Community Care Access Centre Accountability Reforms:

Executive Director Perceptions

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Abstract

The purpose of this study was to explore how four purposefully selected executive directors of Community Care Access Centres (CCACs) understood the idea of accountability, and how they viewed the accountability reforms that had been imposed on their sector of health care over the previous three years. Data were collected through personal interviews and a reflective journal. An analysis of key documents and the reflective journal informed the data analysis. The findings suggest that executive directors perceive that accountability relationships have shifted since reforms have been implemented. They noted that CCACs have become more accountable to the provincial government at the expense of accountability to the local community. From their perspective, the demand for greater standardization and bureaucratization has left fewer opportunities to adapt programs to meet particular community needs and has slowed the ability to respond quickly to community inquiries and concerns.
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CHAPTER ONE: THE PROBLEM

This study investigated executive directors' perspectives of accountability as well as the accountability reforms that have taken place in CCACs in Ontario over the last eight years. More specifically, the study focused on executive directors' perceptions of the reforms undertaken to increase accountability and whether or not executive directors perceive that accountability had changed. This chapter outlines the background to the research problem and provides some general context for the research setting. It also defines the research problem, provides the rationale for the study, explains the study's purpose and importance, and describes the scope and limitations of the study. A list of Acronyms used in this study may be found in Appendix A.

Background of the Problem

Over the past eight years, the Ontario health care sector has been the site of major restructuring and reform. Reforms have included amalgamations of small independent hospitals and other health care organizations into large corporations, mergers of many healthcare corporations, closures of small hospitals and other small independent healthcare organizations, and comprehensive governance reforms. In all of these changes, one of the primary stated goals has been to improve accountability for the delivery of health care.

The task of restructuring the health care system was delegated to the Health Services Restructuring Commission (HSRC) which was formed in April 1996 at the direction of the premier of Ontario. As an arms-length agency, the HSRC reported directly to the provincial government through cabinet and not to the existing healthcare bureaucracy. This move by the government was aimed at giving the Commission a free
hand at making recommendations and minimizing any opportunities for vested interests within the system to influence the outcomes. The original HSRC mandate was focused on the restructuring of hospitals; however, the HSRC used its discretionary powers to quickly broaden its focus in order to accommodate a broader systems-based approach. This approach went beyond the siting and sizing of hospitals and included recommendations regarding other supports within the healthcare system (such as home care) which were necessary to allow hospital restructuring to succeed. The Commission felt this broader approach was essential not only to the success of hospital restructuring but for future successes in meaningful reform of the healthcare sector.

One of the first of many non-hospital based recommendations from the HSRC was to support the planned reform of the delivery of long-term health care services for Ontario residents (HSRC, 1997). In January of 1996, the government of Ontario announced that 43 CCACs would be created across the province. The CCACs were created through the amalgamation of 38 Home Care Programs and 36 Placement Coordination Agencies (providing placement into long-term care facilities) into 43 CCACs, each representing a specific geographic area within the province of Ontario. The stated mandate of the CCACs was to provide a single access point for patient entry into the long-term care system.

CCACs became operational in April of 1997 as independent, not-for-profit corporations governed by locally elected, volunteer boards of directors. Prior to this, most home care programs were administered by local health departments as part of the municipal structure or run by local community service providers, such as the Victorian
Order of Nurses. Most placement programs were run as small independent organizations with volunteer boards and handfuls of staff.

The volunteer boards of directors for CCACs were focused on five key areas:

1. Satisfying the needs of the local consumers who elected them.
2. Ensuring a happy and productive workforce despite considerable upheaval and restructuring of roles resulting from the transition to CCACs.
3. Monitoring the bottom line to ensure that funds allocated by the Ministry of Health and Long-Term Care (MOHLTC) were appropriately expended on the organization’s key priorities.
4. Strategic planning and the establishment of long-term goals for the organization that would inform the key operational priorities of staff.
5. Recruiting successors that would fulfill the board’s vision of balanced consumer and business representation in the governance of CCACs.

(Whitmore, 1999, pg. 51)

As part of the restructuring process, CCACs were asked to redefine their model of service delivery. Up until this point, CCACs had acted either as direct providers of home care services to the public or had a mix of directly employed service providers and contract agencies. The vast majority of the contract providers under the old system were not-for-profit agencies such as the Victorian Order of Nurses or the Red Cross.

Under the new model of service delivery, direct client services were purchased by CCACs from external service providers through a Request for Proposal (RFP) process. This process was mandated by the government at part of a new managed competition policy. This policy shift resulted in CCACs uniformly adopting a brokerage model of
service whereby the CCAC role was to assess the needs of individual consumers and authorize a service plan from a range of mandated services, supplies, and equipment in order to address those assessed needs. The CCAC was then responsible for ensuring that the service plan continued to be appropriate based on reassessment of client needs at various intervals. Implied in this model was an accountability ethos based on value for money.

The separation of the roles of purchaser and provider was a key outcome of the new brokerage model. This model contrasted sharply with the previous model of home care programs where the programs employed both resource coordinators (purchasers) and direct service providers. Under the new brokerage model, internally employed direct service providers such as nurses, homemakers, or rehabilitation therapists had to be divested from CCAC employment in order to ensure the separation of the purchaser role and the provider role into separate entities.

The competitive RFP process also forced CCACs to open up the home care sector to bids for service delivery from all interested parties including the for-profit sector that had been largely excluded under the previous system. This process was viewed as a type of passive privatization of the home care sector and was opposed by many consumers and members of the public who feared that private for-profit involvement in health care would lead to a reduction in the quality of services provided (Denton, 2004).

At this stage, accountability of CCACs to the MOHLTC was addressed through service agreements that included a service plan and a budget. As well, the Ontario Association of Community Care Access Centers (OACCAC) worked with the Ministry to develop a mutually agreed upon accountability framework (See Figure 1).
The MOHLTC-OACCAC Accountability Framework was developed with reference to the following eight principles: (a) ethical behavior, (b) prudent and lawful use of public resources, (c) value for money, (d) quality of service provision, (e) fairness and equity, (f) openness and transparency, (g) appropriate administration, and (h) balanced expectations and capacities.

Much of the focus was on promoting efficiency and cost effectiveness of services provided by the CCACs. At that time, the HSRC was reviewing and recommending specific strategies in order to restructure the health system in an effort to ensure the sustainability of healthcare services over the coming years. One of the keys to the successful restructuring of the health care system, according to the HSRC, was to reduce acute care services and increase the availability of in-home services in order to reduce system reliance on acute care hospital beds (HSRC, 1997). The government was anxious to ensure, in light of considerable public outcry, that this shifting of resources produced not only economic savings, but also measurable positive health outcomes for the population it was intended to serve.

In 2001, there were two key occurrences that together produced a tide of change that continues to significantly affect the structure and governance of CCACs. The first of these occurrences was the introduction of Bill 46, “an Act respecting the accountability of public sector organizations” on May 9, 2001. The second was the
Figure 1. MOHLTC-OACCAC Accountability Framework, 1999, p.2.
Operational Review of the Hamilton-Wentworth CCAC (MOHLTC, 2000).

The goals of the Public Sector Accountability Act were to:

1. Initiate best practice in public sector organizations by measuring their performance against established goals and by reporting publicly on the progress made.

2. Improve program effectiveness and public accountability by promoting a stronger focus on the results and service quality of public sector organizations.

3. Improve decision-making in public sector organizations by ensuring that relevant information is available to the public about each organization’s objectives and about the effectiveness and efficiency of the organization’s activities in meeting those objectives.

4. Improve service delivery by requiring that public sector organizations prepare a plan to meet identified objectives and to provide information on results and service quality achieved.

5. Improve fiscal responsibility by requiring public sector organizations to prepare and deliver a yearly balanced budget.

Although the first four goals outlined in the Act were compatible with the existing directions of the CCACs based on their accountability framework and the strategic directions set by the board, the final goal was considered problematic. The problem arose with the considerable pressure placed on CCACs by their local constituents to increase the amount of community services provided. Expectations had been elevated by the HSRC recommendations for enhanced community-based services to replace acute care
hospital beds closed through restructuring orders from the HSRC. Consequently, CCAC boards were placed in the uncomfortable position of choosing either to run deficits in defiance of the government or to incur the wrath of local constituents for reducing service levels at a time of great need. Many of the boards took quite seriously their number one goal of satisfying local consumers and chose to defy the government by refusing to cut services and by approving a deficit budget.

The Hamilton-Wentworth CCAC was one such CCAC that experienced the added complication there had been great deal of local dissatisfaction with its governance and management. Added to this, there was considerable negative local and provincial press regarding CCACs in general due to their perceived inability to adequately provide for the services consumers were demanding. The Ministry became concerned enough with both the provincial situation, and the local Hamilton-Wentworth situation, to undertake an operational review of the Hamilton-Wentworth CCAC (MOHLTC, 2000). This Operational Review found that the CCAC had: (a) a ballooning deficit with no plans for how to control the situation; (b) decreased efficiency and effectiveness of service delivery to the public; (c) deteriorating staff morale; (d) multiple departures from provincial policies for CCACs; (e) a high turnover rate among senior staff; (f) a board that was naïve about public accountability, arrogant in its modus operandi, and oblivious to the need for proactive communications with its primary stakeholders; (g) inadequate strategic direction and leadership; and (h) failure to ensure accountability and transparency in its day-to-day operations.

As a direct result of the Hamilton-Wentworth findings, as well as the considerable negative press surrounding CCACs in general, the government moved quickly,
appointing a supervisor for the Hamilton-Wentworth CCAC and dismissing the existing board and CEO. An operational review was also conducted of the Ottawa-Carlton CCAC within a similar time period and although the findings were not as significant as those of the Hamilton-Wentworth CCAC, the government was left with the overall impression that there was considerable need for change in governance practices of CCACs.

The CCACs had been placed in a difficult situation. To quote from Flood, Sinclair, & Erdmann (2004): “The CCACs were expected to be accountable and simultaneously balance the competing pressures from the provincial government, providers and local citizens. This mandate was simply unrealistic given the limits of their budgets and authority and their very newness” (p.17). Flood et al. also argued that CCACs such as Ottawa-Carlton and Hamilton-Wentworth had in effect been handicapped from the very beginning of their mandate because their creation coincided with major spending cuts.

The government had already commissioned A Review of Community Care Access Centres by PricewaterhouseCoopers (1999). This report identified many of the same issues regarding accountability and clarification of expectations that were identified in the Hamilton-Wentworth and Ottawa-Carlton Operational Reviews. However, the PricewaterhouseCoopers report was reflective of the broader sector of CCACs and did not share many of the specific concerns found in the Operational Reviews. It reflected the practices of many well run CCACs.

Based on both the specific recommendations and findings of the Hamilton-Wentworth Operational Review and the more general findings of the PricewaterhouseCoopers Report, the MOHLTC launched a CCAC governance reform
strategy that resulted in the passage of a new Act for CCACs, the Community Care Access Corporations Act (2001). The goals of CCAC governance reform and the passage of this new Act for CCACs were stated by the government to be as follows (MOHLTC, 2001a):

1. The creation of an effective governance structure for CCACs.
2. Improved linkages to local communities.
3. Improved accountability to government.
4. Improved allocation of resources.
5. Clear standards and guidelines for CCACs to follow.
7. Technology that will support the new structure and expectations.

The new Act was designed to increase the accountability of CCACs to the government through the reclassification of CCACs from independent not-for-profit corporations to operational service agencies. The CCACs thus became statutory corporations with a new relationship with the government based on a Memorandum of Understanding (MOU) that replaced the former service agreements. In a press release dated July 6, 2002, the MOHLTC stated the intended outcomes of the new legislation to be: “Under the Community Care Access Corporations Act, 2001, the government will be able to convert CCACs into statutory corporations that consistently apply all ministry policies, directive and guidelines” (MOHLTC, 2001b, p.1).

Under the new Act, the elected volunteer boards of directors were replaced with volunteer boards appointed by the Ministry through an Order-in Council (OIC). Chief executive officers (CEOs) were replaced with executive directors who were subject to
appointment through the OIC process upon recommendation for hire by the Ministry appointed boards of directors. Through this process, there was an opportunity for anyone in a governance or executive leadership position that may have been in opposition to the government’s direction for CCACs to be removed. The end result was felt by some consumer advocacy groups such as Canadian Association of Retired Persons (CARP) to have resulted in a considerable loss of the consumer voice in CCAC governance.

Area of Inquiry

CCACs have undergone extensive governance reform over the past three years for the express purpose of increasing accountability. These reforms included (a) moving from independent not-for-profit corporations to statutory corporations; (b) no longer having board members elected by the members of the corporation, but rather appointed by the government through an OIC; and (c) replacing CEOs hired by the board with executive directors appointed through an OIC.

The newly appointed executive directors were charged with much of the responsibility to carry out the reforms despite having had very little input into the process. The new demands placed on executive directors and boards were outlined in a government mandated MOU that replaced the former service agreements. Executive directors were also expected to submit and report on yearly business plans that were based on government-developed templates which replaced the much simpler service plan expectations of the past.

This study seeks to explore the experiences and insights of four of those executive directors who lived through the government-mandated accountability reforms in CCACs in Ontario. Although improved accountability has been the stated goal behind many of
the policy and governance changes affecting CCACs, no analysis has been done of the reforms regarding their success in improving CCAC accountability.

**Purpose of the Study**

The purpose of this study was to explore how purposefully selected executive directors of Community Care Access Centres (CCACs) understood the idea of accountability, and how they viewed the accountability reforms that had been imposed on their sector of the Ontario health care system over the previous three years. The study focused on the executive directors' perceptions regarding the reforms undertaken to increase accountability; whether or not the reforms had strengthened or weakened accountability; and if so, in what ways.

Both the process of reforms as experienced by the participants and the perceived outcomes of the reform initiatives will be examined in order to provide insights into the overall success of the reforms in improving accountability within the CCAC sector.

**Rationale**

If the reform of CCACs is to be viewed as a positive action by the government and as an effective tool for improving accountability, then an analysis of the executive directors' perceptions regarding the outcomes of the reform provide a valuable contribution to the practical and theoretical knowledge bases. This analysis informs future thinking on governance reforms related to the improvement of accountability mechanisms not only in the CCAC sector, but also in other publicly administered programs both internal and external to the healthcare system.

Reviews of the Canadian literature in healthcare reveals that the available research on accountability is scant. For example, Penney (2002), in her review of the
accountability literature, states that "The majority of the literature was from the United States, followed by Britain and then Australia and New Zealand" (p. 78). Similarly, Johnson (2001) notes that the published literature is limited on the subject of accountability in Canadian healthcare. The Queens Health Policy Research Unit (QHPRU, 1999) in their literature review state, "Despite an extensive and detailed search, the number of relevant sources identified in the published literature remains disappointingly small" (p. 7). As well as a paucity of material, authors such as MacDonald and Shortt (Queens Health Policy Research Unit, 1999) also note that the quality of the published material is highly variable.

This study is focused at the policy implementation stage, where the government's broadly stated policy initiatives and goals of the CCAC reforms have been transformed into programs, procedures, and regulations. The intent of the study is to inform the policy decision-making process. As Rist (2001) indicates, "...there is seldom enough research-based information available in the policy arena" (p. 1003). "Furthermore, there has been very little systematic work undertaken to determine which policy tools work best, in which circumstances, and for which target populations" (p. 1006).

Methodology

This study used a qualitative methodology to collect data. Study data was collected using two major data sources: key informant interviews and key document analysis. Key informant interviews (see Appendix B) were employed as the main data collection tool. These interviews were coded and the themes that emerged from the coding were compared for verification purposes to themes found in key government documents related to accountability within CCACs and to the researcher's thoughts as
recorded both in a personal journal and in e-mails exchanged throughout the process with the thesis advisor.

**Delimitations**

The study was delimited to four executive directors of Ontario CCACs who had been employed as executive directors during the three years when CCACs were subject to government-driven accountability reforms. The documents analyzed were those key documents that informed or directed the executive directors in their implementation of the CCAC accountability reforms. Data were collected and analyzed over a two month period from the end of April to early June 2004.

**Limitations**

Time and travel constraints limited the sample size of this study. Additional key informant interviews could have strengthened the breadth of the insights generated by this study. It can be argued that by purposefully selecting participants the perspectives generated may have been limited, but this approach was essential to the purpose of the study. Due to the specificity of the study, the applicability of the insights from this study to the broader healthcare sector that has not yet undergone accountability reforms is limited. Similarly, the specific results of this study are situational and would be of limited use to jurisdictions outside of Ontario. The small number of subjects provided a more limited sampling and restricted the potential breadth of the results, but it did allow for an opportunity to look at the interview results in more depth.

The executive directors were limited in the amount of time they were willing to devote to this study. While generous with their time for the interviews, all the executive
directors declined the offer to review their interview transcripts, which would have added further methodological rigor to the study process.

**Assumptions**

It was assumed that the executive directors would be willing participants in the study. It was further assumed that they would provide honest and reflective answers to the interview questions with the intent of informing the study, and that the data they provided would be rich enough to inform our understanding of accountability. The sample size was limited at the suggestion of the proposal review committee under the assumption that it would be sufficient and that, once analyzed, divergent data would not emerge from additional interviews (Ritchie, Lewis, & Elam, 2003).

Although the specific results of this study are not necessarily transferable, it is assumed that theoretical insights will be useful to settings outside of this study and thus be of interest to the broader healthcare sector, to other sectors such as the education sector, and to jurisdictions outside of Ontario.

**Significance**

The outcomes of this study inform the government, the executive directors, and boards of CCACs, regarding how reforms changed accountability relationships as perceived by the executive directors. The public benefits from this study through the education it provides on accountability and how its principles were applied to a specific sector of the health care system. The knowledge generated by this study also may be of use to governments, managers, and the public when contemplating future reforms of both the healthcare sector and other sectors with similar governance structures and accountability issues to healthcare such as the education sector. The lessons learned in the
healthcare sector related to accountability reforms may be informative to the education sector as it struggles with reforms aimed at increasing accountability within educational organizations. Researchers in all areas of governance and policy development may also use the findings of this study to further their efforts in understanding accountability issues and reforms in their area of interest.

Document Overview

In the following chapter (Chapter Two) a review of the literature regarding accountability is provided. Chapter Two also reviews definitions of accountability, accountability’s links to the New Public Management philosophy, healthcare reforms and accountability, accountability’s links to power, various approaches to accountability including devolution, and concludes with a review of citizen involvement in accountability.

Chapter Three gives an overview of the methodology chosen for this study. It begins with a rationale for the chosen methodology followed by a discussion of the research design and participant selection. It then reviews the procedures used for data collection, document analysis, and data analysis. Chapter Three concludes with a discussion of the methodological parameters of the study, trustworthiness and credibility of the results, researcher bias, and ethical considerations.

Chapter Four provides an introduction to the participants in this study and gives an overview of the findings. Results of the study are discussed as relevant to both the process of the reforms and the outcomes of the reforms. The findings of the study are organized as they relate to definitions of accountability and as they relate to Kuchapski’s
(2002) three principles of transparency, disclosure, and redress. An overview of the key document findings is also provided in Chapter Four.

Chapter Five provides a summary of the important findings for this study. A discussion of the findings is then embedded in the literature. The implications of the study findings are further considered as they relate to theory, practice, and research. Chapter Five concludes this paper with some reflections from the researcher and a final summary of the study.
CHAPTER TWO: LITERATURE REVIEW

This chapter reviews literature regarding accountability in the healthcare sector in Canada along with additional literature from some non-healthcare and non-Canadian sectors in order to expand on key points. This chapter reviews definitions of accountability, health care reforms in Ontario, the influence of the New Public Management approach, accountability’s links to power, various approaches to accountability including the specific approach taken by Ontario, and the role of citizens in public sector accountability.

Materials were obtained from a wide variety of sources including a Medline search using the search parameters of Canada, accountability, social responsibility, social control policies, governing boards, health care reform, and health policy. An additional Web of Science search was conducted using the same parameters to ensure all relevant materials were captured. The services of a librarian from McMaster University skilled in database searches were used to assist in the search.

Defining Accountability

The definitions of accountability are numerous, but share common aspects. McCandless (1993) defined accountability from an auditor’s perspective as “the obligation to answer publicly for the discharge of responsibilities that affect the public in important ways. The obligation to act is the responsibility, and the obligation to report is accountability” (p. 14). He further advised, “Management should also make visible its rationale for decision-making. It can be argued that disclosure of the decisions and the rationale for them are the essence of accountability” (p. 14). In further works, he defines accountability and responsibility: “Responsibility is an obligation to act, while
accountability is the obligation to answer for an action” (McCandless & Wright, 1993, p. 111). McCandless’ work, although written for auditors, covers most of the essential aspects of accountability definitions found in the health care literature (Davidson, 1999; Flood et al., 2004; Penney, 2002). The Queens Health Policy Research Unit (1999) in their overview on accountability provides the following definition that is based on a review of all the accountability concepts they found in the literature:

Set within an implicit ethical context, accountability is the obligation to answer to an authority which conferred a responsibility, together with the resources and delegated authority to achieve it, with the understanding that inadequate performance will result in corrective intervention. (p.16)

The definition of accountability developed jointly by the MOHLTC and the OACCAC that is most pertinent to this thesis is found in a position paper published by OACCAC (2001). It states:

Accountability is the requirement to explain and accept responsibility for carrying out a mandate in light of agreed upon expectations. It is the obligation to answer for results and the manner in which responsibilities are discharged. Accountability cannot be delegated. (p. 2)

**Accountability and the New Public Management**

Much of the recent focus on accountability is situated in a philosophy of New Public Management. Hood (1995) described New Public Management as “a model that reverses the separation of public and private sector management practices and places emphasis on accountability for results rather than process accountability” (Cited in Penney, 2002, p. 19).
Penney classified governmental approaches to accountability reforms as being either procedural or consequential. She describes the procedural approach as being more traditional and based on management procedures, practices and systems, and compliance to rules and regulations. The consequential approach emphasizes results, outcomes, and impacts. Noble (1990) supports the trend towards consequential accountability for hospital CEOs in his work describing the new accountabilities and performance outcomes for hospital CEOs. Penny goes as far to expand the consequential approach into a value-for-money concept.

Thomas (1997) further explores the movement towards consequential accountability as a subset of the ongoing government reform movement called New Public Management. In this approach to government reform, a reduction in the size and scope of government is favored along with decentralization of authority and a sharing of responsibility with the private sector. Governments under New Public Management favor increasing privatization and an expectation that results will be shown based on published performance measures and customer satisfaction standards. Entrepreneurship and risk-taking are valued. Contracting out of services to the private sector and the separation of the purchaser role from the provider role, such as occurred within the CCAC sector, the move to annual business plans, and standardized outcome measures are hallmarks of the New Public Management approach within healthcare.

As suggested by Thomas (1997), the motivation behind the move to New Public Management is to reverse declining public confidence in the government and public service. Hood (1995) described public servants operating under traditional public sector management as “…budget maximizing bureaucrats whose activities need to be closely
costed and evaluated” (Cited in Penney, 2002, p. 19). Under New Public Management, a greater trust is placed in private sector methods and markets. An important element and method advocated for achieving improved public confidence within the New Public Management approach is the move away from process-based accountability to results-based accountability. Clearly, the New Public Management philosophy has greatly influenced many of the accountability reforms put in place over the past ten years in Ontario.

**Accountability and Healthcare Reform**

Healthcare reform has been a driving force behind most government actions towards healthcare over the last decade. These reforms are not unique and have taken place across the country. In most provinces except Ontario, healthcare reform took the form of regionalization. In all provinces it was seen as an essential strategy to deal with funding cuts (Penney, 2002). Much of the impetus for this reform has stemmed from a growing concern that the existing system of healthcare delivery in Canada was inefficient and unsustainable (Flood et al., 2004).

In February of 1999 the Social Union Framework Agreement was established through an agreement between Ottawa and the provinces. It marked an evolution from a decentralized federal model of social programs to a model of collaborative federalism whereby federal and provincial governments work collaboratively to attain policy goals. It was felt that this approach would strengthen intergovernmental co-operation in a number of areas including healthcare (Wilson, 2000).

The Health Accord was developed at the same time as the Social Union Framework Agreement with the specific purpose of ensuring that the provinces would
adhere to the five principles of the Canada Health Act: universality, accessibility, portability, comprehensiveness, and public administration. The strength of Health Accord was that it allowed for a national health program with a common set of principles while at the same time protecting the jurisdictional autonomy of the provinces. The drawback was that it relied upon negotiations between the elected officials and effectively excludes the public from any debate (Wilson, 2000).

**Accountability’s Link to Power**

The why of accountability seems to be self-evident, and yet it produces many varied responses in the literature. Johnson (2001) suggests that accountability mechanisms are not only aimed at preventing the abuse of power, but also serve to enhance responsiveness, improve administrative efficiency, and increase transparency of decision-making.

Davidson (1999) presents the notion that healthcare reform is aimed at reducing the power and authority of ministry bureaucrats, health care managers, and especially health care professionals. He states that a key policy objective of healthcare reform in British Columbia is to improve accountability of healthcare professionals and providers by strengthening democratic accountability at the community level. This reduces the opportunity for bureaucrats to negotiate accountability agreements directly with the provider and professionals in a way that leaves the public out of the debate.

Day & Klein (1987) as cited by Penney (2002) draw a link between accountability and power differently when they describe being unaccountable as being all-powerful. This view speaks to the “off the rails” label that is often applied to organizations or leaders that are both lacking in accountability and are arrogant in their beliefs that
accountability is not required of them in the same manner as it is expected of them by others. These organizations or leaders are also often described as "a law unto themselves," and hence the analogy with being all-powerful or seemingly above the law.

Flood et al. (2004) argue that in order to close the "accountability gap" in healthcare, governments have chosen to devolve responsibility and authority for decision-making from central governments to Regional Health Authorities (RHAs) while retaining policy making at the central government level. Rohal & Mulder (1993) and Lomas (1997) suggest that the motivation for the move towards devolution of decision-making powers to the local level and increased public involvement in decision-making is more closely tied to reducing the direct accountability, and therefore blame, to the government for decisions made, particularly in times of fiscal restraints where cutbacks are required. Flood et al. (2004) coined this action by the central government "Devolution of Misery" (p. 22). Using the logic of Day & Klein (1987) and others, the government in this scenario retains the power to set policies, yet devolves both the accountability and the blame for unpopular decisions resulting from those policies to the local level.

**Approaches to Accountability**

The Queens Health Policy Research Unit (QHPRU, 1999) categorized accountability into two tiers: internal and external. Internal accountability was described as being within a level of government or organization and described as a hierarchical relationship with those at the top holding the power. External accountability was described as being demonstrated through the ways in which organizations or levels relate to external groups. Emphasis was placed on the need for external accountability through relationships that were classified as political (reporting to or having the support of elected
officials), financial (subject to audits), constitutional/legal (where redress can be sought through the courts), managerial (performance is measured by the attainment of policy objectives), ethical (based on shared beliefs about justice and equity), and clinical (whereby the professional is answerable only to their professional body). Many of these relationships were formal and some overtly articulated. The democratic relationship was more implicit. In the democratic relationship to accountability, the provincial government is elected by citizens and accountable to the public through the legislature. The legislature delegates accountability for publicly funded healthcare to the Minister of Health, and the Minister in turn holds the bureaucrats and provincially funded healthcare services agencies accountable through various performance agreements, such as business plans and memorandums of understanding.

Thomas (1997) sees the categorization of approaches or dimensions of accountability differently. He theorizes that the recent discourse on accountability in healthcare has focused largely on what he calls the administrative dimension. In this dimension, there exists what Thomas feels is a preoccupation with hierarchical relationships and reporting on the products or outcomes of health services. Thomas sets out in his work a number of other dimensions to accountability in healthcare including the political dimension, the constitutional dimension, the legal dimension, and the professional dimension. The professional dimension, according to Thomas, appears focused on professional norms and behaviors, and the quality of services delivered. The political dimension is focused on responsiveness to stakeholders, election platforms, and commitments to voters; the constitutional dimension is more complex and involves the subsets of governance, regionalization, and citizen engagement. The preoccupation with
outcomes, as referred to in Thomas' administrative dimension, ties in with both New Public Management and Ontario's business plan approach to accountability with the emphasis it places on standardized reporting requirements related to both finance and organizational performance.

Daniels & Sabin (1998) advocate the use of four conditions as part of an accountability relationship for a reasonable approach to decision-making in health care. The four conditions are (a) publicity, wherein the public has access to the decisions and rationales; (b) relevance, wherein rationales rest on evidence, reasons, and principles that are based on the common good; (c) appeals, wherein there is a mechanism for dispute resolution; and (d) enforcement, wherein there is either public or voluntary regulation of the process to ensure that the first three conditions are met. This approach ties in nicely with the three principles of the framework for accountability in education (transparency, disclosure, and redress) developed by Kuchapski (2002).

Kuchapski (2002) developed a framework centered around three principles of accountability: transparency, disclosure, and redress. She traced these principles through western democracy and linked accountability features back to the principles. She also developed four elements of accountability: communication, planning, evaluation, and governance. Kuchapski refers to the principle of transparency as the openness and inclusiveness of decision-making processes, governance structures, and operations. Transparency in decision-making allows for understanding or participation by those from outside the organization in decision-making. For effective citizen participation to occur, transparency also requires understandability of the information.
Disclosure refers to the timely release of information or data that relates to an organization’s success or failure in achieving its mandates (Kuchapski, 2002). This may include data that are used in the decision-making process such as financial forecasts. According to Kuchapski, disclosed information is always partial, never neutral, and often only a snapshot view of an organization’s performance rendered after the fact. Disclosed information can therefore be quite limited in its ability to predict future performance of an organization.

Redress refers to opportunities to resolve disputes or conflicts. It ensures that an organization remains responsive to the needs or wishes of its stakeholders. Opportunities for redress may include a review of a decision through an appeals process that would allow that decision to be overturned if it was found to be supported by the use of incorrect processes or data. Redress can also be expressed in the form or sanctions or rewards based on an organization’s success in meeting agreed upon targets.

The various processes that ensure accountability in a given sector are specific to the type of accountability relationship they support. The stakeholders in a given accountability relationship define the type of relationship and the processes to be used. For example, accountability relationships between the public and healthcare providers are clinical and ethical in nature. Accountability is achieved through the expectations set out by the various licensing bodies that govern these professions. The accountability relationship between the province and the public is political. A governing party is elected by the public and implements the accountability approach or processes specific to the ideology of that government as articulated in their campaign platform. In Ontario’s case, the Conservative Party governed the province throughout the duration of accountability
reforms in long term care and Ontario’s approach to accountability naturally reflects the ideological approach to accountability particular to that political party. In the case of the Conservative Party, this ideological approach was grounded in the New Public Management philosophy and thereby resulted in the implementation of CCAC accountability reforms such as Business Plans and Memoranda of Understanding.

Devolution and Accountability Reforms

Most provinces in Canada, with the exception of Ontario, chose to devolve authority for healthcare delivery and decision-making regarding funding allocations to RHAs. Flood et al. (2004) see devolution as a first step to accountability reform. They argue that the accountability debate needs to be refocused from funding to governance and should include incentives that reward gains in healthcare outcomes as opposed to volumes of services delivered regardless of their effectiveness.

Devolving difficult decisions regarding resource allocation is described by Lomas (1997) as an attempt by governments to share responsibility in the eyes of the public for the provision of care in times of fiscal restraint. RHAs are responsible for defining local needs and providing services to meet those needs. These RHAs have a dual accountability relationship: to the public for quality service delivery, and to government for the appropriate use of funding (Penney, 2002).

Ontario’s Approach to Accountability

The Ontario approach to accountability has been described in the literature as “diffused and confused” (Flood et al., 2004, p.11). In Ontario, the RHA route has been rejected in favor of accountability frameworks, business plans, balanced scorecards, and special purpose legislation. The previous hallmark of the Ontario approach was the
requirement for all ministries that annual business plans be produced and published (QHPRU, 1999). Bill 8 (Commitment to the Future of Medicare Act, 2004), now passed into law, has created additional common accountability expectations for all hospitals, CCACs, long-term care facilities, and independent health facilities in Ontario.

The objective of Bill 8, according to the MOHLTC, is to ensure that the healthcare system in Ontario is consumer-centered, is accountable to the people, and is focused on outcomes. The overall goal is to ensure the sustainability of Ontario’s healthcare system. In a press release regarding Bill 8, the Minister of Health, George Smitherman, spoke of fostering better integration, restricting the role of hospitals, and expanding the role of community-based services. The mechanisms used to accomplish this are as yet undefined. Key to Bill 8 is the establishment of accountability agreements that are to be negotiated between all public sector healthcare boards and the Minister of Health (Smitherman, 2004). Strong objections regarding many aspects of this Bill were lodged by the hospital sector including the 60-day time limit placed on the negotiation phase for these agreements, after which the government can enforce their version of the proposed agreement. Also of great concern to the hospitals was the proposed dual accountability to both the organization’s board and the MOHLTC faced by CEOs and executive directors of their affected healthcare organizations. This situation already exists for executive directors of CCACs under the Community Care Access Center Corporations Act of 2001 and has been an area of ongoing concern within the sector. Upon final reading of the Bill, the Ontario Hospital Association (OHA) had managed to lobby successfully for an amendment regarding the negotiation phase which extended the
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time limit to 90 days; however, they were not successful in removing dual accountability to both boards and the MOHLTC for CEOs and executive directors.

The government of Ontario has also recently announced legislation, not yet passed into law, which further strengthens the New Public Management philosophy in Ontario’s approach to public-sector accountability. Bill 18, An Act Respecting the Provincial Auditor, will give the government enhanced abilities to conduct specific value-for-money audits on various public-sector institutions including hospitals. The government describes this move as a key means of securing increased accountability of the public sector. The hospitals, however, argue this will result in “…increased governmental intervention and subsequent control over the activities of hospitals, and a corresponding loss of hospital autonomy and community governance” (Scott, Hearn & Wakulowsky, 2004, p.1)

The Ontario government’s business plan approach is another example of New Public Management influences in Ontario’s approach to accountability in the public sector. The business plan places an emphasis on organizational vision, definition of core business, strategic directions, performance measures and outcomes, and budget projections. The MOHLTC is seen as one of the more aggressive ministries in their approach to accountability through the use of both standard business plans and accountability frameworks. QHPRU (1999) suggested that the Ministry is focusing its efforts more closely on the work of CCACs and other community agencies and applying less rigorous scrutiny to the hospital sector. This argument may no longer hold water with the introduction of Bills 8 and 18. Flood et al.’s (2004) criticism remains valid that Ontario’s current individual institution business plan approach results in little attention
being paid to the intersecting lines of accountability between organizations and across sectors leaving Ontario mired in its healthcare silos.

One emerging tool that is advocated for the demonstration of accountability by public sector organizations and is in line with the business plan or outcomes focused approach to accountability is the Balanced Score Card developed by Kaplan & Norton (2001). This tool has been further refined in recent years in order to apply more closely to the healthcare sector by Ball, Harper, Moore, & Verlaan-Cole (2004). This approach to accountability in healthcare is based on the development of an ongoing constructive organizational conversation where the qualities of accountability are defined as respect, trust, inquiry, moderation, curiosity, and mutuality. The Balanced Score Card seeks to blend accountability structures, mechanisms, and practices with increased individual and team empowerment. It consists of four quadrants that are measured on an ongoing basis using mutually agreed upon methodologies for measurement. The four quadrants are (a) financial (revenue, costs, efficiency/effectiveness, and leveraged use of resources); (b) customer (health outcomes, customer satisfaction, quality of care, and perceived value); (c) organizational processes (core processes, support processes, integrated service design, and accountability processes); and (d) learning and growth (strategic competencies of management and staff, information capital, and alignment and culture) (Harper & Ball, 2002).

The Balanced Score Card is then published yearly as part of the organizational dialogue with its citizenry. This approach of demonstrating results based on publicly shared performance measures is a key element of the New Public Management
movement. Kuchapski (2002) would argue that this is not a genuine dialogue but rather one-way flow of information from elites to the citizens.

### Citizen Involvement in Accountability

A common theme regarding the basis for the accountability movement is its essential ties to democratic political systems. The Lambert Commission (1979) found that accountability is a working principle of our parliamentary system of government and a process whose effective functioning was essential to democratic government. These views are echoed by the Queens Health Policy Research Unit’s Inventory and Analysis of Accountability Practices in the Canadian Health System (QHPRU, 1999) and are further supported by Kuchapski’s (2001) doctoral research aimed to re-conceptualize accountability for education in which she identifies accountability as a fundamental principle of democracy. As a principle of democracy, accountability requires that politicians be held accountable to citizens, and that bureaucrats be held accountable to politicians, or to the government.

Much of the literature reviewed touched on the role of citizens in the development of good accountability mechanisms within today’s healthcare governance and delivery systems. Penney (2002) places this approach in the paradigm of participatory democracy. She argues that this paradigm effectively shifts the focus of public organizations to the purpose of participation, representation, and incorporation of the view of citizens and away from responding to superiors or special interest groups. Davidson (1999) describes how the focus on reforms in British Columbia started out in this vein but quickly changed direction away from citizen empowerment and toward a policy focusing on accountability to the Ministry of Health. He describes this as a retreat from political
accountability to the community and an advance toward managerial accountability to the government. It can be argued that the identical approach has been taken here in Ontario.

The original idea behind citizen involvement was that citizen involvement would increase the transparency of processes, allow for full disclosure of actions, and provide the public with the opportunity to seek reasons for the action and redress for undesirable outcomes (Davidson, 1999). This description fits nicely with the framework for accountability in education as outlined by Kuchapski (2002, 2001). In Kuchapski’s framework, three key principles of accountability are articulated: transparency of process, disclosure of information, and redress or responsiveness to the will of the people. Kuchapski also supports the argument put forward by Penney (2002) and others in the health care literature that accountability is a fundamental principle of democratic society.

How the will of the people is accurately reflected in the decisions of governing boards is a subject of much debate in the literature. For example, Ableson and Lomas (1996) found that randomly selected citizen respondents in their study were less interested in involvement in specific types of decisions with the exceptions of planning and priority setting. They were also the least willing group to take responsibility for decision-making, preferring instead to leave responsibility for decision-making in the hands of elected officials, experts, and the provincial government. Flood et al. (2004) argue that health care governance structures must have representatives that are seen to have real authority and legitimacy in the eyes of the public and are not seen as government lap-dogs. Similarly, Lomas, Veenstra, & Woods (1997) found in their series of papers on devolving authority for health care that lay people may be competent in helping to restructure the system; however, professionals are required to support their
thinking and add to their knowledge bases. Frankish, Kwan Ratner, Higgins, & Larsen (2002) expand on this thinking regarding a more limited role for lay persons in decision-making on community-based boards of governance such as RHAs with their statement that “there is little empirical evidence that they make better decisions (and thus produce better health outcomes), allocate resources more appropriately, or use resources more efficiently than did the authorities that existed before their creation” (p. 1476). Frankish et al. also point out that few citizens can afford to donate the necessary time and resources to participate at the governance level.

Lomas et al. (1997) also argue that there exists a strong need for citizen involvement in governing boards due to the perceived feelings of accountability to, and representation of, local citizens by board members. Board members in this study felt accountable to and representative of all the citizens in their jurisdiction and their declared intention was to represent the interests of the local citizens unambiguously in making the healthcare system more effective and efficient. Lomas et al. argue that strong feelings of lay board members are essential to counteract the structural influences in place leading many board members to favor the interests of provincial governments and providers over those of the citizens.

There were considerable challenges associated with the goal of citizen representation discussed in the literature. The first challenge relates to how that representation is obtained. Descriptive representation is one approach often used by citizen groups when selecting representatives. In this approach, demographic characteristics such as age, gender, and ethnicity are important. Frankish et al. (2002) argue that this approach detracts from an emphasis on accountability of the
representatives to their constituents. The preferred approach according to Frankish et al. is related to whom the representatives look after and whose interests they pursue rather than what they look like. They also further caution that those who tend to be most vocal or that volunteer may be the least representative of the community.

Representation based on shared experiences, where needs are assessed actively by the representatives, was found to enhance the legitimacy of representation (Phillips, 1995). Lomas et al. (1997) supported the idea that lay representatives, in order to be accountable, must move between representing the broader community, and acting for those disadvantaged groups that rarely have a voice in decision-making such as the poor and mentally ill. They also cautioned that unless board elections attract large voter turnout, electing those more accountable to minority interest groups than those more accountable to the community at large might fragment the board member’s accountability.

The accountability of elected representatives versus appointed representatives was also hotly debated in the literature and not everyone agrees on its merits (Frankish et al. 2002). Davidson (1999) supported the election of board members as a method of increasing legitimacy of the board members in the eyes of the public and of enhancing their accountability to local citizenry. Frankish et al. state that the advantage of appointing board members is that it ensures a range of knowledge, skills, and viewpoints. They caution that the downside to appointed board member is the perception that decisions made by appointees will coincide with the political interests of the government and not necessarily the local citizenry.
Daniels & Sabin (1998) advise that the ultimate moral authority for making health care decisions should rest with the public, and they caution that consumer participation is neither a necessary or sufficient condition for ensuring accountability for decisions made. They focus more on the process of decision-making as being the source of good accountability rather than the make-up of the decision-making body.

**Summary**

A review of the Canadian literature in healthcare reveals that the available research on accountability is scant. MacDonald & Shortt (1999) also note that the quality of the published material is highly variable. The definition of accountability developed jointly by the MOHLTC and OACCAC was most pertinent to this thesis.

Much of the impetus behind accountability reforms in healthcare stemmed from a growing concern that the existing system of healthcare delivery in Canada was inefficient and unsustainable. The literature revealed that Ontario’s approach to accountability naturally reflected the ideological approach to accountability grounded in the New Public Management philosophy. New Public Management was described by Penney (2002) as a model that reverses the separation of public and private sector management practices and places emphasis on accountability for results rather than process accountability. In this approach to government reform, a reduction in the size and scope of government is favored along with decentralization of authority and a sharing of responsibility with the private sector. As well, a greater trust is placed in private sector methods and markets.

Flood et al. (2004) argued that in order to close the “accountability gap” in healthcare, governments have chosen to devolve responsibility and authority for decision-making from central governments to RHAs while retaining policy making at the central
government level. In Ontario, the RHA route was rejected in favor of accountability frameworks, business plans, balanced scorecards, and special purpose legislation. Flood et al. also pointed out that Ontario’s current individual institution approach to accountability results in little attention being paid to the intersecting lines of accountability between organizations and across sectors leaving Ontario mired in its healthcare silos.

Much of the literature reviewed touched on the role of citizens in the development of good accountability mechanisms within today’s healthcare governance and delivery systems. The arguments supporting citizen involvement were that citizen involvement would increase the transparency of processes, allow for full disclosure of actions, and provide the public with the opportunity to seek reasons for the action and redress for undesirable outcomes. Some authors focused more on the process of decision-making as being the source of good accountability rather than the make-up of the decision-making body.

Kuchapski’s (2001) framework centered on three principles of accountability: transparency, disclosure, and redress. She traced these principles through western democracy and linked accountability features back to the principles. Kuchapski referred to the principle of transparency as the openness and inclusiveness of decision-making processes, governance structures, and operations. Disclosure was described as the timely release of information or data that relates to an organization’s success or failure in achieving its mandates. Redress was addressed through opportunities to resolve disputes or conflicts and ensuring that an organization remains responsive to the needs or wishes
of its stakeholders. The three principles of this framework were used to frame the analysis of the findings for this study.
CHAPTER THREE: METHODOLOGY AND PROCEDURES

The purpose of this study was to investigate executive directors’ perceptions regarding the CCAC reforms undertaken by the government in order to improve accountability within the sector. These reforms were initiated in the year 2001 when the CCAC Act was passed and continued into early 2004 when the study took place. Because of a particular interest in the perception of the executive directors who had experienced the reforms, a qualitative methodology was chosen over the quantitative approach, which is a more familiar approach to both the healthcare sector and this researcher.

This chapter provides an overview of the methodology chosen for this thesis. It begins with the rationale for the chosen methodology followed by a discussion of the research design and participant selection. It then reviews the procedures used for data collection, document analysis, and data analysis. The chapter concludes with a discussion of the methodological parameters of the study, authenticity of the results, and ethical considerations.

Rationale for Methodology

A qualitative research design guided this research. This design was selected because qualitative methods are context specific and appreciate the sequencing of events. Qualitative methods also provided a more flexible approach to the study question. As Rist (2001) argues, a ground-level view of policy implementation (in this case the CCAC reforms) is best achieved through qualitative research. And finally, a qualitative approach was more suitable to this study than a quantitative approach where validity could not be demonstrated with such a small sample size.
The qualitative approach to research is described by Ratcliff (2003) as naturalistic. By naturalistic Ratcliff means the researcher does not attempt to control events and the research is holistic in its orientation. Its purpose is to provide descriptions of phenomenon and events, and to uncover the meaning behind actions. As Berg (2001) states, “Qualitative research thus refers to the meanings, concepts, definitions, characteristics, metaphors, symbols, and descriptions of things” (p. 2). Its strengths lie in its depth and detail, the openness with which it is conducted, and its attempts to avoid prejudgments. Because it is directed at uncovering the meanings behind actions, it tends to be sensitive to the context. The qualitative research design is flexible and dynamic, and the qualitative researcher is empathetic to the research subjects (Berg).

The approach used in this study is descriptive and allows the researcher to view the experiences and events that occurred through the eyes of executive directors who lived through the accountability reforms mandated by the provincial government. It allows for a composite portrait of this group to be drawn that reflects their interpretations and perceptions of events rather than that of the researcher. It also places importance on the participants’ frame of reference rather than the researcher’s. In general, the qualitative approach was well suited to this study because its strengths lie in exploring complex issues and its approach allows the participants to reflect on a process such as the CCAC reform process that occurred over time (Snape & Spencer, 2003).

Research Design

In this study, data were collected using two major data sources: key informant interviews and key document analysis. Key informant interviews were employed as the main data collection tool. These interviews were coded and the themes that emerged from
the coding were compared for verification purposes to themes found in key government documents related to accountability within CCACs.

The literature review informed the development of specific questions to explore with the study participants. It also guided the data analysis. Principles of accountability identified in the literature were used to assist in framing the research findings and analysis.

**Participant Selection**

The method of participant selection used for this study was a combination of purposeful selection and convenience sampling. For convenience purposes, sampling was limited to the regional areas of South Central, South West and Central East Ontario due to their proximity to the researcher. Participants were selected purposefully on the basis of their positions as executive directors of CCACs that have undergone accountability reforms during their tenure as executive directors. They were purposefully rather than randomly selected because they were recognized by the researcher as having a good understanding of the impact governance changes have had on the day-to-day operations of the CCACs. It was believed that the EDs selected for this study would provide unique insights into the extent to which recent reforms served to increase (or decrease) accountability in the CCACs.

There were fifteen executive directors whose CCACs were within the geographic parameters of this study. Eligible participants were limited to those who occupied the position of executive director for the entire three-year reform period and who were located within the geographic parameters. Seven executive directors met the eligibility criteria for inclusion in the study. In order to control for the possibility of gender bias
(Cresswell, 1998; Gilchrist & Williams, 1999), an equal number of male and female executive directors were selected. As well, the researcher’s own executive director was excluded as an eligible participant to reduce over-familiarity and the potential that this would affect both the quality of her responses and the researcher’s ability to be objective in the interpretation of results. The four participants selected were those that best met the selection criteria and had played a visible role within the CCAC community on various accountability reform initiatives.

**Interviews**

Interviewing as a research tool is well established in both quantitative and qualitative research. The qualitative approach looks at the interview as a negotiated interaction between the participant and the interviewer leading to a shared creation of the results. The semi-structured or guided interview approach was used in this research. In addition, open-ended interviews were used to allow for greater flexibility. When exploring policy issues in research, the qualitative approach has inherent strengths in that it allows the interviewer to follow the respondent into an exploration of unexpected dimensions that arise during the interview. These dimensions would be lost in a more structured quantitative approach. It is argued that a qualitative approach is likely to produce a more truthful account. The argument put forward by Denzin (cited in Dinwall & Murphy, 2000, p. 85) is that a more intimate and comfortable approach to interviewing leads to greater openness and truthfulness.

The personal interview approach was chosen in order to extract in-depth information and to ensure greater privacy to the participants. The focus group approach was discarded due to the potential for a lack of confidentiality for participants and the
inhibiting nature of focus groups that influences responses given in front of peers who may have somewhat competitive relationships (Neuman, 2000). Key informant interviews were used in this study due to their three main strengths. They allowed the researcher to gather information efficiently, to gain access to information otherwise unavailable, and to gain a particular understanding or interpretation of cultural information unique to executive directors of CCACs (Crabtree & Miller 1999).

According to Neuman (2000), studying elites is often difficult as they are difficult for the average researcher to access. As well, elites have limited time that they are willing to grant researchers, and they have great expectations that the researcher will be well prepared in the subject area and use their time wisely. This placed an increased importance on ensuring that the interview questions were well worded and insightful. It was important for the interviewees to feel that their time was well spent and that the research being conducted was worthy of their time and attention.

The researcher’s own executive director was used to field test the proposed interview questions (Gilchrist & Williams, 1999) in order to gain access to her insights as to the appropriateness of the questions given the goals of the study and the need to use the executive directors’ time wisely. This also provided a safe environment in which to practice and test the interview processes. As a result of the field test, some of the questions were reordered to provide a better flow to the interview and a few questions were re-worded to allow for greater clarity of understanding; however, no significant changes to the questions were required.

A series of questions (see Appendix B) were administered to each informant as part of a semi-structured interview process. Open-ended questions were used in order to
gain a better understanding of the participant’s views and knowledge of the subject (Neuman, 2000). Interviews were planned to be approximately one hour in length. All interviews were tape-recorded, with permission. Due to the busy schedule of executive directors and the need to make efficient use of the researcher’s time with them, the questions were provided to the executive directors a week ahead of the scheduled interview date in order that they may be prepared, have an opportunity to seek clarification where necessary, and have done some personal reflection on the subject prior to the interview.

Asking the respondents identical questions does not guarantee that all will hear and interpret these questions in the same fashion (Murphy & Dingwall, 2003). The use of clarifying or exploring supplemental questions assisted in the creation of a shared understanding between the researcher and the participants. The goal was to arrive at an equivalence of meaning for the entire interview rather than identical wording. It is also possible to have many different interpretations of the same event. In this study, four executive directors were interviewed regarding their perceptions of the same reform process for all CCACs. In this way, it was possible to examine this event from a number of different perspectives allowing the researcher to both identify and validate common themes that emerged and to isolate individual perceptions that were not reported by all participants (Crabtree & Miller, 1999).

It is important to stress that interviews by their very nature are both socially and contextually constrained events. The informants remain aware throughout the process of how their responses could be judged by both researcher and others. The qualitative
The approach used in this study allowed me as a researcher to explore the way in which the respondents define their experiences related to CCAC reforms.

**Document Analysis**

The use of documents to supplement interviewing is well established in the qualitative research literature. Document analysis is seen as an unobtrusive and non-reactive method of objectively gathering data on a particular subject area. It can provide valuable evidence regarding a person’s or organization’s intent and reveal what an organization or person is required to do in order to demonstrate legitimacy (Murphy & Dingwall, 2003). It is also a valuable source for fact checking and for authentication of results drawn from interviews or observations. It is important that the decision to gather and analyze documents is linked to the research questions developed in the conceptual framework of the study (Marshall & Rossman, 1995).

In this study, key document analysis was conducted in order to determine and authenticate critical elements of the issues and challenges facing executive directors who were charged with implementing the many reforms associated with strengthening accountability in CCACs. The documents chosen for this analysis were those documents that were intended by the MOHLTC to direct or guide the executive directors in the policy implementation phase of CCAC reforms. These documents included the CCAC Business Plan Template (see Appendix C) and the Memorandum of Understanding for CCACs (see Appendix D). These documents are both available to the general public.

**Personal Journal**

In order to achieve greater trustworthiness of the results (Gilchrist & Williams, 1999), the researcher supplemented tape recordings with field notes taken during the
interview process and personal reflective notes and e-mail transcripts between the researcher and the thesis advisor recorded on an ongoing basis throughout the thesis development. The personal reflective notes and field notes were referred to in the data analysis phase in order to enhance credibility of results. Field notes and personal reflections provide a valuable source of triangulation for any conclusions drawn from the interview phase or key document analysis (Cresswell, 1998)

Data Analysis

Coding of the interview transcripts and key documents was conducted using color coded highlighters (Coffey & Atkinson, 1996). The first round of coding looked for the three a priori codes of transparency, disclosure, and redress, based on Kuchapski’s (2002) accountability framework. Subsequent coding looked for sub themes, or emergent codes that supplemented the main framework of analysis. Although the formal coding and analysis of the interviews was conducted after the interview process, the informal analysis occurred from the start of the first interview. Field notes were taken throughout each interview as a supplement to the tape recording process and to facilitate the start of informal coding. This note taking regarding key concepts or issues that arose allowed the researcher to flag topics or comments that merited further exploration through the supplemental questions to that informant or through subsequent interviews with other informants.

Key documents published by the MOHLTC that are for use by executive directors in the daily application of the reform processes advocated by the MOHLTC such as the Business Plan Template (see Appendix C) and the Memorandum of Understanding for CCACs (see Appendix D) were also used as part of the data analysis. These key
documents provided an additional source of verification for the results that emerged (Cresswell, 1998).

Trustworthiness and Credibility of the Results

Two types of data were analyzed, (a) key informant interviews and (b) key documents. The key documents provided one source of triangulation (Cresswell, 1998; Lincoln & Guba, 1995) that were used to further strengthen the trustworthiness of the results. The extent to which the EDs provided common or consistent responses to the questions also suggested trustworthiness of the results. Review of the researcher notes kept through the data collection phase provided another source of triangulation, which further supported the trustworthiness of the data. Trustworthiness was further strengthened by the external review of the proposal to ensure that the design of the study was defensible and by the use of a published theoretical framework with which to analyze the data. Lastly, an audit trail of recordings, notes, and other documents allowed for independent tracking of this work to ensure the results are trustworthy. In the analysis phase, this work was also reviewed with the thesis advisor, which provided an additional source of validation to both the results and the conclusions drawn from those results (Cresswell, 1998).

Researcher Bias

Because this was a qualitative study, the researcher acted as the research instrument. Therefore, it must be assumed that the personal experiences of the researcher had some effect on the attitudes, values, and beliefs with which this thesis was approached. Furthermore, because the researcher occupied a management position in a CCAC in Southern Ontario during the accountability reforms, she had met the EDs who
participated in this study in the course of her work. This was helpful in that it provided access to the EDs that may not have been possible otherwise. It also provided a knowledge base related to accountability reforms that proved useful for assisting with data analysis. Although the researcher’s experience in CCACs added an element of credibility and trust, it may have caused some participants to be less open with her because she was not an impersonal third party. Also, because of the researcher’s personal experience with CCAC reforms, it must be acknowledged that she held preconceived ideas regarding what the findings of this research study would be. For example, the researcher noted in her journal that she expected the executive directors to be more supportive of specific government strategies aimed at strengthening CCAC accountability. To minimize bias, researcher noted her biases in her research journal, reviewed the interview transcripts with her faculty advisor, and made an effort to falsify claims made while analyzing data.

**Ethical Considerations**

Approval for this research was received from Brock University in accordance with the Principles of Ethical Research with Human Participants (FHB III: 8.2) and was subject to review by the Sub-Committee on Research with Human Participants (FHB III: 8.3). All data collected were retained and stored in a confidential manner.

All study participants were assured that their comments will remain confidential and that no one will be identified through their comments by either the researcher or by future publication of this research. This allowed the informants to speak freely to the researcher and to be free of any fear of retribution for negative comments that they may chose to make regarding the process of reform or its outcomes (Cresswell, 1998).
Elites are slow to trust researchers as any lack of discretion on the part of the researcher may cause an elite a great loss of personal privacy or public reputation (Cresswell, 1998). In order to address these concerns, all subject participants were offered a copy of their interview transcripts and allowed the opportunity to remove anything with which they were uncomfortable with or that may compromise their privacy and protection of identity. All informants chose to decline this opportunity. A follow-up interview would have been required to accomplish this task. It is possible that due to the level of trust in both the researcher as a known member of the CCAC community and in the safeguards outlined in the research design the informants felt this was not a required step and therefore not a wise investment of their time. All informants did, however, express interest in seeing a final copy of the paper.

Summary

In summary, a qualitative research methodology was chosen for this thesis because the researcher was interested in obtaining insights and opinions of experienced executive directors. Four executive directors were interviewed using semi-structured interviews. Key government documents were analyzed to provide additional insights related to accountability within CCACs. A personal journal was also employed as was the literature to guide analysis and to frame the study findings.

This chapter began with a rationale for the chosen methodology followed by a discussion of the research design and participant selection. It then reviewed the procedures used for data collection, document analysis, and data analysis. The chapter concluded with a discussion of the authenticity of the results and ethical considerations.
CHAPTER FOUR: FINDINGS

This study examined executive directors’ perceptions of accountability and the CCAC reforms undertaken by the Ontario government to improve accountability within their sector. These reforms were initiated in 2001 when CCACs were placed under the Community Care Access Centre Corporations Act. Data for this study were gathered using key informant interviews of CCAC executive directors who were in situ and leading CCACs at the time of the accountability reform process. Further data were gathered through analysis of key documents developed by the MOHLTC to guide the executive directors in the policy implementation phase of CCAC reforms. These documents included the Business Plan template for CCACs and the MOU between the MOHLTC and CCACs. A personal journal and research notes were also used to support the analysis and findings.

In this chapter executive directors’ perceptions of accountability and the CCAC accountability reforms are summarized. The findings are presented as they relate to definitions of accountability and changes in accountability relationships. The processes and outcomes of the reforms are linked to the key concepts of transparency, disclosure, and redress found in Kuchapski’s (2002) framework. The results of the key informant interviews are also used to develop additional themes regarding the processes and outcomes of the reforms.

Introduction to the Participants

The four participants in this study were executive directors of CCACs at the time of the CCAC accountability reforms. All participants had held the position of most senior executive within a CCAC since their inception in 1997. The participants were thus all
proven leaders within the sector and had strong track records. As well, the participant executive directors were not removed from the leadership role in the CCAC sector by the government when the opportunity existed in 2001 with the advent of OIC appointments for all executive directors and board members. Not all the participants were leading the same CCAC at the time of the accountability reforms that they had governed since the inception of CCACs. These transfers were either voluntary or involuntary in nature. All participants possessed a graduate degree; their specializations varied.

In order to protect the identity of the respondents in the analysis of the data collected from the key informant interviews, each respondent was assigned a letter of the alphabet. The four letters used were A, B, C, and D. These letters were randomly assigned and are used consistently to represent a specific respondent.

**Defining Accountability**

In defining accountability, most respondents used analogies related to fiscal responsibility. These analogies ranged from simply “living within your budget” to the more complex concept of “value-for-money”. One executive director used the MOHLTC definition of accountability when asked for his/her personal definition. All of the respondents were clear that fiscal responsibility was a key outcome for any accountability framework. This correlated with the balanced budget directives found in both the MOU and the business plan template for CCACs.

Beyond the realm of fiscal responsibility, all of the respondents spoke of the need to produce certain key operational outcomes as part of their accountability expectations, although they varied in their descriptions of what those specific outcomes should be. For some, the main focus was squarely on outcomes associated with the delivery of services
to clients. For others, the expected outcomes were more politically defined and less influenced by their clients or local communities. As described by respondent A,

It really comes down to ensuring that the prescribed legislation is adhered to and then there’s an audit trail that demonstrates where the organization is fulfilling all of the obligations that are defined within that legislative mandate.

All respondents were asked to reflect on the changes in the nature of the accountability relationships for CCACs that had occurred over the period from CCAC creation to the end of the accountability reforms. Respondent C summarized the changes,

Well, seven years ago I was a Chief Executive Officer whose accountability was to the board. We got the majority of our funding from government and we knew that we had to keep government happy, but we had to balance that with keeping clients happy, meeting community need and so on. Now that has shifted. The community and the client are not as involved in that accountability relationship. The focus has shifted to the relationship with the funder.

Prior to the accountability reforms, CCACs were not-for-profit corporations governed by the Corporations Act and they were free to determine their own locally developed strategic directions and operational plans to achieve those directions. As described by Respondent D, “…before it was easier because I could decide how I wanted to demonstrate my accountability.”

The CCAC business plans are evaluated by MOHLTC staff and shared with the Minister of Health. Because the Chair of the CCAC board now reports directly to the Minister of Health, the executive directors have a dual reporting relationship to their provincially appointed board of directors and to the Minister of Health. Respondent B
described one of the challenges associated with defining accountabilities in the context of this new dual reporting relationship:

It resulted in a board feeling in many respects frustrated because they were not certain as to the dual reporting relationship and what that meant in terms of their own accountability. So there was actually some confusion that was introduced around accountability...

Respondent C recognized the limitations to the definition of accountability that was used in the reforms and noted that “Accountability in the literature is much broader than that. But we have focused it down and then even muddied that.”

Two executive directors articulated their knowledge regarding the principle of transparency as part of their personal definition of accountability. Respondent D stated “…I define accountability as demonstrating transparency to the public and to the government for the money that we’re given as it relates to the patient care we deliver.” Respondent A described “…first and foremost a need for transparency around decision-making that occurs within the organization.” None of the executive directors included the principle of redress in their personal definition of accountability, yet all of them spoke later of redress issues as they described what it meant to them to be accountable.

Respondents were asked to describe what it is to be accountable from the perspective of an executive director of a CCAC. Accountability was a concept that all the key informant executive directors were familiar with and able to define. One might assume that this comfort level with accountability was a function of the strong focus on accountability in healthcare over the past several years; yet many of the executive directors felt that their personal knowledge of accountability and what it meant to be
accountable had not changed significantly over the reform period. What had changed was the manner in which their accountability was to be demonstrated or affected within their respective organizations. In other words, it was the processes of accountability that the executive directors felt had changed more significantly for them rather than the outcomes. In the past, processes for demonstrating accountability were left to the discretion of the executive directors and the locally elected board of directors. After the CCAC accountability reforms, the executive directors described accountability processes and procedures as having become much more standardized and prescriptive.

**Disclosure**

One of the questions guiding this research was whether or not the changes in structure and processes associated with the accountability reforms of CCACs increased the disclosure of information. Respondent A described that CCAC’s pre-existing process of disclosure:

> We’ve got 23 indicators that we monitor on a regular basis, that roll up to a dashboard, that then the board and our stakeholders have, to see how well we’re doing.

Respondent D also referred to the evolution of the processes of disclosure within a given CCAC:

> ...we’ve had a Balanced Scorecard approach to an organizational operating plan and strategic planning and we’ve taken the Balanced Scorecard and moved that to the Canadian Health Services Accreditation standards.

The executive directors in these two examples both felt strongly that, when creating their own local indicators, demonstrating adherence to third party national or international standards was a more meaningful process.
Respondent B expressed frustration at the timing issues associated with the MOU restrictions on disclosure. “Lots of times you are called to give a statement immediately and you’re not always able to do that when you have to go through one or two different avenues.” The inability to provide a timely response to local issues when called by the press or other key stakeholder groups was considered a limiting factor to the executive directors’ accountability to the local community. Respondent A described the MOU restrictions regarding disclosure as “a higher level of micro management that’s introduced more inefficiency because there’s more checking and double checking and the process is becoming slowed down.”

The information approved for disclosure was also described by the executive directors as more standardized and therefore less reflective of local interests. As well, the disclosure was felt by the executive directors to be sanitized and less likely to reflect negatively on the government of the day.

The final aspect of disclosure that the executive directors described as having shifted as a result of the reforms is related to the parties to whom information was disclosed. All of the executive directors expressed the view that prior to the reforms there was a stronger sense of responsibility to disclose information locally to clients, stakeholders, and the community. After the reforms, the disclosure expectations were felt by the executive directors to be more directed at disclosing information to the MOHLTC and less directed at local interests. Respondent C described the outcome of this shift in focus of the accountability relationship as follows:

The community and the client are not as involved in the accountability relationship. The focus has shifted to the relationship with the funder...
If you drew an accountability map, there may be fewer players on it.

Disclosure was one of the outcome expectations of CCAC accountability reforms with which the executive directors appeared most comfortable. At no point did any of the executive directors express reluctance to disclose information or discomfort with any of the content or outcomes of the disclosure expectations placed upon them by the government, local communities, or the public in general. It was the process by which disclosure was sought, mandated in a standardized template without the flexibility to reflect local influences, which was not so wholly supported.

The development of performance measurements or key outcome indicators and the reporting of those measurements or indicators was an activity that all the executive directors saw as critical. In fact, all indicated that these activities were in place to a greater or lesser degree within their respective organizations prior to the reforms. Some had developed internal accountability frameworks with specific reporting requirements to their boards, the government, and their communities clearly articulated. Others relied on either the balanced scorecard approach or the accreditation process developed by the Canadian Council on Health Services Accreditation to guide the development of their outcome tracking and reporting mechanisms.

All of the executive directors spoke of a loss of autonomy around (a) what was disclosed, (b) to whom it was disclosed, (c) in what format the disclosure occurred, and (d) the timing of the disclosures. Before the reforms, communication processes regarding CCAC outcomes and performance measures with local community stakeholders was within the realm of the executive director and local CCAC board to direct. Many produced reports to their communities that shared results regarding indicators of local
interests, as well as the standard audited financial statements that were mandated as part of the Corporations Act that the CCACs were under at that time. With the reforms came a much more regimented process of disclosure that significantly restricted the disclosure of information by the local boards and executive directors to their communities.

**Transparency**

How the accountability reform changes in process and outcomes affected the CCACs and executive directors in the application of the principle of transparency was another key area of inquiry for this study.

The focus within the business plan template on a common set of goals and objectives for all CCACs across the province was mentioned by three of the executive directors as having resulted in increased standardization and a loss of local creativity and innovation within individual CCACs. Respondent A went so far as to suggest that standardization promoted a mentality of stagnation. It was also described as resulting in a loss of the ability to respond to unique local needs as many of the indicators mandated in the business plan template were felt to be less meaningful on an individual CCAC basis. As Respondent B described it:

A community has its own heart and spirit and its own needs and demographics. We can try and have standards that are pretty well consistent across the province but it doesn’t mean that your communities respond the same way, and to the extent the CCAC has to be responsive to your community then there is the need to be different.
Respondent B made one additional point regarding the disadvantages of the standardization approach, observing, “you tend to go to the lowest common denominator.”

Another negative aspect of the standardization movement described by the executive directors was the level of fear created by the processes of standardization. The executive directors described seeing people who were labeled as resistors or naysayers during the reforms being removed from their positions by the government. The resulting fear of job loss for many of the CCAC executive directors was described by the executive directors as having a negative influence on innovation and risk taking behaviors.

Respondent A stated,

[whereas]...before you might have had a higher level of innovation and risk-taking behavior, now you’re seeing people saying, ‘well I’m going to wait until I get a memo from the province because my accountability is to the province’

Issues surrounding trust, another key requirement for transparency in an accountability relationship, arose in two of the key informant interviews. Respondent A noted:

Where there may have been a very trusting relationship before, now there was really a sense that there was a different kind of relationship. You had to work through it and redevelop the trust.

One of the changes associated with the accountability reforms, which was seen as a positive change by two of the executive directors, was the creation of Community Advisory Councils (CACs). As described by Respondent A, “One of the pieces that came out of the reform that I really didn’t at the time have a sense was going to be much value
added was the CAC.” Reflecting upon one of the positive outcomes associated with the accountability reforms, this executive director further stated “I think the more we can grow that and bring the public and stakeholders together into the process, then I think that we are achieving accountability.” Respondent C also mentioned the positive influence of their local CAC: “It’s very effective here...we facilitated their coming together and continue to facilitate that and they’re becoming a vibrant voice for particularly seniors in the community and others.” The CACs were seen by both these executive directors as restoring some of the involvement of local stakeholders in the decision-making processes and thereby strengthening transparency.

The issue of trust also arose in discussions of the process of accountability reform used by the MOHLTC. Three of the executive directors provided examples of personal and board discomfort with the expectations placed upon them by the MOHLTC and the extent to which their concerns were heard or responded to appropriately. They spoke of mandated agreements that heavily favoured the government’s position at the expense of the CCAC’s preferred position and of changes that were forced upon them in a top-down approach with no regard for the individual CCAC’s capacity to accept the changes within the established timeframes. Respondent D summarized the executive directors’ concerns this way:

... the government needed to have an open and transparent process to be accountable for the accountability framework. They didn’t do that. They incubated it in the basement and said, ‘Here it is.’

Issues of power and control were also linked to the principle of transparency. The executive directors were unanimous in their perception of decreased individual autonomy
in their role as executive directors. Respondent B expressed frustration at being held accountable for things beyond the control of the executive director,

...if something went wrong it was because you were incompetent or inadequate or there was a failing, but in fact when you looked through it and do the final analysis, I can’t be held accountable for what I don’t control.

Two of the executive directors specifically called for a greater devolution of authority from the government to the local CCACs as a method for improving the accountability of individual CCACs. Respondent B argued it would be “…in the best interests of the Ministry and the Minister to have that devolution.”

Respondent D described the power shift that occurred between the CCACs and the MOHLTC as follows: “I think the government does still try to work with us as a partner but we’re not on even footing. It’s a power imbalance.” Two of the executive directors went as far as to describe reforms as being motivated by a desire for increased command and control over CCACs by the government. To quote Respondent A on this subject:

I think the politicians in the previous government believed if they were able to exercise more control then they could manage the service delivery and the public image of the CCACs much better. I think that’s been a big part of the agenda, to exert more control.

The executive directors did express some optimism, however, that with the recent change in government the focus on political control of CCACs appeared to be lessening and that there could be some opportunity in the future to remediate some of the current power imbalances.
One of the main process concerns to which the executive directors referred when speaking of local loss of control for CCACs was the process of OIC appointments for both executive directors and members of the boards of the CCACs. Respondent B described it this way:

Originally, of course, the governing board was comprised of members of the community who were elected from their peers to be on a board. Then that moved in 2002 to the OIC appointments whereby, from a perception standpoint, there seemed to be those that were more connected with particular parties in power at that time.

This was a clear example to them of where the political arm of government had acquired increased power over CCAC governance as a direct outcome of the accountability reforms. Respondent C also regretted the move to an OIC process for board members because its outcome was seen as resulting in the loss of local representation of the diversity and geography of the community that they served.

Some executive directors spoke optimistically of recent government signals regarding a willingness to discontinue OIC appointments for executive directors as an example of where the change in government was producing opportunities to lessen power imbalances. The executive directors did not appear very optimistic regarding the government’s willingness to make changes to the OIC processes that resulted in appointed rather than elected board members for all CCACs.

Respondent C described the negative outcomes associated with the process of OIC appointments for CCAC board members as follows:
They're not accountable to the community even though they may feel connected to the community and bring a community perspective to their monitoring activities. There's no accountability to the community because they are appointed by government. They are accountable to the people who put them there.

Along with the change to an OIC process for executive director appointments, the change in the executive director's reporting relationship with the board as a direct outcome of the accountability reforms was cited as also resulting in a significant power shift in favor of the political arm of the government. The executive directors, while understanding that they were dually accountable to both their boards and Cabinet, felt that if there was to be a conflict between the two, Cabinet was the ultimate authority. Respondent C described it, "...when they appoint me, my accountability is to Cabinet".

A lack of political power within the CCAC sector in general was cited by two of the executive directors as one reason that the accountability reform movement in healthcare started with CCACs and not hospitals. As Respondent B observed, "We are an easy mark and it was something imposed with little to no negotiation." Three of the executive directors referred to Bill 8 and the negotiations between the MOHLTC and the hospital sector regarding accountability reforms as an example of where the stronger political power of the hospital sector forced some of the changes to the accountability reform process that the CCACs were unable to achieve, such as gaining agreement for additional negotiations to occur around the accountability agreements and preventing the requirement of OIC appointments for board members and CEOs of hospitals.

Unfortunately, the word transparency was sometimes used by the executive directors in reference to the principle of disclosure, thereby making transparency a more
difficult principle to tease out of the findings. The one process of transparency that was most often referred to by the executive directors was standardization. Although the benefits of more standardized processes for many CCAC activities such as reporting of outcomes were acknowledged by all the executive directors, the negative outcomes of the standardization movement were more often expressed.

Other aspects of transparency that were mentioned by the executive directors included a loss of trust, particularly between the CCACs and the government, a loss of stakeholder involvement, primarily related to the involvement of local citizens in CCAC governance, and the power imbalance that came out of the reforms which resulted in increased control over CCACs by the government.

Redress

One of the purposes of this study was to determine whether or not the changes in structure and processes of CCACs increased the opportunities for redress. As related to redress for clients, Respondent B was the only executive director to express the idea that clients of the CCACs had enhanced expectations of the CCAC as a result of the reforms and that they tended to be a “little more vocal in their disagreements in terms of the level of the service or the mix” as a result. The other executive directors were silent on the issue of redress for clients.

Redress can also be expressed in the form of sanctions or rewards. The lack of incentives or rewards as an outcome of the accountability reforms was a deficit mentioned by two of the executive directors. Respondent D stated, “Praise and accolades are not enough. There should be some kind of system bonus. Maybe it is more money for
client care.” Respondent B described the need for incentives in the system quite simply: “If there’s an incentive to be accountable, it will happen.”

Although incentives to be more accountable were seen as lacking, according to the executive directors there was no apparent lack of sanctions for CCACs and executive directors that were not being accountable. Some described the accountability reform process as punitive; others felt that being seen as accepting of the reforms was an essential element to keeping their jobs. Respondent C described this punitive approach through the threatening message given to a particular CCAC board by a cabinet minister. Respondent C described this message as not having been stated directly to Respondent C by the cabinet minister but rather as relayed to Respondent C by the Chair of the board. The message was paraphrased by Respondent C as “I got your last executive director fired, I can get your current executive director fired.” Other respondents credited being seen as co-operative with the government as a key to having survived the reforms and remaining employed in their role as executive director. Respondent D stated, “I think that is what kept me my job.”

Equity was also an element of redress that the executive directors identified as requiring improvement under the new accountability framework. The continued funding inequities between CCACs and the disconnects between the various silos within healthcare were cited as major barriers to an overall accountable healthcare system. In this area, it was felt that the government did not go far enough with the reform process and failed to take the opportunity to make meaningful changes that would benefit the entire healthcare system. Respondent B described it this way:
You can no longer treat one component of the sector differently from the others. You can’t continue to beat on CCACs as an example without standing back and taking a systems view...There has to be a commitment to have accountability agreements with all in the system.

One of the main areas of concern with the outcomes of the reforms expressed by the executive directors was the shift in focus regarding CCAC responsiveness. The majority of the executive directors spoke of the shift as moving away from responsiveness to the community and towards increased responsiveness to the government. Reflecting this, Respondent A stated, “It’s easier to ignore the needs of the community and the needs of the clients in the current accountability framework.” The executive directors also spoke of a desire to readjust the focus of responsiveness to the broader healthcare system whereby they would be held accountable for the level of system integration of services to clients and overall system responsiveness between the various healthcare silos. For example, Respondent B suggested, “Let’s not be so focused on the agreement between government and the agency that we lose sight of what this is really about. Let’s hold each other accountable within the sector.” The ultimate goal expressed was the creation of a seamless system of care for clients that coordinated key decisions and activities despite having multiple governance structures.

**Changes to the Balance of Accountability**

A common theme found running throughout the executive directors’ responses was in regards to the change in the nature of accountability relationships as perceived by the executive directors. Respondent C described this shift in relationship as follows,
Well, seven years ago I was a Chief Executive Officer whose accountability was to the board. We got the majority of our funding from government and we knew that we had to keep government happy, but we had to balance that with keeping clients happy, meeting community need and so on. Now that has shifted. The community and the client are not as involved in that accountability relationship.

The focus has shifted to the relationship with the funder.

The shift in the accountability relationships between the CCAC executive directors, the government, and local citizens represented a significant change for the executive directors from that which existed prior to the reforms. Respondent A, commented on dilemma of an executive director required to choose between the interests of the government and those of the local community as a result of the reforms. It was noted that post-reform, loyalties would have to be defined as first to the government and then to clients. It was also noted that the board was not comfortable with the change.

Respondent C echoed this perceived weakening of the accountability relationship between executive directors and their community based boards when describing the government as the “ultimate boss.”

Respondent B outlined the strengthening of the accountability relationship between the CCAC and the government and described the post-reform relationship as “more overt” and “a more direct link to the government.” Similarly, Respondent C described a shift away from a focus on customer satisfaction and stated, “It’s easier to ignore the needs of the community and the needs of the clients in the current accountability framework.”
In describing the pre-reform accountability relationships, Respondent C commented, "What we did was try to balance community need, client need, fiscal resources and what we thought was appropriate." This same executive director also reflected on the perception that CCACs were much more locally focused prior to the reforms.

**Key Findings from the Business Plan Template**

The MOHLTC Business Plan Template (see Appendix D) provides all CCACs with a standardized list of goals described under three accountability statements which are outlined in the section titled Performance Commitments. The three accountability statements outlined in the Business Plan Template are as follows:

1. Provide Ontarians with fair and equitable access to community based services so that Ontarians are better able to remain in their homes and/or desired community.

2. Facilitate partnerships with healthcare and broader human services so that different parts of the system work together.

3. Arrange cost-effective, well-managed services to eligible clients, which are within available resources and in accordance with applicable legislation, regulations, and ministry policy.

Each of the three accountability statements has mandated goals and outcome expectations that support the statement. The first of the ten mandated goals of the business plan is listed below with the supporting outcome expectations underneath:

1. Provide a range of CCAC services for eligible people in community settings while maximizing the use of client and community resources.
a. Service plans are consistent with client needs.

b. Assessment of long-stay clients is standardized using Resident Assessment Instrument-Home Care (RAI-HC).

c. Eligible people who need services the most receive services.

The remaining nine mandated goals for CCACs found in the Business Plan Template are as follows:

2. Arrange for support and relief for people who provide care for an eligible person at home.

3. Provide information about, and make referral to, community-based services, long-term care facilities, and other services.

4. Manage admissions to long-term care facilities, including recommending feasible alternatives.

5. Continuously monitor and improve the quality of services to clients.

6. Collaborate with community partners to implement efficient and effective strategies for service delivery.

7. Establish and maintain an effective governance system.

8. Effectively manage the organization’s human resources.

9. Manage an effective procurement and contract management process.

10. Demonstrate effective and efficient operations.

The reporting requirements outlined in the template ensure CCAC disclosure of key performance indicators or outcomes determined by the MOHLTC. The main goal of the template is to ensure standardization of outcome reporting for CCACs. Within the business plan template, there is some opportunity for individual CCACs to provide
additional objectives and performance measures; however, these objectives and measures must be related to one of the ten goals mandated by the MOHLTC. CCACs are not free to determine their own goals within the business planning process.

CCACs are also expected to conduct, and are mandated to report to the MOLHTC the results of, client satisfaction surveys. Outcome expectation 5.1 of the business plan template states, “ Clients are satisfied with the services they receive through the CCAC”. Specific strategies to be implemented by CCACs in the event of poor satisfaction survey results are included in expectations found in the business plan template in order to ensure CCAC responsiveness to issues of local concern.

Key Findings from the Memorandum of Understanding

The MOU between the MOHLTC and the CCAC board (see Appendix C) is a legal document with the following statement of purpose listed in Section 1.1.1:

To clarify the operational, accountability, financial, administrative, auditing, and reporting relationships between the Minister of Health and Long-Term Care and the CCAC. This Memorandum sets out the framework for accountability between the Minister and the Chair of the CCAC and meets the requirement of the Management Board of Cabinet Directive on Agency Establishment and Accountability, dated February 2000.

The MOU also outlines the process for review of a CCAC, gives some guiding principles, describes the accountability relationships, and outlines roles and responsibilities for the Minister, Deputy Minister, CCAC board, CCAC board chair, and Executive Director. Other sections include consultation and communication processes,
financial arrangements, reporting requirements, audit requirements, and other administrative issues such as records management.

The MOU has several sections that speak directly to the application of accountability principles. The MOU outlines the revised expectations regarding disclosure of information in Section 5.1.2.7: “The CCAC shall consult with, and keep the Ministry advised in advance of any public release with sufficient time to allow a considered response by the Minister.” The restrictions placed on CCAC communication processes are further articulated in the MOU section 5.2.1:

The CCAC shall work co-operatively with the Ministry to develop and implement a comprehensive, multifaceted communications strategy that is coordinated with the Ministry’s efforts. This communication strategy is part of the CCAC’s business plan and shall be submitted annually by the CCAC to the Ministry for approval.

Another expectation related to the principle of transparency can be found in the MOU in section 13.1.2: b which stipulates: “The members of the CCAC Board are appointed by the Lieutenant Governor in Council pursuant to section 7(1) of the Act”. It also states: “The Lieutenant Governor in Council pursuant to section 7(4) of the Act may designate the Chair and a Vice-Chair of the CCAC from among the members of the board”. The MOU does not stipulate the need to have any specific local geographic or diversity representation nor does it stipulate any constituent representation. It is silent regarding the selection criteria for board members other than a conflict of interest provision.
Further items related to transparency were found in the MOU section 3.1.1(d) where it states, “The Executive Director is accountable to the Board and to the Minister...” This creates a dual reporting relationship for the executive directors whereby they report both to the CCAC board and the Minister of Health and Long-Term Care. There is no mention of what an executive director should do if the Minister and the board are not in agreement in their directions to the executive director.

Also mandated in the MOU, in relation to the principle of transparency, is the implementation of CACs. In the MOU, the CCAC board is responsible for “establishing a Community Advisory Council in accordance with section 9 of the Act and any regulation make pertaining thereto.” The CACs, although not in a governance role, do report directly to the CCAC board and act in an advisory capacity to the board. The CACs consist of “expert members” of the local community such as representatives of hospitals and community services agencies.

In regards to the principle of redress, the MOU outlined a process for review of a CCAC at the discretion of the Minister of Health and Long-Term Care or Management Board of Cabinet. Section 1.7.5 states, “The results of the periodic review may include options for changes to the CCAC’s mandate, consolidation, alternative service delivery, appointment of a supervisor under the Act, and termination of the CCAC”. The MOU also directs the board in Section 4.3.1 to comply with the Minister’s direction regarding “corrective action to be taken”.

Summary

This chapter summarized the major findings of this study based on four CCAC executive directors’ perceptions of both the processes and outcomes of the CCAC
accountability reforms as expressed through key informant interviews. In addition to the key informant interviews, key documents were reviewed and summarized and the reflections from both a personal journal and research notes were incorporated into the findings. The findings were organized as they related to definitions of accountability and the key concepts of transparency, disclosure and redress found in Kuchapski's (2002) framework.

The key findings regarding executive director definitions of accountability were related to the changes that had occurred as a result of the reforms. Although the executive directors felt that their personal knowledge and understanding of accountability had not changed, the processes by which their accountability was to be demonstrated had undergone significant change. These new accountability processes were described as more standardized and restrictive than had been experienced by the executive directors in the past.

Disclosure was also changed for the executive directors as a result of the reforms. Both the processes and the content for disclosure had become much more standardized after the reforms. The executive directors described a loss of autonomy regarding the content, timing, format, and inclusiveness of what they could disclose and were particularly concerned with the restrictions to disclosure of information that had been shared in the past with their local communities in a timelier manner. All the executive directors remained supportive of disclosure as a basic expectation of accountability.

Standardization was mentioned as a key area of change affecting both the disclosure and transparency of CCAC processes. The more standardized processes for the disclosure of information facilitated better benchmarking and comparison of performance
between CCACs which the executive directors acknowledged enhanced transparency. The more negative outcomes of the CCAC reforms on transparency, however, were often cited by the executive directors. These negative changes included the loss of trust between the CCACs and the government as a result of both the process by which the reforms were implemented and the shift in the power base which resulted in an outcome of perceived loss of control by the executive directors. The perceived loss of stakeholder involvement in CCAC governance was also a key finding related to outcomes in the area of transparency.

Redress related to the rights of clients of the CCAC to appeal decisions or influence changes was mostly overlooked in the executive director responses. The focus of the discussions related to redress centered on the perceived outcome of increased sanctions and a lack of rewards related to executive director and CCAC performance, and the lack of a process to increase equity between CCACs. Responsiveness to the community was also described as reduced as an outcome of the increased focus on responsiveness to government. Finally, there was a call for greater focus on overall system responsiveness as a way of strengthening accountability processes within the healthcare system.

*Balance of accountability blurb...*
CHAPTER FIVE: CONCLUSIONS, IMPLICATIONS AND RELECTIONS

This chapter provides a summary of the study, discuss its findings, and suggest implications for theory, practice, and research based on those findings. To conclude, it provides some reflections from the author as the researcher regarding the experiences associated with this work and some final thoughts on how this work contributes to the study of accountability.

Summary of the Study

CCACs have undergone extensive governance reform over the past three years for the express purpose of increasing accountability. These reforms included (a) moving from independent not-for-profit corporations to statutory corporations; (b) no longer having board members elected by the members of the corporation, but rather appointed by the government through OIC; and (c) replacing CEOs hired by the board with executive directors appointed through OIC.

This study explored the experiences and insights of four executive directors who lived through the government-mandated accountability reforms in CCACs in Ontario. Although improved accountability has been the stated goal behind many of the policy and governance changes affecting CCACs, no analysis has been done of the reforms regarding their success in improving CCAC accountability.

The purpose of this study was to explore how purposefully selected executive directors of CCACs understood the idea of accountability, and how they viewed the accountability reforms that had been imposed on their sector of the Ontario health care system over the last three years. Specifically, the study focused on executive directors’
perceptions regarding the reforms undertaken to increase accountability; whether or not they have served to do so, and if so, in what ways.

A review of the Canadian literature in healthcare reveals that the available research on accountability is scant (Johnson, 2001; Penney, 2002). As well as a paucity of material, authors such as MacDonald & Shortt (Queens Health Policy Research Unit, 1999) also note that the quality of the published material is highly variable. Additional literature from some non-healthcare and non-Canadian sectors was used in order to expand on key points.

Key topics that emerged from the literature review included various definitions of accountability. The definition of accountability developed jointly by the MOHLTC and OACCAC that is most pertinent to this thesis was found in a position paper published by OACCAC (2001). It states:

Accountability is the requirement to explain and accept responsibility for carrying out a mandate in light of agreed upon expectations. It is the obligation to answer for results and the manner in which responsibilities are discharged.

Accountability cannot be delegated. (p. 2)

Much of the impetus behind accountability reforms in healthcare has stemmed from a growing concern that the existing system of healthcare delivery in Canada was inefficient and unsustainable (Flood et al., 2004). The Conservative Party governed the province of Ontario throughout the duration of accountability reforms and Ontario’s approach to accountability naturally reflects the ideological approach to accountability particular to that political party. In the case of the Conservative Party, this ideological approach was grounded in the New Public Management philosophy. Hood (1995) as
cited by Penney (2002) described New Public Management as “a model that reverses the separation of public and private sector management practices and places emphasis on accountability for results rather than process accountability.” (p. 19) In this approach to government reform, a reduction in the size and scope of government is favored along with decentralization of authority and a sharing of responsibility with the private sector. Under New Public Management, a greater trust is placed in private sector methods and markets.

Flood et al. (2004) argue that in order to close the “accountability gap” in healthcare, governments have chosen to devolve responsibility and authority for decision-making from central governments to RHAs while retaining policy making at the central government level. In this scenario, the government retains the power to set policies, yet devolves both the accountability and the blame for unpopular decisions resulting from those policies to the local level (Day & Klein, 1987). In Ontario, the RHA route was rejected in favor of accountability frameworks, business plans, balanced scorecards, and special purpose legislation. Flood et al. point out that Ontario’s current individual institution approach to accountability results in little attention being paid to the intersecting lines of accountability between organizations and across sectors leaving Ontario mired in its healthcare silos.

Much of the literature reviewed touched on the role of citizens in the development of good accountability mechanisms within today’s healthcare governance and delivery systems. The argument supporting citizen involvement is that citizen involvement would increase the transparency of processes, allow for full disclosure of actions, and provide the public with the opportunity to seek reasons for the action and redress for undesirable
outcomes (Davidson, 1999). Lomas et al. (1997) also argue that there exists a strong need for citizen involvement in governing boards due to the perceived feelings of accountability to and representation of local citizens by board members. Representation based on shared experiences, where needs are assessed actively by the representatives, was found to enhance the legitimacy of representation (Phillips, 1995). Daniels & Sabin (1998) focused more on the process of decision-making as being the source of good accountability rather than the make-up of the decision-making body.

Kuchapski (2002) developed a framework centered on three principles of accountability: transparency, disclosure, and redress. She traced these principles through western democracy and linked accountability features back to the principles. Kuchapski refers to the principle of transparency as the openness and inclusiveness of decision-making processes, governance structures, and operations. Disclosure refers to the timely release of information or data that relates to an organization’s success or failure in achieving its mandates. Redress refers to opportunities to resolve disputes or conflicts. It ensures that an organization remains responsive to the needs or wishes of its stakeholders.

This framework was used to frame the analysis of the findings for this study.

A qualitative methodology was used for this study. This approach was descriptive and allowed the researcher to view the experiences and events that occurred through the eyes of executive directors who had lived through the accountability reforms mandated by the provincial government. Four executive directors were purposefully selected to participate in semi-structured key informant interviews that formed the basis for the findings of this study. Coding of the interview transcripts and key documents was conducted using color coded highlighters (Coffey & Atkinson, 1996). The first round of
coding looked for the three a priori codes of transparency, disclosure, and redress, based on Kuchapski's (2002) accountability framework. Subsequent coding looked for sub themes, or emergent codes, that supplemented the main framework of analysis.

Also included in the findings were the results of an analysis of key documents; the CCAC Business Plan template and the Memorandum of Understanding for CCACs. Personal reflections and the literature on accountability were used to support the analysis of the findings and the development of implications for theory, practice, and further research.

The three principles of accountability, disclosure, transparency, and redress found in Kuchapski's (2002) framework were used to organize and report on the findings of this study. According to the data, the executive directors had a good understanding of accountability, its principles, and its procedures prior to the accountability reforms. What changed with the reforms was not their knowledge of accountability and its processes but the manner in which accountability was implemented for CCACs. The executive directors spoke of a loss of local autonomy in deciding how to demonstrate their accountability and of changes to their accountability and to whom they felt most accountable. Increased standardization was described as strengthening the ability to benchmark and compare CCAC performance provincially but also as resulting in a loss of autonomy in reporting outcomes that were meaningful locally.

The executive directors described concerns with the processes by which the reforms were implemented. The executive directors further expressed their concerns regarding the perceived loss of stakeholder involvement in CCAC governance and a shift in power away from the CCACs and towards greater control for government over CCACs
and the executive directors. They described an increase in sanctions and a lack of rewards related to executive director and CCAC performance as a result of the reforms. They spoke of a loss of trust between the CCACs and the government. The results also revealed the lack of a process to increase equity between CCACs. Responsiveness to the community was described as reduced as an outcome of the increased focus on responsiveness to government. Finally, the executive directors called for a greater focus on overall system responsiveness as a way of strengthening accountability processes within the healthcare system.

Discussion

One of the major findings of this study was related to the executive directors’ knowledge and perceptions regarding accountability. All four executive directors articulated that their personal knowledge and understanding of the principles of accountability and their application had not changed as a result of the reforms. What had changed for the executive directors were the processes by which they were expected to express or put into practice their accountabilities.

Prior to the reforms, CCACs were not-for-profit corporations with community membership. The board was elected by the members and the community had the opportunity to ensure that the board represented their local diversity and interests. The members of the board were given the opportunity to set the key operational outcomes and strategic directions for the local CCAC. Measures of performance were locally developed and reflected the key operational outcomes for a given CCAC. Under this system, many CCAC boards chose to incur operating deficits rather than limit services to their local citizens (PricewaterhouseCoopers, 1999). The accountability process changes
described by the executive directors refocused the CCACs towards more results based accountability procedures and away from process based accountability with its citizen involvement in CCAC governance and decision-making.

The goals of the CCAC Reform Project (2001) as cited by the Conservative government included balanced budgets and fiscal accountability, improved accountability to government, the creation of effective governance structures for CCACs, and improved allocation of resources. In stating these goals, the inference was that the existing governance structures for CCACs were not effective, that CCACs lacked appropriate fiscal accountability, were not as accountable to government as they should be, and were not making good decisions regarding allocation of resources. The shift away from a focus on citizens and local communities combined with a greater emphasis on results based accountability appears to have been based on a fundamental change in government ideology.

This ideological change by government was reflected in the move away from traditional management philosophies and towards a philosophy of New Public Management. Under a New Public Management philosophy, organizational focus is shifted towards key clients and away from citizens and communities. Accountability by results is also a major focus of the New Public Management approach and fiscal responsibility is a key operational outcome (Rouillard, 1997). Contracting out of services to the private sector and the separation of the purchaser role from the provider role are also hallmarks of the New Public Management philosophy but these changes had already taken place for CCACs in 1997, prior to the CCAC accountability reforms in 2001, and cannot be linked to the goals of the reform.
As suggested by Thomas (1997), the motivation behind moving to New Public Management is to reverse declining public confidence in the government and public service. The Hamilton-Wentworth CCAC Operational Review (MOHLTC, 2000) and PricewaterhouseCoopers Review of CCACs in Ontario (1999) had articulated just such a decline in confidence in the governance of CCACs. The implementation of the accountability reforms can be argued to be a direct response by the government to that decline in public confidence. Given the philosophical orientation of the government of the time it is no wonder that the implementation of a New Public Management approach to accountability reforms was the answer. Davidson (1999) describes how the focus on reforms in British Columbia also changed direction away from citizen empowerment and toward a policy focusing on accountability to the Ministry of Health. He describes this as a retreat from political accountability to the community and an advance toward managerial accountability to the government.

The study findings related to the principle of disclosure highlight the restrictions placed on disclosure as a direct outcome of the accountability reforms. The findings indicate that the content of disclosed information is now more standardized and the process by which information is disclosed to the public is more controlled by the government and less timely than the previous process. Although all the executive directors were supportive of the requirement to disclose information to the public, they were critical of the local loss of autonomy or control over the content, format, timing, and inclusiveness of what could now be disclosed.

The business plan is a primary accountability document for CCACs and, once completed, it represents an agreement between the CCAC and the MOHLTC regarding
performance expectations for that CCAC. It is described in the business plan guide as both promoting and reflecting the responsibilities outlined in the MOU. The main goal of the template is to standardize CCAC reporting of key performance measures, presumably for the purpose of comparison of individual CCAC performance by the government, since the completed business plans are not public documents.

The expectations outlined in the business plan template clearly support the executive directors’ view of a more standardized approach to disclosure of information that is highly controlled by the MOHLTC. These changes are a direct outcome of the CCAC accountability reforms. Negotiations between the MOHLTC and the OACCAC resulted in some CCAC input into the development of the goals, but not all the changes suggested by the OACCAC were supported in the revisions to the initial draft of the Business Plan template by the MOHLTC. The template also reflects New Public Management outcome expectations that results will be shown based on published performance measures and customer satisfaction standards.

The executive directors’ concerns regarding the increased restrictions placed on their abilities to disclose information as a result of the CCAC accountability reforms reflected the limitations to the principle of disclosure as described in the literature by Kuchapski (2002). Kuchapski describes partial disclosure as a potential way to focus attention away from those in power and as being vulnerable to “touch-ups and distortions” so that those with a vested interest can be viewed in a positive light (p. 154). Kuchapski also discusses the time delay associated with disclosure and describes it as another limitation, particularly when it is not coupled with a focus on transparency. The process by which CCAC disclosure is controlled by the MOHLTC as a result of the
accountability reforms allows the government to limit the content or outcomes that are disclosed by the CCACs thereby sanitizing or censoring out anything that might reflect poorly on the government or is not in line with key government messaging. These limitations placed on disclosure as a result of the reforms appear to have served to weaken CCAC accountability in this area.

Kuchapski (2002) also describes the lack of explanation for disclosed information, the lack of a link between the disclosed information and a vision for the organization, and the lack of any predictive value to disclosed information as further limitations to the principle of disclosure. These were areas that for the most part did not emerge through the key informant interview process. One of the executive directors did make a positive reference regarding the predictive value of disclosure and the ability of disclosed information to prove that an organization is moving in a positive direction. Kuchapski argues, however, that disclosed information is merely a snapshot view of an organization and provides no guarantee that future actions will be based on the information disclosed. In the corporate world, there exist many unfortunate examples such as Enron which support Kuchapski’s view.

In Kuchapski’s (2002) discussion of the relationship between transparency and power, she argues that in order for an organization to be truly transparent, there is a need to expose the power relationships, to consider power inequities if any, and to examine the degree to which reforms related to accountability change power relationships. Transparency within a given sector be it healthcare, education, or the corporate sector, requires a shared commitment to established goals and a mutual and reciprocal relationship between entities. Many of the concerns expressed by the executive directors
were tied to the issue of power and the various ways in which power had shifted towards government as an outcome of the reforms. This shift in power, or control as described by the executive directors, appears to have weakened CCACs’ ability to establish a mutual, reciprocal, and trusting relationship with government. This outcome places a further limitation on CCAC accountability as it relates to the principle of transparency.

Transparency is described by Kuchapski (2002) as both requiring and increasing trust. Participation of stakeholders and other interested citizens in governance and other decision-making processes is a way of using transparency to increase the trust these groups have in the operations of an organization. The findings of this study indicate that trust between the MOHLTC and the CCACs were weakened by the reforms. This loss of trust was related not only to the outcomes of the reforms and the changes in power associated with those outcomes, but also with the process by which the reforms were implemented by the government.

One of the most significant areas of concern expressed by the executive directors regarding the reform implementation process was the lack of consultation that occurred. The government was described in the findings by one executive director as having “incubated” the accountability reforms “in the basement”. Another executive director described their own personal and board discomfort with the expectations placed upon them by the MOHLTC and the extent to which their concerns were heard or responded to appropriately. The government in this case did not implement a process that met a key part their own definition of accountability: “Accountability is the requirement to explain and accept responsibility for carrying out a mandate in light of agreed upon expectations” (MOH & OACCAC, 1999, p. 1). The lack of a process between the MOHLTC and the
CCACs by which to determine mutually agreed upon expectations appears to be one of the main sources of the loss of trust between the government and the CCACs.

The Lambert Commission (1979) found that accountability is a working principle of our parliamentary system of government and a process whose effective functioning was essential to democratic government. Essential to organizational transparency is democratic governance. It involves opening up the governance structures and decision-making processes for participation by interested citizens (Kuchapski, 2002). Daniels & Sabin (1998) advise that the ultimate moral authority for making health care decisions should rest with the public. All these authors focus on the processes for decision-making as being the source of good organizational accountability and advocate for local citizens to have a voice in the decision-making processes.

The findings of this study reveal a fundamental change to the role of citizens in CCAC governance. The move to OIC appointments for executive directors and board members means that board members are no longer elected by the community but rather appointed by Cabinet. The members of the board have the opportunity to influence the key operational outcomes and strategic directions for the local CCAC. Lomas et al. (1997) argue that there exists a strong need for citizen involvement in governing boards due to the perceived feelings of accountability to and representation of local citizens by board members. The change in board membership process to the OIC process was viewed by the executive directors as limiting the local communities’ opportunities to ensure that the CCAC boards represent their local diversity and interests. One executive director described the appointed board members as accountable only to the government and not to the local community.
One of the limitations of community representation as described by Kuchapski (2002) is that those who chose to participate in a governance role do not necessarily represent the interests of the majority. Frankish et al. (2002) state that the advantage of appointing board members is that it ensures a range of knowledge, skills, and viewpoints. They caution that the downside to appointed board members is the perception that decisions made by appointees will coincide with the political interests of the government and not necessarily the local citizenry.

Frankish et al. (2002) similarly argue that the demographic and geographic approach to representation detracts from an emphasis on accountability of the representatives to their constituents. The preferred approach according to Frankish et al. is related to whom the representatives look after and whose interests they pursue rather than what they look like or where they live. They also further caution that those who tend to be most vocal or that volunteer may be the least representative of the community.

The notion that OIC appointments for board members have effectively diminished the voice of the local community in CCAC governance is therefore not supported by the accountability literature. However, Flood et al. (2004) argue that health care governance structures must have representatives that are seen to have real authority and legitimacy in the eyes of the public and are not seen as government lap-dogs. The skills and abilities of those appointed to the CCAC boards combined with the willingness to listen to local community concerns appear to be the critical elements to good democratic governance and accountability. Representation based on shared experiences, where needs are assessed actively by the representatives, was found to enhance the legitimacy of representation (Phillips, 1995). Penney (2002) places this approach in the paradigm of
participatory democracy. She argues that this paradigm effectively shifts the focus of public organizations to the purpose of participation, representation, and incorporation of the view of citizens and away from responding to superiors or special interest groups.

Increased standardization of reporting requirements was a core part of the CCAC accountability reform processes as described by the executive directors. One of the methods noted by Kuchapski (2002) that has been used to improve transparency within organizations is standardization. The introduction of province-wide benchmarking allowed those CCACs that were not performing well to be more easily spotted.

The negative side of standardization as described by the executive directors was the loss of individual CCAC determination over what outcome indicators were meaningful and how they were to be reported locally to interested stakeholders. The other significant finding related to standardization was a sense of fear over being seen as at odds with the rest of the CCACs in the province. This was described in the findings as having had a negative influence on creativity and risk-taking at the executive director level. The loss of local creativity and risk-taking associated with standardization may in reality be a temporary loss resulting more from the instability and reduced sense of job security for executive directors created within the sector at the time of the reforms rather than a permanent loss as a result of the reforms themselves. Over time, the lasting influences of the reforms on creativity and risk-taking will become clearer. If these reforms are truly based in the New Public Management philosophy, then according to Thomas (1997), risk-taking and entrepreneurship will be valued under the reformed system.
One of the major findings of this study included a call by two of the executive directors for greater system responsiveness to local stakeholders through devolution of decision-making authority from government to the local healthcare system. This devolution of decision-making was described as essential to achieving system wide accountability. Flood et al. (2004) argue that in order to close the “accountability gap” in healthcare, most provincial governments in Canada have chosen to devolve responsibility and authority for decision-making from central governments to RHAs while retaining policy making at the central government level. They describe devolution as a first step to accountability reform.

Rohal & Mulder (1993) and Lomas (1997) suggest that moving towards devolution of decision-making powers to the local level and increased public involvement in decision-making is tied to reducing the direct accountability of government for decisions made, particularly in times of fiscal restraints where cutbacks are required. Flood et al. (2004) coined this action by the central government “Devolution of Misery” (p. 22). According to Day & Klein (1987), the government in this scenario retains the power to set policies, yet devolves both the accountability and the blame for unpopular decisions resulting from those policies to the local level. Although Flood et al.’s arguments support the executive directors’ view that devolution is a key requirement to improving accountability in healthcare in Ontario; the works of Day & Klein, Flood et al., Lomas (1997), and Rohal & Mulder (1993) all suggest that this devolution of decision-making authority also means the possible devolution of blame, including blame for policy decisions that are not within local control.
Johnson (2001) suggests that accountability mechanisms are not only aimed at preventing the abuse of power, but also serve to enhance responsiveness, improve administrative efficiency, and increase transparency of decision-making. Flood et al (2004) argue that the major advantage to devolution of authority is the shifting of decision-making closer to the community served, thereby providing greater opportunity for direct accountability. “The closer and more connected such decision-makers are to the citizen’s community, the easier it is for citizens’ voices to be heard” (p. 14).

Another major advantage of a more devolved decision-making approach as described by Flood et al. (2004) is the shift in role of government from manager to governor. They argue a provincial government should be held accountable by the public for governance decisions, not managerial decisions. They advise that government should “row less and steer more” (p. 8) and that “Answering to the electorate every four years does not provide accountability for most of the decisions and actions designed to govern and manage an equitable and efficient health care system” (p. 3).

Ontario’s current individual institution accountability approach results in little attention being paid to the intersecting lines of accountability between organizations and across sectors, leaving Ontario mired in its healthcare silos. The system in Ontario has each organization focused on their accountability relationship with the MOHLTC and not with the other key stakeholders within the system. This is a key accountability deficit which the accountability reforms to date have not addressed. However, the call for greater devolution of decision-making in Ontario’s healthcare system to the local level and better integration and responsiveness of the overall system appears recently to have been heard by the current government.
The creation of Local Health Integration Networks (LHINs) was announced by the Premier of Ontario on September 9th, 2004 (MOHLTC Press Release, 2004). The purpose of the LHINs is described as to better plan, coordinate, and fund services at the local level. LHINs were also cited by the premier as a crucial step to achieving a healthcare system that is better integrated and more responsive to patients. This change is intended to take some of the current decision-making authority away from government and moving it to the local healthcare community. This shift in decision-making authority is intended to build on the strengths of the local communities and respect and support local governance of healthcare delivery organizations. The details regarding LHINs, including what structure they will take once implemented, have not yet been announced. Whether or not the LHINs are successful in fixing the system-wide accountability deficits that currently exist in healthcare in Ontario will be the subject of future study and evaluation.

Executive directors were mostly silent on the issue of redress related to the rights of clients or citizens to appeal decisions or influence changes if they were unhappy with the CCAC. Prior to the reforms, CCACs already had in place legislation regarding client rights and responsibilities including the right to appeal decisions with which they did not agree (Long-Term Care Act, 1994). This legislation did not change with the reforms and this is most likely the reason why this was not seen by the executive directors as an issue associated with the accountability reforms.

Redress is also expressed in the form of sanctions or rewards. The results of this study included concerns from two executive directors that there were insufficient rewards in the system as a result of the reforms. Flood et al. (2004) support the executive
directors, views when they argue that the accountability debate needs to be refocused from funding to governance and should include incentives that reward gains in healthcare outcomes as opposed to volumes of services delivered regardless of their effectiveness.

To illustrate the changes in accountability relationships that resulted from the reforms, the analogy of a balance of accountability is used. The EDs indicated that there was a more balanced approach to accountability relationships before the reforms because accountability to local citizens was greater. In their view, no stakeholder group appeared to dominate the accountability relationship; however, the EDs all felt that as a result of the reforms, accountability to government now dominated, and consequently, the balance of accountability has shifted away from local citizens in favor of the provincial government. Two figures were developed to illustrate this change. Figure 2 highlights the changes to the balance of CCAC accountability between the government and the local citizens after the accountability reforms. The shift in the accountability balance towards government is shown as creating an imbalance of CCAC accountability between government and local citizens that now favors the interests of government.

Figure 3 reflects the researcher’s interpretation of a revised CCAC Accountability Framework based on changes in accountability demands. In this figure, the accountability relationship with government show stronger linkages while the accountability relationship with local citizens is weakened, reflecting the shift in the balance of accountability between the two key CCAC stakeholders.
Figure 2. Changes to Post Reform Balance of Accountability
Implications

The implications found in this study arise from the executive director respondents' suggestions regarding what should or could have been done differently. The implications are based on the discussion regarding which principles and procedures of accountability were strengthened by the reforms and which were not strengthened or improved. The implications also discuss what learning should arise from the finding and conclusions. Lastly the implications suggest areas of further study based on the results of this study and suggest other perspectives and methodologies that may be of interest to scholars researching this area.

Implications for Theory and Practice

One of the most important practical implications identified in this study related to the process used to develop the accountability reforms. All executive directors noted the reforms would have been more effective and creative if executive directors, and others involved in the CCAC at the local level, had been more involved in developing the
reforms and in planning for their implementation. The executive directors described a loss of trust in the government associated with both the manner in which the reforms were implemented and some of the outcomes of the reforms. This loss of trust resulted in a more conservative approach to leadership for many of the executive directors. The loss of risk-taking behaviors also resulted in less local creativity and innovation. This suggests that the reforms could have been more effective and successful if the government had involved the executive directors to a greater extent.

As the memory of the accountability reforms fades, and a new government begins to build trust with the executive directors, there is an opportunity to restore some of that lost innovation and creativity that could further enrich the CCAC sector and strengthen the currently defined measures of accountability as well as other measures of success. In order to do this, a greater sense of job security for executive directors and more genuine opportunities for the executive directors to be involved in key decision-making regarding changes to the CCAC sector will be required.

Examples of specific areas in which the executive directors felt reforms could have resulted in improved overall accountability for CCACs were numerous. One major area that is now starting to be addressed by the government through the creation of LHINs, is the need for greater system integration and responsiveness. It was felt by the executive directors that greater systems integration across the healthcare silos such as CCACs, hospitals, Long-Term Care facilities, and public health could result in a greater overall system accountability that in the end would benefit the local citizens as consumers of the system.
The call for greater devolution of decision-making power from government to local integrated healthcare systems is another key finding that arose from this study. The executive directors' comments implied that the current power imbalances between the CCACs and the government were an impediment to the executive directors' effectiveness in working with both government and other members of the healthcare system in a collaborative and meaningful way in order to improve overall system efficiency and effectiveness. Devolution of power is one method of improving accountability within the CCACs and the other players within the sector by enabling local solutions and actions that would result in an improved responsiveness to local needs and a move away from the one size fits all approach taken by the government throughout the CCAC accountability reforms.

The need to improve both system integration and responsiveness, and devolution of decision-making to the local level are areas that require further action. The success of the recently announced LHINs in addressing the call for greater integration and responsiveness of the local healthcare systems is not yet determined and will require review and evaluation once implemented in order to ensure that these key accountability deficits have been addressed through the creation of this new structure.

Another area of changes suggested by some of the executive directors was a move away from OIC appointed board members and back to a local governance system. This position also reflects the position taken by the OHA in their negotiations regarding the recently enacted healthcare accountability legislation in Ontario when they successfully opposed any move away from locally elected citizen governance for hospitals. The suggestion that this move away from OIC appointed boards will improve local CCAC
accountability is not wholly supported by the results of this study. The evidence from the literature indicates that appointed boards may be just as accountable to local citizens as elected boards. This change would, however, strengthen local democratic involvement in CCAC governance, place CCACs more in line with the governance practices of their hospital partners, and provide the executive directors with a greater sense that their boards' interests are vested primarily in the needs of the local community.

The OIC appointment process for executive directors has other implications associated with it. The executive directors described a sense of primary allegiance to the MOHLTC as the body that controls their appointment and thereby their continued employment. This primary allegiance to the MOHLTC potentially places the executive directors at odds in their accountability relationship with their employer, the CCAC board, and with local citizens. Although none of the executive directors described this situation as having occurred up to this point, the potential for this to occur is very real and presents some unique challenges for the executive directors. The dual accountability relationship with both the Minister of Health and the CCAC board that the executive directors described has the potential to create a significant ethical dilemma for any executive director that is caught in crossfire of opposing views from their board and the Minister of Health. It also provides for very little direct accountability by executive directors to local citizens and thereby undermines the democratic foundations upon which accountability was founded. The MOHLTC should look seriously at changing this dual accountability relationship and ensure that executive directors have one clear line of accountability to their boards. The CCAC boards should have the only accountability relationship between the MOHLTC and the CCACs.
The current procedures and processes for CCAC disclosure whereby annual reports to local citizens are published well after the fact, contain very limited data and no real outcome measures beyond a balanced budget statement, does not demonstrate the type of disclosure necessary for good democratic accountability. The Balanced Score Card is a widely accepted accountability procedure developed by Kaplan & Norton in 2001 for the business world. This tool has been further refined in recent years in order to apply more closely to the health care sector by Ball et al. (2004).

The Balanced Score Card approach to accountability is based on the development of an ongoing constructive organizational conversation where the qualities of accountability are defined as respect, trust, inquiry, moderation, curiosity, and mutuality. The Balanced Score Card seeks to blend accountability structures, mechanisms, and practices with increased individual and team empowerment and is published yearly as part of the organizational dialogue with its citizenry. The hospital system currently publishes an annual hospital report card that includes hospital sector-wide measures of performance in key areas. Moving forward as a group to develop a similar CCAC report card, or better still, working with the hospital sector to develop an interagency system-wide measure of outcomes, would be a key move for CCACs in improving overall healthcare accountability.

The principles and procedures of accountability referred to by the executive directors when defining and describing accountability were shaped by their accountability reform experiences. Those experiences reflected the New Public Management ideology of the Progressive Conservative party, the governing party in Ontario at the time of the reforms. Another government with different ideologies may have still moved forward
with accountability reforms, but may have implemented the reforms differently, choosing to focus on more process-based accountability procedures found in the traditional management approach rather than the results based accountability procedures associated with New Public Management. In order to more fully understand accountability, its principles and procedures, the entire healthcare sector would benefit from further education regarding accountability and how it might be strengthened, including a discussion of procedures that reflect both New Public Management and traditional management ideologies and a balanced review of the strengths and weaknesses associated with the various approaches. In order to ensure widespread participation by current and future healthcare leaders in education regarding accountability, the Canadian College of Health Service Executives should make this education available as part of its mandatory maintenance of certification process for all Certified Health Executives.

The experiences of the healthcare sector with accountability reforms may also be of interest to other public service sectors. In particular, the education could benefit from some of the insights arising from this study as accountability has also been a recent focus in that sector. For example, the government's move towards more outcomes based accountability in education has resulted in greater emphasis being placed on student scores on standardized testing as a measure of a school's effectiveness. Although standardized testing may strengthen the lines of accountability to government, it may serve to reduce accountability to the local community, and to students who are not easily standardized. As well, it may reduce school involvement in planning and implementing more creative ways to increase accountability.
Implications for Research

This study was based on the perspectives of four purposefully selected executive directors of CCACs. To further understand the CCAC reforms and their effectiveness in influencing accountability and the understandings and procedures associated with accountability within the CCAC sector, it would be beneficial to get input from a broader selection of executive directors as well as other key stakeholders in the system. The perspectives of the ministry bureaucrats, who implemented the reforms at the direction of the political party in power, may provide additional valuable insights into both the findings and implications of this study. Their voices would provide additional thoughts and perhaps a differing view regarding both the processes and outcomes of the CCAC accountability reforms.

The members of CCAC boards are another source of insights in the CCAC reforms that would enrich the findings of this study. Many existing CCAC board members were appointed by the government at the time of the reforms. It would useful to determine their perspectives regarding the reforms and how those perspectives compare with the board members who were not appointed to the new boards. Similarly, the voices of the executive directors who lost their jobs as a result of the reforms would have added depth to the findings. Lastly, the local citizens and consumers of CCAC services could provide valuable perspectives on whether or not the reforms improved the accountability of their local CCACs.

In order to gain insights into a broader range of perspectives a quantitative methodology such as surveying could be employed. This would allow for a much greater sample size. The downside to this approach is that it would result in a loss of detail and
in a much narrower set of findings. However, in combination with more in-depth interviewing of a randomly selected sample, this approach could lead to broader study results that would be more generalizable to the entire CCAC sector.

The impact of the introduction of LHINs into the local healthcare delivery system will require further study. It will be important to determine if the introduction of LHINs reduces any of the current accountability deficits highlighted in this study. It would also be of value to examine Ontario’s choice of LHINs as a method of devolving decision-making to the local level as compared to the approach of most other provinces in Canada of implementing RHAs.

**Reflections**

My greatest personal learning associated with this study was related to the challenge of being a round peg trying to fit into a square hole. I am by nature and by training a concrete positivist thinker who attempted to broaden my horizons through conducting a qualitative research study. Although I believe that I was successful in meeting my objective of learning about qualitative research and completing a qualitative research study, it is not an experience I am likely to repeat in the future. I have learned that given any discretion in how to proceed or any lack of knowledge or guidance in appropriate qualitative methodology, I immediately revert back to my basic quantitative nature. This resulted in several frustrating re-writes of this thesis at various points along the way.

Another insight gained into my own strengths and weaknesses as researcher came as a result of writing up this research. Although I became adept at writing 15 page papers for my various courses towards this degree, I struggled mightily with the depth and
volume of writing required by a qualitative study. Given the chance to talk my way through the whole event, I would have been quite eloquent. However, being constrained to the written form of expression, I found myself to be well short of erudite. My writing skills, which are more business oriented, did not support the more reflective and dense writing style required for this study. This contributed to, but was not the only factor in, the length of time it took me to complete this work.

In the data collection phase of the study, I was pleased to realize that the executive directors were willing to give of their time in order to be a key informant in the study. I was surprised, however, to learn that once the interview was completed, all four executive directors declined the opportunity to review the transcripts of the interview and provide feedback. It appears that they all felt comfortable being quoted directly and did not feel the need to review or edit their comments. It also implied a level of trust in me as the researcher that I would use the data responsibly. In light of this, I have been very careful in what data and what personal reflections I have included in this study. There was some information that I chose not to include as it was not essential to the outcome of the study and may have been uncomfortable for some of the executive directors if it was put into publication.

This trusting relationship with the executive directors, combined with my desire to remain in a positive ongoing relationship with this group, did have the potential to influence or bias my findings. To deal with this problem, I ensured that I mentioned any of the areas where I made a judgment call not to include data to my advisor and sought her guidance on the final decision.
null
My intimate knowledge of the CCAC sector held the greatest area of potential bias for my findings, as well as the greatest insights into the research. I went into this study with my own preconceived ideas of what I might find. To some extent I found what I expected to find. The executive directors were knowledgeable about the principles and procedures of accountability and had lots of ideas as to how accountability could be further strengthened in the CCAC sector. I also found many things that I did not expect. Some of the executive directors surprised me with their comments and did not give the answers I would have predicted. This fact reassures me that I was effective in keeping an open mind throughout this research and did not allow my preconceived thinking to stop me from discovering key findings that I did not expect.

As I move forward with my career in healthcare, I will be able to use much of the knowledge gained from my experiences in obtaining my Master of Education degree. Although my official title and job description are not one of educator, there are many opportunities for me to apply and share with others the skills and knowledge I have gained. In my role of Assistant Clinical Professor at McMaster University, the skills I have learned from my fellow students and professors in the Masters of Education program at Brock will allow me to become more proficient at my role and bring greater benefit to my students.

**Final Statement**

Throughout the process of this study, I have learned a great deal about both accountability and the challenges of leadership in today’s world. Despite being an insider within both the healthcare leadership group and the CCAC sector, I was surprised by many of the insights I gained. I have renewed respect for the outstanding people who
lead us in our quest for a better healthcare system. Their enthusiasm and dedication to the job are unfailing, despite the numerous adversities and sometimes personal tolls faced.

The many changes to procedures and processes aimed at improving the healthcare system through strengthened accountability are all well intended. Despite the challenges and limitations associated with many of the changes, the ultimate goal behind these changes is to provide a better system of healthcare for the citizens and a subsequent improvement in the overall health of our communities. With so little empirical evidence to go on, much of the debate regarding which ideology or set of procedures is best to follow in order to achieve better accountability is poorly informed.

It would seem that the greatest challenge to achieving the goal of improved accountability lies not in determining which ideology is best, which procedure or process to use, or in how to reconfigure the system. The greatest challenge appears to be in understanding and conceptualizing accountability. Only when the principles and procedures of accountability are truly understood can they be successfully transformed into procedures and processes that are then applied and evaluated as to their ultimate success or failure.

There remains a great deal of scholarly work to be done in the area of accountability. It is my hope that this work has contributed to the literature in this regard and will assist future scholars in coming closer to the goal of truly understanding accountability and how to strengthen its application in order that we all might benefit in the end for generations to come.
REFERENCES


Long-Term Care Act, S.O. c. 26 (1994).


Queens Health Policy Research Unit. (1999). *An inventory and analysis of accountability practices in the Canadian health system*. Kingston, ON: Queen’s University, Author.


Publications


Appendix A

List of Acronyms

CAC  Community Advisory Council
CARP  Canadian Association of Retired Persons
CCAC  Community Care Access Centre
CEO  Chief Executive Officer
HSRC  Health Service Restructuring Commission
LHIN  Local Health Integration Network
MOHLTC  Ministry of Health and Long-Term Care
MOU  Memorandum of Understanding
OACCAC  Ontario Association of Community Care Access Centres
OIC  Order-in-Council
OHA  Ontario Hospital Association
QHPU  Queen’s Health Policy Unit
RAI-HC  Resident Assessment Instrument - Home Care
RFP  Request for Proposals
RHA  Regional Health Authority
Appendix B

RESEARCH QUESTIONS

1. How would you personally describe what it is to be accountable as an executive director of a CCAC?

2. How has the focus on and importance of accountability as a key responsibility for executive directors changed from the initial formation of CCACs in 1997 to the present?

3. How have the CCAC reforms affected your knowledge and application of accountability principles within your CCAC?

4. To whom do you feel you are most accountable?

5. For what do you feel you are most accountable?

6. Do you think there have been any negative consequences of the accountability reform movement in CCACs or healthcare in general?

7. What have been the positive outcomes of the accountability reform movement?

8. How would you have changed the process?

9. How do you feel that accountability could be further strengthened within CCACs?
Appendix C

CCAC Business Plan Template

CCAC Business Plan Template
For
Fiscal Years 2004/05 – 2006/07

Template Instructions

1. Refer to the Guide when completing the Template. The Template does not include instructions.

2. This template is a Microsoft Word-based document.

3. Text fields, represented by <<...>>», and tables are included in the template for CCACs to provide the narrative and data/information requested.

   Delete the text field indicators (and information/references to the Guide) prior to filling the text fields with data/information.

   Tables can be adjusted as needed (e.g., adding rows and/or columns, increasing column width, using 8.5"x11" size paper, etc.) but table row and column headings should not be changed. Refer to “Help” in Microsoft Word for further details.

4. A business plan cover page is provided. Page numbering is provided as a footer in the bottom right-hand corner of the template document. Amend page numbering as needed.

5. Attached to this business plan template are:

   - Attachment 1: Completed Tables 1, 2 and part of Table 4 for all CCACs (Excel File)
   - Attachment 2: MIS Budget Forms for 2004/05 (Excel file)
   - Attachment 3: Financial Forecast Forms for 2004/05-2006/07 (Excel file)
Business Plan

For

Fiscal Years 2004/05 – 2006/07

Name of CCAC: <<Insert Name of CCAC.>>

Date: <<Insert Date>>
Section 5.1

CCAC BUSINESS PLAN CERTIFICATE

For

Fiscal Years 2004/05 – 2006/07

The Board of Directors has approved the Business Plan and Budget Request, and is responsible for ensuring that management fulfils its responsibility for implementation of the Business Plan and for reporting to the ministry.

The Business Plan represents the current and forecasted operating and financial position of the CCAC. This plan is based on management’s best estimates, determined through experience and judgement and in accordance with ministry guidelines.

__________________________________________  _________________________
Executive Director                         Date

__________________________________________  _________________________
Chair, Board of Directors                   Date
5.2 Introduction

<<CCAC to provide the four required items in the introductory remarks. Refer to page 1 in the Guide.>>

5.3 Mandate

The mandate of <<Insert name of CCAC.>> as stated in Community Care Access Corporation Act, 2001 is:

- To provide, directly or indirectly, health and related social services and supplies and equipment for the care of persons.
- To provide, directly or indirectly, goods and services to assist relatives, friends and others in the provision of care for such persons.
- To manage the placement of persons into long-term care facilities.
- To provide information to the public about community-based services, long-term care facilities, and related health and social services.
- To cooperate with other organizations that have similar objects.

5.4 Strategic Directions

<< CCAC to provide its strategic directions (and vision/mission, where existing). Refer to page 11 in the Guide.>>

5.5 CCAC Profile and Programs

5.5a Organizational Profile

<< Attach an organizational chart for the CCAC. Refer to page 12 in the Guide.>>

5.5b Catchment Area/Geographic Location Profile

<< CCAC to provide the three required catchment area/geographic location information items. Refer to page 12 in the Guide.>>

5.5c Demographic Profile of the CCAC's Catchment and Client Population

Information:
<< Tables 1 and 2 are provided in Attachment 1. CCAC to complete Tables 3, 4 (columns 3 and 4 only; columns 1 and 2 are provided in Attachment 1), 5a and 5b. Refer to page 12 in the Guide.>>
Table 3: Individual Clients Served by the CCAC (In-Home, LTC, Publicly Funded Schools and Private/Home Schools)

<table>
<thead>
<tr>
<th>Data Source: CCAC Case Management System</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>0–19</td>
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<tr>
<td>20–64</td>
</tr>
<tr>
<td>65–74</td>
</tr>
<tr>
<td>75–84</td>
</tr>
<tr>
<td>85+</td>
</tr>
<tr>
<td>Totals</td>
</tr>
</tbody>
</table>

Table 4: Languages of Individuals Served by the CCAC

<table>
<thead>
<tr>
<th>Data Sources</th>
<th>Statistics Canada 2001 Catchment Area Data</th>
<th>CCAC Case Management System 02/03 CCAC Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Languages</td>
<td># of Individuals</td>
<td>Ranking of languages spoken in the catchment area</td>
</tr>
<tr>
<td>English</td>
<td></td>
<td></td>
</tr>
<tr>
<td>French</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Italian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portuguese</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spanish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Languages</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Refer to Attachment 1
### Table 5a: CCAC Home Care Client Referral Sources

<table>
<thead>
<tr>
<th>Data Source: CCAC Case Management System</th>
<th>2002/2003 (# and %)</th>
<th>2003/2004 Projection (# and %)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>% (row #/ total # x 100)</td>
</tr>
<tr>
<td>Initial Assessment Referral Source: Location of the Client Prior to Admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital within Catchment Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital outside Catchment Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTC Facility within Catchment Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTC Facility outside Catchment Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 5b: CCAC Placement Referral Sources

<table>
<thead>
<tr>
<th>Data Source: CCAC Case Management System</th>
<th>2002/2003 (# and %)</th>
<th>2003/2004 (# and %)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>% (row #/ total # x 100)</td>
</tr>
<tr>
<td>Location of the Client Referred for Placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital within Catchment Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital outside Catchment Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTC Facility within Catchment Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTC Facility outside Catchment Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.5d Service Profile

Information:
<<CCAC to complete the tables 6, 7, 8, 9. Refer to page 13 in the Guide>>

Table 6: CCAC Services and Programs That Are Not Part of the CCAC Base Allocation Funding

<table>
<thead>
<tr>
<th>Data Source: CCAC Case Management System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Activities Provided through the CCAC with Alternate Funding Sources</td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

Table 7: CCAC Office Locations

<table>
<thead>
<tr>
<th>Site</th>
<th>Location/Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td></td>
</tr>
<tr>
<td>Secondary 1</td>
<td></td>
</tr>
<tr>
<td>Secondary 2</td>
<td></td>
</tr>
</tbody>
</table>

Table 8: Service Availability/Accessibility

<table>
<thead>
<tr>
<th>Services</th>
<th>Regular Business Days and Hours</th>
<th>Extended Business Days and Hours</th>
<th>On-Call Days and Hours</th>
<th>Location of Service Provision (for service providers)</th>
<th>Explanation for Lack of Service Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCAC offices</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCAC in-take</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Visiting Nursing</td>
<td></td>
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<tr>
<td>Shift Nursing</td>
<td></td>
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<tr>
<td>Homemaking/PSW</td>
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<tr>
<td>OT</td>
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<tr>
<td>PT</td>
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<td></td>
</tr>
</tbody>
</table>
Table 9: Ethnocultural, Linguistic, Spiritual, Familial Characteristics of Clients

<table>
<thead>
<tr>
<th>Needs Category</th>
<th>Key Issues</th>
<th>CCAC Activities</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnocultural Characteristics</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Linguistic Characteristics</td>
<td></td>
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<tr>
<td>Spiritual Characteristics</td>
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<tr>
<td>Familial Characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.5e Analysis of Section 5.6 - CCAC Profile and Programs (5.5a, 5.5b, 5.5c, 5.5d)

<< Provide an analysis of Section 5.5. Refer to page 14 in the Guide. >>
5.6 Environmental Scan

CCACs to complete the following tables. Refer to page 15 in the Guide.

Table 10: Environment Scan Table

<table>
<thead>
<tr>
<th>Accountability Statements</th>
<th>Key Issues</th>
<th>Impact on Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide Ontarians with fair and equitable access to community based services so that Ontarians are better able to remain in their home and/or desired community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitate partnerships with health care and broader human services so that different parts of the system work together</td>
<td></td>
<td></td>
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<tr>
<td>Arrange cost-effective, well managed services to eligible clients within available resources and in accordance with applicable legislation, regulations and ministry policy</td>
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</tbody>
</table>
5.7 Performance Commitments

Accountability Statement (Part 1) – Provide Ontarians with fair and equitable access to community-based services so that Ontarians are better able to remain in their home and/or desired community.

Goal 1: CCAC Services Delivered to Eligible People

Provide a range of CCAC services for eligible people in community settings while maximizing the use of client and community resources.

Outcome Expectations

1.1 Service plans are consistent with client needs.
1.2 Assessment of long-stay clients is standardized using Resident Assessment Instrument-Home Care (RAI-HC).
1.3 Eligible people who need services the most, receive services.

Measures

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>2002/03</th>
<th>2003/04 Projections to Year End</th>
<th>Projections 2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOH1.1a: % Clients who achieve goals on discharge [source: CCAC Case Management System/OIICAS]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Indicators</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOH1.1b: % Service plans that are consistent with clients' needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOH1.2: % Compliant assessments (in accordance with MOHLTC guidelines as set by LTC Priority Project)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>2002/03</td>
<td>2003/04 Projections to Year End</td>
<td>Projections 2004/05</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>---------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>MOH1.3a: # and % Clients waiting for service initiation by service (annual average using month end actuals) [source: CCAC Case Management System]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>#</td>
<td>% (row #/total # of clients waiting x 100)</td>
<td>Service</td>
</tr>
<tr>
<td>Visiting Nursing</td>
<td></td>
<td></td>
<td>Visiting Nursing</td>
</tr>
<tr>
<td>Shift Nursing</td>
<td></td>
<td></td>
<td>Shift Nursing</td>
</tr>
<tr>
<td>Home making/P SW</td>
<td></td>
<td></td>
<td>Home making/P SW</td>
</tr>
<tr>
<td>OT</td>
<td></td>
<td></td>
<td>OT</td>
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<tr>
<td>PT</td>
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</tr>
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<td>SLP</td>
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</tr>
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<td></td>
<td>Dietetics</td>
</tr>
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<td>Publicly Funded Schools</td>
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<td>Publicly Funded Schools</td>
</tr>
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<td>Privately Funded Schools</td>
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<td>Privately Funded Schools</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>MOH1.3b: Average time clients waiting for service initiation from admission to first visit (in days) [source: CCAC Case Management System]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td># of days</td>
<td></td>
<td>Service</td>
</tr>
<tr>
<td>Visiting Nursing</td>
<td></td>
<td></td>
<td>Visiting Nursing</td>
</tr>
<tr>
<td>Shift Nursing</td>
<td></td>
<td></td>
<td>Shift Nursing</td>
</tr>
<tr>
<td>Home making/P SW</td>
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<td>Home making/P SW</td>
</tr>
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<td>OT</td>
<td></td>
<td></td>
<td>OT</td>
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<tr>
<td>PT</td>
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<td></td>
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</tr>
<tr>
<td>SLP</td>
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<td>Dietetics</td>
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<td>Dietetics</td>
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<td>Privately Funded School</td>
<td></td>
<td></td>
<td>Privately Funded School</td>
</tr>
<tr>
<td>Service</td>
<td>% (total # of service units / total number of unique individuals by service activity)</td>
<td>Service</td>
<td>% (total # of service units / total number of unique individuals by service activity)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Visiting Nursing</td>
<td>Visiting Nursing</td>
<td>Visiting Nursing</td>
<td>Visiting Nursing</td>
</tr>
<tr>
<td>Shift Nursing</td>
<td>Shift Nursing</td>
<td>Shift Nursing</td>
<td>Shift Nursing</td>
</tr>
<tr>
<td>Home making/P SW</td>
<td>Home making/P SW</td>
<td>Home making/P SW</td>
<td>Home making/P SW</td>
</tr>
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<td>OT</td>
<td>OT</td>
<td>OT</td>
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<td>PT</td>
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<td>Dietetics</td>
<td>Dietetics</td>
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<tr>
<td>Privately Funded School</td>
<td>Privately Funded School</td>
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</tbody>
</table>

CCAC Objectives in Support of Goal and/or Outcome Expectation(s)

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<tr>
<th>CCAC Objective</th>
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</table>

CCAC Performance Measures

<table>
<thead>
<tr>
<th>Output/Outcome Measures</th>
<th>2002/03</th>
<th>2003/04 Projections to Year End</th>
<th>Projections 2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCAC:</td>
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<tr>
<td>CCAC:</td>
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</tbody>
</table>
Utilize the table below to provide contextual information for ministry Service Indicators 1.3a, b, c>

<table>
<thead>
<tr>
<th>Service</th>
<th>Management Strategy (e.g. prioritization)</th>
<th>Analysis of Service Utilization Patterns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting Nursing</td>
<td></td>
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<tr>
<td>Shift Nursing</td>
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<td>Homemaking / PSW</td>
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<td>OT</td>
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<td>SW</td>
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<tr>
<td>Dietetic</td>
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<tr>
<td>Public School</td>
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<tr>
<td>Private School</td>
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</tbody>
</table>

Planned Activities Related to the Goal for the Upcoming Fiscal Year: <<Outline the CCAC's plans for the upcoming fiscal year related to service provision to clients.>>

Accountability Statement (Part 1) – Provide Ontarians with fair and equitable access to community-based services so that they are better able to remain in their home and/or desired community.

Goal 2: Support for People who Provide Care for CCAC Clients

Arrange for support and relief for people who provide care for an eligible person at home.

Outcome Expectations

2.1 Support and relief are arranged by the CCAC for people who provide care for an eligible person at home.
### Measures

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>2002/2003</th>
<th>2003/04 Projections to Year End</th>
<th>Projections 2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOH2.1 Satisfaction of people who provide care for an eligible person at home with support and relief services arranged by the CCAC (Source: CCAC Client Satisfaction Survey)</td>
<td></td>
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</tbody>
</table>

**CCAC Objectives in Support of Goal and/or Outcome Expectation(s)**

<table>
<thead>
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</tbody>
</table>

**Analysis/Explanation:** << Provide contextual information for the performance measures, e.g., reasons for the projections.>>

**Planned Activities Related to the Goal for the Upcoming Fiscal Year:** <<Outline the CCAC’s plans for the upcoming fiscal year related to respite service to clients>>
Accountability Statement (Part 1) – Provide Ontarians with fair and equitable access to community-based services so that they are better able to remain in their home and/or desired community.

Goal 3: Provision of Information and Referral Services

Provide information about, and make referral to, community-based services, long-term care facilities, and other services.

Outcome Expectations

3.1 CCAC responds to information and referral queries with accurate, up-to-date information in a timely manner.

Measures

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>2002/2003</th>
<th>2003/04 Projections to Year End</th>
<th>Projections 2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOH3.1 Client Satisfaction with I&amp;R Services (Source: CCAC Client Satisfaction Survey)</td>
<td></td>
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</tbody>
</table>

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</tbody>
</table>

Analysis/Explanation: << Provide contextual information for the performance measures, e.g., reasons for the projections.>>
Planned Activities Related to the Goal for the Upcoming Fiscal Year: «Outline the CCAC’s plans for the upcoming fiscal year related to the I&R service for clients.>>

Accountability Statement (Part 1) – Provide Ontarians with fair and equitable access to community-based services so that they are better able to remain in their home and/or desired community.

**Goal 4: Management of Admissions to LTC Facilities**

Manage admissions to long-term care facilities, including recommending feasible alternatives.

**Outcome Expectations**

4.1 Clients and their families are supported in their decision regarding placement in a long-term care facility including exploration of feasible alternatives.

4.2 Long term care beds are filled expeditiously when there are willing and eligible applicants to fill them.

**Measures**

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>MOH4.1: Client satisfaction related to admissions to LTC Facilities (Source: CCAC Client Satisfaction Survey)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOH4.2: Average # of days for priority 1 clients to be placed in a LTC Facility (Source: CCAC Case Management System)</td>
<td></td>
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</tr>
</tbody>
</table>

**CCAC Objectives in Support of Goal and/or Outcome Expectation(s)**

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CCAC Performance Measures

Output/Outcome Measures

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</tbody>
</table>

Analysis/Explanation: << Provide contextual information for the performance measures, e.g., reasons for the projections.>>

Planned Activities Related to the Goal for the Upcoming Fiscal Year: <<Outline the CCAC’s plans for the upcoming fiscal year related to LTC Facility Placement.>>

Accountability Statement (Part 1) – Provide Ontarians with fair and equitable access to community-based services so that they are better able to remain in their home and/or desired community.

Goal 5: Quality Service

Continuously monitor and improve the quality of services to clients.

Outcome Expectations

5.1 Clients are satisfied with the services they receive through the CCAC (including purchased services).

5.2 Risks to clients are mitigated or reduced.

Measures

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<tr>
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</thead>
<tbody>
<tr>
<td>MOH5.1 Client satisfaction with the CCAC (Source: CCAC Client Satisfaction Survey)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MOH5.2a # and % High risk client-related occurrences per fiscal year (circumstances that have the potential to cause harm or damage) (Source: CCAC Occurrence Management System)

<table>
<thead>
<tr>
<th>#</th>
<th>% (total # of high risk occurrences / annual total # individual CCAC clients x 100)</th>
<th>#</th>
<th>% (total # of high risk occurrences / annual total # individual CCAC clients x 100)</th>
<th>#</th>
<th>% (total # of high risk occurrences / annual total # individual CCAC clients x 100)</th>
</tr>
</thead>
</table>

Service Indicator

MOH5.2b Total # and % of client complaints received by the CCAC (include all complaints including those related to CCAC and Service Provider services) (Source: CCAC Complaints Management System)

<table>
<thead>
<tr>
<th>#</th>
<th>% (total # of annual complaints/ annual total # individual CCAC clients x 100)</th>
<th>#</th>
<th>% (total # of annual complaints/ annual total # individual CCAC clients x 100)</th>
<th>#</th>
<th>% (total # of annual complaints/ annual total # individual CCAC clients x 100)</th>
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</tbody>
</table>

**Analysis/Explanation:** << Provide contextual information for the performance measures, e.g., reasons for the projections.>>

**Planned Activities Related to the Goal for the Upcoming Fiscal Year:**
<< Outline the CCAC’s plans for the upcoming fiscal year related to continuous quality improvement (“CQI”) activities which may include but should not be limited to activities that further develop performance measures.>>
Accountability Statement (Part 2) – Facilitate partnerships with health care and broader human services so that different parts of the system work together.

Goal 6: Collaboration with Health and Social System Partners

Collaborate with community partners to implement efficient and effective strategies for service delivery.

Outcome Expectations

6.1 Smoother transition of clients through the continuum of care.

Measures

<table>
<thead>
<tr>
<th>Current Status Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Item Identifier</strong></td>
</tr>
<tr>
<td>6.a</td>
</tr>
<tr>
<td>6.b</td>
</tr>
<tr>
<td>6.c</td>
</tr>
</tbody>
</table>

CCAC Objectives in Support of Goal and/or Outcome Expectation(s)

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<tr>
<th>CCAC Objective</th>
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<table>
<thead>
<tr>
<th>CCAC Performance Measures</th>
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<tbody>
<tr>
<td><strong>Output/Outcome Measures</strong></td>
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<tr>
<td>Measure</td>
</tr>
<tr>
<td>CCAC:</td>
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<tr>
<td>CCAC:</td>
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</tbody>
</table>
Analysis/Explanation: << Provide contextual information for the performance measures, e.g., reasons for the projections.>>

Planned Activities Related to the Goal for the Upcoming Fiscal Year: <<Outline the CCAC’s plans for the upcoming fiscal year related to activities that facilitate the transition of clients through the continuum of care.>>

Accountability Statement (Part 3) – Arrange cost-effective, well-managed services to eligible clients, which are within available resources and in accordance with applicable legislation, regulations, and ministry policy.

Goal 7: Governance

Establish and maintain an effective governance system.

Outcome Expectations

7.1 The Board demonstrates its accountability to the ministry.

Measures

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Status</td>
<td>% (total # of CCAC BP objectives (STATUS) / total # of CCAC objectives in the BP x 100)</td>
<td>% (total # of CCAC BP objectives (STATUS) / total # of CCAC objectives in the BP x 100)</td>
</tr>
<tr>
<td>MOH7.1a # and % Annual business plan objectives: 1. achieved 2. partially achieved 3. not achieved by year-end (Source: CCAC Business Plan)</td>
<td>Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partially Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not Achieved</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MOH7.1b # and % Variance year-end total expenditures to total budget

<table>
<thead>
<tr>
<th></th>
<th>% (year end total expenditures/ total approved budgeted expenditures x 100)</th>
<th>% (forecasted year end total expenditures [form 2] / total approved budget [form 2] x 100)</th>
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</table>

CCAC Objectives in Support of Goal and/or Outcome Expectation(s)

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<th>Objective</th>
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</table>

CCAC Performance Measures

<table>
<thead>
<tr>
<th>Measure</th>
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</table>

Analysis/Explanation: << Provide contextual information for the performance measures, e.g., reasons for the projections.>>

Planned Activities Related to the Goal for the Upcoming Fiscal Year:
<<Outline the CCAC’s plans for the upcoming fiscal year related to the CCAC’s Board activities.>>

Accountability Statement (Part 3) – Arrange cost-effective, well-managed services to eligible clients, which are within available resources and in accordance with applicable legislation, regulations, and ministry policy.

Goal 8: Human Resource Plan

Effectively manage the organization’s human resources.
Outcome Expectations

8.1 The CCAC has staff with the necessary skills to perform its business effectively.

Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>2002/2003</th>
<th>2003/04 Projections to Year End</th>
<th>Projections 2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOH8.1a # and % of Staff Turnover Rates* (Source: CCAC Human Resources System)</td>
<td>#</td>
<td>% (total # of staff who have exited the CCAC within the year / total # of CCAC staff x 100)</td>
<td>#</td>
</tr>
<tr>
<td>MOH8.1b # and % Absenteeism Rates** (Source: CCAC Human Resources System)</td>
<td>#</td>
<td>% (total # of employee days absent from work (paid or unpaid) / total # of staff days worked x 100)</td>
<td>#</td>
</tr>
</tbody>
</table>

*Includes all reasons for exiting the organization, for example retirements, voluntary departures for new positions outside the organization.
** The CCAC data should exclude WSIB and LTD cases.
*** MOHLTC performance measures under development
### CCAC Objectives in Support of Goal and/or Outcome Expectation(s)

<table>
<thead>
<tr>
<th>Objective</th>
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### CCAC Performance Measures

<table>
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<tr>
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<td>CCAC:</td>
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</tbody>
</table>

#### Analysis/Explanation
<<Provide contextual information, e.g., comparison of 8.1a and 8.1b to national averages, major human resource issues anticipated for the up-coming fiscal year, the current status of collective bargaining and potential impact on CCAC operations and human resource planning, retirements, new training requirements for staff due to technological change, impact of ministry new initiatives, etc.>>

<<Utilize the table below to provide information for ministry on the status of collective agreements for CCAC staff>>

<table>
<thead>
<tr>
<th>Collective Agreements for CCAC Staff</th>
<th>Term of Collective Agreement (Indicate start and termination dates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collective Agreements (List all contracts)</td>
<td>Start date</td>
</tr>
<tr>
<td></td>
<td>Termination date</td>
</tr>
<tr>
<td></td>
<td>Start date</td>
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<td>Termination date</td>
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<tr>
<td></td>
<td>Start date</td>
</tr>
<tr>
<td></td>
<td>Termination date</td>
</tr>
</tbody>
</table>
Planned Activities Related to the Goal for the Upcoming Fiscal Year:
<<Outline the CCAC’s plans for the upcoming fiscal year related to the CCAC’s human resource activities, including staff learning strategies or plans.>>

Accountability Statement (Part 3) – Provide cost-effective, well-managed services to eligible clients who, are within available resources and in accordance with applicable legislation, regulations, and ministry policy.

Goal 9: Procurement and Contract Management

Manage an effective procurement and contract management process.

Outcome Expectations

9.1 Contracted agencies meet their commitments to provide quality goods and services to CCAC clients.

Measures

<table>
<thead>
<tr>
<th>Service Indicator*</th>
<th>Measure</th>
<th>2002/2003</th>
<th>2003/04</th>
<th>Projections</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Projections to Year End</td>
<td>2004/05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of refusal</td>
<td>% of referrals</td>
<td>% of refusal</td>
</tr>
<tr>
<td>MOH9.1 # and % Service refusals due to service providers’ inability to serve clients</td>
<td># of refusals</td>
<td># of referrals</td>
<td>(total # of refusals / total # of referrals x 100)</td>
<td># of refusals</td>
</tr>
<tr>
<td>a. Service provider related factors (e.g., lack of human resources, language barrier)</td>
<td>Visiting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Client related factors (e.g., high risk)</td>
<td>Nursing</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
(Source: CCAC Occurrence Management/Procurement System)

<table>
<thead>
<tr>
<th>nature in servicing client, client not available.</th>
<th>SW</th>
<th>Dietetics</th>
</tr>
</thead>
<tbody>
<tr>
<td>way Funded Schools</td>
<td></td>
<td></td>
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<tr>
<td>Privately Funded Schools</td>
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<td></td>
</tr>
</tbody>
</table>

b. Client Related Factors

| Visiting Nursing |     |           |
| Shift Nursing    |     |           |
| PSW/ Home Making |     |           |
| OT               |     |           |
| PT               |     |           |
| SLP              |     |           |
| SW               |     |           |

Dietetics

Publicly Funded Schools

Privately Funded Schools

*** MOHLTC performance measures under development

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<td>CCAC:</td>
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</tbody>
</table>

**Analysis/Explanation:** << Provide contextual information for the performance measures, e.g., reasons for the projections.>>

**Planned Activities Related to the Goal for the Upcoming fiscal Year:**
<<Outline the CCAC’s plans for the upcoming fiscal year related to procurement and contract management activities.>>

**Accountability Statement (Part 3) –** Arrange cost-effective, well-managed services to eligible clients, which are within available resources and in accordance with applicable legislation, regulations, and ministry policy.

**Goal 10: Balanced Budget**

Demonstrate effective and efficient operations.

**Outcome Expectations**

10.1 Client needs are balanced with resources available.
10.2 Funds are used as intended.

**NOTE:** Complete and append the MIS budget forms for fiscal year 2004/2005. Refer to page 7 in the Guide.
## Measures

### Performance Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>2002/2003</th>
<th>2003/04 Projections to Year End</th>
<th>Projections 2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOH10.1a. % Variance of units of service provided to units of service budgeted each fiscal year by service (Source: MIS)</td>
<td>(year end # of units of service provided / year end # of budgeted units x 100)</td>
<td>(year end # of units of service provided [form 3] / # of budgeted units [form 3] x 100)</td>
<td>(forecasted year end # of units of service provided [form 3] / # of budgeted units [form 3] x 100)</td>
</tr>
<tr>
<td>Service Way</td>
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<td></td>
</tr>
<tr>
<td>Visiting Nursing</td>
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<td>Home making/P SW</td>
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<td>OT</td>
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<td>PT</td>
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<td>SLP</td>
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<td>SW</td>
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<tr>
<td>Dietetics</td>
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</table>

### Measure

<table>
<thead>
<tr>
<th>Measure</th>
<th>2002/2003</th>
<th>2003/04 Projections to Year End</th>
<th>Projections 2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOH10.2a. Total administrative costs as % of total expenditures (Source: MIS)</td>
<td>(year end admin and support costs / year end total expenses x 100)</td>
<td>(admin and support costs [form 2b, line 17, F/A group #2] / total expenses [form 2, line 17 fund type 2] x 100)</td>
<td>(admin and support costs [form 2b, line 17 F/A group #2] / total expenses [form 2, line 17 fund type 2] x 100)</td>
</tr>
<tr>
<td>MOH10.2b. Total case management costs as % of total expenditures (Source: MIS)</td>
<td>(year end case management costs / year end total expenses x 100)</td>
<td>(case management costs [form 2b, line 17 F/A group #5] / total expenses [form 2, line 17 fund type 2] x 100)</td>
<td>(case management costs [form 2b, line 17 F/A group #5] / total expenses [form 2, line 17 fund type 2] x 100)</td>
</tr>
</tbody>
</table>
CCAC Objectives in Support of Goal and/or Outcome Expectation(s)

<table>
<thead>
<tr>
<th>CCAC Objective</th>
<th>CCAC Objective</th>
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</table>

CCAC Performance Measures

<table>
<thead>
<tr>
<th>Output/Outcome Measures</th>
<th>2002/03</th>
<th>2003/04 Projections to Year End</th>
<th>Projections 2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCAC:</td>
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<tr>
<td>CCAC:</td>
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</table>

**Analysis/Explanation:** << Provide brief rationale/contextual information for:

a. the budget. *If necessary*, provide more detail on the 2004/05 Proposed Balanced Budget Summary Table (above) (e.g., highlight adjustments made from the last approved budget in order to deal with the key issues and challenges previously identified in the Environmental Scan) and

b. the performance measures (e.g., financial stresses impacting service utilization for the up-coming fiscal year).>>

<<Utilize the tables below to provide information for ministry on the proposed CCAC budget>>

### 2004/05 Proposed Balanced Budget Summary

<table>
<thead>
<tr>
<th>Accounting Centre</th>
<th>2003/2004 Approved Budget as of 30/9/03</th>
<th>2004/2005 Proposed Balanced Budget ($ and %)</th>
<th>Reason(s) or Assumptions for Change</th>
<th>Strategy to Balance Budget and Anticipated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>REVENUE</td>
<td></td>
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<tr>
<td>MOHLTC Fiscal Subsidy</td>
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<tr>
<td>Non MOHLTC Revenue</td>
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</tbody>
</table>
### EXPENSES

<table>
<thead>
<tr>
<th>Item</th>
<th>2003/04</th>
<th>2004/05</th>
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<tbody>
<tr>
<td>Salaries</td>
<td></td>
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<tr>
<td>Total</td>
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<tr>
<td>Benefit Contributions</td>
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<tr>
<td>Supplies and Other</td>
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<tr>
<td>Referred Out Expenses</td>
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<tr>
<td>Equipment</td>
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<tr>
<td>One-time Expenses</td>
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<tr>
<td>Building and Grounds</td>
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</tbody>
</table>

**NET SURPLUS (Deficit)**

**Total (Note: total stated here should match Budget Request)**

### Other Funded Activities

<table>
<thead>
<tr>
<th>Other Activities Funded through the CCAC in 2004/05 (refer to chart listing activities in Table 6)</th>
<th>2003/04</th>
<th>2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sources of Funding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Budgeted Costs of the Activity in 2003/04 and</td>
<td></td>
<td></td>
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<tr>
<td>3. Number of FTEs</td>
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</table>

<table>
<thead>
<tr>
<th>Source</th>
<th>Cost</th>
<th>FTEs</th>
<th>Source</th>
<th>Cost</th>
<th>FTEs</th>
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</tbody>
</table>

**Total**

**Planned Activities Related to the Goal for the Upcoming Fiscal Year:**

<<Outline the CCAC's plans for the upcoming fiscal year related to the CCAC's financial management activities, including cost monitoring, control, contingency/recovery planning to remain within budget if needed.>>
5.8 Risk Assessment and Management

5.8a Risk Assessment and Management
"<CCACs to complete the following table. Refer to page 20 in the Guide.>>

Table 10: Risk Assessment and Management

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Likelihood of Occurrence (high, med, low)</th>
<th>Impact if Risk Realized (high, med, low)</th>
<th>Description of Impact if Risk Factor Realized (i.e. potential impact on CCAC, clients, community, ministry, etc.)</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

5.8b: Analysis
"<CCACs to highlight pertinent issues related to each risk factor. Refer to page 20 in the Guide.>>"
5.9 Financial Forecast for Current Fiscal Year 2003/04 and Fiscal Years 2004/05 – 2006/07

5.9a: Information:
<<CCAC to complete the attached Financial Forecast Form. Refer to page 22 in the Guide.>>

5.9b: Analysis
<< The CCAC to provide a brief explanation of the rationale/key factors behind the forecasts. Refer to page 23 in the Guide.>>

6.0 Annual CCAC Communications Plan: Community and Stakeholder Outreach

Communication Goal

Each CCAC, in collaboration with the ministry, will develop and implement a communication plan for its community and stakeholder outreach activities

6.1 Objectives

<<CCAC to provide its communications objectives for its coordinated proactive communications activities. Refer to page 25 in the Guide.>>

<table>
<thead>
<tr>
<th>CCAC Communication</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

6.2 Strategy

<<CCAC to provide the over-arching communications strategy that will guide its planned proactive communications activities. Refer to page 25 in the Guide.>>

6.3 Key Stakeholder / Target Audiences

<<CCACs to provide a list and description of their key stakeholders, and identify, from that list, which stakeholders will be target audiences for upcoming communications activities. Refer to page 25 in the Guide.>>
6.4 Proactive Communications Activities

<<CCAC to complete the table below with its proactive communications activities including information on timing, target audiences, and key message for each activity. Refer to page 26 in the Guide >>

<table>
<thead>
<tr>
<th>Activities</th>
<th>Timing</th>
<th>Target Audiences</th>
<th>Key Message</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

6.5 Measuring Effectiveness

<<CCAC to provide its proactive communications evaluation measures. Refer to page 25 in the Guide.>>
MEMORANDUM OF UNDERSTANDING

BETWEEN:

THE MINISTER OF HEALTH AND LONG-TERM CARE

and

THE CHAIR OF COMMUNITY CARE ACCESS CENTRE OF HALTON

1.0 INTRODUCTION

1.1 Purpose

1.1.1 The purpose of this Memorandum is to clarify the operational, accountability, financial, administrative, auditing and reporting relationships between the Minister of Health and Long-Term Care and the CCAC. This Memorandum sets out the framework for accountability between the Minister and the Chair of the CCAC and meets the requirements of the Management Board of Cabinet Directive on Agency Establishment and Accountability, dated February 2000.

1.1.2 The Minister and the Board shall act according to the responsibilities set out for each in this Memorandum. This Memorandum shall not affect, modify or interfere with the responsibilities of either the Minister or the Board under law. For greater certainty, this Memorandum shall not limit in any way the ability, authority and obligation of the Board to manage the CCAC in light of the best interests of the CCAC and in accordance with the other legal duties and responsibilities of the Board, including, without limitation, any duties of care or fiduciary duties. These legal duties and responsibilities shall prevail over any provision of this Memorandum in the event of any conflict between the provisions of this Memorandum and the legal duties and responsibilities of the Board.

1.1.3 The CCAC is responsible for all of its business and operations in accordance with applicable Government policy and generally accepted management and accounting principles.

1.2 Definitions

1.2.1 As used in this Memorandum of Understanding the following terms have the following meanings:
Act means the Community Care Access Corporations Act, 2001, as amended from time to time, or any legislation enacted in addition or in substitution for it;

Board means the Board of Directors of the CCAC whose members are appointed by the Lieutenant Governor in Council for a determined period;

By-laws means the by-laws as adopted by the Board providing for the internal governance and operation of the CCAC;

Chair means the appointed member of the Board designated under subsection 7(4) under the Act;

CCAC means the Community Care Access Centre of Halton designated as a community care access corporation in O. Reg. 33/02 under the Community Care Access Corporations Act, 2001;

Deputy Minister means the Deputy Minister of Health and Long-Term Care;

Executive Director means the senior employee of the CCAC who is appointed as Executive Director by the Lieutenant Governor in Council, is employed by the Board and is the chief executive officer of the CCAC, all under section 10 of the Act;

Government means the Government of Ontario;

Long-Term Care Act, 1994 means the Long-Term Care Act, 1994, S.O. 1994, chapter 26;

Long-Term Care Facility means an approved charitable home for the aged as defined in the Charitable Institutions Act, a home as defined in the Homes for the Aged and Rest Homes Act, or a nursing home as defined in the Nursing Homes Act;

Long-Term Care Facility Legislation means the Charitable Institutions Act, R.S.O. 1990, c. C.9, the Home for the Aged and Rest Homes Act, R.O. 1990, c. H.13, and the Nursing Homes Act, R.S.O. 1990, c. N.7, all as amended;

Memorandum means this Memorandum of Understanding;

Minister means the Minister of Health and Long-Term Care, who is a Provincial Member of Parliament, appointed to preside over and have charge of Community Care Access Corporations and all their functions;
Ministry means the Ministry of Health and Long-Term Care;

Placement Coordination Services means a program of determining eligibility for admission to a Long-Term Care Facility, managing the waiting list and priorities for admission to a Long-Term Care Facility, and authorizing admission to a Long-Term Care Facility.

1.2.2 Expressions used in this Memorandum have the same meaning as in the Long-Term Care Act, 1994, unless the context requires otherwise.

1.3 CCAC Classification

1.3.1 The CCAC has been designated as an Operational Service Agency in accordance with the Management Board of Cabinet Directive on Agency Establishment and Accountability, 2001, and is subject to Directives of the Management Board of Cabinet applicable to Operational Service Agencies set out in Schedule A to this Memorandum;

1.3.2 The CCAC is a corporation without share capital. The CCAC is not subject to the Corporations Act or the Corporations Information Act.

1.3.3 The CCAC is not a Crown agent. The CCAC, while accountable to the Minister and Ministry, operates at arm's length from the Government.

1.3.4 The CCAC has all the capacity and powers of a natural person for the purpose of carrying out the CCAC's functions, except as limited by the Act or by a regulation made by the Minister.

1.4 Legislative Authority and Mandate

1.4.1 The legislative authority of the CCAC is set out in the Act.

1.4.2 The CCAC's mandate and objects as set out in section 5 of the Act are:

(a) To provide, directly or indirectly, health and related social services and supplies and equipment for the care of persons.

(b) To provide, directly or indirectly, goods and services to assist relatives, friends and others in the provision of care for such persons.

(c) To manage the placement of persons into long-term care facilities.
(d) To provide information to the public about community-based services, long-term care facilities, and related health and social services.

(e) To cooperate with other organizations that have similar objects.

1.4.3 Under the Act, the CCAC is governed and managed by the Board, which is appointed by the Lieutenant Governor in Council.

1.4.4 The CCAC is deemed to be an approved agency under the Long-Term Care Act, 1994 and is approved to provide, or arrange for the provision of services specified under the Long-Term Care Act, 1994 in O. Reg. 33/02.

1.4.5 The CCAC shall provide, directly or indirectly, the services specified in O. Reg. 33/02 in accordance with the Long-Term Care Act, 1994 and its Business Plan submitted under section 7.0. Funding for the Fiscal Period shall be applied to provide, directly or indirectly, the services as set out in the Business Plan for that Fiscal Period in accordance with the Business Plan for that Fiscal Period, and shall not be applied for any other purpose without the prior written approval of the Ministry.

1.4.6 As an approved agency under the Long-Term Care Act, 1994, the CCAC shall comply with the provisions of the Long-Term Care Act, 1994.

1.4.7 The CCAC shall provide Placement Coordination Services and comply with the provisions of the Long-Term Care Facility Legislation, including the regulations made thereunder, all as amended. The CCAC shall comply with the policies, procedures and guidelines as set out in the Long-Term Care Facility Program Manual, dated December 20, 1993, or any manual which replaces it, as applicable, as amended from time to time by the Ministry; and the Placement Coordination Services Manual, dated July 1, 1994, or any manual which replaces it, as applicable, as amended from time to time by the Ministry.

1.4.8 The CCAC shall provide any other services approved by the Ministry in the Business Plan.

1.4.9 The CCAC shall ensure that persons in a profession governed by the Regulated Health Professions Act who provide services for the CCAC, either directly or indirectly, provide those services in accordance with written standards of professional practice relating to those professions, or with other applicable laws and regulations. The CCAC shall ensure that other persons who provide services for the CCAC, either directly or
indirectly, provide those services in accordance with their written standards of practice, or any laws and regulations that apply to them.

1.4.10 The CCAC shall comply with all Ministry directives, policies, guidelines and procedures relating to the CCAC's mandate, and responsibilities set out in this Memorandum.

1.5 Conflict of Interest

1.5.1 Pursuant to section 6 of the Act, the CCAC and its members of the Board are subject to sections 132, 134 (1) and 136 of the Business Corporations Act, which deal with disclosure of conflict of interest and indemnification of the Board members. Furthermore, the CCAC and the Board are responsible for developing conflict of interest and post-service rules for the CCAC, which are to be in accordance with the Business Corporations Act and the principles of the Conflict of Interest & Post-Service Directive for Public Servants and Officials and this Memorandum, including any government or Ministry guidelines on conflict of interest.

1.5.2 The CCAC shall ensure that all services it provides, either directly or indirectly, are carried out in all of their aspects without a conflict of interest by any director, officer, or employee. For these purposes, a conflict of interest includes a situation in which a director, officer or employee of the CCAC or any member of his or her immediate family is able to benefit financially from the services provided hereunder. For the purpose of this section, "financial benefit" shall not include the receipt or delivery of services provided to a person through the CCAC in the ordinary course of business.

1.6 Duration of Memorandum

1.6.1 This Memorandum becomes effective on the date on which the last person signs it for a period of five (5) years or until replaced with a further Memorandum. This Memorandum must not be signed before it has been reviewed and approved by the Management Board of Cabinet.

1.7 Process for Review and Amendment Of the Memorandum

1.7.1 This Memorandum shall be reviewed upon appointment of a new Minister or designation of a new Chair of the CCAC. The purpose of the review is to ensure that the Minister or the Chair, as the case may be, is aware of this Memorandum and to give them the opportunity to review the appropriateness of its provisions.
1.7.2 This Memorandum may be amended with the agreement of the Minister and the CCAC. Either the Minister or the CCAC may propose amendments to the Memorandum. All amendments must be made in writing and approved by the Board, the Minister and Management Board of Cabinet before a revised Memorandum can be signed.

1.7.3 This Memorandum is subject to periodic review initiated at the discretion and direction of the Minister. The CCAC may request that the Minister review this Memorandum.

1.7.4 In the event of a review initiated at the direction of the Minister, the Minister shall submit any recommendations regarding changes to the Memorandum to Management Board of Cabinet for approval. The Minister shall discuss any such recommendations with the CCAC.

Process for Review of the CCAC

1.7.5 At their discretion, the Minister or Management Board of Cabinet may require that the CCAC undergo a review. In requiring such a review, the Minister or Management Board of Cabinet shall determine the timing and responsibility for conducting the review, the roles of the Chair and Deputy Minister and how any other parties shall be involved. The results of the periodic review may include options for changes to the CCAC's mandate, consolidation, alternative service delivery, appointment of a supervisor under the Act, and termination of the CCAC.

1.7.6 The Minister or Management Board of Cabinet may direct that a review of the CCAC may include but is not limited to the following matters:

(a) Mandate and responsibilities;
(b) Aims and objectives;
(c) Performance measurement systems;
(d) Impact on clients, stakeholders and the public;
(e) Organizational structure;
(f) Management systems;
(g) Information systems;
(h) Reporting relationships and reports;
(i) Corporate plan and planning;
(j) Budgeting and financial systems; and
(k) Human resources and human resource management systems.

Process for Review of the Act
1.7.7 The Minister must undertake a comprehensive review of the Act five years after it comes into force under section 21 of the Act. The Act received Royal Assent on December 14, 2001, and is in force as of that date.

2.0 GUIDING PRINCIPLES

2.1.1 The Minister recognizes that the CCAC is a statutory entity which operates at arm's length from the Government and which exercises powers and performs duties in accordance with its mandate under the Act and its duties and obligations under the Long-Term Care Act, 1994 and the Long-Term Care Facility Legislation.

2.1.2 The CCAC acknowledges that it is accountable to the Government in exercising its mandate. Accountability is a fundamental principle to be observed in the management, administration and operations of the CCAC.

2.1.3 The CCAC shall conduct itself according to the management principles of the Government of Ontario. These principles include ethical behaviour, accountability, excellence in management, wise use of public resources, value for money, high-quality service to the public, fair and equitable access to high quality service and openness and transparency.

2.1.4 The CCAC shall ensure that the CCAC's operations are in compliance with the Government's and the Ministry's directives, policies, guidelines and procedures and its obligations under the Act, the Long-Term Care Act, 1994, the Long-Term Care Facility Legislation, and any regulations thereunder.

3.0 ACCOUNTABILITY RELATIONSHIP

3.1.1 The accountability relationship is as follows:
(a) The Minister is accountable to the Legislature for the CCAC’s fulfillment of its mandate, its compliance with Government policies and for reporting to the Legislature on the affairs, activities and operations of the CCAC.

(b) The Chair is accountable to the Minister for the performance of the CCAC in fulfilling its mandate and for carrying out the roles and responsibilities assigned to the Chair by the Act, the Long-Term Care Act, 1994, the Long-Term Care Facility Legislation, Management Board Directives and this Memorandum.

(c) The Deputy Minister is accountable to the Minister for the performance of the Ministry in respect of this Memorandum and for carrying out the roles and responsibilities assigned to him or her by the Minister and by Management Board Directives, the Act, the Long-Term Care Act, 1994, and this Memorandum.

(d) The Executive Director is accountable to the Board of the CCAC and to the Minister and works under the direction of the Chair in implementing the Board's decisions.

(e) The Board is accountable to the Minister through the Chair to ensure that the Executive Director's responsibilities are met. The Chair and the Board of the CCAC shall ensure that the Executive Director's performance contract includes the Executive Director's responsibilities, his or her reporting obligations to the Chair, and the standards to be met in performing those responsibilities and obligations. The Executive Director's performance contract shall stipulate performance objectives of the Board through the Chair, which objectives must be approved by the Minister.

(f) The CCAC staff report to and are accountable to the Executive Director for their performance.
4.0 ROLES AND RESPONSIBILITIES

4.1 Minister

4.1.1 The Minister is responsible for:

(a) monitoring the activities of the CCAC to ensure its mandate is being fulfilled and that it is in compliance with relevant Government and Ministry directives, guidelines, policies and procedures, the Act and the Long-Term Care Act, 1994, Long-Term Care Facility Legislation, and any regulations made thereunder;

(b) communicating to the Chair the Government's priorities and policy directions within which the CCAC is required to operate;

(c) reporting and responding to the Legislative Assembly on the affairs of the CCAC;

(d) reporting and responding to Cabinet on the CCAC's performance and compliance with the Government's policy directions and operational policies;

(e) when appropriate or necessary, taking action or directing / recommending that corrective action be taken in respect of the CCAC's mandate or operation;

(f) reviewing and approving the CCAC's multi-year plans and reports in accordance with section 7 of this Memorandum;

(g) reviewing, approving and presenting the recommended annual allocation for the CCAC as part of the Government's Business Planning and Allocation Process;

(h) receiving and making the CCAC's annual report available to the public;

(i) the administration of the Act;

(j) recommending appointment and re-appointments pursuant to the process for agency appointments established by legislation or Management Board of Cabinet;

(k) fixing the salary or other remuneration and the benefits, including rights relating to severance, termination, retirement and superannuation, of the Executive Director of the CCAC;
(l) reviewing and approving the performance objectives for the Executive Director;

(m) directing a periodic review of the CCAC and making recommendations to Management Board of Cabinet after the conclusion of the review;

(n) undertaking a comprehensive review of the Act five years after it comes into force in accordance with section 21 of the Act; and

(o) meeting with the Chair annually.

The Minister may delegate his/her authority to the Deputy Minister or to any other person, subject to such limitations, conditions and requirements as the Minister may set out in the delegation.

4.2 Deputy Minister

4.2.1 The Deputy Minister is responsible for providing advice, support and assistance to the Minister in the execution of the Minister's duties in regard to the CCAC by:

(a) providing a process for assessing whether the CCAC is fulfilling its mandate, in concert with relevant Government and Ministry directives, guidelines, policies and procedures, the Act and the Long-Term Care Act, 1994, Long-Term Care Facility Legislation, and any regulations made thereunder;

(b) monitoring the CCAC on behalf of the Minister as to whether the CCAC is fulfilling its mandate and responsibilities in concert with relevant Government and Ministry directives, guidelines, policies and procedures and identifying any need for corrective action and/or recommending to the Minister ways of resolving issues;

(c) ensuring that all accountability and reporting requirements as set out in this Memorandum have been met;

(d) consulting with the CCAC's Executive Director and/or Chair, as needed, on matters of mutual importance and on Management Board of Cabinet Directives and Ministry policies;
4.3 The Board

4.3.1 The Board is responsible for:

(a) directing the affairs of the CCAC so as to fulfill its mandate and responsibilities as set out in the Act, the Long-Term Care Act, 1994, Long-Term Care Facility Legislation, the CCAC's By-laws, its approved Business and Strategic Plans and the relevant Government and Ministry's directives, guidelines, policies and procedures set out in this Memorandum or that may be communicated by the Minister in the future;

(b) establishing the goal, objectives and strategic direction for the CCAC, consistent with its mandate, responsibilities and objectives, this Memorandum and within the Government and Ministry's directive, guidelines, policies and procedures;

(c) making decisions consistent with the business plan approved for the CCAC;

(d) employing as its Executive Director the person appointed by the Lieutenant Governor in Council under section 10(1) of the Act, and terminating that person's employment as Executive Director when the appointment expires or if the Lieutenant Governor in Council revokes the person's appointment;

(e) providing the salary and other remuneration and benefits to the Executive Director as fixed by the Minister under section 10(4) of the Act;

(f) ensuring that the Executive Director is responsible and accountable to the Board for the day-to-day management of the CCAC;

(g) directing the preparation of the CCAC's Business Plan, annual report, regular financial reports, and such other reports as requested by the Ministry, in keeping with the Management Board of Cabinet's requirements and this Memorandum;

(h) approving the Memorandum in a timely manner and authorizing the Chair to sign it on behalf of the Board;
(i) approving for submission to the Minister in a timely manner the CCAC's proposed multi-year and annual plans and reports as described in section 7 of this Memorandum;

(j) setting performance objectives for the Executive Director

(k) passing by-laws or resolutions regulating its procedure and generally for the conduct and management of the affairs of the CCAC, with any change or amendment to the by-laws to be approved in writing by the Minister;

(l) monitoring the use of funds and assets, and setting policies, to ensure that funds and assets are used with integrity and honesty and that the CCAC operates within its approved funding;

(m) ensuring that the CCAC is operated and managed in an efficient and effective manner according to accepted business and financial practices and in accordance with Operational Service provincial agency requirements;

(n) ensuring compliance with the Act, the Long-Term Care Act, 1994, Long-Term Care Facility Legislation, and Government and Ministry directives, guidelines, policies and procedures, including any Minister's directions issued under section 11 of the Act;

(o) arranging for audits of the CCAC, as needed;

(p) directing corrective action be taken, if needed, and undertaking any corrective action at the behest of the Minister;

(q) cooperating with any periodic review directed by the Minister or Management Board of Cabinet;

(r) establishing a Community Advisory Council in accordance with section 9 of the Act and any regulation made pertaining thereto;

(s) promoting linkages with other community agencies, hospitals, and long-term care facilities, and any other organization, as appropriate; and

(t) ensuring the development of an effective performance measurement and management system for assessing the CCAC's performance.

4.4 Chair
4.4.1 The Chair is responsible for:

(a) seeking strategic policy direction from the Minister;

(b) providing strategic leadership and overall direction to the Board and ensuring the implementation of the goals, objectives and strategic direction of the CCAC;

(c) convening and chairing meetings of the Board;

(d) communicating the Board’s goals, objectives and strategic direction to the Executive Director;

(e) with the Executive Director developing performance objectives for the Executive Director incorporating those set by the Board, and which must be approved by the Minister;

(f) communicating performance objectives approved by the Minister to the Executive Director; reviewing the performance of the Executive Director; and making recommendations to the Minister about the appointment of the Executive Director;

(g) ensuring that the Minister is provided with such information regarding the CCAC as the Minister may require in order to carry out the Minister’s responsibilities;

(h) reporting to the Minister, as requested, on the CCAC’s activities and guidelines and on practices under which the CCAC operates;

(i) monitoring the performance of the CCAC;

(j) signing the Memorandum for the CCAC as directed by the Board;

(k) forwarding to the Minister by the dates specified by the Minister or Ministry the Board’s approved multi-year and annual plans and reports described in section 7 of this Memorandum;

(l) ensuring that any significant additions, deletions or amendments to the CCAC’s plans referred to in clause (k) are communicated to the Minister and in time for their approval, where appropriate, by the Minister and the Management Board of Cabinet, before implementation;

(m) ensuring that all CCAC board members and staff are informed of and comply with all relevant conflict of interest guidelines. Conflict of interest matters should be handled in accordance with
Government guidelines and section 132 of the Business Corporations Act, and the regulations made thereunder; advising the Minister of the nature of any declared conflict of interest by board members where the conflict of interest is identified in the Ministry's conflict of interest guidelines for CCACs;

(n) notifying the Minister promptly of any board or Executive Director vacancies;

(o) consulting with the Minister in advance and receiving the Minister's approval if the CCAC plans to embark on any enterprise or activity which may impact on the Government's and Ministry's directives, policies, guidelines and procedures, the Long-Term Care Act, 1994, Long-Term Care Facility Legislation, and any regulations made thereunder;

(p) ensuring that all Board members are informed of their roles, responsibilities and obligations and ensuring that all Board members receive the necessary training and orientation to carry out their responsibilities;

(q) cooperating with any periodic review directed by the Minister of Management Board of Cabinet; and

(r) attending and/or making presentations before Cabinet or committees of Cabinet or the Legislature on matters concerning the affairs of the CCAC when requested to do so.

4.5 Executive Director

4.5.1 The Executive Director of the CCAC is responsible for:

(a) providing leadership, guidance and management to the CCAC staff, including human and financial resources management, in accordance with accepted business and financial practices and standards, the Act, the Long-Term Care Act, 1994, Long-Term Care Facility Legislation, and regulations under all of them, and the Government's and Ministry's directives, policies, guidelines and procedures set out in this Memorandum or that may be communicated by the Minister in the future;

(b) managing the day-to-day functions of the CCAC and the fulfillment of its mandate;
(c) translating the goals, objectives and strategic direction of the Board into operational plans and activities in accordance with the approved Business Plan;

(d) keeping the Board informed of the implementation of policy and the operations of the CCAC;

(e) providing the Board and Chair with advice and assistance in meeting their responsibilities;

(f) advising the Chair and the Board on compliance with Government and Ministry directives, guidelines, policies and procedures;

(g) preparing for approval by the Board the CCAC’s proposed multi-year and annual reports and plans as described in section 7 of this Memorandum;

(h) implementing a system of performance measures for the CCAC and reporting on them to the Chair and the Board;

(i) establishing a financial management framework to support decision-making and appropriate systems so that a CCAC operates within its approved business plan;

(j) applying board policies so that public funds are used with integrity and honesty, and within the approved CCAC budget;

(k) maintaining effective communication with the Deputy Minister, staff of the Ministry and key stakeholders;

(l) undertaking reviews, evaluations and reports of the CCAC’s activities at the request of the Board or the Ministry and advising the Board and the Ministry, as appropriate, of the results;

(m) meeting the performance objectives set by the Board through the Chair and approved by the Minister;

(n) ensuring that the Deputy Minister is provided with such information regarding the CCAC as the Minister may require or request in order to carry out his or her responsibilities;

(o) consulting with the Deputy Minister on matters of mutual importance and on Government and Ministry directives, guidelines, policies and procedures;

(p) keeping the Ministry and the Chair advised of issues or events, including contentious matters, that may concern the Minister, the
Deputy Minister and the Chair in the exercise of their respective responsibilities (e.g. issues of wrongdoing or impropriety, litigation);

(q) cooperating with any periodic review directed by the Minister or Management Board of Cabinet;

(r) establishing a system for the retention of CCAC formal documents and for appropriately making such documents publicly available;

(s) preparing, for approval by the Board, a performance review system for CCAC staff and implementing the system; and

(t) implementing the training and orientation, under the direction of the Chair, of members of the Board with respect to their roles, responsibilities and obligations.

4.6 ADMINISTRATIVE RESPONSIBILITIES

4.6.1 (a) The CCAC is an Operational Service agency subject to the financial, human resources and administrative policies, guidelines and directives of the Management Board of Cabinet that apply to Operational Service agencies as set out in Schedule A.

(b) The Board is responsible for all the business operations of the CCAC.

(c) The CCAC shall comply with all applicable federal, provincial and municipal laws, rules, orders, regulations and by-laws which, by law, apply to it, including but not limited to the Ontario Human Rights Code, and the French Language Services Act.

(d) The CCAC shall have policies and procedures, approved by its Board, to deal with issues of conflict of interest that are consistent with section 1.5 of this Memorandum, Government and Ministry directives, guidelines, policies and procedures. The Board, staff and members of subsidiary bodies shall follow these policies and procedures.
5.0 CONSULTATION AND COMMUNICATIONS

5.1 Obligation to consult and to provide effective communication

5.1.1 The Minister and the Chair recognize that the timely exchange of information and consultation is essential to success in discharging their respective responsibilities.

5.1.2 The parties therefore agree that:

1. The Executive Director or Chair shall immediately advise the Ministry, where possible, of issues or events, including contentious matters, which concern or can reasonably be expected to concern the Minister in the exercise of the Minister's responsibilities.

2. The Chair shall inform the Minister of the impact of the Government's policies on the CCAC's plans or operational activities.

3. The Minister shall consult with the Chair on initiatives proposed to amend the legislation which governs the CCAC's mandate or operations or which otherwise shall have a significant impact on the CCAC, as appropriate.

4. The Minister and the Chair shall meet as needed to discuss issues relating to the delivery of the CCAC's mandate. The Deputy Minister shall meet with the Chair or the Executive Director as needed, to discuss issues relating to the efficient operation of the CCAC.

5. The Ministry shall have a Senior Liaison Committee consisting of Ministry and CCAC staff which will meet at least two times a year or as the agenda warrants, to discuss matters of mutual interest. The agenda and minutes shall be prepared in consultation with both the Ministry and the Board.

6. (a) The CCAC shall meet with the Regional Director of the Ministry or his or her designate on a regular basis.

(b) The CCAC shall invite the Regional Director or his or her designate to all Board meetings, and shall give the Regional Director advance notice of the time and place of such meetings, along with copies of agendas. The Regional Director or his or her designate may attend all Board meetings to discuss matters of interest to the Ministry.
7. The Ministry and the CCAC shall consult with each other and keep each other advised of significant public issues, communication strategies and publications. The CCAC shall consult with, and keep the Ministry advised in advance of any public release with sufficient time to allow a considered response by the Minister. In all its communications with the public, the CCAC shall recognize its corporate responsibilities as a Government agency.

8. The Ministry and the CCAC shall keep each other informed of the results of stakeholder and other public consultations and discussions.

5.2 Communications and Media Relations

5.2.1 The CCAC shall work co-operatively with the Ministry to develop and implement a comprehensive, multifaceted communications strategy that is coordinated with the Ministry's efforts. This communication strategy is part of the CCAC's business plan and shall be submitted annually by the CCAC to the Ministry for approval.

5.2.2 The CCAC shall respond in a timely manner to public inquiries, complaints and concerns with respect to the activities and operations of the CCAC.

6.0 FINANCIAL ARRANGEMENTS

6.1 CCAC Funding

6.1.1 The CCAC is funded through transfer payments from the Ministry derived from the Consolidated Revenue Fund based on the Government's Business Planning and Allocation process.

6.1.2 Financial arrangements are subject to amendments made by the Minister, Management Board of Cabinet or the Legislature and by fiscal policies issued (or promoted) through the Ministry of Finance and by such revenue policy directives as the Management Board of Cabinet may issue.

6.1.3 The CCAC shall provide all information and advice as requested to support the Minister throughout the Business Planning and Allocation process.
6.1.4 Financial procedures of the CCAC must be consistent with Management Board Directives and Guidelines, as determined by Management Board of Cabinet, the Minister of Finance or the Minister, and other directives of the Ministry and Government.

6.1.5 Responsibility for the maintenance of documentation and information to support expenditures, including books of account and related records, and financial management control, information systems and management practices, is assigned to the Executive Director.

6.1.6 The CCAC shall recognize the financial support of the Government of Ontario, through the Ministry of Health and Long-Term Care, in all its financial, educational, and promotional materials, in accordance with guidelines established by the Ministry and with the Visual Identity directive, and shall refer to itself by its full legal name in all formal documents;

6.1.7 The Board recognizes its high degree of responsibility to ensure that public funds and assets are used responsibly and appropriately, with integrity and honesty. In this manner, there shall be no per diem remuneration for Board members.
6.2 **Indemnification and Insurance**

6.2.1 The CCAC agrees to indemnify and to save harmless the Minister and the Ministry, and its employees, independent contractors and agents from and against all claims, losses, damages, costs, demands, expenses, contracts, actions and other proceedings, made, sustained, brought, prosecuted, threatened to be brought or prosecuted, in any manner based upon, occasioned by or attributable to anything done or omitted to be done on the part of the CCAC, its directors, officers, employees, independent contractors or agents in connection with the responsibilities of the CCAC or its directors, officers, employees, independent contractors or agents.

6.2.2 The indemnity referred to in paragraph 6.2.1 shall not extend to any claims, losses, damages, costs, demands, expenses, contracts, actions or other proceedings of any kind or nature to the extent that they are based on, occasioned by, or attributable to anything negligently done or omitted to be done by the Ministry or its employees, independent contractors or agents in connection with this Memorandum.

6.2.3 The CCAC's ability to indemnify or reimburse the Minister and the Ministry shall not affect or prejudice the Minister or Ministry from exercising any other rights under law.

6.2.4 The CCAC shall protect itself from and against all claims that might arise from anything done or omitted to be done by the CCAC or its directors, officers, employees, independent contractors or agents under this Agreement, and more specifically all claims that might arise from anything done or omitted to be done under this Agreement where bodily injury (including personal injury), death, or property damage, including loss of use thereof, is caused.

6.2.5 For the purpose of paragraph 6.2.4, and without restricting the generality of that paragraph, the CCAC shall maintain in full force and effect during the term of this Agreement, at its own expense, a policy of comprehensive general liability insurance, in form and substance reasonably acceptable to the Ministry, with prior consultation, providing coverage for a limit of not less than two million ($2,000,000.00) dollars for each occurrence of a claim of bodily injury (including personal injury), death, or property damage, including loss of use thereof, that may arise directly or indirectly from the acts or omissions of the CCAC or its directors, officers, employees, independent contractors or agents under this Agreement.
6.2.6 The insurance policy referred to in paragraph 6.2.5 shall include the following terms:

(a) a clause that includes Her Majesty the Queen in Right of Ontario, as represented by the Minister of Health and Long-Term Care, and the Minister's employees, independent contractors and agents as additional named insureds;

(b) a cross-liability insurance clause endorsement acceptable to the Ministry;

(c) a clause requiring the insurer to provide thirty (30) days prior written notice to the Ministry in the manner set forth in the policy in the event of the termination, expiry, or variation of the insurance policy; and

(d) a clause including liability arising out of contract or agreement.

6.2.7 The CCAC shall submit to the Ministry upon notice by the Ministry proof of the insurance coverage in the form of a certificate and a copy of the relevant portion or portions of the insurance policy incorporating the terms and clauses referred to in paragraphs 6.2.5 and 6.2.6.

6.2.8 The CCAC shall maintain Directors and Officers, Errors and Omissions insurance for its Board at all times.

6.3 Acquisition of Goods and Services and Real Property

6.3.1 The CCAC and the Board are responsible for developing rules for the CCAC regarding the acquisition and disposal of goods and services and real property, which rules are to be in accordance with the principles of the Management Board of Cabinet's Directives concerning the acquisition of goods and services and real property. The CCAC shall act in accordance with these rules, and in the spirit that reflects the basic principles on which those Directives are based.
6.3.2 Pursuant to subsection 6(2) of the Act, the CCAC shall not acquire or dispose of real property, including leases, without the prior written approval of the Minister.

6.3.3 Pursuant to subsection 6(3) of the Act, the CCAC shall not borrow money on its credit or give security against its property without the prior written approval of the Minister. Pursuant to subsection 6(3) of the Act, the Minister hereby gives approval to the CCAC to borrow money on its credit up to the amount of $2,661,067 at any one time.

6.3.4 The CCAC shall not dispose of any asset with a current value greater than Twenty-Five Thousand Dollars ($25,000.00) that has been paid for with funds from the Government without the prior written consent of the Ministry, which consent may not be unreasonably withheld.

6.3.5 The CCAC pays Goods and Services Tax (GST) and is eligible for a rebate on the amounts paid.

7.0 REPORTING REQUIREMENTS

7.1 Business Plan, Performance Measurement, Annual Reports

7.1.1 The Chair, through the Executive Director, shall ensure that the CCAC implements a system of performance measurement and reporting, annually or more frequently as required. The system shall include commitments to attaining specific performance goals through specific steps within specified time frames.

7.1.2 The Board shall submit the following annual and multi-year plans to the Minister for approval, consistent with the Government’s policy parameters and the objects of the CCAC under the Act:

(a) An Annual Report upon the affairs of the CCAC within 4 months of the end of the fiscal year of the CCAC, consisting of:

(i) the CCAC’s audited financial statements;
(ii) a description of the CCAC’s activities for the fiscal year;
(iii) the objectives and planned results documented in the CCAC’s business plan;
(iv) the extent to which the objectives and planned results were achieved; and
(v) an explanation for any significant variances between actual and planned results.
(b) A Business Plan, on or before November 1 of each year for the next fiscal year of the CCAC, completed annually, in accordance with the Government's current fiscal year's requirements, as provided by the Ministry, and the minimum contents for a business plan as set out in Appendix D of the Agency and Accountability Directive and the Planning, Funding & Accountability Policies & Procedures Manual for Long-Term Care Services (Dec 2000), as amended from time to time, including but not limited to:

(i) operating plan, describing the objectives and results that the CCAC expects to achieve for the upcoming fiscal year. The objectives and the results shall be based on the mandate, objects and responsibilities of the CCAC and shall advance the Government's, Ministry's and CCAC's priorities and policies;

(ii) a three (3) year business plan;

(iii) the Board's audited financial statements for the previous year;

(iv) a system of performance measures that are tied to the CCAC's performance management and that are consistent with Government policies and directions; and

The Minister shall review the Business Plan and shall advise the Board as to whether or not he or she approves the overall direction envisaged by the CCAC and if not, where and in what ways the overall directions of the Business Plan are at variance with the Government's policies and priorities.

7.1.3 The Board shall make available to the public each Minister approved annual report and business plan that it prepares pursuant to Section 7.1.2.

7.1.4 The Board shall inform the Minister of any intended activities that may result in significant additions, deletions or amendments to its approved Business Plan in sufficient time for the Minister to consider the intended activities before the CCAC enters into any binding financial or operational commitments with respect thereto.
7.2 Financial Reports

7.2.1 The Board shall prepare and present to the Minister quarterly financial reports within 30 days after the end of each quarter on an accrual (Public Sector Accounting Board, PSAB) basis setting out the following:

(a) Year to date actual expenditures (capital, operating and transfer payment) of the CCAC;

(b) The fiscal year-end financial forecast of the CCAC's expenditures and revenues; and

(c) An explanation to the satisfaction of the Minister about any major variances (if any) from the approved operating budget.

7.2.2 The Board shall also prepare and present to the Minister monthly financial reports within 30 days after the end of each month.

7.2.3 The CCAC shall submit to the Minister an audited annual financial report within 4 months after the end of the fiscal year for which the report relates in accordance with subsection 11(2) of the Act, which report shall be included in the annual report. This audited annual financial report shall clearly describe the CCAC's expenditures and revenues and shall categorize them in accordance with generally accepted accounting principles.

7.2.4 The timeframes set out in this section for submitting reports and plans may be revised by the Minister to enable the Minister to meet the Business Planning and Allocation Process requirements and the Minister shall provide advance notice of such changes in timeframes, as far as possible.
7.3 Other reports

7.3.1 The Chair shall submit on behalf of the board the following reports and documents to the Minister for review in a timely manner:

(a) all other reports or changes to official reports, including Strategic Plans, as the Minister may require from time to time; and

(b) any promotional and information materials of the CCAC.

7.3.2 The CCAC shall submit to the Minister any other reports or information as may be requested by the Minister or Ministry from time to time, within the time frames established by the Minister or Ministry.

8.0 AUDIT ARRANGEMENTS

8.1 Audit

8.1.1 As provided in subsection 12(1) of the Act, and in order to ensure accountability, the CCAC shall be required to appoint one or more auditors who are licensed under the Public Accountancy Act. The auditor shall audit annually the financial transactions and accounts of the CCAC for the previous fiscal year.

8.1.2 The CCAC is required to provide a copy of the auditor’s report to the Minister within 4 months after the end of the fiscal year for which the report relates in accordance with subsection 11(2) of the Act as set out in section 7.2.3 above.

8.1.3 In addition to the annual financial audit provided for under the Act, the CCAC shall be subject to such other audits as the Minister or the Provincial Auditor may determine to be appropriate. When the Minister directs that there be such an audit, the Chair shall ensure that the Board, the Executive Director and the staff of the CCAC cooperate in facilitating the audit within the timeframes established by the Minister or Ministry.

8.1.4 The Chair may request an external audit of the financial transactions or management controls of the CCAC at the CCAC’s expense.
8.2 Ministry/Government Audit Results

8.2.1 The results of any audit conducted by the Ministry/Government staff shall be shared with the Board and with the Minister in relation to any material audit. The Board through the Chair shall be accorded an opportunity to enter comments into the audit record.

9.0 SUPERVISOR

9.1.1 The Minister has the authority to appoint a supervisor for the CCAC when it is in the public interest. The supervisor shall be able to exercise all of the rights and powers and perform all of the duties of the CCAC, unless the appointment provides otherwise. The supervisor shall be required to follow directions given by the Minister and report to the Minister as required.

9.1.2 The personal information acquired by the supervisor is the Ministry's property and shall be deemed to be under the Ministry's control for the purposes of the Freedom of Information and Protection of Privacy Act (FIPPA).

10.0 ADMINISTRATIVE ARRANGEMENTS

10.1 Sharing Data and Reports

10.1 The Board through the Chair shall, at the request of the Minister or the Deputy Minister, supply specific data and other information relating to the operations of the CCAC as required for the purposes of Ministry administration.

10.2 Collection and Use of Personal Information

10.2 The Long-Term Care Act, 1994 contains provisions that provide for access to personal information while at the same time protecting the privacy of this information and with which the CCAC shall comply since it is an approved agency under the Long-Term Care Act, 1994. Information collected by the Ministry shall be subject to the Freedom of Information and Protection of Privacy Act. Personal information shall remain protected and its collection use and disclosure restricted.

10.3 Confidential Information
10.3.1 In this section, **Confidential Information** means any Materials, data, information or item in any form, acquired by the CCAC or the CCAC's Personnel from the Ministry and marked confidential, including all formats and expressions thereof,

10.3.2 The CCAC shall use Confidential Information within the CCAC only to the extent necessary, and in that regard shall give it to its directors, officers, employees or agents only if any of them need to know in order to carry out their responsibilities.

10.3.3 During the Term of this Memorandum, the CCAC and its directors, officers, employees or agents shall treat as confidential any Confidential Information and shall not use, exploit or disclose such Confidential Information other than as is required for the carrying out of its or their responsibilities under this Memorandum, without the prior written consent of the Ministry. This obligation does not apply to Confidential Information that is known to the public at the time it is made available to the CCAC other than through a breach of this section or becomes known to the public after the time it is made available to the CCAC other than through a breach of this section.

10.3.4 The CCAC shall advise its directors, officers, employees or agents of the requirements of paragraphs 10.3.2 and 10.3.3 and shall take all reasonable action to ensure compliance of the directors, officers, employees or agents with those paragraphs as if those paragraphs applied to them.

10.3.5 In addition to any other rights, liabilities, or provisions under this Agreement, the CCAC shall be liable for all damages, costs, expenses, losses, claims, or actions arising from any non-compliance by the CCAC’s directors, officers, employees or agents with paragraphs 10.3.2 and 10.3.3.

10.4 Legal Services

10.4 The CCAC shall secure legal services through the retention of independent counsel, if required, in accordance with the Ministry's policy for CCACs on the acquisition and use of legal services.

10.5 Executive Director Selection

10.5 The Executive Director for the CCAC is appointed by the Lieutenant Governor in Council pursuant to subsection 10(1) of the Act and is
employed by the Board as its chief executive officer under subsections 10(2) and (3) of the Act.

11.0 CUSTOMER SERVICE QUALITY REVIEW PROCESS

11.1 The CCAC shall develop and operationalize a formal process for responding to complaints about the quality of service received by customers/clients of the CCAC. This process shall be consistent with the Government's quality service initiative and the *Long-Term Care Act, 1994*.

12.0 RECORDED INFORMATION MANAGEMENT

12.1.1 The Executive Director shall identify an appropriate management position that shall have corporate responsibility for the efficient and effective management of recorded information.

12.1.2 The Executive Director shall protect the legal, fiscal and other interests of the CCAC by ensuring on-going viability, integrity, preservation and security of all recorded information, created, commissioned or acquired by the CCAC. This includes all electronic records (regardless of media, application or location) such as e-mails, information posted on websites, database datasets, special media records (e.g. video) and all records stored on personal computers and shared drives. The Executive Director shall report to the Board annually on the management of recorded information of the CCAC.

12.1.3 The appropriate management position with corporate responsibility for the management of recorded information shall:

(a) Ensure that staff follow appropriately defined processes of retention and disposal consistent with the Management Board Directive on Management of Recorded Information;
(b) Ensure that staff create full, accurate and reliable records that document and support significant business transactions, decisions, events, policies and programs;
(c) Hold staff accountable for managing the recorded information that is under their control and custody; and
(d) Ensure that recorded information identified during retention scheduling as having permanent value is safeguarded so as to protect
its ongoing accessibility and integrity and ensure that information identified as not having permanent value is disposed of in a timely manner.

13.0 STAFFING AND APPOINTMENTS

13.1.1 CCAC employees are appointed by the CCAC and are not employees under the Public Service Act.

13.1.2 The members of the CCAC Board are appointed by the Lieutenant Governor in Council pursuant to section 7(1) of the Act.

13.1.3 The Lieutenant Governor in Council pursuant to section 7(4) of the Act may designate the Chair and a Vice-Chair of the CCAC from among the members of the Board.

The parties have signed this Memorandum as of the date indicated.

Heinz Schweinbenz, Chair
Community Care Access Centre of Halton

Sandra Shadwick, Executive Director
Community Care Access Centre of Halton

The Honourable Tony Clement
Minister of Health and Long-Term Care

Philip Hassen
Approved by the Management Board of Cabinet on: June 20, 2002
SCHEDULE A

List of Directives, Policies and Guidelines Applicable to CCACs *

(If a Directive is listed the Policy and Guideline also applies. Guidelines or Policies are listed only if there is no corresponding Directive)

1. CCACs shall comply with the following Management Board of Cabinet Directives, Policies and Guidelines:

   Government Appointees Directive

   Visual Identity Directive

2. The following Management Board of Cabinet Directive, Policies and Guidelines do not apply to CCACs. However, CCACs currently have policies which relate to the following Management Board of Cabinet Directives, Policies and Guidelines, and the CCACs policies will be consistent with the principles of these directives:

   Enhancing Privacy: Computer Matching of Personal Information Directive

   Information and Information Technology Security Directive

   Travel Management & General Expenses Directive
* This list is not exhaustive. Amended, revised or successive directives, policies and guidelines contained in this list continue to apply to CCACs until the list is updated.
Appendix E

Brock Research Ethics Approval

The Brock University Research Ethics Board has reviewed the above research proposal.

DECISION: Accepted as Clarified

This project has been approved for the period of January 6, 2004 to September 30, 2004 subject to full REB ratification at the Research Ethics Board's next scheduled meeting. The approval may be extended upon request. The study may now proceed.

Please note that the Research Ethics Board (REB) requires that you adhere to the protocol as last reviewed and approved by the REB. The Board must approve any modifications before they can be implemented. If you wish to modify your research project, please refer to [www.BrockU.ca/researchservices/forms.html](http://www.BrockU.ca/researchservices/forms.html) to complete the appropriate form [REB-03 (2001) Request for Clearance of a Revision or Modification to an Ongoing Application](http://www.BrockU.ca/researchservices/forms.html).

Adverse or unexpected events must be reported to the REB as soon as possible with an indication of how these events affect, in the view of the Principal Investigator, the safety of the participants and the continuation of the protocol.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and approvals of those facilities or institutions are obtained and filed with the REB prior to the initiation of any research protocols.

The Tri-Council Policy Statement requires that ongoing research be monitored. A Final Report is required for all projects, with the exception of undergraduate projects, upon completion of the project. Researchers with projects lasting more than one year are required to submit a Continuing Review Report annually. The Office of Research Services will contact you when this form [REB-02 (2001) Continuing Review/Final Report](http://www.BrockU.ca/researchservices/forms.html) is required.

Please quote your REB file number on all future correspondence.