# CCACs—Community Care Access Centres—Home Care Program

## 1.0 Background

**Overview:** Ontario's 14 Community Care Access Centres (CCACs) are responsible for providing home-care services to Ontarians who might otherwise need to stay in hospitals or long-term-care homes. This includes frail elderly people and people with disabilities who need help to live as independently as possible in their own homes.

Home care is funded by the Ministry of Health and Long-Term Care (Ministry). To be eligible for home-care services, a person must be insured under the Ontario Health Insurance Plan. Referrals to home-care services can come from hospitals, family physicians, or clients and/or their families.

Home care used to serve primarily clients with low to moderate care needs, but now serves clients with increasingly more complex medical and social-support needs. This change came about primarily after July 2009, when all Ontario hospitals were expected to keep alternate-levels-of-care patients to a minimum (alternate levels of care refers to when a patient is occupying a bed in a hospital, but does not require the intensity of resources or services provided in this care setting). In the year ending March 31, 2015, 60% of home-care clients were senior adults (aged 65 years and over), 20% were adults (aged 18 to 64 years), 15% were children and 5% were palliative.

**Service Delivery Model:** CCACs, through their staff of care co-ordinators, assess individuals to determine if their health needs qualify for home-care services, and to develop care plans for those who qualify. CCACs then contract with about 160 private-sector service providers to provide home-care services directly to clients, in the form of professional (i.e., nursing and therapy) and/or personal support (i.e., bathing and toileting) services. These service providers are either for-profit or not-for-profit. The CCAC care co-ordinators manage client cases, and reassess and adjust care plans on an ongoing basis.

**Community Support Services:** CCAC care co-ordinators also act as navigators to community services and can refer clients to the approximately 800 community support service agencies (support agencies) that offer community support services (such as meals on wheels, transportation, respite care, and home maintenance and repair) and homemaking services (such as housekeeping and laundry support). Some community support services and homemaking services may require co-payment from clients. Similar to CCACs, support agencies are funded by the Ministry through the Local Health Integration Networks.

Because support agencies were historically set up by volunteers to serve local needs, these services are not available everywhere. Generally, urban areas offer more community support services than rural and northern areas, but still, urban areas may not have all the services needed to meet changing needs.

The role of support agencies may soon change: a regulatory amendment made in July 2014 and a related set of ministry guidelines issued in April 2014 allow support agencies, in addition to CCACs, to provide personal support services for lower-needs clients. Once a client is referred to a support agency, the agency then becomes responsible for that client, including care co-ordination and provision of personal support services.

**Accountability Relationship:** Each CCAC is accountable to one of the 14 Local Health Integration Networks (LHINs), which are mandated to fund health-service providers such as hospitals, CCACs and support agencies in defined geographic regions. The LHINs, in turn, are accountable to the Ministry, which sets the overall strategic direction for health care in Ontario.

The Ontario Association of Community Care Access Centres (Association) was incorporated in 1998 to represent all 14 CCACs. It receives most of its funding from the Ministry and the CCACs through membership fees. Effective May 2015, the Association's board of directors is composed of three externally recruited members in addition to nine representatives from CCACs, for a total of 12 members. With a staff of about 190, the Association provides shared services such as procurement, policy and research, and information management to the CCACs.

**Spending on Home Care:** For the year ending March 31, 2015, Ontario spent a total of $2.5 billion to provide home-care services to 713,500 clients, as shown in **Figure 1**. (This figure shows CCACs' spending on home-care services only rather than CCAC's total expenses, in the year ending March 31, 2015. In comparison, a similar figure included in the *Special Report on Community Care Access Centres—Financial Operations and Service Delivery* that our Office tabled in September 2015 showed total CCAC expenses, and for a different year—2014.) This represents a 42% increase in funding and

Figure 1: Home-care Funding and Clients Served by CCACs, Year Ending March 31, 2015
Source of data: Ministry of Health and Long-Term Care

| | Home-care Funding ($ million) | # of Clients Served | Home-care Funding per Client Served ($) |
|---|---|---|---|
| North Simcoe Muskoka | 100 | 24,932 | 4,027 |
| Champlain | 231 | 58,305 | 3,957 |
| North East | 136 | 35,652 | 3,802 |
| South East | 122 | 32,349 | 3,769 |
| Hamilton Niagara Haldimand Brant | 311 | 82,686 | 3,756 |
| Erie St. Clair | 142 | 38,790 | 3,668 |
| North West | 53 | 14,783 | 3,564 |
| South West | 210 | 59,346 | 3,547 |
| Central | 285 | 82,587 | 3,457 |
| Waterloo Wellington | 133 | 38,986 | 3,403 |
| Central East | 276 | 82,611 | 3,346 |
| Toronto Central | 250 | 74,822 | 3,338 |
| Mississauga Halton | 160 | 49,004 | 3,271 |
| Central West | 111 | 38,640 | 2,879 |
| **Provincial Total** | **2,520** | **713,493** | **3,532** |

a 22% increase in the number of clients served compared to the year ending March 31, 2009 (a year before our last audit of home-care services); in 2008/09, CCACs spent $1.76 billion to serve about 586,400 clients.

Over the past decade between 2005/06 and 2014/15, overall CCAC funding (which includes funding for home care and other CCAC services, such as long-term-care home placement) has increased by 73% from $1.4 billion to $2.5 billion, but has remained a relatively constant 4% to 5% of overall provincial health spending. In recent years, the Ministry has increased funding to the CCACs in several areas. For instance, in the 2015 provincial Budget, the government announced funding increases in the home and community sector over three years between 2015/16 and 2017/18 at 5% a year, for a total of $750 million. The government did not specify how these increases would be allocated to the 14 CCACs and the approximately 800 support agencies in the sector. In addition, to help CCACs meet the government's five-day wait-time target for nursing and personal support services for complex clients, the Ministry allocated $75 million to the CCACs through the LHINs in each of 2013/14 and 2014/15: $15 million went toward nursing services and $60 million to personal support services. These funding increases show that the Ministry continues to work toward expanding home and community care to ensure that people receive care as close to home as possible, one of several priorities set out in the September 2014 mandate letter from the Premier to the Minister of Health and Long-Term Care.

CCACs must not spend more than they receive each year according to their respective agreements with their funding LHIN.

**Government Priority:** In April 2014, the Minister of Health and Long-Term Care committed to a vision of home and community care that is reliable, robust and accessible; that is client-centred and highly integrated with the other health and community supports; and that is accountable and

transparent, and provides value to both clients and taxpayers. In September 2014, an Expert Group on Home and Community Care (Expert Group) was formed to provide specific, practical recommendations to enable the Ministry to achieve its vision. The Expert Group released a report, *Bringing Care Home,* in March 2015. The report contained 16 recommendations to create a better client- and family-centred home and community care sector, as shown in **Appendix 1**.

A September 2014 mandate letter from the Premier to the Minister of Health and Long-Term Care said the expansion of home and community care was a government priority.

In May 2015, the Ministry issued *Patients First: A Roadmap to Strengthen Home and Community Care,* which was informed by the work of the Expert Group. The document outlines 10 initiatives intended to be implemented from 2015 to 2017 to transform the home- and community-care sector. **Appendix 2** shows these 10 initiatives.

**Care Co-ordinator Roles:** CCAC care co-ordinators are regulated health professionals—mostly nurses, social workers and occupational therapists—who are responsible for assessing clients and managing their home care. They work directly with clients and their families, either at the CCACs or at hospitals. Care co-ordinators create individual plans of service—called care plans—that set out the type and amount of services to be provided, collaborating with the clients' primary care providers (such as nurse practitioners) and other care partners such as family physicians and other community agencies. As well, care co-ordinators provide support to clients as they move between services and care settings (such as between long-term-care homes and supportive housing), and across geographic boundaries.

To enable care co-ordinators to spend more time with clients, CCACs employ team assistants who provide administrative support services, such as updating client files, setting up client appointments, and discharging clients at the direction of the care

co-ordinators. Unlike care co-ordinators, team assistants are not regulated health professionals.

As of March 31, 2015, 5,100 or three-quarters of the CCAC's 6,775 staff worked as care co-ordinators and team assistants who manage home-care cases. Their costs account for about 20% of total CCAC funding (the majority of the remaining costs are for procured services from contracted service providers).

**Client Care Model:** To more consistently deliver client services to meet the varying levels of need, the 14 CCACs use a model of care (see **Figure 2**) to guide their service levels to clients.
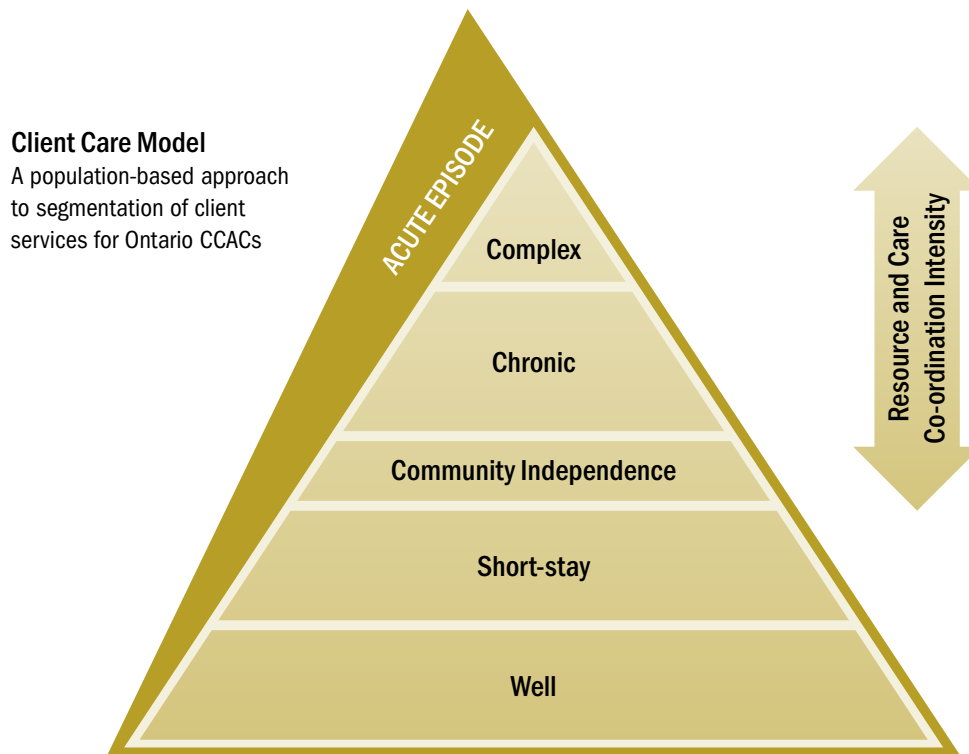
Under the model, clients are assessed by CCAC care co-ordinators based on various factors including the client's health condition, degree of independence, risk of experiencing acute episodes

(an acute episode is a period when an injury is at its worst), and socio-economic factors (such as levels of education and income). The CCAC care co-ordinators then categorize the assessed clients into five population groups: well, short-stay, community independence, chronic, and complex. Each client group would receive specific care co-ordination by CCAC staff who should have specialized know-ledge and case management skills to deal with the care co-ordination level of intensity needed to address the clients' care needs. **Appendix 3** shows the population and sub-population groups, and their respective recommended case management intensity.

**Home-care Assessment Tools:** Once a CCAC confirms a client's eligibility based on the criteria set out in regulation, a CCAC care co-ordinator

## Figure 2: Client Care Model
Source of data: Community Care Access Centres



**Client Care Model**
A population-based approach to segmentation of client services for Ontario CCACs

ACUTE EPISODE

Complex

Chronic

Community Independence

Short-stay

Well

Resource and Care Co-ordination Intensity

Explanatory Notes:
a. Larger population at the base ("well"); smaller population at the top ("complex").
b. Clients can move up and down the triangle between different populations as their needs change.
c. An acute episode can occur at any time for any population group, but potential for an acute episode increases for clients with more acute needs.

assesses the client using standardized assessment tools called Resident Assessment Instruments or RAIs. These tools are developed by a collaborative network of researchers in over 30 countries that belong to an organization called interRAI. There are different RAI tools used across home- and community-based health services, such as long-term-care homes and support agencies. For instance, support agencies use RAI-community health assessment (RAI-CHA) to assess clients' ability to live independently in the community, and CCACs and hospitals use RAI-palliative care (RAI-PC) to assess the needs of palliative clients. But for the purpose of home care, CCAC staff uses RAI-contact assessment (RAI-CA) and RAI-home care (RAI-HC) at specific points in time.

To assess a client's service needs, care co-ordinators administer the RAI-CA, usually over the phone from the CCAC office, within 72 hours of referral. With this tool, care co-ordinators determine whether clients need to be formally assessed right away, need urgent home-care services, and/or need specialized rehabilitation services. Because there is usually a wait before clients are assessed with RAI-HC, each CCAC has developed its own scoring method to use within RAI-CA so service levels can be preliminarily determined and provided right away. If clients are assessed as not needing home-care services, CCAC care co-ordinators may refer them to other community support service agencies to receive needed services such as meals on wheels, homemaking services, and transportation services.

Some CCACs have also developed a shorter pre-screening tool to help their staff quickly determine whether an individual would require an assessment using the RAI-CA. Clients who are pre-screened and determined to be "well" according to the Client Care Model are not subject to the RAI-CA assessment.

If the client is assessed in the initial contact assessment as community independent, chronic or complex, the care co-ordinator must administer the RAI-HC in person at the client's home within seven

to 14 days from the time the contact assessment is completed. The care co-ordinator develops the care plan using results from the RAI-HC assessment as well as other information and clinical judgment. The care plan details the level and type of home-care services that would meet the client's needs. The CCACs developed a scoring method (not endorsed by interRAI) to be applied with the RAI-HC tool. The scoring method generates scores between 0 and 28, with 0 being the lowest level of need for personal support services, and 28 being the highest level of need. Care co-ordinators also use this tool to reassess long-stay clients who have complex, chronic or community-independent characteristics, to determine their continuing need for service or to adjust service levels as required. The Association is working toward implementing the interRAI-HC tool to replace the current RAI-HC by April 2017 (both interRAI-HC and the currently used RAI-HC were developed by the same research collaborative). According to the Association, the interRAI-HC tool will better assess clients' needs.
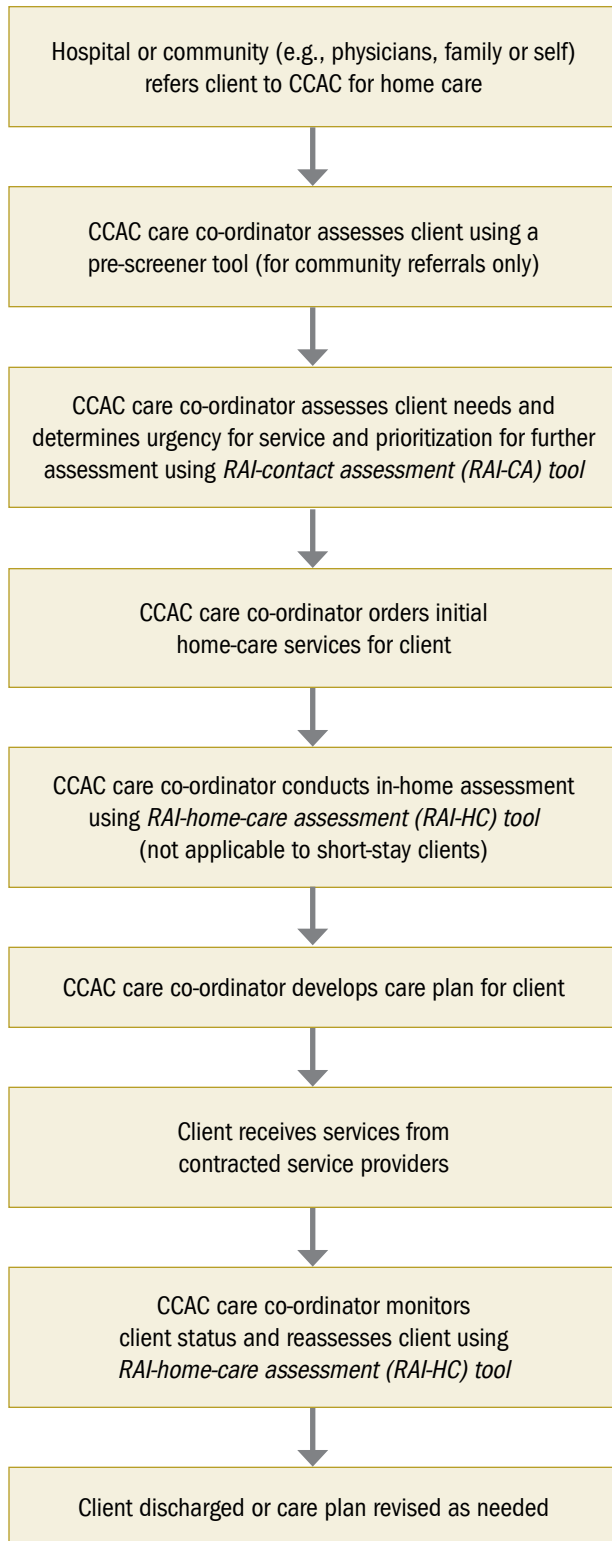
**Figure 3** shows when each of these assessment tools is used in a client's journey through the home-care system.

CCAC clients may also receive nursing and/or therapy services through home care. CCAC care co-ordinators do not need to score the clients to determine these service levels because professional staff (such as registered nurses) determine service levels and number of visits using their professional clinical judgment and following predetermined service guidelines called clinical pathways, which set out the goal, process, duration and plan of care depending on the illness.

**Personal Support Services:** Most of the home-care services are delivered by personal support workers who are employed by private-sector for-profit or not-for-profit service providers. In 2014/15, about three-quarters of contracted service hours were spent on providing personal support services to home-care clients (the remaining hours were delivered by nurses and therapists). According to the

### Figure 3: Client's Journey through the Home-care System* from Referral to Discharge

Prepared by the Office of the Auditor General of Ontario

Hospital or community (e.g., physicians, family or self) refers client to CCAC for home care

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CCAC care co-ordinator assesses client using a pre-screener tool (for community referrals only)

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CCAC care co-ordinator assesses client needs and determines urgency for service and prioritization for further assessment using *RAI-contact assessment (RAI-CA) tool*

↓

CCAC care co-ordinator orders initial home-care services for client

↓

CCAC care co-ordinator conducts in-home assessment using *RAI-home-care assessment (RAI-HC) tool* (not applicable to short-stay clients)

↓

CCAC care co-ordinator develops care plan for client

↓

Client receives services from contracted service providers

↓

CCAC care co-ordinator monitors client status and reassesses client using *RAI-home-care assessment (RAI-HC) tool*

↓

Client discharged or care plan revised as needed

\* Figure illustrates process for personal support services.

*Home Care and Community Services Act, 1994* (Act), personal support services include services to help clients with personal hygiene activities and routine personal activities of living, as well as the provision of equipment and supplies.

A regulation under the Act specifies the maximum amount of personal support services that is to be provided to a client. The regulation was amended in May 2008, effectively raising the maximum amount of time that a client would receive personal support services as follows: a maximum of 120 hours (formerly 80 hours) in the first 30 days of service, and 90 hours (formerly 60 hours) in any subsequent 30-day period. These limits can be exceeded indefinitely in "extraordinary circumstances" for palliative clients and those waiting for placement into a long-term-care home, or for up to 90 days in any 12-month period for other clients.

**Caregiver Support:** The *Community Care Access Corporations Act, 2001* provides six purposes of a CCAC, one of which is to provide, either directly or indirectly, goods and services to assist relatives, friends and others in the provision of home care. It is well known in the sector and among researchers that caregivers such as family members and neighbours play an important role in ensuring that clients are properly cared for so that they can remain in their home for as long as possible. The Expert Group's report also identified an urgent need to support caregivers in their continued care of clients and recommended more resources be provided to increase capacity for in-home and out-of-home scheduled emergency respite services.

# 2.0 Audit Objective and Scope

Our audit objective was to assess whether the Community Care Access Centres (CCACs), in partnership with the Ministry of Health and Long-Term Care (Ministry) and Local Health Integration Networks (LHINs), have processes in place to

provide care co-ordination to home-care clients in a seamless and equitable manner, monitor service providers in accordance with contractual and other requirements, and measure and report on the quality and effectiveness of home-care services provided. Our last audit of home care was conducted in 2010. Due to the importance of this program, we determined that it was appropriate to conduct another review at this time. Senior ministry management accepted our audit objective and associated audit criteria.

We undertook fieldwork from March 2015 to June 2015 and visited three CCACs: Central CCAC (head office in north Toronto), North East CCAC (head office in Sudbury), and Champlain CCAC (head office in Ottawa). We selected these three CCACs to represent the 14 CCACs based on geography, population size, and the mix and volume of professional services provided. The Ministry, through the LHINs, paid these three CCACs a total of $644 million in the year ending March 31, 2015, representing 26% of total funding to all 14 CCACs and about 25% of the total clients served in Ontario. At these CCACs, the focus of our work was on senior adults (aged 65 years and older) and non-senior adults (aged 18 to 64 years) rather than children who may also receive home- and community-care services. We reviewed client files and internal program documents, analyzed program data, and interviewed appropriate staff. We also interviewed staff at the related Local Health Integration Networks, the Ministry, and the Ontario Association of Community Care and Access Centres, which represents all 14 CCACs.

We met with the chair of the Expert Group on Home and Community Care (Expert Group) and considered the Expert Group's work in this audit. In addition, we obtained data from Ombudsman Ontario on complaints about CCACs. In addition, we met with the Canadian Institute for Health Information to determine the type of data collected through the assessment tools in Ontario in comparison with other Canadian jurisdictions. We also met with Health Quality Ontario to determine the role

it plays in evaluating CCAC performance. Furthermore, we obtained an external perspective of home care from the following organizations: the Ontario Community Support Association, Home Care Ontario, the Canadian Home Care Association, the Canadian Caregiver Coalition, the Ontario Nurses' Association, and the Ontario Health Coalition.

We met with two experts knowledgeable in the design and application of the home-care assessment tools. We also interviewed representatives from nine selected service providers on their experience with implementing the personal support workers wage subsidy program. In addition, we conducted research to identify practices used in other Canadian provinces, the United Kingdom, Australia, and the United States to support caregivers of clients.

This audit on home-care services complements the audit we conducted and reported on in the September 2015 Special Report on CCACs in response to a specific motion passed by the Standing Committee on Public Accounts, an all-party committee in the Ontario Legislature. That report covered areas including CCAC expenses, senior executive compensation, nursing services delivered by both CCACs and service providers, and procurement of private-sector service providers.

# 3.0 Summary

The Community Care Access Centres (CCACs) play an integral role in ensuring that clients receive care in the most comfortable place possible—their own homes. Between 2008/09 and 2014/2015, the Ministry of Health and Long-Term Care (Ministry) increased spending on home-care services by 42%. The Ministry has recognized the value of home and community care, issuing a number of reports, as noted in **Section 1.0**, highlighting the importance of strengthening this sector.

Despite these positive efforts, some of the issues we raised in our 2010 audit of the home-care

program still remain. For example, clients are still put on wait-lists and have to face long wait times to obtain personal support services, and clients with the same assessed needs still receive different levels of services depending on where they live in Ontario. These long-standing issues remain primarily because home-care funding to each CCAC is predominantly based on what each received in prior years rather than on actual client needs and priorities. As a result, to stay within budget, each CCAC exercises its own discretion on the types and levels of services it provides—thereby contributing to significant differences in admission criteria and service levels between CCACs. For example, because there are no provincial standards in many critical areas, such as the level of personal support services warranted for different levels of client needs, some clients may receive more services than others, just because of where they live.

Until these overarching issues are addressed, clients in Ontario will continue to receive inequitable home-care services. Our specific observations in this audit include:

- **Whether a person receives personal support services, and the amount of service provided, if any, depends on where the person lives**—Each CCAC can allocate different levels of services to individuals with similar levels of needs because each CCAC develops its own criteria as a result of funding inequities. Thus, an individual assessed to receive services by one CCAC might not receive services at another. For example, at one of the three CCACs we visited, a client receiving a home-care-assessment score of seven would not receive any personal support service because that CCAC only provides services to clients with a score of eight or higher. However, the same client would receive services in the other two CCACs we visited. The level of care the client receives can also differ among CCACs, even for clients with the same assessment score. For example, a client with a home-care-assessment score of 15 could

receive, every week, up to five hours of personal support services in one CCAC we visited, eight hours in the second, and 10 hours in the third. As well, because CCACs cannot incur a deficit, the time of year a client is referred to a CCAC, and that client's level of needs, can influence whether this person receives services or not. For example, at one CCAC we visited, nine times more people were on the wait-list at the end of the fiscal year compared to the beginning of the fiscal year in 2014/15. Within the wait-list, the increase was mainly for clients with high and very high needs. These clients typically require more service hour allocations. This inequity in service levels among CCACs is largely because per client funding for home care varies significantly. Despite reforms in the funding formula that began in April 2012, the province still provides different amounts per client to different CCACs. As well, the availability of community support services varies across the province, so some CCACs may be required to provide more services to their clients when no other agencies can provide the necessary additional support.

- **Care co-ordinators' caseload sizes vary significantly, and some exceed suggested ranges in standard guidelines, so there is little assurance on whether care co-ordination services were consistently provided to all clients**—In two of the CCACs we visited, caseload sizes were not complying with the recommended range in the caseload guidelines developed by the Ontario Association of Community Care Access Centres. For example, one CCAC's care co-ordinators on average carried 30% larger caseloads for chronic clients than recommended. As well, caseload sizes varied within each CCAC—one care co-ordinator's caseload could be as much as double that of another care co-ordinator within the same CCAC. These variations could result in some clients getting better-quality

care co-ordination than others. The third CCAC chose not to follow the recommended ranges, and instead developed its own ranges to manage its resources after it evaluated its experience with the standard caseload guidelines. CCAC staff indicated that the caseload sizes in the Association's guidelines need to be reviewed to more reasonably reflect achievable targets within budgetary constraints.

- **CCACs are not able to provide personal support services to the maximum levels allowed by law**—CCAC care co-ordinators are required to follow local service allocation guidelines and use clinical judgment when determining client service levels. At the time of our audit, clients were for the most part allocated up to a maximum of 60 hours of personal support services per month (any additional hours are subject to CCAC management approval). However, regulatory changes effective May 2008 increased the maximum service level to up to 90 hours per month after the first month of service (clients are allowed up to 120 hours in the first month of service). One of the CCACs we visited monitors how many patients receive over 60 hours of service per month, in order to meet its annual operating budget. At that CCAC, we found that more clients had to wait to receive services if they required the highest number of service hours per month compared to clients with lower service needs. Furthermore, Ontario's regulation is silent on the minimum amount of services that can be provided. As a result, there is no minimum service level requirement for personal support services that CCACs must provide to their clients—for instance, a specified minimum number of baths per week.

- **Clients may not receive appropriate levels of services as CCAC care co-ordinators did not assess or reassess clients on a timely basis**—At the three CCACs we visited, 65% of initial home-care assessments and 32% of reassessments for chronic and complex clients were not conducted within the required time frames in the year ending March 31, 2015. Some clients were not assessed or reassessed in almost one year, and some beyond a year. These delays mean that clients might not receive the appropriate type and level of care as expeditiously as possible, which could result in them remaining in home care longer than they need to—or even in them using hospital emergency services or being hospitalized for periods of time that might not have been necessary.

- **Not all care co-ordinators maintained their proficiency in, and some were not regularly tested on, the use of assessment tools**—At the three CCACs we visited, 33% of care co-ordinators did not maintain their required proficiency in completing assessments by performing the minimum number of assessments per month that the Ministry's provincial standards require. Also, not all care co-ordinators were formally tested on the use of the assessment tools at the required frequency. So there is little assurance that all care co-ordinators were proficient in assessing clients using the assessment tools and were using these tools appropriately to assess client needs.

- **Supports to caregivers such as family members of home-care clients are limited and not consistently available across Ontario**—The amount of support, such as respite care, that a caregiver receives depends on where the caregiver lives, because such services are not always available or easily accessible in all areas within Ontario. Even when CCACs can provide personal support services to relieve the caregivers' burden, those services are provided within the client's allocated service hours, and no additional hours of care are provided. Such arrangements may not provide sufficient support to caregivers to prevent burnout. We noted that the Ministry, in its May 2015, 10-point action plan on home and community care, proposed to invest in

more training and education programs for caregivers.

- **CCAC care co-ordinators may experience difficulties in effectively referring clients to obtain community support services because assessment information and wait-lists are not centralized**—CCACs cannot access assessment information from some community support service agencies because many agencies have chosen not to use the shared information system established for this purpose. As well, CCACs have to contact multiple support agencies to identify available services for meals on wheels, respite care, homemaking and transportation because there are no centralized wait-lists for these services.

- **CCACs' oversight of contracted service providers needs improvement**—CCACs do not consistently conduct site visits to ensure service providers are complying with their contract requirements. We found that none of the CCACs we visited had verified that service providers accurately and completely reported incidents of missed visits. As well, CCACs cannot easily identify instances where the service providers did not provide the needed services at the times required by the clients under a recent change in the definition of "missed visits" to "missed care." Even though CCACs survey clients on how satisfied they are with service provider performance, the results were not reliable because of the high margins of error for some of the client responses.

- **Each CCAC's performance is measured against different targets for performing client services**—Only some of the performance information reported by CCACs is measured against targets. Of those performance areas that have targets, CCACs are held to varying standards because targets are established individually with their respective LHINs. For example, for the performance indicator measuring the percentage of CCAC

home-care clients who made an unplanned emergency department visit within the first 30 days of being discharged from the hospital, the targets across the three CCACs we visited varied from about 4% to 12% in 2014/15.

This report contains 14 recommendations consisting of 31 actions to address our audit findings.

## OVERALL MINISTRY RESPONSE

The Ministry of Health and Long-Term Care (Ministry) appreciates the comprehensive audit conducted by the Office of the Auditor General of Ontario on the provision of home care services by Community Care Access Centres (CCACs). We commit to addressing all the recommendations directed to the Ministry and to working with our partners in the home and community care sector to ensure an appropriate response to all of the Auditor General's recommendations.

As the Ministry noted in its response to the Auditor General's September 2015 Special Report titled *Community Care Access Centres—Financial Operations and Service Delivery*, strengthening home and community care is a key government priority. The Ministry's *Patients First: A Roadmap to Strengthen Home and Community Care* (Roadmap), released in May 2015, outlines the Ministry's plan to transform the way we deliver care at home and in the community through 10 key initiatives. As with the Auditor General's September 2015 report, the observations and recommendations provided through this audit will be considered and incorporated by the Ministry as we work toward our goal of higher-quality, more consistent and better integrated home and community care.

The Auditor General's recommendations in this report are relevant to several of the Roadmap initiatives. The creation of a Levels of Care Framework will support the consistency of available services, levels of service and client assessments across the province. The framework

will represent a system-wide improvement and will address current service and information gaps in home and community care. In addition, the Roadmap also identifies expanding supports for caregivers as a priority. The Ministry is committed to meeting the needs of home and community care clients and their caregivers.

### OVERALL RESPONSE FROM CCACs AND THE ASSOCIATION

CCACs are committed to implementing evidence-based best practices and approaches to improve patient care and will incorporate the feedback from this Auditor General's report, as we have previously. We support standardized approaches that enable consistent patient assessment, data collection and benchmarking locally, provincially, nationally and internationally. That is why CCACs have worked diligently over past years to drive evidence-informed models of service delivery and have regularly assessed, measured and reported on our performance.

The important role of care co-ordinators is highlighted in this report. CCACs believe the value of care co-ordinators cannot be stressed enough as they are the central component of a successful home care system. Care co-ordinators are the single point of contact for patients and their caregivers. They support patients and caregivers by developing care plans that are tailored to patients' evolving needs, ensure services are delivered as planned and are often both an advocate for patients and an ally for caregivers in supporting patients throughout their care journey. Because care co-ordinators assess patient needs and ensure patients receive the best available care when and where they need it, physicians and other providers rely on them as the conduit for communication with patients, including when there is a change in health status.

Over the last 10 years, the complexity of home care patients has grown considerably, presenting new challenges for health partners across the system in supporting increasingly complex patients in their homes. In 2014/15, approximately 70% of CCAC long-stay patients were categorized as complex, compared to less than 40% only five years ago. CCACs' overall patient volume has more than doubled over the last 10 years, to over 700,000 patients in 2014/15.

Any proposals to modernize home and community care must recognize changing patient numbers and needs—and the growing demands on home care. The legislative framework that has shaped our sector and the funding approaches that support CCACs are outdated and have not kept pace with present-day and future needs for home and community care.

CCACs remain committed to continuous improvements in patient care and service, and support the work the province is undertaking in the transformation of home and community care. Based on our proven history of managing change, CCACs will continue to work in partnership with patients and caregivers, the Ministry of Health and Long-Term Care, Local Health Integration Networks, physicians, hospitals, community agencies and service-provider organizations to ensure the delivery of quality home and community care.

# 4.0 Detailed Audit Observations

## 4.1 Assessment of Client and Family Needs Requires Improvement

CCAC care co-ordinators are the single point of contact for clients and co-ordinate supports to clients depending on their care needs, which may

change over time. Their responsibility is to ensure services are delivered as set out in the clients' care plans. Care co-ordinators also work with physicians and other health-care providers in ensuring that the services provided to clients meet clients' needs. In determining client care needs, CCAC care co-ordinators use standard, evidence-based assessment tools in conjunction with clinical judgment, on an ongoing basis.

Assessing and reassessing clients on a timely basis is an important part of managing home-care services, to ensure that clients receive the right service levels at the right time to meet their needs. We had the following concerns with client assessments in the three CCACs we visited: they were not done on a timely basis; care co-ordinators were not consistently tested on their competency in assessing clients; and supports for family caregivers were limited and inconsistently available, even when there was an assessed need for these services.

### 4.1.1 Clients Not Consistently Assessed or Reassessed on a Timely Basis

The eligibility criteria for home-care services require that a person be insured under the Ontario Health Insurance Plan to receive home-care services. CCACs serve clients referred for home-care services from either a hospital or the community. Between 2012/13 and 2014/15, at the three CCACs we visited, the number of hospital and community referrals remained consistent with an average of 52% of referrals from hospital and 48% from the community. CCAC care co-ordinators are expected to conduct an initial contact assessment using RAI-CA for clients referred from the community (whereas clients discharged from hospital may receive an initial assessment in hospital) and then RAI-HC for all clients.

We found that at the three CCACs we visited, CCAC care co-ordinators were not conducting the initial assessments (either the RAI-CA or the RAI-HC) on a timely basis. **Figure 4** shows whether initial assessments and reassessments

were done within prescribed timelines. We had the same observation in our 2010 audit of Home Care Services. Our audit observation in this area is also consistent with the Association's: it found in its January 2013 interim review of the Client Care Model that many CCACs were unable to achieve the service standards of assessing clients within the required period. At the three CCACs we visited, for the year ending March 31, 2015, where CCAC care co-ordinators conducted the RAI-CA assessment, 40% were not done within the required 72 hours; and, where CCAC co-ordinators conducted the more comprehensive RAI-HC assessment, 65% were not done within the required timelines (ranging from seven to 14 days) for the various client population categories. On average, the actual time between referral and RAI-CA assessment was six to eight days rather than within the required three days. RAI-HC assessments were conducted 25 to 28 days after the RAI-CA assessments rather than within the required seven to 14 days.

Regular reassessments are also important to ensure clients who are already receiving home-care services continue to receive services that best meet their needs, or to inform CCAC care co-ordinators when care is no longer required. We found that clients who are already receiving home care are not being reassessed following the prescribed timelines to ensure the care they receive is still appropriate. For the year ending March 31, 2015, of the clients who were reassessed, CCAC care co-ordinators at the three CCACs we visited did not reassess those who were complex and chronic within the required timelines in 32% of the cases, but did reassess all who were community independent within one year of their initial home-care assessment, as required.

Some clients were not reassessed even though they should be. As of July 2015, depending on the CCAC, 34% to 39% of the clients who should be reassessed were not reassessed as required. At one CCAC, more than half of their community independent clients had not received a reassessment within the required one year and were still waiting in July 2015.

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## Figure 4: Required and Actual Timelines for Assessments and Reassessments at Three Selected CCACs, 2014/15

Sources of data: Ontario Association of Community Care Access Centres, Selected Community Care Access Centres

| Population Category | Association Guidelines | Actual Time Span | | | | # of Assessments Overdue | Total # of Assessments Completed | % of Assessments Overdue | # of Assessments Overdue by > 180 Days |
|---|---|---|---|---|---|---|---|---|---|
| | | Average | Median | 90th Percentile | Maximum | | | | |
| **Between Referral and Initial RAI-Contact Assessment** | | | | | | | | | |
| Complex | Within 3 days | 7 days | 3 days | 20 days | 242 days | 1,876 | 4,218 | 44 | 2 |
| Chronic | Within 3 days | 8 days | 2 days | 24 days | 281 days | 7,198 | 17,390 | 41 | 2 |
| Community Independence | Within 3 days | 6 days | 2 days | 17 days | 182 days | 2,745 | 7,818 | 35 | 1 |
| **Total** | | | | | | **11,819** | **29,426** | **40** | |
| **Between Initial RAI-Contact Assessment and Initial Home-care Assessment** | | | | | | | | | |
| Complex | Within 7 days | 25 days | 15 days | 62 days | 349 days | 2,394 | 3,364 | 71 | 29 |
| Chronic | Within 10 days | 28 days | 16 days | 64 days | 432 days | 9,298 | 13,892 | 67 | 186 |
| Community Independence | Within 14 days | 28 days | 16 days | 60 days | 452 days | 2,707 | 5,010 | 54 | 96 |
| **Total** | | | | | | **14,399** | **22,266** | **65** | |
| **Between Initial Home-care Assessment and Reassessment** | | | | | | | | | |
| Complex | Every 3-6 months | 3.6 months | 3.1 months | 7.5 months | 11.6 months | 250 | 1,347 | 19 | 250 |
| Chronic | Every 6 months | 5.1 months | 4.9 months | 9.1 months | 12 months | 1,349 | 3,646 | 37 | 1,349 |
| **Subtotal** | | | | | | **1,599** | **4,993** | **32** | |
| Community Independence | Annually | 5.2 months | 5 months | 9.3 months | 12 months | 0 | 905 | 0 | 347 |

The delays in assessments and reassessments—in some cases as long as a year or more—highlight the concern that clients were not always being assessed by care co-ordinators using these standardized tools, which may result in clients receiving services at levels not matching their needs. Given this concern, all three CCACs implemented processes to remind care co-ordinators of overdue assessments and reassessments, and one CCAC reminded its care co-ordinators of overdue assessments and reassessments again when they were overdue by 18 months. But because the number of overdue assessments and reassessments at the three CCACs we visited was significant as of March 31, 2015, we question whether staff at the CCACs effectively reviewed and acted on the overdue cases contained in the information reports.

The following is one example of an experience of a referred client who did not receive assessments on a timely basis. A client who is over 90 years old lives alone in a retirement home. In September 2014, the client was referred to a CCAC for physiotherapy and personal support services to address the client's decreased mobility and difficulties with activities of daily living. A few weeks later, the CCAC phoned to schedule an initial phone contact assessment for the following month, 52 days after the client's referral and well beyond the three-day timeline for initial contact assessments. The phone assessment produced an RAI score of 21, which is "very high," and the care co-ordinator classified this client as complex. The CCAC did not approve the client for physiotherapy services, and approved only 16 hours of personal support services per month, well below the 90 hours per month allowed under legislation. In December 2014, the client fell and sustained a fracture. The client's family requested additional personal support services, but the care co-ordinator explained that these services were being waitlisted at that time and therefore were not available. The family chose to pay for private care for the additional hours needed. The client's cast came off in January 2015, at which point the family requested physiotherapy services. The CCAC care co-ordinator made a home visit in March 2015, four and a half months after the initial contact assessment and well beyond the seven days required for an initial home-care assessment. Based on the home assessment, the CCAC care co-ordinator determined that the client needed more personal support services, but because such services were subject to a long wait-list, the client did not receive the additional services, and was not approved for physiotherapy services.

### 4.1.2 Care Co-ordinators Did Not Consistently Maintain Proficiency in Assessment Tools

CCACs provide varied training to their new care co-ordinators in the use of the assessment tools. For example, one CCAC provides its new care co-ordinators a minimum of two home visits with a mentor, education sessions, and practice assessments. Another CCAC requires its new care-coordinators to take part in a seven- to 10-day comprehensive orientation program focusing on the use of the assessment tools. This CCAC also offers its new care co-ordinators eLearning and peer support.

In order for the care co-ordinators to remain proficient in their use of the assessment tools, ministry policy requires that each care co-ordinator complete at least eight to 10 assessments per month. We reviewed whether this policy was met at the three CCACs we visited, in four sampled months in 2014/15. We found that 33% of the care co-ordinators did not complete the required minimum number of assessments per month. The CCACs explained that their care co-ordinators did not perform the expected number of assessments because they were casual or part-time staff; some work in hospitals and only perform assessments as needed; and some were on leave or changed positions. However, we noted that the Ministry's policy did not establish a separate minimum requirement of assessments conducted for casual or part-time care co-ordinators.

Ongoing testing could help ensure care co-ordinators continue to be knowledgeable in the use of the assessment tools. There is no provincial standard on how often CCAC care co-ordinators should be tested on the use of these tools. As a result, each of the CCACs developed its own policy prescribing how often care co-ordinators should be tested. Two of the three CCACs we visited required care co-ordinators to be tested every two years for both the in-home assessment tool and the initial contact assessment tool; one CCAC required testing every year for the in-home assessment tool, and every two years for the initial contact assessment tool. In practice, we found that care co-ordinators were not tested at their required training frequency at two of the three CCACs. At these two CCACs, tests were either not delivered at the required time interval, or were not delivered to all care co-ordinators. Specifically, one CCAC conducted tests in 2010 and again in 2013, a three-year period, even though its policy is to test care co-ordinators every two years. About 20% of care co-ordinators did not participate in the 2010 test, and about 5% of care co-ordinators did not participate in the 2013 test. The other CCAC last tested its care co-ordinators in 2011, but 9% of the care co-ordinators either did not participate in or failed that test. At the time of our audit, this CCAC had not required its care co-ordinators to complete testing since 2011, and did not have a planned timeline for future testing.

We noted that long-term-care home staff in Ontario are required to be tested on the assessment tool every year, and Alberta, British Columbia and New Zealand also require their home-care staff to be tested on the assessment tools every year. The Ontario Association of Community Care Access Centres (Association) hired an external organization in 2004 to train and test care co-ordinators on the assessment tools at all 14 CCACs, but the Association does not monitor whether the care co-ordinators have been tested at the required frequency—this is left up to the individual CCACs to monitor.

## RECOMMENDATION 1

To ensure that all home-care clients receive the most appropriate and timely care, Community Care Access Centres, in conjunction with the Ontario Association of Community Care Access Centres, should:
- assess and reassess clients within the required time frames;
- inform clients of the expected wait time for assessments and reassessments, especially when the required time frames will not be met;
- require managers to review reports on overdue assessments and reassessments and better ensure care co-ordinators act on addressing overdue files as soon as possible; and
- require that all CCAC care co-ordinators comply with the minimum number of assessments per month and be tested on the use of the assessment tools each year, and monitor compliance to that requirement.

## RESPONSE FROM CCACs AND THE ASSOCIATION

The Association and CCACs appreciate that the Auditor General acknowledges that patient care and safety are our highest priorities. We are pleased that the Auditor General also recognizes care co-ordinators as highly skilled and regulated health professionals who continuously assess patients using their clinical judgment and an array of important inputs. These include, but are not limited to, information from patients and their caregivers (received in person or by phone), frequent updates from all members of the care team (including physicians and staff from contracted service providers), and the Resident Assessment Instrument, a standardized electronic information-gathering tool. All of these methods assist care co-ordinators in assessing patient needs, strengths and preferences. As information is shared and needs

change, care co-ordinators prioritize patients and adjust plans accordingly to ensure patients get the care they need. CCACs will continue to improve processes for timely assessment and reassessment to determine the best timing for use of assessment tools, and to better articulate guidelines on the use of broad assessment tools in the overall assessment of patient need for care.

### 4.1.3 Minimal Supports to Caregivers

Both the CCACs and the Ministry recognize the importance of caregivers in the care of home-care clients. One of the CCACs we visited set up a council consisting of clients and caregivers that provides advice to the CCAC's board of directors and identifies solutions to improve client services. As well, all CCACs have set up a dedicated webpage on "thehealthline.ca"—a provincial website about CCAC services—that provides information on services and support to caregivers. In fact, the Ministry had recognized the importance of caregivers as early as 2009 when it funded a report on long-term policy implications about caregivers. The report noted that the government should support and encourage greater caregiver participation. The Ministry, along with the Ministry of Labour, has since put in place a number of initiatives to assist caregivers. These include amending legislation to create a job-protected leave of absence of up to eight weeks for family caregivers to provide care and support to a family member with a serious medical condition. They also include improving home-care clients' access to short-term beds in long-term-care homes so that caregivers can get some relief from providing care.

At the time of our audit, we found that the actual support offered to caregivers was still minimal at the three CCACs we visited.

- Within the CCACs, care co-ordinators can arrange for a portion of a client's allocated personal support services to be directed to help provide caregivers with respite care.

However, this block of time comes out of the client's overall personal support hours and is not additional to the client's allocated service hours.

- For services external to the CCACs, CCAC care co-ordinators can refer clients to other agencies to, for example, stay at dedicated short-term beds in long-term-care homes or attend adult day programs, so the caregivers can get some relief. However, these services either have wait-lists, or are not available at all in some communities.

We compared the level of support available to caregivers of home-care clients in Ontario to other jurisdictions and found that other provinces and countries provide more support to caregivers. Currently, Manitoba is the only Canadian province that has passed legislation to formally acknowledge the presence and importance of caregivers in home and community care. Subsequent to the introduction of this legislation in 2011, the Manitoba government in April 2012 appointed a Caregiver Advisory Committee to provide information, advice and recommendations to the Minister of Healthy Living and Seniors. Manitoba further allows qualified primary caregivers to receive a refundable tax credit of up to $1,400 (the maximum allowable amount in 2015). As well, according to the Canadian Caregiver Coalition, Nova Scotia provides financial support to eligible caregivers. Furthermore, according to the Ministry, Australia, the United States and the United Kingdom profile the carer in their assessment of clients' needs; the latter country also has a network of 144 "carers' centres" that offer support, advice, counselling and training to informal caregivers.

We also found that CCACs do not always separately track caregiver aid or services provided; only one of the three CCACs we visited tracked this information. Its data showed that the number of caregiver respite hours decreased 16-fold between 2012/13 and 2014/15, from 18,700 hours to 1,110 hours. This decrease was due to this CCAC, in 2013/14, deciding to modify a program for senior

adults so that only adult day programs, but not caregiver respite care, were provided.

The Ministry proposed further action in its May 2015, 10-point plan to strengthen home and community care to invest in more training and education programs for caregivers. The Expert Group's report also recommended more resources to increase the availability of services that support caregivers, specifically by increasing the capacity for in-home and out-of-home scheduled emergency respite services.

### RECOMMENDATION 2

To support caregivers so that home-care clients can receive care at home for as long as needed and to ensure the level of support to caregivers is sufficient,

- the Ministry of Health and Long-Term Care, through the LHINs, should assess the types of caregiver supports and initiatives available in other jurisdictions, and consider approaches to use in Ontario; and
- Community Care Access Centres should track the amount and type of caregiver support provided, and assess whether supports provided are sufficient and appropriate.

### MINISTRY RESPONSE

The Ministry supports this recommendation and recognizes the importance of putting clients and caregivers first in the planning and delivery of home and community care. As noted in the Auditor General's report, the Ministry has committed to increasing caregiver supports and education as part of the 10-step *Patients First: A Roadmap to Strengthen Home and Community Care*. Under the Roadmap, the Ministry is also working to create a Levels of Care Framework that will take into account both client and caregiver needs in the determination of a care plan.

The Ministry remains committed to engaging and consulting caregivers in the development of all Roadmap initiatives through the Patient and Caregiver Home and Community Care Advisory Table, as well as through project-specific working groups. The Ministry will review caregiver supports and initiatives available in other jurisdictions to inform Ontario's efforts to support caregivers.

### RESPONSE FROM CCACs

CCACs agree there is an extreme shortage of services and support available for caregivers. CCACs work closely with caregivers to support patients where they live, and see first-hand the strain endured by caregivers. All 14 CCACs have created a website called Caregiver Exchange to promote the support and services available. While several CCACs have set up programs to support caregivers, no CCAC has received funding for these services and programs. CCACs look forward to, and welcome, expanded caregiver support.

## 4.2 Co-ordination of In-home Services Could Be Better Managed

Clients receiving services from CCACs are assigned to care co-ordinators. Each care co-ordinator may have a caseload consisting of just one type of client population, or a caseload of mixed-population groups. Care co-ordinators are assigned cases based on four factors: distance to clients' homes; intensity of care co-ordination required; care co-ordination specialty (with specific population groups, such as complex, chronic and community independence); and the level of co-ordination with other health-care providers such as hospitals and community services. Through our audit, we found that care co-ordinators' caseload sizes varied from CCAC to CCAC, and within the same CCAC, and did not meet the provincial guidelines that the Association established; and only one of the CCACs we visited had developed an information report to monitor care co-ordinator caseloads.

### 4.2.1 Care Co-ordinator Caseloads Varied and Did Not Meet Guideline Sizes in 2014/15

Across the three CCACs we visited, most care co-ordinators have single-population caseloads (such as complex, or chronic or short-stay clients), except in rural or large geographic areas where assigning mixed-population caseloads (i.e., a combination of complex and chronic and others) is considered most cost-effective considering travel time and because there may not be sufficient cases from certain client populations. In 2009/10, the Association developed provincial guidelines on caseload sizes for each client population category under the Client Care Model. At the time of our audit, two of the three CCACs we visited followed this provincial model. The third CCAC initially followed the provincial model but in February 2014 conducted a review of its adoption of this model to identify areas for improvement. Based on this evaluation, this CCAC in February 2015 adopted a modified version of the provincial model, which outlines different client categories (called community and congregate care) than the ones called for in the provincial model. This CCAC also developed its own caseload size guidelines for its client categories in spring 2015. It noted that revisions were necessary to better allow it to meet its clients' needs.

Figure 5 shows the comparison of actual caseload sizes and the recommended caseload sizes for each client population category at the three CCACs we visited. Of the two CCACs that followed the Association's caseload guidelines, we found that as of March 31, 2015, the average caseload sizes did not meet these guidelines, and some care co-ordinators carried significantly more or fewer cases than recommended. Specifically:

- at one CCAC, even though the recommended caseload sizes for complex clients ranged from 40 to 60, its care co-ordinators carried on average 71 cases, but as many as 146 cases;

**Figure 5: Comparison of Actual and Recommended Caseload Sizes by Client Population at Three Selected CCACs**

Source of data: Ontario Association of Community Care Access Centres, Selected Community Care Access Centres

| Patient Category | Sub-population | Care Co-ordinator Caseload Sizes per Association Guidelines | Actual Caseload Sizes as of March 31, 2015 | | | |
| | | | CCAC #1 | | CCAC #2 | |
| | | | Average | Range | Average | Range |
|---|---|---|---|---|---|---|
| Complex | Senior adults, adults, palliative | 40–60 | 71 | 46–146 | 44 | 14–60 |
| Chronic | Senior adults, adults, palliative | 80–100 | 119 | 88–170 | 89 | 51–115 |
| Community Independence | Stable at risk, supported independence | 140–160 | 160 | 66–217 | 112 | 70–148 |
| Short-stay | Acute, wound, rehab, oncology | 200–300 | 214 | 116–317 | 294 | 135–365 |

| Patient Category | Care Co-ordinator Caseload Sizes per Local Guidelines | Actual Caseload Sizes as of June 13, 2015 | |
| | | CCAC #3 | |
| | | Average | Range |
|---|---|---|---|
| Congregate care | 150–170 | 169 | 94–220 |
| Community | 90–110 | 91 | 50–113 |
| Palliative | 70 | 62 | 42–71 |
| Short-stay | 300 | 351 | 175–539 |

- at the same CCAC, even though the recommended caseload sizes for chronic clients ranged from 80 to 100, its care co-ordinators carried on average 119 cases, but as many as 170 cases;
- at another CCAC, even though the recommended caseload sizes for community independent clients ranged from 140 to 160, its care co-ordinators carried on average 112 cases, but as few as 70 cases.

CCACs indicated that, in recent years, the increase in the number of clients, especially those with complex and chronic needs, has outpaced the increase in funding for care co-ordination activities. In addition, needs of existing clients change over time, which may warrant additional care co-ordination services. As a result, care co-ordination caseloads cannot always be within the levels required by the standard guidelines.

Care co-ordinators' caseloads could be better managed if data was available to alert management when client cases need to be allocated more equitably among care co-ordinators. Only one of the three CCACs we visited had developed an information report to allow management to monitor care co-ordinator caseloads.

We also found that caseload sizes varied widely even within each of the three CCACs we visited. For instance, as of March 31, 2015, a care co-ordinator at one CCAC was responsible for 30 cases of complex clients, but another care co-ordinator at the same CCAC was responsible for twice as many, or 60 complex clients.

These variations in caseload sizes could affect the quality of care co-ordination. Each client may experience different amounts of care co-ordination depending on which care co-ordinator was assigned to the client, and where in the province the client resides. The Association conducted a review of care co-ordinator caseloads in January 2013 and found that across seven CCACs, only one in five care co-ordinators had caseloads that were within the recommended ranges; over half exceeded the recommended ranges; and one in four were below the recommended ranges.

In addition to the higher-than-recommended caseload sizes, other factors also affect care co-ordination quality. For example, in one of the CCACs we visited, a care co-ordinator who works full-time and is responsible for community independent clients had a caseload of 168 at the time of our audit, above the suggested 140 to 160. But this care co-ordinator also conducted overdue assessments and covered for two other care co-ordinators.

CCACs we visited noted that the recommended caseload ranges were not achievable because of staff vacancies, sick leaves and budgetary constraints, and suggested that the Association review the recommended caseload sizes and mix. One CCAC noted that having single-population caseloads (such as complex, or chronic, etc.) is challenging because clients often do not want to switch to another care co-ordinator when their health needs change, and prefer to stay with the co-ordinator they are familiar with. As well, as noted, one CCAC we visited adopted a modified case management model during 2015. That CCAC set different caseload targets than the Association's caseload targets and, as a result, was better able to meet its own targets. At the time of our audit, the Association had not changed the recommended caseload sizes for care co-ordinators for the various client populations.

### 4.2.2 Phone Contact Follow-up on Clients after Discharge Is Not Effective

Following up on clients after they are discharged from home care to determine their continued well-being could help ensure clients do not unnecessarily return to the hospital and/or to home-care services. We found that care co-ordinators at one CCAC we visited did not follow up with 17% of clients, while another CCAC did not follow up with 82% of clients. The third CCAC did not centrally track whether follow-up calls were made to clients

discharged from CCAC services in the year ending March 31, 2014. At the two CCACs that did complete and track follow-up calls, the average number of days between discharge and follow-up was 64 for the community independence population, contrary to the Association's provincial guideline of 30 days. For complex and chronic clients, the provincial guidelines require CCACs to complete follow-up calls within six weeks; however, on average, the two CCACs we visited followed up with complex clients in 12 weeks and with chronic clients in 11 weeks. CCACs indicated that there is a population of clients who tend to return to home-care services after discharge from home care due to their health conditions, and following up with them after discharge may not significantly affect their return rate. We found that of the clients discharged at the three CCACs we visited in the year ending March 31, 2014, 26% needed to return to home-care services subsequently for the same health condition they had before they were discharged from home care in that year. On average, clients were readmitted to CCACs 181 days after discharge from CCAC services. But of the clients who were discharged from CCAC services for reasons other than admission to hospital, placement in long-term-care home, or being on vacation for more than a month, 20% were readmitted within one month of discharge.

### RECOMMENDATION 3

To ensure care co-ordinators are deployed optimally in accordance with caseload guidelines and to encourage equitable service levels across the province, the Community Care Access Centres, in conjunction with the Ontario Association of Community Care Access Centres, should:

- seek to understand the reasons for caseload variances and determine how these can be addressed;
- reassess and, where necessary, revise current provincial guidelines for care co-ordinator caseload sizes; and

- follow up with discharged clients within the required time frames.

### RESPONSE FROM CCACs

Care co-ordinators play an important role in assessing, planning and co-ordinating services to enable patients to reach their care goals. Given that a growing number of patients want to stay at home, and that the average stay on CCAC services was approximately 15 months for long-stay patients in 2014/15, care co-ordinator caseloads continue to grow. Caseload guidelines are one of several factors CCACs consider when balancing the needs of patients and the growing demand for care. The number of patients they serve cannot be the only measure of the work of care co-ordinators. Measurement would also include the range of care they provide based on each individual patient's need. Patients prefer ongoing relationships with their care co-ordinator, further contributing to growth in caseloads. Moving a patient off of a care co-ordinator's caseload just to meet a target is disruptive to the patient and is not a choice CCACs take if it is not essential. CCACs continue to review caseloads to further understand and develop programs and services that help patients live independently in the community.

## 4.3 Inadequate Information on Community Support Services Available

In addition to admitting clients to receive home-care services, CCAC care co-ordinators are also responsible for referring clients to community support service agencies (support agencies) when the client's needs cannot be met by CCAC home-care services alone, or when the client's needs are lighter and would be better met by support agencies. Some examples of community support services are meals on wheels and respite services, which may include a cost to the client. Since June 2009,

care co-ordinators are also responsible for managing the placement of clients for certain categories of services, such as adult day programs (supervised group programming for dependent adults) and supportive housing/assisted living programs (for people who do not require the level of help provided in a long-term-care home, but can no longer manage their own household).

Since 2013, CCACs have used a web-based, geographically specific listing of resources on a website called "thehealthline.ca" to facilitate their referral activities. However, we found the following issues that hamper the CCACs' ability to efficiently refer clients to appropriate support agencies: CCACs did not consistently track referrals or keep centralized wait-lists for all programs for existing home-care clients; the availability of programs varied across regions; the supply of adult day programs and supportive housing programs did not meet demand; and key client assessment information was not added into an information system and was therefore not shared among CCACs and support agencies.

### 4.3.1 Although Tracking of Referrals to Community Support Service Agencies Is Improving, Limited Data Is Maintained

We found that the three CCACs we visited did not consistently track the referrals they made for their home-care clients or for the general public to community support services. Two CCACs started collecting referral data on adult day programs and supportive housing programs in 2012/13; the third CCAC started doing so in 2013/14. Prior to that, care co-ordinators made notes in individual files when they made a referral to community support services, but they did not compile the statistics on the total number of referrals made. In the year ending March 31, 2015, the three CCACs we visited combined referred about 10,500 people to adult day programs and supportive housing/assisted living programs, up 37% from the year prior.

Data collected on referrals to community support services other than adult day programs and supportive housing/assistive living programs varied among the three CCACs we visited. One CCAC tracked all referrals made; one tracked referrals only on respite care, transportation, and independence training for acquired brain injury clients, but not meals on wheels; and one CCAC did not track any referrals to other community support services.

When CCACs do not maintain complete data on the type of referrals they make to other agencies, they cannot demonstrate that clients were directed to appropriate community support services.

### 4.3.2 Community Support Services Not Consistently Available in All Regions

Across the three CCACs we visited, where referrals were tracked, the number of referrals had increased in the last two years. However, CCAC staff informed us that certain community support services are not available in some regions. In these cases, the CCAC will try to refer clients to other similar services provided by agencies in their regions, or by agencies in other regions. However, if these alternatives are not available, the clients do not get access to the needed community support services at all. For example, we found that hospice care services provided by support agencies are not available in one geographic area of a CCAC that we visited. To address such shortcomings, the Expert Group recommended in April 2015 that each LHIN submit to the Ministry a capacity plan for its region indicating where there are service shortfalls and how any gaps in home-care and community services will be addressed.

### 4.3.3 Wait Time to Access Adult Day Programs and Supportive Housing Programs Varied between CCACs

The number of available adult day programs and supportive housing/assisted living programs are not meeting demand. Wait-lists and wait times

for these services were significant at the three CCACs we visited. All three CCACs maintain central wait-lists for these two programs. On average, 275 people were waiting for adult day programs and 380 people were waiting for supportive housing/assisted living programs in the three CCACs we visited as of March 31, 2015. Some people waited for as long as two and a half years for adult day programs, and two years for supportive housing/assisted living programs. The average wait time varied among the three CCACs: the average wait time for adult day programs was as low as 3.6 months in one CCAC, but more than double that in another CCAC; the average wait time for supportive housing/assisted living services was as low as 2.8 months in one CCAC, but as high as 7.7 months in another CCAC.

### 4.3.4 Centralized Wait-lists Not Available for Other Community Support Services

The three CCACs we visited do not have centralized wait-lists for the other community support services such as meals on wheels and transportation services. To refer clients to these services, care co-ordinators have to contact each support agency to find out if spaces are available. Even though support agencies may have their own wait-lists for these services, the three CCACs do not have real time access to this information. Having this access could improve the CCACs' ability to more efficiently refer clients for these services.

### RECOMMENDATION 4

To effectively navigate clients to obtain necessary community-based services and to ensure current information on the availability of such services is easily accessible to all health service providers and clients, Community Care Access Centres should:

- track all referrals made to community support service agencies; and
- in conjunction with their funding Local Health Integration Networks, consider developing centralized wait-list information for all community support services.

### RESPONSE FROM CCACs

The community support service system is fragmented because there are many entities that provide support in every community. CCACs have developed eReferral, a tool that notes where CCAC patients receive community support services, which is then tracked within the CCAC electronic client record. CCACs provide eReferral to over 500 community support service agencies.

Although CCACs have no regulatory authority to manage wait-lists for community support service agencies, CCACs have the technology capacity and could manage these wait-lists with LHIN and partner agreements and necessary program funding.

### 4.3.5 Limited Sharing of Assessment Information between CCACs and Community Support Service Agencies

When each CCAC, support agency or other health service provider agency takes in a client, an assessment needs to be conducted. As a result, clients dealing with many agencies often have to provide similar information multiple times. In order to reduce client frustration and duplication of efforts, the Ministry introduced, in June 2009, an online system called Integrated Assessment Record to enable agencies to share client assessment information with each other. Between June 2009 and March 2015, the Ministry spent about $24 million to implement, maintain and operate this system.

However, we found that this system did not contain complete client assessment information for use by CCACs and support agencies. The Ministry required only CCACs and long-term-care homes to upload assessment information to the system,

but did not extend that requirement to support agencies, which upload assessment information to the system on a voluntary basis. According to information maintained by the Ministry, as of November 2015, 43% of the support agencies in Ontario that used the RAI assessment tools uploaded assessment information to this system.

In addition, we found that although some data was available in the system, the actual use of the available data was even lower. The LHIN of one of the CCACs we visited surveyed the health-service providers in its region in November 2014 and found that only 37% of them used this system to share assessments. For the three CCACs we visited, less than 1% of the CCAC home-care assessments were viewed by other agencies, and about 5% of the support agencies' assessments were viewed by other providers (most likely CCACs, but could also include other agencies). One CCAC we visited explained that its staff did not use the assessment information in the system because it did not contain certain information, such as assessors' notes, that could include clinical information to help CCAC staff understand the client's situation.

CCAC staff also informed us that the system did not have a feature, such as an electronic notification, that alerts care co-ordinators when a client is also receiving services from another agency. This feature could help CCAC staff know that a client's information is already collected by another agency and on the system, so they would not have to request it from the client again. As well, CCACs indicated that this system is not an interactive health record, but rather a viewer for a limited type of assessment records, and there can be delays of up to 36 hours for assessments to be viewed.

## RECOMMENDATION 5

To increase sharing of assessment information and to avoid duplication of effort, the Ministry of Health and Long-Term Care, in conjunction with the Local Health Integration Networks, should:

- require all health-service providers to upload complete assessment information, including assessor's notes, on a common system; and
- establish a feature in the system to alert staff working in CCACs and community support service agencies when a client's assessment record is already in that common system.

## MINISTRY RESPONSE

The Ministry agrees with the recommendation to increase the sharing of assessment information and reduce the duplication of effort through a common system. The Ministry will evaluate the feasibility of enhancements, including adding assessor's notes and a feature to alert staff when a client's assessment record is available in the system. The Ministry is also seeking independent advice on the best approach for community health partners.

## RESPONSE FROM CCACs

CCACs agree that health-care providers need access to common health records. To that end, the Association helped develop and the CCACs now use the Client Health Record Information System (CHRIS). This sophisticated platform feeds into Ontario's electronic health record through the connecting South Western Ontario (cSWO), connecting North Eastern Ontario (cNEO) and connecting Greater Toronto Area (cGTA) programs, now under the umbrella of connecting Ontario (cOntario). We agree that any common system should have a notification function, and the CHRIS system currently delivers this function. The Association and CCACs continue to enhance our current system to provide better access to critical information to improve patient care planning and service delivery.

## 4.4 Access to Home-care Services Is Inconsistent and Dependent on Funding Levels

Historically, the Ministry has provided different amounts of funding to CCACs. Starting in April 2012, the Ministry began funding reform for a portion of funding provided to CCACs. The intent of the funding reform is to provide funding to CCACs so that similar levels of services are provided to similar types of clients. Using the funding model, a portion of each CCAC's funding (approximately 30%) is redistributed among all CCACs. The redistribution is based on both the expected population growth and the provincial average of services provided to CCAC clients in the province. However, in our audit, we found that this funding reform had not appreciably resolved the inequity in funding, which contributed to inconsistencies in accessing home-care services across the province.

### 4.4.1 Per Client Funding Varies across CCACs

Despite the funding reform that began in 2012/13, most of the funding CCACs received in the year ending March 31, 2015, was still based on amounts they received in previous years. As well, as the CCACs transitioned to the new funding formula, the Ministry did not want to create significant year-over-year changes in any CCAC's funding; as such, the Ministry capped the portion of base funding redistributed by the formula to be no more than a 3% increase or 1% decrease compared to the previous year's base funding. One of the CCACs we visited noted that this restriction has prevented it from fully benefiting from the funding increases that it would have qualified for.

In the year ending March 31, 2015, even after the funding reform formula was applied to all CCACs, the costs of delivering home-care services at CCACs still ranged from $2,879 to $4,027 per client, averaging $3,532 per client. Cost per client also differs by client population group. For

instance, the Local Health Integration Networks, in collaboration with CCACs, completed an analysis on the 2014/15 per-client monthly costs for the different client groups across all 14 CCACs in 2015. That analysis showed that the average monthly costs for long-stay complex (adult) clients ranged from $1,227 to $2,392 per month, and the average monthly costs for long-stay chronic (adult) clients ranged from $566 to $984 per month, depending on the CCAC. The varying funding levels allocated to CCACs have resulted in some CCACs having to place some clients on wait-lists and increasing the qualification threshold at which services are provided. As a result, clients did not receive equitable levels of services, as described in **Sections 4.4.2** and **4.4.3**.

### RECOMMENDATION 6

To ensure CCACs receive funding that enables the provision of equitable service levels across Ontario, the Ministry of Health and Long-Term Care, in conjunction with the Local Health Integration Networks and the Community Care Access Centres, should explore better ways to apply the funding reform formulas to address the funding inequities.

### MINISTRY RESPONSE

The Ministry agrees with this recommendation. The Health Based Allocation Model is designed to enable the Ministry to equitably allocate funding for health services. The Ministry will continue to collaborate with CCACs and LHINs to review the funding formulas and explore adjustments to better ensure equitable service levels.

### RESPONSE FROM CCACs AND THE ASSOCIATION

CCACs and the Ontario Association of Community Care Access Centres are working with the Ministry and the LHINs to develop

improvements in funding formulas that account for varied geography and changing patient complexity and better address current funding inequities. The current funding formula is based on historical funding adopted from a model when patients received the majority of care in an institution instead of at home. The approach to funding should reflect the needs of patient populations and determine the necessary funding required to meet those needs. New formulas would enable strategic investments to implement change in the delivery of services and improve consistency in access to care for patients. Resolving the inequities in home-care funding will lead to greater consistency in care across Ontario.

## 4.4.2 Access to and Extent of Personal Support Services Received May Not Be Equitable

CCACs cannot operate at a deficit. It is at the discretion of each CCAC how it will meet the demand for its personal support services and other home-care services (such as nursing and therapy services) and achieve a balanced budget at year-end. This results in CCACs having to make decisions on whether to provide fewer services to more clients or to provide more services to fewer clients. Even when CCACs assess clients as being eligible to receive home care, they then prioritize personal support services to clients when their needs exceed a locally defined threshold. As well, the level of care the CCACs provide their clients can also differ, even for clients with the same assessment score. The time of year a client is referred to a CCAC for home-care services can also influence whether the person receives timely services or not.

There are no common provincial service prioritization guidelines, and each of the three CCACs we visited had different criteria to prioritize which clients would receive services. For example, a client assessed with a RAI-HC score of seven would not receive any personal support service from one

CCAC we visited because that CCAC prioritizes allocation of services such that only clients with RAI-HC scores of eight or higher would receive services (patients with scores between eight and 10.5 at this CCAC do not receive services immediately; they are placed on a wait-list). But the same client would receive services in the other two CCACs. For some clients, the lack of personal support services could aggravate their health condition and cause them to suffer unnecessarily. These clients could return to the hospital to obtain needed medical care or could later require a greater intensity of home care than originally warranted.

Even when a client has a higher RAI-HC score and therefore is more likely to receive personal support services at most CCACs, the level of service could vary. For example, a client assessed with a RAI-HC score of 15 would be receiving, every week, up to five hours in one CCAC, eight hours in the second, and 10 hours in the third.

To ensure they achieve a balanced budget by year-end, CCACs may adjust their service priority criteria during the year. As a result, a person assessed with a certain score near the beginning of a fiscal year may qualify for services, yet a few months later, because of a change in the local CCAC's service priority criteria, another person with the same assessment score would not qualify for any service. For example, at one CCAC, new clients with RAI-HC scores of 15.5 or higher received services in July 2014, but that CCAC raised the admission threshold to 20 in September 2014; therefore, new clients assessed with a score of 16 to 20, after September 2014, were put on a wait-list for services. At this CCAC, nine times more people were on the wait-list at the end of the fiscal year compared to the beginning of the fiscal year in 2014/15. Within the wait-list, the increase was mainly for clients with high and very high needs. These clients typically require more service hour allocations.

**Figure 6** shows the 2014 and 2015 prioritization criteria used at the three CCACs we visited.

## Figure 6: Comparison of Personal Support Service Levels[1] across Three Selected CCACs, 2014 and 2015

Source of data: Selected Community Care Access Centres

| Priority Level | CCAC #1 Effective from April 2015 | | CCAC #2 Effective from September 2014 | | CCAC #3 Effective from May 2014 | |
|---|---|---|---|---|---|---|
| | RAI-HC Score | # of Hours per Week | RAI-HC Score | # of Hours per Week | RAI-HC Score | # of Hours per Week |
| Low and Moderate | 0–10 | 1–2 | 1–6 | 1 | 0–10.5 | 0 |
| Moderate[2] | n/a | n/a | 7–10 | 2 | n/a | n/a |
| High | 11–16 | 5 | 11–16 | 8 | 11–12.5 | 5 |
| | | | | | 13–15.5 | 10 |
| Very High | 17–28 | 14 | 17–28 | 14 | 16–28 | 15 |

1. Service levels shown represent the maximum amount of hours for clients who live alone (those who live with a family member usually qualify for fewer hours).

2. Two of the three CCACs we visited do not have this priority level.

When CCACs change their service priority criteria to control costs, this can also affect existing clients. CCACs may, after reassessing client needs, discharge clients whose assessed needs no longer meet the revised service priority criteria, even though these clients were previously receiving home-care services. For instance, in September 2014, one CCAC, with the approval of its LHIN, determined that clients whose assessment scores were less than 11 would be reassessed and discharged from CCAC care if appropriate, in anticipation of eventually transferring low-needs clients to support agencies (see **Section 4.4.5**). This CCAC expected that discharging low-needs clients would help it potentially save $6 million a year. This CCAC reassessed some 1,300 out of a total of about 1,800 low-needs clients who were already receiving home care, and discharged 575 clients. It then suspended the discharge process to review the status of the discharged clients. In December 2014, the CCAC conducted a survey with the discharged clients it could reach, and found that 30% of them reported that they were not doing well, and 60% of them reported that they had to rely on care provided by their family and friends, or self-care.

The following is an example of how one CCAC treated clients with similar assessed needs differently. At one CCAC, an 80-year-old client was assessed as a chronic client with a RAI score of 13 in June 2014. The client had decreased mobility, decreased functionality with activities of daily living, and a physical injury. This client was allocated two hours of personal support services per week. In this same CCAC, a 93-year old client was also assessed as a chronic client, but with a slightly higher RAI score of 14 in August 2014. The client had cognitive impairment. However, this client did not receive the needed support service right away in August 2014 after being assessed because the CCAC put the client on a wait-list to receive services. This client did not receive any services from the CCAC until December 2014 when the CCAC approved two hours of personal support services per week.

### 4.4.3 Wait-lists Exist for Personal Support Services and Therapy Services, and Different Prioritization Criteria Applied

CCACs told us that the main reason they place clients on wait-lists is because they do not have the financial capacity to provide the needed services immediately. All three CCACs we visited had wait-lists for personal support services and therapy services as of March 31, 2015. For instance, one CCAC we visited had over 2,000 people with various needs (complex and non-complex) waiting for personal support services, with wait time ranging

from 12 to 198 days. That same CCAC also had 500 people waiting for occupational therapy, with wait time ranging from 20 to 138 days depending on the location within the CCAC. On the other hand, none of the three CCACs we visited had wait-lists for nursing services.

The wait-lists do not reflect the total demand for services, such as those who may be eligible for home-care services as set out in the criteria under the applicable regulation but do not meet the local CCAC service prioritization guidelines. Each of the three CCACs we visited had developed its own wait-list prioritization criteria for personal support services, which varied. For instance, at one CCAC, clients assessed after September 2014 as low to moderate needs with RAI scores of 10.5 and under would not even be added to its wait-list for services. Meanwhile a client with the same score at the other two CCACs would have been placed on their respective wait-lists for services.

In 2013/14, the Ministry made a commitment to publicly reporting and working toward a five-day wait-time target for nursing and personal support services, and required CCACs to meet this target. According to data published by Health Quality Ontario (a government agency created in 2005 that reports to the public the state of the health system in Ontario), from October to December 2014:

- On average, 93% of clients in Ontario received their first nursing visit within five days of being approved for services, but results varied across the 14 CCACs, from about 90% to 97%. The provincial result represents a slight decline from the 2013/14 annual performance of about 94%.
- On average, 85% of clients assessed as complex in Ontario received their first personal support service within five days of being approved for services, but results varied across the 14 CCACs, from about 69% to 95%. The provincial result represents a slight improvement from the 2013/14 annual performance of about 84%.

In its three-year, 10-point plan to strengthen home and community care, the government in May 2015 committed to developing, by 2017, "a capacity plan that includes targets for local communities as well as standards for access to home and community care and for the quality of client experience across the province."

### 4.4.4 Allocation of Services Dependent on Funding Levels

CCAC care co-ordinators are required to follow local service allocation guidelines and use clinical judgment when determining client service levels. Even though CCACs are allowed by regulation effective in May 2008 to provide a client with up to 90 hours of personal support services per month, the CCACs we visited were not, for the most part, providing that level of service. A number of factors influence this: CCACs noted that determination of a service level is a clinical decision made by care co-ordinators that is not determined by the regulated maximum allocation of service. In addition, CCACs must work within their budgetary allocations, which have resulted in each CCAC having to make decisions on whether to provide more services to fewer clients, or fewer services to more clients. To support their decisions, CCACs have each developed local service prioritization guidelines that define maximum service levels to be allocated.

For example, one CCAC was allowing a maximum of 15 hours of personal support services per week (60 hours per month), and the other two CCACs were allowing a maximum of 14 hours of services per week (56 hours per month) to their highest-need clients. These levels reflect the former maximum hours of services allowed (60 hours for services provided after the first 30 days in service) prior to the regulatory change that took effect in May 2008. One of the CCACs we visited monitors how many patients receive over 60 hours of service per month, in order to meet its annual operating budget. We found that clients receiving maximum levels of service tend to be those waiting to be

admitted to long-term-care homes and those in palliative care. For other types of clients, CCAC management told us that they controlled the maximum hours of services in order to contain costs. CCAC care co-ordinators can allocate more hours of services than their locally determined maximum amounts, but only upon management approval.

As well, we found that over the years, CCACs have reduced the maximum hours clients would receive. For instance, between 2010 and 2014, the most hours per week that one CCAC actually provided to its most complex clients declined from 14 to seven. We noted similar reductions in the other two CCACs.

Our review of the other provinces' and territories' maximum number of personal support hours to clients showed variations in the levels of services provided. Some jurisdictions set a maximum number of hours to be provided per month while some did not. For those jurisdictions that did set a limit, the maximum hours ranged from 100 hours to 160 hours per month. Three jurisdictions in our comparison did not establish a maximum number of hours. Ontario's regulated maximum number of hours is at the low end of the range when compared to the other Canadian jurisdictions. We acknowledge that each jurisdiction may include different services under its own definition of personal support services, so it would be prudent for Ontario to compare its maximum allocated hours of personal support services to these jurisdictions' to determine whether Ontario's hours are appropriate.

Ontario's legislation specifies the maximum amount of services that CCACs can provide; however, it is silent on the minimum amount of services that can be provided. As a result, there is no minimum service level requirement for personal support services that CCACs must provide to their clients—for instance, a specified minimum number of baths per week.

## RECOMMENDATION 7

To ensure Ontarians receive equitable and appropriate levels of home-care services, the Ministry of Health and Long-Term Care, in conjunction with the Local Health Integration Networks and the Community Care Access Centres (CCACs), should:

- develop standard guidelines for prioritizing clients for services, and monitor for compliance to those guidelines;
- evaluate ways to provide more service hours closer to the regulated maximum limits for those assessed as requiring such services; and
- consider establishing a minimum level of services that clients can expect to receive from CCACs.

## MINISTRY RESPONSE

The Ministry supports this recommendation and is committed to ensuring that Ontarians receive equitable and appropriate levels of home and community care services. The Ministry will work with CCACs and Local Health Integration Networks to ensure that existing home and community care assessment tools are used effectively. In addition, the first phase of the Ministry's plan to transform home and community care is focused on improving consistency of care and providing Ontarians with a clear understanding of what they can expect from the home and community care sector. As part of the Levels of Care Framework, the Ministry will develop service allocation guidelines and standardized care protocols to ensure that there is consistency in how clients are cared for across the province.

## RESPONSE FROM CCACs AND THE ASSOCIATION

The Association and CCACs are currently working with the Ministry of Health and Long-Term

Care in its development of a Levels of Care Framework for home care in Ontario. We are fully committed to the Ministry's goal of helping develop a sustainable, "value-for-money" framework that ensures services and assessments are consistent and would encourage the province to consider the consistent application of funding to support assessed patient needs.

### 4.4.5 CCACs Still Providing Personal Support Services to Low-needs Clients

Regulatory changes that came into effect in July 2014 allow support agencies, in addition to CCACs, to provide personal support services to clients with lower levels of needs, so CCACs can focus on clients with higher needs. Once a client is referred to a support agency, the agency then becomes responsible for that client, including care co-ordination and provision of personal support services. At the time of our audit, the Ministry and the LHINs were still finalizing the operational changes necessary to divert clients from CCACs to the support agencies. Changes that need to be considered include, for example, clarifying the roles of the CCACs and support agencies regarding care co-ordination for clients with lower levels of need to avoid client confusion.

## RECOMMENDATION 8

To enable Community Care Access Centres (CCACs) to focus their efforts on clients with higher levels of need, the Ministry of Health and Long-Term Care, in collaboration with the Local Health Integration Networks and the CCACs, should expedite the process of transferring and diverting low-needs clients needing personal support services from CCACs to community support service agencies.

### MINISTRY RESPONSE

The Ministry supports this recommendation and is working with the LHINs to ensure safe and appropriate transitions to approved community agencies. The LHINs have begun evaluating the readiness of their funded community agencies to determine their capacity to support this new client population, including seeking the necessary ministry approvals to provide personal support services.

As of fall 2015, the Ministry is providing the Local Health Integration Network Collaborative (LHINC) with funding to support and expedite implementation efforts. Implementation through LHINC will ensure provincial consistency in the approach used across all 14 LHINs, while still allowing for local flexibility. A phased implementation approach is being used, beginning with four early adopter LHINs. These LHINs will test processes, standards and tools to inform a broader provincial rollout. To support the legislative change and clarify the roles of the CCACs and support agencies regarding care co-ordination, the Ministry publicly released two policy guidelines (*Policy Guideline Relating to the Delivery of Personal Support Services by CCACs and CSS Agencies* and *Policy Guideline for CCAC and CSS Agency Collaborative Home and Community-Based Care Co-ordination*). The Ministry will work with the LHINs and with LHINC to ensure that these guidelines are clearly understood and utilized.

### RESPONSE FROM CCACs

LHINs are leading the implementation of regulation changes through pilot sites. CCACs look forward to working with the Ministry and LHINs to evaluate these pilots to ensure that services for patients are accessible and not further fragmented.

## 4.5 Oversight of Contracted Service Providers Needs Improvement

Since October 2012, the CCACs have used a standard service contract that reflects the Ministry's Contract Management Guidelines for CCACs, which includes a set of performance standards for all their contracted service providers that provide nursing, therapy and personal support services (explained in **Section 1.0** under **Service Delivery Model**). The performance standards include, for example, service providers accepting a certain proportion of client referrals from CCACs within specified times, and CCACs receiving client discharge reports for nursing and therapy services from service providers by required deadlines. The CCACs also contract with an external survey firm to assess overall client satisfaction with the service providers' performance, as well as to assess the impact on the client's care when service providers were late for scheduled visits, or sent different personnel for each visit. We discussed details of contract changes prior to October 2012 in the *Special Report on CCACs—Financial Operations and Service Delivery* issued in September 2015.

As a part of monitoring service providers, the CCACs conduct quarterly or monthly meetings with all their service providers to discuss areas including achievement of performance targets, complaints received, and the status of new and ongoing initiatives. CCACs may issue quality improvement notices to service providers when CCACs identify areas of improvement required by service providers to improve client care. When performance issues are not resolved, CCACs may decrease the service volume allocated to a poorly performing service provider, or may terminate the service provider contract. Service providers are also required to submit annual reports and audited financial statements to the CCACs for review. The annual reports contain information such as a summary of the service provider's performance in the year, a summary of results from staff satisfaction surveys, and the status of ongoing quality-improvement initiatives, if any.

However, the CCACs do not assess the service providers for meeting client outcomes; they do not always apply corrective action when service providers underperform; their client satisfaction rates are not always reliable; and they do not consistently conduct site visits to service providers. We also had further concerns about the Ministry's planning and implementation, and the Ministry's, the LHINs' and the CCACs' oversight of the personal support worker wage subsidy program.

### 4.5.1 Service Providers Not Assessed for Meeting Client Outcomes

From November 2012 to September 2014, the Ontario Association of Community Care Access Centres (Association) developed and collected data for three outcome indicators for a project to assess the effectiveness of treatment for certain wound care areas and for hip and knee replacement care. These indicators measured areas such as hospital readmission rate and the final outcomes achieved. However, in September 2014, the Association paused this project, and CCACs stopped measuring these outcome indicators. We discussed details of this project in the Special Report on CCACs issued in September 2015.

While the indicators set out in the October 2014 standard service provider contracts (the most recent iteration of the contracts at the time of the audit) include measures of client experience (for example, whether clients were satisfied with the care that service providers delivered—see **Section 4.5.3** for discussion on survey results reliability), they do not measure outcomes, such as how often clients return to hospitals after receiving home care. As a result, CCACs cannot determine whether the level and quality of services provided to home-care clients have reduced the risk that they need to return to a hospital setting.

### 4.5.2 Corrective Actions Inconsistently Applied When Service Providers Underperformed

One CCAC we visited did not always apply corrective measures to service providers that did not meet expected levels of performance. For instance, half of our sample of service providers that supply shift nursing services to this CCAC did not meet the required 90% acceptance referral rate as stated in the contract in 2014/15. Instead, they accepted between 35% and 74% of the referrals made to them, for reasons such as insufficient staffing levels. Similarly, over 80% of its service providers that deliver nursing services on its behalf did not meet their overall satisfaction rate target of 90% in 2013/14. This CCAC had in other cases applied corrective actions such as reducing the referrals made to the service provider, or issuing a quality improvement notice, but after it assessed the appropriateness of applying corrective actions, did not apply any contract remedy in these cases.

CCACs also monitor service providers for missed visits. Before October 2014, the definition of a missed visit was inconsistent across CCACs. For instance, if a service provider arrived late, some CCACs required it to be reported, while other CCACs did not. The target for missed visits also varied across CCACs. For example, the target for missed nursing visits ranged from 0.2% to 0.55% in the three CCACs we visited. Service providers generally met these targets. However, as of October 2014, the Association standardized the definition of a missed visit so that the CCACs can collect and assess consistent data. This indicator is now referred to as "missed care." All CCACs are required to consistently interpret missed care as whether the care provided was in accordance with the client's care plan. When a service provider notifies the client that a visit will be missed and reschedules a visit with the client, the incident will not be captured as missed care under the new definition, even though it was counted as a missed visit by some CCACs under the former definition.

Also, this new definition will make it more difficult to identify instances where the service provider did not provide the needed services at the times required by the clients, such as late arrivals, if the care plan does not specifically refer to a time and day of visit (but rather something less specific such as two visits a week). At the time of our audit, a target had not been set for the new missed care indicator as the CCACs needed time to collect performance results under this new definition to be able to establish a baseline for measurement, but the CCACs plan to set such a target by April 2016.

### RECOMMENDATION 9

To help ensure that service providers provide the best-quality home-care services to clients, Community Care Access Centres should:

- develop performance indicators and targets and collect relevant data that measure client outcomes;
- reassess the use of "missed care" versus tracking all possible scenarios of missed, rescheduled and late visits; and
- consistently apply appropriate corrective actions to service providers that perform below expectation.

### RESPONSE FROM CCACs

CCACs follow a rigorous provincial framework for service provider contract management, which is publicly available. CCACs regularly monitor performance and issue quality improvement notices to service providers to improve patient care. Where performance issues are not resolved, CCACs take corrective action by decreasing the amount of service volume allocated to a poorly performing provider or terminating a contract. In January 2015, CCACs clarified the definition of missed care and began collecting data on the refined definition. CCACs are currently using this data to establish performance targets for all occurrences of missed care.

### 4.5.3 Overall Client Satisfaction Rate Not Reliable

The client and caregiver satisfaction survey is one of the few methods of obtaining feedback from CCAC clients. The responses help CCACs monitor service providers and improve new initiatives and programs. This survey includes a standard list of questions about the client's experience, such as "How easy or difficult, on average, has it been to contact your case manager when you needed to?" Based on telephone survey results conducted by an external survey company on behalf of the 14 CCACs, between April 2012 and September 2015, the overall client satisfaction rate was over 90%. However, we found that these standard survey results were not reliable based on the high margins of error for some of the client responses.

Between April 2012 and September 2015, about 30% of the three CCACs' clients who were contacted responded to the telephone survey (referred to as the response rate). This rate is slightly above the average 27% response rate for surveys administered over the phone reported by the company that administers this survey.

We also found that clients' responses to some of the questions in the standard survey contained margins of error that were beyond acceptable levels according to their own methodology. The Association and the CCACs jointly determined that a margin of error of 10% was required for survey results to be considered reliable. Any responses with a higher margin of error would not be reliable or accurate for use in monitoring service providers. We reviewed the results for some of the survey responses and noted instances where the margins of error were much higher than 10% because of a low response rate. For instance, 79% of clients in one CCAC indicated that they were satisfied with a service provider providing continuous care. Compared to a target satisfaction rate of 90%, the CCAC still considered this service provider as having met the target because the margin of error for this question and for this service provider was 18% given the

low response rate (much higher than the required 10% margin of error), and the CCAC adjusted the target down to 72% (calculated as 90% less 18% margin of error).

### RECOMMENDATION 10

To ensure that the client satisfaction survey results can be used to effectively monitor the performance of the service providers, the Ontario Association of Community Care Access Centres, in conjunction with the Community Care Access Centres, should review and revise, where necessary, the client satisfaction survey methodology to increase the accuracy and reliability of survey responses.

### RESPONSE FROM CCACs

CCACs use a nationally recognized tool that is widely used by health-care providers, including hospitals, across Canada. CCACs have implemented strategies to ensure that sample sizes produce statistically significant results in all but the smallest-volume contract providers. These small contracts represent only 4% of overall CCAC service volumes. CCACs will continue to regularly update this survey tool to ensure they are seeking as much feedback from patients as possible. This patient satisfaction survey is only one tool employed by CCACs to assess patient satisfaction across the province; more importantly, all CCACs engage with patients directly to receive their valued feedback so we can continue to improve quality and the patient experience.

### 4.5.4 CCACs Conducted Limited Inspection Audits on Service Providers

In our 2010 audit of home-care services, we found that only one CCAC conducted routine inspection visits to its service providers to monitor the quality of care they delivered. In this current audit, the lack of site visits is still a concern; again, only one of the

three CCACs we audited had conducted routine site visits to inspect its service providers in the three years up to the year ending March 31, 2015. This CCAC reviewed areas such as scheduling standards, use of risk reporting tools, and implementation of certain clinical standards.

On the other hand, the other two CCACs we visited did not consistently conduct site visits. One did not conduct any routine site visits at all, citing lack of resources as a reason. The other CCAC conducted limited inspections of its service providers' internal records, but mainly relied on service providers to conduct self-inspections, specifically to find and report on whether they correctly excluded missed visits from their billings to the CCAC (service providers would have previously reported incidents of missed visits to the CCAC). This CCAC found that, based on self-inspections by service providers, one of its four service providers had not properly excluded missed visits in its billings, which resulted in a quality improvement notice for that service provider. However, this self-inspection would not help the CCAC detect whether the service provider had under-reported the number of missed visits to the CCAC in the first place. Therefore, we are concerned that the lack of site visits by the CCACs, and the reliance on self-reporting, does not sufficiently mitigate the risk of underperformance or billing inaccuracies. This risk could be better mitigated if the CCACs conducted routine inspections of its service providers.

## RECOMMENDATION 11

To ensure that information submitted by service providers is complete, accurate and reflects their performance, the Community Care Access Centres should conduct routine site visits to monitor quality of care and verify the accuracy and completeness of information reported to CCACs.

### RESPONSE FROM CCACs

CCACs are implementing direct reporting by service providers into the CCAC client health record to monitor consistency in patient visits. As this information is currently self-reported on a voluntary basis, CCACs see value in mandatory provincial requirements for automated reporting directly to the CCACs so that CCACs can better monitor service provider performance. Further, a consistent provincial data-collection system will enable CCAC oversight of service provider performance and eliminate the current reliance on self-reported performance data.

## 4.5.5 Reported Complaints about Services up since 2010

Reviewing and monitoring complaints can help identify concerns with a service provider's performance and provide insight into the quality of home-care services provided. The majority of complaints on home care at the three CCACs we visited related to the amount of services received, the quality of care provided by service providers' staff, and admission for services.

In our audit, for the year ending March 31, 2015, we found that the prevalence of complaints at the three CCACs we visited ranged from six to 10 per 1,000 clients. But the CCAC that reported six complaints per 1,000 clients did not fully include all situations that could result in danger, loss or injury as did the other two CCACs; therefore, its actual prevalence of complaints would likely have been much higher. In the 2010 audit, the rate was significantly lower, at three to eight per 1,000 clients, but we visited different CCACs at that time (one was common in both years).

All the complaints we reviewed were generally resolved within the legislated time frame of 60 days, and the actions that the CCACs took to address them were generally appropriate. All CCACs applied a risk rating to each complaint, as required in their policies, but only one CCAC used the rating scale to establish a time frame to address the more severe complaints within a quicker time frame than the legislated 60 days. This CCAC

determined that assigning timelines to different risk levels is an effective method of prioritizing complaints; the other CCACs would benefit from adopting such a policy.

As well, even though the CCACs require service providers to include in an annual report a summary of findings obtained through client complaints received during the year, we found that some service providers reported the nature of complaints received while others only reported the number of complaints. Also, neither the Ministry nor the LHINs require CCACs to report the nature of local complaints. One of the three CCACs we visited reported the nature of complaints to its LHIN as part of a larger report on client safety, but the other two did not. As a result, CCACs cannot easily identify systemic issues.

## RECOMMENDATION 12

To ensure that complaints brought to the attention of either the Community Care Access Centres or the service providers are appropriately addressed on a timely basis, the Community Care Access Centres should:

- prioritize the complaints they receive by level of risk and respond to the most urgent ones first; and
- require service providers to identify common areas of concerns as reported by their complainants, and analyze this information for further action.

### RESPONSE FROM CCACs

CCACs have a well-established, well-articulated and transparent process for responding to patient complaints that is prescribed by regulation. CCACs have implemented systems to track patient complaints and prioritize risk issues to enable effective responses and minimize likelihood of recurrence. Service providers regularly submit a quality-improvement report to CCACs, which includes the number and nature of complaints received, a summary of common themes

and the corrective action that was undertaken to minimize recurrence. We continue to improve data definitions in order to enable CCACs to further expand our capacity to analyze information at the provincial level and further drive province-wide improvements in patient care.

## 4.5.6 Better Oversight and Planning Was Needed for the Personal Support Workers Wage Subsidy Program

In 2014/15, the Ministry provided about $52 million to CCACs so they could increase base wages for personal support workers (PSWs) to aid in recruiting and retaining PSWs to help meet Ontario's growing demand for home- and community-based services. With this funding, CCACs were to amend their contracts with service providers that supply personal support services, requiring them to increase the hourly wages of the PSWs they hire. The goal is to increase the minimum hourly wage of PSWs by $1.50 each year in 2014/15 and 2015/16, and $1.00 in 2016/17 so that the base wage will rise to $16.50 by April 1, 2016. At the time of our audit, the Ministry had determined the preliminary PSW allocation of funding to CCACs for the 2015/16 year to be $53 million.

In June 2015, the Ministry announced changes to the wage subsidy program that included the implementation of a cap on PSW rates of $19 per hour. Therefore, PSWs earning over $19 per hour will no longer be eligible for the Ministry's PSW wage increases. Thus, PSWs who were paid close to $19 an hour previously, and were expecting a $4 per hour increase over the three years, may receive only a portion of the overall pay increase up to $19 an hour.

We identified several concerns with the Ministry's implementation and the Ministry's, the LHINs' and the CCACs' oversight of the PSW wage subsidy program, as outlined below:

- Service providers we contacted told us that although the funding that the Ministry provided initially included an implicit 16%

for benefits, in addition to base salary, actual benefits paid by service providers are higher, ranging from 20% to 25%. Service providers therefore had to cover the gap in funding out of their own pockets. The Ministry has since provided additional funding to cover 22.7% of benefit costs for subsequent years 2015/16 and 2016/17, and retroactively for the 2014/15 year.

- Service providers told us that the increased PSW wage is encroaching on the lower end of the registered practical nurse wage band. If the difference in wages is not maintained, the service providers are concerned that they will be disadvantaged in bargaining when the registered practical nurse collective agreements are up for negotiation. Service providers are also concerned that the PSWs they employ would receive different pay just because some serve CCAC- and other LHIN-funded clients, and others serve private-pay clients. The ministry funding is not intended for the PSWs who serve private-pay clients.

- Service providers are required in their contract with the CCACs to provide all records relating to the PSW wage subsidy funding, upon request, to the CCAC, the LHIN and the Ministry. The three CCACs we visited did not conduct site visits to service providers' premises or request service providers to provide financial records to ensure they used the funding to increase their PSW staff wages. CCACs indicated that they were asked by the Ministry to support the implementation of the PSW wage stabilization initiative by acting as a flow-through for the funds to those employers with whom CCACs had an existing contract. We noted that the Ministry only requires service providers to annually self-declare that they have complied with the wage increases.

## RECOMMENDATION 13

To ensure that the funds provided to recruit and retain personal support workers are spent for the purposes intended, the Community Care Access Centres should conduct inspections of service provider records, on a random basis, and share the results with the Ministry of Health and Long-Term Care.

### MINISTRY RESPONSE

The Ministry supports this recommendation and will work with the Local Health Integration Networks, CCACs and the Ontario Association of Community Care Access Centres to establish a common provincial audit process.

### RESPONSE FROM CCACs

CCACs were asked by the province to support the implementation of the PSW wage stabilization initiative by acting as a flow-through for the funds to those employers with whom CCACs had an existing contract. It is understood that the Ministry will establish a provincial process to conduct audits of the organizations that received the funds to ensure that the funds were used in accordance with the terms and conditions prescribed by the Ministry in each year of the program. The Ministry, in partnership with the LHINs, is accountable for any follow-up related to how employers allocated the funds.

## 4.6 CCACs Measured against Different Targets for Common Areas

CCACs report their performance in various areas to both the LHINs and Health Quality Ontario. **Appendix 4** shows the list of performance measures reported and the entity to which this information is reported. Only results collected by Health Quality Ontario are publicly reported on its website.

We found that the three CCACs report their performance in about 40 different areas to either the LHIN or indirectly to Health Quality Ontario (one CCAC is subject to four additional performance measures at its LHIN's request), up from 13 that we noted in our 2010 audit on home care. We noted that while the majority of the indicators measure output (for instance, number of clients served and cost per service) and client experience (such as wait times from hospital discharge to service initiation), only seven measure outcome (for instance, client readmission to hospital and unplanned emergency visits), as shown in **Appendix 4**.

Fifteen of the performance indicators that are reported to the LHINs, and six of the performance indicators that are reported indirectly to Health Quality Ontario, are measured against targets. Similar to our audit observation in 2010, we continue to note that CCACs are held to different standards because performance targets are established individually between each CCAC and its respective LHIN. For example, for the performance indicator measuring how long 90% of the clients had to wait from the time they were discharged from the hospital to when they received CCAC service, the target across the three CCACs we visited varied from five days to eight days in 2013/14. Similarly, for the performance indicator measuring the percentage of CCAC home-care clients who made an unplanned emergency department visit within the first 30 days of being discharged from the hospital, the target across the three CCACs we visited varied from about 4% to 12% in 2014/15.

The remaining performance indicators reported to the LHINs and indirectly to Health Quality Ontario do not have targets because the information is only collected to allow decision-makers to have an overview of the provincial and local health system. However, it would be prudent to establish benchmarks for these areas.

We found that where targets were set and the indicators relate to home care, the three CCACs we visited did not consistently meet all the performance areas, as shown in **Figure 7**:

- About 60% of the performance targets were met in those areas that were reported to LHINs in the year ending March 31, 2014, the latest information available at the time of our audit. In two of the CCACs visited, patients referred from the community setting (i.e., not referred from hospitals) waited twice as long to receive their first service as the targeted wait time (patients in one CCAC waited on average 94 days against the target of 48 days, and patients in the other CCAC waited on average 47 days against the target of 28 days).

- Only one-third of the performance targets were met in those areas that were reported indirectly to Health Quality Ontario in the year ending March 31, 2015. For example, none of the three CCACs we visited met their targets for the percentage of home-care patients that were readmitted to hospitals within 30 days of hospital discharge—one CCAC had a target of 14% for the hospital readmission rate, but over 20% of its patients were readmitted within 30 days of discharge. This CCAC indicated that the higher-than-expected readmission rate may be due in part to limited availability of walk-in clinics and after-hours clinics in the region, and some patients may not have primary physicians, resulting in a higher hospital readmission rate. As well, one CCAC did not meet its target of having 90% of its patients receive personal support services within five days—instead, it was able to achieve this service level for less than 80% of its clients.

LHINs held meetings with the CCACs to discuss ways the CCACs could better meet targets in the next reporting period. For the six indicators reported to Health Quality Ontario, if the targets are not met, some CCAC CEOs' compensation may be affected, as set out in their employment contracts. For the remaining 11 CCAC indicators reported by Health Quality Ontario, if CCACs' performance declines year after year, Health Quality Ontario cannot impose any corrective measures

**Figure 7: Comparison of Actual and Targeted Performance in 2013/14 and 2014/15 at Three Selected CCACs**

Sources of data: Selected Community Care Access Centres

| Indicator | CCAC #1 | | | CCAC #2 | | | CCAC #3 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Target | Actual Results in 2013/14 | Met Target? | Target | Actual Results in 2013/14 | Met Target? | Target | Actual Results in 2013/14 | Met Target? |
| **Reported to Local Health Integration Networks** | | | | | | | | | |
| % of total margin | 0% | 0.6% | Yes | 0% | 0% | Yes | 0% | -0.13% | No |
| Balanced budget (indicated by 0 or surplus) | 0+ | $1.6 million | Yes | 0+ | 0 | Yes | 0+ | -$283,000 | No |
| Proportion of budget spent on administration | <=9.8% | 8.2% | Yes | <=10.5% | 9.10% | Yes | <=9% | 7.7% | Yes |
| Variance between forecast and actual expenditures | 0% | 0.3% | No[1] | 0% | 0 | Yes | 0% | -0.13% | Yes |
| Variance between forecast and actual units of service | 0% | 1.3% | No[1] | 0% | 0 | Yes | 0% | 0% | Yes |
| 90th percentile wait time from hospital discharge to service initiation (hospital patients) | < 5 days | 6 days | No | <=6 days | Data not available | n/a | 8 days | 8 days | Yes |
| 50th percentile wait time for home-care services—application to first service (community setting) | 6 days | 8 days | No | | Data not reported | | 1 day | 1 day | Yes |
| 90th percentile wait time for home-care services—application to first service (community setting) | 28 days | 47 days | No | 48 days | 94 days | No | 66 days | 57 days | Yes |
| % of alternate level of care days | <=15% | 12.6% | Yes | <=22% | 20.70% | Yes | <=13.5% | 13% | Yes |
| Clients with MAPLe[2] scores "High" and "Very High" living in the community supported by CCAC | >=6,600 | 7,754 | Yes | >=3,000 | 3,333 | Yes | >=4,500 | 5,960 | Yes |
| Clients placed in long-term care homes with MAPLe[2] scores "High" and "Very High" as a proportion of total patients placed | >=79% | 85% | Yes | >= 79% | 83% | Yes | >=79% | 82% | Yes |
| % of people registered with Health Care Connect who are referred | >=79% | 91% | Yes | >=76% | 79% | Yes | >=76% | n/a | n/a |
| # of new hospital clients admitted to Home First Program[3] per month | 200 | 200 | Yes | | Data not reported | | 90 | 79.3 | No |

| Indicator | CCAC #1 | | | CCAC #2 | | | CCAC #3 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Target | Actual Results in 2014/15 | Met Target? | Target | Actual Results in 2014/15 | Met Target? | Target | Actual Results in 2014/15 | Met Target? |
| **Reported to Health Quality Ontario** | | | | | | | | | |
| Client experience—% of clients who report overall satisfaction | >=92.2% | 91.4% | No | >=90% | 92.4% | Yes | >=94.5% | 93% | No |
| % unplanned emergency department visits within 30 days after discharge from hospital by home-care clients referred to CCAC while in hospital | <=4.1% | 4.2% | No | <=12% | 14.3% | No | <=7.7% | 7.3% | Yes |
| % of hospital readmissions within 30 days of discharge from hospital for home-care clients who receive their referrals to CCAC while in hospital | <=17.4% | 18.7% | No | <=14% | 20.5% | No | <=17.9% | 18.8% | No |
| % of long-stay home-care clients who fell in the last 90 days | <=27.1% | 30.6% | No | <=35.5% | 36.8% | No | <=34.5% | 38% | No |
| Five-day wait time for personal support services—% of complex care clients receiving services within wait time | >=80.2% | 84.1% | Yes | >=81.4% | 84.2% | Yes | >=90% | 79.6% | No |
| Five-day wait time for nursing services—% of clients receiving services within wait time | >=92.7% | 94.9% | Yes | >=93% | 93.7% | Yes | >=95% | 93.4% | No |

1. LHINs allow CCACs to perform within an acceptable range that is slightly above or below the targeted level of performance. Even though the CCAC did not meet the target, it performed within the acceptable range.

2. MAPLe—Method for Assigning Priority Levels—is an output of the RAI-HC assessment. It predicts admission to long-term care and may indicate caregiver distress.

3. Home First Program helps frail senior patients get out of the hospital and back into their homes as soon as possible, instead of assuming that a long-term-care home is the only option.

on the CCACs because the CCACs are not directly accountable to Health Quality Ontario.

Further, CCACs rely on other entities to provide some of the information that they use to measure their own performance. For instance, an external survey company provides CCACs with results on client satisfaction, and the Ministry provides CCACs with data on hospital readmission. However, in both cases, CCACs experience a six-month delay in obtaining the information needed to measure their own performance in these areas.

## RECOMMENDATION 14

To ensure that critical operational and financial areas are consistently assessed and are transparent to the public, the Ministry of Health and Long-Term Care, in collaboration with the Local Health Integration Networks, the Community Care Access Centres, and Health Quality Ontario, where applicable, should:

- review and assess whether all the indicators collected continue to be relevant for determining efficient and effective performance of home care;
- make more CCAC results on performance measures publicly available;
- consider establishing targets for all performance areas where needed;
- develop more outcome-based indicators to measure against overall CCAC performance; and
- make hospital readmission data available to Community Care Access Centres on a more timely basis.

## MINISTRY RESPONSE

The Ministry agrees with this recommendation. Indicators are developed through LHIN-led tables that include ministry representation. The Ministry will ensure there is alignment of CCAC indicators with the system-level indicators in the Ministry-LHIN Accountability Agreement

(MLAA), as well as with provincial strategies and initiatives.

The 2015–18 MLAA includes three indicators related to home and community care. The Ministry collaborated with LHINs to recommend provincial targets for all three indicators. Two indicators are new to the MLAA, although currently reported by Health Quality Ontario:

- percentage of home-care clients with complex needs who received their personal support visit within five days of the date that they were authorized for personal support services; and
- percentage of home-care clients who received their nursing visit within five days of the date they were authorized for nursing services.

The third indicator is the "90th percentile wait time from community for CCAC in-home services: application from community setting to first CCAC service (excluding case management)."

As part of *Patients First: A Roadmap to Strengthen Home and Community Care*, the Ministry will continue to review performance indicators and targets for home and community care and will work to make them publicly available.

The Ministry will also work with CCACs and other relevant partners, including the LHINs, to provide relevant data on hospital readmission and emergency room visits.

## RESPONSE FROM CCACs

Every year, at the provincial and regional level, CCACs, the Ministry and the LHINs review performance indicators to ensure they are relevant. Together, we remove irrelevant indicators, identify outcome-based indicators and set progressive evidence-informed targets. We will continue working together to support the sharing of information at local and provincial tables to promote transparency and accountability in order to provide Ontarians with the information they need as patients and caregivers.

## Appendix 1—March 2015 Recommendations of the Expert Group on Home and Community Care, *Bringing Care Home*

Source of data: Expert Group on Home and Community Care

| 1 | That the Ministry of Health and Long-Term Care (Ministry) endorse the principles of client- and family-centred care as expressed in the proposed Home and Community Care Charter and incorporate them into the development of all relevant policies, regulations funding and accountability strategies for this sector. |
|---|---|
| | And that the Local Health Integration Networks (LHINs), working with the Ministry, use the proposed Home and Community Care Charter for the planning, delivery and evaluation of home care and community services. |
| 2 | That the Ministry provide more resources to increase the availability of services that support family caregivers and, in particular, increase the capacity for in-home and out-of-home scheduled and emergency respite services. When respite services are identified as being needed by a family caregiver(s), these services should be explicitly included in the care plan. |
| 3 | That the Ministry explicitly define which home care and community services are eligible for provincial funding (i.e., the available 'basket of services') and under what circumstances. A clear statement of what families can expect and under what circumstances should be made easily accessible so that families can better anticipate and participate in the creation of sustainable care plans. Eligibility for all services should be determined using a common standardized assessment tool that is also publicly accessible. |
| 4 | That the Ministry take a leadership role in working collaboratively with other ministries in defining a single and co-ordinated basket of services for clients and families whose needs cross multiple ministries. |
| 5 | That each LHIN submit to the Ministry an evidence-informed capacity plan for its region indicating where there are shortfalls and how any gaps in home care and community services will be addressed. These plans should use a common provincial framework using standardized data sets and tools, and the plans should be updated every three years. |
| 6 | That the Ministry allow the LHINs discretion to direct funds to reflect the priorities within their region to meet client and family home care and community service needs, even if that means re-allocating money across the various funding envelopes. |
| 7 | That the Deputy Minister of Health and Long-Term Care, through the Council of Deputy Ministers, take a leadership role in developing an integrated plan for defining and delivering a single, co-ordinated needs-based statement of benefits (i.e., an inventory of home and community services) for children and adults with long-term complex needs and their families provided by all relevant Ontario ministries (e.g., Ministry of Children and Youth Services, Ministry of Community and Social Services, Ministry of Municipal Affairs and Housing, Ministry of Transportation). |
| 8 | That LHINs, in collaboration with the LHINs' Primary Care Leads, develop and implement strategies to improve two-way communication between primary care providers and home and community care providers. |
| 9 | That, where performance agreements with primary care providers exist (e.g., with Family Health Teams and Community Health Centres), the LHINs take responsibility for managing performance against the service standards in these agreements and making these results publicly available. |
| 10 | That the Ministry proceed to issue its planned Integrated Funding Project Expression of Interest to develop models for home and community care for populations with short-term post-acute needs. |
| 11 | That the Ministry direct the LHINs to select and fund the most appropriate lead agency or agencies to design and co-ordinate the delivery of outcomes-based home and community care for populations requiring home and community care for a long term within their LHIN. |
| 12 | That the Ministry take a leadership role in working collaboratively with other ministries in defining a single and co-ordinated needs-based envelope of funding for services for clients and families whose needs cross multiple ministries. |
| 13 | That the Ministry increase the funding available for self-directed funding for clients and families with high needs and that care coordinators work with families and support them whether they choose self-directed funding or an agency provider. |
| 14 | That Health Quality Ontario, working in partnership with the LHINs, finalize and implement system performance indicators and, in consultation with providers and families, develop and implement a scorecard for the home and community care sector. The scorecard should be publicly reported, and all publicly-supported home care and community support service providers should be required to submit quality improvement plans on an annual basis. |
| 15 | That the Ministry tie funding for home and community care services (e.g., home care, community support services, primary care) to the achievement of clearly defined outcomes and results. |
| 16 | That the Ministry appoint Home and Community Care Implementation Co-Leads (one Co-Lead from within and one from outside of the Ministry), with appropriate support, to guide and monitor the implementation of the recommendations in this report, reporting annually to the Minister of Health and Long-Term Care. |

## Appendix 2—May 2015 Ten Steps to Strengthen Home and Community Care, *Patients First: A Roadmap to Strengthen Home and Community Care*

Source of data: Ministry of Health and Long-Term Care

| | |
|---|---|
| 1 | Develop a statement of home and community care values |
| 2 | Create a Levels of Care Framework |
| 3 | Increase funding for home and community care |
| 4 | Move forward with bundled care |
| 5 | Offer self-directed care |
| 6 | Expand caregiver supports |
| 7 | Enhanced support for personal support workers |
| 8 | [Offer] more nursing services |
| 9 | Provide greater choice for palliative and end-of-life care |
| 10 | Develop a capacity plan |

# Appendix 3—Population Characteristics and Levels of Care Co-ordination[1] Intensity

Source of data: Ontario Association of Community Care Access Centres

| Population Category | Population Definition | Sub-populations | Examples of Illnesses | CCAC Care Co-ordination[1] Intensity |
|---|---|---|---|---|
| Complex[2] | • Complex medical, physical, cognitive and social conditions at risk for hospitalization, alternate level of care or premature institutionalization<br>• One or more health/chronic conditions with complicating factors<br>• Direct care needs unpredictable and unstable<br>• Support network exists, but patient is not self-reliant, with high risks in more than one area<br>• RAI assessment score 17+<br>• High case management to support patient goals/outcomes | Senior adults, adults, palliative | • Dementia<br>• Hip fracture<br>• Alzheimer's<br>• Dysphagia (difficulty swallowing)<br>• Parkinson's | • High intensity to manage complex array of services and care requirements<br>• Significant role in co-ordination/effective system navigation<br>• High engagement with care partners within and beyond health sector<br>• Outcomes-oriented monitoring |
| Chronic[2] | • One or more health/chronic conditions with complicating factors<br>• Direct-care needs are stable and predictable<br>• Self-reliant and/or can achieve stability with right support network<br>• RAI assessment score 11–16<br>• Moderate case management intensity required for goals and outcomes | Senior adults, adults, palliative | • Dementia<br>• Alzheimer's<br>• Fractures<br>• Congestive heart failure<br>• Falls | • Moderate case management intensity focused on helping client manage health conditions and preventing further decline<br>• Creation of support networks to address functional needs<br>• System navigation and outcomes-oriented monitoring |

| Population Category | Population Definition | Sub-populations | Examples of Illnesses | CCAC Care Co-ordination[1] Intensity |
|---|---|---|---|---|
| Community Independence[2] | • May have one or more health/chronic conditions<br>• Capable of independent living (anticipate end of service within a year)<br>• Has stable support network and/or can be self-reliant<br>• RAI assessment score of 1–10<br>• Low case management intensity to support goals and outcomes | Stable at risk; supported independence | • Congestive heart failure<br>• Chronic obstructive pulmonary disease<br>• Osteoarthritis<br>• Depression<br>• Dementia | • Moderate to low case management intensity<br>• Focus toward increased independence via effective pathways and system navigation<br>• Opportunities for prevention of further disability should be considered for this population to prevent avoidable escalation of care needs |
| Short Stay[3] | • Short-term acute need<br>• Usually a clearly identified and predictable outcome and recovery time or potential to regain functional status<br>• Requires short-term education, care or support<br>• Stable and predictable care trajectory | Acute, wound, rehab, oncology | • Cellulitis (a spreading bacterial infection of the skin and tissues beneath the skin)<br>• Dysphagia (difficulty swallowing)<br>• Osteoarthritis<br>• Urinary retention<br>• Breast cancer | • Low case management intensity<br>• Focus upon clients with exceptions to the pathway/expected outcomes<br>• Focused outcome monitoring and system navigation for clients with exceptions and additional needs off the pathway |
| Well | • Does not receive CCAC services<br>• Does not have chronic or acute illness/injury<br>• Is self-reliant and manages health needs<br>• Health needs are related to health promotion and prevention | n/a | • Anxiety<br>• Depression<br>• Osteoarthritis<br>• Ovarian mass<br>• Falls | • No case management<br>• Referred to community service agencies for needed services such as meals on wheels, transportation, adult day programs, friendly visiting services, homemaking services, etc. |

1. Formerly known as case management.

2. These clients typically receive services for longer than a year; also called "long-stay" clients.

3. These clients typically receive services for less than a year and are expected to achieve their treatment goals.

## Appendix 4—Summary of CCAC Performance Indicators, 2013/14 and 2014/15

Sources of data: Community Care Access Centres, Health Quality Ontario

| | Source of Indicator | | | | Type of Indicator | | |
|---|---|---|---|---|---|---|---|
| Indicator | Local Health Integration Networks—Core Indicators[1] | Local Health Integration Networks—Explanatory Indicators[1] | Health Quality Ontario—Public Reporting[1] | Health Quality Ontario—Quality Improvement Plan[2] | Output-based Indicator | Outcome-based Indicator | Client-centric Indicator |
| 1 % of total margin | X | | | | X | | |
| 2 Balanced budget | X | | | | X | | |
| 3 Proportion of budget spent on administration | X | | | | X | | |
| 4 Variance between forecast and actual expenditures | X | | | | X | | |
| 5 Variance between forecast and actual units of service | X | | | | X | | |
| 6 Service activity by functional centre[3] | X | | | | X | | |
| 7 # of individuals served | X | | | | X | | |
| 8 90th percentile wait time from hospital discharge to service initiation (hospital patients) | X | | | | X | | X |
| 9 50th percentile wait time for home-care services—application to first service (community setting) | X | | | | X | | X |
| 10 90th percentile wait time for home-care services—application to first service (community setting) | X | | | | X | | X |
| 11 % of alternate level of care days (for people who were in hospital beds and now served by CCAC) | X | | | | X | | |
| 12 Clients with MAPLe[4] scores "High" and "Very High" living in the community supported by CCAC | X | | | | X | | X |
| 13 Clients placed in long-term care homes with MAPLe[4] scores "High" and "Very High" as a proportion of total patients placed | X | | | | X | | |
| 14 % of people registered with Health Care Connect who are referred | X | | | | X | | X |
| 15 # of new hospital clients admitted to Home First Program[5] per month | X | | | | X | | X |

| Indicator | Source of Indicator | | | | Type of Indicator | | |
|---|---|---|---|---|---|---|---|
| | Local Health Integration Networks—Core Indicators[1] | Local Health Integration Networks—Explanatory Indicators[1] | Health Quality Ontario—Public Reporting[1] | Health Quality Ontario—Quality Improvement Plan[2] | Output-based Indicator | Outcome-based Indicator | Client-centric Indicator |
| 16 Cost per unit service (by functional centre[3]) | X | X | | | X | | |
| 17 Cost per individual served (by program/service/functional centre) | | X | | | X | | |
| 18 Access wait time from hospital discharge to service initiation—short-stay acute clients | | X | | | X | | X |
| 19 Access wait time from hospital discharge to service initiation—short-stay rehab clients | | X | | | X | | X |
| 20 Access wait time from hospital discharge to service initiation—long-stay complex clients | | X | | | X | | X |
| 21 90th percentile wait time from community setting to community home care services—short-stay acute clients | | X | | | X | | X |
| 22 90th percentile wait time from community setting to community home care services—short-stay rehab clients | | X | | | X | | X |
| 23 90th percentile wait time from community setting to community home care services—long-stay complex clients | | X | | | X | | X |
| 24 Average monthly cost per episode—adult short-stay acute clients | | X | | | X | | |
| 25 Average monthly cost per episode—adult long-stay complex clients | | X | | | X | | |
| 26 Average monthly cost per episode—end of life clients | | X | | | X | | |
| 27 Average monthly cost per episode—end of life clients—in the three months immediately preceding death | | X | | | X | | |
| 28 Average monthly cost per episode—children medically fragile | | X | | | X | | |
| 29 Expenditures incurred for clients receiving maximum service hours[6] | | X | | | X | | |
| 30 Total joint funding (hips & knees)[6] | | X | | | X | | |
| 31 Dialysis clients[6] | | X | | | X | | |
| 32 # of persons waiting for service (by functional centre)[6] | | X | | | X | | X |

| | Indicator | Source of Indicator | | | | Type of Indicator | | |
|---|---|---|---|---|---|---|---|---|
| | | Local Health Integration Networks—Core Indicators[1] | Local Health Integration Networks—Explanatory Indicators[1] | Health Quality Ontario—Public Reporting[1] | Health Quality Ontario—Quality Improvement Plan[2] | Output-based Indicator | Outcome-based Indicator | Client-centric Indicator |
| 33 | Client experience—overall satisfaction | | X | X | X | | X | X |
| 34 | % of unplanned emergency department visits within 30 days after discharge from hospital by home-care clients referred to CCAC while in hospital | | | X | X | | X | X |
| 35 | % of hospital readmissions within 30 days of discharge from hospital for home-care clients who receive their referrals to CCAC while in hospital | | | X | X | | X | X |
| 36 | % of long-stay home-care clients who fell in the last 90 days | | | X | X | | X | X |
| 37 | Five-day wait time for personal support services for complex care clients | | | X | X | X | | X |
| 38 | Five-day wait time for nursing services | | | X | X | X | | X |
| 39 | % of home-care patients who have newly developed bladder incontinence or whose bladder functioning has not improved since their previous assessment | | | X | | | X | X |
| 40 | % of home-care patients with a new problem communicating or existing communication problem that did not improve since their previous assessment | | | X | | | X | X |
| 41 | % of home-care clients with a new pressure ulcer (Stage 2 to 4) | | | X | | | X | X |
| 42 | % of home-care clients placed in long-term care who could have stayed home or somewhere else in the community | | | X | | X | | |
| 43 | % of home-care clients who have not received influenza vaccination in the past two years | | | X | | X | | |

1. Measured in 2013/14.
2. Measured in 2014/15. A Quality Improvement Plan is a set of quality commitments that a health-care organization makes to improve quality through focused targets and actions, as required under the *Excellent Care for All Act.*
3. Functional centres are created for program areas, such as care co-ordination, occupational therapy and personal support, for information-tracking purposes.
4. MAPLe—Method for Assigning Priority Levels is an output of the RAI-HC assessment. It predicts admission to long-term care and may indicate caregiver distress.
5. Home First Program helps frail senior patients get out of the hospital and back into their homes as soon as possible, instead of assuming that a long-term-care home is the only option.
6. Measured by one of three CCACs we visited but not the other two.