Patient/Care-Based Funding
Long-Term Care

User Summary

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Patient/Care-Based Funding - Long-Term Care
User Summary

1 Introduction
Patient/Care-Based Funding (PCBF) is one of the tools used by Alberta Health Services (AHS) to optimize the allocation of available funds to serve the population health needs within AHS’ mandate. Starting April 1st 2009, the PCBF methodology was implemented for long-term care (LTC) funding. This was a shift away from the several different funding methods previously employed. As a provincial system, PCBF promotes the most equitable and practical use of limited resources and funds.

This user summary provides an overview of the PCBF methodology, motivations and objectives. This document gives:
- A detailed explanation of the PCBF model for LTC;
- The implications of PCBF facing staff of LTC facilities;
- A glossary of terms related to LTC and PCBF

2 What is PCBF?
PCBF is a method used by funders to pay for desired health services. It is an output-based allocation method which classifies residents/patients by clinical acuity and resource use to enable consistent and appropriate funding. PCBF provides funding based on care provided to residents/patients as opposed to funding a specific type of bed. The key objective of PCBF is to align incentives within the health system so that the most appropriate services are delivered for the most efficient funding levels. There are two key aspects of PCBF:

a) Grouping residents/patients of similar clinical acuity and resource consumption:
- The PCBF model relies on the averaging of resident/patient groups such that each group’s costs and clinical characteristics are similar and comparable across sites.
- Residents/patients are grouped into clusters based on similar clinical circumstances and levels of care resourcing required.

b) Quantifying resource use of these groups: the PCBF model requires that all resident/patient groups be assigned a quantitative value, i.e. dollars, reflecting the costs of resources needed to treat the residents/patients within each grouping. It is very important that this value is set at an appropriate level. If dollar values are too
low, the delivery of services to the resident/patient is not adequately compensated. If values are too high, there may be a reduced incentive for efficient service delivery. To more accurately ensure that dollar values are set at an efficient level, those values can be adjusted for the site-specific characteristics of a given facility.

Notably, **PCBF in LTC does not control the overall amount of provincial funding to be applied**; rather, it is an allocation methodology used to determine the most optimal distribution of such funding. During implementation of PCBF for LTC, there was a multi-year phase-in to full PCBF and a period of “no-loss” funding for all sites. Looking forward, acuity-based redistribution will, as realized with PCBF, alleviate the cost pressures experienced by sites that have experienced higher-than-average acuity increases in recent years.

PCBF can help to ensure the services provided by AHS meet a high standard of quality and are delivered in a timely and equitable manner. PCBF is an approach, aligned with other AHS strategies, that is tied to an understanding of the appropriate type, number and mix of services for a particular population being served. Implementation of PCBF includes a number of safeguards, notably, ensuring the quality of care.

### 3  PCBF for LTC

LTC is part of the Continuing Care continuum of services in Alberta. LTC services are those provided to residents assessed as having complex, unpredictable medical needs requiring 24-hour on-site registered nursing care. Upon admission to a LTC facility, the resident’s acuity is then re-assessed using the Resident Assessment Instrument Minimum Data Set 2.0 tool (RAI MDS 2.0).

#### 3.1  What Prompted a PCBF Funding Model?

PCBF is generally understood as a fair and equitable method of allocating resources as it has clear links between resident acuity and funding. Before AHS was formed, there were many different funding formulas and funding advices used by each of the former Regional Health Authorities (RHAs). As a result, it was difficult to compare facilities given the wide variations in funding mechanisms, reporting requirements and reporting authorities. With the creation of AHS, a province-wide funding model was essential to ensure the efficiency and equity of resource allocation and subsequent service provision. In a provincial context, PCBF has been adapted to the locally preexisting reporting systems to create a funding model that is flexible and extensive. As a result, PCBF provides incentives to facilities throughout the province to provide consistent, comparable and transparent information regarding clinical indicators and resource consumption.
PCBF results in an improved alignment of the services provided by LTC operators to the health care needs of residents. PCBF provides funding based on the actual care provided to residents as opposed to funding purely based on the types of bed, thus moving towards a system where funding is more appropriately linked to resident acuity.

3.2 What are the Main Objectives and Key Features of PCBF in LTC?

The key objectives of the model include the following:

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

In line with the foregoing objectives, AHS has stipulated the following key features - in the PCBF model:

1. Standardized funding method that promotes efficiency and provides incentives for improving quality.
2. Uniform and comprehensive funding advice (including LTC and other types of continuing care) for all operators.
3. Valid and reliable case mix tool
4. Transparent and equitable cost data, using provincially averaged rates except for mutually recognized and unavoidable cost differences.
5. Incentive mechanisms that can be implemented easily and amended simply.
6. Assurance of data quality via regular monitoring and, when required, audits.

3.3 Elements of the PCBF Model for LTC (including PCBF-related elements and non-PCBF elements included on Funding Advices)

The following are the elements of the PCBF model (these elements are shown in Diagram 1):

- Variable funding
- Sharable nursing staff funding floors
- Fixed funding
- Other PCBF
• Quality Incentive Funding (QIF) – although is not part of the PCBF funding formula, it is a vital component of LTC are funding as is included here for that purpose. There is a separate methodology for calculating QIF and the funding is allocated separately from PCBF. Before describing these elements, however, several key terms are defined, as follows

Resource Utilization Groups (RUG):
The RUG system was developed by a consortium of researchers (interRAI) for use at no charge. It is a case mix grouping system providing a resident-specific way of allocating resources based on the variable costs of care for residents with differing health service needs. Alberta uses the RUG III system; residents are placed into one of forty-four categories, based on their health services needs and the resources required to meet those needs. Please refer to Diagram 2 for a schematic of the RUG III system.

Minimum Data Set (MDS) 2.0:
This data set comprises elements collected during resident assessments. PCBF uses a subset of the MDS in calculating funding for LTC sites.

Case Mix Index (CMI):
The index is a set of values indicating relative resource use. Each RUG has an associated CMI, which is calculated using Alberta data. The calculation formula is:

\[ \text{CMI} = \frac{\text{Resource use associated with a particular RUG}}{\text{System average resource use}} \]

Weighed Resident Day (WRD):
This is the main determinant of resident care activity in PCBF. Resident days (unweighted) are the number of days a resident spends at a site, e.g. if a resident stays 365 days, the person would have 365 resident days. The basic calculation formula is:

\[ \text{WRD} = \# \text{ of residents} \times \# \text{ of days} \times \text{CMI} \]

Data Sources:
Currently, PCBF receives Census and RUG information for each site on a monthly basis. This information is submitted by each site’s software vendor and processed monthly by PCBF. To ensure accuracy and completeness of data prior to calculating funding, PCBF distributes monthly reports to each site, parent organization, and Zone, for their review. In events where a record does not correctly capture the resident’s circumstances, the site contacts PCBF to discuss and implement a remediation plan.

Additionally, each quarter the RAI Review team receives a report showing LTC sites whose CMI trends significantly differ from provincial patterns. The team then follows up with the sites to ensure assessments completed are accurate.
Elements of PCBF

Variable Funding or WRD Funding

This element comprises approximately 85% of total PCBF. The main driver of variable funding is WRD. It is related directly to the care provided, which varies according to the number of residents, their clinical complexity and their health services needs.

Variable funding is calculated based on funded WRD per day, care providers’ (RN, LPN, HCA, professional therapies and non-professional therapies) salary rates, and paid-to-worked hours ratios.

Another part of this element is Care-related Supplies (CRS) funding, which is calculated as:

\[ \text{CRS} = \text{funded WRD per day} \times \text{rate calculated for CRS per WRD} \times \text{# of days in the funding period} \]

Sharable Nursing Staff Funding Floors

This element applies mainly to very small sites, in which LTC and another service, e.g. acute care, are co-located. As such, this applies nearly exclusively to AHS owned-and-operated facilities in small communities.

Some of these sites can share staff between services to provide the LTC operation with 24 x 7 RN coverage and clinical staffing for safe two-person lifts/transfers. Where staff sharing has been indicated as possible or occurring, PCBF does not provide top-up funding for 24 x 7 RN coverage or clinical staffing for safe two-person lifts/transfers.

During the 2012/13 fiscal year, it was discovered that some sites indicated erroneously that staff were sharable and the resulting funding was insufficient for adequate operations. PCBF amended funding to provide floor funding for the coverage described above. The revised funding applies to sites with 25 or fewer beds, where RNs or other nursing staff were indicated as being sharable within the facility. The funding floors provide additional resources to cover a maximum of 0.5 FTE RN and 1.5 FTE for other nursing personnel at shared sites.

Fixed Funding or Bed-based Funding

This element recognizes the support required for bed-based care at sites and its main driver is site capacity (bed numbers); it comprises approximately 15% of total PCBF. Components of fixed funding are:
• Care-related Administration (CRA):
This may include functions such as educator, RAI coordinator and infection prevention/control professional. Zones and parent organizations have discretion on how this funding is used; there are no accountabilities associated with it.

• Resident Care Management (RCM):
This includes the Director of Care (DOC) salary and some direct support items deemed ordinary, necessary and reasonable (supplies, staff) associated with the DOC function. The calculation of RCM is:

$$RCM = \text{# of funded beds at the end of the previous funding period} \times \text{a calculated per diem rate} \times \text{# of days in the funding period}.$$ 

• CM top-up:
For sites with 37 or fewer beds, this top-up adds hours to comply with minimum RCM staffing requirements. If the RCM funding is less than the prescribed minimum level, the top-up is provided.

Other PCBF or Funding Related to PCBF
There are two parts to this funding:

• Turnover:
This recognizes the extra work required when a resident is discharged and the bed is being prepared for a newly admitted resident. The calculation of turnover funding is:

$$\text{Turnover funding} = \text{Annual # of new admissions} \times \text{the calculated provincial per diem rate} \times \text{5 days}$$

*Note: the “5 days” refers to 5 consecutive calendar days.*

The expectation is the turnover will be completed in 5 days or less.

• Phase-in Adjustment:
This is a temporary funding element and applies to each qualifying site (in each funding period) to allow a gradual decrease from historical funding levels to PCBF levels (for those sites that have been historically over-funded). Because phase-in depends on the ownership status, effective Mar. 1, 2013, only contracted LTC sites can have a non-zero phase-in factor.

• Funding Floors and Ceilings:
In 2013/14 funding year, PCBF introduced funding floors and ceilings for the first time. These act as minimum and maximum thresholds applied against year-to-year funding for each LTC site (on a per-bed basis, adjusted for inflation)

- **Funding Floors:**
  
  Ensure sites do not realize reductions in funding beyond the set threshold. This maintains sustainable operations at the site. The floor threshold is set each funding year. In 2013/14, floors were set at 3.5%. This means no LTC site saw a reduction of more than 3.5% in their PCBF funding. In 2014/15, funding floors were set at 0.75%.

- **Funding Ceilings:**
  
  Capture potential assessment upcoding or data errors resulting in overfunding. If calculated funding for a certain site represents a significant increase as compared to previous year’s funding (on a per-bed basis, adjusted for inflation), a funding ceiling is applied where funding amounts beyond the ceiling threshold are withheld pending review. PCBF acknowledges that significant increases in funding could result from legitimate increases in CMI levels. Thus, funding ceilings are considered a temporary measure until verification of assessment data is complete. If the RAI Review team detects systematic upcoding at the site, the ceiling is maintained. PCBF is currently in the process of outlining possible disincentives to also be applied to the infracting site. If it is found that assessments are accurate, the ceiling is lifted and the site receives the incremental funding originally withheld. In 2013/14 and 2014/15, funding ceiling was set at 9%.

**Quality Incentive Funding (QIF)**

QIF (an amount allocated annually) comes from a separate funding pool and is not, therefore, taken from the overall PCBF amount provided for LTC operations. As stated above, it is a vital element of care funding and is included in this summary because of its importance. Sites meeting or exceeding a set of indicators or criteria receive QIF; if the criteria are not met, the site receives no QIF. Appendix 2 shows the criteria used for allocating QIF for fiscal year 2011/12.

In 2011/12, a site could receive QIF equal to 0.2% of its operational funding allocation, if all quality criteria were met. Over time, it is expected QIF will change as a result of, for example, revised criteria and changes to the size of the QIF pool.

As stated above, while QIF is part of PCBF conceptually, it is calculated separately and is not part of PCBF LTC funding advice.
Non-PCBF Items Included on LTC Funding Advices

Although the non-PCBF amount appears on funding advices, it is not part of the PCBF model calculations. These non-PCBF amounts are calculated separately and added “below-the-line” of total PCBF on funding advices. An example of a non-PCBF item is funding for drugs used routinely (this excludes high-cost pharmaceuticals) for resident care, in which case the net value of non-PCBF can be a negative. Non-PCBF items are calculated by AHS Business Advisory Services and provided to PCBF so the amount can be added at the bottom of funding advices.

Diagram 1: The PCBF, PCBF-related and non-PCBF Components of LTC Funding for Care
Diagram 2: 44 Group Version of RUG III InterRAI Case-Mix System

RUG-III Classification
5.12 Version - 44 groups

Resident

Special Rehabilitation

NO

Extensive Services

TREATMENTS/ADL

0-1

2-3

4-5

SE1

SE2

SE3

Special Care

ADL

7-14 SSA

15-16 SSB

17-18 SSC

Clinically Complex

ADL

4-11 CA

12-16 CB

17-18 CC

Impaired Cognition

ADL

4-5 IA

6-10 IB

Behavioral Problems

ADL

4-5 RA

6-10 BB

Reduced Physical Functions

ADL

4-5 PA

6-9 PB

9-10 PC

11-15 PD

16-18 PE

NURSING REHABILITATION (0-1 OR 2+)

CA no

yes

no

yes

no

yes

no

yes

DEPRESSION (YES/NO)

IB1

IB2

BA no

yes

no

yes

no

yes

no

yes

I

A1

A2

B

NURSING REHABILITATION (0-1 OR 2+)

PA1

PA2

PB1

PB2

PC1

PC2

PD1

PD2

PE1

PE2

NURSING REHABILITATION (0-1 OR 2+)
Items Excluded From PCBF and “Below-the-Line” Adjustments

PCBF does not provide accommodation funding (this funding covers the cost of food services, housekeeping, etc). Accommodation is funded through accommodation charges to residents. The PCBF model is designed solely to allocate funding for care.

Capital costs are not funded via the PCBF model. There are separate funding sources for items such as capital improvements to sites.

3.4 Constants in Model

In addition to using RUG as an important determinant of the funding allocated to sites, values of constants are required to calculate the variable and fixed elements. Constant values in the PCBF model were determined in collaboration with Alberta Continuing Care Association (ACCA) representatives. Further, constant values were calculated within annual budget limits of the LTC facility provincial funding envelope. Constant values were calculated for the following aspects of the PCBF model:

1. Nursing – Hourly paid rate for Registered Nurses (RN), Licensed Practical Nurses (LPN) and Health Care Assistants (HCA)
2. Therapies – Hourly paid rate of professional and non-professional therapies
3. Resident care management – Dollar amount per bed day
4. Care related supplies – Dollar amount per weighted resident day
5. Care/administration – Dollar amount per bed day
6. Resident turnover – Dollar amount per admission

The constant values for RN, LPN, HCA, pro and non-pro therapies and the resident care management are determined based on the 'typical' hours worked as well as non-worked days, overtime, statutory holidays and hours spent on orientation. Wage rates for the determined total hours worked are based on AHS union agreements and are benchmarked against internally budgeted rates. The rates were calculated using provincial data and set at the approximate mid-level step of respective salary grids. Since the rates were set, they have been altered each year by the amount of the overall inflation increase for AHS budgets.

Care-related supplies are set per WRD based on the average rate as demonstrated in care supplies and related care support by former RHA funding formulas. Care and administration costs are calculated per bed and estimated as approximately 11.5% of direct care hour costs. Resident turnover is determined per turnover based on an analysis of subsidiary cost experience.
3.5 **Accountabilities**

Six accountabilities (Appendix 3) come into formal effect on Apr. 1/13. On the same date, a multisite (or shared) arrangement for three of the six accountabilities becomes effective. The multisite aspect of the affected accountabilities provides short-term flexibility to zones and operators to address, for example, staffing challenges.

The specifics about the accountabilities are as follows:

- Accountabilities 1, 2 and 3 (as listed in Appendix Y) are site-specific and will be monitored and reported as such. Keeping these three accountabilities site-specific is compliant with Alberta’s *Nursing Homes Operation Regulation*.
- Accountabilities 4, 5 and 6 can be shared at the AHS zone and parent organization (within any particular zone) levels
  - The intention is not to have a permanent exemption for individual sites relative to accountabilities 4, 5 and 6. Rather, having these accountabilities sharable provides flexibility to zones and organizations within zones to address short-term challenges, e.g. staffing difficulties at a particular site.
  - Continuation of shared accountability status depends on achieving thresholds associated with quality indicators, i.e. on a site-specific basis, zones and parent organizations must meet or exceed quality thresholds to have accountabilities 4, 5 and 6 shared.

3.6 **Annual Recalculation of the Alberta CMIs**

As explained earlier in this document, CMI represent the intensity of the Resource Use (RU) by RUG relative to the system-wide mean RU.

As the basis of the annual PCBF allocation, PCBF recalculates the CMI for each RUG category annually, as recommended by the developers of the RUGs (InterRAI). This maintains accurate CMI relative values for each RUG group, with a provincial weighted average CMI across all RUG groups of 1. Components for calculating CMI values are:

1. Resident days: Count of days using data housed in the LTC database
2. Wage rates: Wages by type of staff as provided by AHS Business Advisory Services (BAS)
3. Staff time: Minutes by type of staff per day per RUG group based on the U.S. STRIVE (Staff Time and Resource Verification) study. For the RAI 2.0 RUG CMIs, values from the Canadian CAN-STRIVE study should be available within five years.
The first step in determining the CMI value is to calculate the Wage-Weighted Minutes (WWM) for each RUG category.

\[
WWM_{RUG_i} = \sum_{j=1}^{\text{# of Staff Types}} \text{Relative Wage Rate}_{RUG_i \text{Staff Type } j} \times \text{Staff Minutes}_{Staff Type j}
\]

Each RUG group’s RU is calculated by multiplying the WWM for each RUG group by that group’s resident days.

\[
RU_{RUG_i} = WWM_{RUG_i} \times \text{Client days}_{RUG_i}
\]

The RU per RUG is summed across all RUG groups. The total is divided by the total resident days across all RUG groups to provide a calibration value (the system-wide mean RU per resident day).

\[
\text{Calibration Value} = \frac{\sum_{i=1}^{\text{# of RUGs}} RU_{RUG_i}}{\sum_{i=1}^{\text{# of RUGs}} \text{Client days}_{RUG_i}}
\]

The CMI for each RUG group is obtained by dividing the WWM for each RUG group by the calibration value.

3.7 What are Some Possible Implications Facing Operational Staff?

The key implication for operational staff from the implementation of PCBF in LTC is the need for accurate and timely collection of data. Each of the elements of PCBF in LTC relies on various data collections. The completion of RAI assessments and ensuring the competency of assessors can be time consuming. The intent of using the RAI 2.0 assessment instrument is primarily to collect timely information for care planning and quality improvement, with a by-product of providing RUGs for funding purposes. Consideration is being taken to ensure that the data collection workload on operational staff is reasonable.

Another implication of PCBF is that funding levels and accountabilities may require a change in staffing at some sites. For example, increases or decreases in staffing categories (resulting from PCBF funding levels and accountability requirements) have implications for care-related work processes.

3.8 Current Limitations

The application of PCBF requires valid and reliable measurement systems that are able to assign values of expected resource consumption to resident/patient-specific outputs. Other methods of funding are used where these data are not available or where this methodology is not suitable in the formulation of sensible funding.
decisions. At present, LTC specialty units are not funded via PCBF; rather, they are block-funded. PCBF is working on ways in which the funding model can be applied to residents who are in these units. Once the care of residents in specialty units can be funded fairly and equitably via PCBF, the units will no longer be block-funded separately from the rest of LTC.

Summary of Monitoring and Review Processes
Long-Term Care (LTC) Activity-Based Funding (PCBF) requires valid and reliable Resident Assessment Instrument (RAI) 2.0 Data. A comprehensive monitoring strategy triggers RAI data entry reviews. An AHS team reviews RAI coding, business processes, and adherence to provincial and CIHI standards and does post-review follow-up. During the onsite review, an AHS provincial/zone team will review RAI coding and education processes and resident records, identify any anomalies within these records and review business processes. In addition, records of RAI education and staff competency will be reviewed. Outcomes of the review may include coding changes, process changes and/or focused staff education. The review team will also be responsible for required follow-up.

All LTC facilities are randomly scheduled to be reviewed at least once every two to three years and more frequently as prompted by quarterly monitoring reports. The number of facilities selected for review based on the factors identified below is limited by available resources.

Monitoring and review can be triggered by several factors, including:

1. **PCBF Data Analysis Report**
The quality of LTC RAI data is formally monitored in part by PCBF using the monthly cross-sectional site average CMI comparison and longitudinal site average CMI trend analyses. Outlier sites are then identified and sent to Primary and Community Care for review. For sites where acceptable causes of variation are not readily known, a targeted formal RAI review may be conducted.
   a) **Monthly Cross-sectional CMI comparison**
      *Compared the monthly site average CMI for each site to provincial average CMI. Sites exhibiting CMIs two standard deviations higher or lower than provincial average are identified as outliers.*
   b) **Longitudinal CMI trend monitoring**

1 The timelines are highly dependent on available resources, documentation quality (i.e., time required to investigate each facility), required follow-up, and investigation rigor.
Compares weekly acuity trends at each site to provincial acuity trends, as measured by CMI. Sites are grouped based on the number of beds, and those exhibiting CMI changes larger than 4.5 standard deviations from provincial CMI changes for their peer group for two or more consecutive reporting periods are flagged for further investigation.

2. Quality of Care
Occasionally, quality of care issues may be identified at a certain site via media attention or otherwise. In these circumstances, the Zone may request a RAI review in addition to a Quality Audit.

3. Inconsistent Practice
Inconsistent business processes may be identified through discussions at the Zone or following site visits by other teams. These may trigger a RAI review.

4. Frequency of Data Errors
PCBF distributes monthly data error reports to sites and Zones. A RAI review may be triggered if a site consistently has many errors.

5. Zone Request
PCBF distributes monthly CMI comparison reports to AHS Zones. Occasionally, the Zones request RAI reviews be completed if reported CMIs are inconsistent with expectations.

6. Site Request
Occasionally, an LTC site requests it gets audited.

7. Proximity
If a rural site is being reviewed, other LTC sites within the same geographic area will likely be reviewed as well.

8. Funding Ceilings
Whenever a site has a funding ceiling applied. Funding ceilings are applied if year-to-year funding (calculated on a per bed basis, adjusted for inflation) increases beyond a certain threshold.

9. Random Selection
Sites may be randomly selected for a review. The team aims to review all sites once within a two to three year timeframe.
3.9 Emergency Situations

In the event of an emergency, funding is adjusted past the first 30 days. In order to qualify as an emergency, it must satisfy the following four criteria:

- Lies outside the site’s control
- Could not have been reasonably avoided
- Qualifies for business interruption insurance claim
- Resident displacement from the site occurs

AHS will provide regular PCBF payments for the first 30 days of emergency, followed by an adjustment based on observed occupancy and CMI at the site. The amount of the funding adjustment will be communicated to the provider.

AHS will issue a statement outlining the additional care funding provided during the emergency for submission to the site’s insurance provider. Once the provider receives its insurance payout, AHS will recover the care component of the insurance payout, to the extent of the amount stated on the statement it previously issued.

4 Stakeholder Engagement

Sessions have been held to orient stakeholders to the PCBF model for LTC funding. Stakeholders include internal AHS staff; Alberta Health (AH), Alberta Continuing Care Association (ACCA), Alberta Senior Citizens Housing Association (ASCHA) and the community of LTC operators. There is representation from AH, ACCA and ASCHA on the AHS PCBF Continuing Care Working Group.

Effective engagement is an ongoing process, as are improvements to engagement. Stakeholder involvement is a vital part of developing, implementing and evaluating PCBF.

5 Summary and Conclusion

The intent of PCBF is to align incentives within the health system so that the most appropriate services are delivered at the most reasonable price to meet the needs of the population served. Successful implementation of PCBF in LTC requires valid and reliable measurement systems to assign prices to outputs. PCBF needs to be aligned with a strategy rooted in an understanding of the appropriate type, number and mix of services for a particular population being served. Also, PCBF cannot be implemented without a way to ensure the quality of care.
PCBF will provide a unified funding template for all operators and that template includes LTC and, eventually, SL 3/4/4D. The model also provides equivalent funding for private, voluntary and public institutions. This PCBF funding template makes use of the validated continuing care case mix system, but also has the flexibility to address bed/resident-based funding. It is transparent, equitable and sensitive to cost differences. PCBF allows for various incentives to be built into the funding model. Part of PCBF implementation will involve the phase-in of standardized provincial salaries and worked-to-paid hour ratios. Finally, funding for drugs and resident transfers are not currently included in the PCBF of LTC and are addressed in a different way.

In conclusion, PCBF provides a uniform and standardized method of funding LTC. It has been developed and implemented in consultation with stakeholders and will continue to be refined in that spirit.
Appendix 1 - Glossary of Terms

This glossary relates to the technical terminology used in the Manual. It also contains terms not used in the Manual but used in conjunction with PCBF.

Patient/Care Based Funding (PCBF) – PCBF is a method used by health service purchasers or funding agents to pay for desired health services. Specific health system outputs are funded at specific rates. PCBF is intended to align incentives within the health system so that the most appropriate services are delivered in the best way at the most reasonable price.

Patient/Care Based Funding Long Term Care (PCBF - LTC) – This funding allocation methodology will use interRAI and financial data to allocate available funding based on workload associated with weighted cases. The methodology will, when completely implemented, include financial incentives for achieving quality measures captured by the interRAI MDS 2.0 tool.

Efficiency – is where more output of a given quality cannot be achieved without increasing the amount of inputs. Efficiency within the health system can be classified into three categories: administrative, operational and allocative efficiency¹.

1. **Administrative Efficiency** – is the spending on administrative costs which is necessary to achieve the goals of the organization or the system as a whole. Administrative inefficiency is spending on administrative costs beyond what is necessary.

2. **Operational (or “Technical”) Efficiency** – is the level of production where it is impossible to produce, with given technology, a larger output from the same inputs, or the same output with less inputs. Operational inefficiency occurs in the form of excess costs in the production of a given output.

3. **Allocative Efficiency** – is the allocation of resources such that the inputs to the health system yield the best possible outcomes. An allocatively efficient health system produces an ‘optimal mix’ of health interventions.

**Resource Utilization Group (RUG)** – InterRAI Minimum Data Set (MDS) Version 2.0 assigns one or more RUG categories to each resident. A prioritization algorithm then assigns each individual to a main RUG category based on hierarchical rules, or using the RUG category with the highest Case Mix Index (CMI).

**Case Mix Index (CMI)** – Historically in Alberta, a Case Mix Measure (CMM) was assigned to each long term care resident, the average CMM was calculated for each facility, and then divided by the system-wide CMM to get a Case Mix Index (CMI) for each site. This CMI was then used as an acuity-based adjustment for reimbursement. The terminology is slightly different when the InterRAI systems are used. With these systems, a CMI is associated with each RUG category. The resident is assigned a CMI value associated with the main RUG category assigned to them. Because PCBF is intended to be a resident level funding system, there is no reason to produce site or system averages to determine a site’s funding. However, these averages are useful for reporting purposes.

**Long-Term Supportive** – a resident who is at significant risk of institutionalization due to unstable, chronic health conditions, and/or living condition(s) and/or personal resources.

**Continuing Care** – Continuing care is an integrated range of services supporting the health and wellbeing of individuals living in their own home or in a supportive living or long term care setting. Continuing care residents are not defined by age, diagnosis or the length of time they may require service, but by their need for services.

Source: AHW/AHS

**Home Living** – The primary housing option for persons who are able to live independently and with minimal support services. Home living is the housing option for persons who choose and who are able to maintain active, healthy, independent living while remaining in their family home as long as possible. In order to support continued independent living, basic Home Care services may be provided and/or the individual can purchase services from another agency.

Source: Adapted from ASCS Supportive Living Framework, 2007
Supportive Living – a home-like setting where people can maintain control over their lives while also receiving the support they need. The building is specifically designed with common areas and features to allow individuals to “age in place.” Building features include private space and a safe, secure and barrier-free environment. Supportive living promotes residents’ independence and aging in place through the provision of services such as 24-hour monitoring, emergency response, security, meals, housekeeping, and life-enrichment activities. Publicly-funded personal care and health services are provided to supportive living residents based on their assessed unmet needs.

Source: ASCS Supportive Living Framework, 2007

Long Term Care Facility – a purpose-built care setting providing care to individuals with complex unpredictable medical needs requiring 24 hour on-site Registered Nurse assessment and/or treatment. In addition, professional services may be provided by Licensed Practical Nurses and 24 hour on-site unscheduled and scheduled personal care and support are provided by Health Care Aides. Case management, Registered Nursing, Rehabilitation Therapy, and other consultative services are provided on-site. Long term care facilities include “nursing homes” under the Nursing Homes Act and “auxiliary hospitals” under the Hospitals Act.

Source: Adapted from AHS Living Option Guidelines

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1 The ASCS Supportive Living Framework outlines the services provided at each level of supportive living. The document is current being revised and updated.
## Appendix 2 - Criteria for Allocating QIF in Fiscal Year 2011/12

<table>
<thead>
<tr>
<th>Quality Incentive Submission Criteria</th>
<th>% of QI Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implementation plan and progress report for the conversion from RAI 2.0 RAPs to CAPs Or Implementation plan and progress report for site Quality Improvement initiative based on RAI 2.0 Quality indicators <em>(only applicable for those sites where CAPs software will not be available by March 2012)</em></td>
<td>35%</td>
</tr>
<tr>
<td>2. Action plan and progress report on: Medication Reconciliation on admission <strong>And</strong> Standardized Medication Review Process</td>
<td>25%</td>
</tr>
</tbody>
</table>
| 3. Influenza Immunization Rates for: Staff (2011/2012 target is 75%)*  
  75-89% receives half of the amount  
  90-100% receives full amount | 20%             |
| 4. Influenza Immunization Rates for: Residents (2011/12 target is 95%)*  
  90-94% receives half of the amount  
  95-100% receives full amount | 20%             |
Appendix 3 - LTC Accountabilities

While sites are expected to staff at least at funded levels, the accountabilities allow sites to accommodate special circumstances. Recoveries are dollar-equivalent to the extent thresholds have negative variances. Accountabilities are evaluated independently, but calculations will avoid inappropriate double-recovery.

1) Minimum 24x7 RN

2) RN + LPN + HCA paid hours will be 1.9 per unweighted client day

3) RN paid hours will be ≥ 0.418 paid hours per unweighted client day (22% of 1.9 RN + LPN + HCA paid hours)

4) RN + LPN + HCA + Professional Therapist + Non-Professional Therapist worked hours will be ≥ 2.97 per weighted client day (WCD). (This is the equivalent of 3.6 paid hours per WCD, converted at the provincial worked-hours-per-paid-hour ratio)

5) Minimum 75% of RN, LPN, HCA, Professional Therapist, and Non-Professional Therapist funded worked hours will be realized. (This limit is not be applied where funded worked hours are less than 0.3 FTE in a category)

6) Resident Care Management expenditure will be at the funded level (Recovery based on expenditure variance)

These will be monitored over the following year and amended if necessary. Care quality monitoring is in place to help ensure acceptable standards of care.

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1 Nursing Home Operations Regulations (258/1985, Section 14, subsection 1) which states “An operator shall have at least one nurse on duty at all times in his nursing home, and if at any time none of the nurses on duty are registered nurses or certified graduate nurses, the operator shall ensure that a registered nurse or certified graduate nurse is on call during that time.” Sites are expected to have RNs on-site versus on call, where possible.

2 Nursing Home Operations Regulations (258/1985, Section 14, subsection 5) states “An operator shall cause his nursing and personal services staff to provide an average of at least 1.90 paid hours of combined nursing and personal services per resident per resident day in his nursing home”. Interpretation confirmed with Alberta Health and Wellness, Continuing Care, Health Policy and Service Standards Development, January 18, 2012

3 Nursing Home Operations Regulations (258/1985, Section 14, subsection 6) states “An operator shall ensure that at least 22% of the total number of paid hours of combined nursing and personal services required to be provided by this Regulation is provided by nurses”. Interpretation confirmed with Alberta Health and Wellness, Continuing Care, Health Policy and Service Standards Development, January 18, 2012

4 Substitutions of some types of nurses for some types of therapists are allowed without recovery, as are substitutions of higher-skilled nurses for lower-skilled nurses
   - Professional Therapist recovery will not be applied if RN + Professional Therapist ≥ 75% of total funded
   - Non-Professional Therapist recovery will not be applied if RN + LPN + HCA + Non-Professional Therapist ≥ 75% of total funded
   - HCA recovery will not be applied if RN + LPN + HCA ≥ 75% of total funded
   - LPN recovery will not be applied if RN + LPN ≥ 75% of total funded

5 Currently set as the dollar equivalent of 0.074 worked hours per bed day (i.e., based on the number of beds) x provincial paid-to-worked ratio x provincial Resident Care Manager salary