



Activity Based Funding of Supportive Living

User Introduction

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Activity Based Funding of Supportive Living

User Introduction

1 Introduction

Within healthcare system management, organizational objectives can be achieved via the use of financial incentives. Activity based funding (ABF) is a tool to be used for optimizing the allocation of available government funds to serve the population's needs for health services. An ABF approach will be used to fund supportive living (SL), specifically, supportive living level 3 (SL3), supportive living level 4 (SL4) and supportive living level 4 dementia (SL4D). This is a shift away from the several different formulas and funding advices that were previously used to provide funds to AHS and its contracted partners. ABF moves towards a model of funding that is better designed to achieve the objectives of a provincially unified health system, promoting the most equitable and practical use of limited resources and funds.

Aligned with the "campus of care" vision for the continuum of client care, ABF will ultimately provide operators with one continuing care funding template for SL3 SL4, SL4D and LTC. The model will provide equivalent funding for private, voluntary and public institutions.

This user introduction provides an overview of the ABF methodology and rationale. This document seeks to give a detailed explanation of the ABF model for SL, its implementation and its implications on SL residential settings, primarily referred to as SL facilities. This document also illustrates how ABF in SL aligns with the AHS values of respect, accountability, transparency and engagement. Finally a glossary of terms related to SL 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 predicted care allocated to clients as determined from a comprehensive standardized assessment tool, as opposed to simply funding the services associated with 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:** 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 care settings. The grouping process relies on each member of a cluster having similar functional abilities and requiring similar levels of resources in their care process.

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

Notably, ABF methodologies in SL do not control the overall amount of provincial funding to be applied. Rather, ABF is an allocation methodology used to determine the most optimal distribution of such funding. Also, the current design of the ABF model in SL allows for periodic, most likely annual, funding increases to be additionally disbursed to sites. The allocated amounts of these additional periodic funding increases are to be determined by ABF methodologies. Looking forward, the ABF model in SL will realize acuity-based distributions that will address the costs of providing services to residents of their facilities.

The implementation of ABF methodologies along with clearly defined policies, procedures and performance targets can help to ensure the services funded by AHS meet a high standard of quality and are delivered in a timely and equitable manner. The design of ABF in SL is aligned with strategies that are rooted in an understanding of the appropriate type, number and mix of healthcare services for the particular population being served. Implementation of the ABF model includes safeguards to ensure the quality of care.

3 Activity Based Funding for Supportive Living

SL is part of the Continuing Care continuum of services in Alberta. The provision of SL to Albertans is a fundamental feature of AHS's mandate and an integral part of delivering high quality health care to the province. SL provides a home-like setting so that clients can exercise the most independence and control in their daily lives while also receiving the support and health services they need.

The needs of SL clients vary within and between SL3, SL4 and SL4D settings. Through the AHS Coordinated Access process, clients are individually assessed by AHS for the most appropriate level and program of care using the RAI Home Care (HC) assessment instrument, the AHS living options guidelines and the judgments of care professionals. In SL3, 24 hour on-site scheduled and unscheduled personal care and support services are provided by Health Care Aides, with professional AHS Registered Nurse (RN) services available on an on-call basis. In SL4 and SL4D, 24 hour on-site scheduled and unscheduled professional and personal care and support services are provided by Licensed Practical Nurses (LPN) and Health Care Aides (HCAs) with AHS RN services available on an on-call basis. In all levels, case management and other consultative services are available, primarily through AHS.

In consideration of changes in the severity of client's needs, re-assessments are performed as part of the AHS Coordinated Access process to ensure that the level of care received within any area of the continuing care spectrum is appropriately provided.

3.1 What is Prompting an Activity Based Funding Model?

ABF is generally understood as a fair and equitable method of allocating resources as it clearly links client acuity to funding. Before AHS was established, numerous funding formulas and funding advices were developed and implemented at the regional level by each of the former Regional Health Authorities (RHA). 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. Once AHS was formed, a province-wide funding model was essential to ensure the equality and equitability of resource allocations and subsequent service provisions. In a provincial context, ABF has been adapted to the reporting systems that preexisted locally 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 equal information regarding clinical indicators and resource consumption.

ABF results in an improved alignment of the services provided to meet the health needs of SL clients. ABF provides funding based on the assessed care need of clients as opposed to only funding based on the types of beds, thus moving towards a system where funding is more appropriately linked to client functional status and complexity of care.

3.2 What are the Main Objectives and Key Features of Activity Based Funding in Supportive Living?

Stemming from the reasons prompting the implementation of ABF into SL within Alberta, the key objectives promoted by 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 service and the prices paid for services across the province for clients with similar needs
3. Services provided by both contract services providers and AHS' service providers will be funded in the same manner
4. Provide transparent, predictable funding consistent with the quantity, complexity and quality of the services needed by clients
5. Encourage predictability whenever possible for decision-makers, clients and key stakeholders
6. Provide incentives for improving efficiency in the delivery of SL
7. Achieve financial goals for the Continuing Care sectors of SL and LTC
8. 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 SL:

1. A standardized funding method that promotes efficiency and provides incentives for improving quality
2. To eventually have only one funding advice (including SL3, SL4, SL4D and LTC) for all operators
3. The use of valid and reliable assessment instruments and case mix approaches
4. The funding of drugs and client transportation to be removed from the SL funding advice
5. Transparent and equitable costings, using provincially averaged rates except for mutually recognized and unavoidable cost differences
6. Allowing for incentive mechanisms in funding to be easily introduced and implemented.
7. Supports standardized approaches that facilitate financial and quality accountability

These objectives and features are in line with those of ABF for LTC (implemented in April 2010).

3.3 What is the Activity Based Funding Model for Supportive Living?

The operation of SL facilities can vary considerably depending on a number of factors. These include, but are not limited to, a facility's capacity and occupancy levels, the acuity of the client mix and the resources available to the SL operator for the delivery of supportive care services. As a result of this variability, the provision of care to clients in a given SL setting often requires resources at the site level and at the AHS zone¹ level.

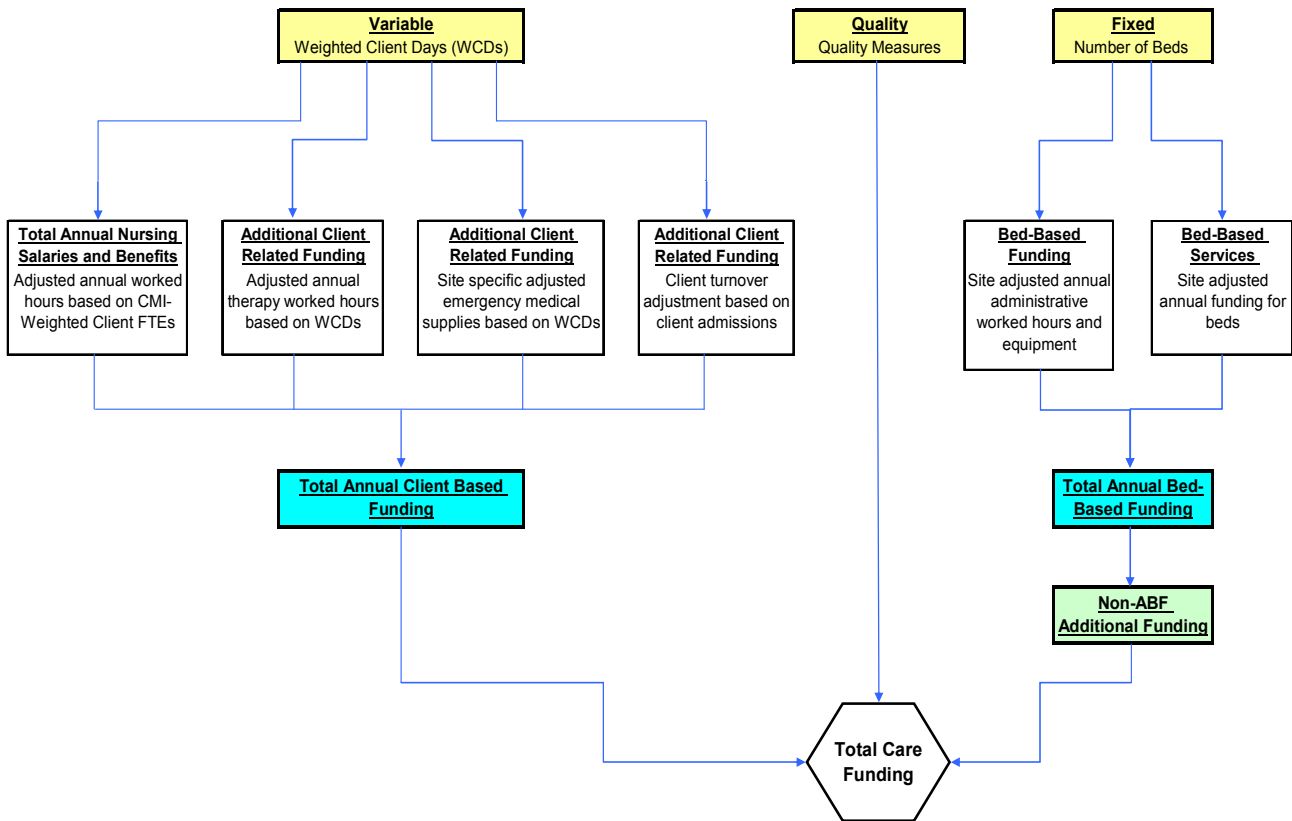
In particular, zone-based funding can allow for the provision of services that may be beyond the capabilities or efficiencies of a particular SL site. Zone-based care provision typically occurs in areas where the cost of provision is impractical or the ability to provide is beyond the scope of the operator. In rare instances, it is also possible for both the zone and the facility's operator to share the provision of a service. The implementation of the ABF model will account for the relative proportions of care that are provided by each party and fund each party accordingly. For instance, the zone may provide resources to a number of its smaller sites for physical therapy and as a result a majority of the portion of the funding for physical therapy will be funded at the zonal level for these sites. Thus, ABF for SL involves the direct provision of SL funds to both the operator of a facility and the zone in which a facility is located.

A key characteristic in the design of the ABF model of SL is the use of bed type adjustments. The term bed type refers to the care services associated with a specific level of SL. If the client requires services associated with those provided in SL4, they are considered to occupy a SL4 bed. Bed type adjustments are able to capture the varying acuity and subsequent resource needs of clients in SL3, SL4 and SL4D. According to an operator's contract, they may provide more than one level of SL to clients, requiring that the bed types of SL3, SL4 and/or SL4D be appropriately weighted in the ABF model. In addressing the variability of client acuity mixes between and through facilities, most elements in the ABF model of SL incorporate a bed type adjustment.

¹ The formation of AHS, April 1, 2009, structures the province into five operational zones; the South zone, the Calgary zone, the Central zone, the Edmonton zone and the North zone.

The ABF model for SL consists of three components: a variable component, a fixed component and a quality component. Diagram 1 is a depiction of the ABF model for SL. 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 sections in the component level above. The next level (the blue boxes) provides the total annual funding from each of the individual workings featured in the middle level. Finally, the lowest level (green box) allows for the incorporation of additional funding that is Non-ABF. A discussion of the variable, fixed and quality components are found following the diagram below.

Diagram 1: The ABF Components of SL Funding



3.3.1 The Variable Component

The variable component of the ABF model relates to those services that change according to the number and type of clients cared for within a SL facility and subsequently determines the total amount of annual client-based funding. There are four key aspects to the variable component of the ABF model; annual nursing salaries and benefits, additional client-related funding for adjusted annual therapy worked hours, additional client-related funding for adjusted emergency medical supplies and additional client-related funding for client turnover. These four elements are further discussed below. The majority of per capita funding is determined with interRAI RUG-III/HC Case Mix Index (CMI) *weighted client days (WCDs)*, predominately nursing and therapy salaries.

While there are four separate elements of the variable component of ABF for SL, a key feature in many of these elements is the use of Weighted Client Days (WCDs). The WCDs are a primary determinant of “Activity” in the ABF 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 Case Mix Indexes (CMIs), that would be attributed to caring for 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 relatively homogenous resource groups and establishing efficient prices for the care of these client groups. Financial data and client data will be made available for the construction of these WCDs. The design of the ABF model in SL 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.

$$WCD = \sum Un - \text{weighted Client Days } (Un - WCDs) * CMI$$

Client	RUG	CMI	Un-WCDs	WCDs
Client 1	1AA	1.20	365	438.00
Client 2	1BB	1.05	365	383.25
Client 3	2AB	0.70	365	255.50
Client 4	3AC	1.04	365	379.60
Client 5	3BD	1.30	365	474.50
Client 6	4AD	0.95	365	346.75
Total	-	-	2190	2277.60

$$CMI = RUG \text{ Specific Usage} / \text{System Average Resource Usage}$$

Client	RUG	CMI	RUG Specific Usage	System Average Resource Usage	CMI
Client 1	1AA	1.20	120	100	1.20
Client 2	1BB	1.05	105	100	1.05
Client 3	2AB	0.70	70	100	0.70

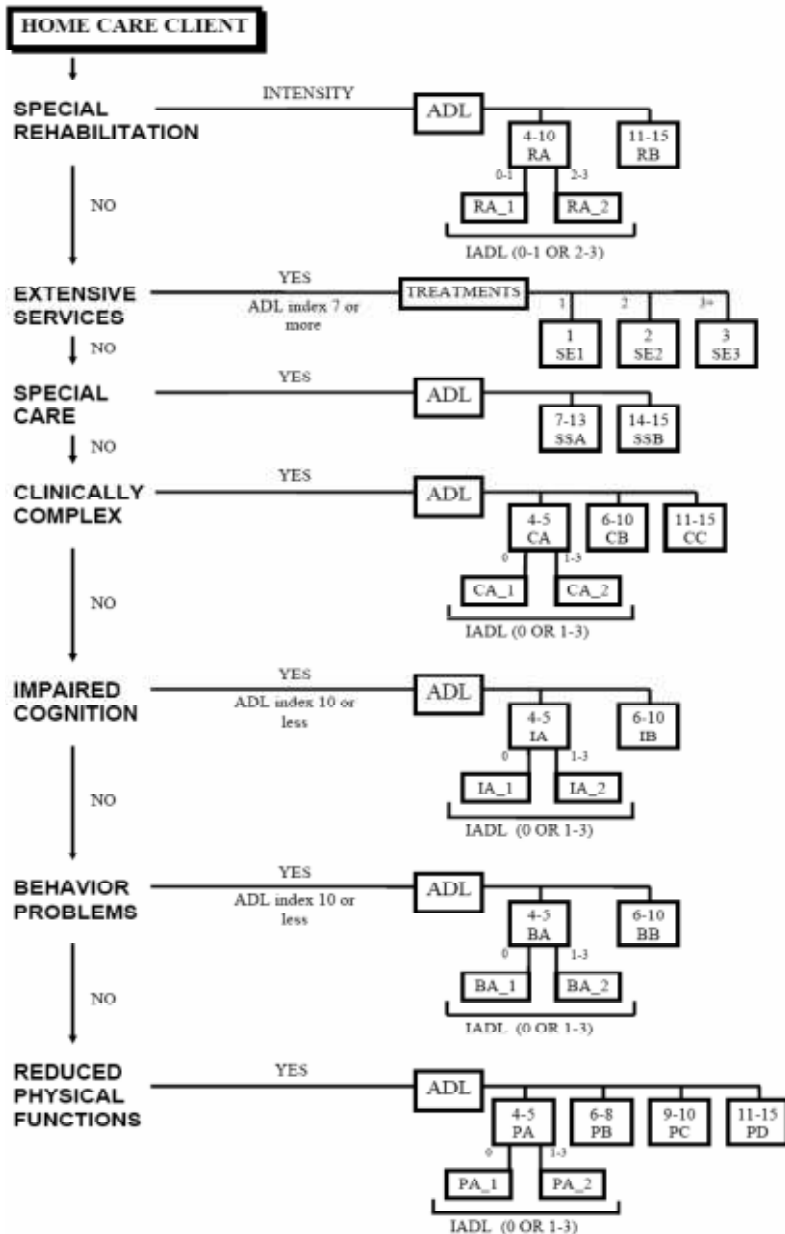
The CMI measure of resource intensity is calculated as the wage weighted RUG specific per client resource usage as a proportion of the system average per client resource usage. Higher CMI values are indicative of a greater level of resources required in the treatment of clients in a specific RUG category.

RUGs were developed by interRAI, a consortium of researchers, clinicians and policy makers committed to improving health care for persons who are elderly, frail, or disabled. InterRAI case-mix systems are used in a number of institutional healthcare settings. For SL applications, the RUG-III tool for home care (RUG-III/HC) consists of a case-mix algorithm that is 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 1.0 of RUG-III/HC uses 74 variables from the interRAI Home Care instrument to create 23 categories of clients with homogeneous resource use patterns. The interRAI RUG-III/HC case-mix system is depicted below.

Diagram 2: 23 Group Version RUG III/HC



RUG-III/HC Home Care Classification



It is recognized that there are defined population groups within SL that are not adequately assessed by the RUG-III/HC tool. These groups include patients suffering from severe mental health issues and dementia. Currently, an investigation of these specialty beds in SL is being undertaken. If these beds can be clearly defined and identified as significantly different from the rest of the SL population, they will be excluded from the ABF model until a tool is able to adequately group and fund these clients is developed.

3.3.1.1 Total Annual Nursing Salaries and Benefits

The ABF model will use labor-market-adjusted CMI 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 and types of SL beds. In turn, these are multiplied by the WCDs to get the provincially funded worked hours.

Provincially funded work hours are multiplied by a site/bed-specific acuity/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/bed-specific factor) to produce the number of paid hours for staff. Paid hours are then multiplied by provincial salaries that are also adjusted to site/bed-specific levels. Aforementioned model phase-in factors and considerations are presented later on.

3.3.1.2 Adjusted Annual Therapy Worked Hours

Clients in SL facilities may require a variety of therapeutic services. Professional and non-professional therapies may be provided in a variety of experts². Therapies are primarily provided by the AHS zones and are based on individual assessments of need and referral for consultation and/or service. The ABF model for therapy worked hours is site/bed-specific adjusted and formulated with the use of WCDs.

3.3.1.3 Site-Specific Adjusted Emergency Medical Supplies

Site-specific adjusted emergency medical supplies are driven by WCDs. The funding for these supplies also accounts for site/bed-specific adjustment factors.

3.3.1.4 Client Turnover

The ABF model includes a pool of funds to address the cost of client turnover.. There is always the possibility of unavoidable turnover periods for, minor maintenance (e.g., room painting or carpet replacement) and compassionate reasons between clients in SL. Thus, ABF for SL sites can be adjusted to account for the number of clients admitted throughout a time period.

² Professional therapies are provided by recreational therapists (RTs), occupational therapists (OTs), physical therapists (PTs), dietitians, social workers, speech language pathologists (SLPs), respiratory therapists and mental health therapists. Non-professional therapies are provided by RT, OT, PT, SLP, respiratory therapy assistants or aides; dietitian aides, social work aides and/or mental health worker aides.

3.3.2 The Fixed Component

The fixed component relates to the total annual bed-based funding for SL facilities. The fixed component of the ABF model is split into two elements: Bed-based funding- site adjusted annual administrative worked hours and equipment and bed based services- site adjusted annual funding for beds. Firstly, bed-based funding - site adjusted annual administrative worked hours and equipment is determined by the number and type of beds adjusted for provincial factors and site-specific phase-in factors. Specifically, this funding measure includes provisions for administration, leadership and equipment. The inclusion of equipment in the SL model for all levels of care is still being determined. It is likely that equipment that is closely tied to care can be funded via the ABF model. However, the majority of other equipment needs shall be addressed via funding outside the model, being dealt with in a manner similar to accommodation and capital funding.

Secondly, SL bed-based services - site adjusted annual funding for beds is also determined by the number and type of beds and adjusted for provincial factors and site-specific factors. This funding measure allows for the provision of case managers, health-professional educators and clinical pharmacists. Depending on the client mix and volume, the extent of supportive care personnel and the resources associated with the bed-based service element of funding can vary considerably. Due to possible provisional limitations of SL facilities, bed-based services are typically largely provided by the zone. As a result, the major proportion of bed-based services funding will be allotted to the zone. Facilities that are able to provide bed-based services in part or in full will be funded according to their portion of provision.

Finally, the ABF model of SL makes allowances for funding that may be necessary to the support services of a facility but not directly related to the number of beds. Non-ABF additional funding includes the provision of RN services. The funding allocated for the provision of an RN is not determined by activity-based measures and the use of site/bed specific factors, rather it is purely determined by the need for an on-call RN. Client services that require the presence of a RN are typically managed on an as needed satellite basis by the zone. Funding for the presence of a 24/7 RN will be completely allocated to the zone in these situations.

3.3.3 The Quality Incentives Component

The ABF model includes a separate funding pool associated with the quality of care and service provided by a facility. Additional funding, a 'quality bonus', will be awarded to facilities that meet or exceed a set of pre-determined quality criteria. Quality criteria are currently and under development. Implementation of this incentive will be phased in as quality information and indicators become available. Decisions regarding quality funding in the ABF model will be made in consultation with operators and stakeholders. The Quality Incentives Component strives to achieve a high quality of care for SL clients.

3.3.4 Out-of-Scope

Accommodation including, but not limited to, meals, housekeeping and capital costs are funded through accommodation charges to clients. The funding model does not include accommodation revenue (including capital financing and hotel costs). The ABF model is designed solely to allocate funding for care and care related costs.

3.4 Constants in the Activity Based Funding Model of Supportive Living

In addition to using RUGs to help determine the variable funding allocated to SL facilities, values of constants are fundamental to the calculation of both the variable and fixed components. Constants are provincially applied values in the ABF model. These values are applied to the number and/or types of beds and/or clients. Constant values include values such as the salaries of health professionals, work to paid hour ratios, supply costs, dollar values for specific tasks and the worked hours for specific health care professionals.

Constants values are subject to change over time, but will remain equal across facilities as they change. Constant values in the ABF model of SL are a work in progress and will be determined in coordination with representatives of AHS, the Alberta Senior Citizens' Housing Association (ASCHA) and the Alberta Continuing Care Association (ACCA) representatives. Further, these constant values will be calculated within annual budget limits of the provincial SL facility funding envelope.

In conjunction with the development of constants, the ABF model of SL will also include staffing minimums for small sites. These minimums are currently under development.

3.5 Model Phase-In Factors and Considerations

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

This balance requires that, prior to the implementation of the ABF model in SL, all relevant stakeholders be oriented and educated on the procedures and guidelines associated with ABF in the operation of SL. Efforts to familiarize those parties concerned with and interested in the ABF model in SL will be made over an ongoing basis, continuing well after implementation.

Current plans specify that immediate to the implementation of ABF in SL, sites will be phased into ABF over a six-year period beginning April 2012. Proposed implementation of the ABF model in SL may also allow for the provision of periodic funding increases to sites. The amount of these periodic funding increases will be determined by ABF methodologies. In general, sites that are underfunded relative to ABF prescribed funding levels will be phased up to a provincially prescribed rate and sites that are overfunded relative to ABF prescribed funding levels will be phased down to a provincially prescribed rate. A number of phase-in factors are currently in development. These will likely include the following:

1. **Acuity/Productivity Phase-In Factor:** accounts for funding based on relevant measurements of a facility's acuity (resource intensity)

It is perceived that the system-wide average acuity in continuing care, including supportive living has increased over the past few years. However, this increase is not uniform across all sites delivering care; 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 will be at risk of reductions in their funding level. The proposed periodic funding increases will ease facilities into ABF as phase-in factors become effective over the six-year phase-in period.

2. **Emergency Medical Supplies Phase-In Factor:** accounts for the differences in the costs of emergency medical supplies and will be subject to a phased introduction over the six year phase-in period beginning April 2012
3. **Bed-Related Phase-In Factor:** accounts for differences in site administration and bed-based funding relative to the size of facility and will be subject to a phased introduction over the six year phase-in period beginning April 2012
4. **Worked-To-Paid-Hour Phase-In Factor:** moves staff to provincially standardized worked-to-paid hour conversion factors and will be subject to a phased introduction over the six year phase-in period beginning April 2012
5. **Salary Phase-In Factor:** moves healthcare personnel to provincially standardized salaries and will be subject to a phased introduction over the six year phase-in period beginning April 2012. Provincial standardized salaries are being developed in order to ensure consistent funding for SL sites. This standardization of salaries does not however mandate how much a site can pay its providers.

3.6 Other Considerations

The ABF model determines the amount of funding that will be provided to a site with the intention that future funding amounts will move toward provincial average rates over the six year phase-in period beginning April 2012. Initially, these phase-in adjustment factors will be set to adjust each site's actual funding to the equivalent of what they are funded at the time of ABF implementation in SL. Phase-in factors will become increasingly effective over time.

The prescribed total ABF amount for sites will be determined annually and made in monthly payments to operators. Adjustments are only made to the monthly funding amounts. If there is a change in the contracted number of beds provided by a particular SL facility, adjustments will be made monthly as these changes occur.

3.7 What are Some Possible Implications Facing Staff?

The key implication for AHS and contracted operational staff from the implementation of ABF in SL is the need for accurate and timely collection of data for funding and care planning and quality improvement purposes. Each of the three components of ABF in SL (variable, fixed and quality) relies on various data collections that may be more extensive than pre-existing data requirements. In the case of SL, where the source of service provisions may vary greatly, client classification and care planning is primarily performed by RN case managers and not SL staff who are directly providing the care. As the providers of care, SL facilities can be assured that appropriate education, training and the use of competency assessments and reviews will facilitate data collection in SL and ensure that acuity sensitive data is of the highest accuracy and quality – during the introduction of ABF funding and on an ongoing basis. Considerations are being made to ensure that the data collection workload on all relevant staff members is reasonable and that there is clear, well developed communication between the RN case manager performing the assessment and the operator’s care team.

3.8 Current Limitations

The application of ABF requires valid and reliable measurement systems able to assign unitary values of expected resource consumption to 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.

Current limitations in SL are primarily concerned with clinical documentation/data collection systems and procedures and the consistency of business practices. To facilitate the implementation of ABF, existing data collection systems in HC and SL have been further developed and business practices and procedures are being established and refined to ensure that clinical documentation/data collection is timely and accurate. Additionally, a subset of AHS HC and SL sites are currently implementing the interRAI HC system. Clinical documentation/data collection systems, procedures and business practices in these and some other AHS zones exhibit significant limitations at the present.

Additionally, the ABF model does not currently address funding for capital or drugs. AHS is working on ways to address these issues.

3.9 Monitoring and Reviewing Processes

Once implemented, AHS will oversee a comprehensive clinical data quality monitoring and reviewing strategy in order to ensure that the data collected is accurate. This will ensure that facilities receive appropriate funding from the ABF model of SL. In general, there will be a system of targeted and regular reviews based on the analyses of interRAI and other data, involving a team of AHS staff with the appropriate expertise. SL facilities will be fully reviewed at least once within a two to three year timeframe. On-site analysis of facilities will involve a team of AHS employees reviewing records and assessing education and business processes. The team will also be responsible for developing regular reports and the recommendation of follow-up actions.

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 the AHS values of Respect, Accountability, Transparency and Engagement.

1. **Respect** – For AHS HC, SL and many operators, the model does require additional clinical assessment and data collection beyond that of current levels. HC and SL staff can be assured that they will receive assistance and collaboration in identifying the assessment and clinical the data collection processes required with the implementation of the ABF model in SL.
2. **Accountability** – AHS administered monitoring and reviewing processes will be developed to maximize data quality and to counter undesirable behaviors that may be created by funding drivers. These processes are currently under development and will be elaborated upon at later design stages of the ABF model for SL
3. **Transparency** – Constants used in the methodology are clearly stated. The model has a clear logical flow and is consistent with the current strategies found in the current ABF area of LTC. The model is flexible and allows for future adjustments to be easily incorporated as the ABF model of SL is implemented
4. **Engagement** – The ABF model integrates SL3, SL4 and SLD with LTC to facilitate a “campus of care”; such as that envisioned by many operators and sites. Moreover, the model can accommodate specific incentives with the use of RUG-level adjustments. AHS has and continues to engage stakeholders to provide information and feedback regarding ABF.

5 Stakeholder Consultation

In the future, sessions will be held to orient stakeholders with the ABF model for SL funding. Stakeholders include internal AHS staff; Alberta Health & Wellness (AHW); Alberta Seniors and Community Supports (ASCS), ASCHA, ACCA, and the community of SL operators. There is representation from the AHW, ASCS, ASCHA, ACCA, and operators on the AHS ABF model Continuing Care Working Group and other relevant sub-groups. In the past, 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 in SL is implemented, workshops will also be available to inform those that may be unfamiliar with ABF methodologies.

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. Successful application of ABF into SL requires valid and reliable measurement systems to assign prices to outputs. ABF needs to be aligned with a strategy that is rooted in an understanding of the appropriate type, number and mix of services for a particular population being served. Responsible ABF implementation will include a number safeguards to ensure the quality of care.

ABF will ultimately provide operators with one continuing care funding template for SL3 SL4, SL4D and LTC. The model will provide equitable funding for private, voluntary and public organizations. This ABF advice makes use of the most relevant continuing care assessment instrument (RAI HC) and case mix methods. ABF allows for various incentives to be built into the funding model. It is transparent, equitable and sensitive to cost differences. An important part of ABF implementation will involve the phase-in of standardized provincial salaries and worked-to-paid hour ratios. While the funding of drugs and client transfers are not currently included in the ABF of SL, they will be addressed at a later time.

In conclusion, ABF provides a consistent standardized method of funding SL. It is being developed in consultation with stakeholders and will be implemented and refined in consultation with these groups. The key elements of ABF are guided by AHS's core values: 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 for the most efficient price.

Source: ABF of AHS

Activity Based Funding Supportive Living (ABF - SL) – 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 HC assessment tool.

Source: ABF of AHS

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.

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.

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.

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.

Source: ‘The Australian Health Care System: The Potential for Efficiency Gains, A Review of the Literature,’ Background Paper by the National Health and Hospitals Reform Commission, 2009

Resource Utilization Groups (RUGs) – derived from the RAI-HC assessment (Resident Assessment Instrument – Home Care). A RUG category is assigned to each client based on relative costs of service they are likely to consume. These groups also provide meaningful clinical descriptions of an individual and/or group of clients. To define the relative costs of service they are likely to consume, a case mix value is also assigned to each RUG category. A prioritization algorithm is then applied based on hierarchical rules (assignment of each client to the highest RUG category), or index-maximizing rules (assignment of each client to the RUG category with the highest Case Mix Index (CMI).)

Source: Adapted from the interRAI website, AIS Mastering the RAI module, Jeff Poss et al. Validation of Resource Utilization Groups Version III for Home Care (RUG-III/HC) Evidence from a Canadian Home Care Jurisdiction

Case Mix Index (CMI) – A CMI is used as an acuity-based adjustment tool in funding strategies. Within InterRAI systems a CMI is associated with each RUG category. The client is assigned a CMI value associated with the main RUG category that is assigned to the client. These CMI weighted RUG categories create clear linkages between client acuity and funding in the ABF model of SL.

Source: as adapted by the ABF team of AHS

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.

Source: ACCIS

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 Care – Publicly-funded health care and support services provided to eligible clients as governed by the Alberta Home Care Program Regulations of the Public Health Act. These services are provided to individuals living with frailty, disability, acute or chronic illness living at home or in a supportive living setting.

Source: AHS Continuing Care Definitions

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 to and who are able to maintain active, healthy, independent living while remaining in their 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 Alberta Seniors and Community Supports (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 buildings are 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 assessed unmet needs.

Source: ASCS Supportive Living Framework, 2007

Designated **Supportive Living Level 3** – Assisted Living (SL3) option where AHS controls access to a specific number of beds according to a contractual agreement between AHS and the operator. Twenty-four hour on-site scheduled and unscheduled personal care and support services are provided by Health Care Aides. Professional health services including Registered Nurse services with 24 hour on-call availability, case management and other consultative services are provided through AHS.

Designated **Supportive Living Level 4** – Enhanced Assisted Living (SL4) option where AHS controls access to a specific number of beds according to a contractual agreement between AHS and the operator. Twenty-four hour on-site scheduled and unscheduled professional and personal care and support services are provided by Licensed Practical Nurses and Health Care Aides. Professional health services including Registered Nurse services with 24 hour on-call availability, case management and other consultative services are provided through AHS.

Designated **Supportive Living Level 4 Dementia** – Enhanced Assisted Living Dementia (SL4-D) option provides services for individuals with moderate dementia that will progress to later stages or other forms of cognitive impairment who require a secure therapeutic environment.

Source: AHS Admission Guidelines for Publicly Funded Continuing Care Living Options, 2010

Long-term Care Facility – A purpose-built congregate care option for individuals with complex, unpredictable medical needs who require 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 Alberta Health Services (AHS) Admission Guidelines for Publicly Funded Continuing Care Living Options, 2010