

# Home Care Services

Follow-up to VFM Section 3.04, *2010 Annual Report*

## Background

Community Care Access Centres (CCACs) contract with service providers to provide home care services to Ontarians who, without these services and supports, might need to be admitted to hospitals or long-term-care homes. Home care also assists frail, elderly people and people with disabilities to live as independently as possible in their own homes.

The CCACs assess potential clients for eligibility and approve provision of professional services, such as nursing, physiotherapy and social work, as well as personal support and homemaking services, such as assistance with daily living. CCACs also authorize admissions to long-term-care homes. In the past three years, home care funding has increased 10.5%, from \$1.9 billion in the 2009/10 fiscal year to \$2.1 billion in the 2011/12 fiscal year. In 2011/12, Ontario provided services to 637,700 clients, compared to about 600,000 clients in the 2009/10 fiscal year—a 6% increase.

There are 14 CCACs in Ontario, each of which reports to one of the province's 14 Local Health Integration Networks (LHINs). The LHINs, in turn, are accountable to the Ministry of Health and Long-Term Care (Ministry).

In 2010, we conducted an audit to assess whether mechanisms were in place to meet home care needs and ensure that services were provided consistently across the province. Our work included

visits to three of the 14 CCACs (South East CCAC, Central CCAC and Hamilton Niagara Haldimand Brant CCAC), and we surveyed the other 11 as part of our audit.

We acknowledged in our 2010 audit that the Ministry had recognized that enhancing home care services offers both cost savings and quality-of-life benefits by allowing people to remain in their homes. We also noted that home care funding had increased substantially since our 2004 audit, and independent CCAC client satisfaction surveys indicated that home care clients were generally satisfied with the services they receive.

However, we noted that some of the main concerns identified in our previous audits (in 1998 and 2004) of the home care program still remained.

Among our significant findings:

- Per capita home care funding varied widely among the 14 CCACs, resulting in funding inequities. Total funding to CCACs had not been allocated on the basis of specific client needs, or even on a more general basis that takes into account such local needs as population size, age and gender of clients, or rural locations.
- Although ministry policy required CCACs to administer programs in a consistent manner to ensure equitable access no matter where clients lived, as a result of funding constraints, one of the three CCACs we visited had prioritized its services so that only those individuals assessed as high-risk or above

would be eligible for personal support services, such as bathing, changing clothes, and assistance with toileting. Clients assessed as moderate-risk in this CCAC were deemed not eligible, while they would have been eligible to receive home care services in the other two CCACs we visited.

- Eleven of the 14 CCACs have a wait list for various home care services. The other three CCACs said that they had virtually no wait lists at all. This is another indicator of a possibly inequitable distribution of resources among the 14 CCACs.
- In the absence of standard service guidelines, each CCAC developed its own guidelines for frequency and duration of services. As a result, the recommended time allocated for each task and the recommended frequency of visits varied, indicating that the level of service for people with similar needs may vary from one CCAC to another.
- Although CCACs had made progress in implementing a standardized initial client-care assessment tool, these assessments were often not done on a timely basis.
- Only one of the CCACs we visited conducted routine, proactive visits to its service providers to monitor the quality of services delivered.
- CCACs expressed concern with not being able to procure services from external service providers competitively. The Ministry had asked them to suspend the competitive procurement process on three occasions since 2002, and, at the time of our 2010 audit, the process was still suspended. This has contributed to significant differences in rates paid to service providers for similar services.
- The 14 CCACs have made good progress in implementing an updated case management information system to provide useful information to help measure and improve performance.

We made a number of recommendations for improvement and received commitments from the

Ministry and the CCACs that they would take action to address our concerns.

## Status of Actions Taken on Recommendations

According to information we received from the Ministry and the three CCACs we visited for our 2010 audit work, some progress has been made in addressing all of the recommendations we made in our *2010 Annual Report*. Most will require more time to be substantially implemented. For example, CCACs expect to have new Standards of Care to better manage caseloads by March 31, 2013. As well, efforts to improve the way funding is allocated to CCACs and the way CCACs pay service providers, to better reflect client needs and in accordance with outcomes, are being phased in. The status of the actions taken is summarized following each recommendation.

### FUNDING OF HOME CARE SERVICES

#### Recommendation 1

*To help ensure that people with similar needs living in different areas of the province receive similar levels of home care service, the Ministry of Health and Long-Term Care, in conjunction with the LHINs, should allocate funds to CCACs primarily on the basis of assessed needs of each local community, using, for instance, the proposed Health Based Allocation Model.*

#### Status

The Ministry informed us that it is undergoing Health System Funding Reform to move away from global funding and toward patient-based funding. Funding is to be allocated to the CCACs using the Health Based Allocation Model (HBAM), which estimates expected expenses at the CCAC level based on demographic, clinical and financial information. Also, funding for some procedures would be allocated under another component

of patient-based funding called quality-based procedures, where health-care providers receive funding for the number of patients they treat for certain types of procedures on a price-by-volume basis, using standard rates for each procedure.

The Ministry informed us that it has modified HBAM to take into account the specific costs of each CCAC and to include the components of the Resident Assessment Instrument – Home Care tool, such as measures of health status, to group CCAC clients. It used the revised HBAM in December 2011 to allocate \$27 million in base funding to the LHINs to begin addressing some of the historical funding inequities among the 14 CCACs. It also applied HBAM in the 2012/13 fiscal year to redistribute approximately 10% of CCAC base funding while ensuring that system stability was maintained and access to services preserved. The Ministry also informed us that in the 2012/13 fiscal year it would use HBAM to determine a portion of the new LHIN base-funding allocation for the community sector announced by the government in that year.

The Ministry said that it would continue to work with the CCACs to further refine the funding model for future years. As part of this process, the Ministry plans to increase the portion of CCAC base funding allocated under Health System Funding Reform until CCACs are receiving 70% of their allocations by patient-based funding, by the 2014/15 fiscal year. The Ministry also indicated that it would provide supports to inform and assist CCACs and LHINs with the transition to the new funding approach.

## DELIVERY OF HOME CARE SERVICES

### Case Management Caseloads

#### Recommendation 2

*To ensure that case managers are deployed optimally and to encourage equitable service levels across the province, the Ministry of Health and Long-Term Care should work with LHINs and the Ontario Association of Community Care Access Centres to establish case manager–client caseload guidelines.*

#### Status

According to the Ministry and the three CCACs, the new Client Care Model under the Integrated Client Care Project (ICCP) is redesigning the way health-care services are provided. The Client Care Model uses a population-based case management approach developed by the Ontario Association of Community Care Access Centres. Clients are categorized into different populations and sub-populations based on factors such as health conditions, degree of independence and risk of acute episodes. The model enables case managers to specialize in specific client populations, co-ordinate client care across the entire health system and monitor the impact of the care provided.

The three CCACs informed us that, also as part of ICCP, they are working to implement Standards of Care, case manager–client caseload guidelines outlining the role and expectations for client services staff by client population and sub-population. The three CCACs informed us that all 14 CCACs were categorizing clients according to consistent definitions of populations and sub-populations to enable caseload realignment among case managers. The standards in place at the time of this follow-up had been approved in July 2011 by all CCACs. They are to evolve as future sub-populations are identified and as implementation occurs. CCACs anticipated complete implementation of the standards by March 31, 2013.

At the time of our follow-up, the Client Care Model was being applied to four areas of care: individuals requiring wound care; individuals requiring palliative care; frail seniors; and medically fragile children. The model focuses on high costs and/or volumes and the potential to improve care and either reduce the cost of care or increase the amount of care provided for the same cost.

The Ministry informed us that it was testing a new wound care model using outcome-based pathways and outcome-based payments at four CCACs, with a goal to apply the new model at all CCACs and for all types of wounds. Five palliative care testing sites have also been launched, and the CCACs

are to begin initial research for outcome-based care pathways for frail seniors and medically fragile children in April 2013. Participating CCACs and service providers are expected to be identified at that time.

According to the Ministry, all work completed as part of the ICCP is being assessed by external evaluators to identify the best policy options for health care and health-care funding and incorporate them into the system.

### Admission to Services or Wait-lists, Service Levels, Monitoring Home Care Services Provided, Client Reassessment for Continued Services

#### Recommendation 3

*To help ensure that an appropriate and consistent level of service is provided to home care clients, Community Care Access Centres should:*

- *monitor case manager adherence to the established timelines for both the initial client assessment and the periodic client reassessments and, where such timelines are not met, ensure that case managers document the reasons in the applicable client files;*
- *enhance external provider oversight to better ensure that the expected and paid-for levels of service are being provided to home care clients; and*
- *regularly review both client complaints and client events to identify any systemic areas requiring further follow-up.*

*To promote equitable funding and service levels across the province, the Ministry of Health and Long-Term Care, in partnership with the LHINs, should consider incorporating summary data from the standardized Resident Assessment Instrument to assist in developing a more client-needs-based funding model and to encourage the CCACs to adopt consistent criteria for prioritizing the differing levels of home care services.*

#### Status

According to the three CCACs, work was underway to enhance the Client Health Related Information

System (CHRIS) to support compliance with the provincially endorsed Standards of Care at the individual client level. This should also enable better monitoring of client assessments and re-assessments. The improved system will remind case managers when assessments are due by client care model and population type according to the Standards of Care. The enhancements to CHRIS began to go live in October 2012.

The three CCACs indicated that they have been monitoring reassessment standards through various means while they waited for the CHRIS enhancements to be fully implemented. The first CCAC has been conducting manual audits of the files of clients who have been identified as not having had an assessment when planned, to ensure that the reasons for this are valid and documented. The second CCAC has been tracking the frequency at which standards are met at the caseload level and the organizational level to help pinpoint problem areas. The third CCAC's case managers were in the process of setting timelines for the frequency at which reassessments should occur, according to type of client population. It had completed its review of caseload files by July 2012 and expected to adjust the frequency of its reassessments to match the new standards of client care for CCACs by the end of November 2012.

The three CCACs informed us that they have adopted an audit framework for the oversight of contracted service providers. The framework includes a process for risk evaluation to pinpoint areas that provincial audit activity should focus on. In 2011 an audit was conducted at three CCACs on the identification, reporting, management and quality-improvement processes related to missed visits. Audit processes for assessing compliance and quality of services were to be further developed by a provincial Missed Visit Working Group throughout 2012.

According to the three CCACs, the Ontario Association of Community Care Access Centres maintains a province-wide reporting site that captures data that can be used to assess service provider

performance. All three CCACs indicated that they regularly review performance data with their service providers and discuss areas where the quality of service could be improved. They also indicated that work was underway to further develop the performance measures to better support the monitoring of client outcomes; their target was to introduce public reporting through Health Quality Ontario at the service provider level by the 2013/14 fiscal year.

All three CCACs informed us that they track complaints and events and monitor these for areas requiring follow-up. The 14 CCACs developed a provincial common events framework to standardize the way in which client complaints and certain key events are tracked and managed across their sectors. The three CCACs informed us that 13 of the CCACs had finished aligning their data capture with the new events framework, and that the remaining CCAC would align its data in the future.

As noted earlier, the Ministry is moving toward patient-based funding and has been working with the CCACs to enhance the Health Based Allocation Model (HBAM), which uses demographic, clinical and financial information to estimate expected expenses at the CCAC level. The Ministry informed us that part of the enhancements to HBAM included incorporating relevant components of the Resident Assessment Instrument – Home Care to allocate funding for long-stay clients. This includes data such as measures of health status, which can be used to group clients and related costs. Also, as noted earlier, CCACs have been working on developing and implementing Standards of Care, which would establish consistent criteria for prioritizing levels of home care services.

## Acquisition of Services from Contractors

### Recommendation 4

*To ensure that home care services are procured from external providers in a cost-effective manner, the Ministry of Health and Long-Term Care should work with LHINs and the Ontario Association of Community Care Access Centres to:*

- *formally evaluate the expected cost savings from allowing CCACs to procure home care services on a competitive basis, keeping in mind the potential impact on clients and service levels; and*
- *in the meantime, conduct a review of service-provider rates by type of service across Ontario to determine whether the significant rate variations are warranted in relation to the actual cost of providing the service.*

### Status

The Ministry informed us that government direction for CCACs to proceed with competitive procurement was still pending at the time of our follow-up, thus the CCACs had not yet been able to start procuring home care services on a competitive basis. The Ministry also informed us that the CCACs are working with their providers to ensure that the providers are aware of performance expectations, are focused on continuous quality improvement as part of their core business, and have appropriate tools, training and information to support quality delivery.

The Ministry indicated that a key design element of its Integrated Client Care Project (ICCP) was the development of an alternative payment process. Following the new process, payment to contracted home care service providers would be based on their achievement of specific client outcomes using evidence-based, best-practice care pathways. At the time of our follow-up, this alternative payment process was being tested at two wound care sites. First, wound care milestones are identified (for example, a wound must be 30% healed in 30 days), and then payment to the provider is to be based on achieving these milestones. The CCACs noted that the work on the alternative payment process would inform the Ministry's patient-based funding initiative as well as the contracting approach in the future. According to the Ministry, patient-based funding addresses rate variations, as payment is based on what it refers to as evidence-based best-practice care pathways as opposed to units of discrete service.

The Ministry informed us that ICCP has also developed the necessary changes to the electronic

information system to accommodate a new type of billing. Instead of units of home care service (volume of service), billing will be done by service bundles tied to client outcomes and established payment amounts. The billing changes were to be rolled out for wound-care populations at half of the CCACs in October 2012, with full implementation to take place by April 2013. According to the Ministry, this billing approach will be applied to palliative care around April 2013 and to other categories of care as the care pathways for them and related payment amounts are determined.

Building on the work conducted under the ICCP, the CCACs launched an initiative in April 2012 referred to as Quality and Value in Home Care. Under this initiative, CCACs are working with service providers and their respective associations to review contract requirements. The reviews are to encompass integration of care; outcome-based methods of reimbursement; service provider performance indicators; contract management that is based on achieving client outcomes; market share allocation; geographic boundaries; and volumes of service.

## DATA MANAGEMENT AND ANALYSIS

### Recommendation 5

*To reap the full benefit of the recent improvements to the case management information system, the Ministry of Health and Long-Term Care, working with the LHINs, should review the summary-level data on a province-wide and regional basis as a means of enhancing its oversight of the home care services currently being provided.*

#### Status

The Ministry informed us that it has conducted annual standard education sessions based on recom-

mendations from the CCAC sector. The last information session, held in March 2012, was to help the Ministry and the CCAC sector to obtain a greater understanding of the issues around data accuracy, consistency and outliers as well as the processes used to address these issues. The Ministry indicated that all 14 CCACs participated in the session.

According to the Ministry, LHIN finance and performance teams are using the CCAC data for comparative purposes and performance monitoring. For example, the financial reviews included utilization or cost comparisons by functional centre and comparative information about how and where each CCAC spent its funds compared to other CCACs.

According to the Ministry, LHINs monitor individual CCAC activity on a monthly and quarterly basis, using dashboards to compare performance to expected results. LHINs also monitor CCAC activity against other CCACs to review and compare performance. Comparisons are made in areas such as case management full-time equivalents; nursing volumes, personal-support volumes and home-making volumes; therapy volumes and expenditures; and school services utilization.

The three CCACs informed us that they report individually to their LHINs on indicators required under their accountability agreements, as well as any additional indicators that LHINs require individual CCACs to regularly report on, based on the priorities in their geographic area. CCACs also indicated they are also often asked to provide additional, ad hoc reports to LHINs and to the Ministry. Various home care quality indicators for long-stay clients—such as community wait times, cognitive functions and client satisfaction with home care services—are reported through Health Quality Ontario's website.