Achieving ICF Direct Care Stability: A Summary of Our Process

ICF Direct Care Advocacy Coalition

9/9/22

Background

- Who We Are: 12 provider agencies serving approximately 1750 residents in over 80 ICFs.
- Our Goal: To determine what is necessary to stabilize a chaotic environment weakened to the point of collapse by the pandemic.
- The Current Situation:
  - Our field has always been plagued by turnover driven by low pay and difficult schedules that require staff to work weekends, nights, evenings, holidays, etc.
  - What changed with the pandemic was the inability to recruit new staff to fill vacancies created by this turnover, which has resulted in increased overtime, management staff filling schedule gaps, the use of staffing agencies, and chronic understaffing.
  - If this situation had only lasted a few months, the crisis would have been manageable, but as weeks stretched to months, and months to years, these approaches have become unsustainable.
  - Our agencies have been forced to discontinue programs, reduce services, discharge hard to serve individuals, not accept new referrals, and watch as quality slips to unacceptable levels. Gut wrenching situations for agencies committed to the individuals and families they serve.
- Our Approach: To develop a strategy to stabilize our services, the group decided to dig into each agency's situation to quantify the problem, listen to each other's stories, and learn from our collective experiences.

Our Process for Developing a Budget Proposal

This summary covers the following three workstreams:

- Stability Rating Survey and Analysis
- Elements of a Proposal Development
- Financial Scenario Deep Dives by Individual Provider Agencies

Note: During our process, the associations achieved legislative success in removing the ICF cap and rollback for FY 2023. We are extremely grateful for their advocacy. It prevented a policy-based worsening of the workforce crisis and reduces the funding gap necessary to achieve system stability.

Stability Rating Survey

Understanding the Current Environment

Determining Stable and Unstable Environments

- What is an unstable environment?
  - These are environments that are providing less hours than necessary to provide active treatment and meet health and safety requirements using sustainable staffing.
  - In simple terms these environments are dramatically understaffed.
- What happens in unstable environments?
  - Community outings become more and more infrequent, hard to serve individuals are not admitted or are discharged for lack of staffing, neglect potentially increases, active treatment is limited. In short providers struggle to provide even custodial care.
  - Staff in these facilities are pushed to work lots of overtime, often being exhausted and forced to work short staffed. Management staff are pushed to fill open shifts, doing work they are not always familiar with. Good, long-term staff get burned out and leave, with the ability to recruit new staff limited by the low starting wage most agencies are forced to pay. Hence, these unstable environments are characterized by critically low staffing levels, manned by exhausted and often inexperienced staff.
- While our field has always struggled with low wages and staffing issues, this crisis is different. It is different in that while turnover has remained somewhat constant, what has changed is the inability to recruit new staff.

Stability Rating Survey – Approach

- Sample Size: The project surveyed 63 different ICF residential settings around the state serving 1,012 individuals.
- Process:
  - While historically settings were often evaluated in terms of turnover percentages, the current situation called for a different approach. After much discussion and some initial experimentation, participating agencies were requested to determine the stability of each of their ICF settings.
  - Stability Rating: Based on survey responses, a "Stability Rating" was calculated for each ICF. This involved first determining the number of Direct Support (DSP) hours required to provide active treatment and meet the health and safety needs of those living in each setting. These "planned hours" were then compared to what was actually provided using sustainable staffing (called "countable hours provided"). When calculating sustainable/countable staffing hours, unsustainable approaches were excluded from the calculation, including overtime exceeding 10%, hours plugged in by management staff, or hours provided by staffing agencies. In short, such approaches that might get agencies through a crisis cannot be sustained for long periods and provide quality services.
  - Self-Perceived Stability Level: In addition to the statistical measure, each agency was asked to report if they felt the environment they were reporting on was considered stable or unstable by program staff.
  - Average Hourly Rate: Agencies also determined the average hourly rate in each of the settings. This average hourly rate is the same rate reported on the cost report for DSPs and Hab supervisors which includes overtime, shift differentials, bonuses, etc. It was collected to determine if a relationship exists between stability and the hourly rate paid.

The Survey Tool

Data Elements	Agency Reported Data	Explanation
Time Period:		Two-week pay period for which you are reporting. (Note: Use a typical time period, not holiday, etc.)
Average Direct Care Wage:		Average Direct Care Wage using the cost report methodology (as reported in Attachment 6, page 1, line 14 of the cost report), which includes overtime, shift differentials, bonuses, etc. (Note: When calculating, use a long enough time period to ensure that this "all-in" rate appropriately reflects your pay structure. In some instances, calculating over only a two week period could fail to capture bonuses you have paid to your workforce or could be impacted by shift differential fluctuations, etc. In such situations, consider using a calculation that spans a few months.)
Self-Perceived Stability Level:		Enter one of the following: Highly Stable, Stable, Highly Unstable, or Critical. (Note: Your perception will inform related discussion and analysis.)
Overall Information: (Note: The following "high level" information will enable the ultimate calculaton of an Agency Stability Rating (ASR), which represents the degree to which an organization is meeting its direct care needs through sustainable approaches.)		
Planned Hours (PH):		Number of direct care hours needed, as identified when beginning the scheduling process for the specified two-week period. (Note: "Needed" reflects hours sought to provide service levels expected by DODD for existing residents. This should be based on certification compliance, including "normal" Active Treatment expectations.)
Total Direct Care Hours Provided (THP):		Total number of direct care hours provided during the period associated with Planned Hours by whomever is used to cover the schedule, including both by employees and contracted staffing. (Note: You must include direct care hours provided by individuals who are not DSPs (i.e., "Non-DSPs") IF their job descriptions include an intentional expectation for them to routinely work some hours in direct care. However, you should not include direct care hours performed by Non-DSPs for whom there is no desired intention for such work, which generally includes those who do not "clock in" when providing direct care. Please see below for more detail.)

Selected Components of Total Direct Care Hours Provided: (Note: The following inputs will enable Total Direct Care Hours Provided (THP) to be converted to Countable Hours Provided (CHP). CHP is used in the Agency Stability Rating calculation.)		
Non-DSP Hours (if applicable): Note: Within some organizations, it might be normal and included in the planned hours for an individual who is not a DSP (i.e., a "Non-DSP"), such as a habilitation supervisor, to work a set number of hours per week in direct care. When that is the case, for the purpose of this worksheet it is necessary to include their direct care hours in Total Direct Care Hours Provided (THP). However, direct care hours worked by Non-DSPs beyond those intended (i.e., "unplanned Non-DSP hours") are considered unsustainable and need to be removed from the Countable Hours Provided calculation. They are identified through the calculation below. (Furthermore, some executives, managers, etc. have stepped in to work direct care hours during the staffing crisis, and their hours generally are not tracked.)		
Total Non-DSP Hours Provided *(if applicable)* :		If direct care hours provided by Non-DSPs were included in Total Direct Care Hours Provided (THP) above, enter the total hours provided by Non-DSPs.
Intended Non-DSP Hours Provided *(if applicable)* :		If Non-DSP hours were included in Total Direct Care Hours Provided (THP) above, enter the direct care hours provided by Non-DSPs that were anticipated in their job descriptions.
Unplanned Non-DSP Hours Provided (UNH): ***automatically calculated***	**0**	Hours provided by Non-DSPs beyond normally intended portion of schedule (UNH = Total Non-DSP Hours Provided - Intended Non-DSP Hours Provided)
Contracted Staffing Hours: Note: For the purpose of this submission, it is assumed that contracted staffing is only used when organizations are unable to meet service level needs with employed DSPs. Therefore, such hours must be removed from the Countable Hours Provided (CHP) calculation.		
Contracted Staffing Hours Provided (CSH):		Hours provided by non-agency staff through a contract with a staffing agency or the individual staff person
Overtime Hours: Note: Some overtime hours, in the aggregate, are both intentional and reasonable. However, for the purpose of this submission "excessive" overtime hours are considered unsustainable and must be removed from the Countable Hours Provided calculation.		
Total OT Hours Provided:		All overtime hours provided as part of Total Direct Care Hours Provided
"Allowable" OT Hours: ***automatically calculated***	**0**	"Reasonable" level of overtime hours, which for purposes of the this worksheet is calculated at 10% of Total Direct Care Hours Provided) ("Allowable" OT Hours = THP x .10)
Excessive Overtime Hours Provided (EOT): ***automatically calculated***	**0**	Overtime hours that exceed 10% of Total Direct Care Hours Provided EOT = Total OT Hours Provided - (Total Direct Care Hours Provided x .10)
Countable Hours Provided (CHP): ***automatically calculated***	**0**	Countable Hours Provided = Total Direct Care Hours Provided - Unplanned Non-DSP Hours Provided - Contracted Staffing Hours Provided - Excessive OT Hours Provided (CHP = THP - UNH - CSH - EOT)
Agency Stability Rating (ASR): ***automatically calculated***	**#DIV/0!**	Agency Stability Rating = (Countable Hours Provided / Planned Hours) x 100 ASR = CHP/PH x 100 (Note: This represents the degree to which an organization is meeting its direct care needs through sustainable approaches.)

Key Stability Survey Findings

Framework:

- From a small pilot survey of group members, it was determined that environments with calculated Stability Ratings below a threshold of around 80% were either highly or critically unstable. The percentage remained consistent when the other group members were surveyed. Therefore, ICFs with Stability Ratings below 80% were deemed "statistically unstable."
- When reporting their Self-Perceived Stability Level, group members were instructed to start with the mindset that normal hiring and scheduling challenges that characterize any industry should be viewed as consistent with a stable environment. They were told to only to characterize ICFs as unstable if they were highly or critically unstable (i.e., in crisis).

Stability Findings:

- 68% of the individuals (690) in the surveyed ICFs are living in environments that are both statistically unstable and self-reported as highly or critically unstable.
- This number increases to 75% (757) when we include ICFs that are above the "statistically unstable" threshold but self-reported as highly unstable.
- Of the 25% of individuals (255) in the surveyed ICFs that are living in stable environments, 52% (132) are in environments where the provider is heavily subsidizing the rate with millions of donated dollars to achieve stability. This is sustainable only in the short term.

How did the Average Hourly Rate Relate to Stability?

- When we started this work, we thought a direct correlation would be found between the hourly rate and the stability rating of a particular environment. Early, rough calculations seemed to indicate that was the case.
- As we dug into more data it became difficult to see such a correlation. Why was that?
  - It was found that things that end up driving variations in rates, particularly things that drive the rate higher, are also things driving instability. Fewer staff (creating an unstable environment) means providing bonuses, pay incentives, and lots of overtime to convince staff to fill vacant shifts just to provide for health and safety. All these things drive the rate higher.
  - This creates what looks like high pay in unstable environments, often higher than what is seen in stable environments.
- Where do the providers get the money to pay these higher rates?
  - When a residential setting is working with fewer staff and significant staff vacancies, overall costs may be down while pay rates are up. We see this playing out in the statewide data:
    - The average DSP wage went up 10% from CY 20 to CY 21, while direct care costs and reimbursement went up only 2%.
    - How could this be? Well, the number of direct are hours went down by 13%. So we can see that dramatically fewer staff are working, creating instability in the ICF program, while also creating a higher hourly rate.

Other Average Hourly Rate-Related Observations

- There are geographic differences in what it takes to create stability. While in general it is more difficult to recruit and retain DSPs in urban areas where there are more employers competing for the same workforce, rural counties near urban areas also have significant challenges.
- There was a wide range in the Average Hourly Rate among stable facilities – from $16.44/hour to $23.05/hour, with a simple average of $19.29/hour (median very similar at $19.38/hour).
- Of significant concern is that we have settings that are both self reported highly unstable/critically unstable and statistically found to be unstable, who have average wages that exceed $20.00/hour. Even at these wages, at certain locations people are not coming in to interview for work. These relatively high wages (resulting from lots of OT and incentives) are affordable only because their workforce has shrunk so low.
- In most environments (both unstable and stable), we are finding that to recruit new staff, it takes a starting wage in the $17/hour to $19/hour range to get folks to work the evening/weekend/nightshift. In some locations, even that is inadequate. An interesting observation was that a few providers used donated dollars and/or one time state/federal dollars (where allowable) to increase their starting rate to the level stated above. What they observed was that in a few months their average rate decreased as the combination of newer staff and less overtime took effect. However, this average rate still required substantial subsidies over the amount of reimbursement.

Elements of a Proposal

Targeting the Budget Request – What is Included and Not Included

Elements of a Budget Proposal (Page 1 of 2)

- Let the statutory reimbursement system run.
  - The "cap and rollback" in FY 22 made the direct care workforce crisis worse, and simply turning it back on for FY 23 (at the last minute) did not undo the additional problems created (let alone address the underlying workforce crisis) – but it did avoid making matters worse.
- Provide an additional increase on the Direct Cost Center over and above the "baseline" of letting the reimbursement system run.
  - While there are challenges in the other three cost centers, letting the reimbursement system run should help mitigate those issues. We want to keep the focus on Direct, because that is the critical need and what sets our field apart.
  - There should be a single increase applied to the entire Direct Cost Center (on top of "baseline"). The concept of providing different levels of increase to subcategories within the cost center (e.g., different increases for DSP and non-DSP) was evaluated, but variations across organizations in the allocation of spending between subcategories made that approach too unpredictable.
  - The add-on can be estimated by determining what percentage increase would be needed to stabilize the direct care workforce right now (i.e., on top of the FY 23 rates). Because policy intervention will be delayed for another year, the percentage should be applied on top of the FY 24 "baseline" (i.e., after letting the reimbursement system run). Note: due to the interplay of cost reports and rate-setting, add-ons will likely be needed to both FY 24 and FY 25 rates to achieve the necessary funding increase during the FY 24-25 biennium (and enable FY 26 to not require augmentation beyond the statutory reimbursement system).

Elements of a Budget Proposal (Page 2 of 2)

- The additional increase on the Direct Cost Center should incorporate assumptions related to anticipated increases in total hours provided and increases in Adult Day Services.
  - As the direct care workforce stabilizes (as a result of the budget initiative), we expect more direct care hours will be provided.
  - As the direct care workforce stabilizes (as a result of the budget initiative) and as COVID impacts continue to moderate and/or become part of the new normal, we expect Adult Day Services expenditures will increase.
  - Both total hours provided and Adult Day Services are broad-based dynamics faced across all ICFs.
- Separate proposals should be developed around Vent and High Behavior.
  - While these issues are of great importance, they are not broad-based across all ICFs, so we need to guard against inflating the general budget request for specialized issues.
- A "modernization" component must be part of the package.
  - We recognize that a funding boost is critical for our industry – especially considering the challenging nature of our work relative to other, higher-paying fields, as well as the higher premium needed to attract workers to any in-person jobs.
  - However, we need to specifically recognize how our industry is adapting for the future, and we must commit to do more.
  - A "modernization" component must not only be incorporated as an add-on – it should serve as a foundation for the entire proposal.

Financial Scenario Deep Dives by Individual Provider Agencies

Determining the Broad-Based Budget Request Needed to Achieve Stability

Financial Scenario

- After spending months examining agency data on stability, and many discussions with agency directors on the topic, the group decided to thoroughly test an assumption. If starting wages needed to be at $17 to $19/hour to recruit, then an average overall wage of around $22/hour would be needed to stabilize the system RIGHT NOW.
- Looking at statewide cost report data, we determined that would require an increase of 21.4% above an estimate of the Average Hourly Rate capacity (DSP and Hab supervisors) incorporated in the FY 23 rates.
- However, consistent with our "Elements of a Proposal" work, we determined we need to account for likely increased hours provided after the Average Hourly Rate receives budget support, as well as on increase in spending on Adult Day Services. We added 5% points for these components.
- This brought the entire scenario to a 26.4% increase applied to the Direct Cost Center above the FY 23 rates, which would result in a 15.9% increase on the entire rate.
- We asked all 12 agencies to do a deep-dive financial analysis to evaluate if, after factoring in the additional revenue from both the FY 23 rate increase and this hypothetical "26.4% add-on" scenario, they could adjust their DSP pay rates (starting and overall) in such a way that they could get their ICFs to stability TODAY – not a year from now, but TODAY. That is because, as previously explained, this number would be treated as an add-on to the direct rate AFTER the system runs in FY 24; the FY 24 baseline increase will factor in the inflation that occurs between today and the new rates in FY 24.

This was the financial scenario for full evaluation by all group members. Each agency's leadership team, including CFOs, performed a deep-dive analysis. They made calculations of the "pots" of money made available by the FY 23 rate increase and the 26.4% add-on scenario. They modeled how they would adjust their starting rates in light of their individual market workforce conditions. They made assumptions about their ability to hire, their resulting hours provided, and anticipated shifts in their Average Hourly Rate. They considered many other factors, such as their current reliance on donated funds and their waiting lists.

The amount was determined to be insufficient given the historic nature of the workforce crisis. More work is needed.

Confidential - Working document, NOT a proposal

For Discussion During ICF Advocacy Campaign Meeting (7/29/22)

Draft Scenario to be Reviewed and Refined

	Current % of Rate	Composition of Direct Cost Center (percentage point)	Increase Scenario (* see below for DSP)	Scenario Impact on Total Rate
Direct Cost Center	60%		*26.4%*	
DSP Portion		30%	26.4%	7.9%
Non-DSP Portion		30%	26.4%	7.9%
Other 3 Cost Centers (Indirect, Capital, Protected)	40%			0.0%
Total Rate	100%			15.9%

	CY 20 Cost Report (statewide calculation)	CY 21 Cost Report (statewide calculation)	Increase from CY 20 to CY 21	FY 23 Est. Rate Capacity (statewide average) using 10% inflation assumption	Scenario Target (statewide average, not ICF specific)	Increase from FY 23 Est. Rate Capacity to Target
Average Direct Care Wage (DSP w/Hab Supervisor)	$14.89	$16.47	10.6%	$18.12	$22.00	21.4%
Additional Bump to Add Back 1/2 of Direct Care Hours Lost						3.0%
Additional Bump Related to Day Services						2.0%
Targeted Increase for DSP Portion of Direct Cost Center						26.4%

Note: Vent and high behavior needs to be considered separately.

Additional Consideration: “Modernization”

- While significantly increasing ICF rates will move the ICF program in the right direction to address the worsening direct care workforce crisis, by itself it will not get us to long-term stability. Providers, with the help of staff, individuals served and their families need to continue to figure out how to modernize the program and provide quality services with a shrinking workforce. This evolution will involve two key initiatives that our group feels should be an integral part of any proposal involving significant new funds:
- **A significant investment in workforce training.** Faced with the reality of a shrinking workforce, it is essential that the training provided to staff is tailored to fit the complex needs of those served. Whether serving individuals with complex physical challenges, complex medical challenges, complex behavioral challenges, or a mix of these challenges, to not have a highly trained workforce is a disservice to both the individuals served and the staff providing the supports. While we traditionally have often supported these complex needs by simply throwing more staff in the mix, this approach is inefficient and impossible with the current workforce situation. Such training and accompanying compensation matrixes, are best designed by provider agencies who know the individuals served and the training needed to support them.
- **A significant investment in the use technology.** Technology has affected every aspect of labor for the last 30 years and the pace of its impact is rising exponentially. Ohio’s system has to be at the forefront of how technology can shape and improve services to individuals served and improve supports to our workforce. Technology, while not appropriate for every individual, offers a huge opportunity to grow its use and ease the demand on labor, all while better serving those in our system. This effort, needs to happen responsibility as we learn from each other, industry experts, and those we serve to tailor its use to meet the complex needs of those we serve.

Conclusion

- We appreciate the opportunity to share the journey we have been on over the past seven months and hope our exploration, thoughts and observations are helpful.
- We are deeply committed to the ICF program and those who receive services through it. Our goal it to explain and paint a picture of the crisis the ICF program is experiencing and lay out a plan to stabilize and modernize this essential service delivery platform.
- **A final thought to conclude this report:** We found that three quarters of the individuals served in the ICF program are living in unstable environments. Think about your life and if you needed someone to help you go to the bathroom, or feed you, or calm you down when you are unable to manage your feelings, or physically turn you at night so you do not get bed sores, or take you to church one Sunday morning. Yet there were never enough staff to immediately meet these needs, and the staff who were helping you did not know or understand you, or were burned out from working too many hours. This is the life of those living in unstable environments. We are blessed and thankful for the commitment and caring of our current workforce. A workforce that needs better pay, more staff helping them, bettering training, and time off to recharge their batteries to continue what they do so well – caring for and loving those they serve.