

## Chapter 2

### Section 2.01

# Community Care Access Centres—Financial Operations and Service Delivery

Follow-Up on *September 2015 Special Report*

RECOMMENDATION STATUS OVERVIEW						
	# of Actions Recommended	Status of Actions Recommended				
		Fully Implemented	In Process of Being Implemented	Little or No Progress	Will Not Be Implemented	No Longer Applicable
Recommendation 1	1	1				
Recommendation 2	1	0.5				0.5
Recommendation 3	2		2			
Recommendation 4	2		2			
Recommendation 5	1	1				
Recommendation 6	2		2			
Recommendation 7	1	1				
Recommendation 8	1	1				
Recommendation 9	1	1				
Recommendation 10	1		1			
Recommendation 11	1	1				
Recommendation 12	3	1	2			
Recommendation 13	2	2				
Recommendation 14	1		1			
Recommendation 15	2	1	1			
Recommendation 16	1		1			
<b>Total</b>	<b>23</b>	<b>10.5</b>	<b>12</b>	<b>0</b>	<b>0</b>	<b>0.5</b>
<b>%</b>	<b>100</b>	<b>46</b>	<b>52</b>	<b>0</b>	<b>0</b>	<b>2</b>

## Overall Conclusion

*Note: Ontario's Community Care Access Centres (CCACs) were absorbed by the Local Health Integration Networks (LHINs) between May and June 2017.*

According to the information the Ministry of Health and Long-Term Care (Ministry), Health Shared Services Ontario and the CCACs (now part of the LHINs) provided to us, as of June 30, 2017, 46% of the actions we recommended in our *2015 Special Report* had been fully implemented.

The Ministry, Health Shared Services Ontario and the CCACs have made progress in implementing 52% of the recommendations. The Ministry, Health Shared Services Ontario and the CCACs have fully implemented recommendations relating to areas such as earlier finalization of annual funding, following a common CEO compensation framework, changing rapid-response nurses staffing schedules to provide coverage over the weekend, developing staff caseload benchmarks for direct-nursing services, and developing performance indicators for these services. As well, the organizations were in the process of implementing recommendations relating to areas such as analyzing hospital readmission trends for all patients who have received rapid-response nursing services, putting harmonized billing rates for CCACs' contracted service providers in contracts, and developing standard data requirements to measure the cost-effectiveness of care protocols.

Another significant change that was continuing throughout our follow-up period was the streamlining of the service delivery model for home and community care. With the passage of the *Patients First Act, 2016*, the CCACs were dissolved and the responsibility for home and community care was transferred to the LHINs. By the time this follow-up report is released, CCACs would cease to exist.

The status of actions taken on each of our recommendations is described in the report.

## Background

At the time of our 2015 audit, Ontario's 14 Community Care Access Centres (CCACs) were not-for-profit provincial government organizations that helped people access home- and community-based health care and related social services outside a hospital setting. These services included nursing, personal support, physiotherapy and occupational therapy, for example. Each CCAC was overseen and funded by a Local Health Integration Network (LHIN).

Following our *2015 Special Report*, Ontario passed the *Patients First Act* in December 2016. The Act expands the mandate of the LHINs as the single point of accountability for home and community care. At the time of our follow-up work, the Province was in the process of dissolving the CCACs and transferring their staff, resources and responsibilities to the LHINs.

In the 2016/17 fiscal year, CCACs spent about \$2.7 billion (\$2.4 billion in 2013/14), or about 5% of Ontario's total health-care expenditures. In the 2016/17 fiscal year, they served about 760,000 people (compared to about 700,000 people in 2013/14).

CCACs employed mostly care co-ordinators who determined the eligibility for and appropriateness of patient care and support, which was ultimately delivered, for the most part, by about 160 contracted service providers. These service providers ranged in size from individual professional contractors to large multi-disciplinary corporations operating in several provinces. In the 2016/17 fiscal year, six of the 14 (compared to five of the 14 in 2014/15) CCACs employed their own professionals to provide therapy services rather than contracting with external service providers.

In 2011, the Ministry of Health and Long-Term Care (Ministry) directed all CCACs to begin providing direct patient services in three program areas (rapid-response nurses, mental health and

addiction nurses, and palliative care nurse practitioners). Under these programs, CCACs themselves employed and supplied direct-care nurses.

The Ontario Association of Community Care Access Centres (Association), funded by the Ministry and the CCACs, represented all CCACs. The Association provided shared services, such as procurement, policy and research, and information management to the CCACs.

In March 2014, the Standing Committee on Public Accounts requested that we review areas that included expenses, compensation, program effectiveness and procurement of home- and community-care services at the CCACs, their contracted service providers, and the Association. Among our findings included in our September 2015 *CCACs—Financial Operations and Service Delivery* special report:

- **Between 2009/10 and 2013/14, CCAC expenses increased 26% to provide more hours of care to patients with more chronic and complex health needs**—Combined spending by the 14 CCACs rose 26% between April 1, 2009, and March 31, 2014. About 62% of CCAC spending went to contracted service providers to supply services such as nursing, personal support and therapy. In the year ending March 31, 2014, these contracted service providers received from the 14 CCACs a combined total of about \$1.5 billion, up 28% from the year ending March 31, 2010. Over the same period, the hours of care rose by 35% and the number of visits rose by 10%. Also over the same period, CCACs served a patient population with much more chronic and complex health issues. (The number of chronic and complex patients increased by 89% and 77%, respectively.) Spending by the Association increased by 6% over the same period.
- **Costs that CCACs considered to be for “direct patient care” included items that did not involve direct interaction with patients, such as service providers’ overhead and profit**—CCACs follow the provincial health-cost-reporting guidelines

and include all expenses they incur to care for patients as “direct patient care costs.” This encompasses all expenses paid to CCACs’ own clinical staff plus all the expenses they pay to contracted service providers—including the service providers’ overhead costs and profits. Profits are defined as the difference between revenue from CCACs and expenses incurred to provide CCAC directed services, reported by both for-profit and not-for-profit service providers. (CCACs exclude their own overhead and administrative costs in reporting direct patient care costs). Using these rules, CCACs reported spending an average of 92% of their expenses on direct patient care in the year ending March 31, 2014. However, when service-provider overhead costs and profits are excluded from the calculation, the average falls to 81%. Furthermore, within the health-care sector, the definition of the term “direct care” varies. One stricter definition includes only those activities that involve direct interaction with patients. It excludes activities that might *influence* patient care but do not involve interaction, such as documenting patient care activity, travel and staff training. Under this definition that excludes both CCAC and service-provider spending on anything but direct patient interaction, CCACs spent on average 71.5% of total expenditures on direct patient care in the year ending March 31, 2014. If we include the costs of care-co-ordinator travel (which is inherent to home and community care) and documenting patient care (which is required under professional practice standards), CCACs spent an average of 72% of their expenses on direct patient care in the year ending March 31, 2014. Regardless of the definition used, spending on direct patient care benefits patients only to the extent that the care is effective and results in better patient outcomes. Neither the Ministry nor the CCACs and their Association had analyzed how given amounts of spending on any given

patient-care activities correlate with the patient outcomes that result. Such analysis would help CCACs prioritize their spending, and allocate sufficient resources and funds to the most effective patient-care activities.

- **CCAC CEOs' salaries up 27% between 2009 and 2013**—The 14 CCACs paid their CEOs an average of \$249,000 each in 2013 (the most recent year that data was available during our audit), up 27% compared to the average in 2009. Excluding one-time payouts such as severance and vacation pay, the annualized salaries of CEOs at CCACs averaged \$245,300 in 2013, also up 27% since 2009. This was 43% more than what service providers in 2013 paid their executives who they claimed to have similar responsibilities and duties as the CCACs' CEOs. However, in many cases CEOs at CCACs do in fact have different responsibilities and oversee different kinds of organizations than their service-provider CEO-equivalents. In these cases, comparing their compensation is more of an “apples-to-oranges” exercise than an “apples-to-apples” one.
- **Not all CCAC CEOs followed the common compensation framework designed specifically for them; service-provider CEOs followed different frameworks**—While all CCACs agreed to adopt a common CEO compensation framework that was developed in 2012, three had not implemented it at the time of our fieldwork. In addition, compensation for non-CEO senior executives was inconsistent, with CCACs using a variety of different compensation frameworks. Among the nine service providers we visited in this audit, all used different compensation frameworks for their executives (both CEOs and non-CEOs).
- **CCAC nurses and therapists were better paid than their service-provider counterparts in the year ending March 31, 2014**—We found that CCAC nurses were paid on average \$40.80 an hour, compared to an average of \$30 an hour for nurses employed by

service providers. The difference in pay is due to nursing unions negotiating different pay rates with CCACs and service providers. Also, the two CCACs we visited that employed their own in-house therapists paid their therapists significantly more than what they paid service providers for similar services. At one CCAC, the higher pay was because the therapists served a large, sparsely populated geographic area without any service providers (such areas do not have a stable enough volume of work to keep service-provider staff fully employed). At the other, the higher pay was because the therapists' responsibilities were greater than those given to service-provider therapists.

- **No cost/benefit analysis of CCAC nurses directly providing services under three new programs (rapid response, mental health and addiction, and palliative care) was prepared before the programs were launched, and the effectiveness of these programs has not been evaluated**—The Ministry implemented three new programs in 2011 that required CCACs to hire their own nurses and nurse practitioners to directly provide services without the involvement of service providers. However, the Ministry did not first analyze whether service providers could provide the same service more cost-effectively. The programs have now been in place for more than three years but have not been assessed to determine whether they have met their goals. As well, even though both the Ministry and the Association developed some performance indicators for the three programs, most of these indicators did not measure program outcomes, and there were no targets set to ensure performance was meeting expected levels. The rapid-response nurses are supposed to visit patients at home within 24 hours of their being discharged from hospital, but 47% of patients were not visited within 24 hours. One CCAC we visited explained that this standard is not always

met because many patients are discharged on Fridays and there is no nursing coverage on weekends in some parts of the region.

- **Billing rates for the same service categories varied by service provider and CCAC—** Before February 2008, CCACs across Ontario used a competitive process to procure contracted services. The Ministry suspended this process because it heard that patients were concerned about losing their existing support workers whenever a competitive procurement process resulted in a change of service provider. During the use of the competitive process, different billing rates for services were established. Those billing rates did not change, even after CCACs amalgamated from the original 42 to the 14 in 2007. As a result, rates varied widely across CCACs, with some rates in certain service categories being more than double that of others for the same services. Moreover, some CCACs paid the same service provider different billing rates for the same service even within the same CCAC.
- **Service providers use a variety of clinical-care protocols; use of outcome-based pathways do not always result in cost savings—** There are no province-wide standard clinical-care protocols for service providers to use, and some CCACs require service providers to use a different care protocol for their patients than the service providers use for patients in other CCACs with the same type of medical condition. The Association has overseen the development of “outcome-based pathways” for specific conditions, such as wound care and hip and knee replacements, in addition to clinical-care protocols. These pathways state when specific improvements in a patient’s recovery (“outcomes”) should occur. By establishing and using these pathways, CCACs should, in time, be able to shift from paying service providers hourly or per visit to paying them based on achieving specified outcomes. This approach, in turn, should

better enable the Ministry to adjust its health-care funding to hospitals and CCACs. Five CCACs tested the three pathways developed so far, but the Association was still analyzing the results at the time of our audit. As well, although achieving cost savings is not the sole objective for adopting clinical-care protocols and outcome-based pathways, we examined data on the treatment cost per patient before and after the implementation of clinical-care protocols at the three CCACs we visited, and found that the implementation of these tools did not always result in cost savings.

We made 16 recommendations, consisting of 23 actions needed for improvement, and received commitments from the Ministry, the Ontario Association of Community Care Access Centres and the three CCACs we visited during the audit (Central, North East, and Hamilton Niagara Haldimand Brant) that they would take action to address them.

## Important Events Following Our 2015 Audit

In August 2016, the Ministry established a Levels of Care Expert Panel (Expert Panel) to provide advice and recommendations on the development and implementation of a levels-of-care framework in Ontario. The Expert Panel is co-chaired by a physician and a vice president of Health Quality Ontario (an agency created in 2005 to provide advice to the Minister of Health and Long-Term Care on the quality of health care), and a senior director at the former Toronto Central CCAC. The framework is intended to introduce common home- and community-care assessment and care planning practices, and is expected to have significant implications for care co-ordination.

In June 2017, the Expert Panel submitted a final report, *Thriving at Home: A Levels of Care Framework to Improve the Quality and Consistency of Home and Community Care for Ontarians*, to the Ministry. The Ministry expects to work with sector partners to plan for implementing the recommendations

contained within this report through the summer and fall of 2017.

In December 2016, the *Patients First Act, 2016*, was passed. The Act expands the mandate of LHINs as the single point of accountability for home and community care through the transfer of CCAC staff, resources and services to the LHINs. By streamlining the delivery of services and removing a layer of administration within the CCACs, the Ministry expects the health-care system to be more responsive to people's needs. The transfer of all 14 CCACs into LHINs took place in stages, region by region, in May and June 2017.

As well, on March 1, 2017, Health Shared Services Ontario officially became operational. The organization, chaired by an associate deputy minister of the Ministry of Health and Long-Term Care and led by the former chief executive officer of the Ontario Association of Community Care Access Centres (Association), replaced the Ontario Association of Community Care Access Centres and two other former LHIN service organizations. Health Shared Services Ontario is tasked with supporting LHINs with health system integration and providing key shared service functions and supports to the LHINs.

## Status of Actions Taken on Recommendations

We conducted assurance work between April 1, 2017, and June 30, 2017. We obtained written representation from the Ministry of Health and Long-Term Care (Ministry), Health Shared Services Ontario, and the three Local Health Integration Networks (Central, North East, and Hamilton Niagara Haldimand Brant) that have assumed the responsibilities of the former CCACs we visited, that effective September 1, 2017 they have provided us with a complete update of the status of the recommendations we made in the original audit two years ago.

## Overall Expenses of CCACs, Service Providers and Ontario Association of CCACs

### Recommendation 1

*To ensure Community Care Access Centres (CCACs) can properly plan to meet patient-care needs, the Ministry of Health and Long-Term Care, in conjunction with the Local Health Integration Networks, should finalize the annual funding each CCAC will receive before the fiscal year begins or as early in the current fiscal year as possible.*

**Status: Fully implemented.**

### Details

The majority of home care services funding was a base budget that continued from one year to the next, but the finalized budget was subject to change during the year depending on whether the Ministry adjusted funding or implemented new initiatives. The Ministry informed LHINs of changes (an increase) in CCAC funding in April 2017 for the fiscal year 2017/18, compared to November 2014 three fiscal years prior.

## Executive Compensation, Executive and Board Expenses

### Recommendation 2

*To ensure compensation paid to all Community Care Access Centre Chief Executive Officers (CEOs) is consistent and defensible, all Community Care Access Centres should follow a common CEO compensation framework and be required to report any exceptions to their respective Local Health Integration Networks.*

**Status: Fully implemented following the common compensation framework; reporting to LHINs is no longer applicable.**

### Details

We noted in our 2015 audit that while all 14 CCACs agreed to put in place the common CEO compensation framework developed in 2012, one was still in the process of implementing it and two had not yet implemented it at the completion of our audit.

Since the completion of our audit, all CCACs had implemented the compensation framework by the end of 2015.

As all 14 CCACs had completely transitioned to LHINs by the end of June 2017, the second part of our recommendation—that CCACs be required to report any exceptions to the common CEO compensation framework to their respective LHINs—is no longer applicable.

## Direct Patient-Care Costs

### Recommendation 3

*To ensure Community Care Access Centres (CCACs) can consistently identify, compare and manage care co-ordinators' time and activities:*

- *the Ontario Association of Community Care Access Centres, in conjunction with all CCACs, should update the standard care co-ordinator time-tracking report and establish benchmarks for time spent on various care co-ordination activities;*

**Status: In the process of being implemented by December 2018.**

#### Details

The Association (now Health Shared Services Ontario) and the CCACs had begun developing benchmarks for care co-ordinators in the fiscal year 2015/16, including identifying weekly benchmarks for the number of patient visits. They had put this work on hold pending the outcome of the Ministry's initiative to develop a levels-of-care framework that would introduce common home- and community-care standards across the province. The LHINs expect to complete the review of the current care co-ordination benchmarks and guidelines and the associated reporting of care co-ordinators' time as part of the implementation of the levels-of-care framework by December 2018.

At the time of our follow-up, the individual CCACs we visited had implemented some initiatives to monitor care co-ordinators' time and activities.

For example, one CCAC started identifying care co-ordinators' workload targets and tracking care co-ordinators' workload relating to their work with primary-care providers; another CCAC updated the care co-ordinators' workload list in its information system to better reflect the work that care co-ordinators do daily and for new initiatives.

- *all CCACs should use the updated standard care co-ordinator time tracking report.*

**Status: In the process of being implemented by December 2018.**

#### Details

At the time of the follow-up, the levels-of-care framework had just been completed. The LHINs plan to review the framework and review the reporting of care co-ordination time by December 2018.

### Recommendation 4

*To ensure that funds are allocated where they will make the most positive difference for patient care, Community Care Access Centres, in collaboration with the Ontario Association of Community Care Access Centres, should:*

- *analyze the relationship between specific patient-care activities—whether pertaining to direct patient contact or supportive services—and patient outcomes;*

**Status: In the process of being implemented by December 2018.**

#### Details

In 2016, the Association (now Health Shared Services Ontario) began looking at the impact of personal support services on patient outcomes. Personal support services were identified as the starting point because they represent the highest-volume service provided by CCACs across the province. This analysis looks at several key patient outcome indicators, including reduced caregiver

distress and lower rates of application to long-term care homes.

Another area where the sector had begun work in understanding the impact of care on patient outcomes is wound care. One of the goals in outcome-based pathways for wound care is to standardize the delivery of best practices and reporting in wound care. This work was put on hold pending the completion of provincial work led by Health Quality Ontario to develop wound care quality standards that would apply across the health system. The quality standards are expected to be released by the end of 2017. The Ministry is currently planning for implementation of the standards and will be collaborating with the LHINs in key priority areas of implementation in home and community care and other sectors. The LHINs expect that they will implement these quality standards in home and community care by December 2018.

The individual CCACs we visited in our 2015 audit had also undertaken some work to analyze the relationship between specific patient-care activities and patient outcomes. For instance, one CCAC completed an analysis on the outcomes of wound-care patients who received care at home versus those who received care at the CCAC's clinics. Based on the results of this analysis, which looked at outcome, heal time, utilization of services, and cost, the CCAC was better informed in its efforts to shift appropriate patients to care in clinic settings. Similarly, another CCAC changed the way it assigned therapy staff throughout the geographic area to reduce travel time, and used templates in the information system to speed up documentation for therapy services, both of which helped reduce patient wait time for these services.

- *use this information to set resource and funding benchmarks for key patient-care activities.*

**Status: In the process of being implemented by December 2018.**

### Details

At the time of our follow-up work, the Expert Panel had just submitted the levels-of-care framework to the Ministry. This framework contains guidance on resource benchmarks for home- and community-care patient activities. The LHINs expect that they will set resource and funding benchmarks for key patient-care activities by December 2018, following the implementation of the levels-of-care framework and Health Quality Ontario's quality standards.

### Recommendation 5

*To ensure that patients receive equitable and high-quality home- and community-based health care in the most cost-effective manner, the Ministry of Health and Long-Term Care should revisit the service delivery model that currently involves 14 Community Care Access Centres and about 160 private-sector for-profit and not-for-profit service providers.*

**Status: Fully implemented.**

### Details

In December 2016, the government passed the *Patients First Act, 2016*. This Act expands the mandate of LHINs to include the service management and delivery of home and community care. The 14 CCACs transferred their staff, resources and responsibilities into the LHINs in May and June 2017 and subsequently dissolved. Service-provider organizations that held contracts with the former CCACs will continue their contractual relationship with the LHINs. The LHINs will be managing these service contracts. The LHINs are also in the process of establishing sub-regions and aligning service-provider organizations and the delivery of contracted services with the sub-region boundaries.

## Compensation of Nurses and Therapists at CCACs and Contracted Service Providers

### Recommendation 6

*To ensure that the in-house direct-nursing programs and therapy services are delivered as economically as*

possible, the Ministry of Health and Long-Term Care, in conjunction with the Community Care Access Centres (CCACs), should:

- study the compensation paid to CCAC direct-nursing and therapist staff to confirm it is commensurate with the functions performed;  
**Status: In the process of being implemented by March 2018.**

#### Details

CCAC (now LHIN) direct-nursing staff are unionized and compensation is set through the collective bargaining process. CCACs had begun collective agreement negotiations in fall 2016 and LHINs will continue negotiations through 2017 and 2018 as current contracts with the unions representing these staff expire. The home- and community-care sector indicated that negotiated rates for direct-nursing and therapists are based on recent trends in the labour market. The LHINs expected to finalize collective agreement negotiations in 2018.

- incorporate into their assessment of possible changes to the service-delivery model under **Recommendation 5** an evaluation that includes information from all 14 CCACs of whether service-provider organizations or directly employed staff would be able to more cost-effectively deliver the direct-nursing programs (Rapid Response Nursing Program, Mental Health and Addictions Nursing Program, and Palliative Care Nurse Practitioner Program).  
**Status: In the process of being implemented by March 2020.**

#### Details

At the time of our follow-up work, the CCACs we visited noted that they have strengthened their capacity to report on the performance metrics for the direct-nursing programs. Specifically, the CCACs have improved on the indicators, targets, and data collection system, as well as the training to support the implementation of these improvements. The results from this work are available to sup-

port the Ministry in evaluating the direct-nursing services model.

In December 2016, the government passed the *Patients First Act, 2016*. This Act expands the mandate of LHINs to include the service management and delivery of home and community care. The 14 CCACs were dissolved and their staff, resources and responsibilities were transferred into the LHINs in May and June 2017. Following this transition, the Ministry expects to focus on further improvements to the delivery model for home- and community-care services, including assessing whether direct-nursing programs would be delivered more cost-effectively by service-provider organizations or by directly employed staff.

## Comparison of Effectiveness of Home-Care Visits by CCAC Staff and Contracted Service-Provider Staff

### Recommendation 7

*To ensure that medically complex children, and frail adults and seniors with complex needs or high-risk characteristics receive rapid-response nursing services on a timely basis after discharge from hospitals, Community Care Access Centres should arrange rapid-response nurse staffing schedules, including staffing consideration on the weekend when needed, that take the actual times of when patients are discharged from hospital into account.*

**Status: Fully implemented.**

#### Details

We noted in our 2015 audit that all 14 CCACs reported that their rapid-response nurses failed to meet the standard of visiting patients at home within 24 hours following discharge from hospital in the year 2013/14. In our 2015 audit, one of the three CCACs we visited explained that the standard was not always met because many patients were discharged on Fridays, but there was no nursing coverage on weekends in some parts of the region. At the time of our follow-up, all three CCACs had

implemented changes to staff schedules to provide coverage on weekends, based on hospital discharge patterns and demand, with one CCAC having established weekend scheduling in February 2016. As well, two of the three CCACs noted that they monitor whether rapid-response nurses visit patients within 24 hours and 48 hours of being discharged from hospital.

### Recommendation 8

*To ensure that patients eligible for rapid-response nursing are treated fairly and equitably no matter where in the province they live, Community Care Access Centres should follow all provincial program guidelines.*

**Status: Fully implemented.**

#### Details

At the time of the follow-up, all three CCACs we visited were providing rapid-response nursing services seven days a week as required by the provincial program guidelines. One CCAC that was not servicing children with complex needs at the time of our 2015 audit began doing so in February 2017 in selected high-volume geographic areas within the region.

### Recommendation 9

*To reduce the risk that the conditions of school-age children with mental-health issues will worsen unnecessarily, Community Care Access Centres should consider expanding the availability of mental health and addictions nursing services to school-age children in the summer months.*

**Status: Fully implemented.**

#### Details

At the time of our follow-up, all three CCACs we visited had made mental health and addictions nursing services available to school-age children in the summer months. These CCACs used various methods to expand access to their services in the summer months, including connecting patients with nurses through the Ontario Telemedicine

Network technology, reminding school boards that CCAC services continue to support children over the summer even when schools are closed, and linking students transitioning to college or university with community agencies, primary-care providers, and/or supports in their new schools.

### Recommendation 10

*To ensure the cost-effectiveness of medication reconciliation services, Community Care Access Centres should review all the ways their individual patients can receive these services and choose only the most effective and economic option for each patient.*

**Status: In the process of being implemented by December 2017.**

#### Details

In our 2015 audit, we found that while the rapid-response nurses provide medication reconciliation services as part of their regular duties, the same service is being offered by other programs, with some costing up to 70% more than others. After our audit, all CCACs agreed on a standard policy for medication management in April 2016 and medication reconciliation in February 2017.

At the time of this follow-up, all CCACs were in the process of implementing the provincial policy and providing training to their staff in this regard. In most cases, care co-ordinators will identify patients who meet certain criteria according to the standard policy and refer them to the most appropriate medication reconciliation service, either through a community pharmacy, a primary-care provider, a private-sector service provider contracted with the CCACs, or the CCAC's own direct-nursing services staff. At the time of our follow-up, all three CCACs we visited in the 2015 audit had also developed local policies on medication management and reconciliation that were or will be aligned with the provincial policy by December 2017.

### Recommendation 11

*To contribute to direct-nursing programs' improvement, where they are functioning at optimal levels and patients are receiving equitable level of services, Community Care Access Centres should develop staff-caseload benchmark ranges and monitor actual results against these ranges.*

**Status: Fully implemented.**

#### Details

The Association (now Health Shared Services Ontario) and the CCACs developed direct-nursing program staff caseload benchmarks in 2015. At the time of our follow-up, each CCAC compiled caseload data by direct-nursing program every quarter and Health Shared Services Ontario compared this information provincially. To illustrate, in the month of October 2016, on average, each CCAC's rapid response nurse had 42 clients, each mental health and addictions nurse had 26 clients, and each palliative care nurse practitioner had 48 clients. In comparison, the staff-caseload benchmark for each of these three programs was 20 to 30 clients, 20 to 25 clients, and 18 to 23 clients, respectively. Management at the three CCACs we visited also monitored caseload sizes on a regular basis.

### Recommendation 12

*To fully measure the effectiveness of the direct-nursing programs (Rapid Response Nursing Program, Mental Health and Addictions Nursing Program, and Palliative Care Nurse Practitioner Program) at individual Community Care Access Centres (CCACs) and on a provincial level, the Ministry of Health and Long-Term Care should:*

- *make available to CCACs data on hospital readmission and emergency room visits so they can individually monitor their own programs' success;*

**Status: In the process of being implemented by December 2017.**

#### Details

In May 2017, the Ministry provided hospital data to Health Shared Services Ontario. At the time of this follow-up, the two parties were working together to ensure data quality.

- *analyze province-wide the readmission trends for patients who have received rapid-response nursing services;*

**Status: In the process of being implemented by March 2018.**

#### Details

At the time of this follow-up, the Ministry was analyzing readmission trends and noted that it will work with the LHINs to review all three direct-nursing programs.

- *establish targets for the performance indicators developed for all three programs.*

**Status: Fully implemented.**

#### Details

In 2016, a provincial working group comprising the former CCACs and the Association (now Health Shared Services Ontario) refined and finalized direct-nursing programs' targets and indicators. To illustrate some examples, rapid response nurses are expected to provide medication reconciliation to 90% to 95% of their patients; each mental health and addictions nurse is expected to have 20 to 25 active patients; and palliative care nurse practitioners are expected to see 90% to 95% of their patients within five days of the patients being available for a service visit.

### Recommendation 13

*To confirm that service providers deliver high-quality services to patients at home, Community Care Access Centres should:*

- *establish performance targets for occurrences of missed care;*

**Status: Fully implemented.**

### Details

In March 2016, the former CCACs updated the provincial CCAC client service contract performance framework to include targets for missed care. For every 10,000 clients, the CCAC expected the service provider to miss care for no more than five clients.

- *determine, through contacting patients, for example, whether over an agreed time period service providers failed to provide care in accordance with the patients' care plans.*

**Status: Fully implemented.**

### Details

During 2015/16 and 2016/17, the Association (now Health Shared Services Ontario) made several updates to the provincial client satisfaction survey to improve the accuracy and reliability of survey responses. One of the updates involved adding questions to the client and caregiver evaluation survey specifically asking patients and caregivers if service-provider organizations provided services on time, if they kept patients informed of when services would arrive, and if provided services were those agreed to as part of their care plan.

## Existing Contracts between CCACs and Service Providers

### Recommendation 14

*To ensure home-care services are procured from external service providers in a cost-effective manner, the Ministry of Health and Long-Term Care should work with Local Health Integration Networks and the Ontario Association of Community Care Access Centres to put harmonized billing rates in place.*

**Status: In the process of being implemented by March 2018.**

### Details

In October 2015, the Ministry established a working group to advise on a proposed harmonized rate for general personal support services (which accounts for about 80% of all personal support service vol-

umes). This working group included representation from CCACs, the Association (now Health Shared Services Ontario), LHINs, service-provider organizations, and home-care provider associations. The Ministry also undertook two rounds of consultations with service providers about the proposed harmonized rate to confirm numbers and approach. Based on these efforts, the Ministry determined a harmonized rate for general personal support services in April 2017, and issued a directive to require CCACs to amend service contracts with their service providers to reflect the harmonized rate. The Ministry is continuing to work with the LHINs and the LHINs with their health service providers to update other rates.

## Long-Term Cost-Effectiveness of Existing Care Protocols

### Recommendation 15

*To ensure consistent processes are followed in the delivery of patient care across the province, the Ontario Association of Community Care Access Centres, in conjunction with the Community Care Access Centres, should:*

- *confirm that best practices regarding the various clinical-care protocols are used in the province;*

**Status: In the process of being implemented by December 2018.**

### Details

The home- and community-care sector is in the process of developing consistent provincial approaches on various patient populations. For instance, in 2015, the sector implemented new assessment guidelines on the use of a screening tool for all children and youth receiving CCAC mental health and addictions nursing services. The sector is also providing support to Health Quality Ontario in developing quality care standards on hip fractures, venous and mixed venous/arterial leg ulcers, diabetic foot ulcers, and pressure injuries. (Quality standards are concise sets of statements

that will help patients know what to ask for in their care, help health-care professionals know what care they should be offering, and help health-care organizations measure, assess and improve performance.) The sector is awaiting Health Quality Ontario to release its quality standards on wound care before proceeding to implement standardized clinical-care protocols on this condition—the sector expects to do so by December 2018. As well, the sector has worked with the Rehabilitative Care Alliance (a province-wide collaborative established in April 2013 by all 14 LHINs) to develop rehabilitative care best-practice frameworks for patients with hip fracture and primary hip and knee replacement.

- *in collaboration with private-sector service providers, consider standardizing the home-care clinical-care protocols, including standardizing which medical supplies should be used, for the most prevalent health conditions.*

**Status: Fully implemented.**

#### Details

At the time of this follow-up, all three CCACs we visited in the 2015 audit had developed local standards that define the types and the quantities of medical supplies for wound care, and one had further defined local standards for other home-care

services such as catheter care and enteral feeding. The CCACs we visited told us they intended to monitor current best practice on an ongoing basis to ensure standards reflect best practice. They noted that standardizing medical supplies is influenced by local factors such as which supplies the local hospitals use. As a result, standardization would happen by region rather than provincially.

#### Recommendation 16

*To ensure the long-term cost-effectiveness of care protocols can be assessed, the Ontario Association of Community Care Access Centres, in conjunction with the Community Care Access Centres, should develop standard data requirements and collect the necessary data for further analysis.*

**Status: In the process of being implemented by December 2018.**

#### Details

At the time of the follow-up, Health Shared Services Ontario and the CCACs were awaiting Health Quality Ontario to finalize its work on wound care quality standards. Once complete, they expect to use those standards to develop data requirements and begin collecting data for further analysis and performance reporting.