Long-term care homes level-of-care per diem, occupancy and acuity-adjustment funding policy

This policy outlines the funding approach for the level-of-care (LOC) per diem paid to a licensee for each long-term care (LTC) home and for calculating occupancy targets for the different types of beds in LTC homes.

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1. Introduction

This policy outlines the funding approach for the level-of-care (LOC per diem including the adjustments made for acuity and occupancy levels as well as the related supplementary (top-up) funding paid to a licensee for each long-term care (LTC) home.

This policy replaces the Long-Term Care Homes Level-of-Care Per Diem Funding Policy dated April 1, 2018.

All references to the *Fixing Long-Term Care Act, 2021* (FLTCA) and O. Reg 246/22 include all successor legislation and regulation(s) and their corresponding provisions.

This policy incorporates and replaces the previous terms and conditions, funding policies and top-up funding for the following initiatives which were applicable as noted below:

- Registered Practical Nurses in Long-Term Care Funding Policy (applicable from April 1, 2018 up to and including December 31, 2018).
- Funding for an additional registered nurse (RN) in every LTC home (the terms and conditions of this funding were provided by the ministry on May 8, 2018 through letters that amended the then Ministry-LHIN Accountability Agreement) (applicable from May 8, 2018 up to and including December 31, 2018)
- Resident Assessment Instrument Minimum Data Set (RAI-MDS) 2.0 Funding Policy (as referred to in schedule A of the letter of agreement for ministry direct funding to LTC homes (DFA)) (applicable from April 1, 2013 up to and including July 31, 2019, pro-rated for the period from January 1, 2019 up to and including July 31, 2019)

- LTCH Physiotherapy Funding Policy (applicable from April 1, 2016 up to and including March 31, 2019, pro-rated for the period from January 1, 2019 up to and including March 31, 2019)
- Long-Term Care Home (LTCH) Occupancy Targets Policy (applicable from January 1, 2014 up to and including December 31, 2018)
- Funding policy for suspension of admission due to outbreaks. (applicable from July 1, 2010 to December 31, 2018)

Overview of the funding approach for the LOC per diem funding

Ontario Health funds the licensee of a long-term care home the level-of-care per diem for every licensed or approved bed in the home [1] [1], subject to the conditions set out in this policy, other funding and financial management policies, applicable law and any applicable service accountability agreement.

The LOC per diem funding is calculated for each bed using the following formula:

nursing and personal care (NPC) per diem + programs and support services (PSS) per diem + nutritional support (NS) per diem + other accommodation (OA) per diem − resident co-payment revenue per diem = LOC per diem funding

Note: The NPC envelope in the above formula may be adjusted for resident acuity, as appropriate. For more information about acuity adjustment of the NPC envelope see acuity adjustment applied to classified beds of this policy. For more information about resident co-payment revenue see resident accommodation charge of this policy and the LTCH Cash Flow Policy.

The per diem amounts are set by the ministry and are updated by the ministry from time to time. Please see the long-term care home level-of-care per diem funding summary for the specific funding amount under each envelope for the applicable period.

2. Base level-of-care per diem funding components

The base level-of-care per diem represents the per diem amount that has not been modified by a case mix index (CMI), or acuity, adjustment.

The LOC per diem funding consists of four funding components, referred to as envelopes:

- nursing and personal care (NPC). This envelope has both an acuity and a non-acuity adjusted portion
- program and support services (PSS)
- nutritional support (NS)
- other accommodation (OA)

The expenditures that are funded within each envelope, known as eligible expenditures, are described below.

Nursing and personal care (NPC)

The NPC envelope funds expenditures related to:

- nursing and other direct care staff who assess, plan, provide, assist, evaluate and document the direct care provided to residents
- supplies and equipment used by staff to provide care to residents

Program and support services (PSS)

The PSS envelope funds expenditures related to:

- staff
- equipment related to programs
- therapies provided to residents

Nutritional Support (NS)

The NS envelope funds expenditures related to the purchase of raw food including food materials used to sustain life including:

- supplementary substances such as condiments
- prepared therapeutic food supplements as appropriate for a resident ordered by:
    - a physician
    - nurse practitioner
    - registered dietitian
    - registered nurse

It excludes costs related to other programs and cost of food preparation.

Other accommodation (OA)

The OA envelope funds expenditures related to:

- housekeeping services
- buildings and property operations and maintenance
- dietary services (nutrition and hydration services)
- laundry and linen
- general and administrative services
- costs that will maintain or improve the care environment of the long-term care home

For detailed information on eligible expenditures and how they are classified under each envelope please refer to the Eligible Expenditures for Long-Term Care Homes Policy and the Guidelines for Eligible Expenditures for Long-Term Care Homes.

3. Applicability by bed type

All beds in long-term care homes receive the same base LOC per diem for the PSS, NS and OA envelopes in effect for that period as defined in the long-term care home level-of-care per diem funding summary. The LOC per diem amount for the NPC envelope may vary among beds as the amount may be adjusted based on resident acuity, specifically the base amount is adjusted by the home's case mix index (CMI).

Classified beds

Classified beds are long-stay and short-stay respite care beds in a long-term care home that were in operation during the assessment period.

Long-stay beds are intended for individuals requiring:

- 24-hour on-site nursing care
- frequent assistance with activities of daily living
- frequent on-site monitoring and supervision to ensure their well-being

Short-stay respite beds in a long-term care home provide:

- care for individuals whose:
    - caregivers require temporary relief from their caregiving duties
    - require temporary care in order to continue to reside in the community
    - the person is likely to benefit from a short stay in the home
- maximum length of stay is 60 days
- a person can spend a total of 90 days in a short stay bed in a year (combining the amount of days for respite and convalescent care)

The classified beds have their NPC LOC per diem funding adjusted for resident acuity. See acuity adjustment applied to classified beds for an overview of the resident acuity adjustment process.

Unclassified beds

New licensed or approved long-term care beds where, for the purposes of case mix adjustment, the care needs of new residents have not been calculated are referred to as unclassified beds. The unclassified beds are funded at the base level-of-care per diem in effect for that period as defined in the long-term care home level-of-care per diem funding summary. The unclassified beds are funded at a CMI of 1.0.

Convalescent care beds

The NPC LOC per diem funding for convalescent care beds is not adjusted based on the home's CMI. Convalescent care beds receive the base LOC per diem funding, as set in the long-term care home level-of-care per diem funding summary for the applicable period.

Convalescent care beds also receive an additional subsidy to support a recovery of the residents using these beds as they require additional nursing care and therapies when compared to other residents. It is anticipated that these residents will return to their residence within 90 days after admission to the home. The additional subsidy is allocated between the NPC, PSS and OA envelopes. Please refer to the long-term care home level-of-care per diem funding summary for the specific amount of funding that constitutes the additional subsidy at the specified point in time and the allocation of the subsidy between NPC, PSS and OA envelopes. The additional subsidy amounts are set by the ministry and are updated by the ministry from time to time.

Interim beds

Interim beds receive the base LOC per diem funding funded at a CMI of 1.0, as set in the long-term care home level-of-care per diem funding summary for the applicable period.

4. Acuity adjustment applied to classified beds

For the portion of the NPC that is acuity adjusted the NPC funding is calculated based on the formula:

The NPC funding for a home = funded CMI of a home × classified bed count of a home × NPC per diem × number of days in the period under consideration

Case mix index or CMI is intended to represent the measure of relative resource use based on residents' acuity. The CMI for each home represents the average acuity for all the residents of the home in a given year. The CMI is based on resident assessments, reported through the Resident Assessment Instrument-Minimum Data Set (RAI-MDS).

Resource utilization groups (RUGs)

The ministry applies a classification system called resource utilization groups (RUGs) for grouping residents with similar resource utilization based on the care and treatments provided. Each resident's assessment is assigned to the highest weighted RUG cell that they are qualified for based on:

- reported medical conditions
- activities of daily living
- nursing rehabilitation
- therapy

For each assessment, the number of assessed days in the assessment period is calculated and multiplied by the RUG weight to give RUG weighted days (RWD). These values are summed for

all assessments at the home in the assessment period and the ratio of RWD to assessed days is the CMI of a home.

See Appendix A - Introduction to RUGs-III 34 for further information on the RUG classification system and the RUG weight

Three measures of CMI are constructed:

- reported CMI: This represents the CMI derived from the data reported by a home
- special rehabilitation (SR) limited CMI: This represents the CMI derived from the application of a maximum of 5% limit to the assessed days assigned to the special rehabilitation RUG category
- funded CMI: This represents the CMI used for NPC funding and is derived following adjustments to the reported CMI. Key determinant for the change in the NPC funding for a home is the funded CMI.

See Appendix B - Calculating home-level case mix index (CMI) for further information for how home-level CMI is calculated.

5. Resident accommodation charge

Each resident is responsible for paying the charge for accommodation in accordance with the *Fixing Long-Term Care Act, 2021* (FLTCA) and the regulations thereunder. This is often referred to as resident co-payment. A resident who is unable to pay the full charge for basic accommodation may be eligible for a rate reduction in accordance with *Ontario Regulation 246/22* under the FLTCA. See the Rate Reduction Summary Guide for further details.

In the calculation of the LOC per diem funding, the revenue generated from resident accommodation charges is subtracted from the total of the four funding envelopes. Ontario Health may not fund any portion of the resident co-payment unless permitted by the ministry in policy or in an accountability agreement between the ministry and Ontario Health. See base level-of-care per diem funding components for more information on the four funding envelopes.

6. Additional conditions, rules and restrictions on the level-of-care per diem funding and supplementary funding

6.1 Balancing use of funds across NPC, PSS and NS envelopes

A licensee may apply surplus funds from the NPC or PSS envelope to offset over-expenditures in the NPC, PSS or NS envelopes subject to the following conditions:

- surplus funds are the residual amount in each envelope, if any, after subtracting the allowable expenditures from the approved expenditures in the originating envelope. See the LTCH Reconciliation and Recovery Policy for the definition of approved expenditures and allowable expenditures)

- surplus funds will be finally determined through the reconciliation process pursuant to the LTCH Reconciliation and Recovery Policy
- surplus funds in the nutritional support envelope may not be applied to off-set over-expenditures in other envelopes
- funding must be expensed according to the eligibility criteria as outlined in the eligible expenditures for long-term care homes policy

Example of how this flexibility works

Home A has over-**expenditures** in the NPC envelope and surplus funds in the NS and PSS envelopes.

- Home A may not apply surplus funds from the NS envelope to offset over-expenditures in the NPC envelope
- However, Home A may use a portion or all of the surplus funds from the PSS envelope to offset eligible expenses in the NPC envelope, if based on historical patterns and current spending plan, Home A determines that it will not be able to fully utilize the funding available in the PSS envelope.

6.1.1 Global increase to the level-of-care per diem funding

As of April 1, 2019, a global per diem increase to the level-of-care per diem funding was provided to long-term care homes to enhance direct care services as well as to support other operating costs within any of the four envelopes.

The global per diem will not be adjusted by the case mix index. Long-term care homes may allocate up to 32% of the global per diem funding amount to the other accommodation envelope. The greater of the remaining balance or 68% of the global per diem funding amount must be applied against eligible expenditures in the NPC, PSS or NS envelopes.

Long-term care homes will be required to report on the expenditures funded by the global per diem amount on a separate line under each envelope, as applicable.

The total global per diem funding amount will be pro-rated and reconciled based on the related expenditures reported in the applicable envelopes.

Unspent funds and funds not used for the intended and approved purposes are subject to recovery in accordance with the LTCH Reconciliation and Recovery Policy.

For long-term care homes operating a convalescent care program, the global increase applicable to convalescent care beds must be applied against eligible expenditures applicable only to the convalescent care program.

For further information regarding the global increase see long-term care home level-of-care per diem funding summary.

6.2 Nursing and personal care envelope

Registered practical nurses (RPN) in long-term care homes funding policy

As of January 1, 2019, the funding of $69,471 per year provided to every licensed long-term care home with 64 or less licensed or approved beds will be in support of hiring or retaining any direct care staff, preferably registered staff.

Registered nurse (RN) funding

As of January 1, 2019, the annualized funding of $106,000 per year ($79,552 in the 2018-2019 funding year) provided to every licensed long-term care home will be in support of hiring and retaining any direct care staff, preferably registered staff.

Top-up funding for long-term care homes with 64 or fewer licensed or approved beds

As of April 1, 2019, long-term care homes with 64 or fewer licensed or approved beds receive a top-up of $4,529 per year. The combined amount of $180,000 per year, consisting of the prior RPN funding of $69,471 per year plus the prior RN funding of $106,000 per year, as set out above, respectively, plus the top-up of $4,529 per year may be used to hire and or retain any direct care staff in the NPC envelope.

The funding referred to in this section 6.2, is provided in the nursing and personal care envelope. Please refer to the long-term care home level-of-care per diem funding summary for additional information. Unspent funds and funds not used for the intended and approved purposes, are subject to recovery in accordance with the LTCH Reconciliation and Recovery Policy.

Changes to bed counts

Applicable to the funding provided in this section 6.2, in the event of in-year changes to bed counts in an long-term care home, as approved by the ministry, the number of licensed or approved beds shall be determined by dividing the sum of the maximum resident days, maximum convalescent care resident days or maximum interim short-stay resident days, as defined in this policy, by the lesser of 365 days (366 days if leap year) or the number of days beds are operational from January 1 to December 31.

Resident Assessment Instrument Minimum Data Set (RAI-MDS) coordinator position funding

As of August 1, 2019, long-term care homes will receive supplementary per diem funding under the NPC envelope to allow for greater flexibility in the use of the funds while maintaining a RAI-MDS coordinator(s) position and meeting the training and operational requirements as outlined in Appendix C - RAI-MDS coordinator – training and operational requirements.

The supplementary per diem funding is non-acuity adjusted funding provided in the NPC envelope. Funding is subject to the eligibility conditions of that envelope (as set out in the

Eligible Expenditures for Long-Term Care Homes Policy and the guidelines for eligible expenditures for long-term care homes). The per diem amount is set by the ministry and is updated by the ministry from time to time as part of the long-term care home level-of-care per diem funding summary.

6.3 Program and support services envelope

Dietitian time

The licensee may expense in the PSS envelope expenditures related to the provision of 30 minutes per resident per month of registered dietitian time to carry out clinical and nutritional care duties consistent with section 80(2) of *Ontario Regulation 246/22.* The expenditure of the 30 minutes must be related to registered dietitian salary and benefits only. Expenditures beyond the 30 minutes are to be expensed to the OA envelope.

Funding for physiotherapy and other therapy services

As of April 1, 2019, the physiotherapy funding provided for the provision of physiotherapy services for all LTC home residents was added to the level-of-care per diem funding (see the long-term care home level-of-care per diem funding summary) under the PSS envelope. Similarly, the additional physiotherapy subsidy provided for residents in convalescent care beds was added to the additional subsidy under the PSS envelope (see the long-term care home level-of-care per diem funding summary). The funding is subject to the eligibility conditions of that envelope (as set out in the Eligible Expenditures for Long-Term Care Homes Policy and the Guidelines for Eligible Expenditures for LTC Homes).

An objective of the amalgamated funding approach for eligible therapeutic services is to help drive better outcomes for long-term care residents through increased use of inter-professional staffing mixes. The increased funding flexibility for purchasing occupational and recreational therapy services, as well as the support offered through registered social workers, will help provide a broader range of professional care for residents and ultimately aims to enable improved quality of life.

occupational therapist
: means a member of the College of Occupational Therapists of Ontario who holds a certificate of registration authorizing them to practice in Ontario

physiotherapist
: means a member of the College of Physiotherapists of Ontario who holds a certificate of registration authorizing independent practice

physiotherapist support personnel or support personnel
: refers to anyone who provides care under the direction and supervision of a physiotherapist

social worker or social service worker
: means a registered member of the Ontario College of Social Workers and Social Service Workers

6.4 Other accommodation envelope

Nutrition managers and food service workers - minimum staffing requirements

Nutrition managers

- the licensee must comply with requirements set out in section 81 of *Ontario Regulation 246/22* under the FLTCA.
- consistent with subsection 81(4) of *Ontario Regulation 246/22*, the licensee must ensure that the nutrition manager(s) is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection 81(5) of *Ontario Regulation 246/22*, without including any hours spent fulfilling other responsibilities.

Nutrition managers verification of minimum staffing requirements

- the Director as defined under the FLTCA may take into consideration the hours in a week, if any, devoted to producing meals and other food and beverages for non-residents (example, staff or visitors) for the sole purpose of determining whether the licensee is in compliance with the requirements set out in subsection 81(4) and subsection 81(5) of *Ontario Regulation 246/22*.
- an inspector under the FLTCA may apply the following formula to confirm whether the licensee is meeting the minimum requirement set out in section 81 of *Ontario Regulation 246/22* for the nutrition manager(s):

  $M_{total} = [A + (B \div 3 \div 7) + (C \div 3 \div 7)] \times 8 \div 25$
  $= 0.32\ [A + B \div 21 + C \div 21]$, where

  M Total
  is the minimum number of hours of service per week for the management of all resident and non-resident nutritional care and dietary service programs.
  A
  is either,

  - if the occupancy of the home is 97% or more, the licensed bed capacity of the home for the week
  - if the occupancy of the home is less than 97%, the number of residents residing in the home for the week, including absent residents

  B
  is the total number of meals prepared in the home for the week for persons who are not residents of the home where one or both of the following two conditions are met:

  - staff are involved in activities in addition to food preparation including but not limited to the following:
    - distribution of meals

        - receiving, storing and managing of the inventory of food and food service supplies
        - daily cleaning and sanitizing of dishes, utensils and equipment used for meal preparation, delivery or service
    - the menus for residents and persons who are not residents are not the same

In all cases, the following meals are included under B:

- visitors
- staff
- day care
- cafeteria
- catering

B is the sum of meals prepared for each of its components, example:

- meals for visitors
- staff
- day care
- cafeteria

As such, B is calculated using the following formula:

$$B = \sum_{i=1}^{n} b_i$$

Where possible each component, such as b_i, should be measured using the number of meals prepared. For all operations that generate revenue, such as a cafeteria, the following formula should be applied to calculate b_i:

b_i = (average weekly revenue ÷ average cost per meal), where
average cost per meal = nutritional support per diem ÷ 3

C
is the total number of meals prepared in the home for other operations where both of the following two conditions are met:

- long-term care staff is only involved in food preparation and not other activities that may include but are not limited to the following:
    - distribution of meals
    - receiving, storing and managing of the inventory of food and food service supplies

        - daily cleaning and sanitizing of dishes, utensils and equipment used for meal preparation, delivery or service
    - the menus for residents and for persons who are not residents are the same

Food service workers

- the licensee must comply with requirements set out in section 83 of *Ontario Regulation 246/22* under the *Fixing Long-Term Care Act, 2021* (FLTCA).
- consistent with subsection 83(1) of *Ontario Regulation 246/22*, the licensee must ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection 83(2) of *Ontario Regulation 246/22*.

Food service workers verification of minimum staffing requirements

- an inspector may take into consideration the hours in a week, if any, devoted to producing meals and other food and beverages for non-residents (example staff or visitors) for the sole purpose of determining whether the licensee is in compliance with the requirements set out in subsection 83(2) and subsection 83(3) of *Ontario Regulation 246/22*.
- an inspector under the FLTCA may apply the following formula to verify that the licensee is meeting the minimum requirement set out in section 83 of *Ontario Regulation 246/22* for food service workers:

  $M_{total} = [A \times 7 \times 0.45] + [(B \div 3) \times 0.45] + [(C \div 3) \times 0.22]$
  $= 0.45\ [7A + B \div 3] + 0.22\ [C \div 3]$, where

  M Total
  is the minimum number of hours per week for the activities outlined under subsection 83(1) of *Ontario Regulation 246/22* and the same or other activities related to meals for persons who are not residents defined under B and for the preparation of meals under C.

  A, B and C have the same meaning as described for nutrition managers verification of minimum staffing requirements.

  All meals prepared for retirement home operations are included under C unless the two conditions defined for C are not met. The inspector under the FLTCA will determine if there is non-compliance with the FLTCA and *Ontario Regulation 246/22*.

Quality attainment premium (QAP) funding

Long-term care homes will continue to receive the quality attainment premium (QAP) funding per diem as a supplementary line under the other accommodation envelope in accordance with the Long-Term Care Homes Quality Attainment Premium (QAP) Funding Policy. See the long-term care home level-of-care per diem funding summary for the supplementary per diem funding amount for the OA envelope and applicable period.

Basic accommodation premium (BAP) funding

Basic accommodation premium (BAP) funding is provided to an eligible licensee who expands access to basic accommodation in long-term care homes as part of a development or redevelopment project. For the purposes of BAP funding, basic accommodation is as defined in *Ontario Regulation 246/22*, section 3.

Under this policy, an eligible licensee refers to a licensee that has:

- met to the satisfaction of the ministry all the requirements and conditions for receiving either construction funding subsidy (CFS) funding set out in the development agreement tied to the Long-Term Care Home Capital Development Funding Policy, 2020, (2020 CFS) or construction funding set out in a Transfer Payment Agreement (TPA) executed between the ministry and the licensee in 2020 or later for the development or redevelopment of LTC beds, and
- made a binding written commitment (set out in a memorandum of commitment or similar document) approved in writing by the ministry, to provide basic accommodation in at least 50% of the beds in the home (based on the licensed bed capacity of the home as defined in *Ontario Regulation 246/22*, section 1)

The BAP funding will be paid to an eligible licensee for all 2020 CFS-eligible beds, or construction funding-eligible beds under a TPA described immediately above, in the home only if 50% or more of the beds in the home are offered as basic accommodation.

BAP funding will be suspended for any period in which the licensee ceases to designate and operate the stipulated minimum proportion of the beds in the home as basic accommodation in accordance with the licensee's commitment and any past payments in respect of such period will be recovered.

The BAP per diem will be paid as a supplementary line under the other accommodation envelope.

See the long-term care home level-of-care per diem funding summary for the specific amount for the applicable period. The per diem amount is set by the ministry and is updated by the ministry from time to time.

7. Occupancy targets

7.1 Introduction

The occupancy targets that need to be achieved in order to receive the LOC per diem funding based on the number of licensed or approved beds in the home varies by bed type. If a licensee fails to achieve the occupancy target, the LOC per diem funding, in most cases, will be paid based on actual resident days or the days that the resident actually occupied the beds in the home, in accordance with the rules and conditions set out in this policy.

This policy:

- updates the occupancy targets that are in effect in certain situations
- integrates the allowance for lost days due to outbreaks into this policy and as of January 1, 2019 discontinues the separate funding policy for suspension of admission due to outbreaks
- captures changes to the outbreak policy within this policy notably the removal of the reference to "first" choice for purposes of determining resident day credits. Please refer to section 7.6.3 suspension of admissions due to outbreak for more information.

7.2 Overview

Resident occupancy targets for the purpose of LOC per diem funding are set differently for long-stay and short-stay types of beds and are subject to details set out in this policy.

Occupancy target by bed type by envelope

Bed type	Nursing & personal care (NPC) envelope	Program & support services (PSS) envelope	Nutritional Support (NS) envelope	Other accommodation (OA) envelope
Long-stay bed – LOC per diem funding footnote 2 [2]	97%	97%	97%	97%
Long-stay bed – LOC per diem funding (LTC homes operating 64 or fewer long-stay beds) footnote 3 [3]	n/a	n/a	n/a	97%
Designated specialized unit (DSU) long-stay beds - LOC per diem funding) footnote 4 [4]	n/a	n/a	n/a	n/a
Short-stay respite bed – LOC per diem funding footnote 5 [5]	n/a	n/a	n/a	n/a
Convalescent care bed – base LOC per diem funding footnote 6 [6]	n/a	n/a	n/a	n/a
Convalescent care bed – additional subsidy funding footnote 6 [6]	n/a	n/a	n/a	n/a
Interim short-stay bed – LOC per diem funding footnote 7 [7]	90%	90%	90%	90%

The sections below outline the detailed approach for calculating occupancy targets for the different types of beds in long-term care homes. Specifically, there are two separate calculations

to determine occupancy targets for the purpose of funding, both of which include allowances for days lost to outbreaks, if applicable. In the first calculation, long-stay beds and short-stay respite beds are grouped together to set a single target referred to as target long-stay resident days. The second calculation sets the occupancy targets for the interim short-stay beds and it is referred to as target interim short-stay resident days.

Target calculations will be provided in the subsidy calculation worksheet.

7.3 Funding based on long-stay resident days

7.3.1 Funding based on target long-stay resident days

To receive the LOC per diem funding based on full occupancy, the actual occupancy of a home must not be less than the home's target long-stay resident days.

To determine a home's target long-stay resident days the following calculation is applied.

maximum resident days − (allowable long-stay vacancy days + allowable short-stay respite resident days) = target long-stay resident days

Calculation terms defined

allowable long-stay vacancy days

> The number of long-stay bed-days that the ministry or Ontario Health will allow as vacancies for which funding is provided. The current allowable long-stay vacancy days are set at 3% of the home's maximum resident days, as applicable.
>
> **Example**
>
> allowable long-stay vacancy days = (0.03 × maximum resident days) + credited resident days due to outbreak
>
> Long-stay beds are defined as all licensed or approved long-stay beds in the long-stay bed program, including long-stay program beds in a specialized unit.

allowable short-stay respite resident days

> The number of short-stay respite bed-days that the ministry or Ontario Health will fund at the home.

maximum resident days

> The maximum resident days for a home are calculated by multiplying the number of beds in operation (operating capacity) by the number of days in the period under consideration.

The number of beds in operation excludes beds in abeyance, convalescent care beds and interim beds and includes both long-stay beds and short-stay respite beds provided they are part of the regular or temporary licensed or approved capacity of the home.

There will be cases where the number of beds in operation in the home will vary during the year, such as when renovations, expansions or downsizing of the home are taking place.

If two or more residents occupy a bed on the same day it is counted as one resident day.

target long-stay resident days

The minimum number of resident days the licensee must provide service for long-stay residents to receive LOC per diem funding based on maximum resident days in the home as determined in accordance with the calculation set out in the box above.

The target long-stay resident days are commonly referred to as the occupancy target. For further details on calculating the target long-stay resident days refer to the Technical instructions and guidelines for the long-term care home subsidy calculation worksheet.

The total number of maximum resident days, allowable long-stay vacancy days, allowable short-stay respite resident days and target long-stay resident days are calculated for each home annually by the ministry or Ontario Health.

7.3.2 Funding based on actual resident days

Long-stay beds

Subject to the exceptions set out below, an long-term care home that does not achieve the home's target long-stay resident days, or occupancy target, will be funded based on its actual long-stay resident days.

7.3.2.1 Subject to meeting the conditions specified in section 7.3.2.2, to the general rule that a long-term care home that does not achieve the home's target long-stay resident days will be funded solely based on its actual long-stay resident days, the following exceptions apply:

1. if the long-term care home's long-stay vacancy days are greater than 3% and less than or equal to 6% of maximum resident days, the home will be funded based on its actual resident days plus and subject to meeting the conditions in section 7.3.2.2, 2% of its maximum resident days in each applicable quarter
2. if the long-term care home's long-stay vacancy days are greater than 6% and less than or equal to 10% of maximum resident days, the home will be funded based on its actual resident days plus and subject to meeting the conditions in section 7.3.2.2, 1% of its maximum resident days in each applicable quarter

7.3.2.2 As of July 1, 2020, for each quarter in a calendar year, where a calendar year begins on January 1 and ends on December 31, a long-term care home will only fall within one of the two exceptions above in section 7.3.2.1 if,

By the last business day in the quarter the long-term care home is not subject to:

- a suspension of admissions directed by the Director pursuant to section 56 of the FLTCA *Fixing Long-Term Care Act, 2021.*
- a mandatory management order as ordered by the Director pursuant to subsection 157(1) of the *Fixing Long-Term Care Act, 2021*, except if:
    - the licensee has retained a management company acceptable to the Director
    - the Licensee has complied with every other order issued by the Director in respect of the home
- an order revoking their licence pursuant to section 159 of the *Fixing Long-Term Care Act, 2021*
- an active or outstanding Director's order(s) as a result of enforcement action, but which does not include a Director's order from an appeals process (example, a Director's Review)

If section 7.6.1 or section 7.6.4 applies to the long-term care home, then maximum resident days excludes staff orientation and fill period days and occupancy reduction protection days for the calculation under exceptions 1 and 2 in section 7.3.2.1, as applicable.

Where a long-term care home is funded under exception 1 or 2 in section 7.3.2.1, as applicable, the funding will not exceed funding based on maximum resident days.

7.3.2.3 If exception 1 or 2 in section 7.3.2.1 applies to a long-term care home and every condition is met, every reference to funding based on actual resident days or actual occupancy in an LTC Home funding and financial management policy applicable to the long-term care home will be read as the actual resident days or actual occupancy plus the applicable 1% or 2% of maximum resident days, excluding staff orientation and fill period days and occupancy reduction protection days, for the period of time that the conditions for this application of this exception are met.

7.3.3 Long-term care homes operating 64 or fewer long-stay licensed or approved beds

Section 7.3.2 applies with the following exceptions:

7.3.3.1 A long-term care home operating 64 or fewer long-stay licensed or approved beds will have the NPC, PSS and NS envelopes funded based on maximum resident days.

Note: Where a short-stay respite program exists, the short-stay respite bed shall be counted as a long-stay bed.

7.3.3.2 Subject to section 7.3.3.1, in the event of in-year changes to bed counts in a long-term care home, as approved by the ministry in accordance with the *Fixing Long-Term Care Act,*

2021, the number of licensed or approved beds shall be determined by dividing the maximum resident days by the lesser of 365 days (366 days in a leap year) or the number of days beds are operational from January 1 to December 31.

7.3.3.3 Subject to section 7.3.3.1, exceptions 1 and 2 under section 7.3.2.1. shall be replaced with the following:

1. if the long-term care home's long-stay vacancy days, are greater than 3% and less than or equal to 6% of maximum resident days, the OA envelope will be funded based on the long-term care home's actual resident days plus and subject to meeting the conditions in section 7.3.2.2, 2% of its maximum resident days in each applicable quarter.
2. if the long-term care home's long-stay vacancy days are greater than 6% and less than or equal to 10% of maximum resident days, the OA envelope will be funded based on the long-term care home's actual resident days plus and subject to meeting the conditions in section 7.3.2.2, 1% of its maximum resident days in each applicable quarter.

7.3.4 Designated specialized unit (DSU) long-stay beds

A long-term care home operating DSU long-stay beds, will receive the LOC per diem funding based on the allowable DSU long-stay resident days, regardless of the actual occupancy of the DSU long-stay beds in the home.

Where DSU long-stay beds apply, the calculation to determine the target long-stay resident days will subtract the allowable DSU long-stay resident days from the maximum resident days. The following calculation shall apply:

maximum resident days − (allowable long-stay vacancy days + allowable short-stay respite resident days + allowable DSU long-stay resident days) = target long-stay resident days

allowable DSU long-stay resident days

> Where allowable DSU long-stay resident days means the number of DSU long-stay bed-days that the ministry will fund at the home. This is determined to be the number of approved long-stay program beds in operation in a specialized unit program multiplied by the number of days in the period under consideration.

allowable long-stay vacancy days

> The number of long-stay bed-days that the ministry or Ontario Health will allow as vacancies for which funding is provided. The current allowable long-stay vacancy days are set at 3% of the home's maximum resident days, less allowable DSU long-stay resident days.
>
> **Example**

allowable long-stay vacancy days = 0.03 × (maximum resident days less allowable DSU long-stay resident days, if applicable.)

DSU long-stay beds are excluded from section 7.3.2 and section 7.3.3 and every reference to maximum resident days in these sections will exclude the allowable DSU long-stay resident days.

See section 7.8 Example 3 - Occupancy targets for a long-term care home with 98 long-stay beds and 2 DSU long-stay beds to determine how to target long-stay resident days when DSU long-stay beds apply.

7.3.5 Short-stay respite beds

The allowable short-stay respite resident days are subtracted in the calculation of the home's target long-stay resident days. Specifically, where a short-stay respite program exists, the number of resident days approved for the short-stay respite program is separate from the allowable 3% vacancy rate.

Short-stay respite beds receive LOC per diem funding based on allowable short-stay respite resident days regardless of the actual occupancy achieved. This means that short-stay respite beds are not required to meet a specific target for resident days to receive full funding.

7.4 Funding based on interim short-stay resident days

7.4.1 Funding based on target interim short-stay resident days

The maximum interim short-stay resident days and occupancy targets for interim short-stay beds are calculated and monitored separately from other beds in a home. To receive the LOC per diem funding based on full occupancy, the actual occupancy for interim short-stay beds must not be less than the home's target interim short-stay resident days.

To determine a home's target interim short-stay resident days the following calculation is applied:

maximum interim short-stay resident days − allowable interim short-stay vacancy days = target interim short-stay resident days

Allowable interim short-stay vacancy days

> The number of interim short-stay bed-days that the ministry or Ontario Health will allow as vacancies for which funding is provided. The current allowable interim short-stay vacancy days are set at 10% of the home's maximum interim short-stay resident days.

Example

allowable interim short-stay vacancy days = (0.10 × maximum interim short-stay resident days) + credited resident days due to outbreak.

Maximum interim short-stay resident days

The maximum interim short-stay resident days for a home are calculated by multiplying the number of interim short-stay beds in operation (operating capacity) in the home by the number of days in the period under consideration.

Operating capacity is not to exceed the number of licensed or approved interim beds in a home. There will be cases where the number of interim beds in operation in the home will vary during the year such as when renovations, expansions or downsizing of the home are taking place.

If two or more residents occupy a bed on the same day it is counted as one resident day.

Target interim short-stay resident days

The minimum number of resident days the licensee must provide service to interim short-stay residents to receive funding based on maximum interim short-stay resident days in the home. The target Interim short-stay resident days are commonly referred to as the interim short-stay occupancy target.

The total number of maximum interim short-stay resident days, allowable interim short-stay vacancy days and target interim short-stay resident days are calculated for each home annually by the ministry or Ontario Health.

7.4.2 Funding based on actual interim short-stay resident days

If a long-term care home does not achieve its target interim short-stay resident days, funding will be based on the actual interim short-stay resident days.

7.5 Funding based on maximum convalescent care resident days

A long-term care home operating convalescent care beds will receive 100% of the base LOC per diem funding and 100% of the additional subsidy based on the maximum convalescent care resident days, regardless of the actual occupancy of the convalescent care beds in the home, where:

Additional subsidy

An additional subsidy paid for designated convalescent care beds.

Please refer to the long-term care home level-of-care per diem funding summary for the specific amount of funding that constitutes the additional subsidy at the specified point in time and the allocation of the subsidy to NPC, PSS and OA envelopes. The additional subsidy amounts are set by the ministry and are updated by the ministry from time to time.

Base level-of-care per diem

The total per diem subsidy as determined by the ministry in effect for the period under consideration and is comprised of the four funding components of the current funding model (nursing and personal care (NPC) envelope, program and support services (PSS) envelope, nutritional support (NS) envelope and other accommodation (OA) envelope). The base level-of-care per diem represents the per diem amount that has not been modified by a case mix index (CMI) adjustment.

Maximum convalescent care resident days

Maximum convalescent care resident days for a home are calculated by multiplying the number of convalescent care beds in operation (operating capacity) in the home by the number of days in the period under consideration.

Operating capacity is not to exceed the number of licensed or approved beds in a home. There will be cases where the number of beds in operation in the home will vary during the year, such as when renovations, expansions or downsizing of the home are taking place.

If two or more residents occupy a bed on the same day it is counted as one resident day.

7.6 Adjustments of occupancy targets

7.6.1 New and redeveloped beds – staff orientation and fill period

See the Fill Rate Guidelines for New and Redeveloped/Retrofitted ‘D’ Long-Term Care Facilities document for further details.

7.6.2 Interim beds staff orientation and fill period

See the Fill Rate Guidelines for New Interim LTC Beds document for further details.

7.6.3 Suspension of admissions due to outbreaks

During an outbreak of a communicable disease, a medical officer of health or their delegate may recommend that any part of a long-term care home be closed. The medical officer of health may also make an order under the *Health Protection and Promotion Act* requiring that a long-term care home or any part of the home be closed. Any such recommendation or order may cause a bed or beds from being occupied or being available for occupation.

During the period where a bed or beds are not available for occupation due to a recommendation or order with respect to an outbreak of a communicable disease, the number of resident days in the home may be negatively impacted. Based on eligibility, the ministry or Ontario Health may provide resident day credits in the calculation of a home's occupancy target.

Eligibility

The following criteria apply for eligibility to receive resident day credits under this policy:

- in the case of closure of the entire home, the licensee must have done so pursuant to an order from the medical officer of health of the board of health and provide the required documentation
- in the case of a partial closure (example, wing, floor, or residential home area) the licensee must have done so pursuant to an order or recommendation of the medical officer of health or on their recommendation of a public health inspector or public health nurse of the board of health (as a delegate of the medical officer of health) and provide the required documentation

Application of resident day credits

If the licensee meets the eligibility criteria as per section 7.6.3, the ministry may provide resident day credits in the calculation of a home's occupancy target for the purpose of determining the subsidy as follows:

- for vacancies that resulted from a bed or beds not being available for occupation because of an order or recommendation, the ministry may provide resident day credits for that bed or those beds from the date of each vacancy within the period specified in the order or recommendation to the end of the period
- credit is not given for vacancies in the home that existed prior to the order or recommendation. However, the ministry may provide resident day credits for potential new residents who, based on their choice of placement, could have been placed in the home subsequent to the start of the order or recommendation but who were not admitted

This policy does not apply to an unoccupied bed or beds that are not in an area of the home subject to the order or recommendation.

Funding during suspension of admission due to outbreaks

The total credited days, as determined in accordance with this policy, will be added to the allowable vacancy days to determine if the home has met its target long-stay resident days and target interim short-stay resident days. An increase to the allowable vacancy resident days will translate to a decrease to the target resident days by an amount equal to the total credited days. The adjustment to the target calculation will occur at time of overall reconciliation.

Required documentation

To receive the resident day credits as outlined above, the licensee is required to submit the following documentations to the ministry's Financial Management Branch (FMB) as soon as possible after the end of an outbreak period and no later than the date prescribed by the ministry or Ontario Health:

- schedule of vacancies form
    - a copy of the schedule of vacancies form is available in Appendix D – Schedule of vacancies.
- documentation confirming that the bed or beds were not available for occupancy
    - a copy of the order of the medical officer of health
    - where a recommendation was made, a letter from either the medical officer of health or from the public health inspector or public health nurse who had authority to make the recommendation confirming the specific part of the home that is to be closed and the duration for which that part is to remain closed
- letter(s) from the placement coordinator
    - the letter(s) must verify if there are any potential residents that were on the home's waiting list prior to the start date of the order or recommendation who could have been admitted during the period set out in the order or recommendation
    - a copy of the letter from the placement coordinator template is available in Appendix E – Letter for reporting on long-term care homes wait list template.

Please note that the documentation requirements set out above may be in addition to other reporting requirements identified by the ministry or Ontario Health.

7.6.4 Occupancy reduction protection period

Under certain circumstances, a home may be approved for an occupancy reduction protection period during which time modified occupancy and funding rules apply. Please see the Long-Term Care Homes Occupancy Reduction Protection Policy for further details on these rules available at LTCHomes.net. For the purpose of calculating the occupancy targets for the home, the bed days to which occupancy reduction protection applies will be subtracted from the calculation of the home's occupancy target. In addition, allowable vacancy days will also exclude occupancy reduction protection days in calculating the target resident days for homes with occupancy reduction protection period (please see below the amended definition of the allowable vacancy days for each calculation, as applicable).

To determine the target long-stay resident days for the home with occupancy reduction protection period the following calculation is applied:

maximum resident days − (allowable long-stay vacancy days + allowable short-stay respite resident days + occupancy reduction protection days) = target long-stay resident days
where allowable long-stay vacancy days = 0.03 × (maximum resident days − occupancy reduction protection days)

To determine the target interim short-stay resident days for the home with occupancy reduction protection period the following calculation is applied:

maximum interim short-stay resident days − (allowable interim short-stay vacancy days + occupancy reduction protection days) = target interim short-stay resident days
where allowable interim short-stay vacancy days = 0.10 × (maximum interim short-stay resident days − occupancy reduction protection days)

7.7 Reconciliation rules

This policy must be read in conjunction with the level-of-care per diem funding terms contained in this policy, the Eligible Expenditures for Long-Term Care Homes Policy and the LTCH Reconciliation and Recovery Policy among others. As in addition to occupancy targets rules the funding is also subject to other conditions of funding.

7.8 Examples: calculation of occupancy targets for the purpose of funding

Example 1 - Occupancy targets for a long-term care home with 100 long-stay beds

The target long-stay resident days for a home with 100 long-stay beds (none of which are DSU long-stay beds) would be 35,405

Formula

maximum resident days − (allowable long-stay vacancy days + allowable short-stay respite resident days) = target long-stay resident days

36,500 − (1,095 + 0) = 35,405

Calculations

- maximum resident days are 36,500 (100 beds × 365 days)
- allowable long-stay vacancy days is 3% of maximum resident days = 1,095 (36,500 × 0.03)
- allowable short-stay respite resident days is 0 (the home has no short-stay respite beds)
- target long-stay resident days is 36,500 − 1,095 = 35,405

Example 2 - Occupancy targets for a long-term care home with 98 long-stay beds and 2 short-stay respite beds

The target long-stay resident days for a home with 98 long-stay beds (none of which are DSU long-stay beds) and 2 short-stay respite beds is 34,675

Formula

maximum resident days − (allowable long-stay vacancy days + allowable short-stay respite resident days) = target long-stay resident days

36,500 − (1,095 + 730) = 34,675

Calculations

- maximum resident days are 36,500 (100 beds × 365 days)
- allowable long-stay vacancy days is 3% of maximum resident days = 1,095 (36,500 × 0.03)
- allowable short-stay respite resident days is 730 (2 × 365)
- target long-stay resident days is 36,500 − (1,095 + 730) = 34,675

Example 3 - Occupancy targets for a long-term care home with 98 long-stay beds and 2 DSU long-stay beds

The target long-stay resident days for a home with 98 long-stay beds and 2 DSU long-stay beds is 34,697.

Formula

maximum resident days − (allowable long-stay vacancy days + allowable DSU long-stay resident days) = target long-stay resident days

36,500 − (1,073 + 730) = 34,697

Calculations

- maximum resident days are 36,500 (100 beds × 365 days)
- allowable long-stay vacancy days is 3% of (maximum resident days less allowable DSU long-stay resident days) = 1,073 (0.03 × (36,500 − 730))
- allowable DSU long-stay resident days is 730 (2 × 365)
- target long-stay resident days is 36,500 − (1,073 + 730) = 34,697

Appendix A - Introduction to RUGs-III 34

There are two components in a case mix system: a grouping system and a weighting system

- resource utilization groups (RUGs) - the grouping system combines similar residents based on their medical conditions, activities of daily living, etc.
- case mix index (CMI) - the weighting system, compares the relative resource utilization in each grouping

For Ontario’s long-term care sector, the ministry currently uses RUG-III 34 as the grouping system and associated CMI as the weighting system

- there are 7 categories within the 34 RUGs
- the RUG group assigned to an assessment is based on resident's reported medical conditions, activities of daily living, nursing rehabilitation and therapy

7 hierarchical clinical categories

7 hierarchical clinical categories

RUG-III plus category	Category assignment rules	Assignment values	RUG-III group
1 - Extensive services	Treatments and ADL	0 to 1	SE1
1 - Extensive services	Treatments and ADL	2 to 3	SE2
1 - Extensive services	Treatments and ADL	4 to 5	SE3
2 - Special rehabilitation	Intensity and ADL	4 to 9	RAA
2 - Special rehabilitation	Intensity and ADL	10 to 13	RAB
2 - Special rehabilitation	Intensity and ADL	14 to 16	RAC
2 - Special rehabilitation	Intensity and ADL	17 to 18	RAD
3 - Special care	ADL	7 to 14	SSA
3 - Special care	ADL	15 to 16	SSB
3 - Special care	ADL	17 to 18	SSC
4 - Clinically complex	ADL	4 to 11 without depression	CA1
4 - Clinically complex	ADL	4 to 11 with depression	CA2
4 - Clinically complex	ADL	12 to 16 without depression	CB1
4 - Clinically complex	ADL	12 to 16 with depression	CB2
4 - Clinically complex	ADL	17 to 18 without depression	CC1
4 - Clinically complex	ADL	17 to 18 with depression	CC2
5 - Impaired cognition	ADL	4 to 5 nursing rehabilitation 0 to 1	IA1
5 - Impaired cognition	ADL	4 to 5 nursing rehabilitation 2 plus	IA2
5 - Impaired cognition	ADL	6 to 10 nursing rehabilitation 0 to 1	IB1
5 - Impaired cognition	ADL	6 to 10 nursing rehabilitation 2 plus	IB2

7 hierarchical clinical categories			
RUG-III plus category	**Category assignment rules**	**Assignment values**	**RUG-III group**
6 - Behavioural problems	ADL	4 to 5 nursing rehabilitation 0 to 1	BA1
6 - Behavioural problems	ADL	4 to 5 nursing rehabilitation 2 plus	BA2
6 - Behavioural problems	ADL	6 to 10 nursing rehabilitation 0 to 1	BB1
6 - Behavioural problems	ADL	6 to 10 nursing rehabilitation 2 plus	BB2
7 - Reduced physical functions	ADL	4 to 5 nursing rehabilitation 0 to 1	PA1
7 - Reduced physical functions	ADL	4 to 5 nursing rehabilitation 2 plus	PA2
7 - Reduced physical functions	ADL	6 to 8 nursing rehabilitation 0 to 1	PB1
7 - Reduced physical functions	ADL	6 to 8 nursing rehabilitation 2 plus	PB2
7 - Reduced physical functions	ADL	9 to 10 nursing rehabilitation 0 to 1	PC1
7 - Reduced physical functions	ADL	9 to 10 nursing rehabilitation 2 plus	PC2
7 - Reduced physical functions	ADL	11 to 15 nursing rehabilitation 0 to 1	PD1
7 - Reduced physical functions	ADL	11 to 15 nursing rehabilitation 2 plus	PD2
7 - Reduced physical functions	ADL	16 to 18 nursing rehabilitation 0 to 1	PE1

7 hierarchical clinical categories			
RUG-III plus category	**Category assignment rules**	**Assignment values**	**RUG-III group**
7 - Reduced physical functions	ADL	16 to 18 nursing rehabilitation 2 plus	PE2

- each assessment is reviewed to determine which of the 34 RUG groups might apply
- more than one RUG group might apply for each assessment
- each resident's assessment is assigned to the highest weighted RUG group that they are qualified for based on:
    - the reported medical conditions
    - activities of daily living (ADL)
    - nursing rehabilitation and therapy
- the RUG group assigned to an assessment is based on resources used during the assessment observation period (not resources required)
- all resident assessments are used to determine the CMI of a home
- the clinical categories in the 7 hierarchical clinical categories table are hierarchical in nature, extensive services with the highest weighted RUG group and reduced physical function with the lowest weighted RUG group

Clinical categories RUG groups and weight

Category: Extensive services

RUG-III 34	Weight (2009)
SE3	1.9422
SE2	1.591
SE1	1.446

Category: Special rehabilitation

RUG-III 34	Weight (2009)
RAD	1.6125
RAC	1.3492
RAB	1.1973
RAA	1.0167

Category: Special care

RUG-III 34	Weight (2009)
SSC	1.402
SSB	1.3189
SSA	1.2135

Category: Clinically complex

RUG-III 34	Weight (2009)
CC2	1.3794
CC1	1.277
CB2	1.1905
CB1	1.1161
CA2	1.0683
CA1	0.9413

Category: Impaired cognition

RUG-III 34	Weight (2009)
IB2	0.9729
IB1	0.9469
IA2	0.7561
IA1	0.7177

Category: Behavioural problems

RUG-III 34	Weight (2009)
BB2	0.9388
BB1	0.817
BA2	0.7036
BA1	0.6327

Category: Reduced physical function

RUG-III 34	Weight (2009)
PE2	1.1291
PE1	1.1063
PD2	0.9959
PD1	0.9718
PC2	0.9095
PC1	0.8429
PB2	0.7116
PB1	0.7016
PA2	0.6452
PA1	0.6308

Appendix B - Calculating home-level case mix index (CMI)

Sample calculation of a home-level case mix index.

Home-level CMI (reported CMI) calculation

Clinical category	Hierarchy	RUG-III 34	Weight	Reported assessment days	RUG weighted patient days (RWPD) based on reported assessment days
1 - Extensive services	1	SE3	1.9422	201	390
1 - Extensive services	2	SE2	1.5910	358	570
1 - Extensive services	3	SE1	1.4460	31	45
2 - Special rehabilitation	4	RAD	1.6125	n/a	n/a
2 - Special rehabilitation	5	RAC	1.3492	n/a	n/a
2 - Special rehabilitation	6	RAB	1.1973	n/a	n/a
2 - Special rehabilitation	7	RAA	1.0167	n/a	n/a
3 - Special care	8	SSC	1.4020	2,772	3,886
3 - Special care	9	SSB	1.3189	1,690	2,229
3 - Special care	10	SSA	1.2135	1,474	1,789
4 - Clinically complex	11	CC2	1.3794	276	381
4 - Clinically complex	12	CC1	1.2770	1,507	1,924
4 - Clinically complex	13	CB2	1.1905	1,330	1,583
4 - Clinically complex	14	CB1	1.1161	1,944	2,170
4 - Clinically complex	15	CA2	1.0683	1,295	1,383
4 - Clinically complex	16	CA1	0.9413	1,632	1,536
5 - Impaired cognition	17	IB2	0.9729	n/a	n/a
5 - Impaired cognition	18	IB1	0.9469	4,779	4,525
5 - Impaired cognition	19	IA2	0.7561	n/a	n/a
5 - Impaired cognition	20	IA1	0.7177	2,549	1,829

Home-level CMI (reported CMI) calculation

Clinical category	Hierarchy	RUG-III 34	Weight	Reported assessment days	RUG weighted patient days (RWPD) based on reported assessment days
6 - Behavioural problems	21	BB2	0.9388	n/a	n/a
6 - Behavioural problems	22	BB1	0.8917	827	737
6 - Behavioural problems	23	BA2	0.7036	n/a	n/a
6 - Behavioural problems	24	BA1	0.6327	203	128
7 - Reduced physical functions	25	PE2	1.1291	n/a	n/a
7 - Reduced physical functions	26	PE1	1.1063	14,092	15,590
7 - Reduced physical functions	27	PD2	0.9959	n/a	n/a
7 - Reduced physical functions	28	PD1	0.9718	7,537	7,324
7 - Reduced physical functions	29	PC2	0.9095	n/a	n/a
7 - Reduced physical functions	30	PC1	0.8429	381	321
7 - Reduced physical functions	31	PB2	0.7116	n/a	n/a
7 - Reduced physical functions	32	PB1	0.7016	1,589	1,115
7 - Reduced physical functions	33	PA2	0.6452	n/a	n/a
7 - Reduced physical functions	34	PA1	0.6308	4,461	2,814
Total	n/a	n/a	n/a	(A) 50,928	(B) 52,272

Home-level case mix index (CMI) is **1.0264** (52,272 ÷ 50,928)

Calculation

- for each clinical category,

  weight × reported assessment days = RUG weighted patient days (RWPD) based on reported assessment days

- total all the reported assessment days (A)
- total all the RUG weighted patient days (RWPD) based on reported assessment days (B)
- calculate the home-level CMI (C = B ÷ A)

Appendix C - RAI-MDS coordinator – training and operational requirements

Every long-term care home (LTCH) implementing RAI-MDS will select a regulated health care practitioner for the role of RAI-MDS coordinator.

Each RAI-MDS coordinator(s) and any person assisting the RAI-MDS coordinator to perform RAI-MDS function must receive the required training from the Canadian Institute for Health Information (CIHI) to implement the RAI-MDS tool. Long-term care homes may contact the education desk at CIHI to obtain a copy of the RAI-MDS 2.0 user manual. The required RAI-MDS training is provided by CIHI at no cost and is outlined in the CIHI learning and development interRAI in continuing care info sheet. For more information about education and training programs offered by CIHI please visit CIHI's continuing care and residential care web pages or contact CIHI at CCRS@cihi.ca.

Each long-term care home must ensure that the RAI-MDS coordinator(s) and any person assisting the RAI-MDS coordinator to perform the RAI-MDS function complete the RAI-MDS proficiency evaluations on an annual basis.

The ministry may establish additional training requirements under this policy and for this purpose may arrange for access to web-based training for use within the long-term care home. Each long-term care home must comply with these additional training requirements.

Each long-term care home must comply with all applicable requirements set out in the service accountability agreement between the long-term care home and Ontario Health (OH) (LSAA), which include requirements applicable to the collection, use and reporting of RAI-MDS data. Responsibilities of the RAI-MDS coordinator include, but are not limited to:

- attending all applicable RAI-MDS education sessions
- providing RAI-MDS education and computer application training to all RAI-MDS users
- assisting RAI-MDS users to correctly code assessments and providing support for validation of coding
- overseeing the RAI-MDS process according to applicable policies, law and agreements, standards of practice and interRAI requirements (see CIHI RAI-MDS 2.0 user manual)
- liaising with applicable software vendor and representatives to develop a training plan for RAI-MDS users on the computer application
- providing on-site computer application support to all RAI-MDS users in the home
- attending the data submission self-study training by CIHI
- providing ongoing leadership for education, data accuracy, data submission and computer applications of RAI-MDS

Appendix D – Schedule of vacancies

FORM: Schedule of Vacancies

Room #	Bed Type (e.g. long-stay, interim short-stay (Note: (excludes long-stay beds designated for use in a specialized unit program and convalescent care beds)	Date of Vacancy Or Room Closure	Date Completed or Room Opened

Appendix E – Letter for reporting on long-term care homes wait list template

FORM: LETTER FOR REPORTING ON LTC HOME'S WAIT LIST

{Insert agency letterhead here}

RE: Verification of Potential Residents on Long- Term Care Home's Wait List during Partial or Full Suspension of Admissions Due to an Outbreak of a Communicable Disease

Name of LTC Home: _____

Start Date of suspension of admission: _____

End Date of suspension of admission: _____

1. **During the suspension of admission period**, did the home have potential residents on its wait list that could have been admitted to the home?

Check one: ☐ YES ☐ NO

2. **Prior to the start of the suspension of admission period**, the home had _____ (please fill in number, if applicable) potential new residents who were available for admission but who had not yet been admitted.

_____ _____

Signature - Placement Co-ordinator Date

Related information

Related

- Long-Term Care Home Level-of-Care Per Diem Funding Summary
- Long-Term Care Homes Quality Attainment Premium (QAP) Funding Policy
- Fixing Long-Term Care Act, 2021

Footnotes

- footnote [1] Back to paragraph ^ Please note beds in abeyance are excluded as these beds are not in operation.
- footnote [2] Back to paragraph ^ Long-stay beds must achieve 97% occupancy to receive 100% of the level-of-care per diem funding
- footnote [3] Back to paragraph ^ Effective January 1, 2019, long-term care homes operating 64 or fewer long-stay beds will receive 100% of the level-of-care per diem funding in the NPC, PSS and NS envelopes regardless of the actual occupancy achieved (Note: Where a short-stay respite program exists, the short-stay respite bed shall be counted as a long-stay bed)
- footnote [4] Back to paragraph ^ DSU long-stay beds will receive 100% of the LOC per diem funding regardless of the actual occupancy achieved
- footnote [5] Back to paragraph ^ Short-stay respite beds receive 100% of the LOC per diem funding regardless of the actual occupancy achieved
- footnote [6] Back to paragraph ^ Convalescent care beds receive 100% of the base LOC per diem funding regardless of the actual occupancy achieved and 100% of the additional subsidy regardless of the actual occupancy achieved
- footnote [7] Back to paragraph ^ Interim short-stay beds must achieve 90% occupancy to receive 100% of the LOC per diem funding