Home and community care plays a pivotal role in improving the health and quality of life of Ontario patients and those who support them, and it does so using only a small fraction of the province’s health budget.

To provide and sustain strong, patient-centred home care services, there are areas that need tending and mending, and others that require rethinking and retooling. Pricing processes and structures are a case in point. In the interests of transparency, accountability and demonstrating value for money, the connection between services purchased and provided, by whom and for whom, must become more coherent, clear and consistent.

One of the ways to do that is to determine a single provincial rate for each service that is provided, no matter where it is delivered across the province. In 2010, the Auditor General noted “significant differences in rates paid to service providers for similar services” and articulated a need for more transparency and harmonized fee rates and schedules.

Ontario’s Community Care Access Centres (CCACs), who contract with service provider organizations to deliver provincially funded home and community care, agree. With the moratorium on competitive bidding for home care contracts in place since 2008, most services are being delivered under contracts awarded more than nine years ago. Billing rates have increased in some cases, based on local negotiations, with inconsistencies in how rate changes are managed across the province and growing complexities with thousands of billing rates between service providers and CCACs.

As part of the Quality and Value in Home Care initiative, with funds from the Ministry of Health and Long-Term Care, an independent party (Accenture) was commissioned in 2013 to research and analyze the current fee-for-service model.

In October of that year, Accenture delivered its Fee-for-Service Market Assessment Report which drew in part from secondary research and data collection from service providers and CCACs. Since the receipt of the report, some of the identified issues have begun to be addressed by government, and a CCAC Fee-for-Service Task Force has been working on simplifying and standardizing fee rates. Priorities include:

- Standardized provincial rates to help stabilize home and community care workforce
- Mechanisms to bring more transparency to service provision and costs of contracted services
- Reduction in the complexity of processes to encourage innovation and public accountability; reduction in duplication and inconsistency in how services are categorized and defined.

The CCACs are pleased to share the report in the spirit of transparency and accountability and with appreciation to the service provider organizations that participated in the study.
Re: Fee-for-Service Market Assessment Report

Dear Darlene and Michelle,

Last fall the QVHC Pricing and Payment Table (PPT) was tasked with the development of a harmonized and sustainable Fee-for-Service pricing model. Specific requirements for the model included:

- Providing a mechanism for ensuring equity and reasonability in billing rates;
- Enabling the continued provision of high quality home care in the absence of a competitive bidding process;
- Building upon the Contract Performance Framework that is being developed by QVHC to ensure commonly understood quality and performance measures between CCACs and SPOs (Service Provider Organizations); and,
- Simplifying an overly complex rate schedule.

Accenture was retained as an independent third party advisor to assist the PPT with the development of this new harmonized Fee-for-service model, which includes a new rate schedule, a high level implementation plan together with an ongoing review plan.

This work has concluded and is represented by the attached Fee-for-Service Market Assessment report which outlines 42 recommendations for the PPT’s consideration as it embarks on the creation of a standard Fee-for-Service home care service rate schedule for the Province of Ontario.

The report incorporates input from CCACs, SPOs, the OACCAC, and SPO representative associations together with Accenture’s analysis and global jurisdictional research. Perspectives and inputs were gathered over a four month period through interviews with CCACs and SPOs, data requests, PPT meetings and additional stakeholder meetings. Analysis was conducted on more than 14,000 different service rates that currently exist in Ontario, financial data from dozens of SPOs and tens of millions of service records.

The scope of analysis for this engagement and subsequent report included four key elements summarized below:

1. An environmental scan of similar local, provincial, national and international Fee-for-Service market models.  
   (Note: This deliverable was provided as a separate document to the attached report)
2. A financial analysis of rate versus cost of delivering home care services within the sector.
3. The development of a Fee-for-Service model and rate schedule for the Ontario home care market that includes:
   a. Factors that should be taken into account in the pricing structure to account for real cost differences;
   b. Mechanisms for managing rate setting, including recommended rates for October 2014; and
   c. A methodology for ongoing rate management.
4. The development of a high level roadmap that would assist the sector in transitioning the current payment methodology to this new standardized form of Fee-for-Service.
The analysis focused primarily on service rates, service delivery costs and other financial components from CCAC and SPO specific perspectives. Although the relationship between service rates and patient health outcomes was not part of the scope of analysis of this project, the PPT acknowledged that the development of a sustainable fee-for-service model is built upon the need to ensure the continued provision of quality services and capacity to home care patients.

The PPT discussions, research, and analysis conducted for this report have contributed to a number of detailed findings and subsequent recommendations. These recommendations have been thematically categorized and align with the areas of assessment and analysis. Recommendations have been developed across the following four categories:

1. **Provincial Fee-for-Service Rate Schedule Recommendations** – Pricing recommendations have been generated for 33 service categories. These include base rates that have been adjusted for sector sustainability and additional adjustments for travel and other factors.

2. **Provincial Fee-for-Service Rate Schedule Implementation/Transition Recommendations** – Transitioning from the current competitive rate model to a Provincial Fee-for-Service rate schedule will be a complex undertaking. It requires that CCACs coordinate provincially to optimize and manage the resulting effects.

3. **On-going Provincial Fee-for-Service Rate Schedule Maintenance Recommendations** – Managing the Fee schedule is an important component to building in flexibility and enhancing standardization. This requires improvements in data collection and measurement. Doing so will enable the sector to be more strategic as opposed to reactionary to market forces.

4. **Provincial Fee-for-Service Rate Schedule Data Related Recommendations** – Certain core data elements must be enhanced to better enable standardization and improvement measurement options. These should be addressed in congruence with overall transition to the Provincial Fee-for-Service rate schedule.

Should you have any further questions or require any clarification on the report, the analysis or the recommendations, please feel free to contact me directly.

Sincerely,

Sanjay Cherian
Health Industry Lead, Canada
Accenture
Fee-for-Service Market Assessment

Recommendations for a Pricing Model for Home Care Services in Ontario
October 2013
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Executive Summary

In Ontario, the use of community care (home care and community support services) has been increasing in recent years, largely due to increased health sector utilization, underlying demographic pressures, and because it is recognized as a cost effective alternative to care in hospitals and long term care facilities. This pressure on the community care sector is expected to continue to increase over the coming years.

Currently, the Home Care sector (“the sector”) is made up of several stakeholder groups. 14 Community Care Access Centres are responsible for care coordination and administering of Fee-for-Service payments; Service Provider Organizations (SPOs), which range in size from individual professional contractors to large multi-disciplinary providers with wide geographic footprints, deliver a broad range of health services such as Personal Support, Nursing and five types of Therapies; and, various Associations with representation and mandate on behalf of CCACs and SPOs.

Last year, the home care sector provided over six million Nursing visits, one million therapy visits and over 20 million hours of personal support to Ontarians at a cost of over 2.2 billion dollars. Home care patients span a range of care needs, from short stay acute and rehabilitation, to long stay chronic and complex. More than 150 SPOs and individual professionals serve these patients.

In the past, CCACs procured SPO services through a competitive process that was designed to use market competitiveness to ensure value for money, and quality of care. Successful SPOs were assigned a portion of service volumes in a region. This changed in 2008 under direction from the MOHLTC. A moratorium on competition was imposed and CCACs were asked to stop using this process to procure services. In 2012 the Ministry confirmed that competition would not resume.

As a result of this moratorium, the majority of services provided today are being delivered under contracts that were awarded over nine years ago. Although the billing rates established in those contracts have increased over time, it has been on the basis of local negotiations. This has resulted in inconsistency across the province in how rate changes were managed, and in the growth of the complexity of the system, to the point where today there are almost 14,000 specific billing rates between CCACs and SPOs. Additionally, provider organizations, in the aggregate, have not seen rate increases in two to four years and in some cases longer.

The current sector landscape is wrought with operational challenges that include:
- An overall lack of clarity in pricing and payment;
- An overabundance of billing codes, often duplicative in nature;
- A lack of standardized operating processes across CCACs;
- Different fees paid to different SPOs for similar/same services in different CCAC regions;
- Different fees paid to the same SPOs for similar/same services in the same CCAC; and,
- Complex contract management requirements.

Under the auspices of the Quality and Value in Home Care initiative (QVHC), the home care sector has undertaken a collaborative process to address these and many other areas for improvement in order to best position the sector for growth and improved capacity.

Objective

The Pricing and Payment Table (PPT) of QVHC has been tasked with developing a harmonized and sustainable standard Fee-for-Service rate schedule for the Province. The intent is to provide a mechanism for ensuring equity and reasonability in billing rates and enable continued provision of home care without requiring laborious and periodic competitive bidding in each region of the Province. The new Fee-for-Service rate schedule will build upon the Contract Performance Framework which is being developed by QVHC to ensure commonly understood quality and performance measures between CCACs.
and SPOs. A new Fee-for-Service rate schedule also provides an opportunity to simplify an overly complex system and to increase standardization in the way home care services are paid for.

Accenture was retained as an independent third party advisor by the Ontario Association of Community Care Access Centers on behalf of QVHC, to assist with the development of the new Fee-for-Service model, including new rates, and a high level implementation and ongoing review plan. Implementation and transition to the new fee schedule is expected to begin in October 2014.

This initiative consisted of four key scope elements:

1. An environmental scan of similar local, provincial, national, and international Fee-for-Service market models. This included a brief analysis of the various approaches to Fee-for-Service and the applicability to the Ontario Home Care market *(Provided as a separate document)*

2. A financial analysis of rate versus cost of delivering services within the sector.

3. The development of a Fee-for-Service model and rate schedule for the Ontario Home Care market that includes:
   a. Factors that should be taken into account in the pricing structure to account for real cost differences;
   b. Mechanisms for managing rate setting, including recommended rates on October 2014; and,
   c. A methodology for ongoing rate management.

4. The development of a strategy that would assist the sector in transitioning the current payment methodology to this new standardized form of Fee-for-Service.

The sector is separately working on implementing new payment models for certain populations (outcome based or bundled reimbursement) that were outside the scope of this project.

**Methods**

The approach to this initiative follows the collaborative nature and principles employed by the sector. Namely, the Pricing and Payments Table was brought together with representation from CCACs, SPOs and Associations. The Accenture team worked with the PPT and facilitated a consensus driven approach to decision making that centred on each component of the project. This included the design of overarching guiding principles, relevant learnings from the detailed environmental scan, an approach to a pricing model, an implementation approach as well as key components for the ongoing review of the Fee-for-Service schedule. The project was broken out into two phases spanning four months and eight PPT meetings. The first phase determined key sector questions and issues relating to FFS, provided international/cross-sector context for Fee-for-Service model development, and provided an understanding of the status of the Ontario home care environment. The second Phase entailed the development of a pricing model for Ontario home care services and identified how to best implement and maintain this Fee-for-Service rate schedule into the future.

**Analysis Results and Recommendations**

The research, discussion, data analysis, and consultation conducted throughout the preparation of this report, has resulted in a recommended Provincial Fee-for-Service rate schedule for 33 simplified classifications of services currently provided in the sector. The recommended rate schedule is based on actual data provided from both the SPOs and CCACs as well as secondary research.

**Overall Sector Sustainability Results**

The objective of this analysis was to provide some assurance that the CCACs are not overpaying for home care services. The analysis also highlights the financial health of the sector.
The analysis, and resulting findings, is based on a number of factors that include the following:

- An assessment of SPO contribution margin (revenues minus variable expenses);
- An assessment of SPO operating margin (EBITDA - Earnings Before Interest, Taxes [if applicable], Depreciation and Amortization); and,
- A jurisdictional analysis of service provider contribution and operating margin and net income for similar service provisions.

The SPO data showed that the weighted average percentage of operating revenues allocated to delivering patient care was over 86%. Conversely, weighted average SPO contribution margins were observed to be relatively quite low at approximately 14%.

An analysis of SPO operating margins provided even more significant results, especially when compared against data from other jurisdictions. Operating margins, across the sector were very low. Weighted average sector EBITDA, as reported by the SPO data, was 2.14%. Comparatively, net incomes (earnings after taxes, interest, depreciation and amortization) in the jurisdictions researched, ranged from 5.7%-13.7%. Operating margins were particularly low in nursing and personal support, but were comparable for therapy services.

These findings have a number of important implications:

1. The province is receiving value on a financial basis for services purchased from SPOs. Specifically, the evidence should provide the Province and taxpayers assurances that there is no overpayment for home care services.
2. Providers are utilizing their fees to deliver direct patient care. A comparatively high percentage of SPO revenues are allocated to the direct servicing of current provincial home health patient volumes. The data suggests that a small percentage of revenues are allocated to administration and management.
3. SPOs are struggling to serve patients at existing rates such that there is insufficient financial capacity to invest in service improvement options, build additional service capacity or even be incented to maintain provision of service.

Additionally analysis of compensation disparities between the home care, long-term care and hospital sectors was conducted. For Nursing and PSW services, the home care sector has the lowest compensation of all of the sectors. This disparity has created significant recruitment and retention issues for SPOs.

These factors raise significant concerns about overall sector sustainability and its ability to be a viable option to service increasing volumes of required care.

As a result, we are recommending an increase to the average rates to address this sustainability issue for the PSW and Nursing service categories. These sustainability increases will help stabilize the sector. They will not however bring the Home Care sector to parity with Hospitals or LTC facilities.

Movement towards harmonized provincial rates is contingent upon these increases being funded by the MOHLTC. If they are not funded, then the rate recommendations discussed in this document cannot be implemented and would have to be reconsidered.

Note:

- An assessment of the quality of service provision related to outcomes was not considered as part of assessing provider “value”. Quality of care will be monitored through the Contract Performance Framework developed by QVHC.
- The analysis was conducted using data provided voluntarily by SPOs from their financial statements. This data was not audited by Accenture.
- The analysis was not a “Value for Money” audit as defined by the Auditor General.
Recommendations

The discussions, research, and analysis conducted for this report have contributed to a number of detailed findings and subsequent recommendations. These recommendations have been thematically categorized and align with the areas of assessment and analysis. 42 recommendations have been developed across the following four categories:

5. **Provincial Fee-for-Service Rate Schedule Recommendations** – Pricing recommendations have been generated for 33 service categories. These include base rates that have been adjusted for sustainability and additional adjustments for travel and other factors.

6. **Provincial Fee-for-Service Rate Schedule Implementation/Transition Recommendations** – Transitioning from the current competitive rate model to a Provincial Fee-for-Service rate schedule will be a complex undertaking. It requires that CCACs coordinate provincially to optimize and manage the resulting effects.

7. **On-going Provincial Fee-for-Service Rate Schedule Maintenance Recommendations** – Managing the Fee schedule is an important component to building in flexibility and enhancing standardization. This requires improvements in data collection and measurement. Doing so will enable the sector to be more strategic as opposed to reactionary to market forces.

8. **Provincial Fee-for-Service Rate Schedule Data Related Recommendations** – Certain core data elements must be enhanced to better enable standardization and improvement measurement options. These should be addressed in congruence with overall transition to the Provincial Fee-for-Service rate schedule.

1. **Provincial Fee-for-Service Rate Schedule and Impact Recommendations**

The current Home Care rate structure in Ontario is extremely complex and overly cumbersome. There are approximately:

- 14,000 different contracted rates
- 3300 different service codes
- 94 different service categories

For the purposes of this analysis, CHRIS data from April 1st 2012 through March 31st 2013 was analyzed (unless otherwise noted). This represents $1.336 Billion in spend provincially across the 14 CCACs. Although there are 94 service categories in CHRIS, only 75 were reviewed for this report.

Following the research and analysis, we recommend Ontario adopt a “Base + Adjustment” pricing model to define the Ontario home care Fee-for-Service rate schedule. In this model a base rate is set for each service. Adjustments are then applied to account for different factors.

The “Base + Adjustment” pricing model approach was identified as the most viable option because it:

- Matches most closely with the goals of this initiative to move to a standard Provincial rate;
- Assists with reducing complexity;
- Allows for transparent pricing to be developed and understood within the sector;
- Is more closely aligned with current sector pricing than other options and would facilitate transition; and,
- Enables on-going and simplified data capture and performance metrics that can help continuous measurement and identification of areas needing adjustment/refinement.

Through analysis and discussions with the PPT, the following adjustments are recommended for inclusion in the pricing model:

- Travel cost (Mileage and time); and,
- Critical mass threshold.
Three other factors were considered and analyzed, but are not being recommended at this time:

- Geographic labour differences;
- Shift premiums; and,
- Volume.

A fee schedule consisting of base rates for 33 Service categories has been developed. The new base rates were developed using the weighted average rate of services from the 2012-2013 fiscal year. Additionally, we have developed travel rates for 49 Census Divisions to be used as adjustment factors for each in scope service category’s proposed base rate.

Once new rates are fully implemented as recommended, the total funding impact to the province for all services is estimated to be $112,400,000 (5.15% increase to overall CCAC budgets). The range of impact to individual CCACs ranges from 0.99% to 13.42% of current CCAC budgets.

When analyzing the impact to SPOs, the notion of sector risk was considered and evaluated such that rate increases/decreases felt by high volume providers were deemed to have a higher associated provincial risk profile. Conversely, rate adjustments to SPOs with smaller service volumes were deemed to have a lower provincial risk profile associated with a move to the recommended Provincial Fee-for-Service rates.

The analysis showed that under the new rate schedule:

- 21 small SPOs will see an average rate reduction of 7.9% (based on simple average);
- Three large providers will see an average rate reduction of 5.5%;
- 65 smaller SPOs will see an average increase of 18.3%; and,
- 19 large SPOs will see an average rate increase of 10.3%.

The largest individual SPO rate decrease is less than 20%. The majority of provider rate decreases are the result of changes to Therapy services.

Overall the rate adjustments are quite positive for smaller SPOs as the majority will receive rate increases. The response is also positive for larger SPOs. Many will receive rate increases based on PSW and Nursing rate adjustments. Therapy rate adjustments have the most risk to the sector as many more providers may be adversely affected by the rate changes.

The following table summarizes all Provincial Fee-for-Service Rate Schedule related recommendations:

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<th>Provincial Fee-for-Service Rate Schedule Recommendations</th>
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2. **Provincial Fee-for-Service Rate Schedule Implementation/Transition Recommendations**

Implementation of new rates should begin in October 2014 as current contracts will expire. A gradual approach to transition with an implementation period ending in April 2016 was recommended as it:

- Provides sufficient time to collect and integrate sector opinions and impacts;
- Allows for flexibility in rate adjustment, without drawing out transition over a significant number of years; and,
- Allows time for the sector to anticipate issues and develop strategies for the post-implementation future.

While the overall recommended time for implementation is standard for each service, the implementation approach will vary for each service. For example, Nursing and PSW rate implementation should be front loaded, while implementation for Therapies should be gradual over the transition period.

The harmonization of rates in the new Fee-for-Service model is designed to provide a simpler, more equitable set of billing rates across the province, to replace a competitive procurement process that has been defunct for some time. In part, it is designed to redress the inconsistency in rates across the province, and the inconsistency of rate changes over the years, taking into account verifiable factors that influence costs.

As a result, the importance of a coordinated, centralized Provincial approach to the implementation of the rate schedule must be emphasized. CCACs must be in lock step with each other when adjusting rates across SPOs to ensure fairness and to facilitate transition. If this rate schedule is not implemented in a coordinated way across the Province, it will create inequities across CCACs and SPOs. Such inequities will negatively impact overall delivery of care to patients.

The following table summarizes all Provincial Fee-for-Service Rate Schedule Implementation and Transition related recommendations:

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<th>Provincial Fee-for-Service Rate Schedule Implementation/Transition Recommendations</th>
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### On-going Provincial Fee-for-Service Rate Schedule Maintenance Recommendations

The on-going maintenance of the Provincial Fee-for-Service Rate Schedule should include mechanisms to enable continued review of the applicability of rates, market forces as well overall sector health. It is recommended that the sector include an annual assessment of key indicators defined within a basket of specific metrics that can affect Fee-for-Service rates. It is also recommended that a comprehensive re-assessment of sector sustainability and the fee schedule’s suitability for the Ontario home care sector should be carried out every three years.

A provincial body consisting of both CCACs and SPOs should be created to conduct these assessments as well as own and maintain the provincial Fee-for-Service schedule. This body must operate in a collaborative and transparent manner to ensure that rates are sustainable and cost effective. This body should also receive support from an independent third party to facilitate data sharing, collaboration and analysis.

Rate approval must take place at the Provincial level. This body should work with QVHC Oversight, LHINs and the MOHTLC to develop a standardized rate approval process for future rate recommendations and to ensure that rate recommendations receive approval.

The following table summarizes all Provincial Fee-for-Service Rate Schedule on-going maintenance related recommendations:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
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<tr>
<td><strong>29</strong></td>
<td>Impacts to CCACs should be continually monitored to measure actual financial impact versus what might have been projected or otherwise expected.</td>
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<tr>
<td><strong>30</strong></td>
<td>The QVHC steering committee should review interdependencies between the PPT and other Tables which fall under the overall QVHC initiative to ensure that they are aware of the progress being made with model implementation and that they are receiving necessary inputs, such as feedback or data, which they may require to drive the progress of their own QVHC initiatives.</td>
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<tr>
<td><strong>31</strong></td>
<td>A Provincial body consisting of CCAC and SPO representatives should own and be accountable for the rate schedule and future rate reviews. This same body should also be responsible for managing implementation of the new rate schedule. This body should be supported by an independent third party advisor.</td>
</tr>
<tr>
<td><strong>32</strong></td>
<td>The body responsible for ongoing review of rates and the new Fee-for-Service model should work with QVHC Oversight, LHINs and the MOHLTC to establish a standard and criteria based process for approving future rate recommendations.</td>
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<tr>
<td><strong>33</strong></td>
<td>Individual CCACs should not have the ability to opt-out or circumvent the established Provincial rate schedule.</td>
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<td><strong>34</strong></td>
<td>An initial review of the Provincial Fee-for-Service rate implementation impacts, progress, and key issues should occur within six months of model roll-out.</td>
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<tr>
<td><strong>35</strong></td>
<td>The Provincial Fee-for-Service rate schedule should be reviewed on an annual basis, be conducted in line with budgetary planning and be supported by an independent third party. The on-going review should incorporate the process direction within this report.</td>
</tr>
<tr>
<td><strong>36</strong></td>
<td>A comprehensive re-assessment of sector sustainability and the suitability of the Provincial Fee-for-Service model and schedule by an independent third-party should occur every three years after implementation begins.</td>
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</table>
On-Going Provincial Fee-for-Service Rate Schedule Maintenance Recommendations

| 37 | New services that account for at least 0.05% of provincial purchased services spending, and that are provided by more than two CCACs, should be considered for provincial pricing. |

4. Provincial Fee-for-Service Rate Schedule Data Related Recommendations

Throughout this project a significant amount of time requesting, cleansing and analyzing data from CHRIS and CCACs was required. Based on this analysis there are a number of recommendations that should help CCACs, the OACCAC and the body responsible for rate development improve and facilitate data analysis in the future. Most of these recommendations address the establishment of provincial standards for data capture, naming conventions and management of rates and services.

Provincial Fee-for-Service Rate Schedule Data Related Recommendations

| 38 | Standard provincial definitions should be created for all specialized services. These definitions should outline what the service constitutes, who can provide the service and what billing rate the service falls under. |
| 39 | A standard provincial naming convention should exist for all contract, provider and service descriptions within CHRIS. Any existing contracts, provider names, service descriptions, etc. should be moved to the new convention once it is created. |
| 40 | A standard provincial definition for Cluster Care should be developed. This definition should clearly outline what is considered a Cluster Care setting. |
| 41 | A Cluster Care field should be created in CHRIS. All locations considered as Cluster Care settings should be identified. Patient profiles should indicate that they are receiving care in a Cluster Care setting. |
| 42 | A general review of CHRIS should be conducted on a periodic basis to standardize fields, naming conventions, data capture, etc. |
1. Introduction

1.1 Project Background

From CCAC inception until 2004, CCACs selected Service Provider Organizations (SPOs) through a highly regulated competitive process that included pre-qualification and a periodic Request for Proposals (RFP) process with competition. This competition was based on quality and proposed service rate. Volumes were then awarded to providers as a portion or share of a CCAC’s market in a specified geography. Pricing and volume schedules were determined through the RFP process with specific and limited criteria for rate adjustments within a contract and at extension of contracts.

Through a moratorium on competition as directed by the Interim Contract Management Guidelines (June 2008), and more directly through the 2012 Contract Management Guidelines, the MOHLTC has directed CCACs to move away from RFPs as a mechanism for ongoing management of the business relationship between CCACs and SPOs except in very limited circumstances. This has created a need for the sector to develop new mechanisms for ongoing management of the business relationship between CCACs and SPOs that meet public sector requirements for transparency and defensibility.

The 14 CCACs and the SPOs have been working collaboratively through the Quality and Value in Home Care initiative to develop an approach for continuing delivery of ‘Fee-for-Service’ care. As a result, a new business model/framework must be identified that allows ongoing and transparent management of quality, rate and capacity within the sector.

1.2 Project Scope

Accenture was retained as an independent third party advisor by the Ontario Association of Community Care Access Centers on behalf of the Quality and Value in Home Care collaborative effort to assist with the development of a pricing model and framework for ongoing management for the Ontario home care Fee-for-Service based market. The model and framework are to be completed by October 2013, with implementation of the recommended transition plan expected by October 2014.

The project consisted of four key scope elements:

1. An environmental scan of similar local, provincial, national, or international Fee-for-Service market models. This included a brief analysis of the various approaches to Fee-for-Service and the applicability to the Ontario Home Care market (provided as a separate document).

2. A financial analysis of rate versus cost of delivering services within the sector.

3. The development of a Fee-for-Service model for the Ontario Home Care market that includes:
   a. Factors that should be taken into account in the pricing structure to account for real cost differences;
   b. Mechanisms for managing rate setting, including recommended rates for October 2014; and,
   c. A methodology for ongoing rate adjustment.

4. The development of a strategy that would assist the sector in transitioning the current payment methodology to this new form of Fee-for-Service.

The sector is separately working on implementing new payment models for certain populations (outcome based or bundled reimbursement) that were outside the scope of this project.
1.3 Stakeholder Involvement

Quality and Value in Home Care (QVHC) – is a collaborative transformation strategy for the Ontario home care sector being led by Ontario’s CCACs and Service Provider Organizations (SPOs). The goal of QVHC is to create a more robust, coordinated, and accountable home and community care sector, to enable the achievement of health system change expectations as laid out in Ontario’s Action Plan for Health Care. The QVHC Pricing & Payment Table (PPT) was formed as part of that collaboration to accomplish this pricing as well as other work with support from an independent third party.

The Pricing and Payments Table (PPT) is composed of 22 members, including:

- Six representatives from Ontario’s 14 CCACs, comprising a varied geographic representation.
- Six representatives from Ontario’s home and community care service provider community, with variety in terms of size, tax status, service mix, and geographic region served; each of whom also represents one of the Ontario Home Care Association (OHCA), Ontario Community Support Association (OCSA), Ontario Association of Children’s Rehabilitation Services (OACRS) or Alliance of Professional Associations for Community-Based Therapy Services (APACTS).
- One representative of home and community care equipment and supplies vendors.
- ‘Ex-Officio” representation from leadership at the Ontario Home Care Association, Ontario Community Support Association, Ontario Association of Community Care Access Centres, and other QVHC tables.
- Support by three OACCAC staff members.

The PPT periodically invited others with specific subject matter expertise to join the table to support discussion and decision making for certain issues. For example, executives with Provincial Human Resources and Home Care sector Contract Managers.

PPT members were expected to represent their associations as well as the best interests of patients, families, caregivers and the home and community care sector at large in the development of the new pricing model and management framework.

Over the course of this project, PPT members met on a bi-weekly basis to help socialize Accenture’s analysis, give feedback on requested discussion and decision points, and drive progress towards scope timeline and deliverables.

The PPT was guided by an original set of agreed upon values, which formed the basis of the PPT’s work and were used to drive the development of the model:

The Pricing and Payment Table will be:

- **Collaborative** if everyone leaves the table feeling like they have left nothing unsaid.
- **Transparent** if members communicate with appropriate stakeholders / associations / contacts.
- **Objective** if it utilizes a verifiable fact based methodology to guide decision making and recommendations.

The Fee-for-Service Model will be **sustainable** if it:

- Delivers value for money;
- Allows the home care sector to function in the absence of RFP process;
- Provides the ability for SPOs to maintain adequate health human resources;
- Is able to provide services to patients needing care into the future;
- Is flexible enough to be able to take on new services or change existing ones; and,
- Incentivizes quality care.
1.4 Project Approach

The project was broken out into two phases spanning four months and eight PPT meetings:

**Phase I: Assess and Develop Pricing Model Framework**

The objective of Phase I was to determine key sector questions and issues relating to Fee-for-Service pricing, provide international/cross-sector context for rate model development, and understand the current status of the Ontario home care environment.

During Phase I, work was divided into the following five areas:

a. **Conduct internal secondary research:** Over 100 sources were consulted to collect relevant examples and considerations from Fee-for-Service and applicable pricing models internationally.

b. **Condense research findings into an Environmental Scan:** The most relevant information was condensed into a 50-slide Environmental Scan document and bibliography. *(separate document from current report)*

c. **Conduct sector interviews:** 13 interviews were conducted with CCACs, SPOs and Subject Matter Advisors across the province.

d. **Understand sector factors contributing to sector sustainability:** This analysis was broken down into three sub-components:

   i. **Component I: Understand value of services purchased from a financial perspective:** Financial data from over 20 providers representing 85% of services CCACs purchased was analyzed and aggregated to form an understanding of the financial status of the sector from a provider perspective. Part of the analysis included determining if the province was receiving value for purchased services from a financial perspective.

   ii. **Component II: Analyze SPO sector financial sustainability:** Utilizing the data collected from providers, an overall perspective on the financial performance of the sector was developed and then compared with proxy sectors (i.e. Long-Term Care) internationally. This was done by comparing proportion of cost allocated to direct care delivery and Earnings Before Interest, Depreciation, Taxes and Amortization (EBITDA).

   iii. **Component III: Wage Disparity Analysis:** Sector and comparator sector data wage data was collected and analyzed to understand and validate assertions made in interviews and at the PPT about a wage disparity existing between the home care sector, LTC facilities and Hospitals.

   The analysis of sector sustainability was requested by PPT participants as this type of analysis had never before been conducted in the sector, and an objective, fact-based perspective on the issue was required to inform future rate development.

e. **Prepare framework/approach to pricing model:** A FFS model framework was created utilizing insights derived from the environmental scan, perspectives provided by interviewees and considerations provided by the PPT.

**Phase II: Collect Data, Analyze and Generate Provincial Fee Model**

The objective of Phase II was to develop a pricing model for Ontario home care and identify how best to implement and maintain this model into the future. During Phase II, work was divided into the following four areas:

a. **Collect and analyze data:** Data was collected from CCACs and service providers to analyze and understand rate differences across the province, cost differences contributing to current pricing and volume of services being delivered.
b. **Generate the pricing model:** Base and travel rates were generated for services that represented more than 0.05% of provincial spend and were in more than three CCACs. This included but was not limited to Personal Support Worker (PSW), Nursing, Occupational Therapy (OT), Physiotherapy (PT), Speech Language Pathology (SLP), Nutrition and Dietetics (ND) and Social Work (SW).

c. **Identify impact of new rates:** The financial impact of the new pricing was analyzed for both CCACs and SPOs across all services that were priced using the new model.

d. **Develop a high level transition and rate maintenance plan:** The plan was developed using lessons learned from the environmental scan, perspectives voiced in interviews and consensus formed at the PPT. It includes timing and approach to implementation and how the future pricing should be updated and maintained.
1.5 Project Key Questions

In order to develop a fact-based and holistic pricing model, understand the concerns of the sector, and map out the complexities of introducing a new pricing model, a series of key questions were developed with the PPT and organized into an issue tree. (Figure 1.5.1)

There are three primary topic areas in the issue tree, which group the key questions identified:

1. **Fee-for-Service Model Mechanics**: Addresses how current pricing can be modeled and future pricing developed.

2. **Fee-for-Service Model Maintenance**: Addresses how the Fee-for-Service pricing schedule can be maintained in the future.

3. **Fee-for-Service Model Implementation**: Addresses how the new Fee-for-Service pricing schedule should be implemented.

Discussion and analysis throughout the project focused on answering the questions outlined below.

![Figure 1.5.1 – Project Key Questions](image-url)
1.6 Considerations

Please consider the following when interpreting, reviewing, or discussing components of findings and analysis found in this report:

- All pricing, cost analysis and findings reflect the data that was provided by both CCACs and SPOs.
- SPO data was self-reported and provided on a voluntary basis. Service providers were asked to match data provided to their audited financial statements. Accenture did not perform a financial audit of any kind.
- Service quality and patient outcomes were not in-scope for this report and were not considered as part of any of the analysis.
- Results and analysis were consistently shown on an aggregate basis and intended to be reflective of the sector as a whole – the findings discussed in this report may not apply uniformly to every provider across the Province in the same way.
2. The Context for Change in Ontario

In Ontario, the use of community care (home care and community support services) has been increasing in recent years, largely due to increased health sector utilization, underlying demographic pressures, and because it is recognized as a cost effective alternative to care in hospitals and long term care facilities. This pressure on the community care sector is expected to continue to increase over the coming years.

Last year, the home care industry provided over six million Nursing visits, one million therapy visits and over 20 million hours of personal support to Ontarians at a cost of over 2.2 billion dollars. These services are provided to people with needs ranging along a continuum that includes pre-acute intervention, post-acute services and hospice and palliative care. More than 150 provider organizations and individual professionals serve these patients.

In order to achieve better health outcomes for patients, the Ontario healthcare system needs to facilitate better collaboration across the various providers: home care, hospitals, physicians, long term care, pharmacies, etc. In order to facilitate more effective collaboration, the health care system must better align incentives, funding and resources across the care continuum.

Currently, Ontario’s home and community care sector faces a number of challenges:

- **Funding of CCAC services varies widely among the 14 CCACs:** The Auditor General’s report in 2010 stated that “Per capita home care funding varied widely among the 14 CCACs, resulting in funding inequities. Total funding to CCACs had not been allocated on the basis of specific patient needs, or even on a more general basis that takes into account such local needs as population size, age and gender of patients, or rural locations.”

- **Current models of competition were also highlighted by the Auditor General as not being effective:** “CCACs expressed concern with not being able to procure services from external service providers competitively. The Ministry had asked them to suspend the competitive procurement process on three occasions since 2002, and, at the time of our 2010 audit, the process was still suspended. This has contributed to significant differences in rates paid to service providers for similar services.”

- **The Auditor General’s report in 2010 also highlighted the following recommendation:** “To ensure that home care services are procured from external providers in a cost-effective manner, the Ministry of Health and Long-Term Care should work with LHINs and the Ontario Association of Community Care Access Centres to:
  - Formally evaluate the expected cost savings from allowing CCACs to procure home care services on a competitive basis, keeping in mind the potential impact on patients and service levels; and,
  - Conduct a review of service-provider rates by type of service across Ontario to determine whether the significant rate variations are warranted in relation to the actual cost of providing the service.”

Variations in service provider rates make it difficult to monitor and measure the true impact of service from the standpoint of health system savings, outcomes and overall value. It also dramatically increases administrative complexity by posing roadblocks to standardization and simplification. This notion is illustrated by the vast number of billing codes that exist today, over 14,000! Additionally, the vast array of individual provider contracts that require management and administration across different regions and CCAC is another example of this complexity.

The sector has responded in a coordinated way to seek recommendations around how it can improve the organization, funding and quality of the home care sector. One such way is to drive towards a single provincial rate for services within the following categories:

1. PSW – personal support work delivered on a time-unit basis to patients for assistance with activities of daily living such as personal care, transferring, light housekeeping, and child care.

2. Nursing – Nursing care delivered on either a shift (fixed time unit) or visit (single visit) basis to patients.
3. Therapies – the five sub-services which make up the majority of provincial therapies delivered: Physiotherapy (PT), Occupational Therapy (OT), Speech and Language Pathology (SLP), Nutrition and Dietetics (ND), and Social Work (SW).

The work completed to date by the PPT, has uncovered significant challenges within the sector that build off the items highlighted in the Auditor General’s report. Namely, when it comes to service pricing, there is currently very little clarity across the sector. This results from:

- A lack of standardization across billing codes;
- A massive breadth of billing codes (approx. 14,000);
- Differing approaches to pricing services;
- A backlog of old-unused/misused service codes; and,
- Sector wide sustainability issues resulting from long term rate freezes.

As a result, the home care sector is currently operating on a pricing platform that poses a risk to its viability as a key lever in the overall health solution.

Engagement of representation from SPOs, CCACs, and various sector associations has resulted in significant collaboration that has contributed to the findings and recommendations within this report. The sector should be commended for undertaking this complex initiative and for collaborating together to seek solutions that can help Ontarians experience better access to care in the years to come.
3. **Home Care Sector Assessment Key Findings**

3.1 **Environmental Scan**

In order to provide an overview of Fee-for-Service pricing models in other jurisdictions, an Environmental Scan of pricing models for healthcare services was conducted. The objective of the scan was to develop an understanding of pricing approaches, lessons learned, and operational practices which relate to existing Fee-for-Service pricing models (i.e. their mechanics, their maintenance, and their implementation). The scan highlighted relevant concepts and processes from other jurisdictions as well as potential issue areas and questions requiring further investigation. The scan did not offer prescriptive findings or recommendations for the Ontario home care context.

As part of the Environmental Scan, over 100 documents were reviewed from a variety of sources, including academic journals, government reports, news articles, literature from medical associations/advocacy groups, and internal Accenture resources. Over 60 of the most relevant sources were documented and listed in the Scan’s bibliography for further reference or reading.

To mirror the approach used in determining the project key questions and to provide a framework for research, the Environmental Scan was similarly organized around the three main areas of inquiry. Some of the relevant findings extracted through the Scan process included:

- **Model Mechanics**
  - Three general approaches to modeling rates were observed in other jurisdictions, including a base rate + adjustment factor model, an all-in bundled rate, and “quasi” market-set pricing.
  - Several models observed included components such as base rates, cost-based coefficients, and adjustments for geographic/local factors.

- **Model Maintenance**
  - Pricing models are typically managed by government.
  - Updates in other jurisdictions are made on a specified schedule, as well as on the basis of defined “triggers” (e.g. changes in technology, funding, or patient demand).

- **Model Implementation**
  - Successful implementation often depends on a collaborative, proactive approach to identifying and addressing model issues and monitoring sector performance.
  - Comprehensive change management requires a holistic approach to implementation that considers care, payers, providers, and recipients.

For further information on the Environmental Scan methodology or findings, please refer to the complete Environmental Scan document.
3.2 Interview Findings

A series of 13 interviews were conducted with over 40 sector participants (representatives from both CCACs and SPOs as well as sector experts) to collect and document Ontario focused perspectives on the status of the home care sector, the ideal way forward, and key issues or considerations for the new Fee-for-Service model and resulting fee schedule.

Interview questions and discussion were organized based on our key questions and were divided into three categories:

1. **What are the mechanics of the FFS model?** This portion of the interviews focused on how the pricing model would be developed.

2. **How should the model be maintained?** This portion of the interviews focused on how the sector could successfully maintain and administrate the new pricing model over time.

3. **How should the model be implemented?** This portion of the interviews focused on how the new pricing model could be successfully implemented and evaluated.

1. **What are the mechanics of the FFS model?**
   
   **Theme #1:** There needs to be adjustments to service rates as freezes and the status quo are not sustainable.
   
   - Both SPOs and CCACs voiced that two to four years of rate freezes and the absence of competitive bidding over the last six years has directly affected provider and sector sustainability.
   
   - Several CCACs and providers indicated that a consistent provincial rate schedule and consolidation of the current breadth of service rate categories are key benefits of this initiative that should not be overlooked.
   
   - Many interviewees indicated that providers had a multitude of prices and contracts, even within the same CCAC, as legacy contracts from the previous 42 CCACs persist, and that unifying these was a key objective. This has made the existing system overly complex.
   
   - Several CCACs and SPOs mentioned the desire to negotiate some local flexibility to accommodate specific situations in which Provincial rates would have unanticipated consequences.

   **Theme #2:** A “base plus” approach to model pricing is the most logical approach to structuring the calculation of service rates.
   
   - This refers to the setting of a nominal “base rate,” exclusive of other factors, which reflects the cost of delivering the service, and then applying adjustments to the base to address certain considerations that aren’t provincially uniform (i.e. travel rates).

   **Theme #3:** Volume pricing needs to be reviewed and changed in the new model.
   
   - Several interviewees noted that Volume pricing today is less relevant on the upper end of volume scale as:
     
     o The fixed cost base to implement volume pricing is very small relative to the variable costs. As a result, there aren’t many economies of scale to be achieved.
     
     o Volumes continue to increase, and the volume pricing sheet is often out of date after it has been negotiated.
   
   Conversely, it may be important to retain some sort of pricing for low volume so that service delivered below a particular volume threshold is compensated at a higher rate to soften the financial impact on the provider of the low-volume service.

   - Providers also stated that there are administrative burdens associated with management of the volume schedule. Specifically the volume “true-up” is increasingly burdensome and may not create the intended value for CCACs and SPOs.
Theme #4: The idea of incorporating a bonus payment mechanism for exemplary providers received mixed reviews from SPO and CCAC representatives.

- Some CCACs indicated that rewarding providers for good service was a key concern and that there must be some incentive built into the new system to do so. This can continue to be done through market share; however having an additional method might be of value.
- Some SPOs expressed concern with how “exemplary” would be measured and whether it would be fair to providers. Like any evaluation mechanism, there were concerns from SPOs as to whether they would be evaluated for things that are out of their control.
- Most providers felt that they were already being tracked very closely and there wasn’t a need to introduce more complexity through bonus payments for performance.
- There were some SPOs and subject matter advisors that discussed how current indicators may not be the best indicators of performance. For example “Missed Visits” may be highly skewed based on volume.
- Both providers and CCACs want to ensure that indicators do a better job of describing performance.

Theme #5: Sector sustainability and associated human resource challenges are concerns for both providers and CCACs.

- Several interviewees noted that there is a need for a unified, long-term strategy for managing the human resource challenges in the sector.
- Several interviewees noted that wages in the home care sector lag behind other sectors in Ontario, and that sector sustainability should be a key discussion point, with recommendations or a proposed way forward to address these sector issues.
- PSWs were frequently highlighted by both CCACs and SPOs as an area of particular concern. Concerns focused on PSW wages in Home Care compared to Long Term Care and the ability to recruit PSWs over time.
- An interesting perspective put forward is that technology, less flexible scheduling, and more rigorous approaches to time management and route planning have eroded some of the flexibility previously used to attract PSWs and Nurses to their roles, contributing to the recruitment and retention difficulties faced by the sector.
- From a Therapy perspective, SPOs noted that there are significant challenges with retaining therapists in the sector due to benefit disparities between home care and Hospitals/LTC as well as adequate reimbursement for travel time.

2. How should the model be maintained?

Theme #1: CCACs and SPOs should both be able to benefit from cost reductions obtained through innovation.

- CCACs want SPOs to innovate and find ways to reduce costs and deliver services more efficiently or with better patient outcomes.
- Innovation is often a tool used to reduce costs. SPOs will continue to invest in technology, training and improvements to help achieve goals and cost reductions that still meet clinical standards of care. There are however concerns that if SPOs invest, the sector will be to reduce rates as opposed to ensuring shared benefits from the innovation. For example, if a provider’s innovation over time leads to the cost of service delivery being reduced by 20%, how is this benefit allocated?
- There is concern from providers that innovation is seen as a justification for rates to fall, but if this overshadows their benefit, then their incentive to innovate is reduced.
Theme #2: There are costs associated with the increase in reporting and administrative procedures.

- Service providers indicated that over the past several years many new reporting and administrative requirements have been introduced (particularly in SLAs, through KPIs and other measurements). These requirements have added to base costs which haven’t been reflected in rates that have been frozen.
- There is also significant concern amongst service providers around the cost of administering rejected billings. Many providers have staff dedicated to dealing with these rejections.
- The overall sector approach over time should be one that seeks to streamline and consolidate reporting and administrative requirements. The new pricing model should also help streamline and reduce complexity.

Theme #3: Plans for model updates and reviews should consider the possibility and impact of changes in legislation/funding.

- The variety of funding sources for CCACs (annual base funding, new funding announced during the year, one-time funding on an ad-hoc basis from LHINs) and past announcements of new funding and/or policy (April’s changes to funding for physiotherapy) were suggested as examples of the dynamic environment the model will have to operate in.
- In general, success factors mentioned for model updates and reviews include a clear set of rules and timing for making updates, consistent timing for agreed-on annual review periods, and standardized definitions of what might trigger an update.

3. How should the model be implemented?

Theme #1: Implementation cannot be done all at once and must be gradual over time.

- Both CCACs and SPOs indicated and agreed that the phase-in must be gradual. There are many complexities across the sector that will have to be considered and addressed throughout the implementation.
- Several interviewees suggested a six month milestone checkpoint to review the progress of implementation, effect on the sector, and overall implementation success.
- CCAC interviewees emphasized that the effect of rate changes on their funding allocation at a provincial level must be considered and that the impact on CCACs must be measured both individually and in aggregate.
- The core purpose of gradual implementation is to allow time for providers to adjust to new pricing. A few ways to do this have been suggested:
  - A “stepped” process where providers below the new rate are gradually brought up to the new rate and providers above the new rate are gradually brought down.
  - An “initial jump” process where providers below the new rate are brought up quickly and providers above the new rate are gradually brought down; or are allowed to stay at a higher rate (i.e. red lined) until increases bring all providers to the same rate.
- A pilot program was also suggested as an approach to implementation. The new model could be rolled out across one service (ex. PSW) and then lessons learned could be compiled and applied before roll-out of the model for the other services.
3.3 Testing Orthodoxies in the Home Health Sector

Understanding, defining and testing orthodoxies that are held in a given operating context is an important activity to undertake as it helps define potential boundaries that could exist and inhibit progression to desired outcomes.

Orthodoxies are deeply held and widely shared conventions or beliefs about the product, market, or the industry. They often define the “rules of the game” and are more than just pathologies or complaints. However, sometimes they can be self-imposed boundaries on how an organization or sector operates.

It is worthwhile to challenge the existing business model and the conventional wisdom of the industry by turning orthodoxies on their head. Overturning orthodoxies can help us create improvement opportunities where it wasn’t previously thought possible.

Overturning orthodoxies requires one to explicitly question certain elements of the business model and those that are prevalent in the industry. Challenging orthodoxies requires taking both an industry and an internal perspective. Overturning them enables the identification opportunities that arise from looking at our existing business model in a different way.

In this Home Care Sector setting we identified a series of orthodoxies that merited some questioning and discussion. We note that not all of these orthodoxies resulted in significant change within the overall recommendations. However, we identified four orthodoxies that were questioned in order to help develop the most appropriate approach to designing a standardized rate schedule. They are as follows:

Orthodoxy 1 – Nursing and Therapy services should be paid on a per visit basis: This relates to the Provincial “unit measurements” for care delivery. Prior to determining a new Provincial rate for a service, it was important that the PPT discuss and agree on the units of care to which pricing would apply. Currently, overall services could be priced on a visit basis or on a time unit basis, depending on the service. PSW was priced on a time unit basis and Therapies were priced on a visit basis while Nursing could be priced on a visit or time unit (shift) basis.

For Nursing, this forced examination of the notion that some CCACs want to pay these services on an hourly basis. The argument being that “visits” could be up to two hours in length and that created an incentive to “expedite” care such that patients got less time than was deemed paid (i.e. less than 2 hours of service in the visit case).

A number of challenges arose when this orthodoxy was examined:

- Since the employment model and compensation within SPOs is often based on a visit basis, it would be very difficult to change and track to hourly visits in all contexts. A potential disconnect between how SPOs are paid versus their employees could arise that would overlay undue complexity.
- SPOs bare additional risk of patient complexity in a solely hour based model. If a visit takes longer than anticipated (up to the 2 hours), they have to provide the service. Without this, CCACs would have to requisition blocks of time. Standard lengths of time for nurses/therapists to treat specific conditions would have to be established. If the nurse took more time than needed, then the SPO would have to request a change which would require creation of an approval process. This would increase the administrative burden within the sector.

Based on analysis of the current service distributions and PPT discussion:

- Overall services will continue to be on a visit and time unit basis, as the diversity of services delivered by the sector necessitates both approaches.
  - PSW will be priced on a time unit basis, because PSW is typically delivered in increments of an hour;
  - Therapies will be priced on a visit basis, because Therapies are typically delivered as visits by specialized practitioners; and,
  - Nursing will be priced on a visit and shift basis, because, depending on patient needs, Nursing can be either a visit or a time unit-based shift that is consistent in Provincial application.
Orthodoxy 2 – Volume discounts should be provided by provider organizations: This relates to whether a volume scale should be applied to pricing, with a higher rate paid for lower volumes of a service, to compensate providers for the increased cost of providing the service, and a lower rate paid for higher volumes of a service since providers should be making higher revenues from the higher volume. Currently, a volume scale exists for services delivered by providers.

The report addresses this question in some detail – see section 4.6.9. Namely, the orthodoxy in place that volume discounts should be an approach that maintains relevance. SPOs indicated that there isn’t a large cost basis to offer volume discounts because Administrative and Education Delivery expenses are a very small portion of operating costs. This was later validated in our analysis. Additional discussion uncovered the following findings:

- The volume true-up is burdensome from a provider perspective; and,
- As volumes keep increasing and the volume grids are often out of date.

Based on all the factors, PPT discussion, and analysis, the following conclusions were made related to the volume discount orthodoxy:

- The pricing model should set one base rate provincially, as this is consistent with the goals of the PPT and QVHC.
- No volume scale is necessary on the high end, as the new Provincial rate and the lower end should be eliminated to counter balance.
- A “critical mass” threshold should be created on an situational basis by CCACs and SPOs to adjust for situations where a minimum level of service must exist in an area but there is insufficient critical mass of volume for SPOs to allocate full time human resources.

Orthodoxy 3 – Travel should continue to be paid as part of an overall rate: Travel is currently incorporated into all rates. As travel varies provincially this has some effect on the rate variation that exists across the province. There were two concerns with this orthodoxy:

1. For services that are hourly based (primarily PSW), including travel in the rate has a negative impact if the hourly service becomes a fraction of an hour.
2. Remote travel also needs to be considered as the costs (both transportation and time) can be significant. In some CCACs remote travel is separate from existing service rates.

This orthodoxy was centred on the notion that the lump sum model still works because identifying and calculating travel cost would be complex. The other side to the orthodoxy related to incentives. Specifically, having SPOs responsible for managing travel creates an incentive for providers to ensure that they plan routes efficiently, and schedule their employees efficiently. It is assumed that those organizations want to lower their internal travel costs as much as possible.

Data analysis provided some clarity to these questions (see section 3.6.5 and 5.2.2). Travel was a cost component that could be identified and calculated across the province per service in a structured and systematic way. Including this cost component as a separate adjustment in the Provincial Fee-for-Service rates would add clarity to sector pricing. Therefore, the following outcomes resulted:

- The rate for visit-based services, such as Nursing and the five Therapies, should include travel.
- For PSW, travel will be paid on a per visit basis.
- Travel will not be paid in Cluster care settings.
- Remote areas will be considered as exceptions rather than built into the model.

Orthodoxy 4 – The cost of “Not Seen, Not Found” should be included in the standard rate: Not Seen Not Found (NSNF) refers to visits where the provider arrives at the patient’s home to deliver care and cannot locate the patient. NSNF is currently embedded in the cost of doing business. Most CCACs (except for one) do not compensate for a NSNF visit.
Assessment and discussion revealed that adding a rate for NSNF would be complicated to manage. For instance, how would the sector validate that an NSNF visit occurred? How could it be ensured that the provider does appropriate due diligence and facilitates that the visits occur as schedule, by calling ahead etc.?

The outcome and decision forward related to this orthodoxy is as follows:

- Not seen, not found visits should be implicitly included in the rate. They are considered a cost of providing service.
3.4 Understanding Home Care Sector Sustainability and Capacity

In the absence of a competitive rate setting process, a requirement of developing the new Fee-for-Service schedule was to provide a fact-based analysis and understanding of overall sector sustainability. The objectives of the analysis were to provide:

- Evidence to CCACs (and by extension, taxpayers) that they are paying a reasonable rate for the services that are being purchased;
- An objective, evidence-based view of the financial health, performance and sustainability of SPOs;
- Increased credibility for the new pricing model from the perspective of the sector; and
- An understanding of factors that affect the ability of the sector to grow to meet its expanding mandate.

This analysis was conducted in three parts:

I. Analyzing SPO sustainability through peer sector contribution margin and operating margin comparison
II. Understanding the value of services purchased from a financial perspective
III. Analyzing comparative wage differences between sectors

Part I: Analyzing SPO sustainability through peer sector contribution margin and operating margin comparison: This analysis was designed to inform an understanding of overall sector health utilizing peer sector contribution margin and operating margin comparisons.

- Contribution margin is defined as total revenue minus variable expenses and operating margin is defined as EBITDA (Earnings before interest, taxes [if applicable], depreciation and amortization).
- The purpose of this analysis was to provide international/cross-sector comparators to contextualize and further inform recommendations as well as to provide a snapshot of how similar sectors in other jurisdictions were performing in recent years, based on available data.
- The purpose of this analysis was not to provide explicit targets for the Ontario home care sector.
- Data was sourced for 2010-2012, with notes on the operating market/sample as well as the source of the data.

Within the peer sector comparison, there were two comparison metrics taken from other sectors which were used to analyze sector sustainability:

1. Cross-Sector Contribution Margin and Operating Margin Analysis – A comparison between the contribution margins and operating margins observed in the Ontario home care sector and comparable sectors domestically and internationally. This data was collected from provider annual financial reports, sector literature, and from the TRUVEN Health Analytics database.

2. Cross-Sector Patient Focused Spend Analysis – A comparison of the proportion of revenue spent on patient-focused care (i.e. labour) between the Ontario home care sector and comparable sectors. This was calculated as the provider’s total revenue percentage (100%) minus their contribution margin. This data was collected via the provider data request and was not audited against annual financial reports.

Part II: Understanding the value of services purchased from a financial perspective – This analysis was designed to assess the financial performance of the SPOs, with a view to determining, at a high level, the value being received by the CCACs for the provision of services at the existing rates

- The purpose of this component was to provide factual information for the Table’s discussion of sustainability based on data from participating providers, and to assist in developing recommendations for sector sustainability, while comparing factual information from the Ontario home care sector to information from comparable sectors in order to provide context for the findings observed.
• The purpose was not to discuss individual providers or outliers at either end of the range of results; reach a specific target or level of financial performance for the sector; interfere in the autonomy of organizations to manage individual businesses in the manner defined by their leadership. Only Accenture saw results from individual providers, or knew exactly which providers provided data. This analysis was also not intended to be a “Value for Money” audit as defined by the Auditor General.

• All participating providers consented to the analysis methodology and format in which findings would be presented (aggregate view only) prior to release and discussion with the PPT.

• The format and content of the data request was developed and validated with the assistance of the PPT before being sent to the relevant Ontario home care associations for distribution to their members. The data request template had two components:
  o An overall financial analysis of aggregate financial metrics, including the breakdown of provider costs and their overall EBITDA in order to understand provider operating capacity.
  o Financial analysis by service area (Nursing, PSW, Therapies), including the breakdown of provider costs on a per-service basis and their EBITDA by service in order to understand contribution margin and percentage of costs associated with direct patient care.

• In order to complete the analysis, data was requested from selected SPOs and included detailed definitions of required financial inputs as well as a guide to completing the data request. Considerations of the analysis were as follows:
  o Administrative and Education Delivery expenses were captured as a total value by the providers and were allocated to the different service areas as a pro-rated allocation based on revenue by service area.
  o Where expenses in the income statement were a result of purchases from related business (non-arm’s length), income statements for those entities were also required.
  o If additional contextual information was available to provide more clarity around the income statements, providers were instructed to provide it as it would help to better understand any outlier cases (ex: Exceptions and special arrangements with CCACs).
  o Data was requested from the provider’s most recent fiscal year.

Part III: Analyzing comparable wage differences between sectors – Understanding wages in the sector was another important lens for the assessment overall sector sustainability as the sector has had difficulty in retaining human resources all while meeting increased demands from more complex patients.

• The purpose of this component was to understand the variability in wages for similar service provision in other care environments. This was identified as an important variable within the sector sustainability analysis as any gaps would certainly impact the sector’s ability to recruit and retain labour as capacity requirements grow.

• Wage data was gathered across the Home, Long-term Care and Hospital sectors and compared in order to identify wage gaps and potential risks to the Home Care sector.

• Note that the purpose of this analysis was not to make a specific wage recommendation but only to identify whether a gap exists that could contribute to recruiting and retention challenges in the sector. Wage decisions are firmly the responsibility of individual providers and as such very much out of scope for this study.

3.4.1 Analysis of SPO Financials and Peer Comparison – Key Findings

Cross-Sector Analysis of Contribution Margin, Operating Margin and Patient Focused Spend

Before extracting and analyzing Ontario home care operating margins from provider data, research and analysis was conducted to develop a picture of operating margins and net income across similar sectors internationally. Net income as a percentage of revenue was used as a key comparator in the analysis. This information was more readily available than
EBITDA. The exception to this is for data from Long Term Care Canada, where EBITDA as a percentage of Revenue was used. The data came from:

- Publicly available financial statements of providers, for the Long Term Care sector in Canada and the EU, and Long Term Care/Home Care/Clinics in Australia/New Zealand.
- Literature, for the American home care sector. In this case, findings from MedPAC reports on Medicare Payment Policy were used. MedPAC is an independent agency which advises the US Congress on Medicare issues.
- The TRUVEN Health Analytics database, for the American home care sector and related sectors. In this case, data from the ENC (East, North and Central) region was used. This region was the closest reporting region to Ontario geographically, and had the largest sample size of reporting providers.

The data points were consolidated into Table 3.4.1 below, which was then discussed and socialized with the PPT. The analysis indicates that net incomes are generally positive for comparator sectors in other jurisdictions, although they have been decreasing in recent years as governments look to reduce health care expenditures in a difficult economic climate. Some general considerations and discussion points related to the cross-sector analysis include:

- Based on the data shown, Long Term Care net income in Canada, the EU, and Australia/New Zealand was positive and relatively stable from 2010-2012. Lower net income was observed in the EU and Australia/New Zealand than Canada, where statements in the provider financials and related presentations suggested that lower net income was due to high labour costs, required to meet stringent legislative requirements and make investments in comprehensive employee training and retention.
- Home care net income in the USA, as reported by both the MedPAC Congressional report and the TRUVEN Health Analytics database, were close to 20% in 2010 but have since fallen to approximately 12-13%, the main identified driver of which was legislative and governmental pressure to reduce costs. The results are similar between both sources which contribute to confidence about their accuracy.
- Net income for specialty home care services in the USA, such as hospice care or infusion pharmacy (specialized delivery of intravenous drugs and related care) were much higher than the other reported data, but given the limited sample sizes and specific nature of these services, they are less relevant to the Ontario context.

<table>
<thead>
<tr>
<th>Comparator Sector</th>
<th>2012 Average</th>
<th>2011 Average</th>
<th>2010 Average</th>
<th>Operating Market/Notes</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care Canada (EBITDA)</td>
<td>12.86%</td>
<td>11.82%</td>
<td>13.64%</td>
<td>Includes 3 providers with 145 total facilities in Canada and annual revenues of ~ $1.3B</td>
<td>2012/2011 Annual Reports</td>
</tr>
<tr>
<td>Long Term Care – EU (Net Income)</td>
<td>5.69%</td>
<td>5.87%</td>
<td>5.45%</td>
<td>Includes 4 providers with 942 facilities in France, Italy, Spain, Germany, Belgium, and Switzerland</td>
<td>2012/2011 Annual Reports</td>
</tr>
<tr>
<td>LTC, Home Care, Clinics - NZ/AUS (Net Income)</td>
<td>7.50%</td>
<td>7.32%</td>
<td>10.68%</td>
<td>Includes 3 LTC/home care/clinic providers with 112 facilities in Australia and New Zealand</td>
<td>2012/2011 Annual Reports</td>
</tr>
<tr>
<td>Home Care USA (Net Income)</td>
<td>13.7% (Proj.)</td>
<td>14.8%</td>
<td>19.1%</td>
<td>Includes freestanding (non-hospital) urban/rural and for-profit/not-for-profit providers. Payment from Medicare</td>
<td>MedPAC, Reports on Medicare Payment Policy, 2013, 2012</td>
</tr>
<tr>
<td>Home Health USA – ENC Region (Net Income)</td>
<td>11.64%</td>
<td>13.81%</td>
<td>19.35%</td>
<td>Includes 12 responding providers of Home Health care in the ENC region of the USA</td>
<td>TRUVEN Health Analytics Database</td>
</tr>
<tr>
<td>Home Hospice Care USA – ENC Region (Net Income)</td>
<td>31.27%</td>
<td>36.77%</td>
<td>38.13%</td>
<td>Includes 11 responding providers of Home Hospice care in the ENC region of the USA</td>
<td>TRUVEN Health Analytics Database</td>
</tr>
<tr>
<td>Home Infusion Pharmacy USA – ENC Region (Net Income)</td>
<td>21.71%</td>
<td>36.36%</td>
<td>39.11%</td>
<td>Includes 4 responding providers of Home Infusion Pharmacy services in the ENC region of the USA</td>
<td>TRUVEN Health Analytics Database</td>
</tr>
</tbody>
</table>

Table 3.4.1 – Comparative Analysis - Average Net Income or Operating Margin

October 2013
The data points were also consolidated into Table 3.4.2 below, which shows contribution margin as the primary metric, rather than net income or EBITDA. Contribution margin is the result of subtracting variable costs such as direct labour, materials, and supervision from total revenues and dividing the result by total revenues. Therefore, when the contribution margin is subtracted from total revenue, this provides a measure of the proportion of cost allocated to the variable costs associated with patient focused activities.

As observed in the analysis, patient focused spend in the comparator sectors ranged from 58.74-79.35%, with most results around 65%. This suggests that a relatively high proportion of costs are directed towards actually delivering patient care in comparator sectors internationally.

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As observed in the analysis, patient focused spend in the comparator sectors ranged from 58.74-79.35%, with most results around 65%. This suggests that a relatively high proportion of costs are directed towards actually delivering patient care in comparator sectors internationally.

### Table 3.4.2 – Comparative Analysis - Average Contribution Margin and Patient Focused Spend

<table>
<thead>
<tr>
<th>Comparator Sector</th>
<th>Average Contribution Margin</th>
<th>Operating Market/Notes</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2011</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>(% of cost allocated to patient care)</td>
<td>(% of cost allocated to patient care)</td>
<td>(% of cost allocated to patient care)</td>
</tr>
<tr>
<td>Long Term Care Canada</td>
<td>36.98% (63.02%)</td>
<td>36.52% (63.48%)</td>
<td>36.95% (63.05%)</td>
</tr>
<tr>
<td>Long Term Care – EU</td>
<td>34.12% (65.88%)</td>
<td>33.47% (66.53%)</td>
<td>33.25% (66.75%)</td>
</tr>
<tr>
<td>LTC, Home Care, Clinics - NZ/AUS</td>
<td>41.26% (58.74%)</td>
<td>40.81% (59.19%)</td>
<td>39.30% (60.70%)</td>
</tr>
<tr>
<td>Home Health USA – ENC Region</td>
<td>21.16% (78.84%)</td>
<td>20.65% (79.35%)</td>
<td>26.57% (73.43%)</td>
</tr>
<tr>
<td>Home Hospice Care USA – ENC Region</td>
<td>35.75% (64.25%)</td>
<td>35.97% (64.03%)</td>
<td>38.32% (61.68%)</td>
</tr>
<tr>
<td>Home Infusion Pharmacy USA – ENC Region</td>
<td>35.83% (64.17%)</td>
<td>38.09% (61.91%)</td>
<td>24.57% (75.43%)</td>
</tr>
</tbody>
</table>

### Analysis of SPO Financials

The first component of the service provider financial analysis summarizes the overall financial results for all services (PSW, Nursing, and the five main therapies – OT, PT, SLP, ND, and SW), as reported by respondents to the data request described above.

Key components of the analysis are as follows and reflected in the table above:

- A picture of overall health of the sector can be captured by the weighted average column, which adjusts for the relative size of each provider. This analysis suggests that overall SPO operating margins are narrow.
- EBITDA for all providers is just over 2%, and results range from -4.80% to 12.75%. As this refers to operating income before tax and depreciation, actual net income or revenues over expenditures would be lower and in some cases they would represent a deficit.
- The weighted average percentage of cost associated with patient facing activities, such as the costs of direct labour, materials, supervision, and technology for patient care (i.e. Blackberries for personal support workers, not back office IT infrastructure) is 85.71%, which suggests that a large proportion of cost is directed to delivering patient care.
Table 3.4.3 – Financial Analysis, All Services

Financial analysis results are illustrated below for individual services. This breakdown provides additional detail and context for recommendations made at the service level.

PSW

The overall financial results for PSW, as reported by respondents to the data request described above are as follows and captured in the table below:

- Average sector operating margins, as seen in the weighted average column, are low (2.66%) and there is variation in the results observed, with results ranging from -6.64% to 16.79%. Again, since this refers to operating income before tax and depreciation, actual net income or any revenues over expenditures would be even lower.

- Within the sector, 84.56% of the costs of PSW are directed towards patient-facing care costs, a high proportion which is in line with what was observed for Nursing as well as all aggregate services.

Table 3.4.4 – Financial Analysis, PSW
Nursing

The overall financial results for Nursing, as reported by respondents to the data request described above are as follows and captured in the table below:

- Average sector operating margins, as seen in the weighted average column, are low (2.88%), but there is more significant variation in the range of results observed than with total services, with results ranging from -15.23% to 23.55%.
- As seen with all services, a high percentage of cost is devoted to delivering patient care for Nursing, with a weighted average of 85.86% of cost associated with direct patient facing activities.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Labour</td>
<td>67.20%</td>
<td>65.39%</td>
<td>77.00%</td>
<td>74.38%</td>
<td>57.53%</td>
<td>52.16%</td>
<td>65.46%</td>
<td>74.30%</td>
</tr>
<tr>
<td>Travel</td>
<td>5.09%</td>
<td>5.15%</td>
<td>17.00%</td>
<td>9.16%</td>
<td>1.02%</td>
<td>0.00%</td>
<td>5.63%</td>
<td>2.89%</td>
</tr>
<tr>
<td>Materials</td>
<td>0.32%</td>
<td>0.33%</td>
<td>0.91%</td>
<td>0.56%</td>
<td>0.03%</td>
<td>0.00%</td>
<td>0.33%</td>
<td>0.26%</td>
</tr>
<tr>
<td>Total Variable Costs</td>
<td>72.61%</td>
<td>70.87%</td>
<td>82.88%</td>
<td>81.15%</td>
<td>61.52%</td>
<td>57.76%</td>
<td>71.42%</td>
<td>77.45%</td>
</tr>
<tr>
<td>GM before Supervision and Technology</td>
<td>27.39%</td>
<td>29.13%</td>
<td>42.24%</td>
<td>38.48%</td>
<td>18.85%</td>
<td>17.12%</td>
<td>28.58%</td>
<td>22.55%</td>
</tr>
<tr>
<td>Supervision and Coordination</td>
<td>11.56%</td>
<td>11.99%</td>
<td>21.67%</td>
<td>15.80%</td>
<td>8.06%</td>
<td>6.90%</td>
<td>11.49%</td>
<td>11.83%</td>
</tr>
<tr>
<td>Technology</td>
<td>1.70%</td>
<td>1.50%</td>
<td>5.34%</td>
<td>3.11%</td>
<td>0.21%</td>
<td>0.00%</td>
<td>1.62%</td>
<td>2.03%</td>
</tr>
<tr>
<td>GM after Supervision and Technology</td>
<td>14.14%</td>
<td>15.64%</td>
<td>33.07%</td>
<td>23.70%</td>
<td>2.05%</td>
<td>-5.67%</td>
<td>15.47%</td>
<td>8.69%</td>
</tr>
<tr>
<td>Administrative and Education Delivery Expenses</td>
<td>11.26%</td>
<td>13.61%</td>
<td>23.55%</td>
<td>20.18%</td>
<td>9.28%</td>
<td>6.49%</td>
<td>11.54%</td>
<td>10.13%</td>
</tr>
<tr>
<td>EBITDA</td>
<td>2.88%</td>
<td>2.03%</td>
<td>16.17%</td>
<td>10.11%</td>
<td>-6.95%</td>
<td>-15.23%</td>
<td>3.94%</td>
<td>-1.44%</td>
</tr>
<tr>
<td>Percentage of cost associated with patient facing activities</td>
<td>85.86%</td>
<td>84.36%</td>
<td>105.67%</td>
<td>97.95%</td>
<td>76.30%</td>
<td>66.93%</td>
<td>84.53%</td>
<td>91.31%</td>
</tr>
</tbody>
</table>

Table 3.4.5 – Financial Analysis, Nursing

Therapies

The last component of the provider financial analysis summarizes the overall financial results for the five primary therapies – Occupational Therapy, Physiotherapy, Speech and Language Pathology, Nutrition and Dietetics, and Social Work. The overall financial results for therapies, as reported by respondents to the data request described above are as follows and captured in the table below:

- Average EBITDA across the five therapies is higher than that of Nursing or PSW, at 9.38%, although within the range of results, there are still providers operating at a loss or deficit (-2.75% to 13.34%).
- A weighted average of 78.94% of the costs of Therapies are directed towards patient-facing care costs, a proportion which is slightly lower but still in line with what was observed for Nursing, PSW, and all aggregate services.
Table 3.4.6 – Financial Analysis, Therapies (Table 1)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Labour</td>
<td>62.89%</td>
<td>62.49%</td>
<td>60.67%</td>
<td>62.15%</td>
<td>53.24%</td>
</tr>
<tr>
<td>Travel</td>
<td>3.77%</td>
<td>6.67%</td>
<td>7.05%</td>
<td>7.96%</td>
<td>7.61%</td>
</tr>
<tr>
<td>Materials</td>
<td>0.15%</td>
<td>0.15%</td>
<td>0.16%</td>
<td>0.16%</td>
<td>0.16%</td>
</tr>
<tr>
<td>Total Variable Costs</td>
<td>66.81%</td>
<td>69.31%</td>
<td>67.89%</td>
<td>70.26%</td>
<td>61.00%</td>
</tr>
<tr>
<td>GM before Supervision and Technology</td>
<td>33.19%</td>
<td>30.69%</td>
<td>32.11%</td>
<td>29.74%</td>
<td>39.00%</td>
</tr>
<tr>
<td>Supervision and Coordination</td>
<td>10.86%</td>
<td>10.37%</td>
<td>9.00%</td>
<td>11.85%</td>
<td>10.26%</td>
</tr>
<tr>
<td>Technology</td>
<td>0.83%</td>
<td>0.74%</td>
<td>0.62%</td>
<td>0.77%</td>
<td>0.83%</td>
</tr>
<tr>
<td>GM after Supervision and Technology</td>
<td>21.51%</td>
<td>19.58%</td>
<td>22.49%</td>
<td>17.12%</td>
<td>27.91%</td>
</tr>
<tr>
<td>Administrative and Education Delivery Expenses</td>
<td>11.57%</td>
<td>11.57%</td>
<td>12.13%</td>
<td>11.34%</td>
<td>12.52%</td>
</tr>
<tr>
<td>EBITDA</td>
<td>9.94%</td>
<td>8.01%</td>
<td>10.36%</td>
<td>5.78%</td>
<td>15.39%</td>
</tr>
<tr>
<td>Percentage of cost associated with patient facing activities</td>
<td>78.49%</td>
<td>80.42%</td>
<td>77.51%</td>
<td>82.88%</td>
<td>72.09%</td>
</tr>
</tbody>
</table>

Table 3.4.7 – Financial Analysis, Therapies (Table 2)

Cross-Sector Comparison

Based on the comparison of across sectors and the available data from the provider financial analysis, there is a considerable gap in operating margins between Ontario Home Care and comparable sectors worldwide – the total average operating margins for Ontario Home Care were lower than all the comparator group margins observed. This difference is even more apparent when considering that EBITDA is shown for Ontario Home Care, while the comparator group information in Table 3.4.1 shows EBITDA for the Canadian Long Term Care sector and net income for all other sectors; once taxes, depreciation, and other expenses are factored in, we would expect overall net income or revenues over expenditures to be compressed even further.

Similarly, based on the comparison of patient focused spend in Table 3.4.2 and the available data from the provider financial analysis, we see that the average patient focused spend in the Ontario home care sector is 85.71%, driven by Nursing and PSW. Therapies tend to be somewhat lower, but are within a similar range. In comparison, Table 3.4.2 shows patient focused spend in the comparator sectors would range from 58.74-79.35%, with most results around 65%.
This comparison suggests that a relatively high proportion of sector costs are directed towards actually delivering patient care in the Ontario home care sector relative to comparator sectors internationally.

Based on the results of the sector sustainability analysis and the available data within, CCACs, the MOHLTC and, by extension, taxpayers are receiving good value for the services delivered (on a financial basis) by the Ontario home care sector. The narrow operating margins observed do raise concerns about the ongoing sustainability of the sector and its ability to continue delivering high-value care to patients.

An analysis and discussion of home care wage data compared to other sectors, in Section 4.4.3 below, will offer an additional lens through which the current status of the sector and its sustainability can be assessed.

3.4.2 Home Sector Wage Disparity Analysis

To better understand the sector financial information within the context of the broader healthcare environment, and to validate qualitative/anecdotal statements made regarding the disparity in wages between home care and comparable sectors, a review of available cross-sector wage grids was completed.

**Qualitative and Anecdotal Statements Observed**

Through the interview process:

- Concerns about the home care sector’s wage disparity with Hospitals and LTC facilities, and its effects on sector sustainability were expressed by interviewees from both providers and CCACs.

- The human resources leaving for other sectors are often the top performers – skilled, competent workers who face minimal obstacles in securing higher-paying positions at Hospitals or in LTC facilities. Some Human resources are also leaving the home care sector entirely as wages for certain services are so low.

- Several interviewees believed that the cross-sector gap in wages had broadened in recent years and, based on their observation of sector trends, believed that the problem would continue to intensify as demographic changes and policy decisions place greater pressure on home care resources.

The review of industry publications as part of the Environmental Scan also revealed some interesting findings:

- Concerns about the wages paid to home care workers are voiced by home care workers as well as patients, their families, and their primary caregivers.¹

- The wage gap has been a topic of discussion in the industry for many years and has been linked to issues such as difficult recruitment of new human resources, higher employee turnover, and burnout of existing employees.²

The collection of news and public commentary on the home care sector also revealed the following:

- The wage gap for PSWs is at least $5/hour; this gap drives higher turnover, makes recruiting new PSWs difficult, and has a negative impact on the recipients of care³

- The effects of the sector’s wage disparity will only intensify as the population ages, demand for home care services increases, and the differential between new workers entering the sector and those leaving it grows⁴

To develop a fact-based context and perspective on these statements and opinions, Table participants were engaged to submit materials and data on wage rates for Ontario home care workers and two main comparator sectors: Hospitals and

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² Ontario Home Health Care Providers’ Association and Ontario Community Support Association (2010). Home Care Worker Compensation.
Long Term Care (LTC). This data was collected for Personal Support Workers, Registered Nurses, Registered Practical Nurses, and Therapy providers.

The data collected were subject to a number of important limitations and considerations, which were highlighted and validated by the Pricing and Payment Table prior to presentation and discussion:

- Available data was sourced from collective labour agreements, service provider internal information, and sector studies by industry experts.
- Most available rates shown were base rates, exclusive of benefits; it wasn't possible to compare benefits given the available data.
- The agreements from which rates were taken had varying effective dates; only the most recent data were utilized and any data from 2008 or earlier were excluded.
- PSW and RPN wage rates for Long Term Care were taken from a provider collective agreement which was validated as being indicative of wages in other LTC agreements, per industry expert Bob Bass (Bass Associates).

With these considerations in mind, the cross-sector wage findings were as follows in Table 3.4.8:

<table>
<thead>
<tr>
<th>Sector</th>
<th>Personal Support Worker (PSW)</th>
<th>Registered Nurse (RN)</th>
<th>Registered Practical Nurse (RPN)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average rates from 12 providers:</td>
<td>Average rates from 7 providers:</td>
<td>Average rates for 6 providers:</td>
</tr>
<tr>
<td></td>
<td>Min: $14.04      Max: $17.52</td>
<td>Min: $24.91       Max: $35.13</td>
<td>Min: $19.88       Max: $22.60</td>
</tr>
<tr>
<td></td>
<td>Min: $19.08      Max: $20.11</td>
<td>Min: $27.51       Max: $41.65</td>
<td></td>
</tr>
<tr>
<td>Long Term Care</td>
<td>Home for the Aged</td>
<td>Min: $30.17       Max: $43.61</td>
<td>Min: $23.86       Max: $24.88</td>
</tr>
<tr>
<td>Hospital</td>
<td>No information available</td>
<td>Min: $30.17       Max: $43.61</td>
<td>Min: $25.92       Max: $27.10</td>
</tr>
<tr>
<td></td>
<td>Source: ONA Hospital Wage Grids, Effective 2011-2014</td>
<td>Source: OHA collective agreements, Effective 2010-2013</td>
<td></td>
</tr>
</tbody>
</table>

Table 3.4.8 – Comparative Analysis – Cross-Sector Wages for PSW, RN, and RPN

Based on the data provided as a result of this process, we conclude that there is a factual basis for the qualitative concerns and statements made about the wage disparity between Home Care and Hospitals/Long Term Care. Personal Support Workers and Nurses in the home care sector, in the aggregate, are paid less in comparison to their counterparts in Hospitals and Long Term Care service environments.

This interpretation of the results was discussed and validated with the Pricing and Payments Table and further refined through follow up discussion, leading to the additional relevant findings:

- Retirement Homes could be an additional comparator; several Table participants stated that they believed retirement home workers faced a wage disparity similar to Home Care workers; however, as it was beyond the
scope of this analysis and presented significant data collection challenges, no further analysis was done on retirement home wage rates.

- Presenting the wage data on an ex-benefits basis was required for the purpose of making a fair comparison between sectors. There was however, general consensus in PPT discussion that there was also a gap in benefits for Home Care workers compared to other sectors, and that this widened the overall disparity in compensation faced by the sector. This argument has merit and is complemented by the obvious challenges faced by workers who deliver home care – travel to different areas and patients, often fully or partially at their own expense, and the lack of a stable working location. The lack of full benefit information across the various sectors and the difficulty in quantifying the difference between often-variable benefits components meant that a definitive statement on wage disparity including benefits could not be reached.

We did not have enough data to make final conclusions regarding compensation disparities for the five therapies. Anecdotally, the PPT indicated that there are compensation disparity issues between the home care sector, the LTC sector and the Hospital sector. Specifically, there were two types of issues that were discussed at the table:

1. **Benefits**: As therapy practitioners in home care are primarily employed using a contract model, they do not receive benefits. This is in contrast to therapy practitioners in Hospitals or LTC who do receive benefits.

2. **Travel**: Home care therapists have to travel significantly more than therapists in other healthcare sectors and also more than PSWs or nurses. There typically isn’t the ability to cluster home visits as small volumes are spread out over larger areas. Additionally, as therapists are often employed under a contract model, the cost of some travel time is not reimbursed.

Members of the table and interviewees indicated that these factors are contributing to therapist retention problems within the home care sector. In the absence of clear data based evidence, it is not however possible to conclude that there is a wage disparity for therapies between the sectors without further research into the matter.
3.5 Home Care Sector Current State Pricing Findings and Implications

The current Home Care rate structure in Ontario is extremely complex and overly cumbersome. There are approximately:

- 14,000 different contracted rates
- 3300 different service codes
- 94 different service categories

Some individual CCACs have harmonized service rates, from the pre-amalgamated 42 CCAC environment, with SPOs for certain services, whereas others might be paying multiple rates to the same provider within the same geographic area. CCACs also quantify and account for services differently. For example some CCACs have utilized a special Palliative care nursing service code, whereas others have lumped palliative services with general nursing services. Cluster care is sometimes identified in rate codes, but not always.

There are multiple factors that appear to have contributed to the complex rate environment that the sector now faces. Some of the factors include:

- Lack of provincial standardization amongst CCACs operating practices and definitions;
- Legacy rates and contracts from the original 42 CCACs still persist;
- A moratorium on competitive bidding to standardize rates;
- Variation of services offered in different CCACs; and,
- Innovation of care delivery models and approaches to new services.

This complexity comes with a cost both for CCACs (i.e. rate administration, contract negotiations, care coordination) and SPOs (i.e. contract negotiations, rate rejection, billing management).

Throughout this initiative an attempt was made to analyze and explain the variation in current rates across and within different CCACs. Variation in rates was analyzed based on the following:

1. Geographic factors (i.e. population, population density, service area);
2. Economic factors (i.e. household income and personal income, inflation);
3. Timing factors (i.e. when rates were last updated); and,
4. Provider factors (provider size, market share, tax status).

The results of this analysis did not show significant correlation of any of these factors with the billing rates as they are today. A statistically significant model that explained the variation could not be found using the above factors. Some variation could be explained for some CCACs (up to 30% or R squared of 0.3), but nothing above this. This does not mean that the variation cannot be explained. It means that the variation cannot be explained with the factors for which data (outlined above) was available.

However, based on cost data provided by SPOs, travel costs did show some geographic variation (see Section 4.6), which is the basis for a travel adjustment.

If factors that are believed to drive variation in costs are to be identified quantitatively, additional data will need to be explicitly collected in the future that would allow this kind of analysis.

The following section describes some of the variation in current rates/service categories and implications for future rate setting.
3.5.1 Service Categories

For the purposes of this analysis, CHRIS data from April 1st 2012 through March 31st 2013 was analyzed (unless otherwise noted). This represents $1.336 Billion in spend provincially across the 14 CCACs. Although there are 94 service categories in CHRIS, only 75 were reviewed for this report.

Table 3.5.1 outlines the top 15 service categories that represent ~97% of provincial spend. There are an additional 60 relevant service categories that were analyzed as part of this report. A full table breaking down service categories, hours/visits and provincial spend for the FY13 fiscal year can be found in section 5.1.

<table>
<thead>
<tr>
<th>Service Delivery ID</th>
<th>Service Delivery ID Description</th>
<th>Spend (Thousands)</th>
<th>Volume (Hours or Visits)</th>
<th>% of Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>68</td>
<td>Hourly homemaking - combined personal support and housekeeping home</td>
<td>$675,975</td>
<td>22,499,164</td>
<td>50.59%</td>
</tr>
<tr>
<td>14</td>
<td>Visit Nursing home</td>
<td>$298,295</td>
<td>4,971,331</td>
<td>22.32%</td>
</tr>
<tr>
<td>10</td>
<td>Shift Nursing home</td>
<td>$63,458</td>
<td>1,231,714</td>
<td>4.75%</td>
</tr>
<tr>
<td>71</td>
<td>Hourly personal support home</td>
<td>$59,471</td>
<td>1,966,202</td>
<td>4.45%</td>
</tr>
<tr>
<td>41</td>
<td>Visit OT home</td>
<td>$40,518</td>
<td>329,030</td>
<td>3.03%</td>
</tr>
<tr>
<td>50</td>
<td>Visit PT home</td>
<td>$39,513</td>
<td>375,121</td>
<td>2.96%</td>
</tr>
<tr>
<td>61</td>
<td>Visit speech public school</td>
<td>$20,478</td>
<td>174,132</td>
<td>1.53%</td>
</tr>
<tr>
<td>18</td>
<td>Shift Nursing public school</td>
<td>$19,400</td>
<td>376,092</td>
<td>1.45%</td>
</tr>
<tr>
<td>43</td>
<td>Visit OT public school</td>
<td>$16,548</td>
<td>144,335</td>
<td>1.24%</td>
</tr>
<tr>
<td>197</td>
<td>Visit Nursing palliative home</td>
<td>$14,231</td>
<td>211,111</td>
<td>1.06%</td>
</tr>
<tr>
<td>11</td>
<td>Visit Nursing only day clinic</td>
<td>$10,503</td>
<td>291,880</td>
<td>0.79%</td>
</tr>
<tr>
<td>206</td>
<td>Visit Nursing Wound Care home</td>
<td>$9,523</td>
<td>149,395</td>
<td>0.71%</td>
</tr>
<tr>
<td>16</td>
<td>Visit Nursing public school</td>
<td>$9,028</td>
<td>153,971</td>
<td>0.68%</td>
</tr>
<tr>
<td>244</td>
<td>Hourly Nursing only day clinic</td>
<td>$8,813</td>
<td>137,578</td>
<td>0.66%</td>
</tr>
<tr>
<td>73</td>
<td>Hourly homemaking – caregiver respite home</td>
<td>$7,610</td>
<td>258,878</td>
<td>0.57%</td>
</tr>
</tbody>
</table>

Table 3.5.1 – Top 15 Service Categories by Provincial Spend

As can be seen in Table 3.5.1, multiple Service Delivery IDs (SDIDs) represent the same set of services. For example, there are three different PSW SDIDs listed in the table above (68, 71 and 73), and an additional five that are not listed. Some of the SDIDs attempt to differentiate between various care settings; however, there is no verifiable basis for this differentiation.

As a result of the number and variety of SDIDs, services listed in multiple SDIDs have been combined into service groupings to ensure that we have an accurate picture of services being offered, as shown in Figure 3.5.1. For example, the eight PSW categories were combined into one. Eight SDIDs relating to Home Shift/Hourly Nursing were also combined into one category. The groupings are elaborated in section 5.2.

When rolled up to an aggregate level by overall service area (i.e. PSW services, Nursing services, Therapy services and ‘Other’ services) the majority of CCAC spend is on PSW services (55.9%), followed by Nursing services (33.35%) and Therapy services (10.59%). The focus of pricing will be on these three main categories as they represent the bulk of provincial spending.
Figure 3.5.1 – Spend by Service Category
3.6 Proposed Pricing Model

3.6.1 Overview of Models and Selected Approach

Research conducted during the Environmental Scan revealed potential options for Fee-for-Service pricing models that could be utilized as part of this initiative and merited further assessment.

Two of the approaches included:

- **"Base + Adjustment":** In this model a base rate is set for each service being priced. Adjustments are then applied to account for different factors. These factors can include travel costs, geographic wage differences, patient complexity, shift premiums, etc.

- **"All-In" Daily Rate:** In this model a daily fixed service rate is set for a category of patients based on acuity. The SPO provides the services per patient need and bills the CCAC the fixed rate. This is the current practice used as part of the Medicare Palliative Benefit in the United States.

The "All-In" Daily Rate is similar in approach to the Outcomes Based Reimbursement work that is currently being undertaken as part of QVHC. Based on discussions at the PPT, this was recognized as out of scope for the Fee-for-Service pricing work.

"Base + Adjustment" was identified by the table as the most viable option because it:

- Matches most closely with the goals of this initiative to move to a standard Provincial rate.
- Assists with reducing complexity and allows for transparent pricing to be developed and understood within the sector.
- Is more closely aligned with current sector pricing than other options and would facilitate transition.
- Enables on-going and simplified data capture and performance metrics that can help continuous measurement and identification of areas needing adjustment/refinement.

**Recommendation 1**

*CCACs and Providers should adopt a Base + Adjustment pricing methodology for setting billing rates in the provincial Fee-for-Service model.*

3.6.2 Overview of Adjustment Factors

The Environmental Scan research identified a number of potential adjustments that could be applied in the pricing of Home Care services. These potential adjustments included: Travel costs, geographic wage differences, patient acuity, shift premiums, utilization of resources, service category, provider performance and provider education.

Through analysis, discussions with the PPT and additional discussions, the following adjustments are recommended for inclusion in the pricing model:

- Travel cost (Mileage and time); and,
- Critical mass.

Two other factors were considered and analyzed, but are not being recommended at this time:

- Geographic labour differences;
- Shift premiums; and,
- Volume.
Further details and analysis of the above adjustment factors can be found in Sections 3.6.3 through 3.6.11.

3.6.3 Base Rate Methodology

The Base Rate is the standard provincial rate that all SPOs will be paid for a given service.

Two approaches were identified for calculating Base Rates:

1. **Top-Down** – Calculation that uses current billing rates and volumes to determine a weighted average of current billing rates for each service. This is used as a starting point for the Base Rate. The advantage of using this method is that it uses a very detailed and complete data set of all the services that were actually provided over the last year. Therefore, it reflects the complexities of how services are delivered today, and at what rate. The disadvantage with using this approach is that assumptions must be made in order to remove factors from the rate (i.e. travel components).

2. **Bottom-Up** – Calculation that uses SPO data to determine the cost of different components of a service (e.g. labour, travel, supervision, administrative expenses, etc.). The advantage of utilizing this methodology is that it allows for a view of the cost components that cannot be seen explicitly in the top-down approach, and the service into logical financial cost factors. The disadvantage of this approach is that the data that was provided by SPOs was based on best estimates of the average contribution of each cost component for a typical service.

The Top-Down approach was selected as the preferred methodology because the data is more robust and reliable, and because the top down approach creates a Base Rate that is based on the actual services and volumes that have been provided over the last year. There was not enough data available to ensure that the Bottom-Up methodology would fully incorporate costs for SPOs from across the Province. Therefore, the bottom-up approach was deemed as less representative given the data limitations in the sector currently. Additionally, this approach would require some prescription of operating elements in the provider business models. Making such prescriptions is not a viable option in this context as it is the role of SPOs to make operating decisions to run their businesses. The Bottom-Up approach did however inform and validate direction of the Top-Down approach.

**Detailed Rate Calculation**

Four steps were followed to calculate the Base Rate for services:

1. **Analysis of the distribution of rates for a service:** A histogram was created for each service. This histogram indicated where outlier rates existed for a service.

2. **Removal of outliers from the distribution:** Rates outside of two standard deviations were reviewed to determine if they were outliers and should remain as part of the analysis. Rates that were considered outliers and were removed included:
   
   a. Rates that contained a remote travel component;
   
   b. Rates where the description indicated a service that was different from the service being priced; and,
   
   c. Pilot services

   Table 3.6.1 below lists the range of rates that were included in the analysis.

3. **Calculation of the weighted average rate:** Using volume (visits or hours) a weighted average rate was calculated.

4. **Removal of the average cost of travel:** The average travel cost for each service was removed from the average rate. This was done as travel is being reintroduced as an adjustment factor.

5. **Application of adjustment for sector sustainability:** A sustainability adjustment was then applied to form the new base rate. See Section 3.6.4 for further details.
## Fee-for-Service Market Assessment

Recommendations for a Pricing Model for Home Care Services in Ontario

### Table 3.6.1 – Rate Range Included in Analysis

<table>
<thead>
<tr>
<th>Service</th>
<th>Min Rate</th>
<th>Max Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSW</td>
<td>$16</td>
<td>$50</td>
</tr>
<tr>
<td>Nursing visit home</td>
<td>$36</td>
<td>$120</td>
</tr>
<tr>
<td>Nursing visit school</td>
<td>$38</td>
<td>$76</td>
</tr>
<tr>
<td>Nursing shift home</td>
<td>$34</td>
<td>$74</td>
</tr>
<tr>
<td>Nursing shift school</td>
<td>$35</td>
<td>$71</td>
</tr>
<tr>
<td>Nursing visit clinic</td>
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<td>$55</td>
</tr>
<tr>
<td>Nursing shift clinic</td>
<td>$40</td>
<td>$88</td>
</tr>
<tr>
<td>ET Nursing visit home</td>
<td>$60</td>
<td>$161</td>
</tr>
<tr>
<td>Continence advisor visit home</td>
<td>$60</td>
<td>$126</td>
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<tr>
<td>OT visit home</td>
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</tr>
<tr>
<td>OT visit school</td>
<td>$60</td>
<td>$175</td>
</tr>
<tr>
<td>PT visit home</td>
<td>$70</td>
<td>$160</td>
</tr>
<tr>
<td>PT visit school</td>
<td>$80</td>
<td>$165</td>
</tr>
<tr>
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<td>$176</td>
</tr>
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<td>$200</td>
</tr>
<tr>
<td>ND visit home</td>
<td>$65</td>
<td>$180</td>
</tr>
</tbody>
</table>

### 3.6.4 Addressing Sector Sustainability in the Base Rate

As discussed in Section 3.4, there are significant sustainability concerns for the Home Care sector in Ontario.

The Financial Analysis showed that operating margins, particularly for PSW and Nursing, were very narrow in the home care sector in Ontario, when compared to other sectors and jurisdictions. This raised concerns about the ongoing financial viability of SPOs and health of the sector, particularly in light of the billing rate freeze that has been in place for two to four years (and in some cases longer). Operating margins for therapies were higher, and more in line with comparators.

In addition, data supported the assertions made at the PPT and in interviews that there is a significant wage disparity between the Home Care sector and other care environments (e.g. LTC, Hospitals). This has raised concerns about the SPO’s ongoing ability to compete for health human resources effectively, to hire and retain staff, and to maintain the capacity required to serve home care patients at current levels. The trend toward increasing volumes of patients and services in Home Care will actually put pressure on CCACs and SPOs to increase capacity in the coming years.

These two factors taken together highlight a significant risk for the sustainability of the Home Care sector if it continues to operate under current billing rates. They point to the need to provide CCACs and SPOs with the financial wherewithal to effectively provide Home Care services into the future.

Current billing rates for PSW and Nursing services are not able to address these sector sustainability concerns. The evidence clearly identifies the need for an overall increase in billing rates in the Fee-for-Service model, for PSW and Nursing services.
The recommended adjustments begin to address some of the concerns outlined above. They will also help ensure better care for Ontarians by:

- Supporting SPOs to move to a more solid operating foundation;
- Supporting SPOs to take the steps necessary to attract and retain more skilled individuals; and,
- Enabling provider organizations to invest in continuous improvement as well as the ability to expand overall operating capacity.

In establishing the sustainability adjustment, the following issues were considered:

- The magnitude of the wage disparity between the home care sector and other healthcare sectors that offer PSW and Nursing services;
- The findings of the Financial Analysis which showed narrow operating margins for SPOs, particularly those offering PSW and Nursing Services;
- The freezing of billing rates for the last two to four years; and,
- The current economic environment of spending restraint and the trend toward austerity of the healthcare sector overall.

In light of all of these factors, we are recommending a 10% increase in weighted average rates (not including travel), for PSW and Nursing services. Travel is factored out of this as there are no recommended increases to travel rates at this time. If travel were factored in, the actual increase for PSW services would be approximately 9.47%. The increase for nursing services would be between 9.24% and 10%, depending on the service type.

This sustainability adjustment does not however bring the Home Care sector to parity with the Hospital or LTC sector. These adjustments serve to stabilize the sector. A strong argument could be made that the increase should be higher, given the magnitude of the sustainability factors discussed above. However, we believe that a 10% increase in the weighted average billing rate balances the need of the sector to improve its sustainability with the need of the healthcare sector as a whole to maximize the value it receives for money spent on services. It is entirely possible that additional sustainability adjustments may be required and recommended through future rate reviews.

We are not recommending a sustainability adjustment for any therapy services at this time. The outcomes of the financial analysis of therapy providers appear more in line with cross-sector comparators. As previously mentioned, anecdotal references indicate that therapies are facing human resource retention issues and there are compensation gaps specifically related to benefits and travel. Unfortunately data supporting those assertions was not available at the time this report was written. If data were to become available for the sector, this recommendation should be reviewed.

**Recommendation 2:**

A sustainability adjustment of 10% should be applied to the weighted average rate (excluding cost of travel) to determine a new Base Rate for PSW services.

**Recommendation 3:**

A sustainability adjustment of 10% should be applied to weighted average rates (excluding cost of travel) to determine a new Base Rate for Nursing services.
Recommendation 4:

*Base Rates for Physiotherapy, Occupational Therapy, Social Work, Nutrition and Dietetics, and Speech Language Pathology should be set to the current weighted average rate (excluding cost of travel).*

If Recommendations 2 and 3 are not implemented, then rate harmonization should not be pursued for PSW and Nursing services. By attempting to harmonize rates for these services without making these adjustments, the sector would be destabilized even further. Current SPO financial operating conditions are already precarious and it would be very difficult for providers to implement new unadjusted PSW and Nursing rates. This is discussed further in section 4.2.
3.6.5 Travel Rate Adjustment

Travel is an integral part of service delivery in the Home Care sector. There are specific costs associated with travel in the sector including transportation (mileage or public transit fares) and travel time. Costs vary based on geographic areas such as urban, rural and remote settings.

Approach

The challenge associated with pricing travel was ensuring that the methodology was transparent, reflective and deemed as fair for SPOs and for CCACs. Setting one travel rate provincially for each service might be manageable for the larger SPOs that operate across all CCACs as travel costs would average out for them; however, this would disadvantage SPOs who only operate in one CCAC or in one region of a CCAC (especially in the case of the five therapies), as their travel rates might be very high and might not average out to the provincial rate.

For these reasons, we decided to address travel using a more granular approach and setting travel rates at the Census Division level.

A Census Division (CD) is an intermediate geographic area between the province / territory level and the municipality (census subdivision), used by Statistics Canada as a reporting geography for census data. These geographic areas align to provincially legislated areas (such as county and regional district) or their equivalents. There are three types: Single-tier municipalities (usually larger), regional municipalities or counties and districts.

The Census Division level was chosen because:

- It provided established geographic boundaries aligned to census data (set by Statistics Canada);
- Was granular enough to provide pricing for urban and rural settings;
- Still provided the ability to set a rate structure provincially; and,
- Did not create an excessive number of travel rates. There are 49 CDs as opposed to 546 Census Sub-Divisions. There is an average of 4.6 CDs per CCAC.

A table of CDs by CCAC can be found in Section 5.3.

Additionally, as travel incorporates both transportation costs and travel time, travel costs were developed for each service type.

Recommendation 5:

An adjustment for travel should be applied to each Base Rate, based on the geographic location of the patient, to reflect the estimated cost of travel in each census division.

If travel rates are not set at the Census Division level, then the body responsible for implementation should determine a travel reimbursement mechanism that pays for travel at a level that is smaller than each CCAC (i.e. regions within CCACs). As previously mentioned, going to a provincial travel rate would be detrimental to smaller providers that do not have an operational footprint across the Province. Establishing a travel rate for each CCAC may also be harmful to smaller providers as some CCACs span both large rural and urban regions.

PSW Travel

As noted earlier in the orthodoxy section and the base rate analysis, PSW travel has always been included in the hourly rate paid to providers. The PPT table decided that PSW travel should be paid on a visit basis like all other services. This decision was made to account for the variation in practice when it comes to managing PSW visit length.

Travel is not a proportional component of the PSW rate. For example, whether a PSW spends 30 minutes or 60 minutes with a patient, the travel cost remains the same. If CCACs had the same practice when it came to authorizing PSW visit lengths, travel costs would average out in the PSW service rate. This is not taking place. In CCACs that are authorizing more short visits, SPOs are not being paid for the full cost of travel. As well, there is evidence that referral patterns are changing over time with more shorter visits becoming more prevalent. A per visit travel component will better reflect both current and future practices.

This is a shift in approach to travel for PSW and will require some adjustments to CHRIS and provider systems. Implementation considerations are discussed further in Section 5.2.2.

Recommendation 6:

**CCACs should adopt a PSW travel payment model where travel is paid on a visit basis.**

Remote Travel

Remote travel has been separated out of this analysis as the costs associated with travel to remote regions is significantly higher than when travelling in urban or rural settings. As such, remote travel should be treated on an exception basis. A procedure outlining how to determine the rate of remote travel can be found in Section 4.3.6.

Cluster Care

In the pricing model it is assumed that when services are offered in Cluster Care settings, a travel rate is not added on to those services. Travel is not included as the provider must only travel within a building to deliver care and does not need to travel back and forth between multiple patient sites. This is the benefit of having Cluster Care.

Calculation of Current Travel Rates for PSW and Nursing Services

Travel adjustments were calculated based on four components:

1. **CCAC travel costs provided by SPOs through the data request:** SPOs were asked to provide an estimate of the cost of travel, per visit (or hour) of service, for each service category. They were asked to provide the cost of travel mileage, and the labour cost for the time spent travelling. Most SPOs provided data at the CCAC level; however some provide data at the sub-regional level. For consistency, we aggregated all the data to the CCAC level.

   **Note:** We used a weighted average cost of travel by CCAC based on volume as the basis for CCAC travel costs. The exception to this was when the data reported represented less than 75% of CCAC volumes. In those cases we utilized a simple average of travel costs. This was done to ensure that the costs utilized in the calculation reflected the sector costs as much as possible.

2. **Population density factor:** We utilized the natural logarithm of population density for each Census Division. The natural logarithm was used to account for the significant density variation from urban to rural settings thus making the rate to density relationship linear. This approach is commonly used in regression analysis when analyzing population density.

   **Note:** Some CDs are comprised of Census Sub-Divisions called Unorganized Areas (NOs as per statistics Canada). These regions are located in Northern Ontario and are comprised of significant land
areas with very small populations. For the purposes of this analysis, we have removed them from the density calculations and considered them remote travel areas.

3. **Service Volume:** This was incorporated to factor in the volume of services being provided in a CD. This is predicated on an assumption that as volume increases in a CD, the amount of travel required in that CD decreases.

4. **Constant:** The constant was the unknown component of the equation that we were trying to solve for.

Equation 3.6.1 and Equation 3.6.2 represent the mathematical equations for how we disaggregated travel costs from the CCAC level to the Census Division level.

\[
\text{Average Travel Cost by CCAC} = \sum_{\text{for each CD}} \frac{CD \text{ Svc Volume}}{\text{Total Svc Volume}} \times \ln(CD \text{ Pop. Density}) \times \text{CCAC Constant}
\]

*Equation 3.6.1 – CCAC Travel Cost Calculation*

\[
CD \text{ Travel rate} = \text{Constant} \text{ for CCAC} \times \ln(CD \text{ Pop. Density})
\]

*Equation 3.6.2 – CD Travel Rate Cost Calculation*

As data was available for all categories except the CCAC Constant (and by extension the travel rate by CD), we built a model in Microsoft Excel to calculate the value of each Census Division. The model utilized Solver, a non-linear optimization engine that is part of the Data Analysis tool pack in Microsoft Excel, to determine these values for each Census Division. Solver utilizes goals, constraints and parameters to determine the optimal values for a solution.

One constraint was also built into the model. The travel rate for a CD could not change from CCAC to CCAC. For example even though the Toronto CD might cross Toronto Central, Central and Central East CCACs, the travel rate for Toronto remained the same.

Rates were calculated for PSW services, Blended, RN and RPN Nursing services. These rates apply to both the home and school settings.

Calculated travel rates can be found in Section 3.7.2.

**Calculation of Current Travel Rates for Therapy Services**

The sample size for Therapy travel cost data was not large enough to approach the analysis in the same way that was used for Nursing and PSW services. As a result, we adapted the methodology and utilized Nursing travel cost information as a proxy to calculate rates. Nursing was utilized as a proxy because it is a professional service and volume concentrations are similar to the five therapies.

There were two additional elements that were required for this part of the analysis:

- Nursing travel cost by CCAC (the proxy); and,
- Weighted average travel as a percentage of revenue.

Note: Table 3.6.2 outlines the percentage of revenues utilized for the calculation. The OT percentage of revenue was pegged at the PT percentage of revenue because the reported percentage appears to be an outlier when compared to data reported by the other therapies.
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<table>
<thead>
<tr>
<th>Therapy</th>
<th>Travel as a percentage of revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>OT</td>
<td>6.67%</td>
</tr>
<tr>
<td>PT</td>
<td>6.67%</td>
</tr>
<tr>
<td>SLP</td>
<td>7.96%</td>
</tr>
<tr>
<td>SW</td>
<td>7.61%</td>
</tr>
<tr>
<td>ND</td>
<td>7.05%</td>
</tr>
</tbody>
</table>

Table 3.6.2 – Travel as a Percentage of Revenue for Therapies

Base CCAC cost rates for Nursing were used as the starting point for the analysis. Once individual CD rates were developed (as per the process outlined in the previous section), these rates were multiplied by an adjustment factor to form the travel rates.

The adjustment factor was calculated using the formula in Equation 3.6.3:

\[
\text{Adjustment factor} = \frac{(\text{Travel cost as a percentage of revenue} \times \text{Total service cost}) - \text{Total calculated travel cost}}{\text{Total calculated travel cost}}
\]

Equation 3.6.3 – Therapy Travel Adjustment Factor Calculation

Note on Population Density

The analysis described above utilizes population density information based on the entire population (Age 0 to 75+) reported by Statistics Canada. The PPT requested that we also analyze pricing based on a population density for a population that is over 75 years of age. This analysis was requested as some CDs might have different proportions of elderly individuals when compared to the general population.

The analysis was performed for PSW services and the results of the analysis are as follows:

- 80% of rates calculated fell within +/- 5% of the rates calculated using standard density. Most CCACs with urban and rural populations fell into this category.
- 90% of rates calculated fall within +/- 10% of the rates calculated using standard density. 6 CDs that are primarily rural and located in CE, NSM, Champlain had differences between 5-10%.
- Less than 10% of rates calculated were more than +/- 10% different than the rates calculated using standard density. Most of the variation occurred in NE and NW CCACs where small variations in rural and remote populations had a significant effect.

The resulting rates in Northern Ontario did not seem as applicable as those determined using the standard population density data set. As a result we continued our analysis utilizing the standard population density as a base for travel rate calculations.

Collecting Additional Travel Cost Data

Travel costs were vigorously discussed during PPT meetings. Input from the PPT, interviewees and data provided by SPOs lead us to believe that travel costs are under reported in the data. Anecdotally, this happens because the individuals delivering services bear a portion of the travel cost. For example, for therapies, travel is often embedded in the visit rate that SPOs pay to sub-contracted therapists and does not get reflected in the data reported.

At this time, we believe that the travel costs included in this analysis provide a foundation to set travel rates. The sector should however work to improve the data used to calculate these rates as they are potentially underestimated.
The sector should begin collecting travel costs at the CD level by service regardless of employment model utilized to develop this fact base. As travel operating models differ from provider to provider it is important that the information collected be calculated in aggregate and reflects data from a variety of providers provincially. This fact base will provide significantly more clarity into the actual cost of travel for home care in the province.

Collection of travel costs by census division will also simplify future travel component calculations as it will remove the necessity to calculate a rate for each CD based on a CCAC average (i.e. the calculation performed above). We recognize that this will require significant effort on the part of SPOs to collect this information and potentially adjust their reporting systems. Given the concerns raised regarding travel rates, the cost benefit should be investigated. If travel cost collection is improved, once there is a sufficient data set, travel rates should be reviewed prior to implementation of the new rates.

**Note on Travel Rates**

Service base rates were developed by removing the average cost of travel from the weighted average service rate. This was done to separate travel from the service delivery. Both base rates and travel rates are part of the overall recommended solution. If any changes are made or proposed to travel rates, base rates must also be adjusted accordingly. The reason for this is that the overall spend, prior to factoring in sustainability adjustments, for each service should remain the same before and after implementation. For example if the average provincial travel rate for PSW services were to increase, then the PSW weighted average rate should decrease. This would ensure that spend on PSW services (prior to any sustainability adjustments) remains the same. If the average provincial travel rate for PSW services were to decrease, then the PSW weighted average rate should increase.

Once implementation is completed, travel rates and base rates can be adjusted separately. Travel will have fully been disaggregated and is no longer tied to the base rate. Travel rates and base rates should be adjusted using the methodology proposed in section 4.3.4.

**Recommendation 7:**

*CCACs and SPOs should create an aggregate, fact base that contains actual travel cost information, both transportation costs and travel time by Census Division regardless of employment model.*

**Recommendation 8:**

*Once a detailed travel cost fact base has been built, travel adjustments should be reviewed. This process should be completed before the new Fee-for-Service rates are implemented.*

### 3.6.6 Critical Mass Adjustment

Within current contracts, there are provisions for pricing adjustments based on step changes in volume. For some services there are rate grids that prescribe what rates will be, based on volume thresholds. SPOs are paid one rate throughout the year and volumes are analyzed at the end of the year. If volume is higher, CCACs obtain a refund from SPOs for what was paid and the adjusted rate. If the volume for that year is lower, then SPOs apply to CCACs to be reimbursed for the rate difference.

These volume adjustments are predicated on two assumptions:

1. As volumes increase, the rate should decrease as service providers gain operating efficiencies and are able to spread out their administrative costs over a larger volume base and continue to be viable.

2. The volume grid remains relatively stable throughout a fixed time period.
At one time, these assumptions may have been true in the sector. They no longer appear to be as applicable.

The financial analysis indicated that variable and semi-variable costs represent the majority of costs for providers (~83%). As a result, the cost base for volume discounts to be applied to is relatively small. Further, it does not account for the increased administrative expenses that are required to manage increasing staff and effort required for providing additional services, etc.

Volumes are continuously increasing in the sector. Interviews and discussion at the PPT indicated that volume grids were evolving continuously and were often out of date in contracts shortly after they were negotiated.

Additionally, the process for reconciliation of volume at the end of the year was cumbersome and required significant effort by both CCACs and SPOs. Although an analysis has not been performed on the costs associated with administering volume adjustments vs. the benefit realized by CCACs and SPOs, the consideration was not ignored.

As a result, we are recommending that volume adjustments not be included in the pricing model.

**Recommendation 9:**

**CCACs should eliminate volume adjustments as part of the contract template with service providers.**

During discussions with the PPT, the concern was raised that in some areas, there isn’t enough critical mass of patients to support a minimum level of service. Services must still be provided in those areas, and there are additional costs with doing so. For example, a nurse may be required in a rural area that has only three patients per day. The SPO must add capacity to service the area as requested by the CCAC, however the nurse would normally see eight patients per day. If the nurse is not travelling during the remainder of the time and cannot service other patients, there is a cost to the provider of having that nurse service the area the remainder of the day.

These situations should be exceptions and only found in rural or remote areas where there is justification to add a resource that won’t be travelling back and forth. This adjustment is not meant to address low volume scenarios where a provider’s volume is lower than expected. The adjustment should also be SPO agnostic.

If the provider is required to travel to a location and is not seeing additional patients due to the travel, the travel adjustment should encompass the cost of travel time. Additionally, if critical mass is being caused because volume is being split between SPOs in an area, then the CCAC should consolidate volumes in that area to rectify the situation.

The size of the adjustment has not been calculated as it is dependent on the specific requirements of the CCAC and capabilities of the SPO. SPOs and CCACs should negotiate locally to determine when a critical mass adjustment is required. This is further discussed in section 4.3.6.

**Recommendation 10:**

*A critical mass adjustment should be established locally between a CCAC and an SPO in the rare cases where the population of patients is too small to be reasonably served without additional costs being incurred to maintain a minimal staffing level.*

3.6.7 Nursing Blended Rates

There are three types of nursing service rates: RN, RPN and blended rates. A blended rate is a rate that combines a proportion of an RN rate and an RPN rate based on an RN to RPN ratio. With a blended rate, SPOs choose whether an RN or an RPN will visit the patient based on clinical requirements.

Section 5.1 provides detailed analysis of current RN, RPN and blended rates.
When calculating new base RN, RPN and blended rates it was necessary to deconstruct current blended rates. There were two reasons for this:

- The RN to RPN ratio differs on a CCAC by CCAC basis. New blended rates needed to incorporate the average provincial RN to RPN ratio.
- The RN and RPN components of blended rates needed to be understood to calculate average RN and RPN rates for the Province.

Blended rates were deconstructed by multiplying the number of blended visits and total cost by the average RN to RPN ratio. Figure 3.6.1 illustrates an example of blended rate decomposition:

Once rates were deconstructed, the results were combined and averaged with the RN and RPN rates from other CCACs. Base rates were then calculated.

The reverse approach was used to calculate the new blended rates. The new RN and RPN rates were multiplied by the RN to RPN ratios and summed. The blending equation can be found in Equation 3.6.4 below.

\[
Blended\ Rate = (RN\ Base\ Rate \times RN\ Ratio) + (RPN\ Base\ Rate \times RPN\ Ratio)
\]

Equation 3.6.4 – Blended Rate Calculation Equation

This process was repeated for all Nursing services as the RN to RPN ratio differed by service.

3.6.8 Nursing Specialty Bands

As determined during the current state assessment, there are specialty nursing services that have significantly different cost structure than the “standard” Nursing visit. Examples of these include ET visits and Continence Care Advisors.

Instead of creating new service rates for each specialty, the PPT suggested addressing this concern through development of a few standard specialty bands, and slotting these specialty services into a band that reflects their cost compared to standard Nursing.

Specialty bands have been developed as a percentage of the base RN visit rate (i.e. 110\% of RN rate for band 1; 120\% for band 2; etc.). Multiple bands exist to provide flexibility for the addition of future specialty nursing services. Each specialty is placed in a band based on specific criteria and bands can have multiple specialties included.

As travel rates include time as a component of the cost, they too should be adjusted proportionately for each band.

Alignment to a Specialty Band
A Nursing service can only be placed in a specialty band if the service requires specialized qualification that is not held by the broader Nursing population, and SPOs incur associated costs to provide that service (i.e. recruiting and retaining the specialty nurse). All services that are currently priced into the standard nursing visit cannot be placed into a specialty band as these are already included in current standard nursing pricing.

Wound Care, Palliative Care and Child Visits will not be included in specialty bands as the costs and average rates for these services do not vary from the standard visit rate. Further details on this analysis can be found in Section 5.2.4.

It is also recognized that bands must be utilized in a consistent way across CCACs and are not a method for circumventing the standard base provincial rate. A procedure for determining where services should be placed in specific bands can be found in Section 4.3.6.

**Proposed Bands**

At this time, we propose that bands be created in increments of 10% above the Base Rate for nursing services, as seen in Table 3.6.3 below. Some bands currently have no specialty services in them, but any specialty services identified in the future can be placed within the appropriate band as needed.

<table>
<thead>
<tr>
<th>Band Number</th>
<th>Percentage of RN Rate</th>
<th>Aligned Nursing Services</th>
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</thead>
<tbody>
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<td>Band 1</td>
<td>110%</td>
<td>None at this time</td>
</tr>
<tr>
<td>Band 2</td>
<td>120%</td>
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<tr>
<td>Band 3</td>
<td>130%</td>
<td>Continence Advisor Visit</td>
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<tr>
<td>Band 4</td>
<td>140%</td>
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<tr>
<td>Band 5</td>
<td>150%</td>
<td>None at this time</td>
</tr>
<tr>
<td>Band 6</td>
<td>160%</td>
<td>ET Visit</td>
</tr>
</tbody>
</table>

Table 3.6.3 – Proposed Nursing Specialty Bands

**Recommendation 11:**

*Specialty band adjustments for Nursing services should be included as part of Provincial Home Care Fee-for-Service rate setting.*

**Recommendation 12:**

*Nursing specialty bands should be based on the RN base rate and calculated as outlined in Table 3.6.3.*

### 3.6.9 Nursing Clinic Rate Calculations and adjustments

There are a variety of different operating models for ambulatory Nursing clinics across and within CCACs. Clinics vary based on the rate type (i.e. visit and hourly rates) and the party responsible for paying operating costs (i.e. rent, facilities, etc.).

The four most common types of clinics are:

- Visit based clinics where SPOs cover operating costs
- Visit based clinics where CCACs cover operating costs
- Hourly based clinics where SPOs cover operating costs
- Hourly based clinics where CCACs cover operating costs

The challenge with developing standard provincial rates for clinics is that operating costs vary significantly based on geography. For example, rent in downtown Toronto is different from rent in Welland. Data explaining the variation in operating costs was not available for this analysis.

**Recommendation 13:**

*An adjustment for Nursing clinic operating costs should be applied to each clinic Base Rate where SPOs pay for the operating costs of the clinic. This adjustment should be negotiated at the local level between CCACs and SPOs.*

Clinic Rate Calculation

Two types of clinic rates were developed: a visit based rate and an hourly based rate.

In order to calculate the average weighted rate for each clinic type, we utilized data from CCACs that pay for the cost of operating the clinics. This was done to ensure that operating costs were not included in the base rate. Rate data from seven CCACs that operate in a variety of geographies across Ontario was included in this analysis.

Table 3.6.4 outlines the average rate differences (including RN and RPN rates) between clinics where CCACs cover operating costs.

<table>
<thead>
<tr>
<th>Average Clinic Rate where CCACs pay for Operating Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit rate clinic</td>
</tr>
<tr>
<td>$30.43</td>
</tr>
<tr>
<td>Hourly rate clinic</td>
</tr>
<tr>
<td>$59.91</td>
</tr>
</tbody>
</table>

**Table 3.6.4 – Nursing Clinic Rate Comparison by Operating Model**

Rates were calculated using the same methodology as Nursing home visits/shifts. Blended rates were also decomposed and reblinked.

Further analysis by the sector should be undertaken to ensure that proposed clinic rates are also reflective of CCACs not included in this analysis.

**Recommendation 14:**

*Further analysis by the sector should be conducted to refine understanding of the cost of clinics and to ensure that the proposed clinic rates are reflective of CCACs not included in the analysis. This analysis should be conducted prior to the current pricing model being implemented.*

Given the variety of different operating models within CCACs and within the sectors, an effort should be made by the sector to define best practices as they relate to running a clinic and paying for clinic services.
Recommendation 15:
CCACs and SPOs should evaluate and implement options to standardize clinic operating models across the Province.

Clinic Specialty Bands
Specialty bands should also apply to the clinic setting. Unfortunately, not enough data currently exists to define bands for these services as volumes for specialty services in clinics are quite low. Bands developed for nursing visits in homes could potentially apply in this context. The same percentages should apply as the cost ratio between specialty service visits and standard RN Nursing visits should not differ between the home and clinic setting.

Recommendation 16:
Additional data should be collected to determine and finalize specialty band adjustments for Nursing services that take place in the clinic setting.

3.6.10 Geographic Labour Cost Adjustment

When the model adjustment factors were originally being determined, a geographic labour cost adjustment was considered. The rationale for this consideration was to compensate providers for the labour cost variations that exist in different labour markets across the province. For example the labour cost associated with providing a service in Toronto might be different than providing that same service in Temiskaming Shores (irrespective of travel). As such, an adjustment could be made for the area that had higher labour cost.

Although billing rates do not in and of themselves determine wage rates, wage rates do represent the most significant portion of SPO service costs. It was hypothesized that there might be a correlation between the actual variation in labour costs in different CCACs, and some objective geographic economic/demographic measure. If such a correlation existed, it would make sense to adjust billing rates to reflect these objective differences.

Like travel, creation of an adjustment factor was contingent on the ability to utilize an index or mathematical model that could explain the variation in labour costs across the province.

After further research and analysis, we are not recommending the inclusion of a geographic wage adjustment for three reasons:

1. The differences between weighted average labour costs across CCACs do not point to Urban / Rural variation as might have been expected.

Provider labour costs (wages and benefits) for PSW and Nursing, obtained through the SPO data request, were aggregated across SPOs and analyzed at the CCAC level.

For PSW costs, we did not find significant variation in labour costs across the different CCACs. For Nursing, we did find a variation in labour costs across CCACs; however the causes of this variation did not appear to be due to differences between urban and rural markets. This variation could be attributable to other factors including when service rates were set in the area, labour availability in the market, SPO specific operational factors or other factors.

There was a large enough data sample size to analyze PSW and Nursing services across most CCACs. The sample size was too small however to conduct this analysis for Therapies.
2. A statistically significant geographic wage index describing the variation does not appear to exist at this time
   As previously mentioned, in order to generate the adjustment factors an index or mathematical model was required. Unfortunately we were unable to find, nor was the PPT able to provide, an index that could explain the variation that was observed in the labour costs.

   An attempt was made to find a correlation between average household income and personal income information available through Statistics Canada. Correlations were not significant and therefore did not explain the variation.

3. An analysis of service provision comparators showed that the standard approach to pricing within the Province focuses on a single provincial rate
   Similar comparators provincially do not make geographic adjustments. For example the OHIP fee schedule does not vary based on geography. Independent providers (physicians) are paid one rate for their services regardless of where they operate in the province. Other parallels can also be found with Registered Nurses in hospitals as well as Teachers in the Education system.

Recommendation 17:

In the absence of an accepted wage index, adjustments for geographic labour cost differences should not be included as an adjustment in the Provincial Fee-for-Service rate setting.

Should an index or data set be made available that can explain the variation in rates across services, inclusion of this adjustment factor can be re-evaluated.

3.6.11 Shift Premium Adjustment

Two types of shift premium adjustments were also reviewed as potential pricing adjustments:

1. **24x7 Shifts:** Shifts that are required to ensure services are available 24 hours a day, 7 days a week. These would include evening shifts, night shifts, weekend shifts and Holidays.

2. **Peak Labour Premium Shifts:** These are shifts where it may be difficult to find labour or resources. This type of shift categorization does not currently exist today. An example is the 7-10 AM window for Personal Support services where it is difficult to find incremental PSWs to staff.

The PPT concluded that a Shift Premium adjustment should not be included at this time because:

- The cost of providing 24x7 coverage is already embedded in current rates.
- Adding this additional rate would increase billing reconciliation complexity unnecessarily and may lead to increased billing rejection rates.
- A potential unintended consequence of adding the peak labour premium is that services may get scheduled based on cost efficiencies as opposed to patient needs.
- The size of peak labour premium adjustment required to attract additional PSWs to work in during peak periods would be significant and would likely not be viable.

This analysis was conducted on weekend and Holiday shifts. This provides a baseline for data that is embedded in the current pricing. If weekend and holiday shifts were to increase or decrease significantly in quantity, pricing should be adjusted as providers would see either cost increases or cost decreases as a result. The baseline can be found in Section 5.4.
Recommendation 18:

CCACs and SPOs should establish a baseline for the number of shifts that currently take place during evenings and nights for each service.

Recommendation 19:

CCACs and SPOs should monitor the year over year trends with respect to shifts and adjust pricing accordingly if the number of weekend, evening, night or holiday shifts deviates from the baseline.

3.6.12 Scope of Services

Services were identified as in scope for the Provincial Fee-for-Service pricing using the following criteria:

- Service represented more than 0.05% of provincial spend (~$600,000); and,
- Service was offered by more than two CCACs.

Today CCAC systems recognize 75 services that were in scope for this report. After PPT review and consultation with contracts experts in CCACs, the following simplified list of services to be priced was developed.

Table 3.6.5 below outlines the scope of services:

<table>
<thead>
<tr>
<th>Setting</th>
<th>Home</th>
<th>School</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSW</td>
<td>PSW Hourly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing (Visit)</td>
<td>Blended Visit</td>
<td>Blended Visit</td>
<td>Blended Visit</td>
</tr>
<tr>
<td></td>
<td>RN Visit</td>
<td>RN Visit</td>
<td>RN Visit</td>
</tr>
<tr>
<td></td>
<td>RPN Visit</td>
<td>RPN Visit</td>
<td>RPN Visit</td>
</tr>
<tr>
<td></td>
<td>Specialty Band Service Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing (Shift/Hourly)</td>
<td>Blended Hourly</td>
<td>Blended Hourly</td>
<td>Blended Hourly</td>
</tr>
<tr>
<td></td>
<td>RN Hourly</td>
<td>RN Hourly</td>
<td>RN Hourly</td>
</tr>
<tr>
<td></td>
<td>RPN Hourly</td>
<td>RPN Hourly</td>
<td>RPN Hourly</td>
</tr>
<tr>
<td>OT</td>
<td>OT Visit</td>
<td>OT Visit</td>
<td></td>
</tr>
<tr>
<td>PT</td>
<td>PT Visit</td>
<td>PT Visit</td>
<td></td>
</tr>
<tr>
<td>SLP</td>
<td>SLP Visit</td>
<td>SLP Visit</td>
<td></td>
</tr>
<tr>
<td>SW</td>
<td>SW Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ND</td>
<td>ND Visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3.6.5 – Scope of Services

Nursing Initial Assessment Visit

During initial discussions with the PPT, a suggestion was made to create a new Nursing service rate for Initial Assessment visits. The rationale for the creation of this rate was that the time required for the initial assessment was significantly different from the “standard” Nursing visit.
Data was not available to validate this hypothesis. Also the cost of providing an initial assessment is already embedded in the current Nursing visit rates. Finally, after further review, the table concluded that operationalizing such a rate would be complex. As a result, this service was not priced nor is it being recommended.

Other Services

The PPT also contemplated including additional services to the scope of this report. Please see Table 3.6.6 below for a full list of these services. As some of these services were new, data was not available from which rate setting could occur. Other services exist today, however they are so few in number the data available to set rates from is too small. As a result, standard Provincial pricing for these services was not developed. A methodology for Provincial rate setting for these services is outlined in Section 4.3.6.

At the time this report was being written, a variety of different rates were being negotiated between CCACs and SPOs for Physiotherapy Clinics and PT Assistants. Although not enough data was available to price these services, standardized rates for these services should be developed in the near future. These rates should be standardized, and one base rate set as soon as possible using the methodologies outlined in this report. If these rates are not standardized, CCACs will find themselves with a number of different rates for the same service.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Home</th>
<th>Clinic</th>
<th>Group Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (Visit)</td>
<td>Telemedicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OT</td>
<td>OT Assistant Visit</td>
<td>OT Visit</td>
<td>OT Visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OT Assistant Visit</td>
<td></td>
</tr>
<tr>
<td>PT</td>
<td>PT Assistant Visit</td>
<td>PT Visit</td>
<td>PT Visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PT Assistant Visit</td>
<td></td>
</tr>
<tr>
<td>SLP</td>
<td>CD Assistant Visit</td>
<td>SLP Visit</td>
<td>SLP Visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CD Assistant Visit</td>
<td></td>
</tr>
<tr>
<td>SW</td>
<td>SW Assistant Visit</td>
<td></td>
<td>ND Visit</td>
</tr>
<tr>
<td>ND</td>
<td>ND Assistant Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Pharmacy Consultation Visit</td>
<td>Respiratory Therapy Visit</td>
<td>Respiratory Therapy Visit</td>
</tr>
<tr>
<td></td>
<td>Lab Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respiratory Therapy Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychology Visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3.6.6 – Other Services
3.7 Rates

3.7.1 Service Rates

Table 3.7.1 below outlines the proposed Provincial Base rates for each service. The Base Rate column does not include travel. These are the rates that will be paid to providers.

The “Base Rate + Travel” column highlights the total base rate with the weighted average Provincial cost of travel included. As travel should be paid at the Census Division level, the full rate paid to Providers will differ from Census Division to Census Division.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Service Type</th>
<th>Setting</th>
<th>Base Rate</th>
<th>Base Rate + Avg Prov. Travel</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSW</td>
<td>PSW</td>
<td>Home / Home School</td>
<td>$31.04</td>
<td>$32.83</td>
</tr>
<tr>
<td>Nursing</td>
<td>Blended Visit</td>
<td>Home</td>
<td>$61.61</td>
<td>$65.97</td>
</tr>
<tr>
<td>Nursing</td>
<td>RN Visit</td>
<td>Home</td>
<td>$65.87</td>
<td>$70.53</td>
</tr>
<tr>
<td>Nursing</td>
<td>RPN Visit</td>
<td>Home</td>
<td>$55.42</td>
<td>$59.34</td>
</tr>
<tr>
<td>Nursing</td>
<td>Specialty Band 1 Visit</td>
<td>Home</td>
<td>$72.45</td>
<td>$77.58</td>
</tr>
<tr>
<td>Nursing</td>
<td>Specialty Band 2 Visit</td>
<td>Home</td>
<td>$79.04</td>
<td>$84.63</td>
</tr>
<tr>
<td>Nursing</td>
<td>Specialty Band 3 Visit</td>
<td>Home</td>
<td>$85.63</td>
<td>$91.69</td>
</tr>
<tr>
<td>Nursing</td>
<td>Specialty Band 4 Visit</td>
<td>Home</td>
<td>$92.21</td>
<td>$98.74</td>
</tr>
<tr>
<td>Nursing</td>
<td>Specialty Band 5 Visit</td>
<td>Home</td>
<td>$98.80</td>
<td>$105.79</td>
</tr>
<tr>
<td>Nursing</td>
<td>Specialty Band 6 Visit</td>
<td>Home</td>
<td>$105.39</td>
<td>$112.84</td>
</tr>
<tr>
<td>Nursing</td>
<td>Blended Visit</td>
<td>School</td>
<td>$59.55</td>
<td>$63.95</td>
</tr>
<tr>
<td>Nursing</td>
<td>RN Visit</td>
<td>School</td>
<td>$65.52</td>
<td>$70.36</td>
</tr>
<tr>
<td>Nursing</td>
<td>RPN Visit</td>
<td>School</td>
<td>$55.73</td>
<td>$59.84</td>
</tr>
<tr>
<td>Nursing</td>
<td>Blended Shift/ Hourly</td>
<td>Home</td>
<td>$56.96</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing</td>
<td>RN Shift/ Hourly</td>
<td>Home</td>
<td>$62.27</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing</td>
<td>RPN Shift/ Hourly</td>
<td>Home</td>
<td>$51.94</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing</td>
<td>Blended Shift/ Hourly</td>
<td>School</td>
<td>$55.87</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing</td>
<td>RN Shift/ Hourly</td>
<td>School</td>
<td>$61.60</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing</td>
<td>RPN Shift/ Hourly</td>
<td>School</td>
<td>$51.97</td>
<td>N/A</td>
</tr>
<tr>
<td>Therapy</td>
<td>OT</td>
<td>Home</td>
<td>$114.63</td>
<td>$122.60</td>
</tr>
<tr>
<td>Therapy</td>
<td>OT</td>
<td>School</td>
<td>$104.95</td>
<td>$112.92</td>
</tr>
<tr>
<td>Therapy</td>
<td>PT</td>
<td>Home</td>
<td>$98.24</td>
<td>$105.29</td>
</tr>
<tr>
<td>Therapy</td>
<td>PT</td>
<td>School</td>
<td>$103.33</td>
<td>$110.33</td>
</tr>
<tr>
<td>Therapy</td>
<td>SLP</td>
<td>Home</td>
<td>$128.88</td>
<td>$137.80</td>
</tr>
<tr>
<td>Therapy</td>
<td>SLP</td>
<td>School</td>
<td>$110.94</td>
<td>$119.51</td>
</tr>
<tr>
<td>Therapy</td>
<td>ND</td>
<td>Home</td>
<td>$112.25</td>
<td>$121.96</td>
</tr>
<tr>
<td>Therapy</td>
<td>SW</td>
<td>Home</td>
<td>$138.14</td>
<td>$149.52</td>
</tr>
</tbody>
</table>

Table 3.7.1 – Provincial Fee-for-Service Rate Schedule

**Recommendation 20:**

CCACs should adopt the proposed Provincial Fee-for-Service rate schedule outlined in the Base Rate column of Table 3.7.1 of this document.
Clinic rates have been separated out from the primary rate table as additional work still needs to be conducted to finalize these rates. Once clinic rates have been finalized, they should be included in Table 3.7.1.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Service Type</th>
<th>Setting</th>
<th>Base Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>Blended Visit</td>
<td>Clinic</td>
<td>$33.48</td>
</tr>
<tr>
<td>Nursing</td>
<td>RN Visit</td>
<td>Clinic</td>
<td>$35.44</td>
</tr>
<tr>
<td>Nursing</td>
<td>RPN Visit</td>
<td>Clinic</td>
<td>$28.42</td>
</tr>
<tr>
<td>Nursing</td>
<td>Blended Shift/Hourly</td>
<td>Clinic</td>
<td>$65.91</td>
</tr>
<tr>
<td>Nursing</td>
<td>RN Shift/Hourly</td>
<td>Clinic</td>
<td>$66.39</td>
</tr>
<tr>
<td>Nursing</td>
<td>RPN Shift/Hourly</td>
<td>Clinic</td>
<td>$58.61</td>
</tr>
</tbody>
</table>

Table 3.7.2 – Proposed Nursing Clinic Fee-for-Service Rate Schedule

3.7.2 Travel Rates by Census Division

Table 3.7.3 below outlines proposed travel rates for each service type.

Travel rates for specialty nursing bands are not included below. The travel rate for each band should be calculated by taking the base RN Nursing travel rate and adding the applicable Band adjustment. For example travel rates for Nursing Specialty Band 6 in CD 3501 would be $12.43 = $7.77*1.6.

<table>
<thead>
<tr>
<th>CD</th>
<th>CD Name</th>
<th>PSW</th>
<th>Nursing Blended</th>
<th>Nursing RN</th>
<th>Nursing RPN</th>
<th>OT</th>
<th>PT</th>
<th>ND</th>
<th>SW</th>
<th>SLP</th>
</tr>
</thead>
<tbody>
<tr>
<td>3501</td>
<td>Stormont, Dundas and Glengarry</td>
<td>$3.08</td>
<td>$6.81</td>
<td>$7.77</td>
<td>$5.46</td>
<td>$15.41</td>
<td>$12.89</td>
<td>$17.53</td>
<td>$19.96</td>
<td>$16.23</td>
</tr>
<tr>
<td>3502</td>
<td>Prescott and Russell</td>
<td>$2.89</td>
<td>$6.38</td>
<td>$7.27</td>
<td>$5.11</td>
<td>$14.43</td>
<td>$12.07</td>
<td>$16.42</td>
<td>$18.70</td>
<td>$15.20</td>
</tr>
<tr>
<td>3506</td>
<td>Ottawa</td>
<td>$1.88</td>
<td>$4.16</td>
<td>$4.74</td>
<td>$3.33</td>
<td>$9.41</td>
<td>$7.87</td>
<td>$10.70</td>
<td>$12.19</td>
<td>$9.91</td>
</tr>
<tr>
<td>3509</td>
<td>Lanark</td>
<td>$2.72</td>
<td>$6.10</td>
<td>$6.95</td>
<td>$4.88</td>
<td>$11.66</td>
<td>$10.03</td>
<td>$13.64</td>
<td>$15.53</td>
<td>$12.97</td>
</tr>
<tr>
<td>3510</td>
<td>Frontenac</td>
<td>$2.27</td>
<td>$5.10</td>
<td>$5.81</td>
<td>$4.08</td>
<td>$9.75</td>
<td>$8.38</td>
<td>$11.40</td>
<td>$12.98</td>
<td>$10.85</td>
</tr>
<tr>
<td>3511</td>
<td>Lennox and Addington</td>
<td>$3.11</td>
<td>$6.97</td>
<td>$7.95</td>
<td>$5.58</td>
<td>$13.33</td>
<td>$11.46</td>
<td>$15.59</td>
<td>$17.75</td>
<td>$14.83</td>
</tr>
<tr>
<td>3512</td>
<td>Hastings</td>
<td>$2.70</td>
<td>$6.05</td>
<td>$6.90</td>
<td>$4.85</td>
<td>$11.58</td>
<td>$9.96</td>
<td>$13.54</td>
<td>$15.42</td>
<td>$12.89</td>
</tr>
<tr>
<td>3513</td>
<td>Prince Edward</td>
<td>$2.63</td>
<td>$5.89</td>
<td>$6.72</td>
<td>$4.72</td>
<td>$11.28</td>
<td>$9.70</td>
<td>$13.19</td>
<td>$15.01</td>
<td>$12.55</td>
</tr>
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<td>Northumberland</td>
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<td>$5.14</td>
<td>$5.86</td>
<td>$4.12</td>
<td>$9.86</td>
<td>$8.16</td>
<td>$11.71</td>
<td>$13.33</td>
<td>$10.27</td>
</tr>
<tr>
<td>3515</td>
<td>Peterborough</td>
<td>$3.41</td>
<td>$5.44</td>
<td>$6.20</td>
<td>$4.36</td>
<td>$10.44</td>
<td>$8.64</td>
<td>$12.39</td>
<td>$14.11</td>
<td>$10.87</td>
</tr>
<tr>
<td>3516</td>
<td>Kawartha Lakes</td>
<td>$3.83</td>
<td>$6.11</td>
<td>$6.97</td>
<td>$4.90</td>
<td>$11.72</td>
<td>$9.70</td>
<td>$13.91</td>
<td>$15.84</td>
<td>$12.21</td>
</tr>
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<td>3518</td>
<td>Durham</td>
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<td>$3.53</td>
<td>$4.02</td>
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<td>$6.77</td>
<td>$5.60</td>
<td>$8.04</td>
<td>$9.15</td>
<td>$7.05</td>
</tr>
<tr>
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<td>York</td>
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<td>$3.39</td>
<td>$3.86</td>
<td>$2.71</td>
<td>$6.45</td>
<td>$5.44</td>
<td>$7.36</td>
<td>$8.38</td>
<td>$7.08</td>
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<tr>
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<td>$9.75</td>
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<td>$9.01</td>
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### Table 3.7.3 – Provincial Fee-for-Service Travel Rate Schedule

<table>
<thead>
<tr>
<th>CD</th>
<th>CD Name</th>
<th>PSW</th>
<th>Nursing Blended</th>
<th>Nursing RN</th>
<th>Nursing RPN</th>
<th>OT</th>
<th>PT</th>
<th>ND</th>
<th>SW</th>
<th>SLP</th>
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<td>$20.68</td>
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<td>$24.53</td>
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<td>$17.48</td>
<td>$21.36</td>
<td>$24.32</td>
<td>$25.34</td>
</tr>
<tr>
<td>3553</td>
<td>Greater Sudbury / Grand Sudbury (city)</td>
<td>$2.02</td>
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<td>$7.93</td>
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<td>$16.82</td>
<td>$17.52</td>
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<td>$15.27</td>
<td>$11.98</td>
<td>$17.91</td>
<td>$20.39</td>
<td>$16.18</td>
</tr>
</tbody>
</table>

**Recommendation 21:**

CCACs should adopt the proposed Travel rate schedule outlined in Table 3.7.3 of this document.
3.8 Financial Implications to CCACs and SPOs

As discussed in Section 3.5, the Current State analysis, there are a significant number of different service rates across the province. This variety of different rates ensures that each CCAC and SPO will be impacted in one way or another when the move to standard Provincial rates occurs.

This impact analysis assumes that funding is made available to cover the increased rates for PSW and Nursing services and that CCAC purchasing power is affected equally.

Note that both the CCAC and SPO impact analyses represent estimated impacts. There is potential for some error in the results as they were based on assumptions which include:

- Service volumes are the same as those observed from April 2012 through March 2013;
- Geographic service information in CHRIS is accurate;
- Remote travel and visits to remote areas are excluded; and,
- Critical mass adjustments are excluded.

3.8.1 Impact by Service Area

When not factoring in the sustainability adjustment, the net impact on overall services is zero. The total being spent on services today should be the same as tomorrow (provided the listed assumptions are correct).

When factoring in the recommended sustainability adjustment, PSW and Nursing services are impacted differently than Therapies. Ultimately the sustainability adjustment has resulted in a 9.4% total increase for PSW services and a 9.5% total increase for nursing services. For Therapies there is no difference in CCAC spend today vs. spend tomorrow.

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Current Spend (Thousands)</th>
<th>Current Spend plus sustainability increase (Thousands)</th>
<th>Impact as a percentage of CCAC Spend (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSW</td>
<td>$747,012</td>
<td>$817,246</td>
<td>9.4%</td>
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<tr>
<td>Nursing</td>
<td>$444,853</td>
<td>$487,029</td>
<td>9.5%</td>
</tr>
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<td>Therapy</td>
<td>$137,436</td>
<td>$137,436</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>$1,329,300</td>
<td>$1,441,710</td>
<td>8.5%</td>
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</tbody>
</table>

Table 3.8.1 – Impact by Service Area

3.8.2 CCAC Impact Analysis

For CCACs the impact analysis is based on overall cost reductions or cost increases by moving to the new Provincial rate schedule. The total impact should be considered on a Province wide basis as there is one payer for the services.

The underlying assumption is that funds can be reallocated from one CCAC to another. That means that if costs decrease in one CCAC, the savings can be reallocated to another CCAC that has cost increases. If this is not the case, then CCACs will each feel individual impacts differently and it will cost the overall Provincial health system more to deliver services than it should. Discussion of provincial optimization is discussed further in Section 4.2.

Estimated Overall Impact

Once new rates are fully implemented as recommended, the total funding impact to the province for all services is estimated to be $112 Million (5.15% increase in total CCAC operating budget). Table 3.8.2 below outlines the impact to individual CCACs.
Table 3.8.2 – Impact of All Service Rates on CCACs

Estimated PSW Impact

Once new rates are fully implemented as recommended, the total funding impact to the province for PSW services is estimated to be $70 Million (9.4% increase).

Table 3.8.3 below outlines the impact to individual CCACs.
Estimated Nursing Impact

This impact analysis represents the aggregate analysis for Visit and Hourly based Nursing services. Once new rates are fully implemented as recommended, the total funding impact to the province for nursing services is estimated to be $42 Million (9.5% increase).

Table 3.8.4 below outlines the impact to individual CCACs.

<table>
<thead>
<tr>
<th>CCAC</th>
<th>Increase in Cost (Thousands)</th>
<th>Impact as a percentage of spend</th>
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</thead>
<tbody>
<tr>
<td>A</td>
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<td>8.0%</td>
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<tr>
<td>B</td>
<td>$3,904</td>
<td>16.4%</td>
</tr>
<tr>
<td>C</td>
<td>$4,378</td>
<td>19.7%</td>
</tr>
<tr>
<td>D</td>
<td>$236</td>
<td>1.2%</td>
</tr>
<tr>
<td>E</td>
<td>$4,638</td>
<td>9.3%</td>
</tr>
<tr>
<td>F</td>
<td>$1,987</td>
<td>6.7%</td>
</tr>
<tr>
<td>G</td>
<td>$5,218</td>
<td>12.3%</td>
</tr>
<tr>
<td>H</td>
<td>$2,897</td>
<td>6.9%</td>
</tr>
<tr>
<td>I</td>
<td>$676</td>
<td>3.5%</td>
</tr>
<tr>
<td>J</td>
<td>$7,610</td>
<td>12.1%</td>
</tr>
<tr>
<td>K</td>
<td>($79)</td>
<td>-0.2%</td>
</tr>
<tr>
<td>L</td>
<td>$6,213</td>
<td>13.5%</td>
</tr>
<tr>
<td>M</td>
<td>$340</td>
<td>2.0%</td>
</tr>
<tr>
<td>N</td>
<td>$2,087</td>
<td>20.6%</td>
</tr>
<tr>
<td>Total</td>
<td>$42,176</td>
<td>9.5%</td>
</tr>
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</table>

Table 3.8.4 – Impact of Nursing Rates on CCACs

Estimated Therapy Impact

This impact analysis represents the aggregate analysis for OT, PT, SLP, SW and ND therapy services. Once new rates are fully implemented as recommended, the total funding impact to the province for Therapy services is $0 (0% increase).

Table 3.8.5 below outlines the impact to individual CCACs.

<table>
<thead>
<tr>
<th>CCAC</th>
<th>Increase in Cost (Thousands)</th>
<th>Impact as a percentage of spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
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<tr>
<td>B</td>
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</tr>
<tr>
<td>C</td>
<td>$235</td>
<td>8.3%</td>
</tr>
<tr>
<td>D</td>
<td>($708)</td>
<td>-8.8%</td>
</tr>
<tr>
<td>E</td>
<td>($372)</td>
<td>-2.5%</td>
</tr>
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<td>F</td>
<td>($599)</td>
<td>-6.2%</td>
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<tr>
<td>G</td>
<td>($481)</td>
<td>-3.5%</td>
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<tr>
<td>H</td>
<td>($34)</td>
<td>-0.4%</td>
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<tr>
<td>I</td>
<td>($211)</td>
<td>-2.4%</td>
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<tr>
<td>J</td>
<td>$1,962</td>
<td>11.6%</td>
</tr>
<tr>
<td>K</td>
<td>$468</td>
<td>4.4%</td>
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</table>
### 3.8.3 Service Provider Impact Analysis

The impact of moving to one provincial rate will be felt differently across SPOs. There are over 150 individual SPOs in the Province. Some are large and provide services across most CCACs, while others consist of one employee that delivers a service in a region of a CCAC. There is a higher risk to the sector as a whole if a large provider has difficulty adjusting to the new rate. Risks still remain for smaller providers that have to adjust to the new rate as it may impact care offered in a community.

Figure 3.8.2 illustrates a framework matrix that identifies impact risk to the sector. The matrix is divided by volume on the horizontal axis and percentage difference in rate on the y axis. Each quadrant in the matrix represents a certain level of risk to the sector. The two top quadrants pose a lower risk for the sector because these SPOs receive a rate increase. The bottom left quadrant represents moderate risk for the sector as smaller SPOs receive a rate decrease. The bottom right quadrant represents higher risk for the sector as large SPOs receive a rate decrease.

Figure 3.8.2 to Figure 3.8.9 illustrate in more granular detail what the overall impact is to providers, on a percentage basis, without considering volumes. This information is useful as it provides a perspective on how quickly rate changes should be made.

<table>
<thead>
<tr>
<th>CCAC</th>
<th>Increase in Cost (Decrease in Cost) (Thousands)</th>
<th>Impact as a percentage of spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>($631)</td>
<td>-3.9%</td>
</tr>
<tr>
<td>M</td>
<td>($675)</td>
<td>-11.7%</td>
</tr>
<tr>
<td>N</td>
<td>$134</td>
<td>3.7%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Table 3.8.5 – Impact of Therapy Rates on CCACs
All Services

Figure 3.8.2 illustrates the overall impact to SPOs when new rates are fully implemented in the Province. 21 small SPOs will see an average rate reduction of 7.9% (based on simple average). Three large providers will see an average rate reduction of 5.5%.

For the purpose of the overall analysis, high volume providers have over $5 Million in billings to CCACs. 68 SPOs were not included in this analysis because they had less than $30,000 in billings to CCACs during the time period analyzed.

<table>
<thead>
<tr>
<th>SPOs</th>
<th>Avg Increase</th>
<th>Avg Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>66</td>
<td>18.3%</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>7.9%</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>5.5%</td>
<td></td>
</tr>
</tbody>
</table>

Figure 3.8.2 – Impact Matrix for All Services
Figure 3.8.3 – Overall Percentage Impact to SPOs

Figure 3.8.3 illustrates that the largest rate decrease is less than 20%. Overall the rate adjustments are quite positive for smaller SPOs as the majority receives a rate increase. The response is also positive for larger SPOs. Many will receive rate increases based on PSW and Nursing rate adjustments. Therapy rate adjustments have the most risk to the sector.

**PSW Services**

Figure 3.8.4 illustrates the overall impact to SPOs when new PSW rates are fully implemented in the Province. Two smaller SPOs will see an average rate reduction of 7.0% (based on simple average). One larger provider will see an average rate reduction of 1.2%.

For the purpose of the PSW analysis, high volume providers have over 500k PSW hours per year. 34 SPOs were not included in this analysis because they had less than $50,000 in billings to CCACs.

<table>
<thead>
<tr>
<th>21 SPOs</th>
<th>11 SPOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg Increase – 15.9%</td>
<td>Avg Increase – 9.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 SPOs</th>
<th>1 SPOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg Decrease – 7.0%</td>
<td>Avg Decrease – 1.2%</td>
</tr>
</tbody>
</table>

**Figure 3.8.4 – Impact Matrix for PSW Services**
Figure 3.8.5 – Percentage Impact to SPOs for PSW Services

Figure 3.8.5 illustrates that the largest rate decrease is less than 10%. Based on this information, the aggregate risk to the sector of instituting the new rates is low.

**Nursing Services**

Figure 3.8.6 illustrates the overall impact to SPOs when new Nursing rates are fully implemented in the Province. Two small SPOs will see an average rate reduction of 6.2% (based on simple average). Zero large providers will see rate reduction.

For the purpose of the Nursing analysis, high volume providers have over 300k nursing visits per year. Three SPOs were not included in this analysis because they had less than $50,000 in billings to CCACs.
Figure 3.8.7 – Percentage Impact to SPOs for Nursing Services

Figure 3.8.7 illustrates that the largest rate decrease is less than 10%. The aggregate risk to the sector of instituting the new rates is low. The implementation approach for Nursing should be similar to that used for PSWs.

**Therapy Services**

Figure 3.8.8 illustrates the overall impact to SPOs when new Therapy rates are fully implemented in the Province. 16 small SPOs will see an average rate reduction of 8.4% (based on simple average). Seven large providers will see an average rate reduction of 9.26%.

For the purpose of the therapy analysis, high volume providers have over 15k therapy visits per year. 35 SPOs were not included in this analysis because they had less than $30,000 in billings to CCACs.

Figure 3.8.8 – Impact Matrix for Therapy Services
Figure 3.8.9 illustrates that the largest rate decrease is more than 20%. Standard provincial pricing has a positive benefit on smaller providers. There are a number of larger providers that will receive a rate decrease. Given the number of providers negatively affected, the implementation approach for Therapies should be different than for Nursing and PSW rates. Rates should not be decreased by more than 15% in a given year.

**Overall Impact to Volumes**

Table 3.8.6 outlines the proportion of service volumes that would see a rate change increase or decrease based on the new rates. For PSW, Nursing visits and Nursing shifts, a rate increase would apply to the majority of the service volume as a result of increases for sustainability. For the five therapies, the impact is different across each therapy as there is no recommended increase. The number of OT and SLP visits with a rate decrease is higher than the number of visits with a rate increase because some CCACs have significant service volume that is much lower than the average rate.

![SPO Therapy Impact](image)

**Table 3.8.6 – Impact of Rate Changes on Service Volumes**
4. Looking Ahead

4.1 Guiding Principles for the Future

Given the complex stakeholder environment observed in the Ontario home care sector it is crucial that implementation and ongoing maintenance of the Provincial pricing model be done with a set of guiding principles in mind. These principles were built around the notion that:

- The sector needs to play an increased role in the overall health system;
- There are operating sensitivities that must be considered during transition; and
- Awareness and transparency are critical to ensure aligned views to transition.

Based on PPT principles outlined in Section 1.3 we are recommending that the following principles be used to guide the implementation of the new Fee-for-Service model:

- **Collaboration and Transparency**
  - Implementation requires continued sector collaboration and transparency; and,
  - Implementation must involve ongoing feedback from the sector.

- **Feasibility and Sustainability**
  - Implementation is contingent on the participation and buy-in of sector stakeholders; and,
  - Implementation should not destabilize the sector.

- **Proactive Planning**
  - Implementation must consider incentives implied by the model;
  - Implementation must involve milestone reviews; and,
  - Implementation must be flexible enough to accommodate adjustment in light of milestone reviews and feedback.

4.2 Transition Approach, Considerations and Timeline

4.2.1 Implementation Approach Options

Three possible approaches to the implementation of the new Fee-for-Service pricing model emerged from research, interviews, and PPT discussion. These approaches were then validated in discussion with the PPT to determine if alternative approaches existed and identified the potential issues and implications related to three approaches initially identified for consideration. Table 4.2.1 below summarizes the three approaches and their implications:

<table>
<thead>
<tr>
<th>Transition Approach</th>
<th>Description</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immediate Adjustment</strong></td>
<td>Rates are immediately adjusted to reflect the outputs of the new pricing model. Providers with rates below the new rates output by the pricing model are increased immediately, while those with rates above are decreased immediately.</td>
<td>This is the quickest implementation approach with the simplest timeline, but could create significant sustainability issues in the sector for both CCACs and SPOs as rates would change quickly and leave little time for adjustment, provincial coordination etc.</td>
</tr>
</tbody>
</table>
### Table 4.2.1 – Approach Alternatives and Implications

#### 4.2.2 Model Transition Approach Selection and Rationale

Of the transition approaches explored, discussion with the PPT led to the third option, the gradual movement to new pricing, being selected as the best alternative for the Ontario Home Care context. Some of the relevant considerations which contributed to this decision included:

- CCACs and SPOs were unanimous that the first option to immediately make the rate adjustment was not a viable alternative. There could be severe risks to sector sustainability for both CCACs and SPOs, and with an instant implementation, there would be no time to monitor the impacts of rate changes and make adjustments.

- While the option to hold rates at the top and bring rates below that level up gradually through increases for cost of living was intriguing and served as a catalyst for interesting discussion, it was ultimately decided that the feasibility of this approach was a concern. The additional funding or volume decrease required to support a “no decreases” approach to rates made this an uncertain alternative and therefore not an ideal option. Concern was also expressed about what future behaviours a “no decreases” approach would incentivize and whether letting currently higher-priced providers continue to enjoy a rate premium would be fair.

- The gradual movement of providers to the new Provincial pricing is a logical extension of the measured, thoughtful approach the sector has taken with the broader project thus far, and was also the only alternative to measure favorably when compared against all three implementation principles, as discussed in section 5.1:
  - **Collaboration and Transparency:** A gradual approach with a structured implementation timeline could enable a more robust impact monitoring process to take place post-implementation, ensuring that CCAC and SPO voices were still being heard after model roll-out.
  - **Feasibility and Sustainability:** Moving rates both up and down depending on how they would compare to the new Provincial pricing could open up more alternatives to safeguard sector sustainability, by giving the body responsible for model administration flexibility in terms of the implementation timeline and the
intensity of rate change. Of course, this would require robust framework for monitoring impacts, particularly on providers facing decreased rates, but the sector’s existing willingness to take a collaborative approach to system improvement produced comfort in their ability to do so.

- **Proactive Planning:** The gradual approach would enable the setting of review periods in the future to assess the impacts of implementation, as well as allow for the documentation of lessons learned from the process as part of the Ontario home care system's overall evolution.

**Recommendation 22:**

*The implementation approach should follow the gradual movement to new pricing option, with providers who are above new rates decreased and providers below new rates increased, over the recommended implementation period.*

### 4.2.3 Implementation Funding

Funding should be made available to pay for the PSW and Nursing sustainability adjustments. If funding is not available for these sustainability adjustments then rate harmonization should not be pursued for PSW and Nursing services. As previously discussed in section 3.6.4, by attempting to harmonize rates for these services without additional funding, the sector would be destabilized even further. Current SPO financial operating conditions are already precarious and it would be very difficult for providers to implement new unadjusted PSW and Nursing rates.

**Recommendation 23:**

*Funding should be made available to pay for the recommended PSW and Nursing sustainability adjustments. If funding is not made available, the sector should not implement harmonized Provincial rates for PSW and Nursing services as recommended in this report.*

### 4.2.4 Implementation Timeline

The PPT had significant concerns about the implementation timeline for new rates. There were three primary considerations discussed:

1. SPOs have not seen any rate adjustments over the last two to four years. As implementation will not begin until current contracts end in October 2014, any delayed implementation will negatively affect sector sustainability even further.
2. Conversely, the MOHLTC will have to provide funding to implement the new rates. Given current budgetary pressures, and financial considerations, it may take time for this funding to be made available.
3. The sector is moving to a contract schedule that coincides with CCAC fiscal years (i.e. April to March). Implementation of new rates should match this schedule; however the current freeze on rates will end in in October 2014.

Given the complexity of factors and information available, it is difficult to prescribe exact dates for when all rate adjustments should occur. The sector, LHINs and the MOHLTC should develop a detailed implementation timeline based on the recommendations outlined below.

We are recommending an implementation of new rates for PSW, Nursing and Therapy services be completed by no later than April 2016.
In order to stabilize the sector, implementation of PSW and Nursing rates should take place as quickly as possible beginning in October 2014, with movement to the new rates being front loaded. A minimum 50% adjustment of the new service rates should occur in October 2014.

As a larger number of Therapy SPOs will be negatively impacted by the new rates and Therapy implementation will be more complicated, implementation of the new rates should take place evenly through April 2016.

**Recommendation 24:**
*Provided funding is available to implement the recommended PSW rates, implementation should be completed by April 2016. The sector and the MOHLTC should try to accelerate implementation of new PSW rates by front loading rate adjustments.*

**Recommendation 25:**
*Provided funding is available to implement the recommended Nursing rates, implementation should be completed by April 2016. The sector and the MOHLTC should try to accelerate implementation of new Nursing rates by front loading rate adjustments.*

**Recommendation 26:**
*Treatment rate implementation should be completed by April 2016, with the up/down changes to providers occurring evenly over that period. Providers should not see more than a 15% decrease in rates in a given year.*

### 4.2.5 Implementation Ownership

Although the selection of a gradual approach for implementation of the new rate structure has clear benefits, the roll-out must be carefully planned and executed to ensure that benefits are realized, that negative impact to the sector is minimized, and that implementation is seen as a success by all sector participants. A critical component of doing so is determining a group responsible for the fee schedule’s implementation and maintenance during initial roll-out and beyond.

Research from the Environmental Scan has shown that ownership of similar health care pricing models in other jurisdictions is often the purview of the relevant state or regional government.

In this context however, the collaborative approach taken by QVHC has shown that there are significant benefits that can be realized when CCACs and SPOs work together to come to a consensus on rates. The collaborative approach leads to a shared understanding of issues and challenges, builds trust within the sector, and allows for meaningful input from all of the stakeholders in a complex system.

Implementation and review of the rate schedule should be undertaken by a body made up of CCACs and SPOs. Further details on the group can be found in the following sections.

### 4.2.6 Importance of Provincial Coordination

The importance of a coordinated, centralized Provincial approach to the implementation of the pricing model cannot be discounted. It is arguably the most crucial contributing factor to a successful implementation that considers and monitors the impacts of the new rate model and fee schedule on the sector as a whole and minimizes the risk of delays or negative impacts to sector sustainability. The harmonization of rates in the new Fee-for-Service model is designed to provide a simpler, more equitable set of billing rates across the province, to replace a competitive procurement process that has
been defunct for some time. In part, it is designed to redress the inconsistency in rates across the province, and the inconsistency of rate changes over the years, taking into account verifiable factors that influence costs.

The starting point for the new model is an average billing rate for each service, to which, in some cases, a sustainability adjustment is recommended. The new model is not intended to change the purchasing power of one CCAC differently from another. (Purchasing power represents the amount of services that can be purchased from SPOs given funding and prevailing billing rates) The intent of the model is to implement rate changes so that the purchasing power of all the CCACs is affected to the same degree. This will require careful monitoring and may require some level-setting in CCAC funding, to equal out changes in purchasing power. If coordination and level-setting does not take place, inequities will be created across CCACs.

**Recommendation 27:**

The Fee-for-Service model should be implemented so that the impact of new billing rates affects the purchasing power of CCACs equally.

**Recommendation 28:**

Deployment of new rates should be done in a centralized, consistent way across CCAC boundaries. All CCACs must collaborate and coordinate to ensure a standardized approach to implementation that will result in Provincial Fee-for-Service rates.

**Recommendation 29:**

Impacts to CCACs should be continually monitored to measure actual financial impact versus what might have been projected or otherwise expected.

4.2.7 Roles and Responsibilities of Relevant Entities

Given the complex stakeholder situation described in Section 2 of this report, care must be taken to identify required activities for the various entities that will be responsible, both directly and indirectly, for successful rate schedule implementation. Based on research from other jurisdictions as described in the Environmental Scan, as well as PPT discussion, there are roles and responsibilities which all sector participants can consider to play their part in a successful implementation.

The group responsible for implementation should be tasked to:

- Monitor the progress of implementation and ensure sector feedback and concerns are documented; and,
- Begin developing the process and framework for the review of rates in the future.
The new Fee-for-Service model has broad implications for the sector, and a more detailed analysis of implementation issues will need to be completed by other tables of QVHC. At a minimum, the following tables should be engaged in planning the implementation, and making the changes required to make it possible:

- The Human Resources Table;
- The Business Process and Technology Enablers Table;
- The Performance Management Table;
- The Engagement Table and,
- The Contracts Table.

**Recommendation 30:**

The QVHC steering committee should review interdependencies between the PPT and other Tables which fall under the overall QVHC initiative to ensure that they are aware of the progress being made with model implementation and that they are receiving necessary inputs, such as feedback or data, which they may require to drive the progress of their own QVHC initiatives.

### 4.2.8 Additional Implementation Concerns

Although the guiding principles, ownership recommendations, and measures for Provincial bodies identified and discussed thus far will contribute to the sector’s successful transition to the new pricing model, there are still implementation concerns which merit identification and discussion, so that the group responsible for the new model is aware of them and prepared to address them once the transition has begun. There are two primary concerns which have been identified through PPT discussion and socialization with relevant stakeholders:

- **Ability to implement and administer travel rates:**
  
  The ability of the sector to accurately estimate the costs of travel is a technological hurdle which will require testing and validation in advance to ensure that pricing using the outputs of the new model results in the expected outcomes.

  Providers are also concerned that the travel rate may be treated as a separate component of the overall rate which is subject to flexibility/negotiation and could lead to opportunities for billing rejection. Travel must be an automatic add-on within the total cost of a service that cannot be selected or separated out by care coordinators.

  Lastly, the extents to which travel rates fairly compensate employees for travel are also a concern. The methodology to developing these rates has been clearly described and discussed, both in this report as well as in PPT. These rates were developed with available data and the sector should undertake steps to validate and adjust rates as described in Section 4.3.4.

- **Technology and billing changes:** Technology changes within the sector as a result the new pricing model, both for CCACs (CHRIS) and for SPOs (their respective data systems) pose some implementation risks which each sector participant will have to assess readiness for implementation and mitigation strategies. As the province as a whole is moving from 14,000 separate service rates to fewer than 50, introduction of new rates as a data input should be easier than current rate administration.
4.3 Ongoing Fee Schedule Reviews, Ownership and Approval

In addition to selecting a group responsible for implementation, there are other key components relating to the management of the new rate structure that must be considered. These components include determining who is responsible for ownership of the rate schedule, who will approve future rate recommendations and when the fee schedule should be reviewed.

4.3.1 Fee Schedule Ownership

In the absence of a competitive, market based rate setting process, management of rates must be different from the past. Individual SPOs can no longer be setting varying prices with individual CCACs. CCACs can no longer have the operational flexibility to manage their own rates independently from other CCACs.

This new Provincial rate setting approach does not mean that CCACs, the MOHLTC or LHIN Oversight should be responsible for setting future rates by themselves. These groups do not have all the data or sector knowledge that would ensure rates would be sustainable. Examples of this data, held by SPOs includes: service delivery costs, individual market conditions, operational challenges, etc.

For the sector to be sustainable and for rate setting to function in the future, CCACs and SPOs need to work together as partners. They each need to bring their expertise and fact base to the table in a collaborative and transparent manner. They need to do so to ensure that rates are set based on informed decisions that factor in market conditions, operational factors, service requirements and Provincial budgetary considerations.

A Provincial body consisting of CCAC and SPO representatives should be accountable for the rate schedule and future rate reviews. This same body should also be responsible for managing implementation of the new rate schedule as recommended in section 4.2. The group should:

- Utilize a management approach that emphasizes collaboration and communication between CCACs and SPOs and mutual cooperation to solve issues and drive sector improvements and innovation;
- Have an in-depth understanding of the sector, Provincial service mix, patient requirements, sector costs, operational requirements, budgetary considerations, service requirements, etc.
- Have comfort with statistics, data analysis, and data modeling for the purposes of continued analysis of sector data and fact-based problem solving of sector issues; and,
- Have support of an independent third party advisor to facilitate the rate review process, perform data analysis as required and provide independent recommendations and advice.

4.3.2 Fee Schedule Approval

As development of a rate schedule created a standardized and simplified Provincial rate structure, approval of new rates is still required at a Provincial level. Sector funders (i.e. LHINs and the MOHLTC) should be involved in the rate approval process. The Provincial body responsible for rate reviews should work with QVHC Oversight, LHINs and the MOHLTC to develop a process for approving future rate recommendations. This approval process should be based on clear, standardized and fact based criteria.

Individual CCACs should not have the ability to opt-out or circumvent the Provincial rate schedule. Doing so, would undermine standardization efforts and would also create inequalities and inefficiencies across the Province.
Recommendation 31:

A Provincial body consisting of CCAC and SPO representatives should own and be accountable for the rate schedule and future rate reviews. This same body should also be responsible for managing implementation of the new rate schedule. This body should be supported by an independent third party advisor.

Recommendation 32:

The body responsible for ongoing review of rates and the new Fee-for-Service model should work with QVHC Oversight, LHINs and the MOHLTC to establish standard, criteria based process for approving future rate recommendations.

Recommendation 33:

Individual CCACs should not have the ability to opt-out or circumvent the established Provincial rate schedule.

4.3.3 Timeline for Review

A timeline for reviews should be established in advance. Research and PPT discussion have provided guidance here, with the following considerations:

- Reviews of the fee schedule should be conducted on an annual basis each at a time that is congruent with CCAC budgeting and funding reviews, and allows for the fee schedule to reflect the impact of the latest Provincial budget.

- PPT participants have indicated that a review of the progress of rate schedule implementation and its effects would be an important step towards ensuring implementation is done carefully and any issues are being heard. This should take place within six months of initial roll-out, and could be consolidated with the first annual fee schedule review period.

- Travel rates should specifically be singled out for review prior to roll-out, given the concerns with their implementation described in Section 5.2.

- PPT participants have also indicated that a comprehensive re-assessment of sector sustainability and the Fee-for-Service rate setting model’s suitability for the Ontario home care context should be carried out by an independent third party; setting this two to three years after implementation, at the same time as annual review, would allow for enough elapsed time and data accumulation to identify implementation impacts and sector trends.

Recommendation 34:

An initial review of the Provincial Fee-for-Service rate implementation impacts, progress, and key issues should occur within six months of model roll-out.
Recommendation 35:

The Provincial Fee-for-Service rate schedule should be reviewed on an annual basis, be conducted in line with budgetary planning and be supported by an independent third party. The on-going review should incorporate the process direction within this report.

Recommendation 36:

A comprehensive re-assessment of sector sustainability and the suitability of the Provincial Fee-for-Service model and schedule by an independent third-party should occur every three years after implementation begins.

It is important to note that the first rate review will take place one year after implementation begins. It is possible that additional rate adjustments may be recommended as implementation rates recommended in this report is still in progress.

4.3.4 Future Rate Schedule Review

As described in recommendation 3.1, the provincial body that manages the Fee-for-Service should review some aspects of the model on an annual basis. An approach, outlined below, has been designed and aims to provide a structured approach to fee schedule review. This proposed approach is anchored in the principle that decisions must be supported by a strong fact base. The review of the schedule includes a review of base rates and a review of travel rates.

**Base Rate review**

The Base rate review includes two key components:

- **Baseline basket indicators**: These are fact based indicators that capture changes to key model inputs that occurred over a period of time. For example, examine an illustrative case where the provincial RN/RPN ratio for Nursing home visits changed from 65:35 to 55:45 over the course of the year. This would indicate that the blended rate for that service type should be adjusted. Each indicator is categorized into a basket that aligns to cost categories (i.e. labour, supervision and coordination, materials, technology, administration etc.). A list of proposed indicators can be found below.

- **Sector sustainability review**: The sector sustainability review as detailed above and in section 3.4 provides a perspective on overall sector operating and fiscal health. It also provides a breakdown of average sector cost components.

The process for rate review should be the following:

1. On an annual basis, the baseline indicators are refreshed and analyzed. If the indicators have changed, this should trigger a rate review.

2. A percentage adjustment is calculated for each basket category.

3. The sum of the weighted average of all basket components is then totalled to form an overall rate adjustment factor. Weighted averages are developed by using data provided in the sustainability analysis that is refreshed every three years.

4. Rates are updated by taking the overall adjustment factor and multiplying it against the existing rate. Rates can either increase or decrease depending on the adjustment factor.

The following elements are proposed as indicators that should be included in the basket:

- **Shifts**: The number of weekend, holiday or night shifts/visits compared to a baseline.
- **RN to RPN ratio**: Provincial RN to RPN ratio for each service compared to a baseline. This applies only to nursing services.

- **Changes to Service Level Agreements (SLA)**: Changes to SLAs potentially have an impact on service delivery. If a change occurs, the cost impact of that SLA should be reviewed provincially on a case by case basis.

Additional elements may be required and the body managing rates should evaluate these indicators every three years. An important consideration is that the sector will now have to collect data for these indicators. This will require a change to data collection methodologies, approaches, and data sharing between CCACs and SPOs. The body managing implementation of the rates should develop a plan to collect this data. Improved data collection and measurement will result in improved transparency and sector ability to make informed decisions with increased pace.

Other future adjustment triggers could include changes in technology, legislation, or patient demand. The group responsible for rates should re-assess if significant changes have occurred in these areas or other areas that may be relevant to rates. If such a change has occurred, the necessary adjustment should be determined by an analysis of the change’s impact on sector costs/rates.

### 4.3.5 Travel Rate Review

Travel review should be made using a similar approach to the Base Rate review. Adjustments should be made based on indicators which include:

- **Mileage costs**: This includes average cost of fuel or average cost of public transportation depending on CD.

- **Population density**: Changes to population density would indicate the amount and travel distance required.

- **Service volume**: Service volume by census division. Similar to population density, this would account for how much travel is required in a given area.

- **Changes in labour cost**: As time is also a component of travel costs, it should be included as an indicator. The approach to compiling this indicator should match that outlined in the Base Rate.

An aggregate fact base maintained by CCACs and SPOs that contains actual travel cost information (both transportation costs and travel time by Census Division regardless of employment model) could assist in the travel rate review process.

### 4.3.6 Additional Methodologies and Procedures

Per discussion with the PPT and interviews with both provider and CCAC representatives, the implementation and maintenance of the new fee schedule into the future must also consider:

- How to address **remote region service delivery**, where the pricing model does not apply due to significant distances traveled and/or costs incurred in delivering service.

- How to address **“insufficient critical mass” service delivery**, where there is a minimum required service level established by the CCAC but low volumes in that area make it difficult for the provider to reach a critical mass at which home care human resources can be reliably allocated.

- How to determine Provincial **rates for new services** which may be developed on a local basis.

**Remote Travel Adjustment Methodology**

Payment for remote travel applies for travel to areas where significant costs for transportation and/or significant travel times are required above and beyond what can be accurately captured by the existing travel rate adjustment in the new pricing model.

Definitions as to what constitutes remote travel and how it is compensated should be agreed upon ahead of time at the CCAC-SPO level, with a static mechanism and approach for all services and includes the following considerations:

1. A standard set of remote regions identified by each CCAC.
2. If service is required in a defined remote area, the CCAC and provider should agree on the travel cost before the service is delivered. Costs should be broken down between transportation costs and travel time costs.

**Critical Mass Adjustment Methodology**

Payment for insufficient critical mass situations applies where the provider is required to deliver minimum levels of service to an area where the level of service required may not warrant full time resources and requires special arrangements to connect patients with care workers. The following approach is recommended for management of the critical mass adjustment:

1. The concept of critical mass should be SPO-agnostic (uniformly applicable to all SPOs), with a standard approach to determining whether the concept applies.

2. CCACs and SPOs should set definitions of what qualifies as critical mass and why. This definition should be consistent provincially.

3. If required service is low in a geographic area, per the definition of critical mass, the CCAC and SPO should determine and agree to the extra rate add-on.

4. If required service is low due to division of overall volume across several SPOs, the CCAC should assess how volume can be more efficiently allocated to avoid the situation in the future.

**Nursing Band Service Categorization Methodology**

As new Nursing services are developed and implemented within CCACs, a procedure is required for placing the service in a Nursing band. This procedure comprises three separate cases:

1. **Nursing service is only offered in one CCAC**: CCAC and SPOs work together to determine where the service should fall given the different bands available. SPOs must provide information to demonstrate that there is a cost difference compared to the “standard” Nursing visit. Once the service has been banded, it must be verified and approved by the group that manages provincial pricing.

   The service cannot fall on a different band for different service providers. There is also a risk that this may set a provincial precedent for the banding of that service. When a service is expanded from one CCAC to multiple CCAC a review should take place to ensure that banding is consistent across the province.

2. **Nursing service is offered in multiple CCACs**: The provincial body that maintains the FFS rate list will work with CCACs and SPOs to determine which band a specific Nursing service should fall in. SPOs must provide information to demonstrate that there is a cost difference compared to the “standard” Nursing visit.

3. **A new band is required**: The provincial body that maintains the FFS rate list will work with CCACs and SPOs to determine where new bands should be created. A new band should only be created when the proposed rate for the new service is significantly different from existing bands.

**Suggested New Service Addition Methodology**

The process for new service addition is intended to encourage a consistent Provincial approach, while not stifling CCAC-level innovation in terms of new service development. Per discussion with the PPT and interviews with sector participants, CCACs and SPOs must have the freedom to continually develop new services and improve service offerings to the Ontario public. There should be a consistent method by which this is done. The following approach has to service addition has is being recommended:

1. A service should be considered new and eligible for local rate negotiation when it is below the threshold of 0.05% of Provincial spend and is only offered in fewer than three CCACs.

2. Once the service exceeds these limits, it should be reviewed and added to the fee schedule at the Provincial level by the group responsible for rate management. This should be done by requesting rates and cost breakdowns for
the service from providers, with travel time and mileage broken out separately, and comparing the rates/costs to existing services.

3. Once included in the Provincial model, the group responsible for maintaining pricing will need to model the impact of the new service addition in a transparent manner and, within 1-2 years (once historical data is available), the sustainability of the new service rate should be re-assessed as part of the regular schedule of model reviews described in the previous section.

Recommendation 37:

New services that account for at least 0.05% of provincial purchased services spending, and that are provided by more than two CCACs, should be considered for provincial pricing.
4.4 Additional Data Related Recommendations

Throughout this project a significant amount of time requesting, cleansing and analyzing data from CHRIS and CCACs was required. Based on this analysis there are a number of recommendations that should help CCACs and the OACCAC to improve and facilitate data analysis in the future. Most of these recommendations address the establishment of provincial standards for data capture, naming conventions and management of rates and services.

**Recommendation 38:**

*Standard provincial definitions should be created for all specialized services. These definitions should outline what the service constitutes, who can provide the service and what billing rate the service falls under.*

**Recommendation 39:**

*A standard provincial naming convention should exist for all contract, provider and service descriptions within CHRIS. Any existing contracts, provider names, service descriptions, etc. should be moved to the new convention once it is created.*

**Recommendation 40:**

*A standard provincial definition for Cluster Care should be developed. This definition should clearly outline what is considered a Cluster Care setting.*

**Recommendation 41:**

*A Cluster Care field should be created in CHRIS. All locations considered as Cluster Care settings should be identified. Patient profiles should indicate that they are receiving care in a Cluster Care setting.*

**Recommendation 42:**

*A general review of CHRIS should be conducted on a periodic basis to standardize fields, naming conventions, data capture, etc.*
## Appendices and Exhibits

### 5.1 List of Current Service Categories and Associated Spend

The table represents data from April 1st 2012 through March 31st 2013.

<table>
<thead>
<tr>
<th>Service Delivery ID</th>
<th>Service Delivery ID Description</th>
<th>Spend (Thousands)</th>
<th>Volume (Hours or Visits)</th>
<th>% of Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>68</td>
<td>Hourly Homemaking - Combined personal support and housekeeping home</td>
<td>$675,976</td>
<td>22,499,164</td>
<td>50.5855%</td>
</tr>
<tr>
<td>14</td>
<td>Visit Nursing home</td>
<td>$298,296</td>
<td>4,971,331</td>
<td>22.3224%</td>
</tr>
<tr>
<td>10</td>
<td>Shift Nursing home</td>
<td>$63,459</td>
<td>1,231,714</td>
<td>4.7488%</td>
</tr>
<tr>
<td>71</td>
<td>Hourly personal support home</td>
<td>$59,471</td>
<td>1,966,202</td>
<td>4.4504%</td>
</tr>
<tr>
<td>41</td>
<td>Visit OT home</td>
<td>$40,518</td>
<td>329,030</td>
<td>3.0321%</td>
</tr>
<tr>
<td>50</td>
<td>Visit PT home</td>
<td>$39,514</td>
<td>375,121</td>
<td>2.9570%</td>
</tr>
<tr>
<td>61</td>
<td>Visit speech public school</td>
<td>$20,478</td>
<td>174,132</td>
<td>1.5324%</td>
</tr>
<tr>
<td>18</td>
<td>Shift Nursing public school</td>
<td>$19,400</td>
<td>144,335</td>
<td>1.4518%</td>
</tr>
<tr>
<td>43</td>
<td>Visit OT public school</td>
<td>$16,549</td>
<td>144,335</td>
<td>1.2384%</td>
</tr>
<tr>
<td>197</td>
<td>Visit Nursing palliative home</td>
<td>$14,231</td>
<td>211,111</td>
<td>1.0650%</td>
</tr>
<tr>
<td>11</td>
<td>Visit Nursing only day clinic</td>
<td>$10,503</td>
<td>291,880</td>
<td>0.7860%</td>
</tr>
<tr>
<td>206</td>
<td>Visit Nursing wound care home</td>
<td>$9,524</td>
<td>149,395</td>
<td>0.7127%</td>
</tr>
<tr>
<td>16</td>
<td>Visit Nursing public school</td>
<td>$9,029</td>
<td>153,971</td>
<td>0.6756%</td>
</tr>
<tr>
<td>244</td>
<td>Hourly Nursing only day clinic</td>
<td>$8,814</td>
<td>137,578</td>
<td>0.6596%</td>
</tr>
<tr>
<td>73</td>
<td>Hourly homemaking - caregiver respite home</td>
<td>$7,611</td>
<td>258,878</td>
<td>0.5695%</td>
</tr>
<tr>
<td>143</td>
<td>Visit social work home</td>
<td>$6,463</td>
<td>43,273</td>
<td>0.4836%</td>
</tr>
<tr>
<td>28</td>
<td>Visit dietician home</td>
<td>$5,435</td>
<td>44,538</td>
<td>0.4067%</td>
</tr>
<tr>
<td>59</td>
<td>Visit speech home</td>
<td>$4,521</td>
<td>32,662</td>
<td>0.3383%</td>
</tr>
<tr>
<td>52</td>
<td>Visit PT public school</td>
<td>$3,298</td>
<td>28,903</td>
<td>0.2468%</td>
</tr>
<tr>
<td>221</td>
<td>Shift Nursing RPN home</td>
<td>$2,458</td>
<td>54,369</td>
<td>0.1839%</td>
</tr>
<tr>
<td>220</td>
<td>Shift Nursing RN home</td>
<td>$2,334</td>
<td>41,709</td>
<td>0.1746%</td>
</tr>
<tr>
<td>5</td>
<td>Hourly personal support private/home School</td>
<td>$2,108</td>
<td>79,203</td>
<td>0.1577%</td>
</tr>
<tr>
<td>60</td>
<td>Visit speech private/home school</td>
<td>$2,013</td>
<td>16,914</td>
<td>0.1506%</td>
</tr>
<tr>
<td>148</td>
<td>Visit ET home</td>
<td>$1,902</td>
<td>19,003</td>
<td>0.1423%</td>
</tr>
<tr>
<td>187</td>
<td>Shift Nursing palliative home</td>
<td>$1,531</td>
<td>29,303</td>
<td>0.1146%</td>
</tr>
<tr>
<td>69</td>
<td>Hourly homemaking - housekeeping home</td>
<td>$1,225</td>
<td>41,261</td>
<td>0.0916%</td>
</tr>
<tr>
<td>42</td>
<td>Visit OT private/home school</td>
<td>$1,206</td>
<td>11,360</td>
<td>0.0902%</td>
</tr>
<tr>
<td>622</td>
<td>Hourly SLP group public school multi-patient billing cap</td>
<td>$995</td>
<td>13,921</td>
<td>0.0744%</td>
</tr>
<tr>
<td>222</td>
<td>Shift Nursing RN public school</td>
<td>$834</td>
<td>14,508</td>
<td>0.0624%</td>
</tr>
<tr>
<td>159</td>
<td>Hourly attendant care</td>
<td>$726</td>
<td>26,259</td>
<td>0.0543%</td>
</tr>
<tr>
<td>223</td>
<td>Shift Nursing RPN public school</td>
<td>$690</td>
<td>15,482</td>
<td>0.0517%</td>
</tr>
<tr>
<td>190</td>
<td>Visit pharmacy consultation home</td>
<td>$685</td>
<td>3,046</td>
<td>0.0513%</td>
</tr>
<tr>
<td>189</td>
<td>Shift Nursing residential hospice</td>
<td>$500</td>
<td>10,028</td>
<td>0.0374%</td>
</tr>
<tr>
<td>Service Delivery ID</td>
<td>Service Delivery ID Description</td>
<td>Spend (Thousands)</td>
<td>Volume (Hours or Visits)</td>
<td>% of Spend</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------------</td>
<td>------------------</td>
<td>--------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>77</td>
<td>Visit lab home</td>
<td>$434</td>
<td>16,041</td>
<td>0.0325%</td>
</tr>
<tr>
<td>188</td>
<td>Hourly personal support residential hospice</td>
<td>$395</td>
<td>15,766</td>
<td>0.0296%</td>
</tr>
<tr>
<td>212</td>
<td>Visit Nursing mental health home</td>
<td>$370</td>
<td>5,404</td>
<td>0.0277%</td>
</tr>
<tr>
<td>611</td>
<td>Hourly Nursing only day clinic multi-patient billing cap</td>
<td>$283</td>
<td>5,332</td>
<td>0.0212%</td>
</tr>
<tr>
<td>20</td>
<td>Shift Nursing private/home school</td>
<td>$230</td>
<td>4,471</td>
<td>0.0172%</td>
</tr>
<tr>
<td>218</td>
<td>Visit Nursing dialysis home</td>
<td>$227</td>
<td>3,200</td>
<td>0.0170%</td>
</tr>
<tr>
<td>610</td>
<td>Hourly Homemaking - combined PS&amp;H home multi-patient billing cap</td>
<td>$202</td>
<td>6,934</td>
<td>0.0151%</td>
</tr>
<tr>
<td>616</td>
<td>Hourly Nursing public school multi-patient billing cap</td>
<td>$171</td>
<td>3,024</td>
<td>0.0128%</td>
</tr>
<tr>
<td>226</td>
<td>Hourly psychologist home</td>
<td>$161</td>
<td>1,858</td>
<td>0.0121%</td>
</tr>
<tr>
<td>193</td>
<td>Visit Nursing continence home</td>
<td>$160</td>
<td>1,768</td>
<td>0.0120%</td>
</tr>
<tr>
<td>230</td>
<td>Hourly Nursing geriatric home</td>
<td>$150</td>
<td>2,417</td>
<td>0.0112%</td>
</tr>
<tr>
<td>51</td>
<td>Visit PT private/home school</td>
<td>$135</td>
<td>1,189</td>
<td>0.0101%</td>
</tr>
<tr>
<td>15</td>
<td>Visit Nursing private/home school</td>
<td>$134</td>
<td>2,557</td>
<td>0.0100%</td>
</tr>
<tr>
<td>163</td>
<td>Hourly Nursing home</td>
<td>$128</td>
<td>2,096</td>
<td>0.0096%</td>
</tr>
<tr>
<td>319</td>
<td>Visit OT Falls assessment home</td>
<td>$96</td>
<td>556</td>
<td>0.0072%</td>
</tr>
<tr>
<td>614</td>
<td>Hourly Nursing home multi-patient billing cap</td>
<td>$92</td>
<td>1,604</td>
<td>0.0069%</td>
</tr>
<tr>
<td>185</td>
<td>Hourly pharmacy consultation home</td>
<td>$88</td>
<td>713</td>
<td>0.0066%</td>
</tr>
<tr>
<td>475</td>
<td>Visit PT falls assessment home</td>
<td>$87</td>
<td>757</td>
<td>0.0065%</td>
</tr>
<tr>
<td>29</td>
<td>Visit dietician public school</td>
<td>$59</td>
<td>456</td>
<td>0.0044%</td>
</tr>
<tr>
<td>234</td>
<td>Visit social work geriatric home</td>
<td>$48</td>
<td>271</td>
<td>0.0036%</td>
</tr>
<tr>
<td>24</td>
<td>Shift Nursing only day clinic</td>
<td>$46</td>
<td>752</td>
<td>0.0034%</td>
</tr>
<tr>
<td>131</td>
<td>Visit RT home</td>
<td>$41</td>
<td>334</td>
<td>0.0031%</td>
</tr>
<tr>
<td>320</td>
<td>Visit Nursing falls assessment home</td>
<td>$40</td>
<td>598</td>
<td>0.0030%</td>
</tr>
<tr>
<td>201</td>
<td>Visit OT residential Hospice</td>
<td>$39</td>
<td>343</td>
<td>0.0029%</td>
</tr>
<tr>
<td>330</td>
<td>Visit Nursing Chemotherapy home</td>
<td>$35</td>
<td>449</td>
<td>0.0026%</td>
</tr>
<tr>
<td>481</td>
<td>Visit Nursing foot care Nursing only day clinic - AAH</td>
<td>$27</td>
<td>380</td>
<td>0.0020%</td>
</tr>
<tr>
<td>202</td>
<td>Visit PT residential hospice</td>
<td>$26</td>
<td>229</td>
<td>0.0019%</td>
</tr>
<tr>
<td>321</td>
<td>Hourly personal support exercise program home</td>
<td>$24</td>
<td>780</td>
<td>0.0018%</td>
</tr>
<tr>
<td>580</td>
<td>Hourly lab home</td>
<td>$13</td>
<td>330</td>
<td>0.0010%</td>
</tr>
<tr>
<td>152</td>
<td>Visit ET Nursing only clinic</td>
<td>$11</td>
<td>89</td>
<td>0.0008%</td>
</tr>
<tr>
<td>175</td>
<td>Hourly PT public school</td>
<td>$7.9</td>
<td>76</td>
<td>0.0006%</td>
</tr>
<tr>
<td>232</td>
<td>Visit OT geriatric home</td>
<td>$7.4</td>
<td>54</td>
<td>0.0006%</td>
</tr>
<tr>
<td>176</td>
<td>Hourly speech public school</td>
<td>$7.3</td>
<td>87</td>
<td>0.0005%</td>
</tr>
<tr>
<td>178</td>
<td>Hourly OT public school</td>
<td>$6.9</td>
<td>66</td>
<td>0.0005%</td>
</tr>
<tr>
<td>217</td>
<td>Visit cognitive multi-disciplinary assessment home</td>
<td>$5.3</td>
<td>38</td>
<td>0.0004%</td>
</tr>
<tr>
<td>491</td>
<td>Hourly SLP group public school</td>
<td>$5.1</td>
<td>60</td>
<td>0.0004%</td>
</tr>
<tr>
<td>322</td>
<td>Visit Nursing medication management home</td>
<td>$4.5</td>
<td>66</td>
<td>0.0003%</td>
</tr>
</tbody>
</table>
## Table 5.1.1 – Full Service Category and Spend Breakdown

<table>
<thead>
<tr>
<th>Service Delivery ID</th>
<th>Service Delivery ID Description</th>
<th>Spend (Thousands)</th>
<th>Volume (Hours or Visits)</th>
<th>% of Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>Visit PT therapy only day clinic</td>
<td>$4.4</td>
<td>80</td>
<td>0.0003%</td>
</tr>
<tr>
<td>507</td>
<td>Hourly other service home</td>
<td>$3.7</td>
<td>59</td>
<td>0.0003%</td>
</tr>
<tr>
<td>31</td>
<td>Visit dietician private/home school</td>
<td>$1.4</td>
<td>11</td>
<td>0.0001%</td>
</tr>
<tr>
<td>205</td>
<td>Visit social work residential hospice</td>
<td>$1.3</td>
<td>9</td>
<td>0.0001%</td>
</tr>
<tr>
<td>199</td>
<td>Visit ET residential hospice</td>
<td>$0.8</td>
<td>10</td>
<td>0.0001%</td>
</tr>
</tbody>
</table>
5.2 Detailed Current State Analysis

5.2.1 Note on Rate Distribution Charts

The rate distribution charts are histograms that show the distribution of rates across the province, as a percent of the total provincial hours or visits. The graphs show the provincial distribution of rates with detail about each CCAC’s contribution to each histogram bar.

5.2.2 PSW Rate and Service Findings

The analysis contained in this section applies to the following service codes in CHRIS:

- 5 – Hourly personal support private/home School
- 68 – Hourly homemaking – combined personal support and housekeeping
- 69 – Hourly homemaking – housekeeping home
- 71 – Hourly personal support home
- 73 – Hourly homemaking – caregiver respite home
- 188 – Hourly personal support residential hospice
- 321 – Hourly personal support exercise program home
- 610 – Hourly homemaking – combined PS&H home multi-patient billing cap

Distribution of PSW Rates

Table 5.2.1 and Figure 5.2.1 quantify and illustrate the distribution in rates for PSW services.

<table>
<thead>
<tr>
<th>Weighted Average Rate</th>
<th>Standard Deviation</th>
<th>Min Rate</th>
<th>Max Rate</th>
<th>Total Number of Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>$29.93</td>
<td>$2.23</td>
<td>$15.00</td>
<td>$50.19</td>
<td>24,890,286</td>
</tr>
</tbody>
</table>

Table 5.2.1 – Distribution of PSW Rates

Figure 5.2.1 analysis not factor out hours that included two PSWs, were in remote areas or other outlying factors. The $15 rate represents a NSNF visit in one CCAC.
95% of PSW hours were at a rate of $25.47 through $34.39 (within 2 standard deviations). This represents a range of approximately $10.00.

There is significant variation in the rates paid by different CCACs. Most CCACs have rates that span the overall distribution. There are, however, some CCACs that are more concentrated on the lower end of the distribution and others that are concentrated on the higher end of the distribution. Some of this distribution is due to travel rates and to different
approaches to rate increases through the years. When moving to a standard provincial rate, this will have an impact on the average rate paid by these CCACs more so than on others.

Length of PSW Visits

SPOs are currently paid for PSW services on an hourly basis. This may include one hour, multiple hours or fractions of hours. In order to make decisions relating to PSW travel reimbursement, the PPT table wanted to know the average PSW visit length and if CCACs were requisitioning PSW hours differently.

Figure 5.2.3 illustrates that over half (54.5%) of PSW visits lasted one hour. Just over one quarter of visits lasted less than 1 hour (26.95%) and the remainder of visits were longer than one hour.

Members of the PPT and Contract Managers in CCACs have indicated that the 0.25 hour visits are in Cluster Care settings where there is no real travel required between patients. Inference derived from data analyzed in CHRIS seems to support this hypothesis; however, because Cluster Care is not explicitly or uniformly captured, we were not able to fully verify the hypothesis.

Figure 5.2.3 – Distribution of PSW Visits by Time Unit

Figure 5.2.4 and Figure 5.2.5 illustrate that the number of PSW visits lasting less than one hour are growing at a faster rate than PSW visits that last an hour. Quarter hour visits are growing at a rate that is almost three times faster than hour long visits. Please note that for this analysis, data from April 1st 2011 through March 1st 2013 was included in the analysis.
Figure 5.2.4 – PSW Visit Type Growth by Month

<table>
<thead>
<tr>
<th>Length of Visit</th>
<th>Growth Rate Over Last Two Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter hour</td>
<td>2.7%</td>
</tr>
<tr>
<td>Half hour</td>
<td>1.3%</td>
</tr>
<tr>
<td>Three-quarter hour</td>
<td>1.7%</td>
</tr>
<tr>
<td>Hour</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Table 5.2.2 – Growth Rate of PSW Visits by Visit Length

Figure 5.2.5 outlines the overall proportion or ‘share’ of visit types by each CCAC. Each band adds up to 100%. If CCACs were requisitioning short (<1 hour), average (1 hour) and longer (>1 hour) visits using a similar approach, we would expect each visit category to be of equal percentage within each CCAC. The visit category percentages would still be different between each CCAC, because CCACs have a different number of patients to serve. For example, if this hypothesis were true, each visit category for CCAC A would be at ~6%, each visit category for CCAC B would be at ~6%, for CCAC D at 14%, etc.
Based on Figure 5.2.5 this hypothesis is disproved and the data shows that CCACs are requisitioning PSW visit lengths differently. CCACs B, M and N are utilizing shorter PSW visits proportionately more than other CCACs. CCACs G and H are using longer visits proportionately more than other CCACs.

![Share of PSW Visits](includes 0.25 hour visits)

**Figure 5.2.5 – Proportion of PSW Visits by Length**

### 5.2.3 Home Nursing Visit Rate and Service Findings

The analysis contained within this section applies to the following service codes in CHRIS:

- 14 – Visit Nursing home
- 197 – Visit Nursing palliative home
- 206 – Visit Nursing wound care home

### Distribution of Nursing Rates

Table 5.2.3 and Figure 5.2.15 to Figure 5.2.18 quantify and illustrate the distribution in rates for Nursing visit services.

<table>
<thead>
<tr>
<th>Nursing Rate Type</th>
<th>Weighted Average Rate (Before Reblending)</th>
<th>Weighted Average Rate (After Reblending)</th>
<th>Standard Deviation</th>
<th>Min Rate</th>
<th>Max Rate</th>
<th>Total Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blended</td>
<td>$63.52</td>
<td>$59.51</td>
<td>$5.42</td>
<td>$28.84</td>
<td>$168.00</td>
<td>1,932,066</td>
</tr>
<tr>
<td>RN</td>
<td>$62.67</td>
<td>$63.32</td>
<td>$7.18</td>
<td>$36.72</td>
<td>$274.18</td>
<td>1,999,781</td>
</tr>
<tr>
<td>RPN</td>
<td>$52.70</td>
<td>$54.30</td>
<td>$5.79</td>
<td>$16.61</td>
<td>$160.53</td>
<td>1,372,122</td>
</tr>
</tbody>
</table>

**Table 5.2.3 – Distribution of Nursing Visit Rates**
Please note that this includes all visits. The max rate is higher compared to the average because of visits to more remote areas. These include additional cost of travel and travel time. The min rate is low because it those visits were Not Seen Not Found rates that were set in one CCAC.

**Blended Rates**

Based on the averages outlined in Table 5.2.3 and Figure 5.2.6, the mean rate for blended visits (before re-blending) is higher than the mean rate of RPN visits. The reason for this difference is that average RN and RPN rates in the CCACs that utilize blended rates is higher than in CCACs that do not use blended rates. If the blended rates were to be deconstructed to the RN and RPN averages and distributions, we would see that average RN and RPN rates increase. As a result, new RN, RPN and blended rates had to be calculated.

Methodology discussing re-blending can be found in Section 3.6.7 as part of the base rate calculation. This approach was performed for all Nursing services.

RN to RPN ratios for each setting can be found in Table 5.2.4.

<table>
<thead>
<tr>
<th>Setting</th>
<th>RN</th>
<th>RPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Visit</td>
<td>59%</td>
<td>41%</td>
</tr>
<tr>
<td>School Visit</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>Home Hourly</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>School Hourly</td>
<td>40%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Table 5.2.4 – RN to RPN Ratio by Setting

![Figure 5.2.6 – Nursing Home Visit Rate Comparison](image-url)
Seven CCACs currently utilize blended rates. Some of these CCACs exclusively use blended rates (i.e. they do not have RN or RPN rates), whereas others will have a combination of blended, RN and RPN rates. 95% of blended Nursing visits had at a rate of $53.04 through $73.44 (within 2 standard deviations).

Like PSW, there is variation with the rates paid by CCACs. Most CCACs have rates that span the distribution. There are, however, some CCACs are more concentrated on the lower end of the distribution and others are concentrated on the higher end of the distribution. When moving to a standard provincial rate, this will have an impact on the average rate paid by these CCACs more so than on others.

Figure 5.2.7 – Blended Nursing Home Visit Rate Distribution by CCAC
5.2.4 Wound Care, Palliative Care and Child Visit Home Nursing Rate Findings

As rate categories were being defined, the PPT required understanding of whether there were significant rate differences between the standard RN visit (SDID 14) and Wound Care visits (SDID 197), Palliative Care visits (for patients with
Service Recipient Code 95) and Child visits (patients under 18 years of age) to ensure that these SDIDs could be merged. The following analysis supports that these visit categories do not require their own SDIDs.

Table 5.2.5 and Figure 5.2.10 to Figure 5.2.12 profile the differences between a standard RN visit (prior to reblanding) and Wound, Palliative and Child visits.

Please note the following:

- Seven CCACs have utilized SDID code 206 – Wound care. The remaining CCACs include wound care as part of normal Nursing visits. This excludes ET visits.
- Ten CCACs have utilized SDID code 197 – Visit Nursing palliative home for some Palliative services. Most Palliative patients received services under SDID 14 – Visit Nursing home.

<table>
<thead>
<tr>
<th>Nursing Rate Type</th>
<th>Weighted Average RN Rate (factoring out other rates)</th>
<th>Weighted Average Rate</th>
<th>Percentage Difference from RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound Care</td>
<td>$62.00</td>
<td>$63.65</td>
<td>2.31%</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>$61.85</td>
<td>$63.31</td>
<td>2.31%</td>
</tr>
<tr>
<td>Child Visits</td>
<td>$63.32</td>
<td>$63.86</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Table 5.2.5 – Differences in Rates Between Standard RN Visits and Other Visit Types

![Wound Care Home Visit Rate Distribution](image-url)
A two sample T-test was conducted between the Palliative care rate distribution and the RN rate distribution for non-palliative patients as well as the adult RN rate and child rate distributions. Both tests concluded that there was no difference between the means.

Figure 5.2.11 – Palliative RN Rates VS Non-Palliative RN Rates

Figure 5.2.12 – Adult RN Rates VS Child RN Rates
For each of the different rate comparisons we can conclude that there isn’t a significant difference in the rates or distributions. Therefore it is not necessary to create a separate rate for Wound Care (non-ET activities) visits, Palliative Care visits and Child visits.

5.2.5 Other Types of Specialty Nursing Home Visits

CCACs are also utilizing other types of specialty Nursing visits and have established rates with SPOs. These include but are not limited to Enterostomal Therapy (ET) visits and Continence Advisor visits. Not all CCACs utilize these services. Other specialty Nursing services were not included because they did not meet the minimum threshold for establishing a provincial rate.

Table 5.2.6 outlines the average rate, standard deviation and number of CCACs with visits coded under the Service Delivery ID. Figure 5.2.13 and Figure 5.2.14 demonstrate the distribution in rates for each of these services by CCAC.

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Average Rate</th>
<th>Standard Deviation</th>
<th>Number of CCACs with visits coded in the SDID</th>
</tr>
</thead>
<tbody>
<tr>
<td>ET (SDID 148)</td>
<td>$100.07</td>
<td>$19.87</td>
<td>7</td>
</tr>
<tr>
<td>Continence Advisor (SDID 193)</td>
<td>$90.42</td>
<td>$21.47</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 5.2.6 – ET and Continence Distribution

From Figure 5.2.13 it appears as though there are two different distributions for ET visits. A standard normal distribution would have been expected as seen in other service distributions. This does not appear to be the case. Further investigation provides an explanation for this category illustrating a disconnect within the distribution.
Contract Managers from various CCACs helped explain the difference seen between rates. Special Conditions of the CCAC contracts allow flexibility in the qualifications considered for ET. Each CCAC may have different standards for ET services. Wound Care courses may offer a few hours on Ostomy Care. Since wound care courses are more prevalent than ET courses, the rates for wound care consultants are likely lower than those for ETs so those agencies would likely charge the lower wound care rate for ET services under those circumstances. There is a shortage of ET certified nurses and CCACs and SPOs may have to utilize nurses with wound care certification and some ET training. Alternatively these CCACs may also pay a premium to have ET trained nurses travel to deliver services.

![Continence Home Visit Rate Distribution by CCAC](image)

Continence Advisory is a service that is much less prevalent provincially as only five CCACs have visits coded under this Service Delivery ID. Continence Advisor nurses are also scarce resources provincially. This service is predominantly found in one CCAC where it was initially developed. The Continence Advisor service listed in the $125-$129 range is a specialty service that is coded under the same SDID, but is different from the other Continence Advisor services. As a result it will be separated out when calculating the recommended provincial base rate for this service.

5.2.6 School Nursing Visit Rate and Service Findings

The analysis in this section applies to the following service codes in CHRIS:

- 16 – Visit Nursing public school
- 15 – Visit Nursing private/home school

**Distribution of Nursing Rates**
Table 5.2.7 and Figure 5.2.15 to Figure 5.2.18 quantify and illustrate the distribution in rates for Nursing visit services.

<table>
<thead>
<tr>
<th>Nursing Rate Type</th>
<th>Weighted Average Rate (Before Reblending)</th>
<th>Weighted Average Rate (After Reblending)</th>
<th>Standard Deviation</th>
<th>Min Rate</th>
<th>Max Rate</th>
<th>Total Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blended</td>
<td>$62.51</td>
<td>$58.54</td>
<td>$6.72</td>
<td>$32.57</td>
<td>$105.14</td>
<td>47,800</td>
</tr>
<tr>
<td>RN</td>
<td>$62.48</td>
<td>$64.40</td>
<td>$5.28</td>
<td>$46.80</td>
<td>$160.53</td>
<td>42,494</td>
</tr>
<tr>
<td>RPN</td>
<td>$53.14</td>
<td>$54.77</td>
<td>$9.39</td>
<td>$38.48</td>
<td>$160.53</td>
<td>66,257</td>
</tr>
</tbody>
</table>

Table 5.2.7 – Nursing School Visit Summary Data by Rate Type

Like the home Nursing visit rates observed above, the maximum rates for school visits are higher than the average due to travel. The minimum is also due to NSNF visits from one CCAC.

In this case the blended rate also has a higher average than the RN rate. A re-blending was also required for school visits. RN visits are more prevalent in the school setting than RN visits.

The average rates for RN and RPN visits are similar to the rates in the home setting. The blended rate is different as RNs are utilized more heavily in the school setting than the home setting; hence the RN to RPN ratio is different.

![School Visit Rate Comparison](image)

Figure 5.2.15 – Nursing School Visit Rate Comparison

Seven CCACs currently utilize blended rates. Three CCACs exclusively use blended rates (i.e. they do not have RN or RPN rates), whereas the remaining four have a combination of blended, RN and RPN rates.
Figure 5.2.16 – Nursing School Visit Rate Blended Rate Distribution by CCAC

Figure 5.2.17 – Nursing School Visit RN Rate Distribution by CCAC
5.2.7 Home Nursing Shift/Hourly Rate and Service Findings

A shift rate is paid on an hourly basis as opposed to the visit basis found in the sections above.

The analysis in this section applies to the following service codes in CHRIS:

- 10 – Shift Nursing home
- 163 – Hourly Nursing home
- 187 – Shift Nursing palliative home
- 189 – Shift Nursing residential hospice
- 220 – Shift Nursing RN home
- 221 – Shift Nursing RPN home
- 230 – Hourly Nursing geriatric home
- 614 – Hourly Nursing home multi-patient billing cap

**Distribution of Nursing Rates**

Table 5.2.8 and Figure 5.2.19 to Figure 5.2.22 quantify and illustrate the distribution in rates for Nursing shift/hourly services.
The average home shift rates are lower than the home visit rates because home shifts are paid on an hourly basis. Comparatively home visits can be up to two hours in length. The average length of a home visit within the sector has not been quantified.

The maximum rate for shifts is closer to the average as there isn’t a travel component built into the rate. The minimum continues to be about half the average due to NSNF visits in one CCAC.

For this service the blended rate falls in between the RN and RPN rates. This is due to heavier use of RPNs for shifts based services.

Table 5.2.8 – Nursing Home Shift/Hourly Summary Data by Rate Type

<table>
<thead>
<tr>
<th>Nursing Rate Type</th>
<th>Weighted Average Rate (Before Reblending)</th>
<th>Weighted Average Rate (After Reblending)</th>
<th>Standard Deviation</th>
<th>Min Rate</th>
<th>Max Rate</th>
<th>Total Number of Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blended</td>
<td>$51.60</td>
<td>$51.78</td>
<td>$4.95</td>
<td>$27.50</td>
<td>$80.03</td>
<td>29,494</td>
</tr>
<tr>
<td>RN</td>
<td>$57.04</td>
<td>$56.61</td>
<td>$5.76</td>
<td>$40.40</td>
<td>$73.61</td>
<td>118,123</td>
</tr>
<tr>
<td>RPN</td>
<td>$47.26</td>
<td>$47.22</td>
<td>$4.21</td>
<td>$34.75</td>
<td>$64.55</td>
<td>97,119</td>
</tr>
</tbody>
</table>

Figure 5.2.19 – Nursing Home Shift Rate Distribution Comparison
The CCAC represented by the dark orange utilizes shift Nursing proportionately more RN shift nurses than other CCACs when compared with the RN home visits. This increased utilization is causing the spike in the $64-$65 rate range.
5.2.8 School Nursing Shift/Hourly Rate and Service Findings

The analysis within this section applies to the following service codes in CHRIS:

- 18 – Shift Nursing public school
- 20 – Shift Nursing private/home school
- 177 – Hourly Nursing public school
- 222 – Shift Nursing RN public school
- 223 – Shift Nursing RPN public school
- 616 – Hourly Nursing public school multi-patient billing cap

Distribution of Nursing Rates

Table 5.2.9 and Figure 5.2.23 to Figure 5.2.26 quantify and illustrate the distribution in rates for Nursing shift/hourly services.

<table>
<thead>
<tr>
<th>Nursing Rate Type</th>
<th>Weighted Average Rate (Before Reblending)</th>
<th>Weighted Average Rate (After Reblending)</th>
<th>Standard Deviation</th>
<th>Min Rate</th>
<th>Max Rate</th>
<th>Total Number of Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blended</td>
<td>$51.95</td>
<td>$50.79</td>
<td>$1.78</td>
<td>$26.06</td>
<td>$61.35</td>
<td>33,802</td>
</tr>
<tr>
<td>RN</td>
<td>$55.75</td>
<td>$56.00</td>
<td>$4.51</td>
<td>$35.77</td>
<td>$70.20</td>
<td>36,082</td>
</tr>
<tr>
<td>RPN</td>
<td>$47.04</td>
<td>$47.24</td>
<td>$4.29</td>
<td>$35.77</td>
<td>$61.88</td>
<td>61,900</td>
</tr>
</tbody>
</table>

Table 5.2.9 – Nursing School Shift/Hourly Summary Data by Rate Type
The average school shift rates are lower than the school visit rates because school shifts are paid on an hourly basis. Comparatively school visits can be up to two hours in length. The average length of a school visit within the sector has not been quantified.

The maximum rate for shifts is closer to the average as there isn’t a remote or rural travel component built into the rate. The minimum continues to be about half the average due to NSNF visits in one CCAC.

Like home shift rates, the blended rate falls in between the RN and RPN rates. This is due to heavier use of RPNs for shifts based services.

![School Shift Rate Distribution Comparison](image_url)

*Figure 5.2.23 – Nursing School Shift Rate Distribution Comparison*
School Shift Blended Rate Distribution by CCAC

Figure 5.2.24 – Nursing School Shift Blended Rate Distribution by CCAC

School RN Shift Rate Distribution by CCAC

Figure 5.2.25 – Nursing School Shift RN Rate Distribution by CCAC
5.2.9 Occupational Therapy (OT) Rate and Service Findings

The analysis within this section applies to the following service codes in CHRIS:

- 41 – Visit OT home
- 201 – Visit OT residential hospice
- 42 – Visit OT private/home school
- 43 – Visit OT public school

Distribution of OT Rates

Table 5.2.10 and Figure 5.2.27 to Figure 5.2.28 quantify and illustrate the distribution in rates for OT services.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Weighted Average Rate</th>
<th>Standard Deviation</th>
<th>Min Rate</th>
<th>Max Rate</th>
<th>Total Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>$123.14</td>
<td>$18.39</td>
<td>$44.85</td>
<td>$619.00</td>
<td>329,605</td>
</tr>
<tr>
<td>School</td>
<td>$114.16</td>
<td>$23.63</td>
<td>$51.50</td>
<td>$457.28</td>
<td>155,839</td>
</tr>
</tbody>
</table>

Table 5.2.10 – Occupational Therapy Rate Summary Data

There are more significant differences between the minimum, maximum and average rates for therapies. Also, the standard deviation is much larger than for PSW and Nursing services. This means that not only is the range larger; there is also more variation amongst the different rates. For OT, the maximum rate is significantly higher as it contains travel costs (time and mileage) associated with visits to a remote area. The minimum rate remains a result of NSNF visits in one CCAC.
For Therapies, the range in the distribution in rates is much higher than for PSW or Nursing services. In the home setting, some of the distribution can be attributed to travel cost variations. Therapy services are not provided in areas as concentrated as PSW or Nursing services would be. Other components of the variation are attributable to CCAC practices. For example, a CCAC had higher OT home rates and lower OT school rates.

In the school setting there are also varied practices. The lower OT school rates are due to a special shared care rate similar to Cluster Care, where multiple patients can be seen in the same location. As a result, travel and other efficiencies can be obtained to reduce the rate of the service. The maximum OT school rate represents a service where four patients are seen in a school.

The variation in approach raises questions as to the standardization that should be required when classifying services. Specifically, something similar to cluster care should be approached in the school setting to capture these variations.

Figure 5.27 – OT Home Visit Rate Distribution by CCAC
5.2.10 Physiotherapy (PT) Rate and Service Findings

The analysis within this section applies to the following service codes in CHRIS:

- 50 – Visit PT home
- 202 – Visit PT residential hospice
- 51 – Visit private/home school
- 52 – Visit public school

### Distribution of PT Rates

Table 3.4.1 and Figure 5.2.29 and Figure 5.2.30 quantify and illustrate the distribution in rates for PT services.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Weighted Average Rate</th>
<th>Standard Deviation</th>
<th>Min Rate</th>
<th>Max Rate</th>
<th>Total Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>$105.34</td>
<td>$16.42</td>
<td>$43.66</td>
<td>$486.00</td>
<td>375,654</td>
</tr>
<tr>
<td>School</td>
<td>$114.11</td>
<td>$24.47</td>
<td>$49.00</td>
<td>$498.24</td>
<td>30,114</td>
</tr>
</tbody>
</table>

**Table 5.2.11 – Physiotherapy Rate Summary Data**

As noted in the OT rate section above, there are significant differences between the minimum, maximum and average rates. These differences are caused by similar factors. For home visits, maximum rates are significantly higher because of visits to more remote regions and minimum rates are NSNF visits in one CCAC.

The variation in the distribution within the school setting continues to demonstrate varied practices and approaches to care delivery within the province. Like in OT, the maximum school rate is for a visit where four patients were seen in a...
school. The large number of school visits in the $80--$84 rate segment is also due to the special care rate established for schools in one CCAC.

Figure 5.2.29 – PT Home Visit Rate Distribution by CCAC

Figure 5.2.30 – PT School Visit Rate Distribution by CCAC
5.2.11 Speech Language Pathology (SLP) Rate and Service Findings

The analysis within this section applies to the following service codes in CHRIS:

- 59 – Visit speech home
- 204 – Visit speech residential hospice
- 60 – Visit speech private/home school
- 61 – Visit speech public school

**Distribution of SLP Rates**

Table 5.2.12 and Figure 5.2.31 and Figure 5.2.32 quantify and illustrate the distribution in rates for SLP services.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Weighted Average Rate</th>
<th>Standard Deviation</th>
<th>Min Rate</th>
<th>Max Rate</th>
<th>Total Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>$138.41</td>
<td>$22.05</td>
<td>$57.00</td>
<td>$406.00</td>
<td>32,685</td>
</tr>
<tr>
<td>School</td>
<td>$117.73</td>
<td>$26.86</td>
<td>$35.00</td>
<td>$814.98</td>
<td>191,271</td>
</tr>
</tbody>
</table>

Table 5.2.12 – Speech Language Pathology Rate Summary Data

As noted in the OT rate section above, there are significant differences between the minimum, maximum and average rates. These differences continue to be caused by similar factors. For home visits, maximum rates are significantly higher because of visits to more remote regions and minimum rates are NSNF visits in one CCAC.

The variation in the distribution within the school setting continues to be due to varied practices across CCACs. The cause of the maximum and minimum rates differs from other therapies. The minimum school rate is the result of an SLP clinic rate established in one CCAC. The maximum rate is attributable to a visit rate where six patients are seen in a school.
5.2.12 Social Work (SW) Rate and Service Findings

The analysis within this section applies to the following service codes in CHRIS:

- 143 – Visit social work home
- 205 – Visit social work residential hospice
- 234 – Visit social work geriatric home

**Distribution of SW Rates**

Table 5.2.13, Figure 5.2.33 quantify and illustrate the distribution in rates for SW services.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Weighted Average Rate</th>
<th>Standard Deviation</th>
<th>Min Rate</th>
<th>Max Rate</th>
<th>Total Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>$149.50</td>
<td>$24.12</td>
<td>$52.00</td>
<td>$239.46</td>
<td>43,589</td>
</tr>
</tbody>
</table>

Table 5.2.13 – Social Work Rate Summary Data

SW is one of the smaller therapies in terms of the number of visits and the amount spent on the service provincially. The range of the rate distribution remains large for Social Work. The variations continue to be caused by different practices amongst CCACs. For home visits, maximum rates are significantly higher because of visits to more remote regions and minimum rates are NSNF visits in one CCAC. One CCAC also has a rate where SW care is delivered over the telephone. This rate is lower than the average.

It is also interesting to note the SW rates for two CCACs. These are both CCACs that incorporate significant rural and remote populations when compared with other CCACs. We would have thought that both CCACs would have rates on the higher end of the distribution. This is however not the case. One CCAC is located on the lower end of the distribution and
the other on the higher end. This also points to a variation in practice even though the geographic considerations should be similar.

Figure 5.2.33 – SW Visit Rate Distribution by CCAC

5.2.13 Nutrition and Dietetics (ND) Rate and Service Findings

The analysis within this section applies to the following service code in CHRIS:

- 28 – Visit dietician home

Distribution of Nutrition and Dietetic Rates

Table 5.2.14, Figure 5.2.34 quantify and illustrate the distribution in rates for PSW services.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Weighted Average Rate</th>
<th>Standard Deviation</th>
<th>Min Rate</th>
<th>Max Rate</th>
<th>Total Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>$122.02</td>
<td>$21.67</td>
<td>$59.23</td>
<td>$352.25</td>
<td>44,588</td>
</tr>
</tbody>
</table>

Table 5.2.14 – Nutrition and Dietetic Rate Summary Data

Like SW, ND is one of the smaller therapies in terms of number of visits and dollars spent provincially on the service. It also has a large range of rates. The minimum rate remains a NSNF rate in one CCAC whereas the maximum rate is due to travel to a more rural region in another CCAC.

There are two areas of the distribution by CCAC chart that are also puzzling. The $75 to $79 rate and the $175 to $179. For other services, the CCAC with rates in the $75 to $79 range was typically more concentrated in the center of distributions. The $175 to $179 rate on the other hand appears to be a specialty service that has a slightly higher rate than the other ND services offered in the CCAC.

This range will make implementation of new rates more complex.
Figure 5.2.34 – ND Home Visit Rate Distribution by CCAC
# 5.3 Census Divisions by CCAC

<table>
<thead>
<tr>
<th>CCAC</th>
<th>CD #</th>
<th>CD Name</th>
<th>CCAC</th>
<th>CD #</th>
<th>CD Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3536</td>
<td>Chatham-Kent</td>
<td>10</td>
<td>3507</td>
<td>Leeds and Grenville</td>
</tr>
<tr>
<td>1</td>
<td>3537</td>
<td>Essex</td>
<td>10</td>
<td>3509</td>
<td>Lanark</td>
</tr>
<tr>
<td>1</td>
<td>3538</td>
<td>Lambton</td>
<td>10</td>
<td>3510</td>
<td>Frontenac</td>
</tr>
<tr>
<td>2</td>
<td>3528</td>
<td>Haldimand-Norfolk</td>
<td>10</td>
<td>3511</td>
<td>Lennox and Addington</td>
</tr>
<tr>
<td>2</td>
<td>3531</td>
<td>Perth</td>
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<td>3512</td>
<td>Hastings</td>
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<td>3532</td>
<td>Oxford</td>
<td>10</td>
<td>3513</td>
<td>Prince Edward</td>
</tr>
<tr>
<td>2</td>
<td>3534</td>
<td>Elgin</td>
<td>10</td>
<td>3514</td>
<td>Northumberland</td>
</tr>
<tr>
<td>2</td>
<td>3539</td>
<td>Middlesex</td>
<td>11</td>
<td>3501</td>
<td>Stormont, Dundas and Glengarry</td>
</tr>
<tr>
<td>2</td>
<td>3540</td>
<td>Huron</td>
<td>11</td>
<td>3502</td>
<td>Prescott and Russell</td>
</tr>
<tr>
<td>2</td>
<td>3541</td>
<td>Bruce</td>
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<td>3506</td>
<td>Ottawa</td>
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<td>Grey</td>
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<td>3507</td>
<td>Leeds and Grenville</td>
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<td>3509</td>
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<td>Brant</td>
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<td>York</td>
<td>13</td>
<td>3552</td>
<td>Sudbury (region)</td>
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<tr>
<td>5</td>
<td>3520</td>
<td>Toronto</td>
<td>13</td>
<td>3553</td>
<td>Greater Sudbury / Grand Sudbury (city)</td>
</tr>
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</tbody>
</table>
5.4 Shift Baselines

As described in Section 3.6.11, an analysis was conducted to determine when services were offered on weekends or Holidays. This analysis serves as an informational baseline for the future. The number of weekend and Holiday shifts is built into the base rates.

PSW Visit Distribution

There is a 41% drop in PSW visits on weekends. Figure 5.4.1 illustrates the drop in PSW weekend shifts. It also indicates that 9% of PSW patients need care on a daily basis.

Nursing Shift and Visit Distribution

There is a 38% drop in home Nursing visits and a 24% drop in clinic Nursing visits on weekends. Figure 5.4.2 illustrates the drop in Nursing services offered during weekends.
Therapy Visit Distribution

There is an 80-90% drop in Therapy visits on weekends. Figure 5.4.3 illustrates the drop in Therapy services on weekends. Most Therapy care is offered during the week and some care takes place on weekends. There is also a difference in the number of visits taking place on Mondays and Fridays.

Figure 5.4.2 – Nursing Shift and Visit Distribution

Figure 5.4.3 – Therapy Visit Distribution
Table 5.4.1 highlights the average drop in services on Holidays. On average, weekends see a larger decrease in visits than most Holidays. Some holidays like Canada Day and Family Day see a smaller drop in visits, whereas Christmas Day sees the sharpest decline in visits.

<table>
<thead>
<tr>
<th>Discipline</th>
<th>With July 1</th>
<th>Without July 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSW</td>
<td>-31%</td>
<td>-34%</td>
</tr>
<tr>
<td>Visit Nursing Home</td>
<td>-22%</td>
<td>-25%</td>
</tr>
<tr>
<td>Shift Nursing Home</td>
<td>-20%</td>
<td>-22%</td>
</tr>
<tr>
<td>Visit Nursing Clinic</td>
<td>-30%</td>
<td>-34%</td>
</tr>
<tr>
<td>Hourly Nursing Clinic</td>
<td>-18%</td>
<td>-21%</td>
</tr>
<tr>
<td>PT Home</td>
<td>-77%</td>
<td>-87%</td>
</tr>
<tr>
<td>OT Home</td>
<td>-84%</td>
<td>-89%</td>
</tr>
<tr>
<td>SLP Home</td>
<td>-76%</td>
<td>-87%</td>
</tr>
<tr>
<td>Dietician Home</td>
<td>-71%</td>
<td>-86%</td>
</tr>
<tr>
<td>Social Work Home</td>
<td>-78%</td>
<td>-90%</td>
</tr>
</tbody>
</table>

Table 5.4.1 – Proportion of Weekend Visits by Discipline