Alberta Health Services

Activity Based Funding of Long-Term Care

User summary

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1 Introduction

Within healthcare system management, organizational objectives can be achieved through the use financial incentivizing strategies. Activity based funding (ABF) is one of the tools used by Alberta Health Services (AHS) that seeks to optimize the allocation of available government funds to serve the population health needs within AHS's mandate. Starting April 1st 2010, the ABF methodology was implemented in the funding of long-term care (LTC). This was a shift away from the several different funding advices previously employed. ABF moves towards a model of funding better designed to achieve the objectives of a provincially unified health system, promoting the most equitable and practical use of limited resources and funds.

This user summary provides an overview of the ABF methodology, motivations and objectives. This document seeks to give a detailed explanation of the ABF model for LTC, a timeline for its implementation and the implications facing the managerial and operational staff of LTC facilities. Additionally, the user summary illustrates how ABF in LTC aligns with the values of respect, accountability, transparency and engagement set forth by AHS. Finally a glossary of terms related to LTC and ABF is provided.

2 What is Activity Based Funding?

ABF is a method used by funding agents to pay for desired health services. It is a form of output-based funding which classifies clients by clinical acuity and resource use in order to enable consistent and appropriate pricing. This funding methodology provides funding based on care allocated to clients as opposed to funding a specific type of bed. The key objective of ABF is to align incentives within the health system so that the most appropriate services are delivered for the most efficient price. There are two key aspects of ABF:

a) **Grouping clients of similar clinical acuity and resource consumption:** the ABF models rely on the averaging of client groups such that their costs and clinical behaviours, as a group, are very similar and comparable across institutions. The grouping process relies on each member of a cluster being of similar clinical circumstance, appearance and requiring similar levels of resources in their treatment process.

b) **Pricing these groups:** ABF model requires that all client/patient groups be assigned a price reflecting the costs of resources needed to treat the clients within each grouping. It is very important that this price is set at an appropriate level. If prices are too low, the delivery of services to the client/patient is not adequately compensated. Alternatively, if prices are too high, providers are not sufficiently motivated to deliver services efficiently. To more accurately ensure that prices are set at an efficient level, prices can be adjusted for the site-specific characteristics of a given facility.

Notably, ABF methodologies in LTC do not control the overall amount of provincial funding to be applied, but rather is an allocation methodology used to determine the most optimal allocation of such funding. LTC sites can be assured that for a period of time during ABF implementation, as sites become familiar with ABF and establish systems and procedures, they will not lose any funding. This "no-loss funding provision" will remain in effect for a reasonable amount of time after the initial implementation of ABF. Looking forward, acuity-based redistribution will, as realized with ABF, alleviate the cost pressures experienced by sites that have experienced higher-than-average acuity increases in recent years.

The implementation of ABF methodologies along with clearly defined policy, procedures and performance targets can help to ensure the services provided by AHS meet a high standard of quality and are delivered in a timely and equitable manner. The use of ABF in line with other policies and procedures is fundamental as the design of ABF needs to be aligned with strategies rooted in an understanding of the appropriate type, number and mix of services for a particular population being served. The implementation of ABF is met with a number of safeguards, e.g. to ensure the quality of care.

3 Activity Based Funding for Long-Term Care

LTC is part of the Continuing Care continuum of services in Alberta. The provision of LTC to Albertans is a fundamental feature of AHS's mandate and an integral part of delivering high quality health care to the province. LTC services are those provided to clients assessed as having complex, unpredictable medical needs requiring 24-hour on-site registered nursing care. Upon admission to a LTC facility, the clients' acuity is then re-assessed using the Resident Assessment Instrument Minimum Data Set 2.0 tool (RAI MDS 2.0).

3.1 What is Prompting a New Activity Based Funding Model?

ABF is generally understood as a fair and equitable method of allocating resources as it has clear links between client acuity and client funding. Prior to the formation of AHS, a multitude of funding formulas and funding advices were developed and implemented at

the regional level by each of the former Regional Health Authorities (RHAs). Consequently, facilities across regions were not comparable given the wide variations in funding mechanisms, reporting requirements, reporting authorities as well as the reporting of quality indicators and financial accountabilities. With the creation of a unified provincial health authority, AHS, a province-wide funding model was essential to ensure the efficiency and equitableness of resource allocations and subsequent service provisions. In a provincial context, ABF has been adapted to the locally preexisting reporting systems to create a funding model that is both flexible and extensive. As a result, ABF implementation will provide incentives to facilities throughout the province to provide consistent, comparable and transparent information regarding clinical indicators and resource consumption.

ABF results in an improved alignment of the services provided by LTC operators to the health care needs of LTC clients. ABF provides funding based on the actual care provided to clients as opposed to funding purely based on the types of bed, thus moving towards a system where funding is more appropriately linked to client acuity.

3.2 What are the Main Objectives and Key Features of Activity Based Funding in Long-Term Care?

Stemming from the reasons prompting the implementation of ABF into LTC within Alberta, the key objectives of the new model are to:

1. Achieve equity in funding allocations by focusing upon the equitable access and quality of services for clients with similar needs.
2. Support consistency in the access to services, the standards of services and the prices paid for services across the province for clients with similar needs. Services provided by both contract service providers and AHS' service providers will be funded in the same manner.
3. Provide transparent, predictable funding consistent with the quantity, complexity and quality of the services needed by clients.
4. Encourage predictability whenever possible for decision-makers, clients and key stakeholders.
5. Provide incentives for improving efficiency and quality in the delivery of LTC.
6. Achieve financial goals for the Continuing Care and LTC sectors.
7. Promote positive health outcomes for Continuing Care clients.

In line with the above objectives, AHS has stipulated the following key features that should exist within its new funding model for LTC:

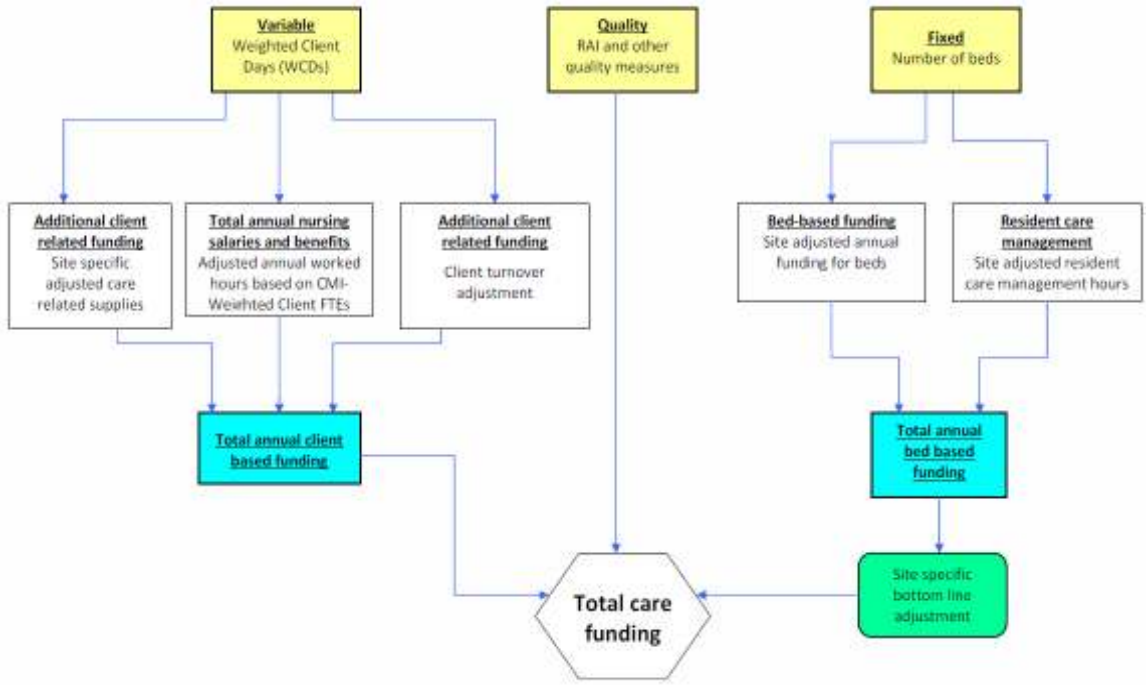
1. A standardized funding method that promotes efficiency and provides incentives for improving quality.
2. Unified funding advice (including LTC and SL3/4/4D) for all operators.
3. The use of a valid and reliable case mix tool.

4. Transparent and equitable costings, using provincially averaged rates except for mutually recognized and unavoidable cost differences.
5. Allowing for incentive mechanisms in funding to be easily introduced and implemented.
6. Assurance of data quality through audit and competency activities

3.3 What is the Activity Based Funding Model for Long-Term Care?

The ABF model for LTC consists of three components: a variable component, a fixed component and a quality component. Diagram 1 is a depiction of the ABF model for LTC. The upper level (yellow boxes) contains the three components (variable, fixed and quality). The middle level (white boxes) demonstrates the type of funding under each of the three sections in the upper level. The next level (the blue boxes) provides the total annual funding from the individual workings featured in the middle level. Finally, the lowest level (green box) presents the adjustment factors that fine-tune the amount of total funding. The variable, fixed and quality components are discussed below.

Diagram 1: The ABF Components of LTC Funding



3.3.1 The Variable Component

The variable component of the ABF model relates to the services that vary according to the number and needs of clients residing in a LTC facility and subsequently determines the total amount annual client-based funding. There are three aspects to the variable component of the ABF model; annual nursing salaries and benefits, additional client-related funding for site-specific adjusted care-related supplies and additional client-related funding for client turnover. These three elements are further discussed below. The majority of the per capita funding is associated with the RAI MDS 2.0 RUG-III Case Mix Index (CMI) weighted client days (WCDs), typically realized as salaries or care-related supplies in the provision of treatment.

While there are three separate elements of the variable component of ABF for LTC, a key feature is the use of WCDs. The WCDs are a primary determinant of “activity” in the Activity Based Funding model. The WCDs of a given facility are determined using the mix of clients served by the facility multiplied by the measure of relevant resource intensities, or CMIs, attributed to treating a client in a given Resource Utilization Group (RUG) category. The activity of a facility is funded on the basis of the volume of clients in each RUG and the respective intensity of the resources specified by each RUG. WCDs are responsive in their design. The use of WCDs across facilities allows for the grouping of clients into resource homogenous groups and the establishment of prices for the treatment of these client groups. Financial data and client data are readily available for

the construction of these WCDs. The design of ABF in LTC is grounded in its allocation of available funding on the basis of the workload, or activity, of a facility. A simple formulation of WCD and CMI calculations are presented below.

WCD *= Un-weighted Client Days * CMI*

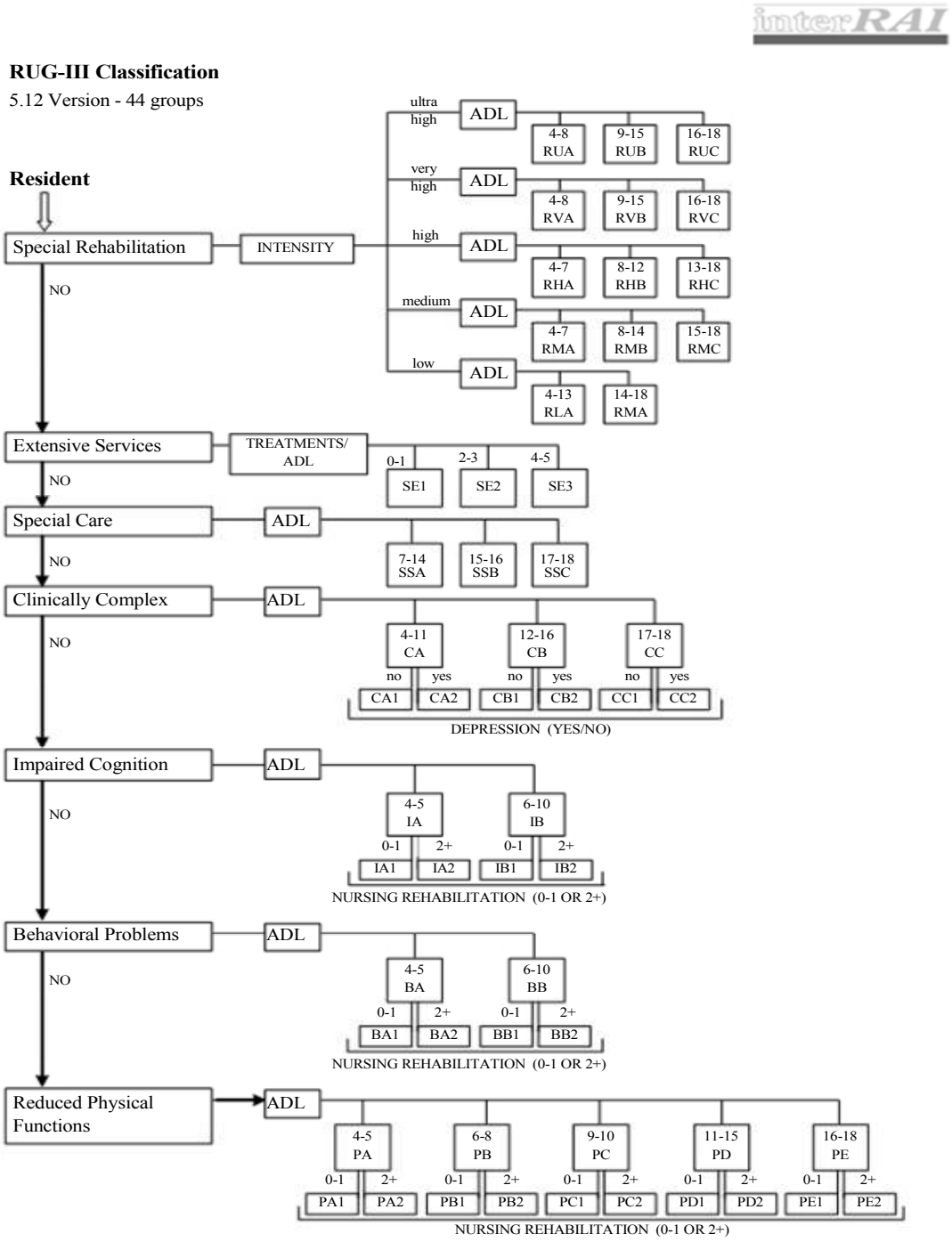
CMI *= RUG Specific Usage / System Average Resource Usage*

CMI is a measure of resource intensity and is calculated for each RUG category. The CMI for each RUG is the resource specific use for an individual RUG divided by the system average resource per client resource usage. A RUG with a higher CMI values are indicative of a greater level of resources required in the treatment of clients in a specific RUG category.

RUGs are developed by interRAI (a consortium of researchers, clinicians and policy makers that provides a no-charge LTC assessment instrument) case-mix systems and are used in institutional LTC settings. The RUG-III tool consists of a case-mix algorithm developed to provide a client-specific means of allocating health care resources based on the variable costs of caring for individuals with different needs. The current Version 5.12 of RUG-III uses 108 variables from the MDS 2.0 to create 44 categories of clients with homogeneous resource use patterns. The RUG-III algorithm explains about 55% of variance in resource use, and it has been validated in a number of countries through a series of international studies. The interRAI case-mix system is depicted below.

The ABF model can make use of RUG-based inputs or bed-based inputs and can easily be modified between the uses of these two input measures. For the fiscal year 2011/2012, RUG-based inputs will be used for ABF in LTC and this is likely to be the case in subsequent funding years.

Diagram 2: 44 Group Version InterRAI Case-Mix Systems



3.3.1.1 Total Annual Nursing Salaries and Benefits

The ABF model uses labor-market-adjusted CMIs values to create WCDs for each RUG category. The model permits the CMIs values associated with each RUG category to be adjusted depending on which incentives are desired. AHS has determined the targeted worked hours per WCD by types of staff. In turn, these are multiplied by the WCDs to get the provincially prescribed funded worked hours.

Provincial prescribed funded work hours are multiplied by a site-specific productivity phase-in factor to adjust worked hours up to currently funded levels for each site. These adjusted work hours are then multiplied by the provincial worked-to-paid hour ratio (also adjusted by a site-specific factor) to produce the number of paid hours for staff. Worked to paid ratios define the ratio between the hours devoted to hands on care (worked hours) and the fully burdened hours which includes hours such as sick time and vacation time (paid hours). Paid hours are then multiplied by provincial salaries that are also adjusted to site-specific levels. Provincial salaries are derived from steps in union agreements with benefits included. The aforementioned model phase-in factors and considerations are presented later on.

There are four types of accountabilities built into the model, each having its associated financial implications. These accountabilities are primarily developed for components of the formula where there may be perverse incentives to inappropriately maximize revenue. In aligning realized patient or client care with funding, all accountabilities are related to hands-on care (worked hours) instead of paid hours. The accountabilities are:

a) The total number of work hours actually provided – stipulates the minimum worked hours for RNs.
b) The mix between types of staff – A LTC facility can substitute up to 25% of hours between RNs, LPNs, HCAs, Pro Therapies, and Non-pro Therapies, 75% of the hours must be provided by the designated category.
c) Compliance with minimum combined staffing levels (RN-Equivalent Hours)– ensuring that with substitution that a minimum number of staffing hours are still provided.
d) Worked hour/WCD- ensures each WCD has at least 2.97 worked hours per client day. 2.97 worked hours per client day is equivalent to 3.6 paid hours per client day (at CMI 100).

3.3.1.2 Site-Specific Adjusted Care-Related Supplies

Site-specific adjusted care-related supplies are also driven by WCDs to reflect the higher use of supplies by higher needs clients. The funding for these supplies also accounts for site-specific adjustment factors.

3.3.1.3 Client Turnover

ABF includes a pool of funds to address the cost of client turnover. It has been suggested unanticipated surges in client turnover pose a significant financial burden for sites, especially for smaller centers. Thus, ABF for LTC sites funding can be adjusted to account for the number of clients discharged throughout a time period.

3.3.2 The Fixed Component

The fixed component relates to the total annual bed-based funding for LTC facilities. The fixed component of ABF is split into two elements: site-adjusted annual funding for beds and site-adjusted resident care management hours. Firstly, site-adjusted annual funding for beds is determined by the number of beds multiplied by provincial factors which, in turn, are multiplied by site-specific phase-in factors. However, determining funding based solely on the number of beds creates an incentive for facilities to reduce occupancy rates to less than optimal levels since having clients in beds increases resources used and reduces profit margins. As such, current ABF modeling includes an accountability associated with occupancy, i.e. a low-occupancy funding adjustment (the green box in diagram 1).

Associated with the bed funding are a number of staff roles, including the resident care management, the Resident Assessment Instrument (RAI) coordinator, the infection control coordinator, and the clinical pharmacist. For smaller sites, ABF compensates by adding worked hours to comply with minimum staffing requirements for the director of care (equating to 0.5 or greater FTE with a 38 bed cut off defining small sites).

3.3.3 The Quality Incentives Component

Beginning in fiscal year 2011-12, the ABF model includes a separate funding pool approved for quality incentives funding (QIF) for long-term care facilities. This represents a 'quality bonus' awarded to facilities meeting or exceeding a set of pre-determined quality criteria. QIF aligns with AHS principles of respect**,** accountability, partnership/ collaboration and transparency and is designed to drive quality and best practice. In doing this, criteria for incentives are client focused, sustainable, dynamic, equitable and evidence based. The QIF is applied provincially and is subject to ongoing evaluation and monitoring.

There is a three phase plan to implement QIF:

- Phase I focuses on the submission of plans and progress reports for quality improvement initiatives as well as 2011 immunization rates.
- In Phase II the model is proposed to include outcome measures such as risk adjusted RAI Quality Indicators and compliance with standards.

- Phase III potentially introduces a quality recognition program that may include additional financial rewards for exceptional quality performance and public reporting.

In 2010-11 all operators automatically received additional quality bonus funding equal to 0.04% of their operating funding. For Phase I (beginning 2011-12) the separate pool of funds for the quality bonus has been increased to so that the total QIF funding a facility is eligible for is 0.2% of the actual 2011-12 operating funding. The potential maximum amount for 2011-12 represents an increase of 0.16% and is a separate part of the overall 3.8% funding increase for LTC in 2011-12.

Phase I QIF will include the following five indicators:

1. One of the following two:
   i. Implementation plan and progress report for the conversion from RAI Resident Assessment Protocols (RAPs) to Client Assessment Protocols (CAPs) **or**
   ii. Implementation plan and progress report for a quality initiative based on RAI quality indicators at site level
2. Action plan and progress report on medication reconciliation on admission **and** standardized medication review process
3. Action plan and progress report on opportunities for improvement from the results of the 2010 LTC Family Satisfaction Survey. LTC sites that did not participate in the Health Quality Council of Alberta (HQCA) LTC satisfaction survey may submit an action plan and progress report on the results from internal processes used to measure family satisfaction.
4. Staff Immunization Rate that meets or exceeds the AHS LTC target (established by AHS Public Health)
5. Resident immunization rate that meets or exceeds the AHS LTC target (established by AHS Public Health)

Implementation of phases II and III will be further developed as quality information and indicators become available. In these latter phases, indicators, measures and thresholds of quality will be specified based on observed evidence and expert consultation. In addition, public reporting strategies will be developed and implemented in collaboration with Alberta Health & Wellness.

A funding submission template and Q & A documents are available on request. The deadline for submission for the 2011-12 year is November 30, 2011.

3.3.4 Out-of-Scope

Accommodation is funded through accommodation charges to clients. The funding model does not include accommodation revenue (including hotel costs). The ABF model is designed solely to allocate funding for care. Additionally, capital costs are not funded via the ABF model and if provided, are provided by the Alberta Government.

3.4 Constants in the Activity Based Funding Model of Long-Term Care

In addition to the utilization of RUGs as an important determinate of the variable funding allocated to LTC facilities, values of constants are fundamental to the calculation of both the variable and fixed components. Constant values in the ABF model are determined in collaboration with Alberta Continuing Care Association (ACCA) representatives. Further, constant values are calculated within annual budget limits of the LTC facility provincial funding envelope. Constant values are calculated for the following aspects of the ABF model for LTC:

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

The constant values for RN, LPN, HCA, pro and non-pro therapies and the resident care management are determined based on the 'typical' hours worked as well as non-worked days, overtime, statutory holidays and hours spent on orientation. Wage rates for the determined total hours worked are based on AHS union agreements and are benchmarked against internally budgeted rates. Care related supplies are set per weighted client day based on the average rate as demonstrated in care supplies and related care support by former Health Region funding formulas. Care/administration costs are calculated per bed and estimated as approximately 11.5% of direct care hour costs. Client turnover is determined per turnover based on an analysis of subsidiary cost experience.

3.5 Model Phase-In Factors and Considerations

ABF is being introduced by AHS into LTC services at a pace balancing the need to generate efficiencies and achieve the desired outcomes of the Alberta Continuing Care Capital and Operational Plan against the risks of causing unintended results for those being served or those providing the services within the system.

The implementation of ABF into LTC began on the April 1st, 2010. Initially there were no funding reallocations for any operator. Additionally, there has been a no-loss provision put in place, whereby current base levels of funding will not be reduced until the no-loss provision ends. This will work in combination with annual funding increases. The ABF model will be used to determine the amount of the funding increase that each site will receive. Once the no-loss funding provision is removed, sites will be phased into ABF over 6, 10 or 26 quarters (starting from October 1st, 2010). Specifically, sites that are underfunded relative to the ABF prescribed funding will be phased up to the prescribed rate over 6 quarters (April 2011). Sites that are overfunded relative to the ABF prescribed funding will be phased down to the prescribed rate over 10 quarters which ends March 31st 2012 (for AHS, Covenant, Capital Care and Carewest sites) or 26 quarters which ends April 2016 (for private operators). The following phase-in factors will apply:

1. **Productivity Phase-In Factor:** Facilitates the re-introduction of acuity (resource intensity) starting in the third quarter of 2010/2011.

   The most recent acuity assessment was done in conjunction with Alberta Residents Classification System (ARCS) in 2005, for the 2006/2007 funding year. For the period of 2007/2008 through 2009/2010, the former RHAs used a variety of methods to estimate site-specific acuity. Some applied across-the-board increases for acuity, as was done by AHS in 2009/2010.

   It is widely suspected that system-wide average acuity in LTC has increased over the past four years. However, this increase is not uniform across all sites; for some sites acuity grew much slower or decreased compared to the provincial average and for other sites acuity grew much faster than the provincial average. For sites whose acuity increased much slower or decreased compared to that of the provincial average, they are at risk of reductions in their funding level. To address this, a no-loss funding provision will be used in combination with annual funding increases.

   The acuity factor will be phased in over 6 or 10 quarters. Ending March 2012, the 6 quarter target applies to facilities that are underfunded relative to the ABF prescribed rate; while the 10 quarter target, ending March 2013, applies to all other sites.

2. **Care-Related Supplies Phase-In Factor:** Accounts for the differences in costs of care-related supplies and will have a 6, 10 or 26 quarter phased introduction.

3. **Bed-Related Phase-In Factor:** Accounts for the differences in site administration and bed-based funding relative to facility size; it has a 6, 10 or 26 quarter phased introduction, with funding reductions for sub-threshold occupancy rates.
4. **Worked-To-Paid-Hour Phase-In Factor***:* Will have a 6, 10 or 26 quarter phased introduction as Alberta moves to standard worked-to-paid hour conversion factors.
5. **Salary Phase-In Factor:** Will have a 6, 10 or 26 quarter phased introduction as Alberta moves to standard salaries for each type of staff.

3.6 Annual Recalculation of the Alberta CMIs

A CMI represents the relative expected cost of care for a client within a Resource Utilization Group (RUG) as compared to the average client in the system. Put differently, CMIs represent the intensity of the Resource Use (RU) by RUG relative to the system-wide mean RU.

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

1. Client days: Count of days using data housed in the LTC database
2. Wage rates: Wages by type of staff as provided by AHS Business Advisory Services (BAS)
3. Staff time: Minutes by type of staff per day per RUG group based on the U.S. STRIVE (Staff Time and Resource Verification) study. For the RAI 2.0 RUG CMIs, values from the Canadian CAN-STRIVE study should be available within five years.

The first step in determining the CMI value is to calculate the Wage-Weighted Minutes (WWM) for each RUG category.

$$WWM_{RUG_i} = \sum_{j=1}^{\#\ of\ Staff\ Types} Relative\ Wage\_Rate_{RUG_i\ Staff\ Type_j} * Staff\_Minutes_{Staff\ Type_j}$$

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

$$RU_{RUG_i} = WWM_{RUG_i} * Client\ days_{RUG_i}$$

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

$$Calibration\_Value = \frac{\sum_{i=1}^{\#\ of\ RUGs} RU_{RUG_i}}{\sum_{i=1}^{\#\ of\ RUGs} Client\ days_{RUG_i}}$$

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

3.7 What are Some Possible Implications Facing Operational Staff?

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

3.8 Current Limitations

The application of ABF requires valid and reliable measurement systems that are able to assign unitary values of expected resource consumption to patient or client specific outputs. Other methods of funding will be considered in cases where these data are not available or where this methodology is not suitable in the formulation of sensible funding decisions. Additionally, ABF does not currently include funding for capital, accommodation, high-cost drugs or client transportation.

3.9 Summary of Monitoring and Review Processes

Long-Term Care (LTC) Activity-Based Funding (ABF) requires valid and reliable Resident Assessment Instrument (RAI) 2.0 Data. A comprehensive monitoring strategy triggers RAI data entry reviews. An AHS team reviews RAI coding, business processes, and adherence to provincial and CIHI standards and does post-review follow-up. All LTC facilities are randomly scheduled to be reviewed at least once every two to three years[1] and more frequently as prompted by quarterly monitoring reports.

[1] The timelines are highly dependent on available resources, documentation quality (i.e., time required to investigate each facility), required follow-up, and investigation rigor.

Monitoring and review will utilize a number of measures, including:

1. **Cross-sectional comparisons**

    a) **Average CMI:** LTC facilities identified as having exceptionally high or low CMIs will be monitored and reviewed.

    b) **Occupancy Outliers:** Facilities with occupancy rates[2] between 96 and 100 percent in a period are 'inliers'. Facilities outside this range are 'outliers' and warrant investigation.

    c) **Percent of clients in rehabilitation categories**- LTC clients in the 14 rehabilitation categories are the most resource-intensive clientele with the highest CMIs. Facilities with particularly high proportions in these rehabilitation categories warrant review.

2. **Longitudinal monitoring**

    a) **Average CMI and variation in CMI:** Charts plot the average CMI movement and variation around average. Control limits are set four standard deviations from average[3]. Separate analysis are conducted on small (<45 beds), medium (46-90 beds) and large (>90 beds). Facilities falling outside of control limits warrant investigation.

Depending on available resources, a number of facilities will be selected from the cross-sectional comparisons and longitudinal monitoring strategies for onsite reviews. It is possible that facilities not identified by either technique will be also selected for monitoring as all facilities will be audited once within a two to three year timeframe. During the onsite review, an AHS provincial/zone team will review RAI coding and education processes and resident records, identify any anomalies within these records and review business processes. In addition, records of RAI education and staff competency will be reviewed. Outcomes of the review may include coding changes, process changes and/or focused staff education. The review team will also be responsible for required follow-up.

[2] LTC facility occupancy rate is a period's client days as a proportion of bed days
[3] Control limits are adjusted for sample size and are not strictly four standard deviations.

4 Alberta Health Services' Values and Key Aspects of Activity Based Funding

The key elements of the ABF model can be illustrated in accordance with several of the AHS values, i.e., respect, accountability, transparency and engagement.

1. **Respect** – For the operators and sites, the model does not require any additional data collection beyond that associated with RUG-III reports, financial reporting and consistent provincial quality accountability reporting. More importantly, despite ABF implementation being effective April 1st, 2010, there is a no-loss provision in place to protect and maintain current base levels of funding.
2. **Accountability** – The model includes "accountabilities" to counter any undesirable behaviors that may be incentivized by funding drivers. Occupancy rates hold facilities accountable for their workload volumes; the Quality Incentive funding model and requirement for submission of quality accountabilities will hold facilities accountable for the quality of care provided; and funded worked hours hold facilities accountable for minimum staffing, professional/non-professional staff mix, and actual worked hours.
3. **Transparency** – Constants used in the methodology are clearly stated and has a clear logical flow. Further, the model can simultaneously accommodate RUG based and bed based funding and can be converted from one to the other with minimum modification. The model has adjustments that are not yet activated but can be easily incorporated in the future.
4. **Engagement** – The LTC model is being integrated and adapted with, SL 3/4/4D, into a "campus of care" vision. Moreover, the model can accommodate specific incentives via RUG-level adjustments. AHS has and continues to engage stakeholders to provide information and feedback regarding ABF.

5 Stakeholder Consultation

Sessions have been held to orient stakeholders to the new ABF model for LTC funding. Stakeholders include internal AHS staff; Alberta Health & Wellness (AHW); Alberta Seniors and Community Supports (ASCS), Alberta Continuing Care Association (ACCA), and the community of LTC operators. There is representation from ASCS, AHW and ACCA on the AHS ABF Continuing Care Working Group and other relevant sub-groups. Orientation sessions have included high level overviews of the model and technical briefings of how the model works (including detailed walk-throughs of the funding template). As ABF is further implemented, workshops will continue to be available for the purposes of educating those that are unfamiliar the ABF methodology.

6 Summary and Conclusion

The intent of ABF is to align incentives within the health system so that the most appropriate services are delivered at the most reasonable price to meet the needs of the population served. Successful implementation of ABF in LTC requires valid and reliable measurement systems to assign prices to outputs. ABF needs to be aligned with a strategy rooted in an understanding of the appropriate type, number and mix of services for a particular population being served. Also, ABF cannot be implemented without a way to ensure the quality of care.

ABF will provide a unified funding template for all operators and that template includes LTC and, eventually, SL 3/4/4D. The model also provides equivalent funding for private, voluntary and public institutions. This ABF funding template makes use of the validated continuing care case mix system (RAI MDS 2.0), but also has the flexibility to address bed/client-based funding. It is transparent, equitable and sensitive to cost differences. ABF allows for various incentives to be built into the funding model. Part of ABF implementation will involve the phase-in of standardized provincial salaries and worked-to-paid hour ratios. Finally, funding for drugs and client transfers are not currently included in the ABF of LTC and will be addressed in a different way.

In conclusion, ABF provides a uniform and standardized method of funding LTC. It has been developed and implemented in consultation with stakeholders and will continue to be refined in that spirit. Indeed, the key elements of ABF are guided by the values of respect, accountability, transparency and engagement.

Appendix 1 - Glossary of Terms

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

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

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

Efficiency – is where more output of a given quality cannot be achieved without increasing the amount of inputs. Efficiency within the health system can be classified into three categories: administrative, operational and allocative efficiency[4].

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

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

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

[4] Source for definitions of efficiency: 'The Australian Health Care System: The Potential for Efficiency Gains, A Review of the Literature, Background paper prepared for the National Health and Hospitals Reform Commission, June 2009'.

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

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

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

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

Source: AHW/AHS

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

Source: Adapted from ASCS Supportive Living Framework, 2007

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

Source: ASCS Supportive Living Framework, 2007[5]

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

Source**:** Adapted from AHS Living Option Guidelines

[5] The ASCS Supportive Living Framework outlines the services provided at each level of supportive living. The document is current being revised and updated.