1. How often in the past four years has your organization had to take action mid-way through the fiscal year to avoid a projected deficit.

By year-end, CCACs are required through their Service Accountability Agreements with Local Health Integration Networks (LHINs) to achieve a balanced budget. CCACs regularly monitor growth in demand for services, and work together with their LHINs to ensure a balanced budget. The *Community Care Access Corporations Act, 2001* requires CCACs to seek approval from the Ministry to borrow money to address cash flow issues that may arise from fluctuations in service demands.

In a White Paper called *Making Way for Change: Transforming Home and Community Care for Ontarians* recommendations were put forward by the Ontario Association of Community Care Access Centres (OACCAC) to stabilize funding and predictability over time, driving sustainable innovation and continuity in patient care.

LHINs are responsible for determining CCACs' budget allocations each year. Funding flows and allocation decisions vary across the province. Allocations were not necessarily driven by need or equity considerations – they are assessed at each LHIN's discretion and based on local system pressures and varying priorities.

Annual funding allocations to CCACs are usually confirmed about mid-way through the fiscal year. By then, the expanding demands, patient volumes and increasing complexity of patients' health care needs leave CCACs little flexibility in their budgets. As a result, CCACs make mid-year adjustments to ensure a balanced budget by year-end. CCACs recognize the importance of maximizing efficiencies to ensure the maximum resources are devoted to patient care. The responses below indicate these efficiencies may include:

- Identification of administrative savings
- Operation of nursing clinics
- Prioritizing resources to provide care first to patients with the most urgent and complex care needs and working with community support services to ensure that 'lower' or 'mild' needs patients have access to the care and supports they require
- Evaluating and maximizing efficiencies in program design and continuous quality improvements (several specific examples are provided below)

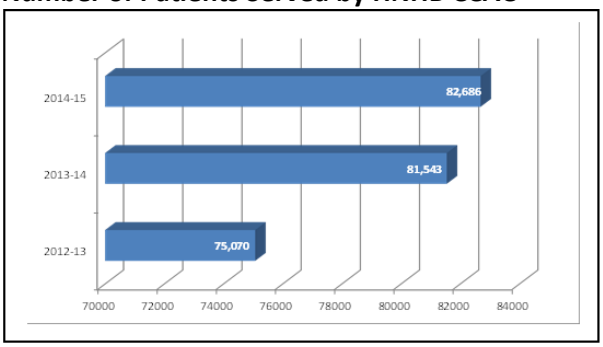
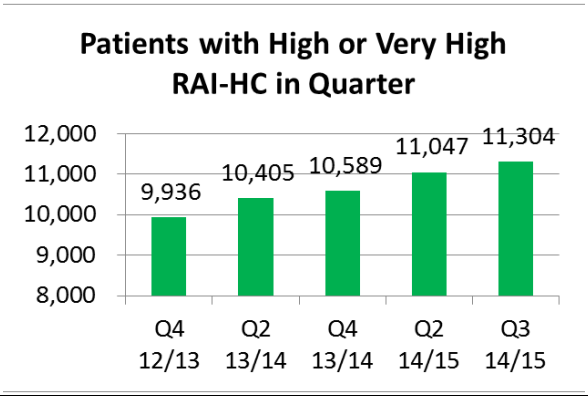
The number of people served through CCACs has increased 101 per cent since 2003/2004,[1] and the people CCACs care for now are more complex. The number of high-needs patients requiring long-term support has grown 73 per cent since 2009/2010.[2] The cost of caring for complex patients with long-term care needs has increased by nearly 21 per cent over the past five years.[3] Most CCAC patients have long-term needs that require multi-year commitments, making budgeting more difficult to predict and manage.

Central CCAC	The Central CCAC continually monitors its fiscal status throughout the year and makes necessary adjustments to maximize quality services and balance the budget, as per the M-SAA requirements. All performance metrics are reviewed on a monthly basis using a balanced scorecard approach and adjustments made as necessary.

[1] Ministry of Health and Long-Term Care Health Data Branch Web Portal, Individuals Served In-Home Health Care (Table 3).
[2] OACCAC utilization report: Average Monthly Active Complex and Chronic referral per cent change from FY2009/2010 to 2013/2014.
[3] MSAA Indicators: Average Monthly Cost Per Episode – Adult Long-Stay Complex from FY 2010/2011 to 2014/2015.

	A factor that significantly impacts the Central CCAC and its ability to provide consistent service levels throughout the year is the timing of in-year funding confirmations. Currently, these confirmations are generally received in the second half of the fiscal year. Following the confirmation of the final in-year funding, and depending on the confirmed funding amount, the Central CCAC took actions to ensure the delivery of balanced financial results. Background information: *M-SAA Conditions of Funding:* *(a) The HSP will:* *(i) Fulfill all obligations in the Agreement, including the Schedules;* *(ii) use the Funding only for the purpose of providing the Services in accordance with Applicable Law and the terms of this Agreement;* *(iii) spend the Funding only in accordance with the Service Plan; and* *(iv) propose, achieve and maintain an Annual Balanced Budget.* *(b) "Annual Balanced Budget" means that, in each fiscal year of the term of this Agreement, the total expenses of the HSP are less than or equal to the total revenue, from all sources, of the HSP.* *(c) The LHIN may impose such additional terms or conditions on the use of the Funding which it considers appropriate for the proper expenditure and management of the Funding.*
Central East CCAC	Response to questions 1 & 2 provided jointly. See question #2.
Central West CCAC	The Central West CCAC continues to experience unprecedented demand for its services and to support patients with increasingly complex needs. We actively manage our budget allocation throughout the year to provide care for as many new patients as possible while honouring our commitment to continue to support existing patients. Each year, we work closely with our LHIN to review base funding and to explore the potential for new funding to support the increasing need in our community. We also meet regularly throughout the year to monitor and review funding challenges and opportunities. As per our Multi-Sector Accountability Agreement (M-SAA) with the Central West LHIN, the Central West CCAC must achieve and maintain a balanced budget each fiscal year.
Champlain CCAC	**Background:** The Champlain CCAC is committed to transparency, quality, and value for money. Detailed on our website we provide comprehensive information on our finances, governance, patient care and performance. See http://healthcareathome.ca/champlain/en/Our-Performance/Transparency-and-Accountability **Response to question #1:** Planning and forecasting is conducted on a monthly basis to ensure we operate within our financial resource allocations – and that we are able to provide care to as many people as possible. With rising demand and acuity, the Champlain CCAC continues to focus on meeting the increasing needs of patients and their families across our region, while continuously improving quality.

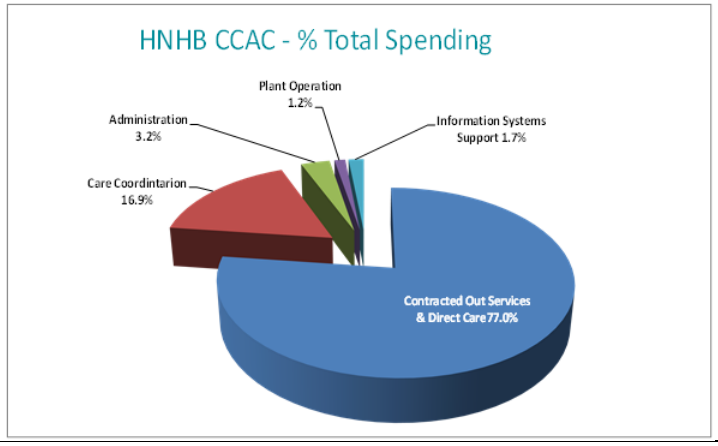
	Detailed on our website you will find comprehensive Board minutes, presentations and reports that outline the budget strategies undertaken, progress and evaluation. See 2012 and 2014: http://healthcareathome.ca/champlain/en/Who-We-Are/Leadership/board/board-meetings-and-materials
Erie St. Clair CCAC	The Erie St. Clair CCAC works closely with the Erie St. Clair LHIN to continuously monitor our progress and the operational pressures we face each fiscal year. The Erie St. Clair CCAC has taken action on two separate occasions in the last four years in order to address operational cost pressures. This occurred in 2011/2012 as well as during the 2014/2015 fiscal year with the intent to balance by March 2016. The Erie St. Clair CCAC continues to take the appropriate steps to manage resources and work to provide more value for the care we provide to meet the community care needs of this region.
Hamilton Niagara Haldimand Brant CCAC	**Background** HNHB CCAC is responsible for leading the delivery of government-funded home care for people in a region made up of more than 1.4 M people. In 2014/15, the CCAC served more than 82,000 individuals across our region. As our health care system continues to evolve – home and community care in particular – HNHB CCAC has continued to align its services to support patient care needs. During this time, such factors as patient preference, changes in the types of home care services, and the government initiative to provide more care closer to home have led to numerous changes in the provision of patient care. As the population ages, more people are receiving care at home and in their community. In 2013-2014, **HNHB CCAC provided care for one out of every 17 people, and half of all seniors aged 85+ in our region.** Our patient population is also growing in its complexity with care needs increasing. **In 2013-2014, nearly 60 per cent of HNHB CCAC's patient care service budget was spent on 10 per cent of our patients.** HNHB CCAC works closely with its service provider partners and many others to support patient care including: • 9 hospital corporations (22 sites) • 85 long-term care homes • 80 community support services • 5 residential hospices • 9 school boards representing 502 schools **Response to question #1:** HNHB CCAC diligently monitors service demands against its budget. We work closely with our LHIN to review changes in demands for services and support access to care. Funding announcements are made throughout the fiscal year (e.g., one-time or recurring). HNHB CCAC adjusts its services to balance demand with available resources and works with the LHIN and other partners to support implementation of new initiatives. Over the past five years, the number of patients cared for by the CCAC has increased significantly (see chart

	below). HNHB LHIN has recognized the increasing demands for home and community care with additional in-year funding. As an example, in 2014/15, HNHB CCAC worked closely with the HNHB LHIN to support additional personal support and in-home nursing care ($13.5M) for patients. **Number of Patients Served by HNHB CCAC**  The needs of patients have also become more complex. This includes patients who have a diagnosis related to cancer, end stage kidney disease, neuromuscular disease, respiratory illness, stroke and heart failure. 
Mississauga Halton CCAC	We serve one in 26 residents in the Mississauga Halton LHIN region. The needs of our patients are changing and we focus on the frailest and at-risk patients in our community – and those patients cost more to care for. The demand for our services continues to outpace funding. We forecast and plan for patient demand and we scrutinize our spending weekly. The funding we receive annually does not match the growth rate of patient needs in our region. The demand from patients leaving hospitals and from people in our community exceeds this funding. Each year, we plan and implement efficiencies. An example is to defer filling vacant positions in our support portfolios. Our organization took action in 2012/13 and this past fiscal year 2014/15 regarding projected deficits as a result of the increased demand in our services. In fiscal 2012/13, the Mississauga Halton CCAC had a deficit of $2.9 million – 2.1% of our budget. This was not a surprise to our board, which anticipated this deficit because the demand for our services continued to outpace funding. We are one of the lowest funded CCACs. It was a temporary situation and the deficit was retired between April 1, 2013 and

	September 2013. In 2014/15 the Mississauga Halton LHIN recognized the double-digit growth in patient demand and enabled the Mississauga Halton CCAC to end the fiscal year within a corridor of one per cent. Our Board of Directors approved a motion which allows us to balance within a corridor of up to one per cent of budget (approximately $1.4 million), rather than requiring us to balance our budget by fiscal year end, March 31, 2015. This is consistent with how hospitals are permitted to manage their budgets. It means we can coordinate care for more patients than budgeted. To provide some context to these numbers, the Mississauga Halton region is home to more than one million residents and has the second fastest growing seniors' population in the province. We care for 1 in 26 residents. And the demand for care from residents will grow exponentially. In our region, in just 15 years, the number of people aged 75 and older will increase 143 per cent. In 20 years, there will be twice the number of seniors in Mississauga Halton than there are today. Anticipating this growth, the Mississauga Halton LHIN undertook a community capacity plan, with the support of the Mississauga Halton CCAC; that plan forecasts and anticipates community demand in our region. Based on extensive research, that study will enable us to develop longer-term planning to meet the needs of all residents in our region. If you would like more information about how we optimize our scare resources or the ground-breaking community capacity study, we will connect you with our subject matter experts.
North East CCAC	The North East CCAC and the NELHIN work closely together to establish and monitor the base budget and any one-time commitments that arise during the year. Necessary adjustments are made to maximize services while achieving a balanced budget. Budget forecasting is done monthly and provides a basis for short-term and long-term planning.
North Simcoe Muskoka CCAC	North Simcoe Muskoka CCAC works closely with the LHIN each year to review base funding, and potential new funding commitments, to support growth and demand of our services and, subsequently, target service utilization levels based on these projections. Further to this, we meet regularly with the LHIN throughout the year to monitor and review funding challenges and opportunities. Our goal every year is to ensure that the CCAC achieves a balanced budget through using our resources in the most efficient way to meet our patient's needs and serve a growing population with chronic and complex needs.
North West CCAC	In each year the NWCCAC and the NW LHIN take action early and throughout the fiscal year to avoid the projected deficit and ensure continued service delivery for patients.
South East CCAC	The South East CCAC works closely with the South East LHIN to review base funding and any expected new funding commitments. We monitor operations throughout the year and make any necessary adjustments to respond to new program initiatives and system pressures.
South West CCAC	In each of the last four years, we have established our budget collaboratively with our LHIN and Board at the beginning of each fiscal year and have maintained that budget plan throughout the fiscal year.

	• We have not had a deficit in the past four years.
Toronto Central CCAC	We have not had to take any mid-year action to avoid a projected deficit in the last 4 years. The demand for CCAC services has been steadily increasing over the last few years and as a result we use annual and multi-year forecasting for financial management. We work closely with our LHIN to develop an annual plan that allows for growth but also ensures stability in community health services for our region.
Waterloo Wellington CCAC	As you know, legislation requires that CCACs end each year with a balanced budget - no deficit and no surplus. We monitor our budget against performance on a monthly basis throughout the year to ensure that we stay on track. Often we don't know our exact budget allocation until well into the fiscal year. This can create the need for in-year adjustment to balance at year-end.
2. What actions have you taken? When?	
Central CCAC	Central CCAC continually looks for opportunities for efficiencies that enable maximum resources to be allocated for patient services. Ongoing monitoring of the budget and service volumes has resulted in a number of actions, including: • Identified administrative savings that could be reallocated to patient services, building capacity to serve more patients. Reduced administrative spend from **8%** of the total budget in 2011-2012 to **7.3%** in 2014-2015. • Increased the percentage of budget spent on services delivered by Central CCAC contracted service providers from **71%** in 2011-2012 to **73%** to 2014-2015. • Transitioned appropriate patients to alternative services, such as assisted living and adult day programs • Reviewed and updated care plans to provide the optimal level of services for each patient based on their changing needs. Embedded continuous review of care plans into ongoing processes to support increased access and equity of services. • Maximized the use of community clinics for nursing services as a best practice - increased the number of clinic visits from **64,520** in 2011- 2012 to **103,639** in 2014-2015. • Introduced two Wildly Important Goals (WIGs) to achieve best practice in care coordination and reduce the personal support wait list for high needs patients. Since December 2014, Central CCAC has reduced the number of high needs patients on the waitlist from 752 to 150 in April 2015 and we continue to make progress with a goal of eliminating waitlists for high needs personal support patients by March 2016. • Utilized waitlists as necessary • No waitlists for nursing and physiotherapy services
Central East CCAC	**Response to questions 1 and 2** In order to live within our means and achieve a balanced budget at year end, which is a legislative requirement, we monitor the volume and care levels of patients on a daily basis and meet weekly to review and discuss our patient utilization. These reviews help us to ensure that we are prioritizing the use of our resources to provide care first to patients with the most urgent and complex care needs, and applying the use of our resources in a consistent and equitable manner.

	We have also developed tools and service planning guidelines which Care Coordinators use in concert with their professional judgment and experience to assist them in consistent care planning for the patients they serve. The standardized RAI Assessment tool used by the Care Coordinators assists them in gathering pertinent information and this information is used in a consistent manner which supports the determination of the levels of Personal Support service required by patients and promotes consistent access to community services and effective and efficient use of financial resources. Central East CCAC has a higher demand for some services and must place some patients on wait-lists until capacity to provide that service becomes available. In order to meet our legislative requirement to achieve a balanced budget, and given this demand, we currently have wait-lists for patients needing in-home Personal Support services excluding Palliative Care patients. In addition we have wait-lists for Occupational Therapy and Speech Language Pathology services for children in school.
Central West CCAC	In keeping with our philosophy of investing resources where they're needed most, the Central West CCAC continuously seeks opportunities to reduce administrative costs and further invest in patient care. For example, we have: • Integrated our non-clinical services with our two hospital partners, resulting in a 30 per cent reduction of overall VP complement and reduction in executive compensation across the three organizations • Optimized other community resources, such as assisted living and adult day programs, as appropriate to support patients' needs • Maximized the use of community nursing clinics as a best practice. In 2014-2015 alone, the Central West CCAC supported 94 per cent more patients through its nursing clinics than in the previous year. • Reviewed and updated patient care plans to support appropriate service adjustments as patients' needs change. • Utilized waitlists for in-home personal support services for patients with less-complex needs when demand exceeded available resources. When a patient is waitlisted, we continue to navigate them to other options available in their community, monitor their status, and provide care to waitlisted patients as resources become available. For more information, wait list/wait time information is available on our website.
Champlain CCAC	As noted in the response to question 1, you will find detailed information on our website with comprehensive Board minutes, presentations and reports that outline the budget strategies undertaken, progress and evaluation. Please refer to 2012 and 2014 – years in which significant actions were undertaken to balance increasing demand with available resource allocations. See: http://healthcareathome.ca/champlain/en/Who-We-Are/Leadership/board/board-meetings-and-materials
Erie St. Clair CCAC	The Erie St Clair CCAC has implemented a number of strategies in order to generate savings and to position the organization to meet the evolving and growing needs of our patients and their families.

	In 2012/13 - 2013/14, the Erie St. Clair CCAC introduced strategies under the "Balancing the Cost of Care" (BCC) initiative to address operational pressures. The BCC is an ongoing internal program meant to seek out and eliminate waste, and to find ways to do more with the resources we receive. This includes reductions in administrative costs, an introduction of a new model for the provision of Personal Support services and the centralization of our medical supplies depot. In 2014/2015, the Erie St. Clair CCAC and the Erie St. Clair LHIN worked collaboratively to develop eleven key strategies using a laddered approach to assist us in achieving a balanced budget. These strategies included an administrative cost reduction of $1 million, a realignment of low and mild need patients that we serve while focusing our resources on the most complex patients who require greater care to be consistent with the provincial sector average. These strategies also included staying within the funding envelope of the Ministry of Health and Long-Term Care funding for direct nursing positions, as well as improving our referral system to community support service agencies to ensure access to a complete basket of services.
Hamilton Niagara Haldimand Brant CCAC	The HNHB CAC continues to support care for as many patients as possible by providing care in the right location (e.g., nursing care centres, therapy clinics), with the most appropriate provider (e.g., enabling providers to work to their full scope of practice) and most appropriate organization (e.g., referral to other community agencies). CCAC Care Coordinators are regulated health professionals who support the development of care plans for their patients that may include services provided by CCAC and/or community support services such as adult day programs, community meal programs, etc. We remain focused on operational efficiency to maximize patient services. See chart below profiling total spending for 2013-2014. 
Mississauga Halton CCAC	In 2012/13, we implemented a number of leading practice initiatives which resulted in savings and redirect funds to serve as many patients as possible. We also re-designed our programs, based on patient data over the previous three years. Our ***Wait at Home*** suite of services (***Wait at Home***, ***Wait at Home Enhanced***) is an example. The **Home First** philosophy, on which those programs are based, recognizes the home environment is the best place for recovery and supports people to return to their homes from hospital wherever possible. It also provides the necessary services to help older adults maintain

	their continued independence in the community. This frees up spaces in hospitals for patients who require medical or surgical procedures, as well as in long-term care homes. To learn more about the ***Home First*** Philosophy I invite you to view the following video which the Health Council of Canada produced: https://www.youtube.com/watch?v=PsFDFsIfh44. The video highlights how the program helps manage alternate level of care (ALC) rates in the province through intensive care coordination and home care supports. Interviewed in the video are a number of our patients who explain how **Home First** helped them remain at home and out of long-term care. In addition, one of our patients is featured on page 67 in the Health Quality Ontario's *Measuring Up* – a yearly report on how Ontario's health system is performing. Muhammad, who came home from the hospital a year ago and is able to remain at home with our services, is featured in the report on page 67 as an example of how the health care system is working well. See HQO Report. (PDF)
North East CCAC	The North East CCAC achieves a balanced budget each year by actively monitoring expenditures and making necessary adjustments. Comprehensive financial forecasts are prepared monthly to support planning. Any necessary changes in service levels are introduced in a timely and sustained way to avoid excessive fluctuations. The NE CCAC is committed to continuous quality improvement and endeavours to minimize the impact of service changes on patients.
North Simcoe Muskoka CCAC	The NSM CCAC strives to achieve efficiency gains through a number of mechanisms implemented each year grounded in a culture of continuous quality improvement embraced by the organization. For example, quality improvement efforts, resulting in efficiencies, maybe focused on patient safety initiatives, best practices reviews, health system improvement partnerships, etc. The CCAC has been involved in developing Quality Improvement Plans for a number of years with the intent to make improvement at both the patient and system level: The current QIP is posted on our public website.
North West CCAC	The NWCCAC and the NW LHIN discuss the service needs of the community and the funding required to provide the services early in each fiscal year. Funding negotiations occur throughout the fiscal year to address the service pressures in the community.
South East CCAC	The SE CCAC works with the SE LHIN, hospital and community based partners to identify priority service areas and efficiency opportunities for adoption throughout the year. Some 2014/15 examples include: reduced administrative travel, improved consistency of service provision across our geography, working with our LHIIN to create a program to provide Assisted Living for Frail Seniors.
South West CCAC	Not applicable.
Toronto Central CCAC	Annually we target a number of quality improvement initiatives to enable us to meet our sustainability and quality improvement objectives. Examples of improvement efforts include: the development of neighborhood care teams (dedicated teams of personal support workers and Care Coordinators caring for a building or neighborhood catchment); using technology to support and extend care to specific populations (tele-homecare & telemedicine); and our advanced wound care practice work. Initiatives are planned over multiple years and are selected and advanced according to the initiatives' potential to

<table>
<tr><td></td><td>meet our quality and sustainability objectives.

Additionally, planning collaboratively with our LHIN to understand and manage growth in home and community care has been an important part of our management strategy.</td></tr>
<tr><td>Waterloo Wellington CCAC</td><td>We start by looking for administrative efficiencies that can be implemented without impact on patient care.
In 2014-2015 and 2013-2014 no further action was required.

In 2012-2013 we faced significant financial challenges and were forced to put some light needs patients on a waitlist for personal support.

Every year for the past four years we have had waitlists for our school health support services. The reason is simple: demand for school health support services far exceeds budgeted resources. This leads to wait times for students with minimal or light needs.</td></tr>
<tr><td colspan="2">3. Has your LHIN provided one-time funding to avoid a deficit? When and how much?</td></tr>
<tr><td>Central CCAC</td><td>No, the Central LHIN has not provided one-time funding to avoid a deficit.

The Central CCAC works closely with the Central LHIN, sharing updated financial and service information throughout the year. The Central LHIN has increased Central CCAC’s funding levels as noted below. Funding is tied to specific deliverables and performance metrics, such as the 5 day wait time for personal support and nursing services.

<table>
<tr><th>Budget Year</th><th>From</th><th>To</th><th>Increased Percentage</th></tr>
<tr><td>2011/12 - 2012/13</td><td>$228,440,011</td><td>$238,614,820</td><td>4%</td></tr>
<tr><td>2012/13 - 2013/14</td><td>$238,614,820</td><td>$258,359,457</td><td>8%</td></tr>
<tr><td>2013/14 - 2014/15</td><td>$258,359,457</td><td>$283,717,762</td><td>10%</td></tr>
</table>
</td></tr>
<tr><td>Central East CCAC</td><td>No.</td></tr>
<tr><td>Central West CCAC</td><td>We continuously work with our LHIN to ensure we are able to optimize scarce health care resources.</td></tr>
<tr><td>Champlain CCAC</td><td>The Champlain LHIN and Champlain CCAC meet regularly throughout the year to review operating plans, forecasts and volume. We receive a combination of one-time and base funding during the year, typically in multiple tranches. Final funding levels are usually confirmed to the LHIN later in the fiscal year. In fiscal 14/15, our base funding contribution was confirmed in November 2014, and we received our last tranche of one-time funds in January 2015.</td></tr>
<tr><td>Erie St. Clair CCAC</td><td>The Erie St. Clair CCAC has been committed to working with our LHIN to identify and implement strategies to address operational pressures. In addition to base funding adjustments, the Erie St. Clair LHIN has provided one-time funding on three separate occasions over the last four years.
In 2011-2012, they provided $1.2 million in one-time funding to maintain services for</td></tr>
</table>

<table>
<tr><td></td><td>complex high needs patients and to reduce wait times in the emergency department, a provincial priority. As well, in 2014/2015 the Erie St. Clair LHIN provided one time funding in the amount of $1.6 million. This funding came in two separate announcements. The first funding allocation as part of this amount was made in February 2015, to address the extra cost incurred by the CCAC as a result of a delay in the opening of a Long-Term Care home. The Erie St. Clair CCAC provided additional resources to patients waiting in the home prior to the opening of the Long-Term Care home. The second funding allocation as part of this amount was made in March 2015, as a one-time funding support to assist with the extraordinary fiscal 2014/15 operating cost pressures.</td></tr>
<tr><td>Hamilton Niagara Haldimand Brant CCAC</td><td>Yes. Due to extraordinary demand, HNHB CCAC received one-time funding of $4M (1.3% of total revenue) in 2013-2014, to achieve a balanced operating position at fiscal year-end.
<table>
<tr><th></th><th>2014-15</th><th>2013-14</th><th>2012-13</th></tr>
<tr><td>Total Revenue (LHIN/MOHLTC)</td><td>307,648,683</td><td>301,471,555</td><td>270,596,234</td></tr>
<tr><td>Year-over-year increase in revenue</td><td>2.05%</td><td>11.41%</td><td></td></tr>
</table>
Over the past two years, CCAC experienced significant increase in demand (see charts in Question #1). Working with the LHIN and other partners, CCAC supports strategies that enable patients to receive care at home and remain living at home or in their community for as long as possible. CCAC has worked closely with HNHB LHIN to monitor and manage increasing pressures and scale resources accordingly.</td></tr>
<tr><td>Mississauga Halton CCAC</td><td>In 2014/15, the Mississauga Halton LHIN provided one-time funding of $1.2 million to offset costs associated with caring for more patients with high-care needs.</td></tr>
<tr><td>North East CCAC</td><td>The North East CCAC receives a mix of base and one-time funding each year as determined in discussions with the NELHIN. One-time funding is usually targeted for specific initiatives.</td></tr>
<tr><td>North Simcoe Muskoka CCAC</td><td>North Simcoe Muskoka CCAC works closely with the LHIN and keeps them apprised of financial pressures. In any given year, we may receive a combination of base and one-timing funding allocations. Due to factors outside of the LHIN's control, the receipt of funding may not be confirmed until the latter part of the fiscal year. In fiscal 2014-15, funding was not confirmed until November 28th, 2014.</td></tr>
<tr><td>North West CCAC</td><td>The LHIN has not provided one-time funding to avoid a deficit.</td></tr>
<tr><td>South East CCAC</td><td>The SE LHIN has provided one-time funding every year for various targeted initiatives. Typically these can vary from small specialty projects such as a few thousand dollars for an electronic interface with a hospital up to $1.5M to maintain services to increasing numbers of complex patients.</td></tr>
<tr><td>South West CCAC</td><td>No.</td></tr>
<tr><td>Toronto Central CCAC</td><td>Yes. The organization received one-time funding of 1.6M in 2014/15 (0.7%). This was a one-time support strategy by the LHIN as the 14/15 community allocation was less than anticipated for the year.</td></tr>
</table>

Waterloo Wellington CCAC	No.

4. In the last two years, has your CCAC in a systematic way either discharged light-needs clients or transitioned light-needs clients to community support services in an effort to save money? If so, please say how many.

Patients with high-care needs include the frail elderly, children who are medically fragile and people who are living with multiple or complex health conditions. Low-mild needs patients, typically, are able to sponge bathe themselves, manage medications, are cognitively sound, do not have any home environment challenges or behavioural symptoms and they do not have any wounds or skin integrity issues. This type of patient may be better served through other community support agenicies.

The responses below demonstrate that CCACs are focused on helping people who need care the most. Decisions about levels of care are based on the assessment of **each** individual. The proportion of a CCAC's budget that is spent supporting people with high-care needs is growing. Other community services are evolving to meet the needs of many of the lower needs patients that have historically received services through CCACs. CCACs are working with LHINs and community service providers to ensure that 'lower' or 'mild' needs patients have access to the care and supports they require.

Central CCAC	An important role of Care Coordinators is to work with patients and caregivers to provide information and service options across the continuum of care, including community support services such as meal delivery and friendly visiting. Over the last two years, the Central CCAC has waitlisted new low and moderate need patients for personal support services based on the RAI assessment and the clinical judgment of Care Coordinators. These patients were provided information and options regarding appropriate community resources based on their choices and goals. In partnership with the numerous community agencies in the region, Central CCAC is developing a strategy to better serve patients with low and moderate needs, with the aim of working together in new ways to help patients and families explore and access a variety of health services, community programs and supported living options that may be available to them in the community. Background Information: The *Home Care and Community Services Act, 1994*, stipulates the following: ***Provision of services*** *23. (1) An approved agency shall ensure that the services outlined in a person's plan of service are provided to the person within a time that is reasonable in the circumstances. 1994, c. 26, s. 23 (1).* ***Waiting list*** *(2) If a community service outlined in a person's plan of service is not immediately available, the approved agency shall place the person on the waiting list for that service and shall advise the person when the service becomes available. 1994, c. 26, s. 23 (2).*
Central East CCAC	Our CCAC has not systematically discharged light-needs patients. In order to meet the needs of light care patients, and support them in getting the care they need, we have worked collaboratively with our Community Support Services agencies to develop

	processes to seamlessly refer appropriate patients from the CCAC to CSS agencies. For several years we have had Community Support Services personnel physically located in our Community Point of Access (Intake) so that patients calling the CECCAC who might best be served by the services offered by the CSS agencies are able to be immediately transferred to these staff to assess their needs and provide services. This process provides a "one-stop" patient-centred response to the requests for care from lighter needs patients, without them needing to make more calls or wait for follow-up calls. CECCAC Care Coordinators also determine eligibility for Assisted Living High Risk Seniors programs and forward the assessment information directly to the LHIN funded organizations that provide services to these patients.
Central West CCAC	No.
Champlain CCAC	Since 2011, the Champlain CCAC has seen an increase of 22.5 per cent in patient referrals. The number of high acuity patients grew by 26 per cent in that same period. Demand and acuity continue to increase. To meet the growing needs of patients and their families – and meet our obligation to operate within our financial resource allocation – the Champlain CCAC is increasingly focused on higher risk, higher need patients. New regulations introduced in 2014 will allow some community support services agencies to provide personal support services. The Champlain CCAC has been identified as an early adopter and is working closely with the LHIN and community partners on the transition of "lighter needs" patients to community agencies. In 2014 the Champlain CCAC transitioned lighter needs patients to community support services. Detailed reports, decision-making frameworks and evaluations can be found on our website: See: http://healthcareathome.ca/champlain/en/Who-We-Are/Leadership/board/board-meetings-and-materials
Erie St. Clair CCAC	The Erie St. Clair CCAC does not systematically discharge patients to LHIN funded Community Support Service providers in order to save money. Transition to Community Support Services may occur if a patient's condition has changed such that they no longer require CCAC services and it is deemed that they may benefit from other community based services. Often a CCAC Care Coordinator may also refer any individual calling initially for health information or support to a Community Support Services provider. The Erie St. Clair CCAC Care Coordinators are experts in community care and strong advocates for community based quality care provision for their patients. A variety of care and service options exist for patients who are assessed as having low care needs from Geriatric Day Programs to Meals on Wheels. The Erie St. Clair CCAC has developed a strong relationship with LHIN funded Community Support Service agencies in order to strengthen our mandate of providing referrals to community resources for patients who are of lower needs. In 2009, the Erie St. Clair CCAC implemented the Community Agency Access tool (known as the CA2), which is an interactive tool that allows Care Coordinators to directly refer patients to services in the community. The number of **referrals** for the last 24 months is listed below. Fluctuations in referrals may be seen with internal education of Care Coordinators and modification of referral tools. Duplication of service is avoided although some patients receive care and service from both the CCAC and Community Support Agencies at the same

time.

CA2 Referrals

Referrals made to Community Support Agencies.

Referral Year	April	May	June	July	August	September	October	November	December	January	February	March
2013/2014	315	318	279	336	271	276	304	288	211	253	271	299
2014/2015	369	365	374	388	313	363	529	500	401	442	172	503

In 2012, the Erie St. Clair CCAC introduced a new Chronic Disease Prevention Management (CDPM) tool that enables Care Coordinators to refer patients directly to specific chronic disease programs with community providers and agencies. The number of **referrals** for the last 24 months is listed below.

CDM Referrals

Referrals made to community providers/agencies with specific chronic disease programs

Referral Year	April	May	June	July	August	September	October	November	December	January	February	March
2013/2014	181	174	136	445	179	132	163	125	88	96	101	106
2014-2015	94	103	92	87	70	94	170	227	230	183	60	205

These innovative tools have enhanced our partnership with local Community Support Agencies and care providers. They have also assisted our Care Coordinators to provide effective community navigation to individuals in our community to a wide range of services that meet their individual needs.

Hamilton Niagara Haldimand Brant CCAC

HNHB CCAC **has not** transitioned or discharged patients in an effort to save money. HNHB LHIN continues to work with community partners and CCAC to support expanded capacity for the provision of care in the community.

With leadership from HNHB LHIN, agencies – including CCAC – have worked together to support the transition of patients with fewer complex care needs to identified community support service providers. During the past several months, HNHB CCAC Care Coordinators and Community Support Service agency staff have worked collaboratively to support approximately 1,000 CCAC patients to receive personal support care from a LHIN-funded community agency. Patients who required only this level of care would be supported by the Community Support Service agency (discharged from CCAC). Should the care needs of an individual change, CCAC would be re-engaged. As such, CCAC funding will be redirected to support care for these patients in 2015-2016.

This work is supported by a policy guideline from the Ministry of Health and Long-Term Care relating to the delivery of personal support services by Community Care Access

	Centres and Community Support Service Agencies (http://www.health.gov.on.ca/en/pro/programs/ccac/). The focus of this policy guideline is to enhance the capacity of Community Support Services agencies to support older adults who are relatively independent and help improve the ability of CCACs to focus on clients with complex and post-acute needs, thereby building on the strengths of the respective agencies.
Mississauga Halton CCAC	Five years ago, with our community partners, we planned for and began referring our patients with stable, low needs to community services agencies where they could receive bathing care and other personal support services at no direct cost to them. This enables us to focus on patients with high-care needs.
North East CCAC	No, we have not systematically discharged light-needs patients. We work closely with the NELHIN and partners in developing care options and capacity that match patient's care needs. We are working with the LHIN presently on a new Ministry initiative that enables community support service providers to provide personal care to low need patients
North Simcoe Muskoka CCAC	No, there has been no systematic discharge of patients with low needs. Care Coordinators review the needs of each patient and discuss options for care, which could result in referrals to Community Support Services (i.e., Independent Living). Connecting patients with a broad array of community and social supports is a key part of the CCAC mandate in providing Information and Referral to our patients and their families.
North West CCAC	No, NW CCAC has not discharged or transitioned light needs patients to community support services.
South East CCAC	We have not discharged to Community Support Services. We have transferred 86 patients to Assisted Living for Frail Seniors, a partnership of the South East LHIN and the VON. This service has been developed to address the needs of high risk seniors who can reside at home and who require the availability of personal support and homemaking services on a 24-hour basis.
South West CCAC	The South West LHIN invested in additional community services such as supportive housing, assisted living and adult day programs. • We have ensured all appropriate referrals to those important partners, including lower needs patients, to avoid duplication of service and care by the most appropriate provider. • No low needs patients needing CCAC services were discharged. • See answers questions 5 and 6.
Toronto Central CCAC	No, we have not discharged or transitioned patients in an effort to save money. Over the last three years, the CCAC has worked closely with the LHIN on a "right place of care" strategy designed to ensure patients are receiving care from the most appropriate service provider. This strategy has included the transition of patients with lower care needs to select community support service providers who were funded to provide this type of care. The intent of the strategy was to build the capacity of the community sector to support

	lower needs patients and to build the capacity for the CCAC to care for patients with higher care needs. This work resulted in the transition of 400 of the 73,000 patients we serve to community support services. The government introduced new regulations in 2014 to enable community support service providers to provide personal care to low needs patients. The expanded role of community support services is in process.
Waterloo Wellington CCAC	No, we never do care planning based on "an effort to save money." Our Care Coordinators are skilled professionals who assess patients individually, and determine the most appropriate providers to meet patient needs. In some cases, that involves a community support service agency in our community. These agencies are an important part of the community care system, and are our valued partners. In 2013 the Ontario Government, as part of the Action Plan for Health Care, changed its policy to enable community support service agencies to provide personal support services for some patients. We welcomed this change, as it enabled the CCAC to direct more resources to caring for patients with the most complex challenges. Care Coordinators direct patients to the most appropriate community resources. Many patients receive services from both CCAC and community support service agencies. Patients who need services from CCAC are not "discharged."

5. In the last two years, has your CCAC started waitlisting light-needs clients in an effort to save money? If so, when did that start and how long are the lists?

When assessing patient care needs, CCAC Care Coordinators prioritize people whose care needs are most urgent. The responses below indicate that patients who need care urgently will get the care they need right away. People with less urgent or complex care needs may either wait for their services to start or be connected with a community resource. These decisions are made according to a patient's individual assessment and care plan.

With a specific emphasis on reducing wait times for patients with the greatest needs, the Ministry of Health and Long-Term Care introduced a new five-day wait time target for all nursing visits and personal support visits for complex patients.

In 2013/2014, 94 per cent patients received their first nursing visit within 5 days and 84 per cent of complex patients received their first personal support service within 5 days.

Central CCAC	Central CCAC has utilized waitlists as per the *Home Care and Community Services Act, 1994* – see response to question 4. Waitlist information is publicly available on Central CCAC's website - http://healthcareathome.ca/central/en/Our-Performance/wait-times. Funding discrepancies among CCACs impact waitlists. Central CCAC has the highest proportion of high and very high needs patients of all CCACs: 31 per cent of the total average active referrals for high and very high needs patients in the province (as of Q3 2014-2015).

	In addition, the Central LHIN region's rapidly growing and aging population combined with historical funding inequities has impacted the need for waitlists. The Central LHIN has the highest projected growth rate among the LHINs. Between 2011 and 2016, the population in the Central LHIN will increase by 10.1 per cent. Currently, 12.5 per cent of residents in the LHIN – or 221,068 people – are seniors aged 65 or higher. This puts Central among the top three LHINs in terms of absolute numbers of seniors. Full implementation of the Health-Based Allocation Model (HBAM) would provide significantly increased funding for the provision of care by the Central CCAC. Partial implementation of HBAM in 2014-2015 resulted in an increase in Central CCAC's base funding by $1.8 million.
Central East CCAC	Our organization has had a wait-list system in place since before the creation of the 14 CCACs for patients needing In-Home Personal Support services and children In-School (School Health Support Services Program) needing Occupational Therapy or Speech services. Our wait-list numbers are posted on our website, and updated monthly. All Central East CCAC wait-lists are reviewed regularly. There are processes in place to ensure patients have regular contact with their Care Coordinator while they are waiting for service to ensure that we are aware of any changes in their conditions which can be factored in as needed in prioritizing their service initiation.
Central West CCAC	The Central West CCAC is currently experiencing significant demand for services across our region. We are committed to providing care to our highest-needs patients first – and when we have invested all available resources in patient care, patients with less-complex needs may be waitlisted for some services. In the past two years, the Central West CCAC has waitlisted personal support services (PSW), occupational therapy, social work, speech-language pathology, and dietetics, as necessary. When a patient is waitlisted, we continue to navigate them to other options available in their community. For more information, wait list/wait time information is available on our website.
Champlain CCAC	The Champlain CCAC posts all wait times by region and service type on a monthly basis. See http://healthcareathome.ca/champlain/en/Our-Performance/wait-times Note: We have recently begun releasing patients from the waitlist for personal support services – there is no wait time for nursing.
Erie St. Clair CCAC	Since April 1, 2013, the Erie St. Clair CCAC has waitlisted 650 unique patients. As of April 22, 2015, only 13 patients are actively waitlisted for a total of 14 services. This reflects a waitlist held by one contracted service provider for School Health Support Services, and these patients represent lower needs children. Otherwise, there is no wait-listing for services.
Hamilton Niagara Haldimand Brant CCAC	In 2014-2015, HNHB CCAC provided care for more than 82,000 people. HNHB CCAC prioritizes patient care needs according to their individual assessment and care plan.

<table>
<tr><td></td><td>HNHB CCAC manages wait lists for several types of services. As patient care plans are developed or modified, care needs are triaged. Services required most urgently are put in place with no wait lists for nursing care and in-home physiotherapy to ensure home safety. If the identified service is less urgent, the patient may need to wait for services to begin. Care Coordinators regularly contact patients who are waiting for services (e.g., personal support) to determine if their care needs or circumstances have changed, requiring a review of their status.

Additional information regarding HNHB CCAC wait times may be found here: http://healthcareathome.ca/hnhb/en/Our-Performance/Wait-Times</td></tr>
<tr><td>Mississauga Halton CCAC</td><td>We continue to experience high growth and demand for services from residents with high-intensity needs that have increased pressure on our resources.

In December 2014, the Mississauga Halton CCAC began deferring our patients with stable light-needs' to community support services, some of which have wait lists. Not all community services organizations have wait lists. It's important to note that those patients deferred for personal support services continue to receive nursing and other therapies from the Mississauga Halton CCAC, without delay, according to their personal care plan developed by our experienced care coordinators. We are not deferring services for patients with high needs living in our community, nor patients with complex care needs leaving hospital. We continue to help those patients by identifying and accessing alternate options, including financial assistance or care from community agencies. They continue to receive care coordination.

We deferred personal support services for 180 patients out of 7,568 patients with intermediate or chronic care needs for personal support services. Again, these patients still received nursing and other therapies.

We waitlist school health support services for children. Our care coordinators continue to support children that require our services by helping families identify to access alternate options including financial assistance or care from community agencies. We do not waitlist children with high health care needs. Please see chart below.

As of Mar 31, 2015
<table>
<tr><th>Service Type \ Service</th><th>Nursing Services</th><th>Personal Support Services</th><th>Physiotherapy</th><th>Occupational Therapy</th><th>Speech Language Therapy</th><th>Nutrition</th><th>Social Work</th></tr>
<tr><td>School Services</td><td></td><td></td><td>40</td><td>1542</td><td>1217</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>North East CCAC</td><td>The North East CCAC does have wait listing process for all services. Waitlists are related to patient need and service availability.</td></tr>
</table>

<table>
<tr><td></td><td></td></tr>
<tr><td>North Simcoe Muskoka CCAC</td><td>NSM CCAC has maintained service wait lists over this period of time. Here are the current wait list figures as of February 28, 2015 as posted on our public website:

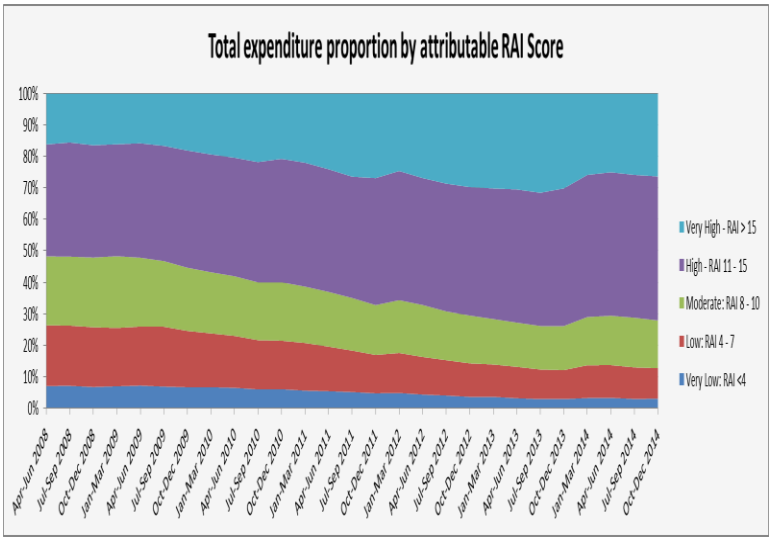
<table>
<tr><th></th><th>Nursing Services</th><th>Personal Support Services</th><th>Physiotherapy</th><th>Occupational Therapy</th><th>Speech Language Therapy</th><th>Nutrition</th><th>Social Work</th></tr>
<tr><td>In-Home Services</td><td>N/A</td><td>411</td><td>71</td><td>135</td><td>49</td><td>10</td><td>45</td></tr>
<tr><td>School Services</td><td>N/A</td><td>N/A</td><td>148</td><td>784</td><td>305</td><td>N/A</td><td>N/A</td></tr>
</table>
(N/A indicates that this service is not wait listed)</td></tr>
<tr><td>North West CCAC</td><td>No.</td></tr>
<tr><td>South East CCAC</td><td>For the first time, the South East CCAC implemented a waitlist for low-need community patients for Personal Support only in September of 2014. The waitlist is posted on the SE CCAC website.</td></tr>
<tr><td>South West CCAC</td><td>No.</td></tr>
<tr><td>Toronto Central CCAC</td><td>No.</td></tr>
<tr><td>Waterloo Wellington CCAC</td><td>As mentioned in the response to questions 4, there is a long history of waitlists of children with light needs for school health support services. These waitlists were not a strategy to save money; they were the result of demand outstripping resources. The current Special Needs Strategy project is working to address resources for these children.

Otherwise there has been no waitlisting in the past two years.</td></tr>
<tr><td colspan="2">6. Can you please provide your RAI score scale, including at which score clients in your CCAC qualify for which kinds of services? As an example, the Champlain CCAC is now discharging/redirecting clients with RAI scores of 11 or lower. Clients with scores between 11 and 20 are automatically waitlisted.</td></tr>
<tr><td colspan="2">All CCACs use standardized assessment tools as an input to a comprehensive assessment of people’s needs and circumstances. A comprehensive assessment is based on many factors, such as their home environment, a person’s formal and informal support system, health care and functional support needs. The responses below confirm that all CCACs use the Resident Assessment Instrument – Home Care (RAI-HC) an internationally recognized, evidence-based tool to inform care planning. However, ultimately care planning decisions are based on the clinical judgment of Care Coordinators taking the totality of person’s needs, circumstances and personal preferences into account, in addition to the outputs from the standardized assessment.

The RAI-HC assessments produce a wide range of evidence-based outputs that consider factors like a person’s need for support with activities of daily living, cognitive status, level of pain, risk of adverse outcomes, mental health, medications and many other factors. All of these outputs help inform Care</td></tr>
</table>

Coordinators in developing individualized service plans for patients. The "RAI-score" is a way of looking at an aggregate of key outputs from the standardized assessment to guide consistent decision-making for patients with similar levels of need, but it is not the only factor considered. As part of care planning, CCAC Care Coordinators consider all of the services that are available in the community to meet a person's needs, including services provide through the CCACs, other community support services, and the support available from friends and family. A patient's plan of care is customized to suit their individual needs and preferences. This may include a service plan that consists of a combination of services from varying community sources. For example, a patient may receive CCAC therapy services, while attending a day program along with additional support from community support service agencies. CCACs are transitioning to an updated assessment tool that has evidence-informed clinical guidelines. In collaboration with the University of Waterloo and the interRAI Group, CCACs are developing new evidenced-informed clinical guidance tools to support Care Coordinators in clinical decision-making related to service planning to support more equitable access to service for patients as the new tool is introduced.	
Central CCAC	The development of a patient's care plan is informed by a number of decision making tools, including the RAI assessment and its outcomes - Client Assessment Protocols (CAPs), Method for Assigning Priority Levels (MAPLe) and other outcome measures associated with a patient's depression, pain, frailty and cognitive ability. The clinical expertise of a CCAC Care Coordinator plays an important role in interpreting this information and incorporating it into the care plan. The CCAC Care Coordinator works closely with the patients and caregivers to understand and include their needs and preferences in the care plan. The RAI is a decision support tool and serves as a guide for developing a patient's care plan – professional assessment by the Care Coordinator is required for determination of eligibility. Central CCAC does not waitlist nursing and physiotherapy services for any patients. Low and moderate needs patients requiring personal support are waitlisted, after an individual assessment of each patient and the family's unique situation.
Central East CCAC	Like all CCACs, we prioritize providing care first to patients with the most urgent and complex care needs. For patients who are assessed and require Personal Support services to transition home from hospital, services are provided in their home and therefore these patients are not wait-listed. Patients residing in the community are assessed and if their RAI Aggregate Score is equal to or greater than 16, and they are a Very High MAPLe* score, they receive service as required. All other patients are wait-listed for Personal Support services (excluding Palliative patients). * MAPLe - Method for Assigning Priority Level – is an algorithm derived from the RAI-HC and provides information about the patient's risk of adverse health outcomes.
Central West CCAC	CCAC Care Coordinators are regulated health professionals who use their clinical skills to assess patients and determine the types and levels of care required to meet their individual needs. Their comprehensive assessment is comprised of a number of elements, including

	an assessment of the patient's physical, cognitive, and functional complexity using the RAI assessment tool. As each patient has unique needs, preferences and circumstances, however, individual care plans are informed by a number of elements. The RAI assessment tool and score is only one aspect of determining the types and levels of care that will best support a given patient.
Champlain CCAC	Patient care plans and service levels are person-specific and based on individualized assessments; the interRAI tool and its outputs do not solely determine service levels for individual patients. The clinical judgment of CCAC Care Coordinators (who are regulated health professionals) determines the level of care provided, based on a comprehensive assessment. This assessment takes into account a patient's physical, cognitive, psychosocial needs, as well as availability of supports to develop an individualized care plan. Please refer to Board minutes, reports, decision-making frameworks and evaluation reports for detailed information on waitlisting and transition/discharge actions: See http://healthcareathome.ca/champlain/en/Who-We-Are/Leadership/board/board-meetings-and-materials
Erie St. Clair CCAC	The assessment to determine a patient's eligibility, health condition or care needs is at the heart of a Care Coordinator's role. A patient's assessment outcome is also based on factors other than health and care needs including the home environment and existing support from family and friends. The Care Coordinator, in their professional judgment, develops a service plan by combining these elements with the outcome of the RAI assessment, a provincially-standardized tool. The Erie St. Clair CCAC, through the role of care coordination, provides community navigation for individuals w with low needs. A variety of other healthcare options exists for these patients and include community support services, municipal services where available, private agencies and support from families/caregivers and neighbours. The RAI score scale is a tool, and does not provide a black-and-white means of assessment for patients, factors listed above, as well as professional Care Coordinator judgment will always play a part in determining service levels.
Hamilton	Care Coordinators are regulated health professionals who work with patients to

Niagara Haldimand Brant CCAC	understand and assess their care needs and develop a care plan. The health needs assessment considers many factors including diagnosis, functional status, formal and informal supports, and the RAI-HC. The RAI-HC explores a number of factors when developing a patient's care plan including health condition, treatment procedures, cognition, psychosocial well-being, and home safety. On its own, the RAI assessment tool and score **<u>does not determine service eligibility or service level</u>**. The majority of HNHB CCAC patients have a RAI score at 11 or above (see chart below). Patients with high levels of service typically have more complex care needs (e.g. patient requires a broad range of services and/or larger number of services). HNHB CCAC continues to explore how the RAI can continue to better inform patient care planning. 
Mississauga Halton CCAC	The RAI-HC is only one tool in assessing each patient's needs. Our Care Coordinators, who are registered, experienced health care professionals, use their clinical judgment and assessment skills to determine a patient's eligibility for care. They develop a personalized care plan that is unique for every individual, based on their patients' health and social needs. Our Care Coordinators work with their patients to ensure that their health goals are met and they monitor their patients to respond if their health care needs change.
North East CCAC	Care Coordinators assess patients to determine physical, functional, cognitive needs, availability of informal supports and caregiver needs. The RAI score is only one element used in determining urgency and amount of services patients receive.
North Simcoe Muskoka CCAC	The clinical judgment of our Care Coordinators (regulated health care professionals) takes into account RAI scores when determining service levels, however, the RAI score is one aspect used to determine the urgency and amount of services patients receive. Care coordination involves the art and science of case management in developing individualized care plans.
North West CCAC	The NWCCAC completes a comprehensive assessment of its long-stay patients. Information from the RAI HC is part of that assessment that helps to identify patient needs, priority for

<table>
<tr><td></td><td>services, and service levels.</td></tr>
<tr><td>South East CCAC</td><td>In the South East CCAC the RAI score is used in addition to other assessment information as part of the Standard service offer for personal support services only. See below:

<table>
<tr><th>RAI Band</th><th>Standard Service offer in hours per month</th></tr>
<tr><td>1-6 (Low)</td><td>Up to 8 hours</td></tr>
<tr><td>7-10 (Moderate)</td><td>Up to 12 hours</td></tr>
<tr><td>11-16 (High)</td><td>Up to 24 hours</td></tr>
<tr><td>17 or higher (Very High)</td><td>Up to 40 hours</td></tr>
<tr><td colspan="2">*Note that eligibility for service maximum packages beyond the above standards are available for patient who are End of Life, Waiting at Home for LTC, Home First or Extenuating Circumstances</td></tr>
</table></td></tr>
<tr><td>South West CCAC</td><td>At South West CCAC, the RAI score does not determine eligibility for service provision. Assessment for services is an individualized process based on the needs of each patient.
The RAI score is only one component in the assessment that supports service planning with the patient.
We have patients receiving CCAC services with RAI scores of 1 and higher.</td></tr>
<tr><td>Toronto Central CCAC</td><td>Our Care Coordinators conduct a comprehensive assessment of their patients to determine the level of care needs required. This comprehensive assessment, conducted by a health care professional, is comprised of various elements including but not limited to:
An assessment of the physical, cognitive, and functional complexity using the RAI assessment tool
An assessment of psychosocial needs and social determinants of health
An assessment of caregiver needs and availability of family supports
Availability of community resources
The comprehensive assessment determines the level of care needs for patients, and supports the development of an appropriate care plan. The RAI assessment tool and score on its own, does not determine the eligibility for service or service levels for individual patients.

Work is currently underway with the University of Waterloo InteRAI research group to advance additional evidence based tools to support care planning and resource allocation tools for the CCAC sector.</td></tr>
<tr><td>Waterloo Wellington CCAC</td><td>The RAI-HC is only part of the assessment process. Care Coordinators are provided with RAI score ranges as guidelines for determining if personal support is needed, but this alone is not used to determine service levels. Many other factors are also considered in care planning.</td></tr>
<tr><td colspan="2">7. Have you changed your RAI score at all in the last two years? If so, how and when?</td></tr>
<tr><td>Central CCAC</td><td>The RAI is a standard patient assessment tool and the RAI-Home Care (RAI-HC) scores have not changed. RAI scores are standard across all CCACs that use the tool.</td></tr>
</table>

Central East CCAC	No.
Central West CCAC	The Resident Assessment Instrument (RAI) is a standard, internationally-recognized assessment tool that is used by all CCACs. The means for calculating RAI scores have not changed. If a patient's needs change, they can be reassessed to determine if a different RAI score more accurately reflects their current needs.
Champlain CCAC	The RAI score, is an output of an internationally used assessment tool. The tool itself has not changed in the last two years. Work is underway with the University of Waterloo InterRAI research group to advance additional evidence based tools to support care planning and resource allocation tools for the community health care sector.
Erie St. Clair CCAC	The RAI tool has not changed in the last two years. The Erie St. Clair CCAC is working to ensure that resources are available for our most complex patients. In order to do so, last fall we undertook a review of how care was being provided, and made a decision to move closer to provincial benchmarks with the objective of providing more appropriate care and managing resources to sustain care for those who need it most. A clinically trained Care Coordinator, in addition to professional judgment, will utilize a variety of standardized validated assessment tools to assess patients for admission to services, to determine the level and type of support required and to reassess and adjust services at regular intervals.
Hamilton Niagara Haldimand Brant CCAC	When developing care plans for patients, Care Coordinators are required to consider a number of factors. The RAI score is derived from the RAI assessment tool. Information from the RAI-HC may inform the types of services needed most urgently and/or the type of organization most appropriate to provide care. In January 2015, HNHB CCAC included the RAI score as one of the factors to consider for personal support services (11+); there are also exceptional patient profiles related to this factor. HNHB CCAC continues to explore how the RAI can continue to better inform patient care planning.
Mississauga Halton CCAC	No, we have not changed our RAI score in the past two years.
North East CCAC	The RAI score is an output of the assessment and has not changed.
North Simcoe Muskoka CCAC	The suite of RAI assessment tools is standardized, valid and reliable. NSM CCAC has not changed the use of RAI assessment tools over the past two years.
North West CCAC	The NWCCAC uses the RAI HC as part of their assessment of patients to help to determine service needs, priority, and service levels. Guidelines are in place to help determine service levels based on need and priority. Using the RAI score to help identify low, moderate, high and very high needs patients has not changed.
South East	The RAI is a standard assessment tool that is one of a suite of assessment tools

CCAC	internationally recognized and used by all CCACs.
South West CCAC	Not applicable.
Toronto Central CCAC	The RAI assessment tools used by the CCAC sector are internationally standardized, valid and reliable. Toronto Central CCAC has not changed our approach to using the RAI assessment tools in the last two years.
Waterloo Wellington CCAC	Not applicable (see question 6).

8. Do you operating any "nursing clinics," for would care? If so, how many and when did they open? Which companies operate the wound care clinics on your CCACs behalf? Do you have any figures that lay out how much money these clinics have saved your CCAC?

The CCAC nursing clinics provide high-quality, convenient, patient-centred care. CCAC nursing clinics are appropriate for patients who are able to access care in this setting, wish to schedule their desired appointment times, and receive high-quality nursing services at their convenience.

You will note that most CCACs are operating nursing clinics in their regions. These clinics provide safe, effective, high-quality care. The clinics help enable greater access to timely care and an effective use of human health resources.

Central CCAC

The Central CCAC operates seven community nursing clinics in the Central region.

Clinic Location	Service Provider	Opening Date
Alliston	Saint Elizabeth Health Care	February 10, 2010
Branson	Saint Elizabeth Heath Care	May 12, 2009
Fairview	Visiting Homemakers Association (VHA) Home HealthCare	September 1, 2013
Keele	Revera Home Health	December 1, 2007
Markham	S.R.T. Med Staff	June 1, 2008
Newmarket	Saint Elizabeth Health Care	September 15, 2007
Vaughan	Bayshore Home Health	January 1, 2008

Our clinics are a great alternative to visiting an emergency department for treatments. Located near hospitals, Central CCAC's seven community clinics offer quick and easy access to specialized nursing services for patients who are mobile. The clinics operate seven days a week, with extended evening hours, giving patients the opportunity to schedule visits at a time that best suits them. This supports patients in returning to their normal routine, including going back to work.

Central CCAC's clinics help build capacity to serve more patients. In comparing the average cost per patient served in a community clinic versus in-home nursing, the Central CCAC saved:

2014-15	2013-2014	2012-13	2011-12
9,670,562.89	5,616,505.66	5,732,661.69	3,912,468.40

	These savings were redirected into other patient services, increasing access to high quality, specialized nursing care for more people in our communities.
Central East CCAC	We have 5 Alternate Care Settings (ACS) that provide Nursing services which includes, but is not limited to, wound care across the CECCCAC geography as follows: Oshawa ACS opened well before the creation of the CECCAC in 2007 and Care Partners is the provider of the Nursing services; Peterborough ACS opened well before the creation of the CECCAC in 2007 and VON is the provider of Nursing services; Lindsay ACS opened in 2011 and Paramed is the provider of Nursing services; 2 Scarborough ACSs opened in 2012 and Paramed is the provider of Nursing services. We estimate that on an annual basis the efficiency of the ACSs is in the range of $750,000.00
Central West CCAC	The Central West CCAC operates three nursing clinics which provide a range of services, including wound care. 1) Our Orangeville Nursing Care Centre operates in partnership with Saint Elizabeth Health Care and opened on May 4, 2009. 2) Our Brampton Nursing Care Centre operates in partnership with Saint Elizabeth Health Care and opened on December 7, 2009. 3) Our Etobicoke Nursing Care Center operates in partnership with Spectrum Health Care and was opened on August 9, 2010. Over the past year alone, these clinics have resulted in savings of almost $470,000.
Champlain CCAC	Yes. The Champlain CCAC has expanded access to community-based nursing clinics over the past year. In 2014/15 we added seven new clinics across the Champlain for a total of 19. Planning is underway to add two additional nursing clinics to expand access to care. Our clinics are staffed by nurses who have specialty training in areas such as wound care and IV therapy. An individual assessment and care planning process is used with each patient to determine if clinic services would provide the best outcomes for their care needs. A patient may start out receiving home care post hospitalization and at a later time receive services in a clinic. In FY2013/14 nursing clinic utilization increased from 18.6 per cent to 22.5 per cent in FY2014/15. (Utilization as a percentage of total visits continues to grow on a monthly basis.) Nursing clinics are an important component of building a sustainable home and community care system. For every one per cent of volume streamed to clinics roughly $200k can be redirected to homebound, higher need, high-risk patients.
Erie St. Clair CCAC	The Erie St. Clair CCAC currently operates three ambulatory nursing clinics serving patients with care needs such as wound care, intravenous therapy, catheter or ostomy care. Patients may begin services at home, but within a few weeks, where medically applicable, may receive their nursing services in a clinic setting in the community. The Chatham site

	opened in 2012, the Sarnia site opened in 2013 and the Windsor site opened in 2014. After an open competition, Bayshore Healthcare was awarded the individual contracts to operate the three clinics within the CCAC facilities. To date, these clinics have been very successful with an increase in patient satisfaction and our ability to operate an effective and efficient environment, meeting the needs our patients and their families.
Hamilton Niagara Haldimand Brant CCAC	HNHB CCAC manages 11 Nursing Care Centres across the HNHB Region. Some Nursing Care Centres have been in operation prior to 2007, when HNHB CCAC was established. One nursing care centre opened in 1995, the most recent opened in 2013, and one nursing care centre changed location in 2014. At these centres, various types of nursing care are offered including: • Wound care • IV therapy • Catheter care • Medication injections • Central PICC line care • Teaching (e.g., diabetic care, catheter care). Care provided in Nursing Care Centres is part of the patient's care plan. Some patients may receive the full course of their treatment at a Nursing Care Centre; others may begin their treatments at home and have their care transitioned to a Nursing Care Centre. Attached please find a list of the Nursing Care Centres, including the name of the agency providing the care at each. In 2014/15, care was provided to more than 11,500 patients in 11 Nursing Care Centres across the HNHB region. By providing care in this setting, the CCAC was able to invest $3.4 M in care for other patients in other settings.  Nursing Care Centre Information Sheet (19
Mississauga Halton CCAC	Our contracted service providers operate nursing clinics, at no direct cost to our patients, in the Mississauga Halton region. Those nursing clinics provide wound care as well as IV therapy, drain care, diabetic foot assessment and screening and other services in our region. Receiving care in a clinic setting empowers our patients to take a proactive role in their recovery. They can arrange for required care at a time and location most convenient for them. In addition, nursing teams at our clinics are highly specialized in wound care and other nursing services. Our care coordinators recognize that not all patients are able to travel to clinics; if that is the case, they arrange for nursing care in the patient's home. We monitor the quality of the nursing clinics through our Contracts team, as we do for all contracted services. There are five clinics in our region and they opened in: • Spectrum and Bayshore – 2009 • Calea and Acclaim Health (two locations) – 2006 – prior to the CCAC amalgamation

	In the past two years, those clinics have saved our Mississauga Halton CCAC approximately $1.3 million – money we've used to provide care for more patients. View one of our patients, St. John Blakeley, who received care at one of our clinics and he states that the care he received was "outstanding." To view the video click here: http://mhccacannualreport.ca/wound_care.html
North East CCAC	Our patients have access to ambulatory nursing clinics throughout the North East CCAC service area, including the Districts of Greater Sudbury, Cochrane, Nipissing, and Algoma. These clinics are managed by either the CCAC or our contracted Service Providers, which include Bayshore Healthcare, Revera Home Health, ParaMed Home Healthcare, and Victorian Order of Nurses. These clinics have been in place since prior to amalgamation (2007). We do not specifically track "how much money these clinics have saved" because the purpose of ambulatory clinics is not simply to save money, but to improve quality of care including efficient use of human health resources, access to care, and timeliness of care (right place, right time philosophy).
North Simcoe Muskoka CCAC	Yes. Two clinics were opened on April 1st, 2009 and they are operated by Bayshore Home Health Care and Saint Elizabeth Health Care. Nursing clinics are appropriate for ambulatory patients. The cost of a nursing visit in a clinic setting is half the cost of providing the service in home.
North West CCAC	The NWCCAC does not operate any nursing clinics.
South East CCAC	Yes. The following is a time table for when nursing clinics were opened in the South East CCAC: 1 opened in 2008 3 opened in 2009 2 opened in 2010 8 opened in 2014 **14 Total** The following companies operate the wound care clinics on SE CCACs behalf: Paramed, Bayshore, Saint Elizabeth Health Care, VON and CBI The cost of a nursing visit in a clinic setting is half the cost of providing the service in home.
South West CCAC	South West CCAC does not directly operate any nursing clinics, however our contracted nursing service providers operate 33 nursing clinics for wound care and other ambulatory nursing care. • South West CCAC supports more than 7 counties covering over 22,000 square kms. • Clinics began in 2007. • These clinics offer patients several advantages; for those who are ambulatory, clinics offer the convenience of making appointments around their schedules. • For patients needing in home care nursing care to start, transitioning to clinics speeds recovery by supporting a return to normal activities. • South West CCAC saved approximately $850,000 in 2013-14 and $1,000,000 in

	2014-15. • Savings are reinvested in providing more care.
Toronto Central CCAC	Our community based nursing clinics have been in operation since 2001 with four locations across the city. Our clinics are staffed by nurses from Calea who have specialty training in wound care and IV therapy. Care Coordinators use a wide variety of community resources to address the care needs of their patients – day programs, community groups, outpatient clinics etc. An individual care assessment and care planning process is used with each patient to determine if clinic services would provide the best outcomes for the patient and their care needs. The four clinics currently operating in our region account for approximately 9 per cent of our total nursing activity. For patients who are best served through a clinic model, the cost differential is in the range of 25 per cent.
Waterloo Wellington CCAC	Yes, the WWCCAC has operated four nursing clinics for more than seven years. Ambulatory patients are referred to the clinics for a variety of services, although wound care is the most common one. The clinics are operated on the CCAC's behalf by several nursing service provider agencies contracted by CCAC. A study conducted at McMaster University in 2005 found that nursing clinics are as effective as home visits, result in the same level of patient satisfaction, reduce the time per visit significantly, and produce the same long-term health costs. By reducing the time per visit, nursing clinics enable us to serve more patients better. We estimate that nursing clinics "save" our CCAC approximately $1,000,000 per year. Those resources are used to support more complex patients in our community.

9. Can you please provide data on the number of missed visits in your CCAC for the last two years? Please provide the raw numbers (ie/total missed visits, if possible on average by day) and missed visits as a percentage of total visits. Please provide the same date by service provider organization.

The term 'missed visit' refers to any scheduled service provider visit to a patient that the service provider fails to attend, either without notifying the patient prior to the scheduled visit, or with notice to the patient prior to the scheduled visit, but without rescheduling the visit as per the requirements of the patient's service plan. It can also be a visit, required by the patient's service plan, that the service provider originally accepts but does not schedule, or subsequently informs the CCAC that it is unable to carry out.

The majority of missed visits are replaced with a follow-up visit as soon as possible. As a result, patients still receive the care outlined in their care plan.

You will note from the responses below that the overall percentage of missed visits across CCACs is quite low. In all cases, less than half a percent for each service. In all cases service providers must report missed visits to the CCAC, so that an assessment can be made regarding mitigation and the safety of the

patient.

Missed visits can occur for a variety of reasons. Some examples include:

- extreme weather
- service providers may arrive at the patient's home and the patient is not available
- another patient may have had an emergency that the service provider must attend to
- service provider may be ill and there is no one to replace them
- there is an error in scheduling and the visit is not made, or made at a later time once the error is discovered
- service provider runs late and the visit is not delivered at the time expected, but is delivered at a later time

CCACs recently revised the definition of 'missed visits' to 'missed care' to make a distinction between when care is delivered at a time that is different than expected, and when care is actually missed.

Through patient surveys, CCACs are able to understand the performance of service provider organizations in the delivery of timely and conveniently scheduled service. What is also important to capture is the incidences of missed care – care that the patient needed at, or by a specific time.

Health Quality Ontario (HQO) reports on patient satisfaction with nursing services and satisfaction with personal support services by CCAC, by service provider. These measures provide a much more comprehensive indication of overall service quality. See HQO Home Care Reporting.

Central CCAC	Missed visits have the potential for missed care, and for this reason all service providers must report these to the CCAC as set out in the service provider contracts. Missed visits can be the result of patients not being available, emergencies with other patients that delay a worker or scheduling conflicts. There are protocols in place to follow up on missed visits by service providers and the CCAC. The overall percentage of missed visits is very small. The attached charts show missed visits by service type – personal support services, nursing, physiotherapy, occupational therapy, speech language pathology, dietary and social work.  Central CCAC Missed Visits.pdf
Central East CCAC	The definition for missed visits has recently been clarified and now refers to missed care with the following definition: missed care means any scheduled visit to a patient, authorized by the CCAC as part of the Patient Care Plan, that has been accepted by the Service Provider but that the Service Provider fails to attend and fails to reschedule in accordance with the Patient Care Plan and includes a visit requested by the Patient Care Plan that the Service Provider originally accepts and then subsequently informs the CCAC that it is unable to carry out (on first visit). This change in definition is not likely to materially impact the overall numbers in the attached chart.  Copy of Scorecard Data - Missed Care.xls
Central	

West CCAC

Missed visits have the potential for missed care, and for this reason all service providers must report these to the CCAC. Missed visits can be the result of patients not being available, emergencies for other patients that delay a worker, or scheduling conflicts. The Central West CCAC works closely with its service providers to ensure that patients receive high-quality care and that the number of missed visits is kept to a minimum.

Overall, the percentage of missed visits is very small. The charts attached show missed visits by service type – personal support services, nursing, physiotherapy, occupational therapy, speech language pathology, dietetics and social work.

Central West CCAC - Missed Visit Informatic

Champlain CCAC

Our FY2014/15 missed visit rate was 0.13%, or 4,222 units/hours of 3,284,249 total units/hours.

Erie St. Clair CCAC

There are many variables when attempting to capture a 'missed visit' such as a patient not being available, emergencies for other patients that delay a worker and communication. The majority of missed visits are replaced with a follow-up visit as soon as possible and therefore most missed visits do not result in missed care. Each service provider is responsible to count and report these missed visits to the Erie St. Clair CCAC. Below is an outline of missed visits/total visit for each service – Nursing, Personal Support, and Therapy, as a well as an annual summary of information from the last 2 years.

	2013/14	2014/15 (6 months)***
Nursing	91	92
PSW	4778*	1941
Therapy	166**	3

*A contracted service provider experienced a labour disruption during this period caused this number to be inflated during this period.
**Physiotherapy reforms inflated this data for this period.
***This data is no longer collected in this format, as it not statistically significant.

Year	Annual Missed Visits	Average Daily	Percentage of overall missed visits
2013/2014	5035	13.8	.0028%
2014/2015	2036	5.6	.0018%

Hamilton Niagara Haldimand Brant CCAC

HNHB CCAC works closely with its contracted service providers to deliver care to patients in the region. Last year, HNHB CCAC provided care to more than 82,000 individuals.
Our contracted service providers report to HNHB CCAC when they are not able to fulfill a scheduled visit. This may be for such reasons as the patient is not available, a care worker may become delayed due to an urgent care need for other patients, weather-related circumstances, or miscommunication. When a visit cannot be fulfilled as scheduled, the visit may be rescheduled for a different time or provided by another agency.

If trends are observed by a particular provider, in a particular region, for a particular service, it may be an indicator of other issues such as change in service demand or human resource capacity. In such instances, CCAC works with its providers to understand the underlying issues and develops strategies to address them.

Below please find tables outlining missed visit reporting (note: data reflects Q1-Q3 for 2014/15; Q4 data for 2014/15 will be available early May):

Nursing	2013/14	2014/15 (Q1-Q3)
# of missed visits	555.00	359.00
total # of scheduled visits	976506.25	812957.00
Missed Visit Rate	0.06%	0.04%
Average # of Missed Visits/Day	1.52	1.31

Personal Support and Homemaking	2013/14	2014/15 (Q1-Q3)
# of missed visits	8183.25	4911
total # of scheduled visits	3377440.5	2775720.5
Missed Visit Rate	0.24%	0.18%
Average # of Missed Visits/Day	22	17.9

Rehab	2013/14	2014/15 (Q1-Q3)
# of missed visits	24	12
total # of scheduled visits	192534	156697
Missed Visit Rate	0.01%	0.01%
Average # of Missed Visits/Day	0.07	0.04

Additional background regarding HNHB CCAC:
Patient and Partner Profile (PDF)
Annual Reports
Additional background regarding CCACs, including patient complexity, budgets, etc. (PDF)

Mississauga Halton CCAC

Missed visits can be the result of patients not being available, patients forgetting that they had an appointment, emergencies for other patients that delay a care provider, weather conditions and general miscommunication. Missed visits are re-scheduled. The information provided in the graph does not single out visits by provider.

Data from April 2013 – December 2014 (7 quarters)

	Total missed visits	**Total scheduled visits**	**% missed visits**
Nursing	103	642,496	0.016%
Personal Support	962	2,831,978	0.034%
Rehabilitation	174	160,511	0.10%

North East CCAC

Overall 2014 missed visit rate was 0.13% (1439) of total visits (1,149,819)
2014 missed visit rate for Nursing services was 0.04% (92) of visits (225,649)
2014 missed visit rate for Personal Support services was 0.15% (1319) of visits (900,425)
2014 missed visit rate for Rehabilitation services was 0.08% (17) of visits (23,745)

North Simcoe Muskoka CCAC

There are a number of reasons why a missed visit may occur. Missed visits can be the result of miscommunication between patient and provider, patients not being available, emergencies for other patients that delay a worker, etc). We recognize that missed visits are a key driver of the patient experience since they have the potential for missed care, and for this reason all service provider organizations must report on missed visits to the CCAC.

North West CCAC


NW CCAC missed visit data.pdf

South East CCAC

2013-2014 data includes the Red Cross Care Partners strike.

	Q1 – Q3 2014-2015		**2013-2014**	
	Missed Visits	Total Visits	Missed Visits	Total Visits
Nursing	102	228,447	115	295,413
Therapy	149	67,059	88	84,640
PSW	1,232	1,178,544	3,959	1,435,117

South West CCAC

<u>Over the last 2 years (2013-14 and 2014-15)</u>

South West Nursing Providers

	○ Delivered 1,076,149 visits – average 1,474 visits per day ○ Missed 865 visits – average 1.18 visits per day ○ .08% of scheduled nursing visits were missed South West Personal Support Providers ○ Delivered 3,058,984 hours of care – average 4,190 hours per day ○ Missed 9376 hours – average 12.8 hours per day ○ .03% of scheduled hours were missed South West Therapy Providers ○ Delivered 265,152 visits – average 363 visits per day ○ Missed 827 visits – average 1.1 visits per day ○ .03% of scheduled visits were missed Missed visits can be the result of patients not being available, emergencies for other patients that delay a worker and general miscommunication. Most missed visits are replaced with a visit within a short time.
Toronto Central CCAC	Our 2014 missed visit rate was 0.05% (1,538) of all visits (3,390,153).
Waterloo Wellington CCAC	The term "missed visits" was recently replaced by the term "missed care." Missed care is defined as "any care that is not delivered in accordance with the Patient Care Plan, as a percentage of all care delivered plus care that is not delivered in accordance with the Patient Care Plan." Our most recent data indicates: • Missed Care rate for nursing- .05% • Missed Care rate for personal support - .13% • Missed Care rate for therapy - .06%