ACCA
Alberta Continuing Care Association

Modernizing Alberta's Continuing Care Funding Model

POSITION PAPER

MAY 7, 2025

CONTENTS

Executive Summary

Alberta's continuing care sector is facing critical operational and financial pressures driven by an outdated funding model that no longer reflects the realities of modern care delivery. Developed in 2008, the current model fails to account for rising resident acuity, inflationary pressures, unionized staffing costs, capital renewal needs, and the demands of technological and system transformation.

Despite a comprehensive review of funding structures conducted by Alberta Health in 2018 -19 and reaffirmed by the 2021 MNP Facility-Based Continuing Care Review, the recommendations from those assessments have yet to be implemented. As a result, continuing care operators—particularly those serving high-acuity populations or operating in rural areas—are increasingly unable to sustain services within the current funding envelope.

In response, the Alberta Continuing Care Association (ACCA), through its Chief Financial Officers (CFO) Committee, undertook an in-depth, province-wide review of the funding and reporting structures underpinning continuing care. This position paper draws from that collaborative analysis, incorporating operational data and provider experience from across the sector. It outlines urgent funding challenges and proposes practical, evidence-informed solutions. The aim is to modernize Alberta's continuing care funding model in a way that ensures sustainability, fairness, and high-quality resident care.

Key Recommendations

1. **Update Health Services Funding Models**: Reform the Patient/Care-Based Funding (PCBF) model used in Type A (long-term care) and the Interim Provincial Model (IPM) used in Type B (supportive living) to better reflect real-time resident acuity, inflation, and actual service demands.

2. **Strengthen Assessment Tools**: Supplement or replace the RAI-MDS (Resident Assessment Instrument – Minimum Data Set) and RUG III+ (Resource Utilization Group) systems with tools that capture acuity in real time and allow for more responsive funding.

3. **Support Staffing Stability:** Update funding formulas to reflect wage increases, sick leave costs, and non-occupational accommodations. Establish stabilization funding to support rural providers and facilities with fewer than 70 beds to address fixed costs like leadership roles, insurance, and technology. Align Alberta's funding threshold with other provinces, where adjustments are made for facilities under 65 beds to reduce financial strain and sustain operations.

4. **Invest in Technology**: Create a dedicated Technology Fund to support IT infrastructure, cybersecurity, digital care tools and resident safety systems to align with Alberta's broader digital health goals.

5. **Address Resident Debt and Financial Risk**: Establish direct pay mechanisms for resident benefits (e.g., AISH, CPP, OAS), introduce a hardship reimbursement fund, and develop clear, ethical provincial policies for managing uncollectable accommodation fees.

6. **Reform Accommodation Fee Structures**: Move beyond basic Consumer Price Index (CPI) adjustments by incorporating region-specific cost drivers and exploring income-based or sliding-scale fee models.

7. **Enable Capital Renewal**: Establish a long-term capital planning framework to ensure facilities meet safety, accessibility, and modernization standards, particularly as Alberta adopts new Continuing Care Design Standards.

8. **Ensure Tax and Utility Fairness**: Implement provincial policy changes to grant municipal tax exemption and public utility rate eligibility to all publicly funded homes, regardless of care type or ownership model.

9. **Modernize Financial Reporting (FIRMS)**: Enhance the Financial Information and Reporting Management System by expanding data fields, improving standard definitions, and enabling operators to access and benchmark their own data.

These recommendations are grounded in real-world operator data and developed through extensive sector collaboration. They form a clear roadmap to modernize Alberta's continuing care funding model in ways that are fair, sustainable, and aligned with today's care realities. Two system-wide challenges emerge consistently across the paper and require urgent policy attention:

- **The funding gap is widening.**
  The current model redistributes limited resources but does not reflect actual costs. A structured "true-up" process permitted under the Master Services Agreement must be implemented to align funding with real-world conditions.

- **Rural–urban disparities are deepening.**
  Smaller and rural operators face higher per-unit costs, staffing instability, and limited capacity to absorb financial shocks. Inconsistent access to supports, including municipal tax relief, further compounds these pressures and contributes to systemic inequities that must be addressed within a revised funding model.

These cross-cutting issues are reflected throughout the paper and underpin many of the recommendations. Addressing them directly is essential to ensuring an equitable, sustainable, and future-ready continuing care system.

This paper represents more than a critique of outdated funding mechanisms—it offers a credible, sector-driven roadmap for reform. With the right leadership and commitment, Alberta can modernize its continuing care funding model to reflect today's realities and tomorrow's needs. The time to act is now.

Introduction

ACCA convened Chief Financial Officers from across Alberta's continuing care sector, including not-for-profit, private, faith-based, rural, urban, and regionally diverse providers, to share operational experiences and identify systemic issues in the current funding models. Their shared perspectives reveal that funding limitations are not isolated technical problems, but rather catalysts for deeper challenges affecting the accessibility, sustainability, and quality of continuing care services across the province.

While Alberta Health completed a comprehensive assessment of the funding model in 2018-19, the findings were not publicly shared or implemented. Operators continue to experience the consequences of outdated assumptions built into the 2008 model. These unaddressed issues now place many continuing care home operators in a position where sustainability is threatened, despite rising demand and increasing expectations for care delivery. This position paper proposes actionable solutions to address the most urgent challenges facing operators.

The MNP Facility-Based Continuing Care Review[1] reaffirmed these concerns, recommending that Alberta Health introduce more flexibility for program-based funding. The report acknowledged that the current funding system lacks responsiveness to changing resident needs and does not adequately support smaller operators, facilities with higher-acuity residents, or homes managing unionized wage pressures. Among its key recommendations was that Alberta Health should consider a thorough assessment of the underlying assumptions/principles/objectives and associated aspects of the funding model.

Position Paper Purpose

This position paper was developed by the Alberta Continuing Care Association's (ACCA) Chief Financial Officers (CFO) Committee through a province-wide collaboration involving continuing care operators across ownership models, geographies, and levels of care. The intent was to examine, with precision and urgency, the systemic funding challenges that jeopardize operational sustainability and service quality within Alberta's continuing care system.

Drawing on extensive operational data, first-hand provider experiences, and input from both rural and urban settings, this paper analyzes the key components of Alberta's current funding model — including

[1] MNP. (2021). *Improving Quality of Life for Residents in Facility-Based Continuing Care: A Review of the Facility-Based Continuing Care (FBCC) Program*. Retrieved from https://open.alberta.ca/dataset/f680d1a6-bee5-4862-8ea4-e78d98b7965d/resource/22092c9c-99bb-4fee-9929-7ce06e71bbd1/download/health-improving-quality-life-residents-facility-based-continuing-care-2021-04-30.pdf

health service funding (PCBF and IPM), assessment methodologies (RAI and RUG-III+), reporting frameworks (FIRMS), and associated issues such as capital infrastructure, staffing cost pressures, and resident affordability. Each section outlines specific issues, their implications, and detailed solutions proposed by sector CFOs.

The purpose of this paper is not only to describe the funding model's shortcomings, but to offer a forward-looking, solution-oriented roadmap for modernization. The recommendations that follow are structured to support government and system partners in aligning continuing care funding with today's realities, enabling fair, transparent, and sustainable resource allocation that meets the needs of residents, operators, and the broader health system.

An Overview of Continuing Care Home Funding Framework in Alberta

Alberta's continuing care sector operates under a blended funding model primarily structured around three core components:

1. **Health Services Funding** (publicly funded care component):
   Provided by Alberta Health Services (AHS), this covers nursing care, personal care, therapies, medications, and clinical staff wages. It is based on assessed resident acuity levels, most often calculated using the RUG-III Plus methodology, which is tied to the RAI-MDS assessment system (specifically for Type A facilities).

2. **Accommodation Fees** (resident-funded component):
   Residents are responsible for paying regulated accommodation fees that cover non-care items such as meals, housekeeping, administration, utilities, and building operations. These fees are capped and set annually by Alberta Health.

3. **Capital Investment** (infrastructure funding):
   Infrastructure support, when available, is provided through grants, Request for Expression of Interest (RFEI) processes, or ad hoc funding streams. There is currently no standardized capital planning model similar to what exists in Alberta Education or other health sectors. While new infrastructure investment is essential to meet care standards and support modernization, the cost of maintaining existing facilities has also increased significantly. Major repairs and lifecycle upgrades often outpace inflation and are not covered through operating funding or accommodation fees. A comprehensive capital strategy that addresses both new builds and ongoing maintenance is needed to ensure safe, sustainable care environments across all regions.

While these three components form the foundation of continuing care funding in Alberta, how they are applied and the challenges that arise can differ significantly depending on the type of care home. Alberta's system recognizes two primary models of facility-based care, each with its own funding structure, operational context, and policy implications. Understanding these distinctions is critical to

identifying where the current funding framework succeeds, where it falls short, and how reform efforts must be tailored to address the unique needs of each model.

Understanding the Two Care Models: Type A and Type B

“Type A” refers to Alberta’s publicly funded long-term care (LTC) homes. These facilities provide 24/7 nursing (RN & LPN) and personal care (HCA) to residents with complex medical, cognitive, and/or physical needs.

To fund these services, Alberta uses a 2008 model called Patient/Care-Based Funding (PCBF), a method that allocates dollars based on the care needs of residents, rather than simply the number of beds (see Appendix A for further technical detail).

“Type B" refers to Alberta’s publicly funded Designated Supportive Living (DSL) facilities. They are designed for individuals with moderate to high care needs who can no longer live independently. These facilities provide 24/7 nursing (LPN) and personal care (HCA). Type B homes bridge the gap between independent living and long-term care, offering both health and hospitality services in a residential setting.

To fund Type B services, Alberta uses the Interim Provincial Model (IPM) introduced in July 2023. While it aims to promote consistency and predictability across providers, it operates very differently from the PCBF model used in LTC and introduces challenges related to equity, flexibility, and responsiveness (see Appendix B for further technical detail).

Neither model includes support for capital infrastructure or facility renewal; they are designed to cover operational costs related to direct care delivery and administration.

Key Distinctions and Policy Implications

Despite these differences, there are important structural and operational similarities between Type A and Type B homes, particularly in how residents contribute financially through standardized accommodation fees and how providers operate under contract with Alberta Health Services (AHS).

To help clarify the relationship between the two models, a detailed comparison of the structural and funding characteristics of Type A and Type B continuing care homes is provided in Appendix C**.** The appendix highlights both the commonalities in funding, operations, and policy, and the distinct differences in how public dollars are allocated, what services are expected, and the degree of flexibility offered within each model.

These distinctions are critical, as they reveal the gaps in equity, responsiveness, and flexibility that exist within Alberta’s current funding framework. While both types of homes are expected to deliver high-

quality, person-centered care, only Type A homes are funded based on resident complexity (acuity), and neither model reflects the actual cost of providing care in today's environment.

Health Services Funding

Health services funding is the core publicly funded component of Alberta's continuing care model. It supports staffing and care delivery services such as nursing, personal care, therapies, and some clinical supplies. This funding is essential to ensuring residents receive the care they need and is structured differently across the two home types.

Understanding how each funding stream functions and where the challenges are is essential to developing an updated, sustainable funding model. The sections that follow provide an in-depth review of each component, beginning with health services funding.

Type A (Long-Term Care) – PCBF Model

Type A homes receive health services funding through the Patient/Care-Based Funding (PCBF) model. PCBF allocates funding based on resident acuity, calculated through standardized clinical assessments. Staff assess each resident using the Resident Assessment Instrument – Minimum Data Set (RAI-MDS 2.0), and those assessments are analyzed through the RUG-III Plus grouping algorithm, which assigns each resident a Case Mix Index (CMI) score. This score reflects the relative intensity of their care needs.

Funding is calculated using a formula based on:

- Number of funded beds
- Occupancy rate
- Average CMI score
- 365 days

This produces a metric called Weighted Resident Days (WRDs), which is then multiplied by hourly wage and care cost "constants" to determine each site's total allocation (see Appendix B for further technical detail).

While the PCBF model is intended to be responsive to resident complexity, operators report that it is limited by retrospective data, delayed assessments, and recalibration of RUG scores that may reduce funding even when acuity remains constant. These limitations are rooted in how resident acuity is assessed and translated into funding, specifically through the RUG III+ system.

Resource Utilization Group Version III Plus (RUG III+)

Alberta Health Services transitioned to the RUG III Plus methodology for resident assessments following the recommendations from the 2021 MNP Facility-Based Continuing Care Review and the

2023 Institute of Health Economics report on Funding Allocation Models for Continuing Care Homes. The RUG III Plus methodology is based on the CAN-STRIVE study conducted in the 2000s, which uniquely reflects Canadian health standards and Canadian resident data. It was intended to better represent the Canadian long-term care resident population and allow AHS to accurately capture the acuity and complexity of residents and efficiently allocate continuing care home resources.
However, the shift to RUG III+ has introduced measurable challenges, particularly in how resident acuity is captured and translated into funding levels. This has had downstream effects on staffing, care delivery, and financial predictability.

Implications

The implementation of RUG III+ has resulted in several unintended consequences that affect not only funding accuracy but also workforce stability, care quality, and system flexibility:

- **Lag Between Resident Needs and Funding**
  RUG III+ relies on delayed and retrospective assessment data (via the RAI-MDS 2.0). As a result, funding often lags behind actual resident needs, leaving operators unable to respond in real time to changes in acuity, particularly during periods of increased care demand.

- **Underrepresentation of Complex Care Needs**
  The categorical nature of RUG III+ oversimplifies resident profiles, leading to underfunding for individuals requiring behavioural support, IV or parenteral care, or with multiple co-morbidities. Homes serving high-acuity populations often cannot access the resources needed to meet care standards.

- **Volatility in Funding and Staffing Stability**
  Annual recalibrations can reduce CMI scores and therefore decrease funding, even when resident complexity remains unchanged. Mid-sized homes are especially affected, as they are not protected by legacy “funding floors.” This creates year-over-year funding variability, impacting staffing models and operational planning.

- **Limits on Innovation and Proactive Care**
  The reactive structure of the model discourages innovation, flexibility, and proactive care investments. Operators are unable to fund wellness, engagement, or non-clinical supports when all funding is tied to historical clinical data.

Recommendation #1: Update Health Services Funding Models

To improve the accuracy, fairness, and responsiveness of resident classification and funding allocation, ACCA recommends a targeted review of the RUG III+ algorithm and its integration with the Case Mix Index (CMI) methodology. This review should:

1. Identify and address gaps in how high-acuity needs are categorized (e.g., behavioural health, complex medical conditions).
2. Include stakeholder consultation and comparative analysis with funding models from other jurisdictions.
3. Introduce real-time acuity measures or interim funding mechanisms to support operators at the time of resident placement.
4. Explore adjustment factors or supplemental streams to ensure sustainable care for residents whose needs exceed current categorization.

While RUG III+ determines how residents are grouped for funding purposes, the accuracy and timing of those groupings depend entirely on the data generated by the Resident Assessment Instrument (RAI-MDS 2.0) — a tool that presents its own challenges in aligning funding with real-time resident needs.

Resident Assessment Instrument (RAI): Timing and Equity Challenges

The Resident Assessment Instrument (RAI-MDS 2.0) is a foundational clinical tool used to assess resident acuity and determine funding allocations in Type A continuing care facilities. However, the data it generates is inherently retrospective, reflecting past resident conditions rather than current acuity levels. This lag creates a misalignment between care needs and funding, preventing operators from adjusting staffing and resources in real time.

As resident complexity increases, frontline staff report growing stress and burnout due to care demands that outpace available resources. The delay in funding adjustments contributes to staffing shortages, operational strain, and suboptimal resident outcomes.

In addition, while RAI assessments drive funding in Type A homes, Type B homes do not use the RAI system, despite often supporting residents with similar or escalating levels of acuity. This inconsistency leads to inequitable funding between facility types based not on need, but on the assessment methodology tied to their model.

Implications

The system's dependence on retrospective RAI data results in multiple operational and equity challenges:

- **Delayed Funding Adjustments**: Funding lags strain cash flow and prevent timely responses to rising acuity, especially after hospital discharges.
- **Staffing Instability and Burnout**: Static funding amid rising care needs leads to understaffing, stress, absenteeism, and turnover.
- **Lack of Flexibility**: Without mid-cycle adjustment mechanisms, operators struggle to plan, reallocate, or adapt care models effectively.

- **Barriers to Innovation**: Tying funding to outdated clinical data discourages wellness-focused, preventive, or resident-directed care approaches.
- **Rural Disadvantages**: Rural and smaller providers face greater administrative burdens with outdated systems and limited staff. These challenges are compounded by staffing shortages and higher per-unit operating costs**,** placing them at a systemic disadvantage.
- **Funding Inequities Between Home Types**: Type B (supportive living) homes support residents with care needs that often mirror those in Type A (long-term care) homes. However, Type B are excluded from Alberta's acuity-based funding model and receive lower rates per classification of worker. This creates a systemic funding disparity that impacts quality and sustainability. The inequity is further compounded by inconsistent application of acuity assessments in Type B settings compared to Type A; and lower base funding rates, which do not reflect the actual complexity of resident care needs. As a result, operators of Type B homes are expected to deliver increasingly complex care without equitable funding, putting both workforce and resident outcomes at risk.

Without modernization, the sector will continue to operate reactively, undermining both the quality of care and operational sustainability.

Recommendation #2: Strengthen Assessment Tools

To ensure timely and equitable funding aligned with resident needs, ACCA recommends:

1. Introducing real-time or predictive acuity assessment tools that can supplement or modernize the current RAI approach.
2. Enabling interim funding adjustments between assessment cycles to respond in a more flexible way to shifts in resident needs.
3. Standardizing funding expectations across home types, so that resource allocation reflects actual acuity, not just the assessment model in use.
4. Expanding the use of care-based metrics or quality/performance indicators beyond the current RAI framework to support more equitable, outcomes-driven funding.

The limitations of Alberta's current assessment tools contribute to a persistent gap between resident needs and the funding available to meet them. As acuity rises without timely funding adjustments, operators are left to manage increasingly complex care demands within static budgets. Nowhere is this misalignment more visible than in workforce planning, where staffing models are strained by rising complexity, cost pressures, and system expectations. The following section explores these compounding staffing challenges in greater detail, along with the structural funding reforms needed to address them.

Staffing Cost Pressures and Funding Misalignment

Staffing costs represent one of the most significant and escalating financial pressures for continuing care operators across Alberta. Rising labour costs, increased sick leave, greater non-occupational accommodation requirements due to mental health challenges, and higher agency staffing reliance are not adequately reflected in current funding models.

Implications

Ongoing staffing cost pressures, combined with rigid funding mechanisms, are creating widening gaps between actual expenditures and available resources:

- Total care staffing costs have increased by 24% over the past five years, while operating funding has only increased by 16%.
- Wage increases resulting from collective bargaining agreements have not been matched by corresponding adjustments to the government-funded wage constants.
- Health Care Aide (HCA) wage funding lags 11.2% behind actual paid rates, creating persistent operational deficits.
- Increased sick leave and non-occupational accommodations, largely unfunded, have created staffing instability and operational risk.
- Accountability requirements have increased without a corresponding increase in flexibility, limiting operators' ability to deploy staff based on resident acuity or changing conditions.

Staffing Compression

Staffing compression occurs when the amount of government funding provided for staff wages does not keep up with the actual wages employers are required to pay. This typically happens when wages increase due to union agreements or inflation, but funding formulas are not adjusted to reflect those increases. As a result, operators are forced to pay the difference out of their own limited budgets, creating financial strain across other parts of the operation. This can impact staffing levels, reduce resources for resident programs, and compromise service quality. This issue affects providers in both urban and rural settings, as wage rates consistently exceed funded amounts across the province. A breakdown of these wage gaps for key staff types, including Licensed Practical Nurses (LPNs) and Health Care Aides (HCAs) is provided in Appendix D: Staffing Compression to Funded Amounts.

Agency Staffing Pressures

Rural and outbreak-affected sites are increasingly dependent on agency staffing to maintain care levels. This has significant cost implications and disrupts continuity of care for residents:

- Agency staffing costs are more than double those of in-house staff.
- Agency reliance costs approximately $1,900 per resident annually.
- Agency use has increased by 68% over five years; sick leave has risen by 34%.

- Small and rural operators are disproportionately affected by these pressures due to workforce shortages and geographic limitations.

Recommendation #3: Support Staffing Stability

To align funding with real workforce pressures and support service continuity, ACCA recommends:

1. Adjusting funded wage constants annually to reflect actual negotiated wage increases, including associated benefits and premiums. Funding should also account for a base level of staffing support and overtime requirements, which are essential to maintaining safe, stable care.
2. Providing supplemental funding to offset increased costs related to sick leave, non-occupational accommodations, and agency staffing reliance.
3. Introducing a rural staffing stabilization fund to support recruitment and retention in high-vacancy and remote areas.
4. Aligning staffing-related accountability requirements with flexible funding tools that enable real-time response to resident and workforce needs.
5. Revisiting staffing assumptions for rural and mid-sized operators with fewer than 70 beds. These facilities struggle to absorb fixed operational costs (e.g., Executive Director, Maintenance Manager, Resident/Programs Manager, Office/Operations Manager) as well as fixed costs like insurance, technology, and administrative overhead. Alberta's current fixed funding threshold of 34 beds is much lower than Ontario and Manitoba, where adjustments are made for facilities under 65 beds. Alberta should consider aligning its model with these jurisdictions to reduce financial strain and support operator stability.

Addressing workforce funding gaps is essential, but it is only one part of the solution. As care demands continue to rise, operators also need tools that enhance efficiency, reduce administrative burden, and support staff in delivering safe, high-quality care. Technology plays a critical role in this equation, yet the current funding model does not reflect or support its integration. The next section explores how modernizing Alberta’s approach to technology investment can help ease staffing pressures, improve care outcomes, and build long-term system resilience.

Technology

The current funding model remains rooted in traditional care delivery methods and does not account for technological advancements that could enhance efficiency, improve resident care, and reduce reliance on labour-intensive processes. Operators face significant barriers in adopting modern care solutions due to outdated IT infrastructure, limited capital investment opportunities, and rising technology costs.

Many communities, particularly those in rural or smaller settings, struggle to maintain even baseline technology such as electronic health records, secure Wi-Fi, and resident engagement platforms because a dedicated funding stream to support these necessary upgrades does not exist.

The cost of software licensing, cybersecurity, and IT maintenance continues to rise annually while operating margins remain constrained. Without investment in innovation, care providers are unable to implement solutions that could improve workflow automation, enhance resident safety, and optimize staff efficiency, ultimately leading to a greater reliance on traditional staffing models that are already under strain.

Implications

A lack of dedicated funding for digital infrastructure has wide-ranging implications for care quality, system efficiency, and the sector's ability to modernize:

- The absence of dedicated funding for information technology in continuing care hinders efficiency, reduces care quality, increases staff pressures, and creates disparities between facilities.
- As healthcare becomes increasingly digitized, the sector's reliance on outdated systems prevents modernization and innovation, reinforcing inefficiencies and higher operational costs.
- Without investment in IT infrastructure, continuing care facilities risk falling further behind other areas of healthcare, leaving residents, families, and staff without the benefits of technological advancements that could improve safety, efficiency, and overall quality of care.
- The current funding model, based on per-hour or per-worker allocations, provides no flexibility to leverage technology in ways that could reduce staffing pressures or support alternative care models. Operators cannot access operating funds to implement or sustain technology-enabled solutions, even when such tools could offset workforce strain.

Recommendation #4: Invest in Technology

To bridge the digital divide and support modernization in continuing care, several key strategies should be considered:

1. **Establishing a Dedicated Technology Fund** to support ongoing investment in essential IT infrastructure, digital care platforms, cybersecurity, and resident safety and engagement technologies. This fund should:
    - Cover both capital and operational technology expenses (e.g., Wi-Fi upgrades, electronic health record systems, licensing, cybersecurity, call bell and resident security/safety systems).
    - Align with broader healthcare digital transformation priorities to ensure system interoperability and integration.

    Ontario's approach offers a useful precedent. Its Medication Safety Technology (MST) and Information Technology Safety (ITS) programs delivered multi-year support for digital

adoption in continuing care. These included a base allocation per home (~$30,000) and an additional amount per bed recognizing that foundational technology costs exist regardless of scale and that base funding is critical to enable participation by small homes.

2. **Leveraging Sector Partnerships to Guide Investment**: One example is the multi-stakeholder Technology Innovation and Investment Roadmap, a collaboration between the Alberta Continuing Care Association (ACCA), Alberta Association on Gerontology (AAG), and Alberta Innovates. This initiative aims to build a coordinated three-year plan to guide investment, support scalable solutions, and promote innovation adoption across Alberta's continuing care system. While not a substitute for dedicated funding, the Roadmap initiative offers a valuable resource to inform government priorities and sector readiness.

3. **Incentivizing Technology Adoption** through policy levers, demonstration projects, and streamlined procurement pathways for technologies that improve care quality, workforce efficiency, or resident experience. Encourage uptake of technologies that enhance care quality, workforce efficiency, and resident experience by:
    - Creating demonstration project opportunities and streamlining procurement pathways.
    - Allowing operators to submit business cases for technology-enabled operating efficiencies or quality improvements.
    - Adjusting the funding model to accommodate technology-related savings or costs particularly considering new design standards which increase baseline operating costs.

Without changes to the funding model, there is no incentive or ability for operators to invest in ongoing technology, even when those investments could significantly improve outcomes or reduce pressure on the workforce.

While investment in technology is critical to support modernization and reduce workforce strain, operators also face persistent financial vulnerabilities that technology alone cannot resolve. Chief among these is the growing exposure to resident debt, as homes are increasingly required to absorb unpaid accommodation fees without recourse or reimbursement. The next section examines this overlooked pressure point, and the policy solutions needed to protect both residents and providers within Alberta's continuing care system.

Resident Debt and Financial Risk Exposure

Operators across both Type A and Type B continuing care homes rely on regulated accommodation fees paid by residents to support non-care services such as meals, housekeeping, and facility operations. However, the current funding model does not include a mechanism to help address situations where accommodation fees go unpaid.

Residents may fall behind on payments for various reasons, including limited income, delays in accessing benefits such as AISH, challenges with financial decision-making, family refusal or elder

abuse. As residents cannot be discharged from care due to non-payment, operators are required to continue delivering services while managing the financial shortfall. Legal recovery options are often limited, resource-intensive, and result in low rates of repayment. Over time, these unpaid amounts accumulate and place additional strain on operating budgets that are already under pressure.

Implications

Without provincial mechanisms to manage bad debt, operators face multiple risks and systemic challenges:

- **Access and Equity Risk**: Operators may avoid admitting residents who are known or perceived to have difficulty paying fees, potentially keeping vulnerable individuals in more expensive acute care settings longer than necessary.
- **Quality Risk**: Operators may be forced to subsidize unpaid fees by cutting costs elsewhere, such as reducing staffing, lowering food or service quality, or reallocating funds intended for care delivery.
- **Operational Burden**: Care providers are ultimately responsible for collecting unpaid co-payments, which have become administratively complex, resource-intensive, and emotionally taxing for administrative and care staff. Time spent navigating debt recovery diverts attention away from core care responsibilities and contributes to workforce stress.
- **Systemic Constraints on Operators**: Current AHS contracts require operators to admit residents within 24 hours of referral, with no ability to screen for financial risk or delay admission. Eviction for non-payment is not a permitted option, and operators are required to continue care regardless of delinquency.
- **Administrative Strain on Social Work Teams**: Social work and administrative staff are increasingly tasked with helping residents and families navigate benefit entitlements (e.g., AISH, OAS, CPP), often without timely resolution, particularly when no Power of Attorney or responsible financial agent is in place.
- **Vulnerability of Dementia and Complex Care Residents**: Residents without financial advocates or legal representation are at higher risk of non-payment. Even when admission agreements outline financial responsibilities, operators face limited legal recourse when a resident's decision-maker fails to pay or misappropriates funds.

Recommendation #5: Address Resident Debt and Financial Risk

To reduce financial risk and support operational stability, particularly in cases where residents are unable or unwilling to pay, ACCA recommends:

1. **Introducing Direct Pay Mechanisms** that allow operators to receive benefits (e.g., AISH, CPP, OAS) directly in cases of chronic delinquency or elevated risk.

2. **Creating a Designated Hardship Fund or Reimbursement Pool** for documented uncollectable resident accommodation debts, particularly where no Power of Attorney or financial resolution is possible.
3. **Providing Legislative and Policy Clarity** to support operators in managing collections ethically and legally while maintaining uninterrupted care and compliance with regulatory expectations.
4. **Conducting a Jurisdictional Scan and Policy Analysis** to evaluate how other provinces manage resident debt in publicly funded care settings, including collection responsibilities, public trustee involvement, and co-payment enforcement. This would help inform a made-in-Alberta model that balances fiscal responsibility with resident protection and operational feasibility.

   Ontario reimburses 50% of unpaid balances at the time of the Annual Reconciliation Report (ARR) with proof of three collection attempts, though funds are received up to three years later. Manitoba funds 75% of uncollected balances within 90 days of resident discharge, also requiring documented collection efforts. These models offer insight into balancing fiscal responsibility with resident protection and operational feasibility. Alberta should develop a clear, ethical framework for managing uncollectable accommodation fees, one that supports provider sustainability while safeguarding access to care.

In addition to the risk of unpaid accommodation fees, operators face structural limitations in how those fees are set and adjusted under provincial policy. Even when residents do pay in full, the regulated rates often fall short of covering the actual cost of non-care services, particularly in high-cost or rural environments. As a result, operators are caught between affordability mandates and fiscal realities with few levers to maintain financial sustainability. The next section explores the broader limitations of Alberta's current accommodation fee model and options for a more responsive approach.

Accommodation Fees and Inflationary Adjustments

Accommodation fees are charged to residents in both Type A and Type B continuing care homes to cover non-care-related expenses such as meals, housekeeping, maintenance, and utilities. These fees are regulated and capped annually by Alberta Health, and increases are typically tied to the Consumer Price Index (CPI), a broad inflation measure based on household goods and services.

While CPI-based adjustments are designed to ensure affordability for residents, they do not reflect the real-world costs faced by operators. Key expenses such as interest rate fluctuations, rising utility and insurance costs, construction fees and aging infrastructure repairs far exceed CPI growth. This creates an increasing gap between what operators can recover through accommodation fees and what they are required to spend to maintain quality, safety, and compliance.

Implications

The current accommodation fee structure leaves operators with limited tools to respond to:

- Maintenance and capital renewal needs in aging or outdated buildings
- Rising borrowing costs associated with facility construction or refinancing
- Labour pressures, including wage increases for non-AHS-funded positions
- Escalating renovation and energy retrofit costs required to meet regulatory or environmental standards

Operators are forced to absorb these costs, delay upgrades, or divert funds from other areas, affecting financial sustainability, resident comfort, and long-term planning. These financial pressures are magnified in rural settings, where smaller scale and geographic isolation make it harder to offset rising costs or access additional support.

National Context

A review of provincial models reveals that Alberta is one of the few provinces that relies solely on flat-rate, CPI-adjusted accommodation fees. In contrast:

- British Columbia, Manitoba, and Saskatchewan use income-tested or sliding-scale models, allowing for greater responsiveness to both resident affordability and operator financial realities.
- Alberta's approach offers simplicity but lacks the flexibility to address individual resident needs or local operating cost pressures.
- Current regulated monthly fees in Alberta range from $2,047 (shared room) to $2,366 (private room), with a legislated minimum disposable income of $357. These fixed rates make it difficult to recover actual costs in higher-expense environments.

Recommendation #6: Reform Accommodation Fee Structures

To support sustainability while maintaining resident affordability, Alberta should modernize its approach to accommodation fee adjustments by:

1. Establishing a supplemental adjustment mechanism that accounts for cost pressures beyond CPI, including:
    - Regional variations in cost of living, interest rates, and utility rates
    - Capital renewal and deferred maintenance pressures

2. Developing a regionally responsive escalation index or cost pressure factor to augment CPI for eligible operators, particularly in rural or high-cost settings.

3. Conducting a review of income-based models used in other provinces to determine the feasibility of offering more flexible or equitable structures in Alberta.

4. Providing targeted grants or funding supplements for maintenance backlogs, environmental retrofits, and renovation expenses that cannot be recovered through regulated accommodation fees. This is a particular pressure for operators of older homes, including those with smaller scale or rural locations. Other provinces offer models Alberta could adapt, for example:
    - Manitoba provides $3 per resident per day for capital spending, tracked and reconciled over three years, with unused funds returned.
    - Ontario offers Comprehensive Minor Capital Funding, which covers maintenance, structural repairs, safety improvements, and falls prevention. It includes a base funding allocation recognizing that every site has foundational costs plus a variable portion based on resident volume.

A made-in-Alberta approach could build on these principles to create a predictable and scalable funding stream that supports infrastructure quality and risk mitigation across all provider types. By better aligning fee structures with actual costs, while protecting low-income residents, Alberta can ensure long-term viability for care providers and safe, quality living environments for residents.
Beyond day-to-day cost pressures, operators also face mounting challenges in maintaining and upgrading the physical infrastructure of care. Current accommodation fee structures do not offer a pathway to recover capital renewal costs, and there is no standardized public investment strategy to support long-term facility upgrades.

As expectations around care environments continue to evolve, including new design standards, infection control, and resident safety, the absence of a coherent capital planning model leaves providers without the tools to invest in the future. The next section outlines the urgent need for a province-wide capital renewal framework that aligns with modernization goals and system sustainability.

Capital Investment and Infrastructure Renewal

While the focus of this paper is operational funding, it is critical to recognize the interdependence between operational stability and capital infrastructure. Alberta's continuing care system cannot be modernized or sustained without addressing the physical spaces in which care is delivered.

Many continuing care homes, particularly older Type A and B facilities, face significant capital renewal needs. These include essential upgrades to meet new Continuing Care Design Standards (CCDS), address aging infrastructure, and support the delivery of safe, high-quality care. Operators also require funding for technology modernization and for adapting facilities to resident needs, such as private rooms, infection control improvements, and smart building systems.

Recommendation #7: Enable Capital Renewal

The CFO Committee supports the direction and recommendations outlined in ACCA's Capital Infrastructure Position Paper (March 2025), which provides a roadmap for addressing the critical

infrastructure and capital planning gaps in Alberta's continuing care sector. We echo key priorities, including:

- Establishing a structured, multi-year capital planning framework aligned with Alberta's broader capital investment strategy.
- Strengthening and formalizing the separation of capital and operational funding streams through a long-term, transparent planning framework to ensure predictability and equity across the sector.
- Providing funding flexibility to meet the new CCDS requirements, particularly for small-home models and rural operators.
- Enhancing transparency and accessibility in capital grant processes.
- Ensuring that all operator types, including non-profit and independent providers have equitable access to capital investment opportunities.

Alberta cannot deliver a modern, integrated, and high-performing continuing care system without also investing in the bricks, mortar, and digital infrastructure required to support it. Both operational and capital investments are essential to future-ready care.

To help catalyze this investment, the Alberta Continuing Care Association will host a national think tank, Invest in Alberta's Continuing Care Sector, on June 17, 2025, in Edmonton. This event will convene C-Suite policymakers, investors, and industry leaders from across Canada to explore strategic opportunities for innovation, capital financing, and sustainable growth in the broad continuing care ecosystem.

With a strong economic foundation, a growing aging population, and an urgent need for infrastructure renewal, Alberta is uniquely positioned to become a national hub for aging-related innovation and investment. This upcoming dialogue is a key opportunity to align strategic capital planning with bold, forward-thinking solutions that will shape the future of care in Alberta.

For a comprehensive overview of infrastructure priorities, please refer to the 2025 Capital Infrastructure Position Paper (https://www.ab-cca.ca/public/download/files/261536).

In addition to the absence of a coordinated capital investment strategy, continuing care operators face other structural inequities that impact financial sustainability. Chief among these is the inconsistent application of tax exemptions and utility rates across provider types. While all operators are expected to deliver publicly funded care within provincial standards, not all receive equitable treatment under municipal or provincial regulations. The following section outlines how aligning tax and utility policy with care delivery expectations can help create a more consistent and sustainable operating environment.

Tax Exemptions

Presently, only Type A homes benefit from municipal property tax exemption, creating disparities among care providers and undermining equity across the continuing care system. The lack of consistent tax treatment adds operational complexity and financial strain for both not-for-profit and independent providers that deliver publicly funded care under contract with Alberta Health Services.

It has been publicly stated by Alberta Health that Type B and Type C homes would also be tax-exempt under the Community Organization Property Tax Exemption Regulation (COPTER). ACCA has been actively advocating for the Ministry of Municipal Affairs to follow through on this commitment by formalizing tax exemption for Type B homes (designated supportive living) and Type C homes (publicly funded hospice settings), including those operated by independent providers.

Implications

The inconsistent application of tax exemptions across provider types leads to several financial and operational consequences for the continuing care sector:

- This inequity imposes direct financial strain on some operators while others receive tax relief for similar services.
- It discourages investment in care services, limits the expansion of needed capacity, and contributes to operational inefficiencies.
- Increased administrative work and financial burdens detract from care delivery, redirecting valuable staff time and funding away from resident support and quality improvement. The financial impact of inconsistent tax treatment is especially challenging for rural providers, who have fewer resources to absorb these additional operating costs.

Recommendation #8: Ensure Tax and Utility Fairness

To ensure equitable treatment of all publicly funded continuing care operators and to reflect Alberta Health's prior commitments, ACCA recommends:

1. Amending provincial legislation to grant tax-exempt status to Types B and C homes, ensuring consistency and aligning with COPTER's principles of equitable treatment for public-benefit organizations.
2. Establishing a standardized provincial framework to ensure consistent access to municipal tax exemptions and public utility rates or, alternatively, providing equivalent grants to offset these costs. This approach would reduce administrative burden and ensure fairness across provider types, including independent and faith-based operators.

A fair and sustainable funding environment requires not only equitable policies, but also effective tools to support planning and accountability. One such tool is the Financial Information and Reporting Management System (FIRMS), which is Alberta Health's primary mechanism for collecting financial and operational data from continuing care providers. The next section highlights how modernizing FIRMS

can help bridge the gap between policy intent and operational reality, enabling better planning, transparency, and evidence-based funding decisions. Without standardized definitions, accessible data, or meaningful feedback loops, operators face significant administrative burden without corresponding value.

Financial Information and Reporting Management System (FIRMS)

As Alberta's continuing care sector works toward modernization, reliable, actionable data will be essential to drive effective policy, funding decisions, and system transformation. One of the most underutilized tools in this regard is the Financial Information and Reporting Management System (FIRMS), a resource that, with targeted improvements, could better support both accountability and strategic planning.

FIRMS is Alberta Health's primary system for collecting quarterly financial and statistical data from continuing care operators. It plays a vital role in capturing operational information intended to inform funding decisions, support accountability, and provide a standardized picture of the sector. However, despite this important function, FIRMS has not yet realized its full potential as a decision-making or planning tool for either government or providers.

Operators have identified several technical and usability challenges that limit the system's value. Definitions for expenditure categories, bed types, and room classifications remain unclear or inconsistently applied, reducing the reliability and comparability of submitted data. This creates challenges not only for operators attempting to report accurately but also for government analysts using the data to shape broader policy and funding models.

Additionally, important cost drivers such as IT infrastructure, deferred maintenance, and overtime are not captured in a way that reflects their growing impact on operational budgets. As these pressures continue to increase, the absence of these elements from FIRMS creates a disconnect between reported expenditures and the actual cost of delivering high-quality care.

Operators also note that there is no mechanism to access or analyze their own data once submitted, nor a clear understanding of how FIRMS data informs policy or funding decisions. As a result, FIRMS is often viewed more as a compliance obligation than a strategic resource, a perception that could be addressed through modernization, collaboration, and transparency.

Implications

While FIRMS was designed as a financial reporting and accountability tool, its current structure creates several challenges that limit its usefulness for operators and policymakers:

- Quarterly reporting requires significant administrative effort but does not currently support internal planning or system-level reform. For rural operators, these administrative burdens are even more difficult to manage due to limited staffing and capacity.

- Lack of standardized definitions limits consistency and weakens the overall quality of data.
- Key operational pressures, including IT, infrastructure, and workforce dynamics, are missing from the dataset.
- Improved transparency and usability could enhance FIRMS as a shared planning and accountability tool.

Recommendation #9: Modernize Financial Reporting (FIRMS)

To improve reporting consistency, financial transparency, and data utility, ACCA recommends the following enhancements to FIRMS:

1. Co-developing standardized definitions and classification guidelines with operators, especially for expenditures, beds, and room types, to improve consistency and data quality.
2. Expanding FIRMS data fields to include emerging and underreported cost pressures such as IT systems, deferred maintenance, and overtime expenditures.
3. Introducing an operator-facing dashboard or reporting interface to allow providers to view, analyze, and benchmark their own data against anonymized sector-wide trends.
4. Strengthening transparency and communication by providing regular updates on how FIRMS data is being used to inform funding models, operational policies, and strategic decisions.

Conclusion

Alberta's continuing care sector stands at a pivotal moment. With rising resident complexity, mounting financial pressures, and an urgent need for infrastructure renewal, the status quo is no longer sustainable. This position paper has identified critical issues within the current funding framework, provided real-world examples from operators across the province, and proposed concrete, actionable solutions rooted in operational evidence and fiscal responsibility.

The recommendations outlined are not aspirational; they are practical and achievable, informed by those on the front lines of care delivery. They reflect the sector's readiness to partner with government to co-design a modernized funding approach that is transparent, equitable, and accountable. Operators are not asking for more funding without rationale; they are asking for a funding model that reflects the true cost of care, enables innovation, supports rural and urban viability, and ensures residents receive the level and quality of care they deserve.

Now is the time to act. By working together, we can build a funding system that not only sustains continuing care today but positions it to meet the needs of tomorrow. The opportunity is here to stabilize the sector, invest wisely, and chart a course toward a stronger, more integrated future for Alberta's continuing care system.

Acknowledgements

The Alberta Continuing Care Association would like to extend its sincere appreciation to the members of the Chief Financial Officers Committee for their leadership, time, and expertise in the development of this position paper.

This work reflects a significant cross-sector effort to articulate the financial realities, pressures, and priorities facing Alberta's continuing care home providers. The insights shared by CFOs from across the province are drawn from their direct experience managing operational and capital funding in diverse settings and have been critical in shaping the analysis and recommendations presented in this paper. Their collective voice underscores the need for an updated, equitable, and sustainable funding framework that supports the delivery of high-quality care for Alberta's seniors, now and into the future.
The following individuals contributed to the development of this position paper as members of the CFO Committee:

Karim Kassam (Chair) Optima Living
Maira Ali, Father Lacombe Society
Karyn Golem, The Brenda Strafford Foundation
Omar Khrushed, Shepherds Care Foundation
Natalie Ku, Optima Living
Lilliana Levesconte, Good Samaritan Society
Linda Revell, Connecting Care
Anna Sereda, Covenant Care
Mark Trenholm, Extendicare
Connie Young, Bethany Care Society
Adam Zanoni, Lethbridge Family Services

Alberta Continuing Care Association:
Abdu El-Zein
Denise Milne
Tara Preston

Appendix A

Current Funding Model for Type A Continuing Care (LTC)

This appendix provides a technical overview of Alberta's PCBF model, which applies to publicly funded Long-Term Care (Type A) homes. For the funding structure for Type B (Designated Supportive Living) homes, see Appendix B.

UNDERSTANDING THE PCBF MODEL

"Type A" refers to Alberta's publicly funded long-term care (LTC) homes. These facilities provide 24/7 nursing and personal care to residents with complex medical, cognitive, or physical needs. To fund these services, Alberta uses a model called Patient/Care-Based Funding (PCBF), a method that allocates dollars based on the care needs of residents, rather than simply the number of beds.

HOW THE PCBF MODEL WORKS

PCBF is designed to allocate public care funding (not accommodation costs) using four key inputs:

1. Funded Beds: the number of LTC beds approved and funded at the facility, based on the previous fiscal year (as of March 31).

2. Occupancy Rate: the percentage of beds that were actually used in the previous calendar year, calculated as Resident Days ÷ Bed Days.

3. Resident Acuity – Case Mix Index (CMI): every resident is assessed by clinical staff using a tool called Resident Assessment Instrument – Minimum Data Set (RAI-MDS 2.0). This assessment is run through the Resource Utilization Groups III Plus (RUG-III+) algorithm, which assigns residents to a category reflecting their care needs. Each category has a CMI value, a numeric score showing how resource-intensive that resident is to care for.

4. Funding Constants: these are government-set hourly funding rates for different care providers (e.g., RNs, LPNs, HCAs) and other care-related costs.

These four elements are used to calculate something called Funded Weighted Resident Days (WRDs), the cornerstone of PCBF:

WRDs = Beds × Occupancy × CMI × 365 days

WRDs are then multiplied by the funding constants to determine the budget each site receives for direct care.

WHAT PCBF COVERS (PUBLIC FUNDING PORTION)

- Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Health Care Aides (HCAs)
- Therapy and rehabilitation staff
- Clinical supplies
- Resident Care Management (RCM) and some administrative support
- Special top-ups (e.g., northern allowance, minimum staffing adjustments)

WHAT PCBF DOES NOT COVER

- Meals, laundry, housekeeping, and utilities (these are covered by resident accommodation fees)
- Building maintenance or capital renewal
- Digital health systems, technology, or innovation initiatives
- Leadership development or recreation
- Emergency needs or flexible staffing in outbreaks

HOW IT WORKS IN PRACTICE

While PCBF is theoretically responsive, funding increases as resident needs increase, in practice, it has serious limitations:

- Lagging Data: assessments are often months out of date. Funding is based on the prior year's acuity and occupancy, not current resident needs.

- Outdated Cost Assumptions: the model is built on 2008-era costs and staffing assumptions. Even with annual inflation adjustments, it doesn't reflect real-world expenses, especially for wages, recruitment, and clinical supplies.

- Rigid Structures: sites have little flexibility to reallocate funding. For example, if resident needs shift mid-year, operators can't easily adapt.

- Inconsistent Impact: small and rural sites, or those not covered by historical "funding floors" are especially vulnerable.

- Staffing Compression: when wages increase through collective bargaining, PCBF funding often doesn't keep pace, leaving operators to cover the shortfall.

THE BIGGER ISSUE

PCBF is a distribution tool, it divides a set amount of money based on resident acuity, but that amount is too small, built on outdated assumptions, and inflexible to modern care realities. In short, PCBF doesn't determine how much funding the sector gets, just how the available dollars are split.

SUMMARY

The Patient/Care-Based Funding (PCBF) model was a meaningful step toward acuity-based funding and works better than a flat-rate approach. However, it is built on a 15-year-old foundation that no longer reflects the true complexity, cost, or expectations of today's long-term care. It redistributes limited dollars but does not modernize or expand the funding pool. A new model is urgently needed, one that adjusts to resident needs in real time, supports innovation and workforce stability, ensures equitable funding across home types, and reflects actual operating costs.

Appendix B

Understanding the Funding Model for Type B Continuing Care (DSL) in Alberta

"Type B" refers to Alberta's publicly funded Designated Supportive Living (DSL) facilities. These homes are designed for individuals with moderate to high care needs who do not yet require 24/7 nursing but can no longer live independently. They bridge the gap between independent living and long-term care, offering both health and hospitality services in a residential setting. To fund DSL services, Alberta uses the Interim Provincial Model (IPM) introduced in July 2023. While it aims to promote consistency and predictability across providers, it operates very differently from the PCBF model used in LTC and introduces challenges related to equity, flexibility, and responsiveness.

HOW THE IPM MODEL WORKS

IPM uses a fixed formula to calculate funding, based on theoretical averages rather than real-time data:

1. Fixed Weighted Resident Days (WRDs)
   • Assumes 100% Occupancy — every bed is considered full year-round.
   • Case Mix Index (CMI) of 100 — each resident is treated as having average care needs.
   This means the formula does not reflect actual occupancy or the complexity of residents being served.

2. Standardized Staffing Assumptions
   • Care hours per bed are pre-set for HCAs, LPNs, and Recreation roles.
   • Hours are multiplied by the number of beds and adjusted for paid-to-worked ratios to generate funding.

3. Leadership and Admin Funding
   • Facilities receive funding for a Director of Care and Staff Educator based on bed numbers.
   • Administrative top-ups:
     - 0–20 beds: +10%
     - 21–50 beds: +7.5%
     - 51+ beds: +5%

WHAT IPM COVERS (PUBLIC FUNDING PORTION)

- Health Care Aides and Licensed Practical Nurses
- Recreation Therapists and Assistants
- Director of Care and Staff Educator roles
- Modest administrative overhead (scaled by site size)
- Minimum staffing top-ups for small/rural facilities

WHAT IPM DOES NOT COVER

- Registered Nurses (RNs), even when required by resident complexity
- Real-time resident assessments or case mix variations
- Digital infrastructure or technology
- Innovation, recreation, or flexible program supports
- Capital renewal, maintenance, or surge capacity

HOW IT WORKS IN PRACTICE

- Homes caring for more medically complex residents receive no additional funding.
- Operators facing staffing pressures, outbreaks, or occupancy challenges receive no adjustments.
- The model locks homes into fixed assumptions while still enforcing staffing expectations.
- Key roles (like RNs and clinical coordinators) are excluded, even when needed for quality care.
- Digital, leadership, and quality-of-life investments must be funded from elsewhere or not at all.

THE BIGGER ISSUE

- IPM treats all homes and residents the same, regardless of actual complexity or utilization.
- It is not a true acuity-based model, unlike PCBF.
- While it simplifies administration, it can lead to inequitable outcomes, especially for smaller or higher-needs operators.
- And despite its name, the 'interim' model is being used as if it's permanent, with staffing and funding decisions now being made around it.

SUMMARY

The IPM model provides structure but not flexibility. It does not reflect the actual needs of residents, the complexity of operations, or the demands of modern care. A future-ready model must:

- Incorporate real-time acuity and occupancy data
- Recognize multidisciplinary staffing needs (including RNs)
- Support innovation, digital tools, and capital renewal
- Align funding with expectations for quality, safety, and access

The IPM model is a step forward in creating equity and consistency across Type B homes, but it remains in 'interim' form. To be effective, the model must evolve to reflect actual resident complexity, occupancy variation, regional staffing realities, and innovation needs. Without these improvements, the IPM risks underfunding operators who are already supporting high-needs residents in community-based settings.

Appendix C

Comparison of Type A and Type B Continuing Care Homes in Alberta

This table outlines the key similarities and differences between Alberta's two primary types of facility-based continuing care homes: Type A (Long-Term Care) and Type B (Designated Supportive Living). It highlights how the models align or diverge across funding, service delivery, and operational expectations.

COMMON ELEMENTS BETWEEN TYPE A AND TYPE B HOMES

Category	Description
Accommodation Fees	Residents in both types pay regulated monthly fees set by Alberta Health for meals, housekeeping, and building operations.
AHS Oversight	Both operate under service agreements with Alberta Health Services (AHS).
Core Staffing Roles	Both include HCAs, LPNs, and (in some cases) therapy staff or contracted professionals.
Capital Gaps	Neither model includes a standardized capital funding stream.
Public/Private Mix	Both include publicly funded services delivered by a mix of public, private, and non-profit providers.

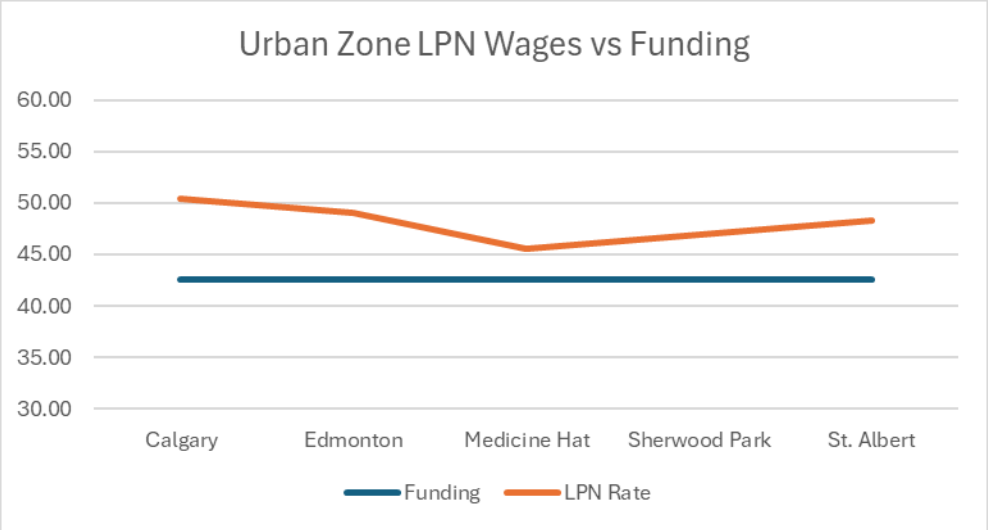
KEY DIFFERENCES BETWEEN TYPE A AND TYPE B HOMES

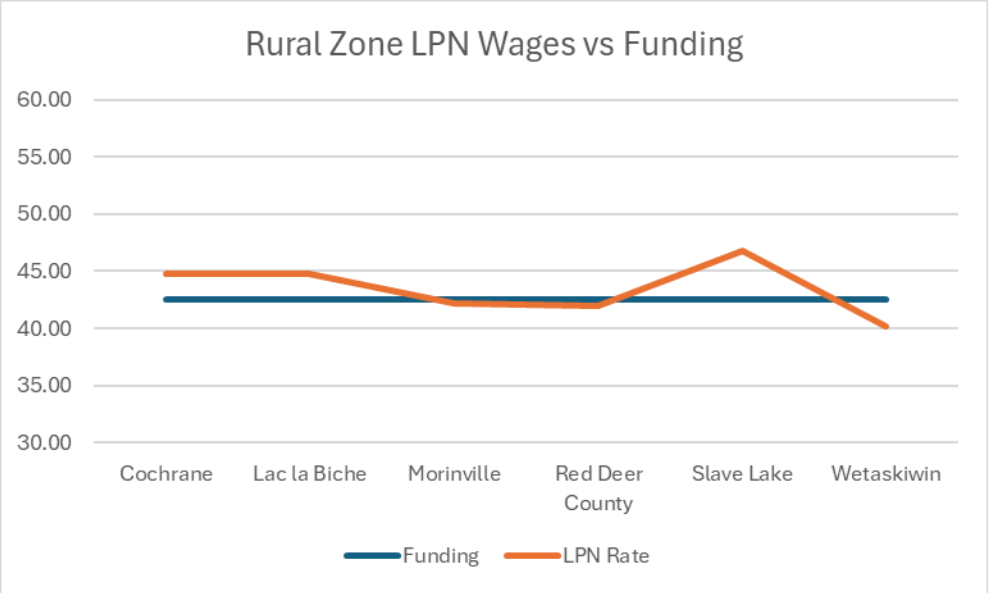
Category	Type A (Long-Term Care)	Type B (Designated Supportive Living)
Funding Model	Patient/Care-Based Funding (PCBF)	Interim Provincial Model (IPM)
Acuity Sensitivity	Uses RAI-MDS and RUG-III Plus to calculate funding by resident needs	No acuity adjustment — assumes average across all beds
Staffing Requirements	24/7 RN coverage required	RN coverage not required 24/7
Leadership Funding	Often embedded or bundled in WRDs	Director of Care and Educator roles funded separately by formula
Flexibility of Funding	Retrospective adjustments only; limited flexibility	Fixed assumptions; no adjustment for acuity or occupancy
Occupancy Assumption	Actual occupancy used in formula	Assumes 100% occupancy regardless of actual volume

Appendix D

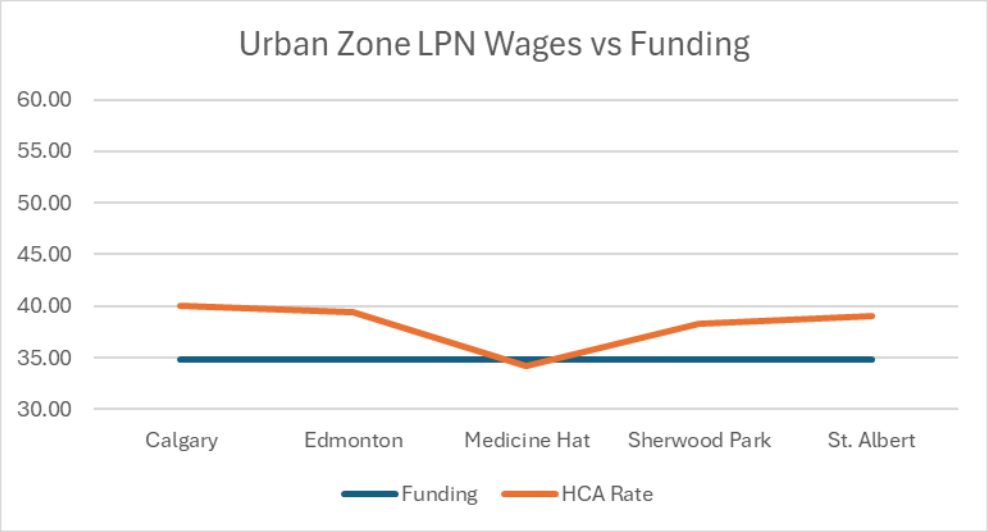
Type B (Supportive Living) Staffing Compression to Funded Amounts

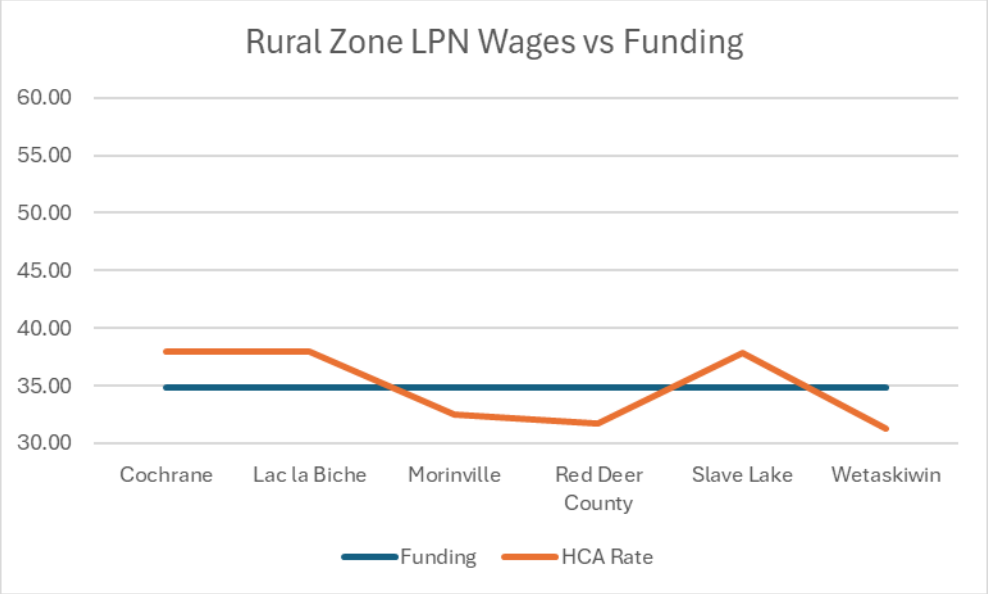
(Calculated using average full burden cost of employee wages, vs funded rate per region)





In both urban and rural settings, LPN wages regularly exceed current funded levels. This pressures operators to subsidize staffing costs through other funding sources, including other staff dollars or accommodation funds. This impacts care delivery, as well as staff quality.





Similarly, health care aid (HCA) wages regularly exceed their funded rate in both urban and rural settings. While HCA staff typically make up the largest population of staff in all home types, wage compression bears further consideration as it furthers operators' need to subsidize increasing wages.