Ministry of Health and Long-Term Care

Home Care Services

Background

Community Care Access Centres (CCACs) are responsible for providing home care services to Ontarians who, without these services and supports, might need to stay in hospitals or long-term-care facilities, or who may require services from other community-based agencies. Home care also assists frail elderly people and people with disabilities to live as independently as possible in their own homes.

Generally, CCACs contract with service providers for home care services rather than provide those services directly. The role of the CCAC is to assess potential clients for eligibility and approve provision of the following services to eligible recipients:
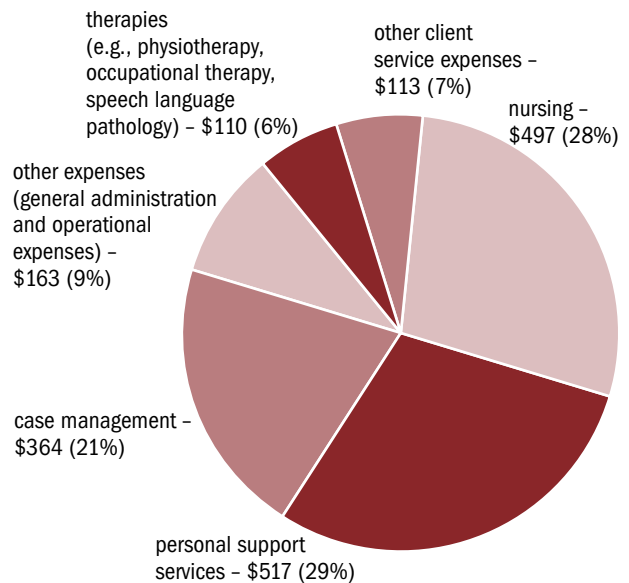
- Professional services—including nursing, occupational therapy, physiotherapy, social work, speech language pathology, and dietetics.
- Personal support and homemaking services—including assistance with daily living, such as personal care.

CCACs also authorize admissions to long-term-care homes.

For the year ended March 31, 2009, Ontario spent a total of $1.76 billion to provide home care services to 586,400 clients. Figure 1 shows

Figure 1: Breakdown of CCAC Expenditures, 2008/09 ($ million)

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

therapies (e.g., physiotherapy, occupational therapy, speech language pathology) – $110 (6%)

other client service expenses – $113 (7%)

nursing – $497 (28%)

other expenses (general administration and operational expenses) – $163 (9%)

case management – $364 (21%)

personal support services – $517 (29%)

a breakdown of CCAC home care expenditures for the 2008/09 fiscal year. At the time of our last audit, reported in our *2004 Annual Report*, total expenditures for similar home care services were $1.22 billion to serve about 350,000 clients. Since then, total expenditures have increased by more than 40% while the number of clients that CCACs serve has increased by more than two-thirds.

According to data provided by the Ministry of Health and Long-Term Care (Ministry) from the

2008/09 fiscal year, the approximate age break-down for admissions to home care services was as follows: 55% of CCAC clients are over 65 years of age; 35% are between 19 and 64; and 10% are under 19. In the 2008/09 fiscal year, home care clients received approximately 19.8 million hours of personal support and nursing care, 6.7 million professional service visits, and 1.3 million case manager visits.

Each CCAC reports to one of the 14 Local Health Integration Networks (LHINs), which, under the *Local Health System Integration Act*, are responsible for planning and funding health-service providers. The LHINs, in turn, are accountable to the Ministry of Health and Long-Term Care.

Audit Objective and Scope

The objective of our audit was to assess whether the Community Care Access Centres (CCACs), Ministry of Health and Long-Term Care, and Local Health Integration Networks (LHINs) had mechanisms in place to:

- meet the needs of people requiring home care services;
- fund services based on client needs and monitor compliance with service requirements to ensure that services are provided equitably and consistently across the province; and
- measure and report on the quality and effectiveness of the services provided in the home.

The scope of our audit included review and analysis of relevant files and administrative procedures, and interviews with appropriate staff at the Ministry, LHINs, and CCACs. We visited three CCACs: South East CCAC (head office in Kingston), Central CCAC (head office in Newmarket), and Hamilton Niagara Haldimand Brant CCAC (head office in Brantford). The expenditures of these three CCACs totalled $526 million, representing about 30% of total CCAC expenditures. We sent a survey to the remaining 11 CCACs that we did not visit.

As part of our audit, we attended visits to clients' homes with case managers from each of the three CCACs. We also met with representatives from the Ontario Association of Community Care Access Centres, the Ontario Home Care Association, the Ontario Health Quality Council, and the Ontario Home Care Research and Knowledge Exchange.

We did not rely on audit reports from the Ministry's Internal Audit Services because it had not conducted any recent work on CCACs.

Summary

The Ministry of Health and Long-Term Care has recognized that enhancing home care services offers both cost savings and quality-of-life benefits by allowing people to remain in their homes as opposed to being in long-term-care facilities, hospitals, or other institutional settings. Home care funding has increased substantially since our last audit, and independent CCAC client satisfaction surveys indicate that home care clients are generally satisfied with the services they receive.

However, some of the main concerns expressed in our previous audits of the home care program, in 2004 and 1998, still remain. Specifically, funding is still not being allocated primarily on the basis of locally assessed client needs but rather remains a historically based allocation. This can result in clients with similar home care needs not receiving similar levels of services. As well, CCACs do not have adequate assurance that services are being acquired from their external providers in the most cost-effective manner. Specifically, we found that:

- The longstanding issue of funding inequities among CCACs for home care services remained largely unresolved. We found that the home care funding per capita across the 14 CCACs still varied widely across the province. For instance, one CCAC received twice as much in per capita funding as another. Total funding to CCACs has not been allocated on

the basis of specific client needs or even on a more representative basis that takes population size, growth, age, gender, rural locations, and other local needs into account. The Ministry has developed a new funding model but its use is, as yet, too limited to have any effect in addressing funding inequities.

- Ministry policy requires CCACs to administer programs in a consistent manner to ensure fair and equitable access for all consumers no matter where they live in the province. Due to funding constraints, one of the three CCACs we visited had prioritized its services so that only those individuals assessed as high-risk or above would be eligible for personal support services, such as bathing, changing clothes, and assistance with toileting. Clients assessed as moderate-risk were deemed not eligible for funded services as a necessary cost-containment measure to achieve a balanced budget. However, we noted at the other two CCACs we visited that clients assessed as moderate-risk were provided with personal support services or placed on a wait-list to receive them.

- Eleven of the 14 CCACs have some form of wait-list for various home care services. Wait-lists were usually caused by a lack of financial resources or a shortage of specialist resources. Although there were about 10,000 people waiting for various services ranging from an average of eight days to 262 days at these 11 CCACs, the other three CCACs said that they had no wait-lists at all. This is another indicator of a possibly inequitable distribution of resources among the 14 CCACs, which can arise when funding is provided on a historical basis rather than a needs basis.

- The absence of standard service guidelines has resulted in each CCAC developing its own guidelines for frequency and duration of services. As a result, guidelines varied in the time allocated for each task and the frequency of service visits recommended. This means that the level of service offered may vary from one CCAC to another.

- CCACs have made good progress in implementing a standardized initial client-care assessment tool. However, these assessments to determine clients' needs were often not being completed on a timely basis. At the CCACs we visited, many clients received their assessments ranging from four days to as long as 15 months after having been identified as requiring home care services. The required periodic reassessments of clients to ensure that service plans continued to meet their needs were also backlogged at all three of the CCACs we visited.

- Only one of the CCACs we visited commenced routine visits to its service providers to monitor the quality of care they delivered. These proactive visits identified problems that needed to be addressed. Better tracking of client events and complaints would also give some indication of the quality of home care provided. The recent effort made by the CCACs to conduct independent, province-wide surveys on client satisfaction is a good initiative.

- More than 70% of CCAC expenditures were for purchases of services such as nursing, personal support/homemaking from external service providers. However, CCACs told us that they could not obtain the best value from providers, from both a cost perspective and a service perspective, because they were not able to procure services competitively. The Ministry has suspended the competitive procurement process on three occasions since 2002 and, at the time of our audit, the process was still under suspension. CCACs advised us that continuity of care was an issue—their clients were concerned about losing their current support workers if a competitive procurement process resulted in a different service provider being selected.

- The lack of competitive procurement process has contributed to significant differences in rates paid to service providers within each CCAC and among the three CCACs we visited. For example, rates paid for shift nursing services by one CCAC could be twice as high as those paid by another CCAC.
- The 14 CCACs have jointly made good progress in implementing an updated case management information system, to provide useful information needed to help measure and improve performance.
- LHINs have accountability agreements with their CCACs that include 13 performance measures and targets. These targets were based on actual CCAC performance for each measure in the 2008 fiscal year. As trend data for all CCACs becomes available and is analyzed, public reporting of certain of these performance benchmarks should be considered.

OVERALL MINISTRY RESPONSE

Home care is a critical component of our health system. Currently, over 600,000 clients receive home care services in Ontario. The Ministry of Health and Long-Term Care (Ministry) recognizes that home care services allow people to remain at home for as long as possible and support our hospitals and long-term-care facilities in functioning properly.

In the 2009/10 fiscal year, the Ministry provided Community Care Access Centres (CCACs) with $1.9 billion in funding—an increase of 56% since 2003/04.

The government's support for the home care and community sector is reflected in its commitment of an unprecedented $1.1 billion investment over four years for an Aging at Home Strategy that will provide seniors and their caregivers with an integrated continuum of community-based services (including home care) that allows them to stay healthy and live more independently in their homes.

Detailed Audit Observations

The way that home care is administered in Ontario has changed since our last audit in 2004. At that time, the Ministry of Health and Long-Term Care, through its Corporate Community Health Division and seven regional offices, provided transfer payments to 42 Community Care Access Centres (CCACs) operating under the *Community Care Access Corporations Act* to provide home care services to Ontarians. Under this structure, the CCACs reported directly to the Ministry's seven regional offices.

In 2006, 14 Local Health Integration Networks (LHINs) were formed under the authority of the *Local Health System Integration Act*. The LHINs were responsible for planning, funding, co-ordinating, and integrating health-care services within their regions. With this new legislation, the Ministry eliminated its seven regional offices. However, the Ministry has retained ultimate accountability for the health-care system by holding each LHIN accountable for the performance of its local health system. Also in 2006, regulation changes to the *Community Care Access Corporations Act* amalgamated the former 42 CCACs to align with the same boundaries as the 14 newly formed LHINs. These 14 became operational on January 1, 2007. The CCACs became non-profit, community-based organizations in 2009. Each of the 14 CCACs reports to its local LHIN.

In 2008, the Ministry issued a strategy to strengthen home care in Ontario. Among the things it called for were increased accountability from CCACs and their service providers; changes to the way client services are delivered; and an enhanced CCAC mandate to enable placement of clients into, for example, adult day-programs and assisted living services in supportive housing. CCACs were also enabled to place persons into chronic-care and rehabilitation beds in public hospitals, thereby leveraging their expertise in case management to improve both client service and health-system efficiency.

The Ministry has recognized the dual benefit of enhancing home care services. Having people receive care in their homes whenever possible not only means better quality-of-life for the patient, it is also far more cost-effective than housing a patient in a hospital, long-term-care facility, or other institutional setting to receive care. One CCAC we spoke to informed us that, for instance, personal support services can enable individuals who have moderate risks/needs to continue living independently in their homes. Not having these services could lead to deterioration in a client's condition that could result in hospitalization or institutionalization.

Home care clients have reported in client satisfaction surveys that they are generally satisfied with the services provided by CCACs. However, some of our key concerns from our previous home care audits have still not been satisfactorily addressed, such as the way home care is funded. Except for the funding of new initiatives, funding for the most part is still largely historically based rather than being based more directly on the local needs of individual CCACs across the province.

FUNDING OF HOME CARE SERVICES

Since our last audit in 2004, home care funding has increased significantly—from $1.22 billion to $1.76 billion in the 2008/09 fiscal year, an increase of more than 40%. Included in this increase for the 2008/09 and 2009/10 fiscal years, the CCACs received 4% base funding increases to support normal service growth and inflation in each year. We found in our audit, however, that the funding increase was not based on an assessment of the local needs of each CCAC. This has not addressed the longstanding issue of some CCACs continuing to receive significantly more per capita funding than others that offer similar services. Some CCACs have undertaken cost-containment and service-level containment measures to balance their budgets, such as increased wait-listing of clients, prioritizing services, and reducing administrative costs, to name a few. As a result, clients with similar conditions may well receive different levels of service across the province.

The inequitable distribution of funds was especially significant in the amount of base funding that CCACs got, which accounted for most of the funding they received.

Base Funding

Our 1998 and 2004 audits of home care and community-based services pointed out that the funding formula needed to take into account specific service needs, ongoing demographic changes, and changes to the health-care system. In the Ministry's 1998 response to our recommendation, it stated that CCACs are required to administer programs in a consistent manner to ensure fair and equitable access for all consumers no matter where they live in the province. The Ministry indicated in 2004 that it had further revised its funding formula to take into account population size, age, gender, rural locations, and the level of home care service needs of people who have been discharged from hospitals.

The Ministry also noted that a Funding and Budget Planning Committee for CCACs was established in March 2004 to oversee the allocation of new funds, monitor the impact of funding allocations, and review and plan for improvements to the funding formula. However, with the realignment of the former 42 CCACs to the current 14 CCACs, accountability for funding was transitioned to the LHINs.

In 2006, the Ministry recognized that there continued to be per capita funding inequities among CCACs and elsewhere in the health-care system. To address this issue, the Ministry has developed another new funding methodology called the Health Based Allocation Model (HBAM). Under this model, funding was to be based on measures of health that take into account demographic factors such as age, gender, socio-economic status, and rural locations. It was also to be based on characteristics of health-service providers, such as specialization, location, and economies of scale. HBAM

is to apply actual past utilization and actual costs incurred in determining the allocation of funds.

Starting in the 2008/09 fiscal year, HBAM was used to determine funding for two new home care initiatives: a program called Aging at Home, and legislative changes that increased the maximum hours of service for clients. However, the Ministry indicated that it had not received government approval to apply the HBAM model to base funding to CCACs for home care. Consequently, funding is still mainly based on historical funding patterns. Given that base funding represented 90% of the funding (since realignment) to the three CCACs we visited, applying HBAM only to new initiatives means that any funding adjustments aimed at achieving equity will occur at an extremely slow rate.

Our review found that many of the funding inequities that existed before realignment still existed after realignment. For instance, at the time of our audit, one CCAC had received twice as much per capita funding as another: $188 per capita for one versus $90 for the other. There may be valid reasons for such differences, such as a lack of community-supportive housing within the LHIN in some regions, as well as other demographic and geographic factors. However, the extent of the variances indicates significant funding inequities likely continue to exist, and they have had an impact on how equitable access to services is from one region to another, as discussed later in this report.

As noted earlier, our 1998 and 2004 reports recommended that funding be based primarily on a region's assessed client needs, and although some funding for new initiatives has been provided to the CCACs based on needs, base funding is still largely historically based.

New Funding Initiatives

Since our last audit in 2004, there have been a number of new initiatives in funding home care services in Ontario. Although they represent positive steps taken by the Ministry in meeting more

specific needs of home care clients, the impact of these initiatives has not yet been significant enough to address the issue of funding inequity across the province. Our review of some of the new initiatives noted the following:

- From 2004/05 to 2009/10, $76 million was provided to CCACs to help reduce wait times for hip and knee replacement surgeries. This funding was to be used to help facilitate patients' early discharge from hospital by providing in-home rehabilitation and support services. It was to cover the costs of additional clients beyond the usual number of clients served in the 2003/04 fiscal year. However, the CCACs we visited that had received the additional funding said they did not know how many additional clients had been served by the funding, because a base number of clients had not been established.

- In each of the 2008/09 and 2009/10 fiscal years, $30 million in additional funding was provided to CCACs to fund an increase in the maximum number of hours of personal support and homemaking services to eligible clients. The funding increase had been brought about by a regulatory change, and was calculated on the basis of the total costs of providing the services to new clients plus the additional costs of providing more hours of care to existing clients. However, the CCACs we visited all indicated that the funds were not sufficient to cover the related costs of the legislative change. Furthermore, the Ministry required CCACs to report only total costs rather than a breakdown by type of client and related costs. Therefore, the way the costs were reported made it difficult for LHINs or the Ministry to assess whether the funding had been sufficient to cover the additional hours resulting from the legislative changes.

- In the 2008/09 fiscal year, the Ministry launched the Aging at Home strategy, a four-year, $1.1 billion health-care initiative designed to allow seniors to live healthy,

independent lives in the comfort and dignity of their own homes. The Ministry based this funding on the new model (HBAM), which does allocate funding largely according to local needs. However, the funding that the 14 CCACs received from this initiative in 2008/09 and 2009/10 totalled only $45 million of the announced $1.1 billion.

The CCACs that we visited acknowledged that funding for new initiatives did provide additional resources, but that sometimes it did not cover the related cost increases, as with the increase of maximum hours of personal support services. Also, funding for new initiatives represented only a small portion of the total funding for home care.

Unless total funding is allocated primarily on the basis of relative local needs, such as is proposed by the new HBAM model, funding inequities across the province will continue to affect the level of services home care clients with similar needs receive in different parts of the province.

RECOMMENDATION 1

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

RESPONSE FROM COMMUNITY CARE ACCESS CENTRES

We agree in principle and support implementation of a patient-based funding model. It should be noted that both community-assessed needs and the availability of community resources play critical roles in determining appropriate home care service levels.

MINISTRY RESPONSE

The Ministry agrees that funds to CCACs should be allocated on the basis of the local community's needs. The Health Based Allocation Model (HBAM) will include both population-based indicators and direct measures of health status to provide a more accurate measure of local health needs. With support from the Ministry, the LHINs could use HBAM to inform their annual incremental funding to CCACs. An important consideration for future goals of HBAM implementation for funding will be to maintain system stability and ensure that access to services is preserved.

DELIVERY OF HOME CARE SERVICES
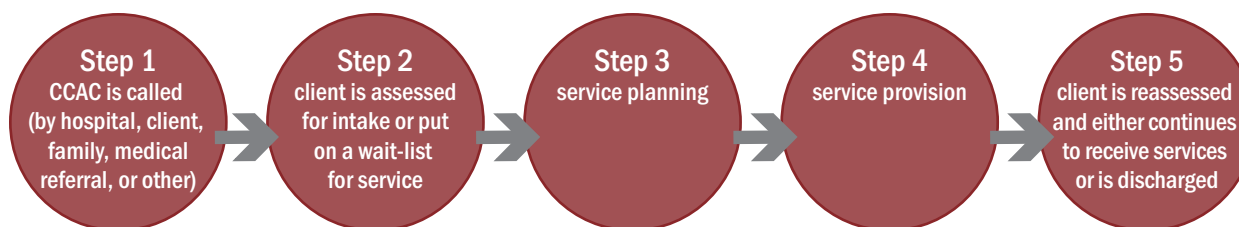
Case Management Caseloads

Almost all of the direct services—professional, personal support, and homemaking—that home care clients receive are provided by external service providers, while CCAC staff are responsible for overseeing the provision of this care. Figure 2 outlines the general steps involved in the delivery of home care services.

CCAC case managers are responsible for ensuring that the right services are provided to the right clients at the right time. They take referral calls, assess the eligibility of potential clients for home care services, develop service plans, and authorize expenditures for services in accordance with the *Home Care and Community Services Act, 1994*. They also conduct periodic reassessments to determine whether clients should continue to receive home care. Finally, case managers are also responsible for monitoring the adequacy of the services provided, through site visits and handling complaints.

The Ministry's information management system includes data on the total number of case managers within each CCAC. To get a better picture of the caseloads by each type of care at the three CCACs

Figure 2: Overview of CCAC Home Care Services

Source of data: Prepared by the Office of the Auditor General of Ontario

Step 1
CCAC is called
(by hospital, client,
family, medical
referral, or other)

Step 2
client is assessed
for intake or put
on a wait-list
for service

Step 3
service planning

Step 4
service provision

Step 5
client is reassessed
and either continues
to receive services
or is discharged

Figure 3: Number of Cases per Case Manager

Source of data: Community Care Access Centres

Type of Care	CCAC #1	CCAC #2	CCAC #3
acute	199	125	131
adult (community)	125	123	101
palliative/oncology	68	77	49
children's	207	135	256

we visited, we collected data on case managers' caseloads; we found that the number of cases per case manager varied significantly, as noted in Figure 3. Case management accounts for more than 20% of the CCACs' budget, as noted in Figure 1. The combination of caseload size and the types of clients within case managers' caseloads has a significant impact on how effectively they can carry out their responsibilities, yet we found that no standard caseload guidelines had been established for the deployment of CCAC case managers. Such standards would provide useful guidance to CCACs in assigning an optimal workload to each case manager. The risk associated with an uneven caseload is that some clients may either not receive timely services or not receive the right level or quality of service.

Tracking relative caseloads across the 14 CCACs would provide useful data for the LHINs and the Ministry in overseeing the equitable delivery of home care services across the province.

RECOMMENDATION 2

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

RESPONSE FROM COMMUNITY CARE ACCESS CENTRES

We agree with this recommendation. Each CCAC should periodically review the assignment of clients to case managers to ensure that it is meeting the needs of the various populations served by CCACs. It should be noted that CCAC clients are not a homogeneous group of people. Their needs vary according to their health status, conditions, and level of risk. Service levels will therefore vary according to client population and community.

MINISTRY RESPONSE

The Ministry is exploring new and specialized roles for CCAC case managers through a provincial project—the Integrated Client Care Project—in partnership with several stakeholders. In addition to introducing specialized population-based case management (that is, according to client conditions, acuity, and other factors), the roles of system navigation

and clinical care co-ordination across the health system will be introduced and evaluated as part of the case management role for complex clients. Changes to the case management model will be evaluated to determine their effectiveness and any efficiencies achieved, with a view to creating optimal case management guidelines for future use.

Processing Calls for Services

Requests for home care services can be made by potential clients, family members, medical referrals, or the general public. In the 2009/10 fiscal year, approximately 60% of referrals to CCACs came from hospitals, which includes hospital physician referrals, and the remaining 40% came from the community, for example, family physicians or family members. When a referral is received, an initial "intake" assessment is completed in person or by phone. This enables the CCAC to help determine a client's initial eligibility for its services or referral to other community-based services.

CCACs have been using various tools to perform these intake assessments. However, they have recognized that the use of a standard assessment tool across the province is important for ensuring that individuals with similar needs receive similar levels of service regardless of where they live. CCACs are currently implementing a standard intake assessment tool for all categories of clients, referred to as the Contact Assessment Tool. A full roll-out of the tool is expected to be completed by March 2011 and, according to the three CCACs we visited, it is intended to be mandatory for all 14 CCACs.

Admission to Services or Wait-lists

After a person has undergone an intake assessment and is found to be eligible for and in need of CCAC services, the *Home Care and Community Services Act, 1994* requires that services be provided "within a time that is reasonable in the circumstances." If a service is not immediately available, the client is placed on a wait-list.

In our *2004 Annual Report*, we noted the lack of specific direction or guidance from the Ministry to CCACs on the ranking of clients to receive services and on the management of wait-lists. We found that this was still the case. Each of the CCACs we visited had developed and was using its own approach to prioritizing clients to be admitted to home care services or placed on wait-lists.

Client Care Assessments

People who have been identified as "adult long-stay clients"—those who are to receive CCAC services for at least 60 uninterrupted days—are assessed using a standard tool called the Resident Assessment Instrument – Home Care (RAI–HC). Our work at three CCACs found that all were assessing adult long-stay clients with the RAI–HC tool.

According to the Ministry's client services policy manual, a case manager must complete the RAI–HC assessment within 14 calendar days of the date a client is identified as a long-stay client. These assessments must be conducted in face-to-face interviews and usually take place in clients' homes. This initial assessment leads to the development of a home care service plan. At CCACs that do not have the resources to provide the services, and depending on the client's assessed priority of need, the client may be placed on a wait-list for some services.

We found that adult long-stay clients were, in many cases, not receiving their initial assessments within the required 14 days. We reviewed a sample of client files at each of the CCACs we visited and found that the time elapsed before clients were assessed ranged from four days to as long as 15 months. We also obtained from two of the CCACs visited reports for one month in 2009 of assessments that were to be completed, and found similar delays in completing the initial assessment.

When we asked them about the delays, the CCACs told us that they could have been caused

by clients not being available within the required 14-day time frame. However, for some of the cases we followed up, there was no documentation of the reasons for lengthy delays.

In our interviews with case managers, they told us that when clients with urgent needs could not wait 14 days to begin receiving services, the case manager would order home care services based on a phone assessment. Although phone assessments may be an interim solution for a client who needs services ordered immediately, they are not comprehensive enough to ensure that the right services are recommended to a client. It is therefore important that a timely initial assessment be conducted in the client's home.

Wait-lists

Clients are placed on wait-lists because either the CCAC does not have the financial capacity to provide the needed services immediately or there is limited availability of the specialist human resources who provide those services. The CCACs we visited and surveyed indicated that, in most cases, the wait for personal support/homemaking services was caused by CCACs not having enough financial capacity to provide them, while the shortage of therapists was the main reason cited for clients being on the therapy wait-list.

As we have outlined, inequities in funding affect the distribution of resources. At the three CCACs we visited as well as the remaining 11 that we surveyed, we found that some had very high wait-list numbers for certain services while others had none. For instance, one CCAC we visited had 1,400 people waiting for speech language pathologists at the end of March 2010. One of the CCACs we surveyed had more than 1,300 waiting for personal support services, and another had more than 770 waiting for occupational therapy services. Although CCACs had no wait-lists for nursing services at the time of our audit, there were about 10,000 people waiting for other home care services, with average wait times that ranged from eight to 262 days. Three of the 14

CCACs indicated that they were able to meet the needs of their clients and had no wait-lists for any home care services.

Variation in Eligibility for Services

The three CCACs we visited were using different approaches to ranking clients in order of priority to receive certain types of home care services when wait-lists are required. Therefore, a client's eligibility to receive a service could vary from one CCAC to another. For example, with respect to personal support:

- At one CCAC, only those individuals assessed as having high risks/needs (according to the RAI–HC assessment) or above were eligible for personal support services, such as bathing, changing clothes, and assistance with toileting. Clients assessed as having moderate risks/needs or below were deemed ineligible for funded personal support services and were not even added to the wait-list. The CCAC informed us that these individuals were instead referred to community agencies, where they would in some cases have to pay for the services themselves. This was described as a necessary cost-containment measure to achieve a balanced budget.
- The second CCAC placed individuals assessed as having moderate risks/needs or below on the wait-list for personal support services, but did not specify a time period within which the services would be provided.
- The third CCAC also placed individuals assessed as having moderate risks/needs or below on a wait-list for personal support services, and advised them that they would receive services within three months.

Service Start Dates

After completing service plans for their clients, case managers order the necessary services from external service providers. It is the service provider who visits the client's home to provide those services.

Although each CCAC established its own approach to prioritization, there was no standard guideline for determining how soon the first service-provider visits to a client should occur. To determine whether services were provided on a timely basis, we applied the individual guidelines for prioritization of clients and wait-list management used by each of the CCACs we visited and found the following:

- The first CCAC applied four different priority levels and time periods for services to commence, ranging from 24 hours to 21 days. In our assessment of compliance with these guidelines, we found that 15% of clients who were to receive services within 24 hours had not. We noted that one client was to start receiving services within seven days, but the required services did not start until 134 days later. The CCAC could not provide an explanation for this delay. At this same CCAC, about two-thirds of clients did receive their first service visit within the established priority-level time periods.

- At another CCAC, there were three priority levels applied, but a time period within which services should start (a maximum of three months) was only specified for clients in the lowest priority level. Otherwise, the decision was based on each case manager's assessment of his or her client's needs. A review of this CCAC's data showed that the majority of clients generally received their first service visit within a month.

- The third CCAC used RAI–HC scores to help it prioritize clients to start receiving personal support services, because it gave the CCAC at least some form of objective measurement. A review of this CCAC's data showed that most of its clients received services within a month.

Service Levels

After a case manager has conducted an assessment to identify a client's home care needs, he or she draws up a service plan detailing how these needs will be met. Our review of files at the three CCACs we visited found that service plans that detailed the assessed needs of clients were in place. However, the way that service levels were established varied from one CCAC to the next.

In the absence of provincial guidelines for determining what level of home care service was appropriate for needs assessed as low, moderate, and high, each CCAC that we visited had developed its own practices. These varied in the frequency and time they allowed for each service to be performed, resulting in clients with similar conditions possibly receiving different levels of service.

For example, bathing assistance is a common home care service provided by a personal service worker. However, the guidelines for this service varied among the CCACs we visited:

- At one CCAC, the guideline called for service providers to spend 30 to 45 minutes with clients for bathing/tub showers and bathroom clean-up. The frequency of help given with bathing was determined by the client's continence, skin conditions, and other related factors.

- At another CCAC, case managers had specific guidelines to set bathing time depending on the needs of the clients: 5–15 minutes per day for one to seven days for those requiring supervision for safe tub transfer; 15–30 minutes per day for one to seven days for those with frequent incontinence; and 30–60 minutes up to twice a day for those with more serious conditions requiring total assistance for bathing.

- The third CCAC had no specific guidelines for time and frequency of client-bathing.

On our visits to three CCACs, we found that all three regularly monitored the client services they ordered against the available funds to help ensure that a balanced budget was achieved, which could also affect the level of services ordered from providers to meet clients' needs.

Monitoring Home Care Services Provided

To ensure that home care services are provided as planned and meet performance standards, CCACs have formal contracts with service providers that establish measures to assess the adequacy of the services being provided. These include site visits to service providers' premises; reviews of performance data, such as referral acceptance rates, significant event reports, and percentage of missed visits; following up on complaints from home care clients, their families, and the community; and conducting client satisfaction surveys.

Site Visits

All three of the CCACs we visited had conducted ad hoc site visits to some of their service providers. This included visits to follow up on complaints received or issues identified, as well as financial compliance audits for targeted funding. Only one CCAC had commenced routine site visits to audit all 14 of its personal support/homemaking service providers between March 2009 and February 2010. We reviewed the findings from this CCAC's site visits completed at the time of our audit and found that this proactive oversight process had identified a number of common deficiencies:

- Three-quarters of the service providers' processes had limited ability to assess whether their staff had delivered the required services in the client's home in a timely manner.
- Half the service providers reviewed had insufficient processes in place to quickly identify scheduling discrepancies, such as missed or cancelled visits.
- Almost 60% of the service providers had inaccurate or unclear definitions of what constituted a missed visit.
- A third of the service providers did not evaluate personal support workers by actually observing them providing services to clients. This indicated that monitoring the quality of personnel was based entirely on feedback received from clients or their families.

This CCAC also informed us that it planned to conduct site visits to audit nursing service providers in the coming year. Another CCAC indicated that the Ontario Association of Community Care Access Centres is now reviewing the implementation of site visits/audits of service providers.

Performance Data Reviews

Service providers are required to submit performance data to CCACs every quarter. The submissions include referral acceptance rates, percentages of missed visits, and urgent-service-request acceptance rates. Service providers are to provide explanations when they do not meet their targets.

We found that all service-provider quarterly submissions of performance measures were self-reported by service providers. Currently the only performance measure that can be validated through the Client Health and Related Information System (CHRIS) is the referral acceptance rate. We reviewed this measure for a sample of personal support service providers for the second quarter of the 2009/10 year. Our review identified differences at all three CCACs between the CCAC-tracked refusal rate and the service-provider self-reported acceptance rate. For example:

- At one CCAC, a service provider reported that it had rejected about 7% of requests for its services in that quarter; our review of the CCAC's data showed that this provider had rejected 39% of requests for its services in the same period.
- At the second CCAC, a service provider reported that it had rejected only about 2% of requests for its services in that quarter; our review of the CCAC's data showed that the provider had rejected more than 10% of requests for its services in the same period.
- At the third CCAC, a service provider reported that it had accepted 100% of requests for its services in that quarter; our review of the CCAC's data showed that the provider had

rejected 12% of requests for its services in the same period.

Service providers are to provide explanations when targets are not achieved. For the above cases, we did not see evidence of reconciliation of the rates and follow-up of the explanations provided by the service providers. The CCACs informed us that they had discussed these items with the service providers and that these discrepancies could have been caused by the way the data had been reported or by human errors made in data entry. However, they would not be able to determine the actual reasons for the differences without doing a reconciliation of the figures. The CCACs indicated that in the vast majority of situations where one service provider refuses a referral, another service provider provides the services with no impact on the client.

All three CCACs we visited had held meetings with all of their service providers as a group as well as with each type of service provider as a group (for example, all nursing providers) to discuss issues related to each sector.

At each of the three CCACs visited, we found varying practices for meeting with individual service providers to discuss issues. One CCAC had a formal agenda and met with each service provider individually at least twice per year. Another only met with individual service providers to discuss specific issues that arose. The third CCAC had issue-specific meetings and had just initiated quarterly meetings with individual service providers in the third quarter of the 2009/10 fiscal year.

Addressing Complaints

A system for reviewing and monitoring complaints can provide insight into the quality of home care services provided. It is also important for maintaining good relationships with clients, their families, and the community.

Each of the three CCACs we visited had a process in place for reviewing complaints. Two had also hired independent mediators to help with handling complaints.

Our review of a sample of complaints at each CCAC found that most of them had been adequately addressed and responded to within the required 60-day period. Consistent among the three CCACs we visited was the small number of complaints they received compared to the number of individual clients served. For instance, in the first three quarters of the 2009/10 fiscal year, one CCAC reported 157 complaints, which represented approximately three complaints per 1,000 clients served. Another reported 225 complaints, representing approximately five complaints per 1,000 clients served. The other CCAC reported 170 complaints for this time period, representing about eight complaints per 1,000 clients served.

Similarly, the number of complaints received through the Long-term Care Action Line was also small—about 270 calls per year. Since 2003, about 25 cases against CCACs have been heard by the Health Services Appeal Board, with only one of those coming after the CCACs realigned.

However, CCACs told us that some issues brought to case managers by clients or family members or even service providers are not classified as formal complaints. These issues would simply be resolved by the case managers and included in the client files.

At the time of our audit, the three CCACs we visited were using different "events management systems" to capture complaints and other issues. We reviewed the data available for these three CCACs and found the number of reported client "events" was significantly greater than the number of formal complaints. Two CCACs reported more than 1,300 events each for nine months, and the other reported more than 600 events for six months. At all three CCACs, client events that related to missed visits by service providers were the most common. All of the CCACs plan to adopt a province-wide events-management framework, which will standardize terminology and definitions so that comparisons and benchmarking can be done between different CCACs and across the province.

To obtain a complete picture of the areas of concern in home care service, both complaints and events must be reviewed. Yet our discussions with the appropriate LHINs indicated that none of them required CCACs to report on the major areas of complaints or client events to help them assess the overall quality of the services being provided by their CCACs.

Client Satisfaction Surveys

Another means used by CCACs to determine the quality of services provided by external service providers is the conducting of client satisfaction surveys. In the spring of 2009, a group of seven CCACs, including two of the CCACs we visited, began participating in a project to introduce a standard provincial survey to evaluate client and caregiver satisfaction. This initiative is co-ordinated by the Ontario Association of Community Care Access Centres with the goal of implementing the provincial survey across all CCACs. In the first two phases of what will be a four-phase survey, more than 4,700 telephone interviews were conducted by an independent party. The survey was completed with a 37% response rate, and 78% of respondents said they were satisfied that the home care services they received were good or excellent.

The survey measured client and caregiver satisfaction with respect to nine areas: overall experience, client-centred care, appointments, quality of care, building relationships and trust, integrated care and support of transitions, willingness to recommend services to others, expectations of quality, and setting up the home for safety. For the two CCACs we visited that had participated in the survey, one outperformed the provincial average in six of the nine key performance areas and the other scored above average in all nine areas.

The results were analyzed by location, types of services received, ethnicity, and household-type. Considering that different types of clients might have different expectations and different satisfaction levels with the home care services they receive, the survey results could also be analyzed,

in future, on the basis of client category (such as acute care, maintenance, long-term support, or rehabilitative care).

Two of the CCACs we visited had also conducted their own surveys to address populations not included in the provincial survey. For example, one CCAC conducted a palliative care survey, to which 90% of palliative clients surveyed in 2009 responded that they were generally satisfied with the services they received.

Another six CCACs that had not participated in the initial phases of the provincial survey were participating at the time of our audit. The remaining CCAC indicated that it intended to participate at a later date.

Client Reassessment for Continued Services

Ministry policy requires home care clients to be reassessed by a case manager at least every six months, or whenever there is a significant change to their medical condition, functional levels, or living circumstances.

Our review of CCAC client files indicated that the six-month reassessment policy was often not followed. Senior managers and case managers at all three of the CCACs that we visited told us that this requirement was not always complied with because of a combination of workload issues and the fact that case managers routinely apply their judgment in timing the reassessments of their clients. Some clients may be reassessed more often than every six months while others may be deemed not to require a regular six-month reassessment.

To determine the extent to which reassessments were not being conducted every six months at each of the CCACs we visited, we reviewed a sample of client files as well as reports of overdue client reassessments for the adult long-stay population. The lengths of time by which the reassessments were overdue as of December 31, 2009, are noted in Figure 4.

Figure 4: Overdue Reassessments for Adult Long-stay Population, as of December 31, 2009 (%)

Source of data: Community Care Access Centres

Overdue by	CCAC #1	CCAC #2	CCAC #3
under 3 months	54	70	47
3–5 months	23	23	25
6 months or more	23	7	28

If reassessments are not performed and documented at least every six months, the CCAC might not be aware of changes to clients' health that would point to a need to increase certain services or enable a reduction of service levels. As well, especially for the frail elderly population, regular reassessments can determine whether the clients should be considered for placement in a long-term-care facility.

Although there might be legitimate reasons to adjust reassessment requirements rather than rigidly adhering to the six-month time frame, CCACs had not developed any guidance or criteria for staff to use in making this decision. As well, the rationale for not conducting the six-month reassessment should be documented in the client's file.

RECOMMENDATION 3

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

- monitor case manager adherence to the established timelines for both the initial client assessment and the periodic client reassessments and, where such timelines are not met, ensure that case managers document the reasons in the applicable client files;
- enhance external provider oversight to better ensure that the expected and paid-for levels of service are being provided to home care clients; and

- regularly review both client complaints and client events to identify any systemic areas requiring further follow-up.

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

RESPONSE FROM COMMUNITY CARE ACCESS CENTRES

We agree that appropriate and equitable levels of services should be provided to home care clients. Specifically:

- CCACs will review the assessment frequencies and set requirements based on research and literature in this area. We agree that all reasons for assessment delays should be documented in the client record.
- CCACs will improve oversight of external providers. Much of the necessary planning for oversight is well underway through established working groups. There will be a formal process for service-provider audits in place in 2011. Also, the Integrated Client Care Project will enhance service-provider accountability and emphasize monitoring of client outcomes.
- CCACs currently take action on and review all client complaints and events. In addition, a provincial Risk Management Framework has been developed and is being implemented across CCACs.

CCACs will work with the Ministry of Health and Long-Term Care to provide any data required in support of patient-based funding models. CCACs will also provide all requested

information to the Ministry/LHINs regarding wait-list and caseload information.

MINISTRY RESPONSE

The Ministry agrees that appropriate and consistent levels of service should be provided to home care clients. The Health Based Allocation Model (HBAM) supports equitable funding, because it includes population-based indicators (for example, age, gender, and socio-economic status) and direct measures of health status to provide accurate measure of local health needs.

The Ministry will work with the LHINs and CCACs to obtain caseload information.

Acquisition of Services from Contractors

CCACs rely on external service providers to provide the home care services that their clients need. The majority of CCAC expenditures are for acquiring these services. The three CCACs we visited each spent over 70% of their budgets on purchasing services—such as nursing, personal support, homemaking, physiotherapy, and social work—from external providers. The CCACs we visited told us that they were often not able to obtain the best value from service providers because they were not able to obtain these services at competitive prices.

From 1997 to 2002, CCACs were required to acquire client services, medical supplies, and equipment through a competitive procurement process for amounts greater than $150,000. However, since 2002 the Ministry has suspended the competitive process on three occasions, and it remained suspended at the time of our audit.

CCACs have found it difficult to operate cost-effectively without the opportunity for different service providers to compete—both from a price perspective and a service-level perspective—since the amalgamation and realignment of CCACs to the new LHIN boundaries. This has been especially problematic because with realignment CCACs

inherited many different service-provider contracts with differing rates and requirements. Many of the service-provider contracts in effect for the period of our review were entered into before 2004, with some as early as 1999. Each CCAC had developed its own process for renewing contract rates and extending contract requirements.

Among the three CCACs visited, we did find significant variations in rates paid to different service providers for the same types of services. For example, shift nursing services could cost almost twice as much for similar work from one CCAC to another, as shown in Figure 5. We also found different rates paid to the same service provider within a single CCAC and to different service providers within a single CCAC for the same type of service. Finally, we found differences in the rates paid to the same provider for the same types of services depending on which CCAC was paying them. Figure 5 illustrates the percentage differences between the lowest and

Figure 5: Difference between Lowest and Highest Rates Paid for Services (%)
Source of data: Community Care Access Centres

	Among 3 CCACs	Within CCAC #1	Within CCAC #2	Within CCAC #3
Nursing				
RN visit	52	40	31	32
RPN visit	82	44	31	32
blended RN/RPN visit	52	19	31	32
RN shift	98	60	22	59
RPN shift	69	69	22	59
blended RN/RPN shift	59	5	–	59
Personal Support	56	29	30	54
Therapies				
occupational therapy	82	43	28	37
physiotherapy	67	25	18	65
speech language pathology	61	45	24	45
dietetics	74	29	32	59
social work	55	43	10	39

highest rates paid for different services both within and among CCACs.

One of the reasons that rates varied significantly was that the current negotiated prices were affected by the original prices that service providers had quoted many years ago, when they submitted bids in response to Requests for Proposals issued by the CCACs.

Some rate variations are caused in part by a fully operational competitive procurement process not having been in effect for some time. CCACs advised us that home care clients have expressed concerns that their individual support workers might change if a competitive procurement process were put back into place. Although the CCACs we visited acknowledged the importance of continuity of care, they indicated that the lack of a competitive process for procuring client services has prevented them from ensuring that those services are provided at the best prices.

While the competitive procurement process was suspended, CCACs had to extend existing contracts with service providers using guidelines that the Ministry had issued. According to those guidelines, the renewals and extensions were to be made within the annual level of funding, and CCACs were to ensure that "fair and reasonable" pricing was obtained for any services they procured.

All three of the CCACs that we visited had successfully renewed their service-provider contracts, basing them on a new standard contract developed in 2007 by the Ontario Association of Community Care Access Centres. However, there is still no standard approach to renewals, and each of the three CCACs we visited went about renewing its contracts differently. For instance, our review of a sample of nursing and personal support contracts at one CCAC found that the rates negotiated in 2008 ranged from a decrease of 3% to an increase of 24% from the previous rates. Another CCAC established a maximum fixed percentage increase for each type of service and negotiated rates up to these maximums. At the same CCAC, we noted that rate

requests outside of these parameters were evaluated by an external expert.

RECOMMENDATION 4

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

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

RESPONSE FROM COMMUNITY CARE ACCESS CENTRES

We agree with this recommendation and are prepared to be involved in a formal evaluation of procurement for CCAC services. However, it is important to note that procurement of services first and foremost is to ensure that quality providers are in place to deliver client care. Although the cost of delivering client care is part of the procurement process, 75% of the provider evaluation is based on quality.

The rate variations across CCACs and across the province are a result of past Requests for Proposals (RFPs), where the service provider's price was accepted if that provider had the highest quality score. Prices are not negotiated at the end of the RFP process. Because there has been no RFP process in place for a number of years, CCACs have renegotiated rates at the time of contract renewal.

We caution that the assumption that an RFP process will result in either reduced rates or rate-spreads may not be correct.

MINISTRY RESPONSE

The Ministry will work with the LHINs and CCACs to analyze the cost drivers across the province that contribute to variations in home care costs.

As part of the Integrated Client Care Project, the Ministry, CCACs, and service providers are testing alternative payment models that are based on outcomes and that reward innovation. This shift is a new way to look at how to improve and sustain our health-care system through change in care delivery. Alternative payment models will be evaluated to ensure that incentives are driving expected efficiencies in care, increasing innovation and resulting in improved quality of care and equitable service levels.

DATA MANAGEMENT AND ANALYSIS

Various data and information systems are in place to help CCACs, LHINs, and the Ministry monitor and evaluate such things as the cost-effectiveness of services, access to services, client assessments, service-provider billing, and case management, as well as to provide overall program information.

Since our last audit in 2004, the Ontario Association of Community Care Access Centres has developed a Client Health and Related Information System (CHRIS), which standardized and consolidated the four legacy systems the CCACs used prior to their realignment. CHRIS enables collection of detailed client information for intake, eligibility, and assessment tracking as well as planning client care and services, ordering services from providers, and billing. At the time of our current audit, all CCACs except for one had fully implemented CHRIS. In general, the three CCACs we visited gave us positive feedback on CHRIS, saying it contributed to improving the efficiency of their case management work.

Although CHRIS does not provide province-wide summary-level information, this information is available through ministry systems, specifically the Ministry's Management Information System (MIS). This system contains quarterly and year-end financial and statistical information submitted by the CCACs, and the Web Enabled Reporting System (WERS) also generates reports for LHIN and CCAC use to help them identify variances between Accountability Agreement performance requirements and actual performance.

Portions of the data captured within CHRIS are uploaded to the Ministry's information systems, such as MIS. However, when we reconciled a sample of data reports between CHRIS and MIS, we did identify variances that arose from inconsistent data definitions and account classifications.

Although the Ministry is responsible for the performance of the overall health system, we found that it had not conducted regular reviews of the province-wide data to assess cost-effectiveness of the services provided and to identify areas that may require further follow-up. Our review of data from the third quarter of the 2009/10 fiscal year identified significant variances among the CCACs. For instance, the total costs per personal support client served ranged from about $2,200 to $4,000. When we followed up with the CCAC that had the highest costs, it indicated that these costs may have been due to the complexity of the clients it served. Also, the average number of days clients waited for service initiation ranged from one day to 121 days. Our follow-up with the CCAC that had the longest wait indicated that the data may not be correct. Both CCACs indicated that they had not received any inquiries from the Ministry about these figures.

Overall, the CCACs and the Ministry have made good progress in collecting information that meets both their client-service-management needs and performance-oversight responsibilities. However, more attention needs to be paid to ensure the consistency and accuracy of data and the initiation of some oversight mechanism to review the data on a province-wide basis to identify areas that may require further follow-up.

RECOMMENDATION 5

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

RESPONSE FROM COMMUNITY CARE ACCESS CENTRES

The CCACs value this recommendation as an important step in building consistency across all CCACs, and would be pleased to assist the Ministry of Health and Long-Term Care and the LHINs with the development of summary reports that would be useful and appropriate to their review processes.

MINISTRY RESPONSE

The Ministry will work with the LHINs to review summary-level data to enhance oversight of home care services. On an annual basis, the Ministry hosts data quality and education sessions focused on improving the quality of financial and statistical data within the CCAC sector. Issues such as data accuracy, consistency, and outliers are identified and discussed in these sessions. The sessions are open for participation to all CCACs and LHINs. The Ministry also facilitates an advisory working group and client services working groups with the CCACs to discuss issues relating to financial and statistical data. The LHINs oversee all services provided by the CCACs by using data reported through the Community Annual Planning Submission and the Community Analysis Tool.

MEASURING CCAC PERFORMANCE

CCACs are evaluated against 13 standard performance measures included in the Accountability Agreements they each hold with their LHINs. These measures cover financial, operational, and statistical areas. Each measure includes an expected performance target to be achieved. For example, CCACs are to achieve a balanced budget, staff turnover should not exceed a specific target percentage, and the wait time from community referral to assessment date should not exceed a specific number of days. We found that performance targets were established individually between each CCAC and its respective LHIN. In lieu of best practice targets, the LHINs and the CCACs said they were using actual performances from the 2007/08 fiscal year as a base for further analysis to set future targets. Over time, consideration could be given to publicly reporting certain key performance measures.

In addition to the standard Accountability Agreement measures, each LHIN may choose to include measures that reflect local priorities. All three CCACs that we visited were held accountable to the LHINs for additional measures. For example, one had to work with hospitals to reduce the number of patients occupying hospital beds who could be served in the community; another was held to a specific time period for the implementation of CHRIS.

All three CCACs had also developed internal scorecards to measure their organizational performance.