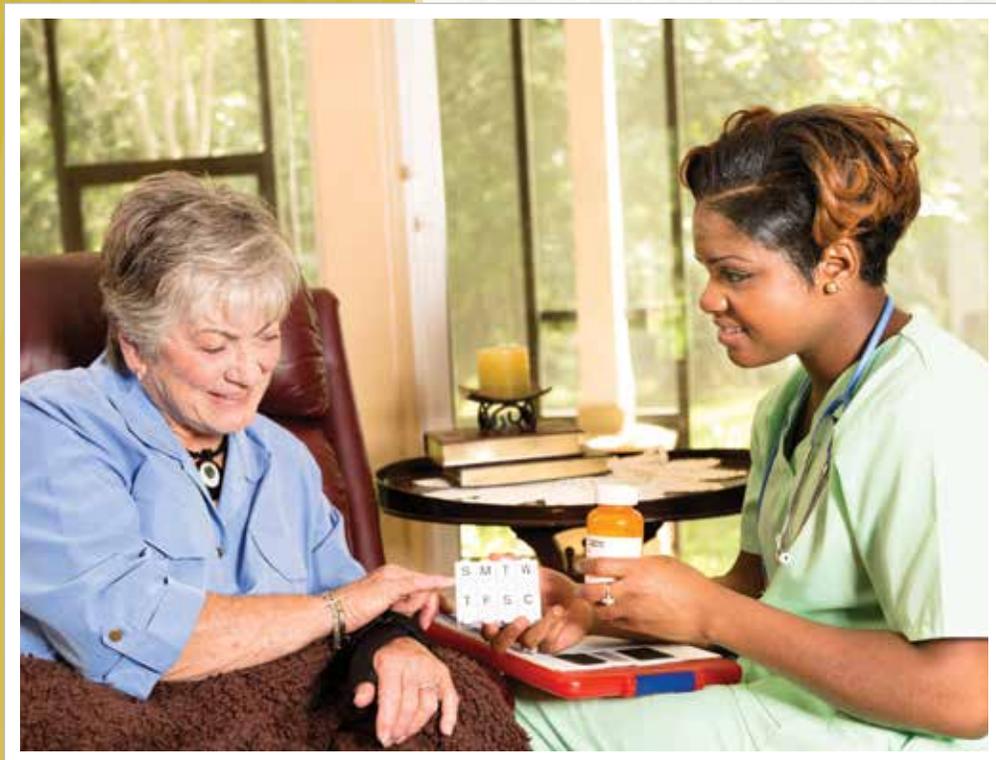




Office of the Auditor General of Ontario

# Community Care Access Centres— Financial Operations and Service Delivery



Special Report  
*September 2015*





## Office of the Auditor General of Ontario

To the Honourable Speaker  
of the Legislative Assembly

I am pleased to transmit my Special Report on  
Community Care Access Centres—Financial  
Operations and Service Delivery, as requested by  
the Standing Committee on Public Accounts under  
Section 17 of the *Auditor General Act*.

A handwritten signature in black ink that reads "Bonnie Lysyk".

Bonnie Lysyk  
Auditor General

September 2015

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# Community Care Access Centres—Financial Operations and Service Delivery

## 1.0 Reflections

The 14 Community Care Access Centres (CCACs) in Ontario are responsible for helping people access home- and community-based health care and related social services outside a hospital setting. Their mission is to provide equitable and individualized access to quality care. The Ministry of Health and Long-Term Care (Ministry), through the Local Health Integration Networks (LHINs), fully fund CCACs' operations. CCAC service is free to eligible Ontario residents.

We audited financial operations and service delivery at CCACs, as well as the Ontario Association of Community Care Access Centres (Association), in response to a request from the Legislature's Standing Committee on Public Accounts in 2014. (Our Office is currently conducting a separate audit focusing on aspects of CCAC home-care services beyond the areas identified in the Committee request. We plan to include the results of this separate audit in our *2015 Annual Report*.)

We concluded that the way in which CCACs operate and deliver services needs to be revisited. Our specific findings and recommendations are detailed in this report.

On the financial side, savings may be found if changes to the current structure of CCACs (including CCACs' relationship with LHINs) and possibilities for streamlining are considered. This could result in a greater proportion of funding going to direct care for patients instead of to the administrative costs of CCACs and their contracted service providers, and to the profit that these service providers (both for-profit and not-for-profit) make from CCAC-funded services. (Not-for-profit service providers can still profit from CCAC-funded services if their revenue from CCACs exceeds expenses they incur to provide CCAC-directed services.) It could also offer opportunities for more consistent adoption of best practices province-wide for spending funds and overseeing employed and contracted staff.

On the service-delivery side, patients' health outcomes may improve if inconsistencies in how the 14 CCACs deliver services are addressed with certain types of care being standardized so that patients with similar conditions are consistently treated using agreed-upon best practices.

To date, there has been no thorough evaluation of the current CCAC service-delivery model to ensure that this model is optimally providing consistent and quality care. A key factor contributing to the inconsistencies in the current model that any evaluation should address is the unsystematic manner in which home- and community-based

health initiatives have evolved in Ontario. Service providers first entered into contracts with CCACs in the 1990s, when 43 CCACs were established across the province. When these CCACs were amalgamated into the current 14 CCACs in 2007, many of the new CCACs inherited the older contracts, which differed in the rates that they paid to contracted service providers for providing common services. In 2008, the Ministry suspended competitive procurement for CCAC contracted services, so the differences in rates remain to this day. In 2012, the Association developed a standard two-year contract that all CCACs signed with their service providers. However, the different rates for providing the same services remained unchanged in these contracts with service providers.

As well, in 2011, the Ministry introduced a new service-delivery approach. As part of a government commitment to create 9,000 new nursing positions, the Ministry directed CCACs to employ *their own nurses* for “rapid-response nursing” (providing transitional care to certain patients just discharged from hospital) and mental health and addictions nursing, and *their own nurse practitioners* for palliative care. Before this approach was launched, only the 160 service providers with whom the CCACs contracted provided all home- and community-based nursing care. Concerns have been raised that this new service-delivery approach contributes to confusion around roles and responsibilities, duplication of some services that both CCACs and service providers deliver, and differences in staff compensation between CCACs and service providers.

Minimizing—or, better still, eliminating—the inconsistencies in the current service-delivery model would likely result in a more equitable home- and community-based health-care system. Doing so would also enable the Ministry, the CCACs and their Association to better plan, monitor and improve patient care.

I appreciate the foresight shown by the all-party Standing Committee on Public Accounts when it requested that we comprehensively review CCAC financial operations and service delivery. As we

completed our work in 2015, three significant reports were issued: *Bringing Care Home* (a report from a government expert group on home and community care), *Patients First: Action Plan for Health Care* (the government’s blueprint for improving the health-care system), and *Patients First: A Roadmap to Strengthen Home and Community Care* (a 10-point plan, informed by the work of the expert group, to improve and expand home and community care over the next three years). Having completed our audit and seeing the release of these reports confirm my belief that this is an optimal time for the government to further undertake a high-level, comprehensive analysis of what kind of a home- and community-based health-care delivery model would provide the highest quality of care most cost-effectively. The solution is not simply to add initiatives and make adjustments to existing services, leaving core problems and inconsistencies entrenched. Instead, the Ministry, CCACs and their Association have an opportunity to bring fresh and innovative perspectives to identifying the outcomes they need to achieve, and to defining the kind of system that can produce those outcomes cost effectively and consistently across the province.

## 2.0 Background

### 2.1 Community Care Access Centres Overview

**Purpose:** Community Care Access Centres (CCACs) are not-for-profit provincial government organizations that help people access home- and community-based health care and related social services outside a hospital setting. Their mission is to provide equitable and individualized access to quality care. Service is free to eligible Ontario residents.

CCACs are responsible mainly to determine eligibility for, and co-ordinate access to, home- and community-based services such as nursing, personal support, and therapy for people of all ages whose

needs range from short-term acute to long-term chronic. They also provide some other services, such as arranging placement of individuals into long-term-care homes. About three-quarters of the services CCACs provide are delivered in people's own homes; the remaining quarter are delivered in schools or clinics, or involve individuals' placement in long-term-care homes. Other than in a small percentage of cases, CCACs do not provide care directly, but contract with service providers (either for-profit or not-for-profit) to supply the required services.

**Regional System:** The CCAC system was first established in 1996. By January 1998, there were 43 CCACs across Ontario, consolidating services formerly provided by 38 home-care programs and 36 co-ordination services for placing individuals in long-term-care homes. In 2003, two CCACs merged, bringing the total to 42; these 42 amalgamated into the current 14 in January 2007. Each of the 14 CCACs covers a distinct region of Ontario, as illustrated in **Figure 1**.

**Spending:** Total CCAC spending in the year ending March 31, 2014, was almost \$2.4 billion, or about 5% of Ontario's total health-care expendi-

tures. Professional clinical services purchased from contracted service providers accounted for 62% of the total, or about \$1.5 billion. **Figure 2** shows that between 2010 and 2014, total CCAC expenses grew from \$1.88 billion to nearly \$2.37 billion, or 26%, with increases for individual CCACs ranging from 16% to 37%. **Figure 3** breaks down spending for each CCAC by population and by number of clients served (either directly or through care co-ordination) for the year ending March 31, 2014.

**Service and Costs:** The CCACs employed a total of 6,630 full-time staff in the year ending March 31, 2014, mostly in such areas as care co-ordination, information technology, and administration. These staff co-ordinated the provision of services for, or directly provided services to, about 700,000 people. Costs ranged between \$2,892 and \$3,775 per person; the average was about \$3,400 per person. Historically, the Ministry has provided different amounts of funding to CCACs. Even though the Ministry began reforming its funding model in 2012, most of the funding CCACs received in the year ending March 31, 2014, was still based on the amounts they received in previous years.

**Figure 1: Locations of Ontario's 14 Community Care Access Centres**

Source of data: Ontario Association of Community Care Access Centres

1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West



**Figure 2: Expenses by Community Care Access Centre Region, Years Ending March 31, 2010–March 31, 2014**

Source of data: Ontario Association of Community Care Access Centres

CCAC	(\$ million)					Overall Increase (%)
	2009/10	2010/11	2011/12	2012/13	2013/14	
Central West	76	82	90	92	103	37
North Simcoe Muskoka	70	77	82	86	94	36
North West	38	40	43	48	52	36
Hamilton Niagara Haldimand Brant	232	250	260	272	303	31
North East	102	107	115	119	133	30
Waterloo Wellington	94	101	110	114	122	30
Toronto Central	182	205	209	214	235	29
South East	94	98	103	109	119	26
Mississauga Halton	116	127	132	142	145	25
Erie St. Clair	102	113	123	119	128	25
Central	207	211	226	237	257	24
Champlain	183	177	199	201	222	22
South West	168	169	179	189	205	22
Central East	216	204	227	241	250	16
<b>Total</b>	<b>1,880</b>	<b>1,961</b>	<b>2,098</b>	<b>2,183</b>	<b>2,368</b>	<b>26</b>

**Figure 3: Expenses, Population Covered, and Clients Served for Each CCAC, Year Ending March 31, 2014**

Source of data: Ontario Association of Community Care Access Centres

CCAC	Expenses (\$ million)	Population (000)	# of Clients Served (000)	Spending Per Capita (\$)	Spending Per Client Served (\$)
North Simcoe Muskoka	94	462	25	204	3,775
Champlain	222	1,300	59	171	3,759
Hamilton Niagara Haldimand Brant	303	1,400	82	216	3,712
North East	133	564	36	236	3,710
North West	52	231	14	224	3,584
South West	205	962	58	213	3,536
South East	119	500	34	238	3,504
Erie St. Clair	128	621	38	205	3,392
Central	257	1,800	78	143	3,300
Toronto Central	235	1,150	74	204	3,169
Waterloo Wellington	122	758	39	161	3,128
Central East	250	1,600	80	156	3,105
Mississauga Halton	145	1,220	47	119	3,081
Central West	103	840	36	123	2,892
<b>Total</b>	<b>2,368</b>	<b>13,408</b>	<b>700</b>	<b>177</b>	<b>3,384</b>

**Care Co-ordination:** CCACs have traditionally focused on co-ordinating care provided by service providers and community support services. CCAC “care co-ordinators” are nurses, social workers and other professionals who determine the eligibility for and appropriateness of patient care and support, which is ultimately delivered, for the most part, by contracted service providers. (In a small percentage of cases, CCAC staff provide patient care directly; see **Direct Patient Services**.) Care co-ordinators are also responsible for ongoing oversight of patient-care plans, adjustments to services provided to patients and periodic patient reassessments. These activities involve communication with primary-care physicians, hospitals, contracted home-care service-provider agencies, and other community agencies providing services such as meals and transportation for patients living at home.

**Contracted Service Providers:** As of March 31, 2014, CCACs bought the majority of home- and community-based services from about 160 service providers under 260 separate contracts. These organizations are either for-profit or not-for-profit. They are, in effect, contractors hired by the CCACs to deliver the health services listed in **Appendix 1**. To deliver care under the direction of the CCACs, they employ a range of professionals, including nurses, personal-support workers, and what are often referred to as “allied health professionals” or “therapists,” including physiotherapists, occupational therapists, speech language pathologists, dietitians, and social workers. (We refer to these professionals as “therapists” in this Special Report.)

Service providers range in size from individual professional contractors to large multi-disciplinary corporations operating in several provinces. Some operate other businesses in addition to serving CCAC clients (such as operating long-term-care homes), and receive other sources of revenue (such as fee-for-service pay from individuals or private insurance plans, contributions from donations and not-for-profit foundations, and revenues from other provincial governments).

**Direct Patient Services:** In some cases, CCACs supply direct care themselves; for example, five CCACs employ professionals who provide therapy services. (Under the *Community Care Access Corporations Act, 2001*, CCACs can provide health and related social services, supplies and equipment directly or indirectly.)

In addition, the Ministry of Health and Long-Term Care (Ministry) directed all CCACs in 2011 to begin providing direct patient services in three program areas:

- **rapid-response nurse program**—provides transitional care to patients just discharged from hospital, available to two specific types of patient: medically complex children, and frail adults and seniors with complex needs or high-risk characteristics;
- **mental health and addictions nurse program**—provides nursing support in the area of mental health and addictions to students in school; and
- **palliative care nurse practitioner program**—provides in-home palliative care delivered by nurse practitioners who have received specialized training beyond that of registered nurses and who are usually paid more than registered nurses.

Because the Ministry established these programs, the Local Health Integration Networks that have a responsibility to oversee the CCACs play a more minor role in setting guidelines for these programs. The major role in setting guidelines is played by the Ministry and the Ontario Association of Community Care Access Centres (Association), a non-profit organization that represents the 14 CCACs (see **Section 2.2** for more information on the Association).

**Section 5.4** and **Section 5.5** discuss these programs in detail.

**Government Priority:** In its 2012 *Action Plan for Health Care*, the Ministry committed to ensuring that patients receive care in the most appropriate setting; whenever possible, this is to be at home

instead of in a hospital or long-term-care facility. Furthermore, a September 2014 mandate letter from the Premier to the Minister of Health and Long-Term Care said the expansion of home and community care was a government priority. The 2012 Action Plan was updated in January 2015 (under the title *Patients First: Action Plan for Health Care*), with the same emphasis placed on home care. In March 2015, an expert group commissioned by the Ministry released a report entitled *Bringing Care Home* that offered strategies to improve the quality and value of care provided by the home- and community-care sector.

According to the Association, home care is an economical way to deliver service. The Association estimated that, in 2014, home care cost about \$45 per day per person, compared to \$450 per day in hospital and \$135 per day in a long-term-care facility. In addition, caring for people in their own home frees up hospital beds for patients with more acute needs.

## 2.2 Governance of CCACs and the Ontario Association of Community Care Access Centres

Each CCAC is overseen and funded by a Local Health Integration Network (LHIN) that shares its geographic boundaries. Every CCAC signs a standard service-accountability agreement with its LHIN, which sets out the LHIN's expectations for the CCAC. The current three-year service-accountability agreements expire in March 2017.

A board of directors governs each CCAC and is responsible to establish strategic direction and ensure program quality and clinical excellence. Since April 2009, CCAC directors have been volunteers recruited from the community.

A chief executive officer (CEO) leads each CCAC, and is accountable to its board of directors. The CEO is responsible for managing operations and finances in accordance with the direction set by the board, and must ensure that the CCAC meets LHIN requirements, ministry directives, and all applicable legislation.

The Association was incorporated in 1998 to represent all CCACs. It receives most of its funding from the Ministry and the CCACs. Its board of directors used to be composed of one representative from each of the 14 CCACs. Effective May 2015, the Association's board of directors is composed of three externally recruited members in addition to nine representatives from CCACs, for a total of 12 members. With a staff of about 190, the Association provides shared services such as procurement, policy and research, and information management to the CCACs.

The key relationships between the Ministry, LHINs, CCACs, the Association and service providers are shown in **Figure 4**.

## 2.3 Legislative Framework for CCAC Executive Compensation

Several key pieces of legislation informed our work in the area of executive compensation at CCACs. We discuss executive compensation in **Section 5.2**.

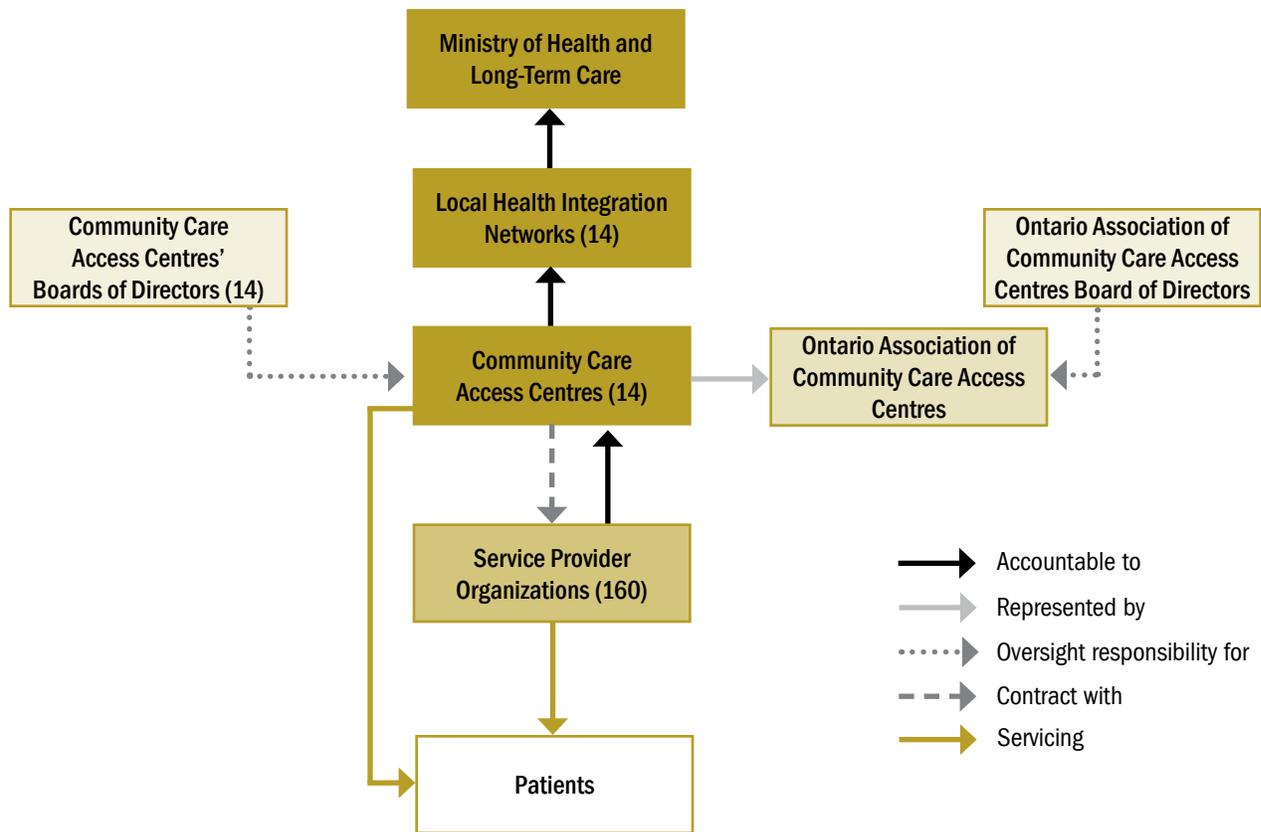
The *Public Sector Compensation Restraint to Protect Public Services Act, 2010* contains salary-restraint measures applicable to certain public-sector employers, including CCACs, effective from March 24, 2010, to March 31, 2012. In those two years, CCACs were prohibited from increasing salaries of non-union employees, such as CEOs and senior executives, except under certain specific conditions, and only if the increase did not bring an employee above a pre-determined pay range.

The *Broader Public Sector Accountability Act, 2010* contains salary-restraint measures covering certain broader-public-sector employers as of April 1, 2012, but does not apply to CCACs.

The *Excellent Care for All Act, 2010* requires every health-care organization to set aside a portion of its executive-pay budget for performance-based compensation, with payment tied to success in meeting improvement targets set out in annual plans. The legislators decided to implement the legislation using a staged approach, beginning with hospitals, then with other health service organizations. At the

**Figure 4: Key Relationships between Entities Involved in the Delivery of Home- and Community-based Health Services**

Prepared by the Office of the Auditor General of Ontario



time of our audit, this Act was proclaimed to apply to hospitals, but had not yet been proclaimed to apply to CCACs.

The *Broader Public Sector Executive Compensation Act, 2014* came into force on March 16, 2015, after we had completed our audit. This Act allows the government to create compensation frameworks for certain executives, including CEOs and vice presidents, at designated broader-public-sector employers, including CCACs. As of June 2015, the government had not established any compensation frameworks applicable to CCAC executives.

## 2.4 Recent Studies

Three significant reports, two of which are specifically on home and community care, were released in 2015:

- *Bringing Care Home*—a report from a government expert group on home and community care;
- *Patients First: Action Plan for Health Care*—the government’s blueprint for improving the health-care system; and
- *Patients First: A Roadmap to Strengthen Home and Community Care*—a 10-point plan, informed by the work of the expert group that wrote *Bringing Care Home*, to improve and expand home and community care over the next three years (2015–17).

All three reports emphasize that improvements are needed in the home- and community-care sector.

## 3.0 Audit Objective and Scope

On March 19, 2014, the Legislature's Standing Committee on Public Accounts (Committee) passed a seven-part motion as follows:

*That the Auditor General conduct an audit of the Community Care Access Centres in the Province of Ontario, including the Ontario Association of Community Care Access Centres. This audit should include, but not be limited to, a focus on the following issues:*

- 1) *Compensation of comparable employee positions in CCACs versus the compensation of the Community Care Providers that the CCACs contract with on a fee-for-service basis.*
- 2) *Executive compensation practices, including expenses of executives and board members of the CCACs and those private-sector entities contracted to the CCAC.*
- 3) *Expenses of the regional CCACs, the Ontario Association of Community Care Access Cen-*

*tres and the private-sector entities contracted to the CCAC.*

- 4) *A review of the CCACs' operating costs.*
- 5) *A review of the existing contracts between CCACs and their community care providers.*
- 6) *A review into the long-term financial efficacy of existing protocols for providing care.*
- 7) *A comparison review into the efficacy and cost effectiveness of home-care visits conducted by health providers directly employed by the CCAC, and by those conducted by health providers employed by organizations contracted by the CCACs.*

We accepted this assignment under Section 17 of the *Auditor General Act*, which states that the Committee can ask the Auditor General to perform special assignments. **Figure 5** shows where the different parts of the motion are addressed in this Special Report.

We conducted our fieldwork between September 2014 and January 2015, and followed up on some additional areas up to June 2015. We drew upon insights we gained during our 2010 audit on Home

**Figure 5: Public Accounts Committee Motion and Organization of this Report**

Sources of data: Standing Committee on Public Accounts and Office of the Auditor General of Ontario

Motion	Report Section
Expenses of the regional CCACs, the Ontario Association of Community Care Access Centres and the private-sector entities contracted to the CCAC	5.1 Overall Expenses of CCACs, Service Providers and Ontario Association of CCACs
Executive compensation practices, including expenses of executives and board members of the CCACs and those private-sector entities contracted to the CCAC	5.2 Executive Compensation, Executive and Board Expenses
A review of the CCACs' operating costs	5.3 Direct Patient-care Costs
Compensation of comparable employee positions in CCACs vs. the compensation of the community-care providers that the CCACs contract with on a fee-for-service basis	5.4 Compensation of Nurses and Therapists at CCACs and Contracted Service Providers
A comparison review into the efficacy and cost-effectiveness of home-care visits conducted by health providers directly employed by the CCACs, and by those conducted by health providers employed by organizations contracted by the CCACs	5.5 Comparison of Effectiveness of Home-care Visits by CCAC Staff and Contracted Service-provider Staff
A review of the existing contracts between CCACs and their community-care providers	5.6 Existing Contracts between CCACs and Service Providers
A review into the long-term financial efficacy of existing protocols for providing care	5.7 Long-term Cost-effectiveness of Existing Care Protocols

Care Services, and examined issues that have emerged since that audit.

For this Special Report, we interviewed key personnel and examined relevant documents of the Ministry of Health and Long-Term Care (Ministry), selected Community Care Access Centres (CCACs), the Ontario Association of Community Care Access Centres (Association), and nine contracted service providers receiving 69% of total CCAC spending on procured direct services in the year ending March 31, 2014. We visited three CCACs that serve regions of various geographical sizes and that have budgets of various sizes. Together, the three spent about 30% of total CCAC expenses in the year ending March 31, 2014. In addition, we met with key personnel from the Local Health Integration Networks (LHINs) that oversee these three CCACs. We obtained information from the 11 remaining CCACs through a survey, and we followed up with all of them regarding their responses. The three CCACs and nine service providers we visited are noted in **Figure 6**.

In our work on senior-executive compensation, we obtained and analyzed compensation informa-

tion for senior executives and board members at all 14 CCACs, and interviewed board chairs in each of the three CCACs we visited. We also obtained similar information from the nine contracted service providers.

In our work on expenses, the financial information we obtained included audited financial statements from all 14 CCACs, the Association, and the nine selected contracted service providers. We also reviewed expense components at all of these organizations. In addition, we looked at expense trends at the CCACs and the Association. Certain CCAC financial data is stored in the province's Management Information System (System), which classifies expenses into two major categories: patient services and administration. We compared a sample of cost categories recorded in audited financial statements to those in the System, and determined that the cost breakdown in the System was reasonable. We then used the data from the System for our analysis of expenses for direct patient care.

We performed additional detailed audit work at each of the three CCACs we visited. We reviewed a sample of service contracts and analyzed service-provider billing rates. We interviewed CCAC nurses, nurse practitioners and their supervisors, and reviewed pertinent documents, including job descriptions and provincial program guides on direct-nursing services. We also assessed how the CCACs measured program effectiveness. As well, we accompanied CCAC care co-ordinators on home visits to better understand the work they do.

In addressing the part of the Committee's motion relating to protocols for providing care, we obtained information on care protocols from all 14 CCACs. We also contacted all of the other Canadian provinces and territories, as well as Australia, Denmark, Sweden and the United Kingdom, to determine their use of care protocols, if any. The Ministry considered these countries as leaders in home-care delivery. We also obtained information from the nine selected contracted service providers about the protocols they used and their perspectives on implementing them.

### Figure 6: Community Care Access Centres and Contracted Service Providers Visited for this Audit

Prepared by the Office of the Auditor General of Ontario

Community Care Access Centres (CCACs)
Central CCAC
North East CCAC
Hamilton Niagara Haldimand Brant CCAC
Contracted Service Providers
Acclaim Health
Bayshore HealthCare
ParaMed Home Health Care, a division of Extendicare Inc.
Red Cross Care Partners
Revera Inc.*
Saint Elizabeth
St. Joseph's Home Care
VON (Victorian Order of Nurses)
We Care Home Health Services

\* During our audit, Revera Inc. sold its home health division to Extendicare Inc.

We met with the Ontario Nurses' Association, which represents most CCAC care co-ordinators in the province, and with the Ontario Health Coalition, which gave us its perspectives on CCAC service delivery.

Service providers supplied us with the financial information we requested, including executive- and nurse-compensation data. However, we cannot provide a high level of assurance on the accuracy and completeness of this information because we do not have the legislative authority to directly examine their financial records.

Our Office is currently conducting a separate audit focusing on aspects of CCAC home-care services beyond the areas identified in the Committee motion. We plan to include the results of this separate audit in our *2015 Annual Report*.

## 4.0 Summary

The Standing Committee on Public Accounts requested that our Office 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. Our observations are as follows:

- **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 in “direct patient care costs” only those activities that involve *direct interaction* with patients. Activities that might *influence* patient care but do not involve interaction, such as documenting patient care activity, travel and staff training, are excluded. 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. Because care-co-ordinator travel is inherent to

home and community care, and documenting patient care is required under professional practice standards, if these two components are included in direct patient care, 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, allocating 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. For non-CEO senior executives, there was a lack of consistency, 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 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. In some cases, they varied widely, 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. The establishment and widespread use of these pathways was intended to enable CCACs to shift from paying service providers hourly or per visit to paying them based on achieving the outcomes in time. This approach was to 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 found that the implementation of these tools did not always result in cost savings.

## OVERALL MINISTRY RESPONSE

The Ministry appreciates the Auditor General’s comprehensive audit of Community Care Access Centres. We commit to addressing all the recommendations directed to the Ministry, and to working with our partners in the home and community care sector to ensure an appropriate response to all the Auditor General’s recommendations.

Strengthening Ontario’s home and community care sector is one of the highest priorities of the Ministry’s *Patients First: Action Plan for Health Care* (Action Plan), released in February 2015. On May 13, 2015, the Ministry released *Patients First: A Roadmap to Strengthen Home and Community Care* (Roadmap), a new plan to improve and expand home and community care. This audit provides valuable observations and recommendations for the Ministry and its partners.

The May 2015 Roadmap includes 10 key initiatives intended to make it easier for patients and their caregivers to access better care at home and in the community. The Auditor General's recommendations are relevant to many aspects of the Ministry's initiatives and will be incorporated into project work plans and timelines.

A key theme in this audit is the careful stewardship of resources supported by taxpayers for the purpose of delivering health care at home. This is central to the goals outlined in the Action Plan and the Ministry appreciates the Auditor General's work and advice in this priority area.

### OVERALL RESPONSE FROM CCACs AND THE ASSOCIATION

Community Care Access Centres (CCACs) appreciate the Auditor General's time and effort in reviewing Ontario's home and community care sector. Building on work CCACs have begun and taking into account the valuable insights offered by the Auditor General will strengthen patient care.

CCACs are well positioned to transform the home and community care system. However, the legislative framework supporting CCACs has not changed in 20 years and has not evolved to reflect the increasing complexity of patient needs and higher volume. While funding for home and community care has been increasing over the last decade, there are historical discrepancies, which create inconsistency in patient care. Also, the way CCACs receive funding prevents effective planning of resources and multi-year forecasting. Progress in establishing new best practices for providing care is hampered by the inability to renegotiate contracts with service providers.

The number of acute-care hospital beds and complex-continuing-care beds in Ontario is lower today than it was 25 years ago. CCACs alleviate pressure on other institutions, where

the costs of providing care are much higher. So while most people prefer to receive care at home, there is also a fiscal benefit to taxpayers.

CCACs strongly believe there are many vital components to patient care. Because there is little insight into the operations of service providers, both non-profit and for-profit companies, it is more difficult to measure outcomes associated with some activities than others. In order to assess the full value for money on all the services provided to patients, greater transparency is required.

Following the recommendations outlined in the Auditor General's report will improve patient care and demonstrate the value for money that CCACs provide. CCACs will continue to work with the Ministry of Health and Long-Term Care, Local Health Integration Networks and all care partners to modernize Ontario's home and community care sector.

## 5.0 Detailed Observations

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

**SUMMARY:** *The Committee motion requested that we review expenses of the regional CCACs, the private-sector service providers contracted to the CCACs, and the Ontario Association of Community Care Access Centres.*

We compared the expenses of the CCACs and the Association between April 1, 2009, and March 31, 2014. We also examined the composition of service-provider expenses based on 2013 and 2014 data from nine service providers (discussed in **Section 5.3.1**).

The Ministry of Health and Long-Term Care provided \$2.4 billion in funding to CCACs in the year ending March 31, 2014.

This was 28% more than CCACs received in the year ending March 31, 2010, and was also greater than the funding increases to hospitals, long-term-care homes and the overall health system over the same period. The 14 CCACs reported an overall 26% increase in expenses in the same period. The largest expense component in their audited financial statements, at 62% of total CCAC expenses and totalling \$1.5 billion for the year ending March 31, 2014, was payments to contracted service providers. The second-largest component, at 20%, was the costs associated with CCAC care co-ordinators. The remaining 18% comprises costs associated with medical supplies and equipment, direct-nursing programs and in-house therapy services (totalling 10%), and administrative services (at 8%).

Service providers on average spent 82% of the funding they received on salaries and benefits for staff who directly delivered patient services, and on medical supplies and equipment (discussed in **Section 5.3.1**).

The Association's expenses increased by 6% over the same period. Most of the Association's expenses are for shared services, including maintenance of a centralized data system and development of standardized information reports.

### 5.1.1 CCACs' 2013/14 Expenses Up 26% Since 2009/10; Association Expenses Up 6%

Ministry funding to CCACs increased by 28% in the period between April 1, 2009, and March 31, 2014. This increase outpaced overall health-care spending in Ontario in the same period (funding to hospitals rose by 11%, to long-term-care homes by 19%, and to the overall health sector by 15%). This reflects the government's commitment to expand home and community care.

In the year ending March 31, 2014, using funding from the Ministry, the 14 CCACs spent a total of \$2.4 billion, up 26% from the \$1.9 billion spent

in the year ending March 31, 2010. During this year, as noted in their audited financial statements, CCACs spent 27% of their expenses on salaries and wages, 6% on medical supplies and equipment, 5% on overhead and 62% on contracted health-service providers. **Figure 7** shows the financial information recorded by CCACs in their audited financial statements and in the government's Management Information System (System) between 2009/10 and 2013/14.

A summary of the Association's audited statements of operations from the year ending March 31, 2010, to the year ending March 31, 2014, is shown in **Figure 8**. The Association receives 55% of its revenue from the 14 CCACs, 43% from the Ministry, and the remaining 2% from conference fees and interest.

In the year ending March 31, 2014, the Association recorded in its audited financial statements about \$40 million in expenses, representing a 6% increase from the year ending March 31, 2010. Salaries and benefits were about \$20 million (including executive-, administrative-, and project-staff compensation). The Association spent most of its remaining funding on information technology.

### 5.1.2 CCACs Spent More Than 60% of Total Expenses on Contracted Service Providers

In the year ending March 31, 2014, about 62% of CCAC expenses were for contracted health-service providers. The 14 CCACs paid them a combined total of about \$1.5 billion to supply nursing, personal support and therapy services to Ontarians, up 28% from the year ending March 31, 2010. Contracted service providers can then use this funding to deliver patient services, and pay for compensation and expenses of executives and, in some cases, board members (see **Section 5.3**). With this increase in funding, under direction from CCACs, service providers delivered 35% more hours of care and 10% more service visits to 14% more clients than they did in the year ending March 31, 2010. The number of patients assessed as having high

needs also increased in this period: the number of chronic patients (patients with conditions or diseases that are persistent or otherwise long-lasting in their effects) increased by 89% to 97,000, and the number of complex patients (patients whose conditions require complex continuous care and frequently require services from different practitioners in multiple settings) increased by 77% to 33,000.

CCACs spent the remaining 38% of their expenses on their own staff, including care co-ordinators, nurses and therapists, and administrative and executive staff, medical supplies and equipment, and overhead. (We discuss compensation of CCAC executive staff in **Section 5.2**).

CCACs' expenses are discussed in more detail in **Section 5.3.2**.

### 5.1.3 LHINs Inform CCACs of Annual Funding Late in the Year

To effectively plan how to spend provided funds and ensure they do not run deficits, CCACs need to know at the beginning of each fiscal year how much money they have to spend in the upcoming year. However, LHINs do not confirm final funding for CCACs until well into the year.

Each CCAC's annual funding is based on the amount it received the year before. In their agreements with CCACs, LHINs indicate the forecasted funding amounts for the next two years. But the decisions LHINs make to plan for their region's health-care services can result in that amount being increased or decreased depending on region-specific priorities and ministry commitments and

**Figure 7: Summary Financial Information Recorded in the Audited Financial Statements and the Management Information System for all CCACs, 2009/10–2013/14 Fiscal Years<sup>1</sup>**

Sources of data: All CCACs

	Amount (\$ million)					% of Total	Overall Increase (%)
	2009/10	2010/11	2011/12	2012/13	2013/14		
Revenue per audited financial statements	1,888	1,996	2,116	2,201	2,389	–	27
Expenses per audited financial statements (A)	1,894	1,976	2,118	2,203	2,390	100	26
Purchased services	1,164	1,195	1,315	1,374	1,488	62	28
Salaries, wages and benefits	482	520	548	572	631	27	31
Other	248	261	255	257	271	11	9
Surplus/(Deficit) <sup>2</sup> per audited financial statements	(6)	20	(2)	(2)	(1)	–	78
Expenses per Management Information System (B)	1,880	1,961	2,098	2,183	2,368	100	26
Patient services	1,709	1,776	1,912	1,993	2,172	91	27
Overhead	171	185	186	190	196	9	15
Difference between expenses reported in audited financial statements and Management Information System <sup>3</sup> (A) – (B)	14	15	20	20	22	–	n/a

1. Each fiscal year begins on April 1 and ends on March 31.

2. Individual CCACs can report deficits in their audited financial statements, even though the Local Health Integration Networks, which provide ministry funding to CCACs, require that CCACs balance their budgets annually. The Ministry uses different accounting criteria than financial-statement auditors use when determining whether CCACs have balanced their budgets. Therefore, a deficit reported by a CCAC does not necessarily mean that the CCAC did not balance its budget.

3. The differences are due to numbers being aggregated differently in the Management Information System (System) than they would be under generally accepted accounting rules used in the audited financial statements. The System allows expenses to be reported net of any recoveries; the audited financial statements do not.

**Figure 8: Ontario Association of Community Care Access Centres' Summary Audited Statements of Operations, 2009/10–2013/14**

Source of data: Ontario Association of Community Care Access Centres

	(\$ 000)					Overall Increase/ (Decrease) (%)
	2009/10	2010/11	2011/12	2012/13	2013/14	
<b>Total Revenue (A)</b>	37,742	37,102	38,745	40,545	40,057	6
Expenses						
Salaries and benefits*	10,884	15,545	19,479	20,168	19,765	82
Shared-technology services*	10,629	8,205	8,155	8,897	6,949	(35)
Business-technology infrastructure*	10,496	9,789	8,759	9,625	10,354	(1)
Other*	5,505	2,658	1,736	1,632	2,821	(49)
<b>Total Expenses (B)</b>	37,514	36,197	38,129	40,321	39,889	6
Surplus (A - B)	228	905	616	223	168	(26)

\* The Office of the Auditor General of Ontario reallocated some of these expenses to make the five years of data consistent and comparable. Actual amounts presented in audited financial statements will differ.

initiatives. When the fiscal year begins on April 1, those decisions are not finalized, but CCACs must proceed with their operations regardless. In 2013 and 2014, some CCACs were not informed of funding changes until October—or even later—less than six months before the end of the fiscal year on March 31. In one case, a CCAC was notified of changes to its funding for a fiscal year just three weeks before that fiscal year ended.

## 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.

## MINISTRY RESPONSE

The Ministry agrees with this recommendation. The majority of CCAC funding is a base budget that continues from one year to the next. The Ministry will review its business processes to

identify opportunities to finalize allocations earlier, and will work with the Local Health Integration Networks to confirm funding amounts for CCACs as early as possible in the fiscal year.

## RESPONSE FROM CCACs

CCACs fully support the recommendation that CCACs' annual funding be received as early as possible in, or before the beginning of, the fiscal year. Funding is often targeted, one-time only and not reflected in increases to base funding. These are some of the factors that have led to historical discrepancies, and which can lead to inconsistency in funding available for patient care. Certainty in funding would enable strategic innovation to implement real change in the delivery of services to patients. Inequity in funding levels, compounded when service enhancements are spread across regions unevenly, creates ongoing challenges regarding equitable access to care. CCACs believe patients would be better served if the province would provide multi-year allocations to ensure CCACs have the ability to plan and deliver sustainable care.

## 5.2 Executive Compensation, Executive and Board Expenses

**SUMMARY:** *The Committee motion requested that we review executive compensation practices, including expenses of executives and board members of the CCACs and of those private-sector organizations contracted to the CCACs.*

We compared the compensation amounts and compensation frameworks for chief executive officers (CEOs) and senior executives at CCACs and their equivalents at the nine contracted service providers we visited. We also compared the reimbursement of expenses to executives and board members in CCACs and service providers.

Although CCACs and service providers both serve patients receiving care at home or in the community, they are structured differently. CCACs are not-for-profit provincial government organizations that employ mostly care co-ordinators (nurses, social workers and other professionals) and contract-management staff who direct and oversee the contracted home-care services delivered to Ontario patients. Service providers, on the other hand, are private-sector entities, either for-profit or not-for-profit, under contract to CCACs. Some service providers are sole-proprietor businesses. In addition to providing nursing, personal support and therapy services to patients on behalf of CCACs, some also operate in other lines of businesses not related to CCACs, some of which are in other provinces or countries. Because of these differences, the executive team structure and the executive staff responsibilities of service providers can differ considerably from those of CCACs. We found that, on average, CCACs pay their executives more than service providers do. But their roles are not exactly comparable, as CCACs and service providers vary in size, mandate and geographic service area. For example, among the 14 CCACs, the

average number of staff the CEO manages is 470. Among the nine service providers we visited, the number of staff the CEO-equivalent manages ranges from 62 to 4,800.

In 2012, an external consultant developed a compensation framework that was intended to help CCAC boards of directors follow a common approach to compensating CCAC CEOs. The framework spelled out such compensation components as salary ranges and performance pay. At the time of our audit, all 14 CCACs had agreed to compensate their executives according to the framework, but three had not yet implemented it and were therefore still compensating their executives according to their own policies. For non-CEO senior executives, there is no single compensation framework across the 14 CCACs. We did find, however, that 11 CCACs had compensation studies supporting their senior executive compensation.

Board members at CCACs are volunteers and do not receive compensation for their work, but they can claim for the expenses they incur in their work. In the year ending March 31, 2014, the CCACs we visited reimbursed an average of \$1,600 per board member in meal and travel costs. Many of the service providers we contacted either did not reimburse any expenses in the year ending March 31, 2014, or appointed board members from among their salaried staff with no policy for reimbursing expenses.

### 5.2.1 Only Limited Comparison of CCAC and Service-provider Executive Compensation Is Possible

Executives at CCACs and at service providers have different responsibilities and oversee different types of organizations; therefore, the executive compensation practices of CCACs and their service providers are different.

Each CCAC is a not-for-profit provincial government organization governed by a volunteer board of directors. The CEO of a CCAC oversees the organization's day-to-day operations and is accountable to the board of directors. CEOs are responsible for staff employed directly by their CCAC and accountable to the public for the contracted services performed by service providers. Among the 14 CCACs, the average number of staff the CEO manages was 470 as of March 31, 2014.

Contracted service providers vary far more widely in their structure, responsibilities and size. They include large organizations that serve several different CCACs (and in some cases operate across Canada, and may also have other lines of business), as well as smaller entities that serve a single geographic area. Of the nine service providers we visited, five are for-profit organizations, unlike the CCACs.

It would be unreasonable to compare the CEOs of these larger national organizations with the CEO of a CCAC because the service-provider CEO would oversee additional business beyond providing contracted health-care services in Ontario. CEOs of large national organizations are paid higher salaries than CCAC CEOs. For instance, the CEO of one large multinational service provider we visited earned almost \$1 million in 2013.

A more reasonable comparison of executives at CCACs and service providers would be between a CCAC CEO and the person at the service provider in charge of business with CCACs in Ontario. This CEO-equivalent's actual title at the service provider is often not "CEO," but "senior vice president," "district executive director" or some other designation. We note here that, among the nine service providers we visited, the number of staff the CEO-equivalent manages ranges from 62 to 4,800 (compared to the CCAC CEO average of 470). In **Section 5.2.2**, we compare the salaries of CCAC CEOs and service-provider CEO-equivalents. Also, not all service-provider CEO-equivalents are directly accountable to the organization's board of directors as CCAC CEOs are.

## 5.2.2 CCAC CEOs and Service-provider CEO-equivalents Differ in Average Salaries, Rates of Salary Increases, Performance Pay and Pensions

In 2013, the 14 CCACs paid their CEOs an average of about \$249,000, representing a 27% increase from 2009, as shown in **Figure 9**. The CEO pay-outs in the years between 2009 and 2013 included base salary and performance pay, as well as one-off payments such as signing bonuses, vacation pay, and severance pay where applicable. The average CEO payout in 2014 was almost identical to that in 2013.

When these one-off payments are excluded, the average compensation for CCAC CEOs in 2013 was \$245,300, still a 27% increase from 2009. Compensation for other CCAC senior executives, not including CEOs, increased by 16%, to \$156,000 over the same period.

We obtained the salaries of CEO-equivalent and non-CEO senior executives between 2011 and 2013 from the nine service providers we visited. According to them, the average compensation of their CEO-equivalent increased by 5%, and their non-CEO senior executives increased by 11%, over that period. In comparison, over the same period, CCAC CEOs compensation increased by 9% and CCAC non-CEO senior executive compensation increased by 11%, as shown in **Figure 10** and **Figure 11**.

**Figure 12** summarizes the differences in compensation and benefits between the CEOs and senior executives at the 14 CCACs and the nine service providers we visited. Service providers supplied us with the compensation data for the individuals they determined to be equivalent in position to the CCAC CEO and non-CEO senior executive positions. We noted that, according to this data, CCACs' compensation was 43% higher for CEOs and 21% higher for senior executives than service providers' compensation for the equivalent positions in 2013. However, as noted earlier, their roles are not exactly comparable.

We also found that CCACs in 2013 offered a lower percentage of base salary as performance

**Figure 9: CCAC CEO Payouts<sup>1</sup> Before Taxable Benefits, 2009–2013**

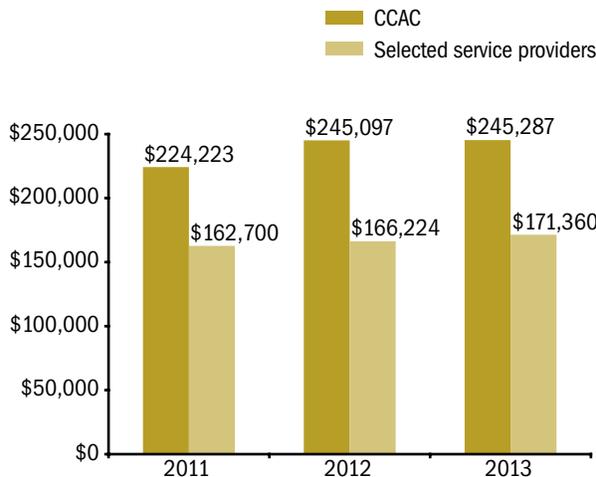
Source of data: Ontario Association of Community Care Access Centres

CCAC	CCAC Complexity Level <sup>2</sup>	2009 (\$)	2010 (\$)	2011 (\$)	2012 (\$)	2013 (\$)	Overall Increase/ (Decrease) (%)
Champlain	5	183,526	301,666	248,686	247,861	314,991	72
Hamilton Niagara Haldimand Brant	5	213,167	250,053	250,053	265,949	300,050	41
South West	5	217,587	259,616	250,000	267,501	288,463	33
North East	— <sup>3</sup>	227,710	248,149	248,142	260,323	288,000	26
Central	5	180,006	302,321	260,011	260,011	277,610	54
Central West	3	186,721 <sup>4</sup>	205,867	224,569	243,159	267,333	43
Mississauga Halton	3	201,492	382,014	227,136	229,895	246,002	23
South East	3	174,462	185,096	340,167	351,539	235,238	35
Toronto Central	5	188,419	260,067	232,517	233,380	233,539	24
Waterloo Wellington	3	227,994	172,572	234,876	548,924	225,951	(1)
Erie St. Clair	3	169,192	220,752	220,752	220,752	220,752	30
North West	— <sup>3</sup>	173,013	177,996	180,546	208,774	204,691	18
North Simcoe Muskoka	2	223,974	199,877	199,877	210,678	200,002	(11)
Central East	— <sup>3</sup>	181,954	182,702	180,769	182,161	181,891	0
<b>Average</b>		<b>196,373</b>	<b>239,196</b>	<b>235,579</b>	<b>266,493</b>	<b>248,894</b>	<b>27</b>

1. Includes base salary, performance pay, signing bonus, vacation pay, and severance pay if applicable.
2. Under a compensation framework established in March 2012, CCAC CEO salary ranges were aligned with the complexity level of the CCAC (with level 1 least complex and level 5 most complex). CCAC boards determined complexity based on factors like size of the CCAC's budget, number of employees, number of patients served and population diversity. See Section 5.2.3 for more detail.
3. The compensation framework had not been implemented by the CCAC at the time of our audit, so the complexity level was not determined.
4. Includes \$59,220 of consulting fees (as opposed to salary) paid to an interim CEO.

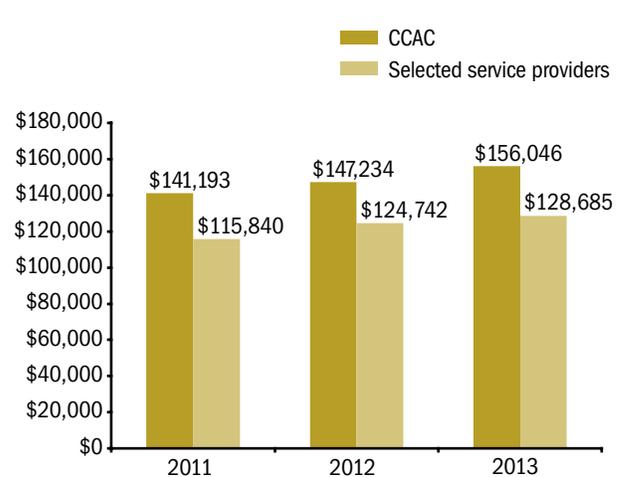
**Figure 10: Average Annualized Salaries of 14 CCAC CEOs and Nine Service-provider CEO-equivalents, 2011–2013**

Sources of data: All CCACs and selected service providers



**Figure 11: Average Annualized Non-CEO Senior Executives' Salaries at 14 CCACs and Nine Service Providers, 2011–2013**

Sources of data: All CCACs and selected service providers



**Figure 12: Summary of Differences in Compensation and Benefits Between CCACs and Selected Service Providers, 2013**

Sources of data: All CCACs and selected service providers

	14 CCACs	Nine Service Providers
Average CEO or CEO-equivalent annualized salary, including performance pay, but excluding taxable benefits	\$245,300	\$171,400
Annual maximum performance pay allowed for CEOs or CEO-equivalents	19% of base salary	40% of base salary*
Average non-CEO senior executive annualized salary, including performance pay, but excluding taxable benefits	\$156,000	\$128,700
Annual maximum performance pay allowed for non-CEO senior executives	4% of base salary	35% of base salary*
Pension plan	Healthcare of Ontario Pension Plan (HOOPP), a defined-benefit plan	Mix of no pension, defined-benefit plan, and defined-contribution plan
Perks	<ul style="list-style-type: none"> <li>• 5 CCACs gave their CEOs car allowances ranging from \$7,800 to \$10,200 per year.</li> <li>• 1 CCAC also gave its CEO a travel allowance of at least \$9,000 per year with no cap.</li> <li>• 8 CCACs did not pay any car allowances.</li> </ul>	<ul style="list-style-type: none"> <li>• 4 service providers gave their CEO-equivalents car allowances ranging from \$6,000 to \$20,400 per year.</li> <li>• 5 service providers did not pay any car allowances.</li> </ul>

\* Based on data from eight of the nine service providers; one service provider reported that it did not pay its executives bonuses for performance.

pay for both their CEOs and senior executives compared to the eight service providers that offered performance pay.

With respect to pensions, CCAC employees are members of a defined-benefit pension plan called the Healthcare of Ontario Pension Plan. Pension plans varied at the selected service providers, and some did not have pension plans.

### 5.2.3 Three CCACs Did Not Follow Common CEO Compensation Framework

Initially, the Ministry set the compensation framework for CCAC CEOs. The *Community Care Access Corporation Act* was amended in 2006 to allow CCACs to independently establish their CEO salaries and benefits beginning April 1, 2009. Six CCACs developed their own compensation frameworks (either internally or with the help of a consultant), while eight purchased and agreed to follow a

common consultant-developed framework called the *Executive Director Compensation Review*. In 2012, a compensation framework called *Principles and Guidelines for CCAC CEO Compensation* was developed by an external consultant engaged by a group of CCACs, so that all their boards of directors would handle their CEO compensation (including salary ranges and performance pay) uniformly and consistently. Between 2009 and 2013, CCACs and the Association had spent a total of about \$360,000 to purchase compensation frameworks.

**Figure 13** shows the CCAC CEO salary ranges in effect between 2009 and 2013 under the *Executive Director Compensation Review* (May 2008 and December 2008) and the *Principles and Guidelines for CCAC CEO Compensation* (March 2012).

The maximum CCAC CEO salary amount in the recommended ranges increased from \$180,000 before April 2009 to \$226,000 for some and \$260,000 for others in April 2009, and then again

to \$351,000 in January 2012. In effect, the top of the CCAC CEO salary range increased by 95% from 2009 to 2013. However, because no CCAC CEO was paid at the top of the salary range in 2013, none of the CCAC CEOs had a 95% pay increase between 2009 and 2013. The largest pay increase over that period was about 70%.

While all 14 CCACs agreed to put in place the common CEO compensation framework, one was still in the process of implementing it but had not completed doing so, and two had not yet implemented it at the completion of our audit. One CCAC that had not implemented it believed this framework did not fairly take into account the unique environment it operated in (it was located in a designated bilingual area and had an Aboriginal population). Nevertheless, the 2013 salary of this CCAC's CEO was within the overall pay range recommended in the framework.

Under the framework, the salary range of a CCAC CEO was to be aligned with the complexity level of each CCAC. As **Figure 14** shows, five levels of complexity were established, with level 1 being the least complex and level 5 the most. The corresponding salary ranges were based on CEO compensation in what the external consultant considered to be comparable entities, including community, complex-continuing-care, and rehabilitation hospitals. **Figure 9** shows the complexity level of each CCAC, determined by each CCAC's board using factors such as size of budget, number of health-care professionals employed, number of patients served, and population diversity. Of the CCACs that had implemented the framework at the time of our audit, one was classified as level 2, five as level 3, and five as level 5. The framework provided for up to 10% of the base salary to be designated as “pay-at-risk” (meaning that up to 10% of the base

**Figure 13: Recommended CCAC CEO Salary Ranges, with Average, Minimum and Maximum Actual Annualized Salaries, 2009–2013**

Sources of data: Ontario Association of Community Care Access Centres, all CCACs

Year	Salary Range Recommended (\$)	Authority	# of CCACs that Accepted the Framework (out of 14)	Actual Annualized CEO Salaries (\$ 000)		
				Avg.	Min.	Max.
2009	Before April 1: 160,000–180,000	Ministry of Health and Long-Term Care	14/14			
	After April 1: 166,000–226,000	<i>Executive Director<sup>a</sup> Compensation Review (May 2008)</i>	3/14 <sup>b</sup>	192	169	229
	170,000–260,000	<i>Executive Director<sup>a</sup> Compensation Review—Revised (December 2008)</i>	5/14 <sup>b</sup>			
2010	166,000–226,000	<i>Executive Director<sup>a</sup> Compensation Review (May 2008)</i>	4/14 <sup>b</sup>	215	179	270
	170,000–260,000	<i>Executive Director<sup>a</sup> Compensation Review—Revised (December 2008)</i>	4/14 <sup>b</sup>			
2011	166,000–226,000	<i>Executive Director<sup>a</sup> Compensation Review (May 2008)<sup>b</sup></i>	4/14 <sup>b</sup>	224	181	260
	170,000–260,000	<i>Executive Director<sup>a</sup> Compensation Review—Revised (December 2008)</i>	4/14 <sup>b</sup>			
2012	145,000–319,000	<i>Principles and Guidelines for CCAC CEO Compensation (2012)</i>	14/14, but 3 had not yet implemented it as of January 2015	245	182	275
2013	145,000–319,000	<i>Principles and Guidelines for CCAC CEO Compensation (2012)</i>	14/14, but 3 had not yet implemented it as of January 2015	245	182	300

a. Prior to 2009, the top executive position at CCACs (now known as Chief Executive Officers) was titled Executive Director.

b. The remaining six CCACs developed their own compensation frameworks instead of accepting the recommendations of the *Executive Director Compensation Review (May 2008)* or *Executive Director Compensation Review—Revised (December 2008)*.

**Figure 14: Salary Bands and Organization Complexity Level for CEOs of CCACs**

Source of data: Ontario Association of Community Care Access Centres

Organization Complexity Level	Base Salary (\$ 000) <sup>1</sup>			Target Total Compensation (\$ 000) <sup>2</sup>		
	Minimum	Median	Maximum	Minimum	Median	Maximum
5	236	278	319	260	306	351
4	209	246	283	230	271	311
3	185	218	250	204	240	275
2	164	193	222	180	212	244
1	145	171	196	160	188	216

1. As explained in this section, up to 10% of the base salary can be withheld, only to be paid if the CEO achieves certain expectations. The CCAC's board decides whether to apply the pay-at-risk option and what percentage (up to 10%) to withhold. The base salary amounts in this figure are what CEOs are paid if nothing is withheld—that is, if boards do not apply the pay-at-risk option, or if they do and the CEO achieves all expectations.

2. As explained in this section, up to 10% of the base salary can be added to the CEO's compensation as performance pay. Again, the CCAC's board decides whether to apply the performance-pay option and what percentage (up to 10%) to add. The target total compensation amounts in this figure include an additional 10% of base salary as performance pay.

salary is withheld, to be paid only when the CEO achieves pre-determined expectations each year), plus an additional performance payment of up to 10% of the base salary for CCAC CEOs who achieve “significant strategic and operational goals.” Each CCAC board may determine to apply pay-at-risk or performance pay, or both. Therefore, the maximum compensation amount that a CEO can earn in a level 5 CCAC is \$351,000 a year, compared to \$244,000 a year for the CEO of a level 2 CCAC.

The *Broader Public Sector Executive Compensation Act, 2014* came into force on March 16, 2015, subsequent to the completion of our audit. This Act enables the government to establish compensation frameworks for executives such as CEOs and vice presidents at designated broader-public-sector entities, including CCACs. It is unclear whether the CCAC CEO compensation framework will change as a result of this.

CCACs follow different compensation frameworks for non-CEO senior executives. There is no single standard compensation framework for non-CEO senior executives across the CCACs, which average five senior executives each. Non-CEO senior executives carry titles such as senior directors and vice presidents, and they manage various operational areas, including corporate services, client services, and quality and performance management. The CEO determines compensation for

these senior executives, with consideration given to the geography, market rates and comparable compensation in other similar organizations. Across the 14 CCACs, three did not have any compensation study supporting their senior executive compensation, and 11 did. Of those 11, two followed two different compensation studies and are using those; the remainder did not. The overall pay range in 2013 for the 14 CCACs' senior executives was \$118,000 to \$190,000.

#### 5.2.4 Service Providers Used Different Compensation Frameworks

Overall, CEO-equivalent and senior executive compensation practices varied among the nine service provider organizations we visited during the audit. Six followed compensation frameworks for their executives (both CEO-equivalents and senior executives), and three did not.

Since service providers are independent businesses that have other sources of revenue besides funding from CCACs, their CEO and senior executive compensation frameworks are different from the CCACs'. Some of the differences in service providers' compensation policies include remunerating employees based on employee experience and using market salary rates that are updated at various times. In comparison, the CCACs' CEO

compensation framework states that CEO remuneration is based on organizational complexity and achievement of expectations and significant goals, and does not specify when the salary ranges will be reviewed again.

### 5.2.5 Reasons Why Various CCAC CEO Compensation Actions Were Taken Are Unclear

CCAC CEOs' salaries are fully funded by Ontario taxpayers. We noted the following instances where it was not clear why some CEOs of CCACs received certain compensation amounts. These examples demonstrate inconsistent practices in compensating CCAC CEOs, both before and after the implementation of the common CEO compensation framework:

- One CEO received a signing incentive payment of \$45,000 in 2009, representing 25% of base salary that year. This is significantly higher than the signing incentive payment of 8% of base pay that was paid to the CEO of another CCAC in 2010. The board of directors in the first case did not document the criteria used to arrive at the 25% incentive but explained to us that the CEO received the signing incentive payment so that his full salary in that year would be consistent with that of other CCAC CEOs.
- One board of directors approved giving its CEO a performance payment of \$38,300—the maximum allowable under the CEO's contract—for the year ending March 31, 2010, even though the CEO did not achieve the highest performance rating.

We also noted three cases where CCAC boards of directors approved increases, but their CEOs declined them:

- One CEO declined a board-approved salary increase of \$50,000 in July 2013 and performance payments of about 7% for 2012/13 and 10% for 2013/14, saying the money should instead be available to other staff in the CCAC.

- Another CEO declined a performance payment of more than \$15,000 in 2013/14, citing the need for prudence in the fiscal environment at the time.
- A third CEO declined performance payments in 2012/13 and 2013/14, also citing the need for prudence in the fiscal environment at the time. The CCAC did not calculate how much the payments would have been.

## 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.

## MINISTRY RESPONSE

The *Broader Public Sector Executive Compensation Act, 2014* (the Act), was proclaimed into force on March 16, 2015. This Act enables the government to establish compensation frameworks for executives such as CEOs and vice presidents at designated broader-public-sector entities, including CCACs. The Ministry will work with the Local Health Integration Networks and other partners to ensure that there is a common and accepted CEO compensation framework in place for all 14 CCACs.

## RESPONSE FROM CCACs

In April 2014, CCACs adopted a common CEO compensation framework developed by external experts and based on market compensation across the broader public sector. As of April 2015, all 14 CCACs are consistent with the common framework. CCACs look forward to working with the government in the implementation of the *Broader Public Sector Executive Compensation Act, 2014*.

### 5.2.6 CCAC Executives Incurred Fewer Expenses than Service-provider Counterparts

We noted that executives at the nine service providers we visited on average incurred higher expenses than their counterparts at CCACs because they often had to travel greater distances to perform their jobs, with some serving more than one CCAC. We found that these higher expenses were reasonable under the circumstances.

In the year ending March 31, 2014, CEOs at the CCACs we visited claimed an average of \$8,300 in expenses each, compared to an average of \$11,000 claimed by their service-provider counterparts. Similarly, CCAC non-CEO executives claimed an average of \$11,000 each in expenses, compared to \$16,000 each for their counterparts at service providers. Expenses claimed by executives at both the CCACs and service providers included travel, accommodation, meals, workshops, conferences and courses.

We also looked at expense reimbursements for boards of directors of CCACs and service providers, but we could not make a reliable comparison because many of the service providers we contacted either paid no expenses in the year ending March 31, 2014, or do not generally reimburse directors for expenses because they are internal employees. The CCACs we visited reimbursed an average of only \$1,600 per board member in meal and travel costs in the year ending March 31, 2014.

## 5.3 Direct Patient-care Costs

**SUMMARY:** *The Committee motion requested that we review the operating costs of the CCACs.*

In reviewing CCACs' operating costs, we looked at the breakdown of costs between direct patient-care costs and costs not directly associated with patient care. To do this, it was necessary to review how the term "direct patient care" is defined in the health-care

sector and what specific costs are included in this definition. How one defines direct patient care is significant. Depending on the definition used, in the year ending March 31, 2014, CCACs, including their contracted service providers, spent anywhere from 71.5% to 92% of their expenses on direct patient care.

Under the CCACs' definition of direct patient care, which is derived from provincial guidelines, 92% of CCACs' total expenses are considered to be "direct patient-care costs." To arrive at this figure, CCACs include their direct nursing costs and the costs of care coordinators, whose functions do not always involve direct *interaction* with patients but can *influence* patient care. Appropriately, the CCACs exclude their own overhead costs in their direct patient-care costs. However, they also include the *full amount* they pay to service providers, some of which goes to service providers' overhead and profit. (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.) In other words, while the CCACs separate out non-direct patient-care costs (overhead) from the portion of total expenses that apply to their own operations, they do not follow the same logic by separating out non-direct patient-care costs (overhead and profit) from the portion of total expenses that they pay service providers. When service-provider overhead and profit are excluded in determining direct patient-care costs, CCACs spend 81% (rather than 92%) of their expenses on direct patient care under the definition derived from the provincial guidelines.

Under a narrower definition, where direct patient services include only those activities involving direct patient contact, the percentage of CCAC spending attributable to direct patient care falls to 71.5%.

Because care-co-ordinator travel is inherent to home and community care, and documenting patient-care activity is required by professional practice standards, these activities could be considered to be part of direct patient care even though they do not involve direct patient interaction. Once they are included in direct patient care, the percentage of expenses that CCACs spent on direct patient care for the year ending March 31, 2014, rises to 72%.

Given that most CCAC operating costs are payments to service providers, we also looked at how much of these payments service providers spent on direct patient care versus other cost components. Once overhead costs are excluded, service-provider activities involve only direct contact with patients. Using the narrower definition, we found that *service providers* on average spent 82% of CCAC payments they received on direct patient care.

Regardless of the definition used, the proportion of funding that goes to direct patient care is only relevant if we know what kinds of patient care are most likely to achieve 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, allocating sufficient resources and funds to the most effective patient-care activities.

### 5.3.1 Service Providers Spent 13% of CCAC Payments on Administrative Expenses and Retained 5% on Average as Profits

In addressing the Committee's concern that part of CCACs' funding to service providers could be for purposes other than providing direct patient care, we examined the composition of the costs for a

sample of service providers. We received financial information from nine service providers (of those, five operate on a for-profit basis). Based on either the 2013 or 2014 financial information they submitted to us, the breakdown for the service providers is as follows:

- 82% of the funding they received from CCACs was spent on direct patient services, comprised mostly of salaries of nurses and personal support workers, and medical supplies and equipment used for patient care.
- 13% was spent on indirect expenses such as executive and administrative staff salaries, and other administrative expenses.
- 5% went to profit (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). The operating-profit margin on CCAC-funded services ranged from 3% to 14% among eight of the nine service providers. One service provider reported a loss of 14% on CCAC work. This result is reasonable when compared with observations made in an assessment report commissioned by the Association, released in September 2014, that examined the fee-for-service market. The report noted that Ontario's home- and community-care service providers' operating margins ranged from -4.80% (representing a loss) to 12.75%. Some service providers have other lines of business that might offset their losses from CCAC work.

It is important to note that, although service providers voluntarily submitted financial information to us in a cost-reporting template that we developed to facilitate this analysis, we are unable to provide a high level of assurance on this information. Because we do not have the legislative authority to directly audit the contracted private-sector contractors that sold services to the CCACs, we were not able to perform audit procedures to verify the accuracy of this information.

### 5.3.2 Definition of Direct Patient Care Affects the Calculation of Direct Patient-care Costs

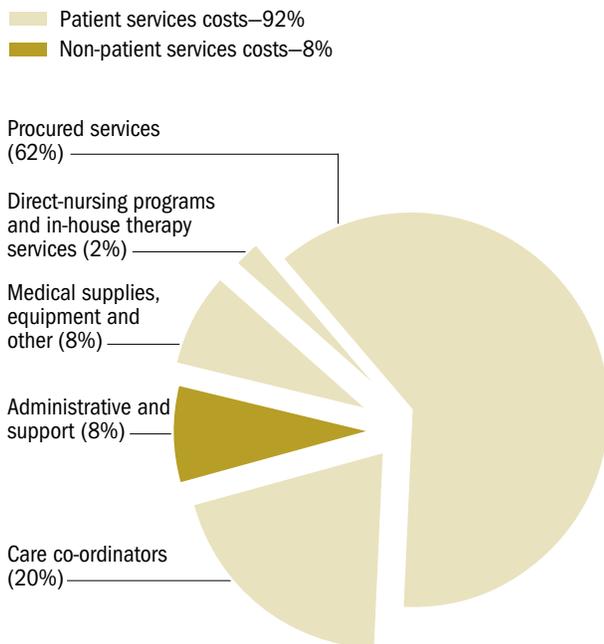
Figures 15a and 15b provide a breakdown of total CCAC expenses by category for the year ending March 31, 2014. Overall, 62% of expenses goes to services procured from service providers, 30% to internal CCAC staffing and administrative costs, and 8% to medical supplies and equipment. All of these amounts include direct patient-care costs. To determine exactly how much is spent on “direct patient care,” it is first necessary to define that term.

#### Definition of Direct-care Costs Varies within the Health-care Sector

Within the health-care sector, there is not a uniform, agreed-upon definition of the term “direct care.” Definitions vary. Sometimes “direct care” implies direct interaction with patients, while other definitions suggest activities that have a direct influence on patient care.

**Figure 15a: Costs of Patient and Non-patient Services, as Defined by CCACs, Year Ending March 31, 2014**

Sources of data: Ontario Association of Community Care Access Centres, all CCACs

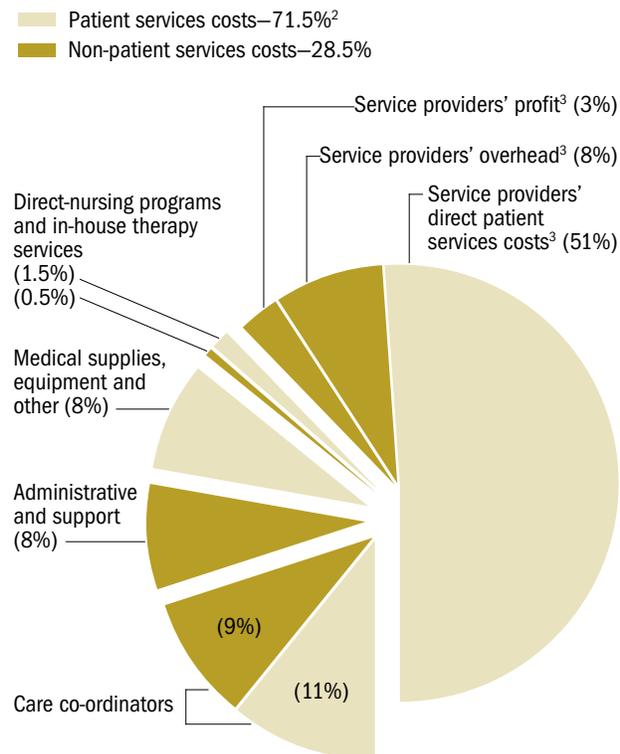


CCACs and their Association define direct patient care as “all costs incurred by CCACs to care for patients safely in their homes and communities. This care, delivered by CCAC staff and contracted service providers, includes care co-ordination, nurse practitioner services, pharmacist services, information and referral services, personal care, nursing, physiotherapy, occupational therapy, dietetics, social work, speech and language pathology, as well as medical supplies and equipment.”

In developing this wording, the CCACs treated all client services as defined in the Ministry’s reporting guidelines as direct patient care. The ministry reporting guidelines are derived from

**Figure 15b: CCAC Costs for Patient and Non-patient Services, Under Alternative Definitions<sup>1</sup> of Patient Services, Year Ending March 31, 2014**

Sources of data: Ontario Association of Community Care Access Centres, all CCACs



1. Refer to Definitions 3 and 4 in Figure 16.
2. Percentage of patient services costs increases to 72% if care co-ordinator travel and documenting patient care activities are classified as patient services.
3. Breakdown based on information submitted by nine selected service providers accounting for 69% of all CCAC-procured direct services in the year ending March 31, 2014. Service providers retained an average profit of 5% (see Section 5.3.1); 3% represents the profit as a percentage of total CCAC expenditures.

the national health-care information reporting system developed by the Canadian Institute for Health Information, a national agency funded by federal and provincial governments that gathers and reports information and statistics on health care. In this reporting system, health-care entities report their costs under the categories of administrative and support services, and inpatient or client services. In compliance with ministry reporting guidelines, CCACs and their Association consider inpatient or client services as direct patient-care costs; in other words, they use the broadest definition of direct-care costs, which extends beyond direct interaction with patients.

**Figure 16** summarizes the different definitions used by other health organizations, including the American Association of Critical-Care Nurses and the American Physical Therapy Association, as well as the definition in the *Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health*. With the exception of the American Physical Therapy Association (which uses a definition consistent with that used by CCACs), all other sources we examined use a narrower definition of direct care, which is limited to only direct contact or interaction with patients.

**Figure 16: Various Definitions for Direct and Indirect Care Costs**

Sources of data: Ontario Association of Community Care Access Centres, CCACs, selected medical literature, and associations

	Included in Patient Services Costs?			
	Definitions			
	1	2	3	4
Profit earned and overhead expenses incurred by service-provider organizations	Yes	Yes	No	No
Costs incurred by service providers that directly affect patients	Yes	Yes	Yes	Yes
Continuing education, travel, professional membership, telecommunications, office supplies, equipment—care co-ordinators	Yes	Yes	No	No
Presentations in community—care co-ordinators	Yes	Yes	No	No
Maintaining patient records—care co-ordinators	Yes	Yes	No	No
Assistants to care co-ordinators	Yes	Yes	No	No
Managers of care co-ordinators	Yes	Yes	No	No
Relationship building, maintaining patient records—direct nursing programs	Yes	Yes	No	No
Medical supplies and equipment	Yes	Yes	Yes	Yes
Direct interaction with patients—direct nursing programs	Yes	Yes	Yes	Yes
Direct interaction with patients—care co-ordinators	Yes	Yes	Yes	Yes
Administrative and support activities such as building occupancy	No	No	No	No
% of direct patient services in total expense	92	92	71.5	71.5

**Definitions:**

1 – Direct patient care: all costs incurred by CCACs to care for patients safely in their homes and communities. This care, delivered by CCAC staff and contracted service providers, includes care co-ordination, nurse practitioner services, pharmacist services, information and referral services, personal care, nursing, physiotherapy, occupational therapy, dietetics, social work, speech and language pathology, as well as medical supplies and equipment.

(Source: CCACs and Ontario Association of Community Care Access Centres)

2 – Direct patient care: the activities in which a therapist participates that have a direct influence on the care of a specific patient or client.

(Source: American Physical Therapy Association)

3 – Direct patient care activities assist the patient in meeting basic needs.

Indirect patient care activities focus on maintaining the environment in which nursing care is delivered and only incidentally involve direct patient contact.

(Source: American Association of Critical Care Nurses)

4 – Direct care: the provision of services to a patient that require some degree of interaction between the patient and the health-care provider. Examples include assessment, performing procedures, teaching, and implementation of a care plan.

Indirect care: services related to patient care but that do not require interaction between the health-care provider and the patient. Examples include charting and scheduling.

(Source: Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition)

### CCAC Definition Attributes a Higher Proportion of Costs to Direct Patient Care

For the year ending March 31, 2014, under their definition of direct patient care, the CCACs reported that, overall, 92% of their expenses were for direct patient care.

Individual CCACs reported direct patient-care costs ranging from 89.9% to 93.8%, as shown in **Figure 17**. The variance in these percentages among the 14 CCACs can be accounted for by the fact that each CCAC is an independent entity free to spend its money as it chooses.

We noted that, as the definition requires, CCACs excluded their overhead costs in their calculation of direct patient-care costs. However, their calculation included *all* of the costs they pay to service providers, which includes service-provider overhead and profit. When service-provider overhead and profit are excluded, overall, 81% of CCAC expenses would be considered direct patient-care costs.

### Alternative Definition Attributes a Lower Proportion of Costs to Direct Patient Care

Under a definition of direct patient care that excludes activities that do not involve direct patient interaction, less spending is attributed to direct patient care. In estimating this amount we noted the following challenges.

#### Time Spent by Care Co-ordinators on Direct Patient Care across CCACs Not Clear

Given the importance to CCACs of monitoring whether their care co-ordinators are spending their time effectively to influence patient outcomes, it would be useful if CCACs tracked care co-ordinators' time in a consistent way.

In 2009, the Association developed a standardized time-tracking report for care co-ordinators, but only one CCAC uses it. Of the remaining 13 CCACs, 12 developed their own custom reports to monitor care co-ordinator caseloads or activities. Unlike the Association version, these reports do not capture the amount of time the co-ordinator spends in contact with each client. One CCAC does not track any aspect of its care co-ordinators' work.

The Association has no power to compel the CCACs to use its standardized report. While the Association represents the CCACs, the CCACs are accountable to their boards of directors, not the Association. The Association notes that these reports are not for provincial analysis and data management but, rather, are "starter reports" to allow CCACs to easily access information about their clients and caseloads, and manage daily activities.

### Expenses and Activities Not Involving Direct Interaction With Patients Must Be Estimated and Excluded

When direct patient care is defined to include only those activities that involve direct patient interaction, CCACs spent 71.5% of their expenditures on direct patient care for the year ending March 31, 2014, as shown in **Figure 16**. In reaching this conclusion, we excluded the following costs, currently included by CCACs in their calculations:

- *Profit earned and overhead expenses incurred by service providers:* We estimated that a portion of CCAC funding to service providers goes to the providers' overhead costs, which include taxes, occupancy costs, executive compensation, office equipment and supplies, and profit. (This is discussed in detail in **Section 5.3.1**.)
- *Costs of support activities recorded in care co-ordinator costs:* These activities include continuing education, travel, professional memberships, telecommunications, office supplies, and the purchase and/or rental of equipment.
- *Care co-ordinators' time spent on indirect activities:* We estimated that care co-ordinators spent about 40% of their time on such support services as making presentations in the community, reading and responding to internal emails, reviewing policies and procedures, and maintaining patient records. This estimate is based on a review of raw time data recorded in the CCAC information system, the only available information to quantify how care co-ordinators allocate their time, in a sampled month in 2014.

**Figure 17: Patient Services and Overhead as a Percentage of Total Expenses, by CCAC, Year Ending March 31, 2014**

Source of data: Ontario Association of Community Care Access Centres

CCAC	Patient Services Expenses as a % of Total Expenses	Overhead Expenses as a % of Total Expenses
Hamilton Niagara Haldimand Brant	93.8	6.2
South East	92.7	7.3
Champlain	92.2	7.8
Central	91.9	8.1
Toronto Central	91.7	8.3
North Simcoe Muskoka	91.6	8.4
Erie St. Clair	91.5	8.5
South West	91.4	8.6
Waterloo Wellington	91.2	8.8
Central East	91.1	8.9
North East	90.5	9.5
Central West	90.5	9.5
Mississauga Halton	90.4	9.6
North West	89.9	10.1
<b>Provincial Total</b>	<b>91.7</b>	<b>8.3</b>

- *Support staff and managers of care co-ordinators:* Assistants to care co-ordinators spend only part of their time on activities involving direct patient contact. Similarly, managers of care co-ordinators do not typically provide direct patient services at all.
- *Direct-nursing programs:* An estimated 60% of the CCACs' costs for delivering nursing services directly (rather than through service providers) were for nurses and nurse practitioners spending time on travel, relationship-building and maintenance of patient records. This estimate was based on interviews we conducted with over 30 direct-nursing-program staff at three CCACs, and time-allocation estimates we received from six other CCACs.

Because care-co-ordinator travel is inherent to home and community care, and documenting patient-care activity is required by professional practice standards, these activities could be considered to be part of direct patient care even though they do not involve direct patient interaction. Once they

are included in direct patient care, the percentage of expenses that CCACs spent on direct patient care for the year ending March 31, 2014, rises to 72%.

#### **No Analysis Done to Correlate Spending on Specific Patient-care Activities to Patient Outcomes**

No matter the definition of direct patient care used, it is unclear what percentage of their costs CCACs should be spending on direct patient care to produce better patient outcomes. We cannot assume, for instance, that having staff spend all their time on direct patient contact would automatically translate into better patient outcomes. Professional development hours, for instance, would not count as direct patient care, but might have a significant impact on patient outcomes. Similarly, patient outcomes might be optimized if a CCAC care co-ordinator spends a certain minimum proportion of time on in-person or phone interaction with the patients and/or their family, but there is no benchmark on what this amount of time should be. Neither

the Ministry nor the CCACs and their Association had analyzed how given amounts of spending on specific patient-care activities correlate with the patient outcomes that result. This analysis could help CCACs prioritize their spending, allocating sufficient resources and funds to the most effective patient-care activities, whether direct or indirect.

### 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; and
- all CCACs should use the updated standard care co-ordinator time tracking report.

### RESPONSE FROM CCACs AND THE ASSOCIATION

CCACs agree on the importance of measuring and tracking the way patient care achieves desired results. The Association is in the process of establishing benchmarks for time spent on various care co-ordinators' activities, such as assessing patients, updating care plans, documenting patient activities and visiting patients. The Association anticipates that reports that can be used to track and manage care co-ordinators' time and activities will be available in December 2015. At that time, CCACs will report actual data against established benchmarks.

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

### RESPONSE FROM CCACs

CCACs, like other health care providers, follow prescribed provincial and national reporting standards. It is relatively easy to demonstrate the value of the time care co-ordinators spend with patients. It is more difficult to measure the value of all the different supportive services that CCAC staff, including care co-ordinators, perform to ensure patients get the care they need. By December 2015, supported by the Association, CCACs will develop a quantitative approach to measure how the various care activities contribute to positive patient outcomes. This approach will include an analysis of the types of care provided and expected patient outcomes.

Through analysis of the data collected using this approach, CCACs will develop benchmarks for care activities for specific patient populations.

### 5.3.3 Service Delivery Model for Home- and Community-care Could Be Streamlined

As described in **Section 2.1**, there are 14 CCACs responsible for direct home- and community-based health care in Ontario. Each employs nurses and nurse practitioners who provide direct-nursing services under three Ministry-directed programs, and five CCACs also employ their own therapists. In addition, CCACs contract services out to 160 private-sector service providers that are either for-profit or not-for-profit.

In such a service-delivery model, administrative and overhead expenses are incurred multiple times

at each organization, and some service providers also profit from the payments they receive from CCACs for providing CCAC-funded services. As we've discussed, the result is that about 72% of every dollar in funding is spent on activities that involve direct patient contact. This percentage is considerably lower than the 92% that the CCACs operating under this service-delivery model consider is being spent on direct patient care.

As reforms and reports on health care, including home and community care specifically, are currently under way in Ontario, this is an opportune time to assess whether the current delivery model—where direct care is spread out over a vast array of organizations, some of which profit from CCAC-funded services and some of whose services could be seen to overlap—could be streamlined for the benefit of patients needing effective health care at home and in the community.

## 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.

## MINISTRY RESPONSE

The Ministry agrees with this recommendation to review the current service delivery approach for home- and community-care in order to ensure patients are receiving equitable and high-quality care. *Patients First: A Roadmap to Strengthen Home and Community Care* is the Ministry's first phase in the plan to transform the way home- and community-care is delivered in Ontario. The plan includes the creation of a Levels of Care Framework to ensure services and assessments are consistently provided across the

province, in addition to reviewing the current approach for setting CCAC contract fee rates for services delivered in the home-care sector by service provider organizations. A review of the service delivery model will follow this work.

## RESPONSE FROM CCACs

CCACs fully support the need to modernize home- and community-care and are well positioned to undertake the transformation. The governing legislation is more than 20 years old, and existing laws and regulations do not reflect the complexity of patient needs, the growing volumes, or the complicated purchase-service model through which CCACs offer services. As the Auditor General notes, CCACs work with over 160 service providers and are not permitted to engage in a competitive process to issue contracts because of a ministry directive. CCACs look forward to continuing to work with the Ministry in developing and implementing a more streamlined and cost-effective service delivery model for patients across Ontario.

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

### SUMMARY: *The Committee motion*

*requested that we review the compensation of comparable employee positions in CCACs and in private-sector service providers with which the CCACs contract on a fee-for-service basis.*

The types of employees who are employed both at CCACs and service providers are nurses and therapists. We compared the functions performed by CCAC and service-provider nurses and therapists, and the compensation paid to them.

We found that before the Ministry directed CCACs to hire their own nurses, it conducted no cost-benefit analysis to determine whether service-provider nurses could

do the work assigned to CCAC nurses more cost-effectively.

On the nursing side, among the three direct-nursing programs, the only viable comparison of nurse compensation was in the area of rapid response. None of the nine service providers we visited have nurses who provide mental health and addiction services to students at school, and none of the nine service providers have nurse practitioners who provide palliative care to patients at home.

Both CCACs and service providers employ registered nurses. There is some overlap in the activities that they perform, but overall their functions are different—service-provider nurses perform “task-driven” functions on patients with varying levels of needs, while CCAC rapid-response nurses coordinate care for and provide consultation to patients with complex needs. We found that CCAC rapid-response nurses were paid more than service-provider nurses because of the higher pay rates their nursing unions negotiated with the CCACs.

On the therapist side, CCAC and service-provider therapists perform comparable functions. CCACs paid their in-house therapists more than what they paid service providers for comparable services.

#### 5.4.1 No Analysis Done on Whether Service Providers Could Deliver Direct Programs

While CCACs have traditionally focused on coordinating care by service providers and community support services, they have the legal authority under the *Community Care Access Corporations Act, 2001* (Act) to provide direct service as well. The Act allows CCACs to provide health and related social services, supplies and equipment directly or indirectly.

In September 2011, the Ministry introduced three direct-care nursing programs (direct programs) at all 14 CCACs: rapid response, mental

health and addiction for students in school, and palliative care. The main objective of these new direct programs was to meet specific patient needs and provide full-time jobs for nurses. **Figure 18** provides program descriptions and goals for each of the three direct programs. The CCACs we visited agreed that direct-program nurses perform services that were previously unavailable to patients.

Since the programs began in September 2011, the LHINs have allocated \$30 million annually to the CCACs to operate these direct programs. This funding was intended to cover 126 rapid-response nurses, 144 mental-health and addiction nurses, and 70 palliative-care nurse practitioners, for a total of 340 nurses/nurse practitioners across the 14 CCACs. The direct programs were part of a 2007 government commitment to create 9,000 new nursing positions.

The Ministry did not conduct any analysis to assess whether service providers could provide the same services more cost-effectively when it requested CCACs to hire professional nursing staff to deliver the direct programs starting in September 2011.

The CCACs’ expansion of work to include providing direct-care services was criticized by many, including stakeholder groups and service providers. Various associations that represent home-care and community mental health and addiction service providers raised their concerns to the Ministry about the decision to place new nurses in CCACs. While they supported the investment in principle, they were concerned that the new direct programs had been developed without first consulting the service-provider nursing community. As well, two of the associations worried that the new positions were placed in the CCACs rather than among contracted service providers. In their view, this had a negative impact on the resource pool in the home- and community-care sectors, and would undermine the competitive process for procuring nursing services in the future. The Ministry held talks with these groups and considered their input, but eventually proceeded with implementing the programs at CCACs.

**Figure 18: Direct Care Nursing Programs—Purposes and Goals**

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

Program	Purpose	Goal
Rapid Response Nursing Program	Focus on care during transition from acute care to home care for eligible individuals.	Reduce re-hospitalization and avoidable emergency department visits by improving the quality of transitions from acute care to home care for two population groups: medically complex children, and frail adults and seniors with complex needs or high-risk characteristics.
Mental Health and Addictions Program	Support district school boards to build capacity to recognize and respond to student mental health and addictions issues.	Provide mental health and addiction supports and services in an inter-disciplinary team with mental health leaders, mental health workers and existing district school board staff to children and youth in Ontario's 72 publicly funded district school boards.
Palliative Care Nurse Practitioner Program	Provide critical capacity to enhance continuity of clinical care co-ordination in palliative care across primary care, home care, community supports, acute and specialty palliative-care sectors.	Improve the value of home and community palliative-care delivery by contributing to reduced hospital admissions, improved pain and symptom management, reduced drug costs, increased access to palliative care from primary care practitioner and reduced referrals to specialist care.

We sought feedback about the direct programs from nine service providers, and eight of them responded. Most said that, in their view, CCACs should be responsible for arranging for care, not providing it directly. Their views are consistent with the recommendations made in a 2005 independent review by former Ontario Health Minister Elinor Caplan entitled *Realizing the Potential of Home Care*, which noted that the mandate of the CCACs should be amended to remove the provision of direct services such as nursing, personal support and therapies. In Caplan's view, this change could help "avoid a conflict of interest between the CCACs' role as gatekeeper of government funding and decision-maker on [the] quantity and nature of services to be provided." The service providers also noted the following concerns:

- The direct programs create confusion around the roles and responsibilities of CCACs and service providers.
- One of the direct programs duplicates medication reconciliation services already offered by service providers.
- Service providers provide 24/7 care, while many of the direct-care nurses employed by CCACs work only standard daytime shifts.

- Service providers face new competition from CCACs in their efforts to recruit highly trained and educated staff. (However, we found that across the 14 CCACs, only about 8% of the nurses hired into the direct nursing programs had been directly employed by service providers prior to joining the CCACs.)

Because the Ministry did not conduct any analysis to assess whether service providers could provide the same services more cost-effectively, we compared the cost to deliver the rapid-response nurse program at the CCACs with the average contract rate that CCACs paid to service providers to obtain nursing services. We included all the costs incurred to provide all types of nursing services. For the CCAC nurses, we included the nurses' salary and benefits, staff education, travel, equipment, supplies, telecommunication and other miscellaneous items. For the service-provider nurses, we included the rate that CCACs pay service providers to cover similar items (that is, wages, benefits, transportation, and training and development of service-provider employees). We found that at the three CCACs we visited, it was costing about \$60 an hour for nursing services delivered by CCAC rapid-response nurses, compared to about \$57 an hour

for nursing services delivered by service-provider nurses with similar credentials. In other words, if CCACs had opted to contract out the services to service providers, they would have saved approximately \$3 an hour per nurse.

#### 5.4.2 CCAC Rapid Response Nurses Paid More Per Hour than Service-provider Nurses

In the year ending March 31, 2014, CCAC nurses were paid a higher hourly wage on average than their counterparts at service providers. However, as noted earlier, nurses employed at CCACs and at service providers perform different functions. Because some nurses at service providers are not represented by bargaining units, and of those who are, some belong to different bargaining units than the nurses at CCACs, their pay rates differ. At the three CCACs we visited, rapid-response nurses earned between \$39.40 and \$43.70 an hour, depending on the region. Across the province, on average, CCAC rapid-response nurses earned \$40.80 an hour. In contrast, the nine service providers we visited paid their registered nurses between \$25 and \$34 an hour, averaging \$30 an hour.

All CCAC nurses employed in the direct programs are represented by bargaining units, including the Ontario Nurses' Association, the Canadian Union of Public Employees, the Canadian Office and Professional Employees Union, and the Ontario Public Service Employees Union. In contrast, not all registered nurses employed by service providers are represented by bargaining units—there were no unionized registered nurses at seven of the nine service providers we contacted. The service-provider nurses who are represented by bargaining units are either represented by some of the same bargaining units that represent the CCAC nurses, or other bargaining units. There are 14 collective agreements covering CCAC nurses. There are 50 collective agreements covering those service-provider nurses who are unionized.

A number of service providers pointed out that the introduction of the direct programs created competition for nursing staff and that they were unable to match the salaries and benefits offered by CCACs. Specifically, while the CCACs received new annual funding of \$30 million from the Ministry to hire the new nurses, service providers told us they have had to pay their employees using the same CCAC billing rates that have existed since February 2008, when the Ministry suspended competitive procurement of services.

CCAC nurses have more predictable work schedules than service-provider nurses, as some service-provider nurses are expected to be on call around the clock, but CCAC nurses are not. Incomes for CCAC nurses are more predictable because they are paid an annual salary while service providers usually pay their nurses an amount per visit or hour (based on the volume of work ordered by the CCACs, which fluctuates).

#### 5.4.3 CCAC Direct-care Nurses Do Different Work than Service-provider Nurses

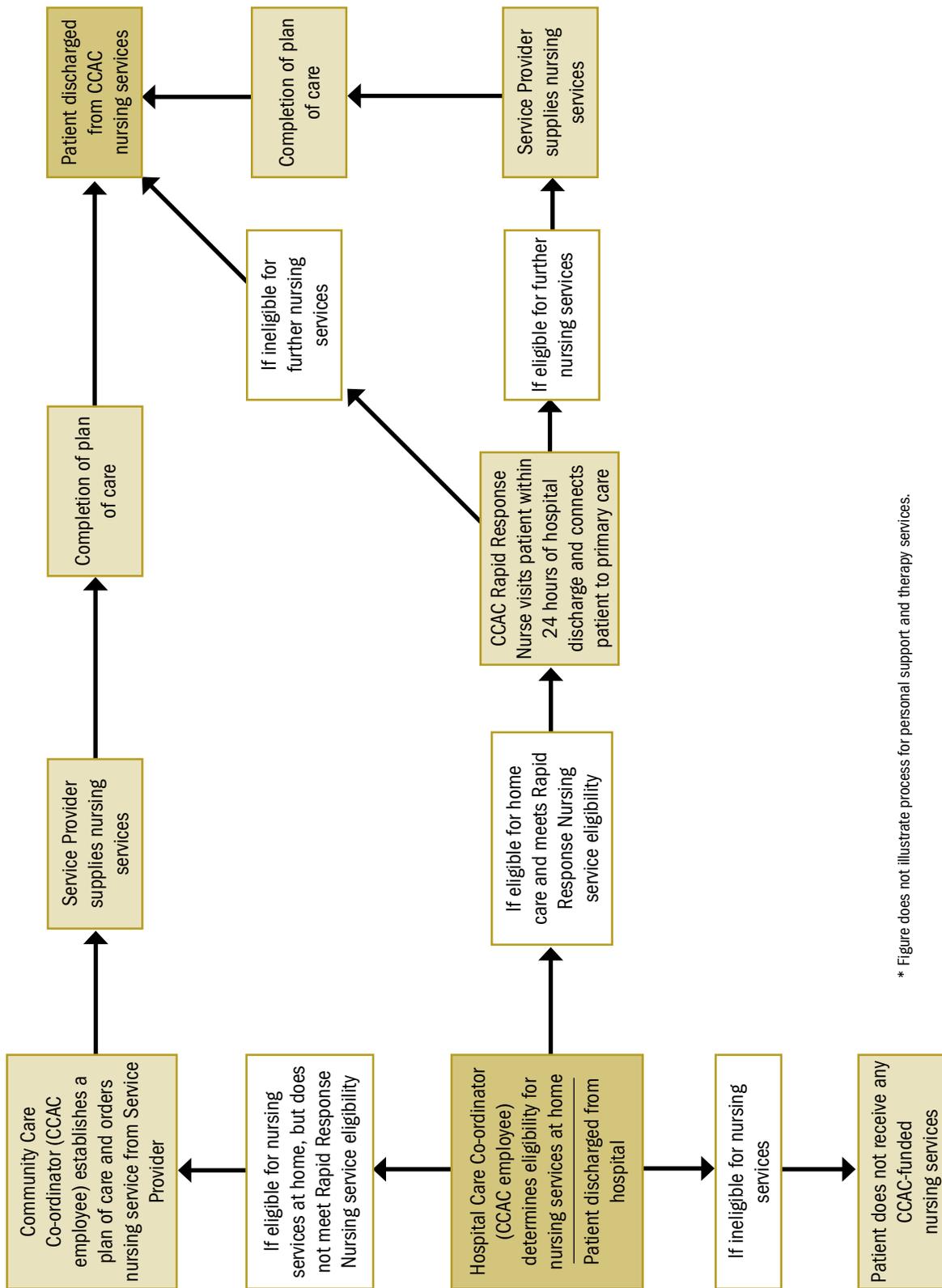
Both CCACs and service providers employ nurses with registered nurse designations. However, these nurses perform different functions and serve patients with different levels of complexity.

The job of rapid-response nurses is to support a safe transition from hospital to home for eligible patients. This service is available for 30 days, after which the rapid-response nurse will transition the patient to care delivered by a service provider nurse, where necessary.

**Figure 19** shows a typical process for a patient likely to receive nursing services after discharge from hospital, and identifies the work performed by service-provider nurses supplying direct clinical services to patients and by CCAC rapid-response nurses supplying specialized rapid-response services to patients. As mentioned, all of this work is performed by registered nurses.

**Figure 19: Typical Process for Patients Potentially Eligible for Nursing Services\* Following Discharge from Hospital**

Prepared by the Office of the Auditor General of Ontario



\* Figure does not illustrate process for personal support and therapy services.

Patients are eligible for the Rapid Response Nursing Program if they have complex needs. This includes two population groups exclusive to the program: medically complex children, and frail adults and seniors with complex needs or high-risk characteristics (such as those with chronic obstructive pulmonary disease or chronic heart failure).

The care provided starts with a home visit by a CCAC nurse within 24 hours of the patient's discharge from hospital. The work includes performing physical assessments, counselling, medication reconciliation, consultation and care co-ordination with other health-care providers. Service-provider nurses perform more "task-driven" functions with patients such as taking blood pressure, performing intravenous injection, and applying or changing wound dressing; they do not co-ordinate care. In other words, CCAC rapid-response nurses tend to focus their services on patients with complex needs, whereas their service-provider counterparts serve patients requiring differing levels of care—not exclusively those who have complex needs.

None of the nine service providers we visited during this audit employ nurses who provide mental health and addiction services to students at school, and none of them employ nurse practitioners who provide palliative care to patients at home.

#### 5.4.4 CCAC Staff Therapists Paid More than Service-provider Staff Therapists Because of Geographic Considerations

We found that, overall, CCACs paid significantly more for their therapists than they did for the same service from contracted service providers. There are generally two reasons why CCACs have historically hired their own therapists: to address patient needs in large geographic areas with low population densities where service providers will not supply care, and to provide specific services to help improve patient outcomes.

In the year ending March 31, 2014, five CCACs hired their own clinicians (therapists) including dietitians, occupational therapists, physiotherapists, social workers and speech language pathologists. Collectively, these five CCACs employed about 130 full-time therapists as of March 31, 2014, with two CCACs having almost 90% of the therapists. When they had additional demands, the CCACs purchased additional services from service providers.

One of the CCACs we visited was one of these five that hired their own therapists. In that region, the geographic area was vast and, according to the CCAC, because service providers would not have a stable work volume to keep their staff fully employed, service-provider staff were not always available or willing to travel. As noted in **Figure 20**, depending on the discipline, CCAC compensation to staff therapists (including travel expenses) in that

**Figure 20: Amounts Paid by One CCAC to its Own Staff and to Service Providers for Therapy Services, Year Ending March 31, 2014**

Source of data: One CCAC

Discipline	CCAC Internal Cost per Visit (\$)	Average Costs Paid to Service Providers per Visit (\$)	Difference Between CCAC Internal Costs and Average Costs Paid to Service Providers (%)
Occupational Therapists	184	131	40
Physiotherapists	114	73	56
Dietitian	167	140	19
Social Worker	177	125	42
Speech Language Pathologist	216	126	71

region can be up to 71% higher than the average costs paid to the service providers (including travel costs) based on the actual number of visits made. The CCAC was aware of the higher cost, but planned to continue employing its own therapists to ensure service stability and equity across the region.

Another CCAC has employed its own occupational therapists as “falls-prevention co-ordinators,” responsible for reducing the rate of patient falls. These therapists make suggestions to patients on the set-up of their homes, among other things, to help reduce the risk of falls. This CCAC considers the arrangement an experimental initiative. The CCAC also envisages that these therapists will help advise and train the other care co-ordinators in falls-prevention. We compared the salary of the falls-prevention co-ordinators with the billing rate of the most expensive service provider for occupational therapy. We noted that the average salary of the falls-prevention co-ordinators was 48% higher but, as mentioned, these CCAC staff were responsible not only for falls prevention but also for advising and training CCAC care co-ordinators in this area, which typical service-provider occupational therapists do not do.

## 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; and
- 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).

## MINISTRY RESPONSE

The Ministry accepts this recommendation regarding the current home- and community-care service delivery model. The Ministry will work with CCACs to evaluate the current compensation rates for CCAC direct-nursing and therapist staff and determine the most cost-effective approach for providing this care.

## RESPONSE FROM CCACs

CCACs expect to be reviewing compensation for both nurses and therapists when collective agreements are due for renewal in 2016 to 2018. CCACs also review compensation locally, based on the appropriate market comparison, including considering whether therapist services are available from contracted service providers.

CCACs believe that the direct provision of nursing and therapy services offers patients consistency, interdisciplinary focus and a stronger connection to primary and hospital care.

## 5.5 Comparison of Effectiveness of Home-care Visits by CCAC Staff and Contracted Service-provider Staff

### SUMMARY: *The Committee motion*

*requested that we review the effectiveness (including cost-effectiveness) of home-care visits conducted by staff directly employed by the CCACs, compared to those conducted by staff employed by private-sector providers contracted by the CCACs.*

This motion, along with the motions in **Sections 5.6** and **5.7**, deal with services (up to this point, in **Sections 5.1** through **5.4**, the motions have dealt with finances). Our overall finding on service provision is that

services are delivered differently depending on whether CCACs or service providers are the direct providers of service and on which CCAC and/or service provider is involved. Neither the Ministry, the Association nor any other party has assessed whether such variations in service delivery result in patients receiving the best-quality services. With the reforms and reports on health care being worked on in Ontario when this Special Report was released, including home and community care specifically, it is an opportune time for such an assessment. This assessment should include determining areas where standardizing services would benefit patients and ensure equity (so that no patients are shortchanged on services simply because of where they live) and areas where service-delivery options should remain flexible.

To assess the effectiveness of home-care visits by CCAC staff, we examined whether CCACs had developed processes to measure whether actual performance in the Rapid Response Nursing Program, the Mental Health and Addictions Program, and the Palliative Care Nurse Practitioner Program is progressing toward the stated goals of these programs. We also looked at whether there were areas where services were duplicated and were therefore not being delivered cost-effectively. We further determined whether the CCACs followed program guidelines.

We found that CCACs did not fully measure their staff's effectiveness in delivering the direct-nursing service, and did not meet the program goal in the Rapid Response Nursing Program.

Although CCACs are reporting their actual performance in the three direct-nursing programs against a set of defined performance indicators, no targets have been set to help determine whether CCACs have achieved the expected level of performance. For example, the CCACs report the number of patients vis-

ited in each of these programs, but no benchmarks are set to measure whether the CCACs have serviced a desired number of patients. Further, CCACs have not fully assessed patient satisfaction with the three direct-nursing programs. We found that only four of the 14 CCACs surveyed patients to determine their satisfaction, but only with one or two of the programs that CCAC staff provide, not all three. Although the Rapid Response Nursing Program is designed to provide transitional home care to select patients within 24 hours of their discharge from hospital, 47% of these patients were not seen within 24 hours in the year ending March 31, 2014.

As for whether services were duplicated, 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 several other programs, with some costing up to 70% more than others. CCACs acknowledged that they provide medication reconciliation services to patients via multiple means, but we could not quantify the number of instances where the same patient had received this service from multiple providers, because none of the three CCACs we visited maintained records on this.

With respect to following program guidelines, we found that one of the CCACs we visited used stricter eligibility criteria for its Rapid Response Nursing Program because of budgetary concerns, so fewer patients received the services that the program was designed to provide. Further, because there are no caseload targets for the three direct-nursing programs at more than half of all CCACs, there is a risk that patients might receive a sub-optimal level of services. For instance, a mental health and addiction nurse could oversee as few as two cases to as many as 61 cases, depending on the CCAC.

When we looked at the effectiveness of home care provided by service providers,

we found the most recent contract that the CCACs updated in October 2014 included new and improved performance indicators that better measure the service providers' quantity and quality of services. These performance indicators measure whether service-provider staff arrived on time, whether patients indicated that service-provider visits were arranged at a convenient time, and whether service providers failed to provide any care exactly as it is laid out in a patient's care plan (termed "missed care"). Regarding the last performance indicator, we found that the three CCACs we visited did not conduct audits to verify whether service providers accurately reported all missed care.

### 5.5.1 Better Monitoring Needed to Assess Whether Home-care Services Delivered by CCAC Staff Are Effective

#### About Half of Patients Are Not Visited by Rapid-response Nurses Within 24 Hours

The standard for the Rapid Response Nursing Program is that patients must be visited at home within 24 hours following discharge from hospital. All 14 CCACs reported that they failed to meet this standard for all their patients for the year ending March 31, 2014, with four of them not meeting the service standard for more than half their patients. Across the 14 CCACs, rapid-response nurses saw 53% of the patients within 24 hours, 19% within 48 hours, and 28% more than 48 hours after they were discharged from hospital. **Figure 21** summarizes CCAC rapid-response nurse performance against the standard in 2013/14, the first year where rapid-response nurses were fully deployed at all 14 CCACs.

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. This is consistent with our 2010 audit on Discharge of Hospital Patients, which noted that more discharges occurred on Fridays than on any other day of the week.

**Figure 21: Percentage of Patients Not Seen by Rapid Response Nurse Within 24 Hours of Hospital Discharge, by CCAC, Year Ending March 31, 2014**

Sources of data: All CCACs

% of Patients Not Seen Within 24 Hours*	# of CCACs
90-99	1
80-89	0
70-79	0
60-69	0
50-59	3
40-49	4
30-39	3
20-29	3
less than 20	0
<b>Total</b>	<b>14</b>

\* Analysis based on hospital discharge data for all CCACs except two, where we used service authorization date instead of hospital discharge date. As well, one CCAC provided data for only half the year.

## 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.

## RESPONSE FROM CCACs

Sometimes CCACs are delayed in setting up the first visit from a rapid-response nurse because a patient and their family may choose to get settled back at home before a rapid-response nurse visits. CCACs will work with hospitals, patients and families to facilitate a timely and smooth transition from hospital back home, and arrange rapid-response nurse staffing schedules based on clinical needs of patients and the pattern of hospital discharges.

### Provincial Eligibility Guidelines for Care and Nurse Staffing under the Rapid Response Nursing Program Not Consistently Followed

There are provincial guidelines that determine patient eligibility for care under the Rapid Response Nursing Program. One CCAC we visited imposed eligibility criteria that were stricter than these provincial guidelines; therefore, fewer patients received the transitional services that the program was designed to provide. As well, this CCAC did not provide services to children with complex needs, contrary to the provincial guidelines. The CCAC explained that it is difficult to meet the provincial guidelines with the existing funding level, which it felt did not consider the challenges of large, rural and remote areas. As a result, some patients leaving hospitals in the area served by this CCAC do not receive the same level of service as patients leaving hospitals in the other CCACs that follow the provincial guidelines.

Provincial guidelines also state that rapid-response nurses are expected to be available seven days a week. However, we found that only one of the three CCACs we visited provided seven-days-a-week service. The other two offered services only five or six days a week.

## 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.

## RESPONSE FROM CCACs

CCACs will work with the Ministry to evaluate whether patient volume and staffing indicators in the program guidelines continue to be appropriate. CCACs will monitor whether these indicators are met in order to achieve the desired patient outcomes of the direct-care nursing programs.

### Lack of Service Continuity During Summer Months for Students Requiring Mental Health and Addictions Nursing Care

School boards have developed their own individual approaches to mental health and addictions services for students. Since the Ministry introduced the Mental Health and Addictions Program in 2011, CCAC mental health and addictions nurses have needed to work with school boards to complement these existing programs. This has meant that the work done by CCAC nurses in mental health and addictions varies by school board. For example, at one CCAC region's school boards, CCAC nurses work one-on-one with students in the schools, while the school board mental health workers are responsible for program development. In another CCAC region's school boards, CCAC nurses are more involved in program development and design, not leaving this solely up to school board staff. CCACs felt that this approach appropriately responds to the local needs and operations of each school board.

We found that, in all CCACs, mental health and addictions nurses provided less service over the summer break. There were no requirements or guidelines regarding service continuity during these months while schools were closed, even though students' problems were ongoing. At one of the three CCACs we visited, we noted cases where students were discharged in June 2014 but their mental health and addictions concerns were not yet resolved. As well, at two of the three CCACs we visited, CCAC management encouraged nurses to take summer holidays. These CCACs explained that some students were not available or not willing to meet with the CCAC mental health and addictions nurses during the summer break.

At the three CCACs we visited, the number of students served by each nurse dropped in the summer months—as much as 53% at one CCAC. At these CCACs, we also noted that more students were discharged in June, when the school year ended, than in any other month in the 2013/14 school year. Based on survey results from the 11

CCACs we did not visit, 53% of patients in one CCAC and 66% in another did not get any nursing care at all during summer 2014.

## 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.

## RESPONSE FROM CCACs

CCACs agree that children who need mental health and addiction services should have consistent access to services. Because patients prefer to take vacation and school referrals decrease substantially over the summer months, fewer students receive mental health and addiction nursing services during the summer. CCACs will better support school-aged children through the summer months by working with school boards, hospitals, teachers and other community partners to determine ways to smoothly transition students in a thoughtful way and in the best interests of the children and their families after the school year ends.

### Multiple Medication Reconciliation Programs Used at CCACs; One Program Costs 70% More than Another

The responsibilities of rapid-response nurses include “medication reconciliation,” which involves taking a patient’s medication history, then interviewing the patient to ensure the medication information is accurate to prevent medication errors. However, this service is already provided to home-care patients through the Ministry’s MedsCheck program, where pharmacists visit patients at home to do this same work. The MedsCheck program costs \$150 per patient visit. According to informa-

tion we obtained directly from the three CCACs we visited and the 11 CCACs we surveyed, home-care patients at 12 of the 14 CCACs receive medication reconciliation service from MedsCheck in addition to similar services provided by the CCAC rapid-response nurses. Of the remaining two CCACs, one uses a third program called Virtual Ward; one indicated that its care co-ordinators, in addition to the rapid-response nurse, would conduct a medication review with the patient at the initial assessment. Furthermore, over half the CCACs spend additional funds to provide the same service through yet other means. For example, one CCAC hires a pharmacist at \$255 per patient visit to visit patients at home. As well, service-provider nurses are required under contract with the CCACs to review patients’ medications and assess whether patients have all the medications required for the delivery of nursing services.

The CCACs we visited did not maintain records to identify instances when the same patient had received medication reconciliation service from multiple providers.

## 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.

## RESPONSE FROM CCACs

CCACs apply industry standards for medication reconciliation and promote safe, effective medicine management for patients. CCACs use a number of medication reconciliation methods tailored to meet patients’ needs, which could vary over the time they are under CCAC care. For example, more complex patients who are considered to be at-risk are educated on the use of their medication as part of medication management.

CCACs will work with service providers and pharmacy partners and develop guidelines for more consistent approaches to medication reconciliation. CCACs expect to implement these new approaches by March 2017.

### Direct-nursing Caseloads Varied Widely

We found that across the province, fewer than half of all CCACs had caseload targets for their three direct-nursing programs. Without such targets, it is difficult to determine whether services are functioning at optimal levels. We also found that caseloads for the three programs at the three CCACs visited varied between April 2013 and September 2014, as shown in **Figure 22**:

- Rapid Response Nursing Program—None of the three CCACs had established caseload targets, and actual caseloads ranged from two to 38 patients per nurse.
- Mental Health and Addictions Program—One CCAC had not established a caseload target, and actual caseloads varied from two to 61 patients per nurse.
- Palliative Care Nurse Practitioner Program—Only one CCAC had established a caseload target, and actual caseloads varied from three to 18 patients per nurse practitioner.

We also noted that the Ministry had allocated five nurse-practitioner positions to each CCAC without considering existing resources, population need, or anticipated demand for palliative-care services. The lack of correlation between the number of positions filled and the need for service results in further variations in caseloads, and increases the likelihood of service not being provided consistently across the palliative patient population. This was also noted in our 2014 audit on Palliative Care.

## 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.

## RESPONSE FROM CCACs

CCACs agree that optimal caseloads in the direct-care nursing programs are important. CCACs expect to establish staff-caseload benchmarks in October 2015. In late 2015, CCACs expect to report actual results against these benchmarks.

**Figure 22: Staff Caseload by Direct-service Nursing Program in Selected CCACs, April 2013–September 2014**

Sources of data: Selected CCACs

Program	Low	High	Average	Target
<b>Rapid Response Nursing Program</b>				
CCAC #1	21	38	26	Not established
CCAC #2	2	29	16	Not established
CCAC #3	4	16	10	Not established
<b>Mental Health and Addictions Program</b>				
CCAC #1	6	25	17	15–20
CCAC #2	2	31	12	20 or more
CCAC #3	3	61	24	Not established
<b>Palliative Care Nurse Practitioner Program</b>				
CCAC #1	10	16	13	Not established
CCAC #2	3	15	10	Not established
CCAC #3	9	18	13	8–14

## Home-care Effectiveness of the Three Direct-nursing Programs Not Fully Measured by Ministry or CCACs

### Performance Indicators Established but No Targets Set to Measure Effectiveness

When the Ministry requested CCACs to directly deliver some home-care services in 2011, the Ministry and the Association developed some performance indicators for these services, such as:

- number of patients served;
- number of visits made; and
- time from when service was authorized to first visit.

CCACs did not begin reporting their performance on these indicators until April 1, 2014—three years after the introduction of the new home-care programs, because CCACs were still recruiting qualified staff to some of the direct-nursing programs well into 2013 and 2014.

CCACs are reporting their performance using these indicators, but there are no benchmarks set for these indicators. Until benchmarks are set, CCACs are only compiling statistics rather than assessing whether the programs have achieved expected outcomes.

CCAC-provided home care also does not have indicators measuring whether all program goals are met. For example, the Palliative Care Nurse Practitioner Program has several goals—including reduced drug costs, reduced referrals to specialist care, and improved pain and symptom management—but none of these goals are measured by performance indicators.

As well, CCAC-provided home care does not have indicators measuring how often CCAC nurses missed making home visits or how often CCAC nurses arrived late. In contrast, as described in **Section 5.5.2**, service providers providing home care are required to report on these performance indicators that look more closely at quality of service.

## Performance Information on Hospital Readmission Visits for the Rapid Response Nursing Program Not Analyzed

One performance indicator has been established that directly relates to the goal of the Rapid Response Nursing Program, which is to reduce return visits and readmissions to hospital. The performance indicator measures the number of unplanned times patients return to hospital after they receive care from a CCAC rapid-response nurse.

We found that even though the Ministry collects this information from hospitals, it does not analyze the overall trends across CCACs to determine all the factors involved in the unplanned return visits and the extent to which the Rapid Response Nursing Program can be shown to have effectively lowered readmissions.

CCACs told us that they themselves could not track unplanned return visits for rapid-response nursing program patients because they could not access this hospital information. The Ministry could help make the information available to CCACs but was not doing so at the time of our audit.

We obtained the hospital-return-visit data from the Ministry for the three CCACs we visited and analyzed it. The data, from June 2013 through September 2014 (the most recent data available at the time of the audit), indicated that the Rapid Response Nursing Program had made a small impact on reducing hospital return visits. The CCACs did not know why the program was not more effective in reducing hospital return visits. Specifically, 21% of patients who received CCAC rapid-response nursing services were *readmitted to hospitals* within 30 days of discharge compared to 24% of patients who did not receive the services; but 37% of patients who received these services *visited hospital emergency rooms* within 30 days of discharge compared to 36% of patients who did not receive the services. These results could indicate that patients were prematurely discharged from hospital. The Ministry also indicated that a potential contributor to these results is that rapid-response nursing program patients have more complex health issues.

The Ministry noted that more current data than September 2014 is available, but it is still subject to review and will not be finalized until summer 2015. Therefore, the effectiveness of the Rapid Response Nursing Program with respect to this performance indicator could not be fully determined at the time of our audit.

#### Few CCACs Surveyed Patients to Measure Program Effectiveness

Only four of the 14 CCACs (one of which we visited) surveyed patients to determine their satisfaction with home-care visits by CCAC staff through the direct programs. However, these CCACs surveyed patients being served by only one or two of the programs that CCAC staff provide, not all three. One CCAC we visited surveyed patients and family members receiving palliative-care nursing services. The survey was conducted in March 2014 and had a response rate of 53%. Respondents were concerned about the lack of coverage over weekends and holidays, and the number of visits provided. They also noted there was confusion over the roles of the various caregivers and agencies involved. In response to these concerns, the CCAC was adjusting the way it delivered these services—such as ensuring that the nurse practitioner and other members of the palliative care team responsible for the patient communicate more, and increasing the number of visits from the nurse practitioner—but had not fully implemented all the changes at the completion of our audit.

### 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;

- analyze province-wide the readmission trends for patients who have received rapid-response nursing services; and
- establish targets for the performance indicators developed for all three programs.

### MINISTRY RESPONSE

The Ministry agrees with this recommendation aimed at measuring the effectiveness of the direct-nursing programs at individual CCACs. The Ministry will work with CCACs and other relevant partners, including the Local Health Integration Networks (LHINs), to provide relevant data on hospital readmission and emergency room visits for the various direct-nursing programs. This will better enable individual CCACs to monitor their progress on these indicators.

The Ministry will also analyze data on hospital readmission and emergency room visits with the goal of assessing the effectiveness of the rapid-response nursing program at the provincial level by the end of 2016.

Additionally, the Ministry will work with the LHINs to set targets for the performance indicators that have been developed and ensure appropriate monitoring of performance to measure effectiveness of the three direct-nursing programs in CCACs.

### RESPONSE FROM CCACs

CCACs fully support the need for timely access to data to measure the effectiveness of the direct-care nursing programs. CCACs look forward to working with the Ministry and the LHINs to access in a more timely way hospital data on readmissions and emergency room visits.

### 5.5.2 Effectiveness of Home-care Visits by Service-provider Staff Not Fully Verified

#### Enhanced Performance Indicators in Service-provider Contracts

Home-care visits by service-provider staff are governed by contracts between the providers and the CCACs. The October 2012 standard contract included performance indicators such as service volume and patient satisfaction. Service providers submit their data on contract performance indicators quarterly.

The CCACs updated the contract in October 2014 to include new performance indicators that better measure the service providers' quantity and quality of services. These included whether patients indicated that service-provider visits were arranged at a convenient time and whether the service-provider staff arrived on time. The CCACs also clarified the definition of the "missed-care" indicator (this indicator captures any ways in which service providers do not provide care exactly as it is laid out in a patient's care plan).

CCACs have set targets for only some performance indicators. For example, at the time of our audit, they did not have targets for missed care, as they needed to study service and performance data received from service providers to establish baselines from which to derive the targets. The CCACs expected to have this work completed by fall 2015.

#### CCACs Could Do More to Verify Service-providers' Reported Results

CCACs need to verify the information that service providers submit quarterly on the contracted performance indicators to ensure it is reasonable and accurate.

CCACs can readily verify some of this performance information. For example, each CCAC sets its own target for service providers' acceptance of referrals, and most require that service providers accept 95% of the referrals. (CCACs would reassign any referrals not accepted to another service provider.) Service providers must enter their

acceptance or rejection of a referral into a computer system that is shared between service providers and the CCACs; the CCACs can easily verify this information and do. Eight of the nine service providers we visited had met their referral-acceptance targets for the year ending March 31, 2014.

However, CCACs cannot readily verify some performance information, such as missed care (the number of times the service provider does not provide care exactly as it is laid out in a patient's care plan). At the time of our audit, the CCACs had not conducted audits to verify the missed-care information reported; instead, they relied on patients and their caregivers to notify the CCAC care coordinators if service-provider staff had not provided specific care as required. Even though the CCACs asked patients via a satisfaction survey whether the service provider arrived on time, the survey did not include a specific question on whether the service provider ever failed to provide the exact care specifically laid out in the patient's care plan.

### 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; and
- 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.

### RESPONSE FROM CCACs

CCACs encourage patient input into the achievement of their care plans. In January 2015, CCACs clarified the definition of missed care and began collecting data on the refined definition. CCACs expect to establish performance targets for occurrences of missed care by fall 2015.

By September 2015, CCACs will begin using a revised survey questionnaire to measure how

well service providers are adhering to patient care plans. The revised survey questionnaire will include questions to patients to validate service-provider-reported missed care. CCACs expect to analyze survey results from across the province by June 2016.

## 5.6 Existing Contracts between CCACs and Service Providers

**SUMMARY:** *The Committee motion requested that we review the existing contracts between CCACs and their service providers delivering community care.*

We looked at how CCACs procured services from private-sector organizations that can be either for-profit or not-for-profit. We also reviewed the changes to contracts since 1997 and analyzed billing rates across the province.

In 2008, the Ministry suspended competitive bidding for home-care contracts, because the Ministry indicated that patients were concerned about losing their existing support workers whenever a competitive procurement process resulted in their service providers being replaced.

In 2012, the Ministry allowed limited competitive procurement under very specific conditions, such as when a CCAC terminates a contract due to poor service-provider performance and is unable to reallocate this work to another already-contracted service provider. Between 2012 and 2014, three of the 14 CCACs terminated contracts due to poor service-provider performance. These CCACs did not need to conduct competitive procurement because they were able to reallocate the work.

We found that contracts changed significantly in October 2012. The number of contracts was reduced by 40% because, where CCACs had multiple contracts with a service provider for different services, they consolidated them into one contract per ser-

vice provider to cover the multiple services. The October 2012 contract had a two-year term and included a number of provisions requiring the CCACs to monitor and manage the service providers' performance. When the latest contracts were signed in October 2014, the contracts' two-year term was lifted—the current contracts have no expiry date. The current contracts also include new performance indicators for service providers to report on quarterly, as explained in **Section 5.5.2**. CCACs included targets for some of these indicators but not for all of them.

We further confirmed that service-provider billing rates are inconsistent across Ontario. These rates were carried forward from the much older contracts and, with few exceptions, were not changed when contracts were standardized in 2012. Even when service providers are providing the same service, the rates CCACs pay them vary significantly, both across CCACs and within the same CCAC. Following an external review of these billing rates, CCACs and the Ministry began discussions on the best approach for a transition to harmonized billing rates. There is no time frame for the expected implementation of rate harmonization in Ontario.

### 5.6.1 No Competitive Bidding in Service Procurement

**Figure 23** outlines key events relating to CCAC service procurement between 1997 and 2014.

CCACs once followed a competitive process to procure services. In February 2008, the Ministry suspended this process. As noted in our 2010 audit of Home Care Services, patients noted that they were concerned about losing their existing support workers if a competitive procurement process resulted in a change of service provider.

In September 2012, the Ministry announced that all CCACs would have to move from a competitive process to a contract-management approach,

**Figure 23: Chronology of Procurement Decisions between 1997 and 2014**

Sources of data: Ministry of Health and Long-Term Care, Ontario Association of Community Care Access Centres, and selected CCACs

Date	Event
1997	Managed competition for CCACs introduced—all CCACs required to acquire client services through a competitive procurement process. CCAC staff ceased performing front-line services over a three-year period.
2002–2003	As part of CCAC reform, competitive bidding was suspended while the Ministry reviewed the procurement policy.
Jul. 2003	The Ministry issued new CCAC procurement policies and procedures on, among other things, standard contracts, contract length, volume bidding and awarding.
Nov. 2004	The Ministry suspended the competitive procurement process in anticipation of a review of home-care procurement that was released in May 2005. The review found the following: <ul style="list-style-type: none"> <li>• Some argued that the procurement model led to a focus on profits, with lower quality of care and less co-operation among providers.</li> <li>• There was a lack of consistent and accessible information needed to measure quality of home care.</li> <li>• The procurement process did not adequately reflect the quality and capability of a service provider to meet the required standard of care.</li> <li>• Some argued that the competitive procurement process led to instability in the system and disruption to clients.</li> </ul>
Jan. 2007	The Ministry issued revised CCAC procurement policies and procedures, thereby signaling a re-start of competitive bidding in July 2007.
Feb. 2008	The Ministry again suspended the competitive procurement process because the Ministry heard that patients were concerned about losing their existing support workers whenever competitive procurement resulted in a change of service provider.
Sep. 2012	The Ministry issued CCAC Contract Management Guidelines detailing the exceptional conditions for allowing competitive bidding and the processes to follow in those cases.
Oct. 2012	CCACs renewed all contracts for a two-year period using standard templates for the provision of nursing, therapy and personal support services. The contracts included strengthened accountabilities related to performance.
2013	The Association commissioned an external consultant to review the billing rates of service providers. The report recommended a 5.15% increase to the overall CCAC budget and a 10% increase to the weighted average billing rate for nursing and personal-support-worker services.
Oct. 2014	All contracts for nursing, therapy and personal support services were renewed with no end date or rate increases. The Association indicated that contract billing rates may be amended subsequent to a rate review.

which requires them to focus on managing and monitoring the performance of service providers to ensure they achieve the performance measures in their contracts. The Ministry expected this would improve home care by setting quality expectations for existing providers. The Ministry allowed competitive procurement of services only when a CCAC:

- had to deal with new services, new volumes and/or other exceptional circumstances;
- had to terminate a service-provider contract for poor performance but could not reallocate the work to its other service providers; or
- could not come to an agreement with a service provider but also could not reallocate the work to its other providers.

Three of the 14 CCACs terminated service-provider contracts for poor performance between 2011 and 2014. However, no new services were competitively procured because, as per the Ministry's stipulation, the CCACs were able to reallocate the work to their other existing service providers.

### 5.6.2 New Standard Contract in 2012 and Continuous Contract Term in 2014

In 2012, the Association finished developing a standard, two-year contract for every service provider and CCAC to use. This contract went into effect in October 2012, replacing all previous contracts.

The previous contracts, some of which were entered into before 2004, had different performance requirements, which were inherited by the 14 CCACs from the original 42 CCACs. As part of contract standardization, many service providers that operated under multiple contracts for different services were awarded single contracts covering all of their different services. As a result, the number of contracts fell to 264 from 440, a reduction of 40%.

The new contract terms covered mandatory service-provider requirements, CCAC monitoring requirements and termination clauses. As well, a performance-standards schedule was updated to include more client-focused performance indicators for service providers to report on to the CCACs.

In October 2014, the CCACs renewed the contract with all of the service providers, with two changes:

- New standard performance indicators were added, most of them with standardized targets for service providers to achieve.
- The contract term, previously of two years, was changed to be continuous. The contract would end only if the CCAC or service provider terminated it.

The service providers agreed to sign this new contract. **Appendix 2** outlines the key contract terms.

### 5.6.3 Billing Rates Varied by Service Provider and CCAC

Because billing rates have not changed since February 2008, they continue to vary (something we also noted in our 2010 audit on Home Care Services). Many service providers continue to be paid according to the original rates agreed to in contracts negotiated with the CCACs before the CCACs merged in 2007. These rates vary significantly, even when paid for the same types of services. In some cases, the same service provider is paid different rates by the same CCAC for the same service.

Billing rates paid to service providers are intended to cover all of the costs and expenses of supplying services, including wages, benefits,

transportation, and training and development of service-provider employees. Even though the contract between the service provider and the CCAC allows CCACs to obtain financial information from the service providers, they have not in fact obtained sufficient information to identify the key factors that affect the providers' cost of delivering services. As a result, they cannot determine if the rates they pay service providers fairly reflect the costs of delivering home- and community-based care.

The only cases where billing rates have changed since 2008 are the following:

- Thirteen CCACs adjusted their service-provider billing rates for personal-support workers between 2010 and 2012 to reflect a change in the *Employment Standards Act* regarding public-holiday pay for casual workers. (One CCAC has already reflected the legislative requirement in its personal-support workers' billing rates.)
- The province's physiotherapy reform in 2013 resulted in most CCACs revising their billing rates or implementing new billing rates for physiotherapy services.
- Two CCACs incorporated the travel costs of contracted therapists into billing rates.

We found in our review of a sample of the contracts in effect at the three CCACs we visited that, in certain service categories, the top billing rate was more than double that of the lowest rate, as illustrated in **Figure 24**. As well, the same service provider could charge different rates for the same service within the same CCAC because its billing rates were determined before the CCACs amalgamated. For instance:

- We noted that a service provider for one CCAC charged three different per-visit rates for nursing services, ranging from \$58.20 to \$70.60, depending on the areas served. We also noted that one provider of personal-support services charged \$48.98 per hour in one area and \$29.50 per hour in another within the same region.

**Figure 24: Difference between the Highest and Lowest Rates Paid to Contracted Service Providers for Services, Year Ending March 31, 2014**

Sources of data: Selected CCACs

	Range Across 3 CCACs (\$)	CCAC #1 (\$)	CCAC #2 (\$)	CCAC #3 (\$)
Visiting Nursing <sup>1,2</sup>	49-73	49-64	52-73	53-71
Shift Nursing <sup>1,3</sup>	46-74	49-65	49-74	46-65
Personal Support <sup>3</sup>	26-49	26-33	27-40	27-49
Occupational Therapy <sup>2</sup>	74-182	119-132	90-126	74-182
Physiotherapy <sup>2</sup>	82-149	106-118	83-103	82-149
Speech Language Pathology <sup>2</sup>	89-187	132-161	113-158	89-187
Dietetics <sup>2</sup>	70-148	96-125	113-146	70-148
Social Work <sup>2</sup>	76-173	150-163	123-173	76-167

1. A visiting nurse provides services for up to two hours per visit; a shift nurse provides services for more than two hours per visit.

2. Per visit, up to two hours.

3. Per hour.

- In another CCAC, we noted that one service provider of personal support workers had four different hourly rates within the region, ranging from \$25.14 to \$30.02. Another provider of nursing services charged \$64.77 in one area and \$72.61 in another within the region.

We found that whether service providers were for-profit or not-for-profit had no significant bearing on their billing rates (at the three CCACs we visited, 70% of the procured services purchased in the year ending March 31, 2014, were from for-profit organizations and 30% from not-for-profit entities). That is, billing rates of for-profit service providers were not always higher than those of not-for-profit service providers. For example, billing rates of for-profit organizations that supplied nursing services were 1% to 15% lower than those of not-for-profit entities, while billing rates of for-profit service providers for occupational therapists and physiotherapists in two of the CCACs were higher than those of not-for-profit providers. There was no discernible trend for other health professionals such as speech and language pathologists, dietitians and social workers.

In October 2013, the Association commissioned an external review of service-provider rates at all CCACs. Released in September 2014, the review found an overall lack of clarity in pricing and payment, with 14,000 contracted rates over 94 differ-

ent service categories. It also noted there was no significant correlation of billing rates to factors such as service area, provider size, market share and when billing rates were last negotiated.

The review contained a number of recommendations, including adjustments to base rates (either up or down) for some service providers, rate adjustments for travel, making the province responsible to approve rates to ensure standardization, and establishing provincial standards for data capture and naming conventions. A provincial working group was reviewing the recommendations and billing rates at the time of our audit. The CCACs and the Ministry were also in discussions regarding the best approach for a transition to harmonized rates, but they had not established a timeline to complete this work.

## 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.

## MINISTRY RESPONSE

The Ministry agrees with this recommendation and is initiating work with CCACs and home-care service providers to move toward harmonized billing rates. The Ministry will work on this initiative over the next two years.

## RESPONSE FROM CCACs

CCACs have been supportive of this direction and agree that harmonized rates will improve cost effectiveness. As the Auditor General notes, home and community care would benefit from a streamlined business model. CCACs have been looking for ways to harmonize rates for some time. However, the structure of the sector and the Ministry's suspension of competitive procurement prevent CCACs from taking substantive action. CCACs welcome the province's involvement in this work and look forward to continued collaboration with the Ministry in the development of harmonized billing rates.

## 5.7 Long-term Cost-effectiveness of Existing Care Protocols

**SUMMARY:** *The Committee motion requested that we review the long-term cost-effectiveness of existing protocols for providing care.*

We examined the types of clinical-care protocols used in Ontario and how service providers use these protocols. We also examined the CCACs' use of a new approach to care that complements the protocols, called an "outcome-based pathway." (Unlike clinical-care protocols, which specify the sequence of activities the service provider should perform, outcome-based pathways specify the outcomes the service provider needs to achieve at specific points in treating particular conditions such as wounds and surgically replaced hips and knees. Outcome-based pathways do not tell service providers *how* to achieve the outcomes but just *when*

the specific outcomes are to be achieved throughout the care period. A concept being considered is that with outcome-based pathways in place, funding for home-care health services could switch from paying service providers per visit to paying them for achieving specific patient outcomes.) Finally, we attempted to evaluate the long-term cost-effectiveness of existing care protocols.

We found that clinical-care protocols are widely used in home care by service providers. However, clinical-care protocols are not standardized the way outcome-based pathways are for use by both CCAC care co-ordinators and service providers. We found cases where the same service provider, under contract with more than one CCAC, was required to apply different protocols to patients with similar medical conditions depending on which CCAC served the patient.

Outcome-based pathways, introduced in 2012, were pilot-tested at five CCACs. This testing, which compared the actual outcomes for patients being treated for hip and knee replacements and wounds with the outcomes the pathway set out for patient recovery, was completed in January 2014. For patients recovering from hip and knee replacements, the specific outcomes expected at the specific times that the pathway defined were actually achieved—patients progressed just as the pathway determined they should. However, for patients recovering from wounds, the specific outcomes expected at the specific times that the pathway defined were not achieved—patients with some types of wounds did not progress as the pathway determined they should. The Association planned to report on the wound-care test data by fall 2015.

We found that the long-term effectiveness and cost-effectiveness of existing care protocols were not clear. To determine effectiveness, it is essential that CCACs track how

many patients treated using the protocols had positive outcomes and how many returned to CCACs for care and/or to hospital because their health worsened; some CCACs do not track this. To determine cost-effectiveness, it is essential that CCACs compare the costs of treating patients using protocols and not using protocols; one CCAC does not do this. Our analysis of treatment-cost data at the three CCACs found that using care protocols did not always result in cost savings.

### 5.7.1 Clinical-care Protocols Used in Ontario But No Common Protocols Developed

#### Characteristics of Clinical-care Protocols

Clinical-care protocols outline the various tasks, called interventions, that health-care providers perform to care for patients with specific health conditions. They exist for a wide range of medical conditions—including wounds, surgically replaced hips and knees, congestive heart failure, and chronic obstructive pulmonary disease—as well as for home safety. Clinical-care protocols almost always include four steps:

1. Conduct an assessment.
2. Develop a care plan.
3. Provide the care.
4. Evaluate the results.

The care plan details the clinical interventions to be performed and identifies the clinical tools to be used to measure progress. For example, the care plan for a diabetic foot ulcer (a type of wound) would state that a home-care nurse needs to rinse the wound, pack it to fill dead space, apply a dressing, encourage the patient to eat regular meals throughout the day, administer needed medications and educate the patient on the care of the foot. After providing this care, the nurse is to indicate in the care plan (which is reviewed by the CCAC care co-ordinator) whether the patient is progressing.

Both service providers and CCACs have been involved in the development of clinical-care proto-

cols. To develop these protocols, CCACs and service providers used information about best practices from organizations such as the Registered Nurses Association of Ontario and the Canadian Wound Care Association.

The use of clinical-care protocols is not unique to Ontario; a number of provinces and territories, as well as the United Kingdom, use them for selected home-care services.

#### CCACs Vary in Their Requirements for Protocol Use

Some CCACs have worked with their service providers to come up with standard care protocols to be used uniformly across the CCAC region. Other CCACs are more “hands off” and have not prescribed the use of specific care protocols. We obtained information from the 14 CCACs to determine the range in required use of protocols. We found that, depending on the CCAC, service providers are required to use anywhere from two to 15 care protocols in their home-care services for CCAC clients. For medical conditions where a CCAC does not require the use of a specific protocol, service providers can use a protocol of their choice (if any exist for that condition).

#### Different Clinical-care Protocols Are Being Used for the Same Conditions But Which Protocol is Most Effective is Unclear

Given that CCACs vary in their requirements for protocol use, we found examples where patients with the same condition were treated using different protocols depending on which CCAC and service provider were responsible for their care. Since no independent analysis has been done on which protocol is most effective, there is a risk that some patients may be receiving better care than others. Having common clinical-care protocols could help reduce this risk. While we recognize the importance of nurses applying their professional judgment when meeting the needs of patients, the following examples suggest that patients’ care can differ fairly significantly as a result of the diverse protocols or different requirements for using protocols:

- One service provider that operates in several CCAC regions has developed its own care protocol for the treatment of pressure ulcer wounds. This care protocol includes a detailed form requiring the nurse to document the wound treatment plan, as well as wound measurement forms for the nurse to fill out weekly. The protocol also provides references for the nurse to look up more information. However, one of the CCACs the service provider has contracted with has developed its own care protocol for the same condition and requires the service provider to use it. When treating this CCAC's patients for pressure ulcer wounds, the nurse has a protocol checklist specifying what to do that is not as detailed as the service-provider's protocol forms, and no references are supplied to help the nurse if more information is needed.
- One CCAC's protocol for enterostomal therapists is to provide negative-pressure wound therapy in three visits over eight weeks. (Enterostomal therapists care for patients who undergo surgery that enables them to discharge bodily wastes through a surgically created opening in the body; the negative-pressure wound therapy involves using a vacuum to draw out fluid from the wound and increase blood flow to the area, speeding healing). Another CCAC, however, did not require the use of a protocol for this medical condition, and its care co-ordinators would apply their judgment in determining the number of visits that the service providers are to make. This could mean that patients served by some CCACs receive more frequent or intense medical intervention than patients with the same condition who are served by other CCACs.

### 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; and
- 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.

### RESPONSE FROM CCACs

CCACs agree it would be beneficial to standardize leading practices used by service providers across Ontario. In fact, given how closely service providers, CCACs, hospitals, primary-care providers, and other health care partners work together, it is important to standardize leading practices across the entire system for patients. CCACs will collaborate with service providers and other experts to implement leading practices for clinical care.

CCACs understand the benefit of consistent protocols. The existing billing rates that CCACs previously negotiated with over 160 service providers have not been updated for many years, which may make it difficult for CCACs to implement standardized clinical-care protocols for home care. CCACs look forward to working with the Ministry to develop and implement a more streamlined and cost-effective service delivery model for patients across Ontario.

### 5.7.2 Outcome-based Pathways a Step Beyond Clinical-care Protocols but their Implementation On Hold

#### Characteristics of Outcome-based Pathways

Outcome-based pathways outline the outcomes that a patient with a specific health condition is expected to achieve at different stages of treatment. For example, a surgical wound is expected to be

20% to 30% smaller in 21 to 28 days, and fully closed in eight weeks; a knee-replacement patient is expected to demonstrate a 90-degree-or-greater knee flexion in 28 days.

A steering committee with representatives from the Association, the CCACs, the Ministry and stakeholder groups developed the pathways using knowledge gained from evidence-based practices. The Association was responsible for overseeing the pathways project. Between 2012 and 2014, it spent \$5.2 million on the development, implementation and testing of outcome-based pathways for three general types of care: wound care (specifically, pathways were developed for 10 different types of wounds), care for patients recovering from total hip replacement, and care for patients recovering from total knee replacement.

The reason these three areas were chosen for pathway development is that patients with these conditions have “predictable care trajectories.” Because their recovery is predictable, it is easier to identify patients who are not recovering in accordance with the progress points laid out in the pathway. When CCAC care co-ordinators, who monitor patients’ recovery, find recovery to be lagging behind schedule, they can direct necessary resources to improve the progress of treatment and get recovery back on track.

Since outcome-based pathways specify outcomes only, without prescribing or recommending how to achieve them, they complement the use of clinical-care protocols. Outcome-based pathways do not eliminate the need for clinical-care protocols, because clinicians still need to follow specific procedures to achieve the patient outcomes within the time frames that the outcome-based pathways stipulate.

The use of outcome-based pathways is unique to Ontario; a number of provinces and territories, as well as the United Kingdom, indicated that they do not use them in their jurisdictions.

### Eventual Goal is to Shift Some Health-care Funding to Outcome Achievement

In 2012, the Ministry began a multi-year project to reform health-care funding. The reforms include basing some funding to hospitals and CCACs on a formula that incorporates the price of a procedure and the volume of patients treated with it *only if* patients achieved the outcomes determined by pathways. By March 31, 2015, about 50% of hospital funding and about 30% of CCAC funding was based on the new funding model that included selected procedures to be funded differently provided that outcomes were achieved.

The Association’s plan to shift how CCACs pay service providers was in line with these ministry reforms. Once the outcome-based pathways developed for the three areas of CCAC home care (wounds, hip-replacement recovery and knee-replacement recovery) were fully tested and found to be effective and reliable predictors of patients’ recovery, the CCACs could shift from paying service providers per visit to paying service providers for achieving the specific patient outcomes on schedule as laid out in the pathways.

### Fewer Patients Receiving CCAC-provided Hip-replacement and Knee-replacement Care Has Put Outcome-based Pathways Implementation on Hold

Although the testing of outcome pathways for CCAC-provided hip-replacement and knee-replacement care progressed between 2012 and 2014, the Ministry made it possible for many more patients to receive this care through hospitals and Ministry-funded clinics *instead of* through CCACs. As a result, far fewer hip-replacement and knee-replacement patients are now being cared for solely through CCACs. Consequently, the Association has put the outcome-based pathways project for these two areas of care on hold. We explain how this came about in the rest of this section. The use of the outcome-based pathways for hip-replacement and knee-replacement care was on a volunteer basis.

Five CCACs volunteered to pilot-test the outcome-based pathways for these types of care starting in 2012 and through 2013.

In early 2014, the Association analyzed the results of the pilot tests. It found that the hip and knee results supported the expected outcomes at each stage of recovery.

With these positive results from the pilot sites, the next steps would be to determine the reimbursement rates for successful achievement of patient outcomes and to implement the outcome-based pathways for these types of care throughout the province. Once all service providers are using the same pathways for their hip-replacement and knee-replacement patients, and all 14 CCACs are tracking and monitoring the results, the CCACs would consider shifting to outcome-based reimbursement.

However, in 2013, at the same time that the five CCACs were testing the pathways, the Ministry made adjustments to how care for some medical conditions was to be provided in different settings (hospitals, Ministry-funded clinics, and patients' homes). These adjustments meant that significantly more patients recovering from hip-replacement and knee-replacement surgeries were eligible to receive care at hospitals as outpatients and at Ministry-funded clinics *instead of* at home through CCACs. According to the Association, this meant there were not enough patients receiving this care through CCACs to make it viable to proceed with the next step of the project: determining the reimbursement rate for achieving outcomes for hip-replacement and knee-replacement patients receiving care at home.

In September 2014, the same steering committee that had developed the outcome-based pathways decided to put the project on hold for hip-and-knee replacement pending clearer indications from the Ministry on how the CCACs' outcome-based pathway approach would fit into the Ministry's overall health reform strategy and funding model. The project continued to be on hold when we finished our audit work in June 2015.

### Tests Showed More Work Needed on Wound-care Outcome-based Pathways, Putting Implementation on Hold

In contrast to the patients tested on the hip-replacement and knee-replacement outcome-based pathways, the patients tested on the wound-care outcome-based pathways did not achieve the outcomes on the schedule laid out in the pathways. The Association therefore put continuing implementation of these pathways on hold. We explain how this came about in the rest of this section.

Four of the five CCACs that volunteered to pilot-test the hip-replacement and knee-replacement outcome-based pathways also volunteered to test the 10 wound-care outcome-based pathways starting in 2012 and through 2013.

In early 2014, the Association analyzed the results for six of the 10 wound-care pathways. It chose these six because they had a large enough sample size and were easier to assess because the healing time was specifically defined (for some wounds, the pathways are designed to keep wounds from getting worse rather than result in evident healing, making it harder to assess the effectiveness of the pathways, so those pathways were not chosen for analysis). The wound-care results for these six pathways varied among the four CCACs. Also, some types of wounds did not heal as quickly as the outcome-based pathway indicated they should.

The steering committee decided to pause the project for wound care pending further analysis of the data and a clearer understanding of the results. It began analyzing the data in April 2015 and was expecting to issue a report with findings and recommendations in fall 2015.

### 5.7.3 Cost-effectiveness of Clinical-care Protocols and Outcome-based Pathways Not Clear

Admittedly, achieving cost savings is not the sole objective for adopting clinical-care protocols and outcome-based pathways. That said, overall, we

found that the long-term cost-effectiveness of the existing clinical-care protocols and outcome-based pathways was not clear. Our observations are summarized in **Figure 25** and are based on the following:

- Two of the three CCACs we visited did have data on the treatment cost per patient before and after their implementation of clinical-care protocols for the three types of care for which outcome-based pathways exist. (The other CCAC we visited provided data for the most recent two years, but it did not maintain data from 2008, the year before it started applying the protocols.) We analyzed this data and found that using clinical-care protocols did not always result in cost savings.
- CCACs did not always have the information needed to determine if patients achieved positive outcomes after receiving care according to care protocols. Five of the 14 CCACs did not track how many patients returned to CCACs for care, and 10 of the 14 CCACs were not able to track how many patients returned to hospital after nurses treated them following the care protocols. Even though one CCAC tracked how many patients were treated according to care protocols and ultimately discharged from home care, this in itself does not necessarily mean a positive patient outcome. It could just be that the patient was transferred to another care setting, such as a hospital or a long-term-care home—the CCAC used the same discharge code for both scenarios.
- Even when CCACs followed the same care protocol, the number of nursing visits required by the time a condition was determined to have healed varied widely among the CCACs we visited. In the case of diabetic foot ulcers, nurses in one CCAC visited patients an average of 32 times by the time they determined that the wound had healed, compared to 50 times in another. Similarly, in the case of venous leg ulcers, nurses in one CCAC visited patients an average of 49 times by the time they determined the wound had healed, compared to 18 times in another.
- Further work on both wound care and hip-and-knee outcome-based pathways was suspended as of September 2014. As previously mentioned, the Association informed us that it needed to further analyze the wound-care results, but this work had not been completed at the time of our audit.

**Figure 25: Savings or (Cost Increases) Incurred After Implementation of Care Protocols, Year Ending March 31, 2014**

Sources of data: Selected CCACs

	CCAC #1	CCAC #2*	CCAC #3
Use of protocols resulted in lower costs	Yes for 4 wound types and hip and knee	Yes for 5 wound types	Yes for 7 wound types and hip and knee
Service cost reduction	2%–36% for wounds, and 5% each for hip and knee	0.5%–23%	14%–23% for wounds, 8%–14% for hip and knee
Savings	\$229,000	\$630,000	\$1.6 million
Use of protocols resulted in higher costs	Yes for 3 wound types	Yes for 4 wound types	Yes for 4 wound types
Service cost increase	2%–8%	0.1%–18%	4%–15%
Additional cost increases	\$403,000	\$1.5 million	\$215,000
Net savings/(cost increases) incurred	(\$174,000)	(\$870,000)	\$1.4 million

\* Analysis for this CCAC is based on cost trends between 2012/13 and 2013/14 rather than before and after implementation of care protocols, as this CCAC did not have cost data from 2008, the year prior to its implementation of the protocols.

## 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.

## RESPONSE FROM CCACs

CCACs recognize that standard data requirements will measure the effectiveness of consistent leading practices. Strong data and measurable protocols provide CCACs with the information necessary to enhance patient care efficiently and manage costs effectively. CCACs recently updated data requirements for the protocols in their reporting system. All CCACs will be trained on the use of these data requirements by March 31, 2017, and CCACs will collect the necessary data to better support and measure the successful implementation of leading clinical practices and pathways.

## Appendix 1—Typical Services Provided by Health-care Staff Employed by Service Providers

Prepared by the Office of the Auditor General of Ontario

Type of Health-care Staff Employed by Service Providers	Typical Services Provided
Nurses	<p>Administer clinical treatments depending on patient needs (for example, apply dressing to wounds, administer medication, monitor medical devices, and provide bed-rest care). Complete reports on patient throughout care, including:</p> <ul style="list-style-type: none"> <li>• an initial report to summarize assessment of patient, care-plan goals, and number and frequency of visits;</li> <li>• a change-of-status report (if the patient's status changes);</li> <li>• a risk-event report (if an event that negatively affects the patient, such as an adverse reaction to medication, occurs);</li> <li>• an interim report (a report summarizing the interim progress made in the patient's recovery); and</li> <li>• a discharge report (a report explaining the nurse's recommendation to discharge the patient).</li> </ul>
Personal support workers	Perform personal support and homemaking tasks (for example, bathe client; assist client with oral hygiene; assist client with elimination of bodily waste; and house-cleaning).
Other Health Professionals	
<ul style="list-style-type: none"> <li>• Physiotherapists</li> </ul>	Assist in the development or improvement of motor skills, perceptual skills and sensory processing skills; carry out massage, traction, passive range of motion and acupressure; apply compression therapy; and administer medical equipment.
<ul style="list-style-type: none"> <li>• Occupational therapists</li> </ul>	Assist in the development, maintenance, restoration or improvement of motor, perceptual, cognitive, communication, sensory-processing and coping skills; prescribe and train patients to use mobility aids, adaptive devices, transfer aids and other equipment; and recommend alterations and renovations to a patient's physical environment to improve safety or to achieve the patient's optimal level of functioning.
<ul style="list-style-type: none"> <li>• Speech language pathologists</li> </ul>	Assist patients with the development, maintenance, restoration or improvement of motor speech, articulation, phonological voice production, cognitive communication, augmentative communication, alternative communication, and resonance.
<ul style="list-style-type: none"> <li>• Dietitians</li> </ul>	Prescribe personalized diets for patients; educate patients about planning menus, safe storage of food, planning of grocery lists, and obtaining access to food; assess, plan and intervene for identified nutritional needs related to swallowing difficulties; and assist with enteral (feeding through the gastrointestinal tract) and parenteral (intravenous) feeding.
<ul style="list-style-type: none"> <li>• Social workers</li> </ul>	Provide counselling and emotional support to patients and/or the caregiver; develop stress-management programs; and assist with obtaining alternative housing.

## Appendix 2—Selected Key CCAC–Service Provider Contract Terms

Prepared by the Office of the Auditor General of Ontario

Contract Terms	Details
Market share	For each service that any service provider supplies (e.g., personal support), the service provider is contractually awarded a certain percentage of the CCAC's expected total allotment for that service. This is known as its "market share" for that service. Thus, a service provider with a 40% market share for a particular service would receive 40% of all referrals made to all service providers supplying that service to the CCAC in the geographic service area. If a service provider has performance issues over a period of time, the CCAC may choose to reduce its market share (that is, reduce the percentage of referrals it makes to that service provider).
Service-provider system and program requirements	<p>Service providers must have the following in place:</p> <ul style="list-style-type: none"> <li>• an information system that stores patient information and communicates with the CCAC system;</li> <li>• a risk-management program that could include a system that tracks and reports risk events (such as a patient fall), and an emergency plan to deal with events such as strikes, natural disasters, etc.;</li> <li>• a quality-management program that could include a system that monitors the service provider's performance and tracks results against the performance indicators; and</li> <li>• human resources requirements that specify that the service provider has to recruit, train and supervise nurses, personal support workers, and/or therapists.</li> </ul> <p>In addition, the service provider shall:</p> <ul style="list-style-type: none"> <li>• monitor patient satisfaction through tracking of patient queries and conducting patient and caregiver satisfaction surveys; and</li> <li>• carry out random audits of patient records at least once per fiscal year to ensure the records are maintained in accordance with application standards and guidelines (e.g., those of the College of Nurses of Ontario).</li> </ul>
Service-provider reporting requirements	<p>Service providers are expected to submit the following reports to the CCACs:</p> <ul style="list-style-type: none"> <li>• every three months: a report of performance results, any missed care and adverse events; and</li> <li>• every year: a report including a summary of the results and outcomes of performance indicator measurement; a valid certificate of good standing issued by the Workplace Safety and Insurance Board; a summary of the results of the staff satisfaction survey; and a summary of findings on patient complaints and risk-event occurrences and the resulting quality improvement actions.</li> </ul>
CCAC contract monitoring	Depending on service-provider performance, CCACs may issue a quality-improvement notice to the service provider, withhold payments or reduce service volume.
Termination	The CCAC or service provider can each terminate the contract with a notice period ranging from 60 days to six months, depending on the circumstances. Circumstances under which the agreement may be terminated include if the service provider or the CCAC default on contract requirements (for instance, if the service provider submits false or misleading information to the CCAC in any two consecutive quarters) and at the convenience of the CCAC or the service provider.



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