthly staffing differential for small homes and a temporary fixed cost subsidy.

Staffing Differential	Temporary Fixed Cost Subsidy
Description and Rationale: Pay a fixed monthly amount ($2,500/month) to meet overall staffing ratio for small homes serving a proven population need. Due to operating standards, PCHs with less than 18 residents are subject to a persistent staffing shortfall of approximately 183 hours/month.	**Description and Rationale:** Pay a "fixed cost" monthly subsidy ($900/month) for vacant beds (on a short-term/temporary basis) up to the equivalent of 50% vacancy. The average breakeven for fixed costs based on funding is 10 residents for a sample of 4 PCH with 17–22 beds (corresponding to an average vacancy of 47%).
Conditions: 1. Must accept 100% of referrals from RHA; 2. Average vacancy for the last 4 quarters is less than or equal to 25%; 3. Homes are smaller than 24 beds (assumes 75% occupancy for homes with 18 residents); and, 4. PCH operates in a region that serves a proven population need as determined by current and future demand for PCH beds (As determined by the PCH Needs Assessment Project).	Conditions: 1. Must accept 100% of referrals from RHA; 2. Current vacancy rate is greater than 50%; and, 3. Trailing 12 months and the 3 year QoQ (quarter over quarter) average vacancy is less than 50%; or, 4. Vacancy is persistently greater than 50% but the RHA has determined that (1) the facility serves a proven population need, (2) there isn't a better/appropriate alternative for residents in the region, and (3) the cost of constructing and operating an appropriately sized PCH to serve the proven population need exceeds the cumulative cost of providing the fixed cost monthly subsidy for the existing facility.
Impact: 1. As of September 2018, there are 27 homes with less than 24 beds (measured based on full occupancy) 2. Referral acceptance is not currently measured; however, 7 homes have a case load where greater than 95% of residents are Level I's which may be an indicator of some risk selection by PCHs 3. Only 16 homes have had average vacancy rates less than or equal to 25% for the past 4 quarters	Impact: 1. Five (5) homes met Condition 1 & 2 over the past 5 years 2. Three (3) homes would be subject to a review according to Condition 3

Appendix D.2: System Impact from Implementing Population Need Differentials

Based on the eligibility criteria outlined in the previous slides, annual program expenditures would be reduced by $163,570 under the new differential funding scheme.

Current State:

Number of PCHs (FY18)	
Small Home Subsidies	13
Isolation Grants	5
Total	**18**

Annual Funding (FY18)	
Small Home Subsidies	$387,510
Isolation Grants	$258,460
Total	**$645,970**

Future State:

Number of PCHs (FY18)	
Staffing Differential	16
Temporary Fixed Cost Subsidy	4*
Total	**20**

Annual Funding (FY18)	
Staffing Differential	$480,000
Temporary Fixed Cost Subsidy	$21,600*
Total	**$501,600**

- 6 homes that historically received either the small home subsidy or the isolation grant would no longer eligible for any additional funding*

Temporary Fixed Cost Subsidy:

- 4 homes formerly eligible for the Isolation Grant would not be eligible for the temporary fixed cost subsidy
- 3 net new homes would be eligible for the temporary fixed cost subsidy

Staffing Differential:

- 6 homes formerly eligible for the Small Home Subsidy would not be eligible for the Staffing Differential
- 9 net new homes would be eligible for the staffing differential

Total Variance of -$153,970

* Estimates for Temporary Fixed Costs excludes the 3 homes subject to a review of financial feasibility and population need. Funding the vacant beds in those 3 homes for 12 months/year would increase expenditures by $194,400.

Appendix D.2: Scenario Analysis – Small Homes

The following scenarios were considered based on the proposed base rates for PCH Level I, II, and Enhanced Care. Does not include recommended differential funding.

Assumptions:

Per Diem Base Rates	Proposed
Level I	2,402
Level II	2,558
Enhanced Care	3,626
Number of Beds	20
Vacancy Rate	**25%**

Number of Residents	
Level I	10
Level II	5
Enhanced Care	0
Total Residents	**15**

Scenario Assumptions:

PCH expenses estimated on a per-head or per-bed basis based on 7 financials from PCHs with 17–22 beds.

The **Base Case** scenario is estimated based on the median per-resident or per-bed expenses for each line item. The **Worst Case** Scenario is estimated based on the maximum per-resident or per-bed expenses. The **Best Case** scenario is estimated based on the minimum per-resident or per-bed expenses.

Scenarios:

	BASE CASE	WORST CASE	BEST CASE	PCH ACTUALS (FY2017)
Total Revenue from Subsidized Clients	441,699	441,699	441,699	441,699
Variable expenses (no. of clients)				
Direct Care and Supporting Salaries*	264,000	272,000	218,000	270,000
Dietetic Services	75,000	138,000	63,000	75,000
Medical Travel & Transportation	16,000	33,000	7,000	16,000
Fixed expenses (no. of beds)				
Facility Expense	71,000	126,000	31,000	106,953**
General Supplies, Administration, and Other	14,000	79,000	2,000	12,033**
Insurance	10,000	26,000	5,000	22,220**
Earnings before Interest and Taxes (Operating Income)	(9,000)	(232,000)	116,000	(60,000)
Operating (EBIT) Margin	**-2%**	**-53%**	**26%**	**-14%**

* Direct Care and Program Support Salaries is estimated as the maximum of either 1) the minimum staffing ratio based on number of residents with a $15.55 (benefits included) hourly wage, or 2) the per-head cost based on financials from PCHS with 17–22 beds.

** Fixed Costs and Vacancy rate for PCH ACTUALS CASE was based on financials for 17 bed facility.

Appendix D.2: Sensitivity for Scenario Analysis

Sensitivity Analysis was completed based on a 20 bed facility for the previously identified scenarios (BASE, BEST, WORST, ACTUALS).

EBIT Margin – Sensitivity (BASE CASE)

Percent of Residents (Level I) \ Vacancy	50%	40%	30%	20%	10%	0%
50%	-4%	-1%	4%	7%	9%	11%
60%	-6%	-3%	3%	5%	7%	9%
70%	-8%	-5%	1%	3%	6%	7%
80%	-10%	-7%	-1%	1%	4%	5%
90%	-13%	-9%	-4%	-1%	2%	3%
100%	-15%	-12%	-6%	-3%	0%	1%

EBIT Margin – Sensitivity (ACTUALS CASE)*

Percent of Residents (Level I) \ Vacancy	50%	40%	30%	20%	10%	0%
50%	-31%	-19%	-14%	-8%	-4%	-1%
60%	-34%	-21%	-16%	-10%	-6%	-3%
70%	-37%	-24%	-18%	-12%	-9%	-6%
80%	-39%	-26%	-21%	-15%	-11%	-8%
90%	-42%	-29%	-23%	-17%	-13%	-10%
100%	-45%	-31%	-26%	-19%	-15%	-12%

* Fixed Costs and Vacancy rate for PCH ACTUALS CASE was based on financials for 17 bed facility.

EBIT Margin – Sensitivity (BEST CASE)

Percent of Residents (Level I) \ Vacancy	50%	40%	30%	20%	10%	0%
50%	-2%	15%	27%	36%	43%	49%
60%	-4%	13%	26%	35%	42%	48%
70%	-6%	12%	24%	34%	41%	47%
80%	-8%	10%	23%	32%	40%	46%
90%	-11%	8%	21%	31%	39%	45%
100%	-13%	6%	19%	29%	37%	44%

EBIT Margin – Sensitivity (WORST CASE)

Percent of Residents (Level I) \ Vacancy	50%	40%	30%	20%	10%	0%
50%	-76%	-53%	-44%	-38%	-33%	-29%
60%	-80%	-56%	-47%	-41%	-35%	-31%
70%	-84%	-59%	-50%	-43%	-38%	-34%
80%	-87%	-62%	-53%	-46%	-41%	-37%
90%	-91%	-66%	-56%	-49%	-44%	-40%
100%	-95%	-69%	-60%	-53%	-47%	-43%

Appendix E: Supplemental benefits detailed analysis & assumptions

Appendix E: Supplemental Rates

Analysis was completed to compare the historical claim amounts to defensible market rates for the following in-scope supplemental benefits:

Accommodation:
Supplemental benefits to assist a client in meeting payments for accommodation. Includes rates for mortgage, and rent and top ups.

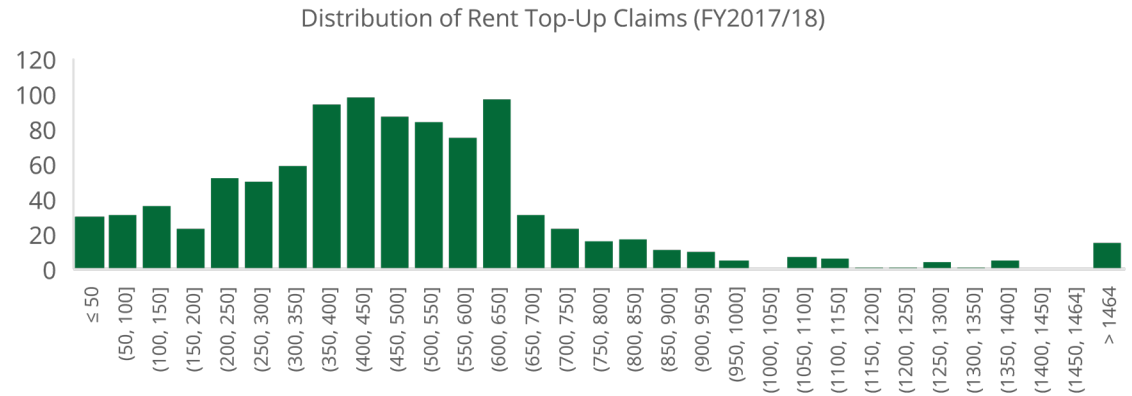
Home Energy:
Supplemental benefits to assist a client in paying for power and/or heating for their accommodation. Includes fuel top ups and fuel & electricity claims.

Benefits for telecommunication services were also considered in this review; however, due to the immateriality of claims in terms of volume and aggregate expenditure amounts, they are excluded from this analysis.

Appendix E: Supplemental Rates – Accommodation

Based on regional differences and utilization levels, we recommend setting a cap for the Rent Top-Ups based on the Average Adjusted Rental Rates from CMHC and paying Mortgage Top-Ups on an individualized basis.

Rent Top-up

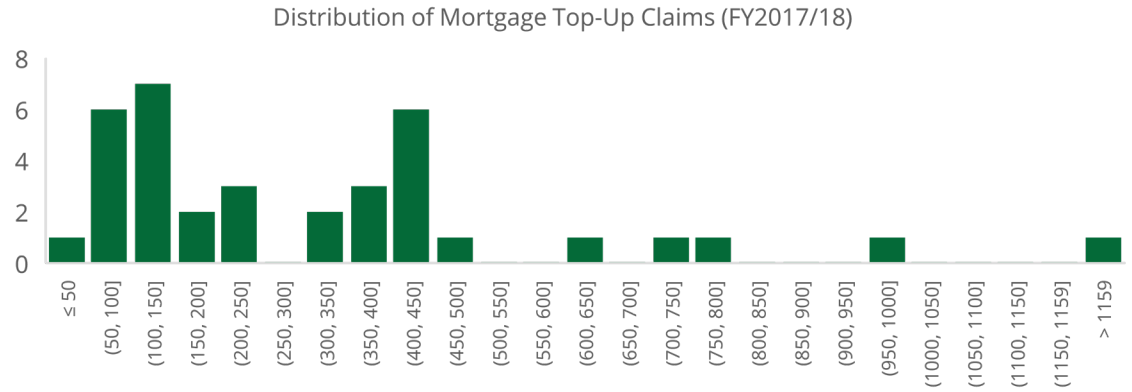


Average Monthly CMHC Rental Rates for a 1 bedroom in NL were $607 for November 2018

	Top-Up	AESL Portion	Total
Max	$ 4,333.33	$ 372.00	$ 4,705.33
Min	$ 1.99	$ 372.00	$ 373.99
Average	**$ 481.95**	**$ 372.00**	**$ 853.95**
90th percentile	$ 751.00	$ 372.00	$ 1,123.00
50th percentile	$ 451.00	$ 372.00	$ 823.00

Std dev	327.29
Clients	**969**
Number of Claims	10,440

Mortgage Top-up



	Top-Up	AESL Portion	Total
Max	$ 1,277.90	$ 372.00	$ 1,649.90
Min	$ 13.86	$ 372.00	$ 385.86
Average	**$ 320.81**	**$ 372.00**	**$ 692.81**
90th percentile	$ 667.90	$ 372.00	$ 1,039.90
50th percentile	$ 239.68	$ 372.00	$ 611.68

Std dev	275.35
Clients	**36**
Number of Claims	355

Source: FY2017/18 CRMS Client Data on Mortgage and Rent Top-Up Claims

Appendix E: Supplemental Rates – Accommodation

Based on regional differences and utilization levels, we recommend setting a cap for the Rent Top-Ups based on the Average Adjusted Rental Rates from CMHC and paying Mortgage Top-Ups on an individualized basis.

Accommodation – CRMS

Benefit Type	Average CRMS Claim (Monthly)	Total (Including $372 AESL Portion)	Standard Deviation
Mortgage Top-ups	$321	$693	$275
Rent Top-ups	$481	$853	$327

Adjusted Average Rent – Canadian Mortgage and Housing Corporation (CMHC)

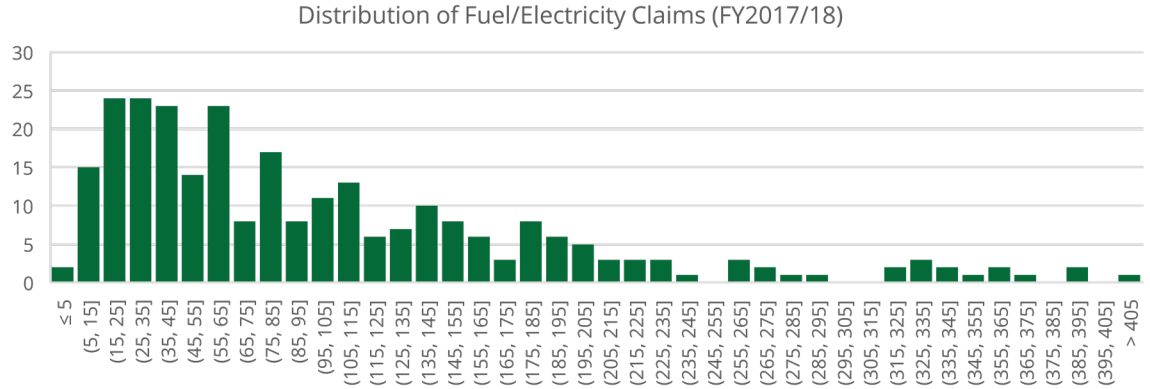
Community	Year	Adjusted Average Monthly Rent (1 Bedroom)*	CRMS Average Rent for Region (including AESL)	CRMS Clients
Happy Valley – Goose Bay	2015	$611	$1,184	5
Stephenville	2015	$515	$690	53
St John's	2017	$773	$903	273
Corner Brook	2017	$604	$876	80
Gander	2017	$595	$937	33
Grand Falls Windsor	2017	$610	$788	41
Median		**$607**		

*Adjusted to Nov 30, 2018 based on Housing Index for NL

Appendix E: Supplemental Rates – Home Energy

Based on regional differences and inconsistency in the distribution of home energy benefits (notably Central Health), we recommend the Department align the policy for home energy top-ups across the RHAs before setting a cap rate.

Fuel/Electricity

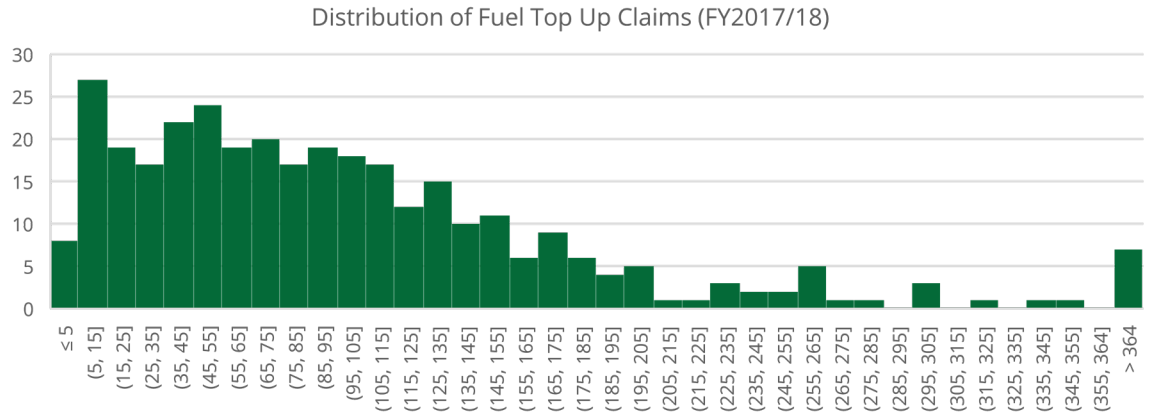


Average Monthly Water, Fuel and Electricity for Principal Accommodation in NL $251 (Stats Can)

	Total (incl. AESL)	EH	CH	WH	LGH
Max	$1,046.00	$ 393.15	$ 465.06	$1,046.00	$ 413.11
Min	$ 75.00	$ 84.73	$ 113.00	$ 75.00	$ 105.66
Average	**$ 175.36**	**$ 172.81**	**$ 286.73**	**$ 159.51**	**$ 194.20**
90th percentile	$ 290.00	$ 258.94	$ 408.57	$ 251.67	$ 320.52
50th percentile	$ 147.85	$ 157.29	$ 268.75	$ 131.00	$ 142.62
Clients	272	32	29	205	5

Std dev	100.12
Clients	272
Claims	2,774

Fuel Top Up



	Total (incl. AESL)	EH	CH	WH	LGH
Max	$ 631.16	$ 631.16	$ –	$ 222.96	$ 604.68
Min	$ 71.76	$ 72.24	$ –	$ 71.76	$ 114.93
Average	**$ 171.14**	**$ 173.36**	**$ –**	**$ 141.85**	**$ 282.53**
90th percentile	$ 268.08	$ 272.35	$ –	$ 200.51	$ 509.34
50th percentile	$ 150.86	$ 158.37	$ –	$ 142.34	$ 128.00
Clients	334	297	0	34	3

Std dev	87.91
Clients	334
Claims	3,189

Source: FY2017/18 CRMS Client Data on Mortgage and Rent Top-Up Claims

Appendix E: Supplemental Rates – Home Energy

Based on regional differences and inconsistency in the distribution of home energy benefits (notably Central Health), we recommend the Department align the policy for home energy top-ups across the RHAs before setting a cap rate.

Fuel/Electricity and Fuel Top Up – CRMS

Benefit Type	Average CRMS Claim (Monthly)	Total (Including $71 AESL Portion)	Standard Deviation
Fuel/Electricity	$104	$175	$100.12
Fuel Top Up	$100	$171	$87.91

Utilities for Principal Accommodation – Statistics Canada

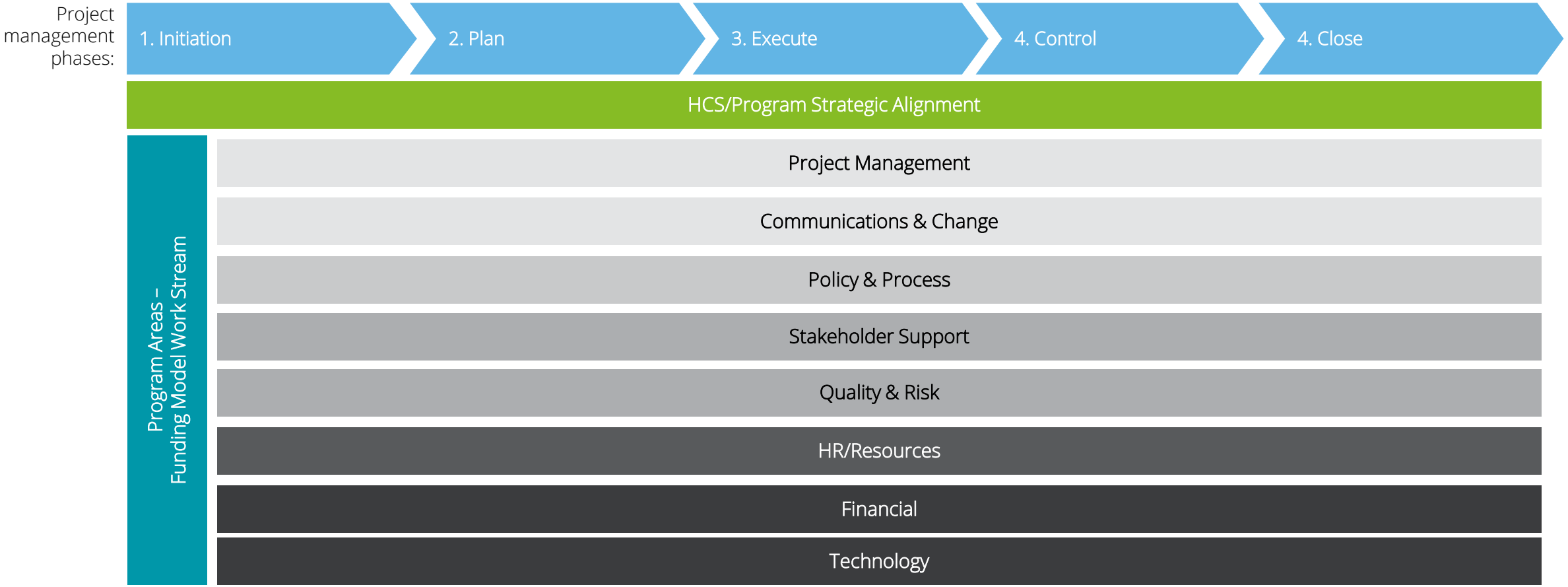
Benefit Type	Annual Expenditure (2017)	Average Home Utilities (Monthly)
Water*, Fuel and Electricity for Principal Accommodation	$3,016	$251/Month

* Water is included in the Statistics Canada figures and cannot be broken out. Included for comparison purposes only.

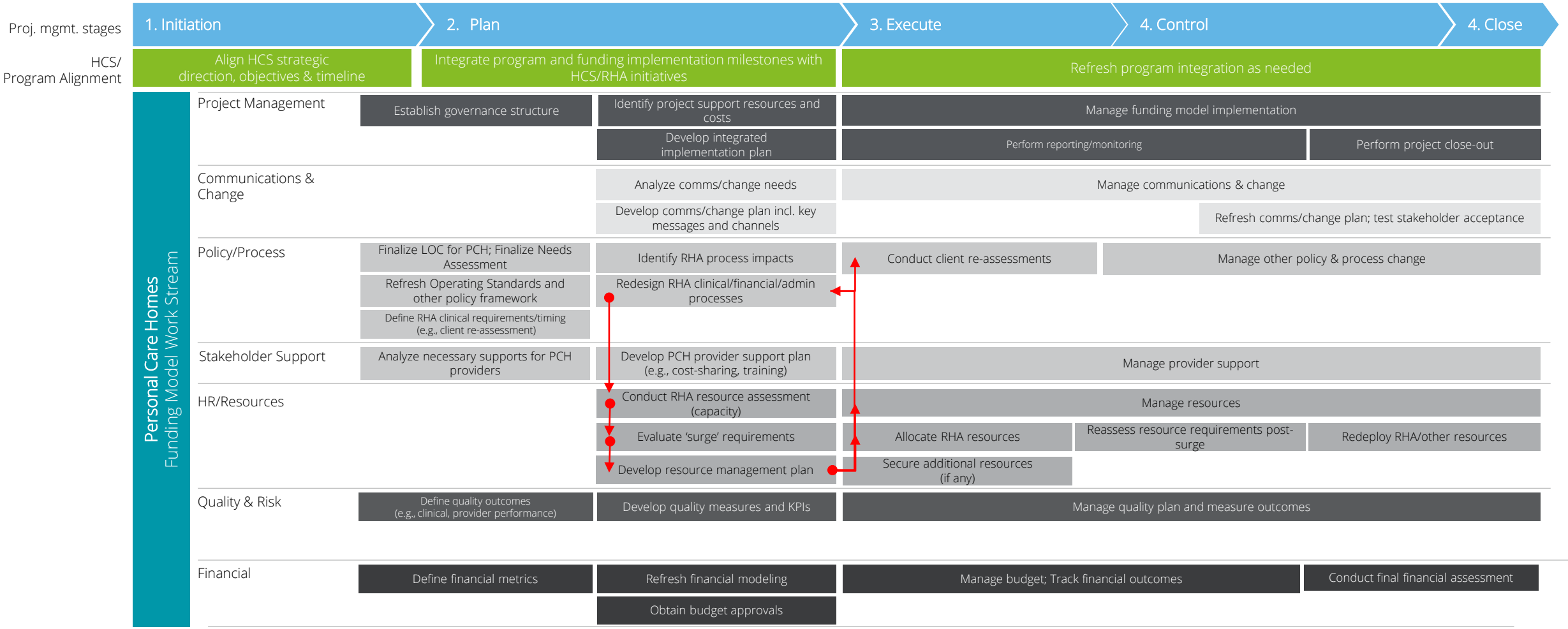
Appendix F: High-Level PHSP & PCH Implementation Plans

Appendix F: Overview of Funding Model Implementation: High-level Approach

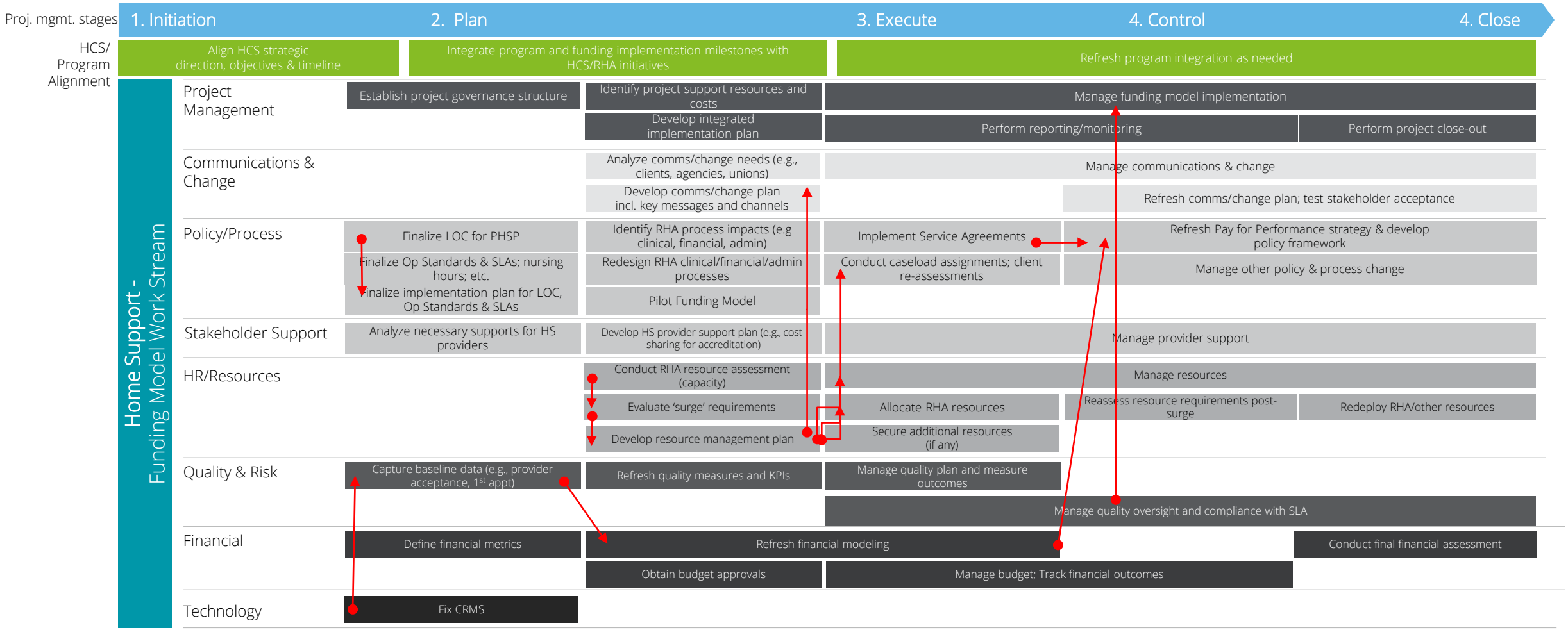
It is recommended that the implementation of new funding models is done on a **program by program basis,** in alignment with other initiatives being undertaken by HCS/RHAs. Implementation should follow five-stages similar to the Project Management Institute (PMI) framework:



Appendix F: High-level Implementation Plan – Personal Care Homes



Appendix F: High-level Implementation Plan – Home Support



Appendix G: Pay for Performance Framework Analysis

Appendix G: Home Support – Agencies: Performance Incentives

There are two types of performance payment frameworks that HCS can consider for the Home Support Incentive Funding scheme

Part of the Department's long-term vision for LTC CSS is to incent greater innovation and performance in community-based service providers. Different models of incentive or reward-based funding have been explored by jurisdictions in Canada, however, as described in earlier sections of this report, there are few examples to date where funding has been tied directly to provider performance.

To assist the Department in moving toward this long-term goal, Deloitte developed different demonstrative pay for performance (P4P) frameworks that could be used to incent providers in programs such as Home Support. The PHSP was selected as the program to a P4P framework because of the planned introduction of Key Performance Indicators (KPIs) as part of the new service level agreement; as such, the PHSP is likely to be the first program to have sufficient "baseline" performance data to use as the foundation for a pay for performance framework.

The following two options have been developed as "example" performance payment frameworks, based on the models identified in our research, to illustrate how performance payments could be introduced to the Home Support program. The first approach is based on payments made for the successful achievement of one or more specific indicators, whereas the second approach is based on scoring performance on a range of indicators.

Option 1

Payment per Indicator:

Payment is made for **achieving targets** on **individual Key Performance Indicators ("KPI")**.

Each KPI is independent, and payments for different targets can be made at different frequencies throughout the year, payment amounts may also differ between different KPIs

Option 2

Scoring System:

Achieving targets for Key Performance Indicators will **contribute "points"** to an individual agency.

Achieving a given number of points within a **set time frame** (e.g., one year) will enable an agency to claim an incentive payment. The points allocated to each KPI can be weighted based on the Department's priorities

Appendix G: Home Support – Agencies: Performance Incentives

Key Performance Indicators from the new PHSP performance indicator reference guide were used as the KPIs for the demonstrative P4P framework

The KPIs listed below are performance indicators that are being implemented as part of the new service level agreements in PHSP. These KPIs were used as the foundation of the demonstrative performance management frameworks; the data collected from these metrics may form the "baseline" performance data required to implement incentive payments. Implementing a performance management framework without "baseline" data runs the risk of having too many or two few agencies achieving performance targets and receiving incentive payments.

Note that, "attainment of accreditation", the last of the listed KPIs is not from the performance management framework but was included due to the Department's focus on the attainment of external accreditation among home support agencies.

Indicator	Goal	Target	Standard	Frequency of report/review
Percentage of service requests accepted by the Service Provider.	To decrease time for supportive services to be put in place	95% of service requests issued by the RHA will be accepted by the Service Provider	98% of service requests issued by the RHA will be accepted by the Service Provider	Quarterly/Annually
Percentage of clients who received first service visit within the time frame indicated in the service request.	To ensure clients receive timely access to support	90% of clients will receive their first service visit within the time frame indicated in the service request.	95% of clients will receive their first service visit within the time frame indicated in the service request.	Quarterly/Annually
Percentage of episodes of missed care.	To ensure clients receive timely access to care	The percentage of episodes of missed care shall not be greater than 2%.	The percentage of episodes of missed care shall not be greater than 1.5%.	Quarterly/Annually
Percentage of Service Provider Progress Reports that have been submitted.	To ensure a client's Service Plan is implemented	90% of Service Provider Progress Reports will be submitted at month's end.	95% of Service Provider Progress Reports due will be submitted at month's end.	Monthly/Quarterly
Percentage of instances where there are inconsistencies in the Confirmation of Service Provision and/or Service Billing Invoices have been delayed or have had an error.	To ensure appropriate financial management	No greater than 5% of submissions have inconsistencies	No greater than 2% of submissions have inconsistencies	Quarterly/Annually
Attainment of accreditation within a defined time period	To encourage agencies to gain accreditation status	Targets and standards can relate to the timing for attaining accreditation. Agencies that are accredited earlier may receive a larger incentive		Annually/Annually

Appendix G: Home Support – Agencies: Performance Incentives

Deloitte generated a number of assumptions that were used to create the example performance payment framework:

- A key assumption of the development of performance frameworks is that the size of potential performance payments are scaled based on the number of home support hours delivered by Home Support Agencies. That is, the achievement of the same indicator by a very small agency and a very large agency would generate performance payments of different value. For the purposes of demonstration only, three levels of provider service volume ("bands") were established:
  - Band 1 for agencies delivering more than 30,000 hours of care each month;
  - Band 2 for agencies delivering between 10,000 and 30,000 hours of care per month; and
  - Band 3 for agencies delivering less than 10,000 hours of care each month.
- It was assumed that key performance indicators would only be tied to performance incentives, not penalties
- For the purposes of discussion, a total annual budget for performance incentives would be limited to $10 million per year.
- Given current market changes in other jurisdictions, it was assumed that the number of agencies in the Province will decrease to 20 home support agencies.

The following table outlines how performance payments might be allocated, based on these assumptions:

Band	Hours of Home Support (Monthly)	Number of Agencies	Maximum Annual Payment per Agency
1	More than 30,000 hours	5	$750k per annum
2	Between 10,000 and 30,000 hours	10	$500k per annum
3	Less than 10,000 hours	5	$250k per annum

Appendix G: Home Support – Agencies: Performance Incentives

Example Performance Framework

KPI	Payment Freq.	Band	Step 1	Step 2	Step 3
Referral Acceptance Rate	Quarterly		95% of referrals accepted	96.5% of referrals accepted	98% of referrals accepted
		1	$25.00k/Quarter	$50.00k/Quarter	$75.00k/Quarter
		2	$16.67k/Quarter	$33.33k/Quarter	$50.00k/Quarter
		3	$8.33k/Quarter	$16.67k/Quarter	$25.00k/Quarter
Accreditation Status	Annually		Accreditation received in Y3+*	Accreditation received in Y2*	Accreditation received in Y1*
		1	$50.00k/Annum	$100.00k/Annum	$150.00k/Annum
		2	$33.33k/Annum	$66.67k/Annum	$100.00k/Annum
		3	$16.67k/Annum	$33.33k/Annum	$50.00k/Annum
Episodes of Missed Care	Quarterly		The percentage of episodes of missed care is less than 2%	The percentage of episodes of missed care is less than 1.75%	The percentage of episodes of missed care is less than 1.5%.
		1	$15.00k/Quarter	$20.00k/Quarter	$25.00k/Quarter
		2	$10.00k/Quarter	$13.33k/Quarter	$16.67k/Quarter
		3	$5.00k/Quarter	$6.67k/Quarter	$8.34k/Quarter
Billing Errors	Quarterly		Less than 5% of submissions have inconsistencies	Less than 3.5% of submissions have inconsistencies	Less than 2% of submissions have inconsistencies
		1	$15.00k/Quarter	$20.00k/Quarter	$25.00k/Quarter
		2	$10.00k/Quarter	$13.33k/Quarter	$16.67k/Quarter
		3	$5.00k/Quarter	$6.67k/Quarter	$8.34k/Quarter
Timeliness of Service Requests	Quarterly		90% of clients receive first service visit within time frame	92.5% of clients receive first service visit within time frame	95% of clients receive first service visit within time frame
		1	$5.00k/Quarter	$10.00k/Quarter	$15.00k/Quarter
		2	$3.33k/Quarter	$6.67k/Quarter	$10.00k/Quarter
		3	$1.67k/Quarter	$3.33k/Quarter	$5.00k/Quarter
Service Provider Progress Reports	Quarterly		90% of Service Provider Progress Reports have been Submitted	92.5% of Service Provider Progress Reports have been Submitted	95% of Service Provider Progress Reports have been Submitted
		1	$5.00k/Quarter	$10.00k/Quarter	$15.00k/Quarter
		2	$3.33k/Quarter	$6.67k/Quarter	$10.00k/Quarter
		3	$1.67k/Quarter	$3.33k/Quarter	$5.00k/Quarter

*Years since launch of performance incentive framework

- Both the **steps** and **payments** should be informed by historical data and scores; **further calibration of targets** is likely required

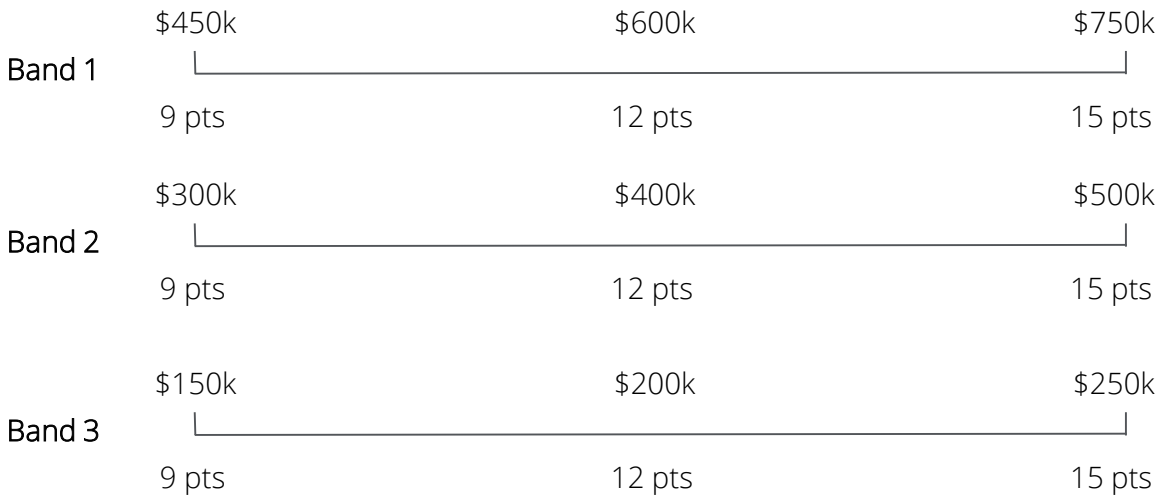
Appendix G: Home Support – Agencies: Performance Incentives

Example Performance Framework

KPI	Weight	Score (Steps)		
		Step 1 (5 points)	Step 2 (10 points)	Step 3 (15 points)
Referral Acceptance Rate	40%	95% of referrals accepted	96.5% of referrals accepted	98% of referrals accepted
Client Satisfaction	30%	90% of clients are satisfied	95% of clients are satisfied	100% of clients are satisfied
Accreditation Status	10%	Accreditation received in Y3+*	Accreditation received in Y2*	Accreditation received in Y1*
Episodes of Missed Care	10%	The percentage of episodes of missed care is less than 2%	The percentage of episodes of missed care is less than 1.75%	The percentage of episodes of missed care is less than 1.5%.
Billing Errors	10%	Less than 5% of submissions have inconsistencies	Less than 3.5% of submissions have inconsistencies	Less than 2% of submissions have inconsistencies

*Years since launch of performance incentive framework

Example Incentive Payment Schedule – All incentives are paid out annually



- The highest an agency can score is 15 points; 15 points should correspond to the full funding amount ($750k per annum)
- Both the **steps** and **payments to point scale** should be informed by historical data and scores;**further calibration of targets is likely required**
- **Penalties** can be implemented to subtract points

Appendix G: Home Support – Agencies: Performance incentives

Each of these performance payment frameworks have their own advantages and disadvantages

	Payment per Indicator	Scoring System
Advantages	**Frequency of Payments:** Payments can be made at different frequencies, enabling the Department to incent certain metrics more frequently when applicable. This may enable the timely remediation of issues	**Holistic view of performance metrics:** As all KPIs contribute to the same payment, providers are encouraged to consider all metrics holistically, rather than picking the metrics that can be achieved more easily
	Simplicity of Framework: The relationship between payment and performance is relatively simple; agencies are more likely to understand the incentive	**Mechanism to implement penalties:** Penalties can be implemented within the scoring system for certain metrics, enabling the Department to penalize certain behaviours without affecting an agency's base funding
		Alignment to Audit Process: If incentives are distributed on an annual basis, the payment schedule would align to the Department's audit/review process
Disadvantages	**Narrowing focus on performance metrics:** As providers can receive funding for individual KPIs, some agencies may only focus on improving certain indicators	**Infrequency of Payments:** As payment for performance (on all metrics) occur within the same time period, this is likely to make incentive payments less frequent. Infrequent payments may diminish the impact of the incentive framework, as agencies may forget about the incentives. It may also affect the timely remediation of issues

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