Ontario Health Coalition

HEALTH FACTS: CHRONIC CARE

Patient Classification and Funding in Chronic Care Hospitals and Long Term Care Facilities

Patient classification has been a key development in hospital funding in Ontario. But patient classification funding is not yet in place for post-acute care services. For rehabilitation and chronic care, hospitals receive global allocations equal to their previous year's allocation plus increases or decreases for changes in programs, plus increases or decreases for changes in province-wide hospital funding. Long term care facilities (like nursing homes or homes for the aged) began using patient classification for funding in the early 1990s. Now patient classification based funding is coming to post-acute hospital care.

RUG III

In 1998, the Ministry of Health decided that the Resource Utilization Group III (RUG III) patient classification system would be used for chronic care. RUG III uses 67 items of data collected as part of the Minimum Data Set (MDS).

RUG III has seven main categories. These groups are: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavioral Problems, and Reduced Physical Function. With the exception of the Rehabilitation group, patients are classified on the basis of clinical characteristics. Each of these main groups is further divided on the basis of the patient's activities of daily living, receipt of certain aspects of care, and the presence or absence of depression. In total, RUG III has 44 funding categories.

Ontario acute care classification categorizes patients using "weighted cases" (see the OCHU/CUPE fact sheet *Hospital Funding*). But the new chronic system uses "weighted days." So a chronic care patient who required a lot of resources might be rated at 1.5 weighted days for each day in the hospital, while one who requires less resources might be weighted at 0.8 weighted days.

MDS RUG III patient classification data has been collected from Ontario hospitals. Cost predictions based on the model were sent to hospitals with chronic beds in September 1999. Hospitals will comment on this data. Following this, they will determine the cost factors which are beyond the control of local hospitals and adjust the model for them. The plan is to begin using the model on April 1, 2000 for new funding (or for funding cuts) and, at a later point, for all funding.

Resident Classification in Nursing Homes and Homes for the Aged

Ontario adopted the Alberta Resident Classification System for funding nursing homes and homes for the aged in 1993. It classifies patients into one of seven groups based on four activities of daily living (eating, toileting, transferring, and dressing), two behavior of daily living indicators (potential for injury to self or others and ineffective coping), and two continence

indicators (urinary and bowel continence). The seven categories are labeled A through G, with A requiring the least resources and G requiring the most.

Reports based on these classifications are used to create a Case Mix Index (CMI). The annual CMI report is usually released in December. The province-wide CMI average is always set at 100. The CMI for individual facilities varies according to the level of acuity in the facility compared to the provincial average. Funding is based on three envelopes: the nursing and personal care envelope, the programming envelope, and the accommodation envelope. Base funding was last adjusted July 1, 1999. Base funding for each envelope (per resident, per day) is:

Nursing and Personal Care: $49.25

Programming: $4.93

Accommodation: $41.50

Total $95.68

Funding for Programming and Accommodation is the same for all facilities. The CMI results affect only the Nursing and Personal Care portion of the funding. If a facility has a CMI higher than 100 it gets more money than the base rate, if it is less than 100, it gets less. So a facility with a CMI of 103.25 would have its Nursing and Personal Care funding adjusted as follows:

$$\frac{103.25 \times \$49.25}{100} = \$50.85$$

As a result, the facility would receive $97.28 per resident per day, $1.60 more than a facility with a CMI of 100. Notably, the province-wide case mix measure (a measure of acuity) has increased 8.57% since classification began in 1992.

Accuracy?

The Ontario government and Ontario Hospital Association formed the Joint Policy and Planning Committee (JPPC) in the early 1990s. It is a key body overseeing hospital funding. It studied the Alberta and RUG III systems in 1994 and concluded that the two models provide different estimates of the amount of resources used by the same patients. So, for example, chronic care patients clustered at the F level under the Alberta system, while they are centred at a lower level of resource intensity in the RUG III system.

This is not unusual. Different workload measurement systems sometimes come up with large differences in the amount of time necessary to care for a patient or resident. But it does raise concerns about the accuracy of these systems and their ability to effectively fund long term care or chronic care facilities.

While the JPPC admitted that it is difficult to resolve which of the two systems best reflects the use of resources, it emphasized the lack of clinical similarity within Alberta categories when endorsing RUG III.

Staff Skepticism

There are a number of good reason why health care workers are skeptical of patient classification systems:

- These funding systems are not open ended. They only distribute among facilities a pre-set amount determined by the provincial government. So if funding is shrinking, or if patients needs across the province are rising, a heavier case load in any specific facility may not result in more resources to deal with that heavier load. This creates cynicism and frustration with the funding system.

- Completing the documentation can be time consuming. Health care workers are often left with the choice of taking care of the patient, completing the documentation, or working overtime for free. In many cases, health care workers are left with no choice; registered staff can lose their certificate for failure to chart.

- When patient classification is done by someone other than those providing the care, the information is less likely to be correct. Care plans are often out of date. Care providers have the most accurate and current knowledge

Convergence?

The JPPC has advised the Ministry of Health to adopt the RUG III patient classification model for nursing homes or homes for the aged as well as chronic care hospital services. The government is interested in a single classification system for both types of facilities. This would squarely raise the question of the same funding for both types of facilities, as the use of the same classification system would allow a direct comparison. Currently, a typical chronic care bed receives more than twice as much provincial funding than a nursing home or home for the aged bed (over $200 versus $95.68 per day).

CUPE Research January 2000 DA:den/opeiu491