

HOME AND COMMUNITY CARE SUPPORT SERVICES



Business Plan

| 2023-24

CONTENTS |

| | |
|---|-----------|
| Message from the Board | 3 |
| Message from the CEO | 4 |
| Introduction | 5 |
| Our Partners | 6 |
| Listening to the People We Serve..... | 6 |
| Environmental Scan | 7 |
| Business Plan at a Glance | 9 |
| Our Engagement Approach | 9 |
| Strategic Priorities | 11 |
| Priority 1: Drive Excellence in Care and Service Delivery ... | 11 |
| Priority 2: Accelerate Innovation and Digital Delivery | 14 |
| Priority 3: Advance Health System Modernization | 17 |
| Priority 4: Invest in our People | 20 |
| Performance Measurement..... | 23 |
| Summary..... | 26 |
| Appendix: By The Numbers | 27 |
| Appendix: Risk and Mitigation Section | 28 |
| Appendix: Communications and Engagement Plan | 30 |
| Appendix: Financials..... | 32 |
| Appendix: Health Human Resources | 33 |
| Appendix: Acronyms Used | 35 |

MESSAGE FROM THE BOARD |



On behalf of the Home and Community Care Support Services Board of Directors, it is my pleasure to present our 2023-2024 Annual Business Plan outlining our continued efforts to provide exceptional care, wherever you call home.

This third Annual Business Plan continues to build on our accomplishments from our initial 21 months, including the development of a new [website](#) to make it easier for people to find the services they need, a [Community Engagement Framework](#) that centres the voices of patients, families and caregivers in our work, and a [People Strategy](#) that ensures our staff is ready to serve the home health care needs of the people of Ontario. The care and well-being of patients and families remains our number one priority. At the same time, our work is driven by equity, efficiency, transparency and effectiveness, so that we are making the most of our valuable resources and meeting the needs of the people who count on us.

We are committed to strong partnerships built across the health care sector, ensuring that patients receive needed services where and when appropriate, and supporting the ongoing work of transforming home and community care to a more integrated and equitable service across Ontario. Over the past year, we have been active participants at Ontario Health Team tables across the province, sharing our expertise and collaborating with partners to improve pathways to care. We will continue this work with our partners to improve patient access to care and develop a transition plan to modernize home and community care, supporting new models of care within Ontario Health Teams and other health organizations.

The Minister of Health has tasked us with the successful integration of Home and Community Care Support Services within the broader health system and innovating to improve service. To help guide our work, Home and Community Care Support Services will continue to focus on our strategic priorities, detailed later in this plan:

- Drive Excellence in Care and Service Delivery
- Accelerate Innovation and Digital Delivery
- Advance Health System Modernization
- Invest in our People

We have advanced each of these strategic priorities since they were introduced in our 2021-2022 Annual Business Plan, including developing a [Quality Framework](#) to ensure our patients received the same high quality care wherever they might live, tightening our digital cybersecurity protocols, collaborating more closely with our contracted service providers to build capacity, and creating new ways to support staff in a hybrid environment so that they can easily shift between in-person and remote work, positioned to be where our patients and partners need us. We look towards future achievements as we work to fulfil our mandate. We will continue our collaboration with health system partners to support high quality, integrated care and build a more connected, seamless, affordable and sustainable health care system.

We will continue to advance progress on equity, inclusion, diversity and anti-racism as we reflect on and respond to the needs of our diverse population, a commitment reflected in our updated [Patient Bill of Rights](#). We look forward to the work ahead as we continue to help everyone to be healthier at home through connected, accessible, patient-centred care.

Joe Parker
Board Chair

MESSAGE FROM THE CEO |



It remains a privilege to lead Home and Community Care Support Services during such a pivotal time. I am pleased to present our 2023-24 Annual Business Plan, which outlines how we will continue to focus on our existing strategic

priorities to ensure exceptional care, wherever our patients call home.

As a key pillar of Ontario's health system, home and community care continues to play a critical role in ensuring Ontarians remain safe and healthy wherever they call home. Home and Community Care Support Services works closely with system partners to help stabilize the health care system as we emerge from the COVID-19 pandemic. In addition, we are supporting system efforts to build a more modernized, connected health care system that is centred on the needs of patients across the province. This focus was reflected in our work last year to support the implementation of [Bill 7, More Beds, Better Care Act 2022](#), enabling the safe transition of people who no longer require treatment in hospitals to temporary care arrangements in long-term care homes, and the new regulation ([O.Reg. 187/22](#)) for Home and Community Care Services under the [Connecting Care Act, 2019](#), resulting in the development of 10 new policies, and a host of educational resources and tools, addressing accessibility, care, safety and rights of patients, families and caregivers.

We are committed to providing a respectful, accessible and inclusive environment for all patients, families, caregivers, employees, partners and the public. We serve a diverse population of patients, each with unique circumstances, culture and health status. In building this plan, we engaged with more than 1,600 people, including patient and

family advisors, Indigenous health care leaders, Francophone planning entities, health care and service provider partners, and our own staff. The input we received not only shaped the contents of this plan, but will also guide the way we implement it. Our valued partners and our staff are key to our success. By continuing to work together, we can build a health care system that helps everyone be healthier at home through connected, accessible, patient-centred care.

Within Home and Community Care Support Services, our people are our greatest asset. This past year, we made a positive difference in the lives of patients and their families by investing in our people to ensure they have the support they need to do their best work in the communities we serve. This includes new learning and development opportunities, an employee wellbeing and wellness program, as well as training on Indigenous cultural safety and active offer of French Language Services, the cornerstone of our new provincial policy. In addition, we conducted an inaugural employee engagement survey which, with over 4,500 completed surveys, led to the development of action plans. Moving forward, we will continue to build on the accomplishments of our [People Strategy](#) to ensure a positive environment that reflects our values and empowers our staff to achieve our organization's mission and vision.

I am excited for the possibilities the future brings and am confident that this plan positions us well to manage the current realities, while guiding us towards an improved and more modernized system where patients, families, caregivers, staff and providers feel safe and valued as partners in home and community care.

Cynthia Martineau
Chief Executive Officer


INTRODUCTION |

WHO WE ARE


We are here to help and ready to serve people across Ontario who need our services. Ontario's 14 Home and Community Care Support Services organizations work together as one team to coordinate home and community-based care for thousands of patients across the province every day.


We assess patient care needs and deliver home and community-based services to support health and well-being. We also provide access and referrals to other community services and manage Ontario's long-term care home placement process.


Our mission is to help everyone to be healthier at home through connected, accessible, patient-centred care. We help patients of all ages and diverse backgrounds, their families and caregivers when they need services, support and guidance to:

- 

Remain safely at home with the support of health and other care professionals
- 

Take an active role in managing their care or their family member's care
- 

Attend school with complex health problems and disabilities
- 

Access mental wellness strategies and addictions support while at school
- 

Return home from hospital and recover at home



Learn to self-manage chronic conditions through virtual technology and coaching



Find a family doctor or nurse practitioner



Find community services that support healthy, independent living



Access respite and resources to support caregiving



Transition to long-term care or supportive housing



Die with dignity in the setting of their choice supported by a team

Each year, 8,900+ staff serve or support more than 640,000 patients of all ages, including more than 27,270 long term care placements. Every day, Home and Community Care Support Services provides approximately 26,900+ nursing visits; 5,600+ therapy visits; and 100,000+ hours of personal support care.

Our Partners

Across the province, Home and Community Care Support Services collaborates with a vast number of partners that are vital to the successful delivery of home care services, either directly or indirectly:

- 680+ community support agencies
- 100+ equipment and supply vendor sites
- 600+ long-term care homes
- 150 hospital sites
- 72 school boards
- 1000s of primary care providers (including family health teams, nurse practitioner-led clinics and community health centres)

We also work with an extensive number of mental health and addictions providers, Ontario Health, Ontario Health Teams, as well as the Ministry of Health and the Ministry of Long-Term Care.

Service Provider Organizations

We have contracts and accountability agreements with more than 150 service provider organizations who deliver frontline care to patients. We maintain oversight of these services to ensure quality and an optimal patient experience.



Listening to the People We Serve

Listening to, and learning from, the people we serve is essential to the work we do. Authentic engagement helps ensure that the programs and services we deliver meet the needs and values of our patients, families and caregivers. It also provides unique improvement opportunities, enhances patient experiences and outcomes, and allows us to deliver equitable home and community care for all.

In embarking on the development of our 2023-24 Annual Business Plan, we sought to engage with the people we serve. This includes our new Community of Advisors (our patients, families, and caregivers) along with a particular focus on Indigenous and Francophone communities. To engage authentically, we were guided by our newly developed and co-designed [Community Engagement Framework](#), which outlines our organization's collective vision for engagement. The Framework includes multiple guiding principles, areas of focus, and enablers that define our approach to preparing, supporting, and reporting back on how input shapes our priorities. These are our critical tenets to ensure people feel heard, valued, and respected.

We are grateful to the people who helped shape our 2023-24 Annual Business Plan. Their ideas, experiences, and values ensure that we are focused on what matters most. As we embark on the initiatives that advance our identified strategic priorities, we are committed to ongoing engagement with our partners and the people we serve to ensure we stay focused on the right priorities and maintain an understanding of preferences and how people expect to be treated.

Environmental Scan

Our health care system continues to evolve, with changes that require ongoing adaptability and innovative solutions. Home and Community Care Support Services remains committed to implementing digital solutions for online service delivery to ensure patient service standards are being met. We pride ourselves on innovation and are continuously exploring new ways to enhance the processes and tools we use to ensure home care service delivery is timely, equitable and accessible, including pursuing delivery methods that have evolved since the COVID-19 pandemic. Digital health remains a key enabler in our system, supporting continuity of care through enhanced integration of electronic health records for patients and health care providers. We are continuously working towards modernizing digital platforms such as virtual care and remote patient monitoring to improve access to care, which has been particularly important throughout the pandemic when in-person access was curtailed or limited.

As risks for cybersecurity and privacy breaches increase within the health care sector and across the globe, we continue to invest in strategies that maintain safe and secure operations to avoid disruption to patient care and ensure security of personal health information.

To address the immediate pressures facing the health system, and to stabilize the health and long-term care sectors for the future, the government announced

the [Plan for Connected and Convenient Care](#). In alignment with the plan, Home and Community Care Support Services is focused on providing the right care in the right place, and easing pressure on emergency departments. Supporting patients to move from hospital to a location that best meets their care needs, whether that be at home, in long-term care, or another setting in the community, is a key priority for us. Facilitating admissions to long-term care and supporting the implementation of the [More Beds, Better Care Act 2022](#) are just some of the ways Home and Community Care Support Services is supporting the government's plan.

Home and Community Care Support Services has also supported implementation of the new [Home and Community Care Services Regulation O. Reg. 187/22](#) under the [Connecting Care Act, 2019](#) by updating provincial policies and guidelines to align with the new legislative and regulatory framework.

Ontario, much like other provinces across Canada, continues to face a shortage of health human resources and an increased demand for home and community care services. While emphasizing health system stability and recovery, Ontario's [Plan for Connected and Convenient Care](#) outlines the necessary actions to bolster Ontario's health care workforce, including adding more domestic and internationally trained nurses and other health care professionals.



Equity, Inclusion, Diversity and Anti-Racism

Home and Community Care Support Services is committed to furthering initiatives to support equity, inclusion, diversity and anti-racism (EIDAR). We have been fulfilling this through actions that are aligned with a Board-endorsed commitment statement:

Home and Community Care Support Services is committed to a culture of equity, inclusion, diversity and anti-racism. We will work collaboratively to eliminate systemic barriers to under-represented and racialized groups, and work towards a workforce that reflects the diverse communities we serve, with the goal of optimizing patient and family outcomes.

We will have an initial focus on the impacts of anti-Black and anti-Indigenous racism.

We engaged our staff through an Employee Engagement Survey to consider how we can build a sense of inclusion that will culminate in improved service delivery for under-represented groups. A thorough review of our organizational policies and procedures is also underway to ensure our EIDAR related values and priorities are reflected in every aspect of our work. Over the past year, we have encouraged and empowered local and provincial staff-led groups, expanding on work underway for the Anti-racism, Inclusion, Social Justice and Equity (ARISE) group, and supported the launch of new working groups such as the Indigenous and Pride groups. Understanding the importance of specialized knowledge, we have initiated the hiring process of a dedicated team that will support future EIDAR initiatives.

In the coming year, we are looking to develop an EIDAR framework that will guide our work, including:

- Reviewing current recruitment policies and procedures with an EIDAR lens to ensure they are relevant and appropriate
- Reviewing current offerings of culturally sensitive education with a view to supporting interactions between staff, service providers, partners, patients, families and caregivers
- Creating an EIDAR toolkit that will provide reference tools for our staff
- Creating opportunities for safe space conversations that will enable and further the important discussions required to make Home and Community Care Supports Services a truly diverse and inclusive organization

We continue to build and strengthen relationships with Indigenous partners, Black communities, community groups, and Francophone partners including the French Language Health Planning Entités, seeking their valuable feedback in the development of this plan.

We acknowledge that while we have made important advancements in this realm, there is still a great deal of work to be done. We are committed to working collaboratively to eliminate systemic barriers experienced by under-represented, marginalized and racialized groups, and to building a workforce that reflects the communities we serve.

BUSINESS PLAN AT A GLANCE |

Our Engagement Approach

To inform our 2023-24 Annual Business Plan, we engaged with our key partners: our patients, families, and caregivers; Indigenous partners; French Language Health Planning Entities; our staff; and health system partners including primary care providers, community support services, long-term care homes, hospitals and our contracted service provider organizations. We used a variety of engagement methods including virtual sessions, small and large group discussions and surveys. This allowed fulsome and varied opportunities to collect real-time and responsive input and supported further discussion around priorities.

Altogether, more than 1,630 people provided feedback on where we could make the greatest strides in 2023-24. We appreciate the opportunity to be able to incorporate their feedback in this plan and in our work moving forward.



Mission

Helping everyone to be healthier at home through connected, accessible, patient-centred care.

Vision

Exceptional care – wherever you call home.

Values



COLLABORATION

Together we embrace inclusion, teamwork, and partnership to realize our full potential



RESPECT

We engage with kindness, empathy, gratitude and compassion



INTEGRITY

We act with transparency and accountability, building trust, and following through on our commitments



EXCELLENCE

We are innovative, responsive, and patient-centred, contributing to positive patient outcomes and a seamless, exceptional experience

Strategic Priorities at a Glance

Objectives

- Provide patient, family and caregiver-centric, high quality home and community care services, long-term care home placement, and access to community services enabling safe, effective, timely and equitable services.
- Optimize organizational capacity to support the best service delivery and supporting Ontario's *Plan for Connected and Convenient Care*.

Initiatives

- Support improved efficiency and system capacity in collaboration with service provider organizations including increased alignment of innovative models of care and expansion of nursing clinics.
- Improve quality, access and equity of care across the province by aligning waitlist management and service planning guidelines so that there is greater consistency in service delivery across the province.
- Standardize quality and safety processes and outcome measures across the province.
- Support increased efficiency and effectiveness in care delivery by standardizing business support services within the organization.

Objectives

- Explore options to advance digital readiness for future state health care delivery models in the context of home health care transformation.
- Support digital transformation and best practices in collaboration with health care system partners and Ontario Health in alignment with the Ontario Health Team Digital Health Playbook.
- Work with Ontario Health on implementing plans that mitigate risks of disruption to patient health care, business operations or a privacy/security breach.

Initiatives

- Integrate digital home care systems in collaboration with system partners.
- Optimize the CHRIS system, in partnership with Ontario Health, to enable consistent configuration and application with Ontario Health Teams and other local partners.
 - Expand Telehomecare and virtual care.
 - Explore innovative service models in collaboration with Ontario Health Teams and other health system partners.
 - Participate in and implement ONE Access initiative in collaboration with the Ministry of Health and Ontario Health.

Objectives

- Recognizing the health human resources challenges across the system, continue to focus on attracting and retaining staff in order to evolve the organization as we prepare for transition to the future state.
- Utilize front-line staff and their roles to their full potential, including providing opportunities to use their clinical skillsets to provide more comprehensive clinical patient care services.

Initiatives

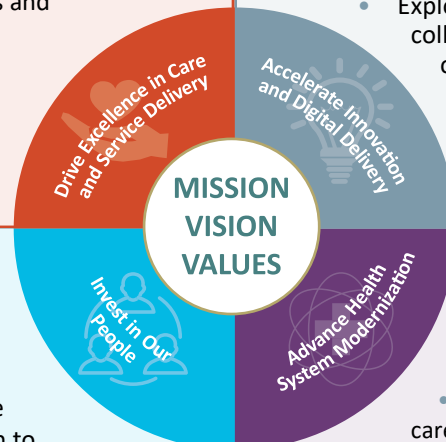
- Build on the accomplishments of our People Strategy, to support workforce stabilization and help prepare staff for the future.

Objectives

- Plan for a successful transition of home care services and delivery to Ontario Health Teams/other health service organizations.
- Implement improvements in long-term care home placement in collaboration with the Ministry of Long-Term Care.
 - Support new models of care delivery enabled by ministry regulations in collaboration with the Ministry of Health, Ministry of Long-Term Care, and Ontario Health.

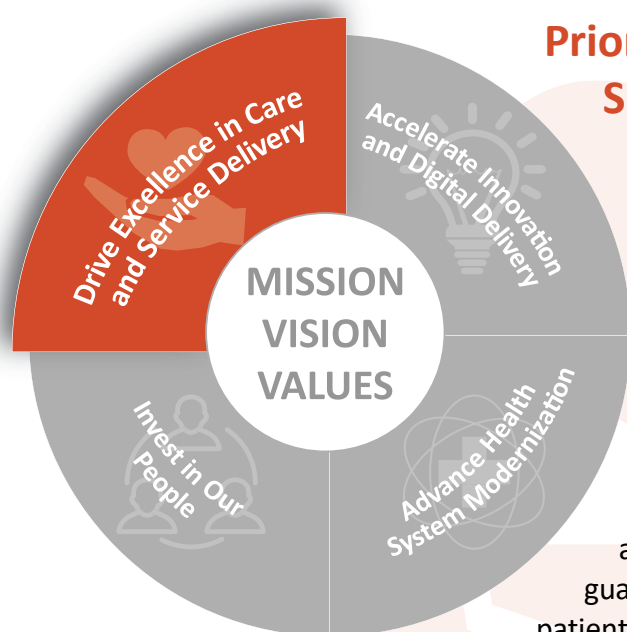
Initiatives

- Through collaboration with partners, patients, families and caregivers, improve and streamline the discharge process from hospital to home.
- Develop a streamlined intake process across the province to support consistent patient experiences.
- Develop and implement online application for long-term care placement.
- Implement a provincial Medical Equipment and Supplies structure.
- Support the Ministry of Health and partners to implement indirect care coordination models.
- Develop a transition plan to modernize home and community care and support the transition of home care delivery to Ontario Health Teams/other health service organizations.



STRATEGIC PRIORITIES |

Our strategic priorities will guide our actions to achieve the mandate set out by the Minister of Health and support the mission and vision set out by the people we serve, our partners, and our staff.



Priority 1: Drive Excellence in Care and Service Delivery

We will continue to focus our efforts on delivering improved patient, family, and caregiver-centred home and community care services, long-term care placement, and access to community services, while navigating health system pressures and managing pandemic recovery. To ensure that the patient voice guides all of our work, we have created new opportunities for patient, family and caregiver engagement through establishing the Provincial Community of Advisors. This work will be done in alignment with our [Community Engagement Framework](#) to guarantee the best, most responsive supports possible to our patients, families and caregivers.

To promote safe, effective, timely and equitable service delivery, we have developed and implemented an updated [Patient Bill of Rights](#), [Abuse Prevention Plan](#) and [Provincial French Language Services Policy](#) in alignment with the [Regulation O.Reg.187/22](#) under the [Connecting Care Act, 2019](#). These foundational resources create a harmonized approach across our organization to drive excellence in care and service delivery, as well as support patient safety and quality of care. Additionally, we developed a [Quality Framework and Policy](#) and [Provincial Quality Toolkit](#), to further strengthen our commitment to creating a culture of continuous quality improvement.

“Home care needs to be the number one priority in the health system.”

– Patient/Family Advisor (November 23, 2022)

Supporting Ontario's [Plan for Connected and Convenient Care](#), we've focused on ways to increase our capacity to provide home and community care to eligible patients, including in small and rural communities. As we work to stabilize and modernize the health care system – easing pressures on hospitals and emergency departments – we will undertake several strategies designed to make the most efficient use of health human resources, and ensure better integration of services to improve patient outcomes. These include expanding innovative models of care and optimal use of nursing

clinics, establishing and supporting transitional care beds in retirement homes, and in hard-to-serve areas, exploring incentives to support service provider organizations and opportunities to directly hire visiting nurses and therapy staff to provide in-home care.

In alignment with the [Fixing Long-Term Care Act, 2021](#), and [Ontario Regulation 246/22](#), our teams are supporting the safe transition of eligible Alternate Level of Care patients who are waiting for long-term care home placement to interim care arrangements in temporary long-term care homes while they wait for placement in a preferred home. To achieve this, we have worked collaboratively with patients and long-term care partners to help determine the best options for patients and their families.

In engaging with Indigenous and Francophone health care leaders and planners, we heard that many of the existing models of care are not created with these groups in mind and that more emphasis is needed on understanding the different Indigenous, First Nations, Inuit, and Métis people and communities, as well as Francophone experiences. Both Indigenous and Francophone individuals shared their concerns about the risk of exclusion and inequitable access to care. We are committed to continue working with these key partners to gain better insights into how we can improve our services and delivery models to better meet their needs.

As we build on what we have accomplished, we will focus on the following strategic objectives:

- Provide patient, family and caregiver-centric, high quality home and community care services, long-term care home placement, and access to community services enabling safe, effective, timely and equitable services.
- Optimize organizational capacity to support the best service delivery and the Ministry's Plan for *Connected and Convenient Care*.

“French is not just a language of choice, but a language of need.”

– French Language Health Planning Entité Partner (November 23, 2022)

We will undertake the following strategic initiatives:

- **Support improved efficiency and system capacity in collaboration with service provider organizations including increased alignment of innovative models of care.**

Innovative models of care includes the Neighbourhood Model of Care, which brings together our care coordination with a lead service provider to support eligible residents living in a building or neighbourhood – offering more coordinated care closer to home. Through these models, we'll make the most efficient use of health human resources and improve navigation and access to services for patients by adding: three more Neighbourhood Models; expanding nursing clinics from 135 to 138 with target is to increase clinic utilization from 68% to 80% for the year; increasing targeted incentives from four to 14; through direct staffing deliver health care to an additional 32 patients daily.

- **Improve quality, access and equity of care across the province by aligning waitlist management and service planning guidelines so that there is greater consistency in service delivery across the province.**

By standardizing waitlist management, there will be greater consistency in processes and service planning guidelines across the province, ensuring the same access to care for all Ontarians waiting to receive services such as personal care, nursing, or therapies, as well as access to adult day programs, assisted living, respite and transitional beds.

- **Standardize quality and safety processes and outcome measures across the province.**

All Ontarians should receive the same high quality care, wherever they might live. Standardizing

quality and safety processes includes the implementation of the Healthcare Insurance Reciprocal of Canada's (HIROC's) Resident Assessment Checklist program, the implementation of a provincial ethics program, the use of standard diabetic foot ulcer treatments to ensure healing within 12 weeks; and the implementation of patient abuse prevention indicators by providing written responses within 10 days.

- **Support increased efficiency and effectiveness in care delivery by standardizing business support services within the organization.**

Standardization within our business support services ensures our front line teams are well supported to be successful in completing their important work.

What does this mean for our patients?

Meet Clovis*

For Clovis, complications from his diabetes are making it difficult to do everyday tasks. He wants to remain at home in his community in rural Northern Ontario, but has experienced many missed visits by home care workers. However, after the Neighbourhood Model of Care was introduced to his apartment building, this problem and many other aspects of his life improved. Personal support workers from the same agency now work day and evening shifts supporting all eligible residents; this creates more regular hours for the workers and more consistent, coordinated care for patients in the building. For Clovis, it means shorter but more frequent visits throughout the day for help with medications, putting on compression socks, and personal care. His family also appreciates the weekly exercise classes, which have helped with his mobility, as well as other services coordinated by Home and Community Care Support Services in the building. When they call his care coordinator for information about his care plan, the conversation is now in French. This change happened after being asked about his mother-tongue during a recent

reassessment. Clovis was hesitant to ask for services in French, but when offered, he gladly accepted. His family has also noticed an improvement in his foot ulcers and was told by his home care nurse that a new type of wound care bandage being used across the province is making a difference.

Driving excellence in care and service delivery touches the lives of all the people we serve, whether it's ensuring that you receive the same high quality care when treated for common conditions such as foot ulcers, or equitable access to services that recognizes and respects your linguistic needs as a Francophone or culture as an Indigenous person. By collaborating with our service provider organizations, we can leverage models of care that address capacity and system problems affecting you and your family, while providing more coordinated and consistent care.

*Clovis is a composite of patients we have heard from, and his story illustrates how our work internally and with system partners can improve the experience of the patients we serve.

How will we know that we are making a difference?

We know how important it is to measure the impact of our initiatives, to ensure they are addressing the needs of patients and supporting system stabilization. Key performance indicators include wait times, nursing visits, therapist visits and personal support service visits, as well as those incidents where visits were not completed. In addition, we will measure the number of patients waiting in an inpatient hospital bed (who no longer require acute care) for discharge to their home, community setting or long-term care home, where their discharge is delayed due to a lack of availability of services and resources required to support the patient's needs.

To see a more comprehensive list of indicators that will be used for this priority, please refer to the 'Performance Measurement' section of the plan.

Priority 2: Accelerate Innovation and Digital Delivery

Digital Health remains a cornerstone of health care system modernization. Home and Community Care Support Services is committed to developing a unified digital infrastructure, processes, and systems, to improve patient and provider experiences, ensure seamless transitions of care, and realize health system efficiencies. We are continuing to digitize our paper forms, while enhancing the security of our patients' data. This has reduced the workload related to manual processes, increasing the amount of time available for direct patient care and improved patient experiences. We have also implemented cybersecurity protocols to ensure patient information remains secure.

Planning continues on digital solutions to support future forms of integrated home health care delivery, including the enhanced use and functionality of the Client Health and Related Information System (CHRIS), which is the provincial tool currently used to support home and community care service delivery.

Integrating our systems with partners brings together a patient's circle of care, so that their medical history and medications are in one place. This removes duplication, reduces errors and addresses the frustration of patients and families having to retell their story, ensuring all partners are aware of changes. This is why over this past year, we have continued to integrate CHRIS with other health information systems to support eReferrals and eNotification. Through eNotification, messages flow from our hospital partners notifying us when patients are admitted or discharged from the emergency department and/or hospital. These messages can then be relayed through Health Partner Gateway (HPG) to the system partners providing care in the home. eReferral allows hospitals and, in the near future, primary care providers, to make referrals directly in their electronic health record into CHRIS, resulting in increased access to timely care. To support emergency department diversion strategies, we continue to work with regional paramedics to integrate CHRIS with paramedic systems. By collaborating with our partners, we are also helping address system capacity.

Digital technologies have enabled new opportunities for care in non-traditional settings, such as providing patients the ability to receive health care from the comfort and safety of their homes in their preferred language. We are continuing to explore the benefits of electronic remote care monitoring systems, combined with coaching, through our Telehomecare programs. By launching a new patient-focused website on a modernized platform with simpler navigation and visual aids, we are also increasing access to our services.

Through our engagements with our community groups, we also heard that moving to virtual care during the pandemic both provided solutions and highlighted inequities in service delivery, access to technology and resulted in feelings of exclusion. Recognizing that there are different levels of knowledge, comfort, and access to technology and the internet, we aim to provide a variety of approaches based on patient needs, preferences, and ability to access services to support patient care. These will augment face-to-face interactions for patients.

Do not replace human contact, only enhance it with technology.”

– Patient/Family Advisor (November 2022)

As we build on what we have accomplished, we will focus on the following strategic objectives:

- Explore options to advance digital readiness for future state health care delivery models in the context of home health care transformation.
- Support digital transformation and best practices in collaboration with health care system partners and Ontario Health in alignment with the [Ontario Health Team Digital Health Playbook](#).
- Work with Ontario Health on implementing digital plans that mitigate risks of disruption to patient health care, business operations or a privacy/security breach.

We will undertake the following strategic initiatives:

- **Integrate digital home care systems in collaboration with system partners**
We will continue integrating our systems with the systems of community paramedics, nurse practitioners and family physicians to ensure all partners in a patient’s circle of care receive updates and notify each other on health changes, medication updates and diagnostics. Through eReferral, primary care providers will also be able to refer their patients for our services more seamlessly. This includes implementing primary care eReferrals in our 14 agencies and expanding the Ontario Hospital Association Integrated Decision Support Solution from five to all our agencies.
- **Optimize the CHRIS system, in partnership with Ontario Health, to enable consistent configuration and application with Ontario Health Teams and other local partners.**
More coordinated care that avoids duplication is the goal of sharing a patient’s electronic medical

record with partners within their circle of care. CHRIS, currently used by Home and Community Care Support Services, will be the platform to share this information.

- **Expand Telehomecare and virtual care.**
Telehomecare combines remote sensing technology with coaching by a nurse to help patients learn to self-manage symptoms related to chronic disease management. Through the program, changes in a patient’s health can also be relayed to their primary care provider. Virtual care employs video conferencing, by both ourselves and our service provider organizations, with eligible patients and caregivers. Both options can be accessed by patients who are comfortable learning or employing these technologies. We will increase the number of chronic heart failure and chronic obstructive pulmonary disease patients on Telehomecare from 5.1% to 8%, and aim to maintain/increase the use of virtual care (currently used by 2% of nursing and 16% of rehabilitation patients).
- **Explore innovative service models in collaboration with Ontario Health Teams and other health system partners.**
By working with Ontario Health Teams and other health system partners, we’ll explore opportunities for better integration of digital health solutions through new service models to better serve patients, families and caregivers.
- **Participate in and implement the ONE Access initiative in collaboration with the Ministry of Health and Ontario Health.**
This consolidates three disparate clinical viewers into ONE Access which will provide enhanced clinical data to providers and serve as the patient portal for Ontario where patients can access their own health record.

What does this mean for our patients?

Meet Faatima and Selma*

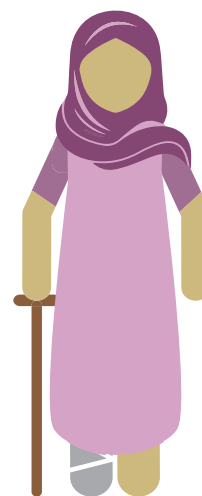
Faatima is Selma's neighbour and often her caregiver with her family living so far away. Worried about Selma's chronic obstructive pulmonary disease (COPD), Faatima went online and found the Telehomecare program on the Home and Community Care Support Services website. She hit the button that says: "Make a Referral." It was so easy – and, she learned, anyone can refer a person for services. After being assessed, Selma began receiving several home care services including being enrolled in Telehomecare. With this program, she'll receive remote monitoring equipment and regular coaching from a nurse to learn how to better self-manage her COPD symptoms. On a recent visit to Selma's home, Faatima became worried about her friend's breathing and called 911. After checking her vitals, reading her health history and reviewing her medications, the paramedics determined that Selma didn't need to go to the hospital, but they did alert Home and Community Care Support Services about her change in symptoms. This led to a notification passed on to Selma's family physician, who called later that day to check up on her. Selma's not really into the latest technological gadgets but is relieved that her health care providers are connected, and also for all the help her friend found her online.

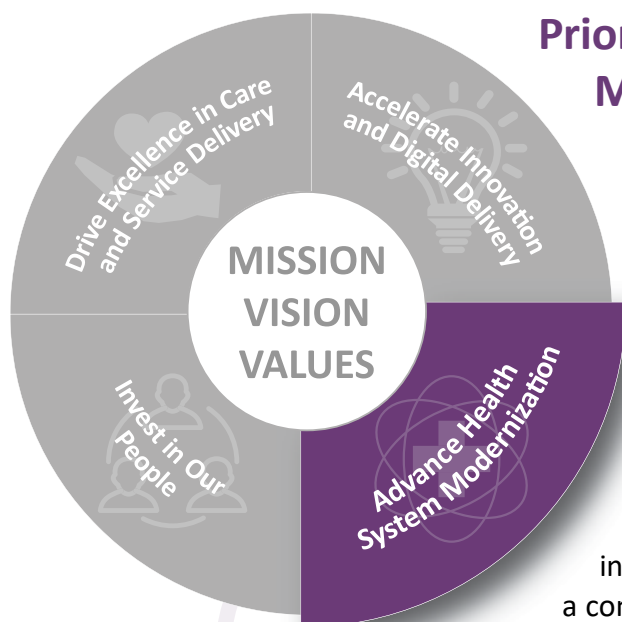
As our world evolves, you can be sure that the care provided is aligned with your preferences and convenience without compromising the quality of care that you are accustomed to. You can receive more timely and convenient access to care through various hybrid options such as remote care monitoring, virtual care, and in-person care to meet your specific needs. With greater system integration and collaboration, you can feel confident that your personal health information and data is safe. All of your providers within your circle of care will have access to the same information, which means reducing where and when you have to retell your story.

*Faatima and Selma are a composite of patients we have heard from, and their story illustrates how our work internally and with system partners can improve the experience of the patients we serve.

How will we know that we are making a difference?

Measuring the effectiveness and impact of our digital initiatives is critical to ensure they are producing results as intended, to enhance system modernization and improve our patients' experiences and outcomes. We will measure the number of virtual visits for nursing and therapy services over regular intervals as well as assess patient feedback. Additionally, we will measure the shift from face-to-face interactions to virtual and/or telephone, and Telehomecare (for patients with chronic heart failure and COPD) services where appropriate. To see a more comprehensive list of indicators that will be used for this priority, please refer to the 'Performance Measurement' section of the plan.





Priority 3: Advance Health System Modernization

To further health care system modernization, we have been working closely with the Ministry of Health, Ontario Health and Ontario Health Teams to enable new ways of organizing and delivering health care that is more connected for patients in their local communities and the health system as a whole. This includes supporting the implementation of the new Home and Community Care Services Regulation within the *Connecting Care Act, 2019*.

Committed to collaborating with our Ontario Health Team partners, we have established foundational elements to help inform and guide home care modernization to ensure there is a consistent approach to care coordination and service delivery across the province. This includes developing a standard Ontario Health Team Participation Agreement, which is now being used to cement

our active participation at Ontario Health Team tables across the province, where we are sharing our knowledge of best practices concerning care coordination and exploring new models of integrated care. To advance integrated care for patients across the full care continuum, we recognize that collaborating with Ontario Health Teams will create a more seamless journey and maintain access to the services they need. This collaboration will support the development of integrated clinical pathways that will provide more seamless, integrated care in the areas of mental health and addiction services, palliative and end-of-life care services and chronic disease management. Our participation in advancing this work supports teams in delivering proactive evidence-based care.

While provincial consistency in service delivery is important, so is equity. Through our engagements, we've heard about the importance of allowing for flexibility and local variations, including cultural, linguistic and geography based needs. As we focus on making improvements to long-term care placement in alignment with regulations and needs, we acknowledge the importance of consulting with patients, families and caregivers from Indigenous communities, and that this process may trigger trauma from past experiences. We will continue to explore options and have conversations with Indigenous communities to gain a better understanding of their needs and experiences, including Trauma-Informed Care, so we can safely and better serve Indigenous patients, families, and caregivers seeking long-term care placement and hospice care.

“It is crucial to provide trauma-informed care that respects experiences First Nations people had in residential schools. Stigma and immature discharges persist with tragic endings.”

– Indigenous Partner (November 2022)

Home and community care services modernization also involves refining and reviewing our processes, so that patients can access the same high quality care, services and equipment wherever they might call home. This includes pursuing improvements in our patient intake process so that we offer a consistent patient experience across the province. We have heard from our partners and patients

that the journey from hospital to home needs improvement, and we will continue to explore ways to streamline this process so that patients don't experience gaps during the handoff between care providers. We will also examine business processes related to medical equipment and supplies management, from ordering to the distribution of medical supplies used by our patients at home to create further efficiencies.

“Modernization has to be focused on what works best for patients, families, caregivers.”

– Patient/Family Advisor (November 2022)

As we build on what we have accomplished, we will focus on the following strategic objectives:

- Plan for a successful transition of home care services and delivery to Ontario Health Teams/ other health service organizations.
- Implement improvements in long-term care home placement in collaboration with the Ministry of Long-Term Care.
- Support new models of care delivery enabled by ministry regulations (*Connecting People to Home and Community Care Act, 2020* and *Regulation 187/22*) in collaboration with the Ministry of Health, Ministry of Long-Term Care, and Ontario Health.

We will undertake the following strategic initiatives:

- **Through collaboration with partners, patients, families and caregivers, improve and streamline the discharge process from hospital to home.** The hand off between hospital and home involves the coordination of many partners and services. With the help of those with lived-experience and our partners, we will work to create a more seamless transition so that patients, when ready for discharge, can do so in a timely way, with no gaps in service.

- **Develop a streamlined intake process across the province to support consistent patient experiences.**

With 14 Home and Community Care Support Services organizations across the province, there is an opportunity to leverage best practices to develop a consistent intake process that can be used to improve the patient experience, ensuring that it meets our commitment to equity, inclusion, diversity and anti-racism.

- **Develop and implement online application for long-term care placement.**

We've heard from some families and patients that applying online would streamline the application process to long-term care homes, so we will look to develop an online process that offers improved access while also safeguarding patient privacy. For those who do not have proficiency or access to technology, we will continue to offer a paper-based application process.

- **Implement a provincial Medical Equipment and Supplies structure.**

By reviewing every aspect of our current system and implementing a modernized structure, we will ensure medical equipment and supplies arrive on time – adding efficiency to our processes that improve the experience for our patients and partners. As the work evolves we will establish indicators aligned with five new provincial contracts.

- **Support the Ministry of Health and partners to implement indirect care coordination models.**

Currently we deliver “direct” care coordination to our patients. With the “indirect care coordination” model newly enabled by the Home and Community Care Services *Regulation O. Reg. 187/22*, another service provider could be contracted to deliver care coordination. For instance, in the future, an Ontario Health Team or a health service provider may establish a contract with another organization to provide care coordination services. With our considerable

expertise, we will work with partners on enhanced models enabled by the *Connecting People to Home and Community Care Act, 2020* to implement **five** indirect care coordination programs.

- **Develop a transition plan to modernize home and community care and support the transition of home care delivery to Ontario Health Teams/other health service organizations.**

We will continue to work with our partners to develop plans to improve the delivery of home and community care, supporting new models care within Ontario Health Teams and other health organizations.

What does this mean for our patients?

Meet Ryan and Kaylee*

After a serious motorcycle accident, Ryan spent many months in hospital undergoing various surgeries and treatments. When it was time to go home, his partner, Kaylee worried about how she would care for him, while also working full time and looking after their two children. However, after meeting with his care coordinator and discharge planner, her worries eased and she was surprised at how seamless the transition from hospital to home turned out to be. Before Ryan left the hospital, all the equipment arrived at their home including a special bed and wound care supplies. A rapid response nurse supported Ryan's arrival home, making sure that they both knew how to use everything. Soon they met the rest of their care team including personal support care workers, physiotherapists and an occupational therapist. When Ryan's health took a turn for the worse, his care coordinator notified his family physician who followed up quickly with a new round of antibiotics.

As processes become more streamlined and different health care providers collaborate across the system, you can expect more timely access and comprehensive, coordinated care, resulting in easier transitions between providers. Through integrated care and the partnership between Home and Community

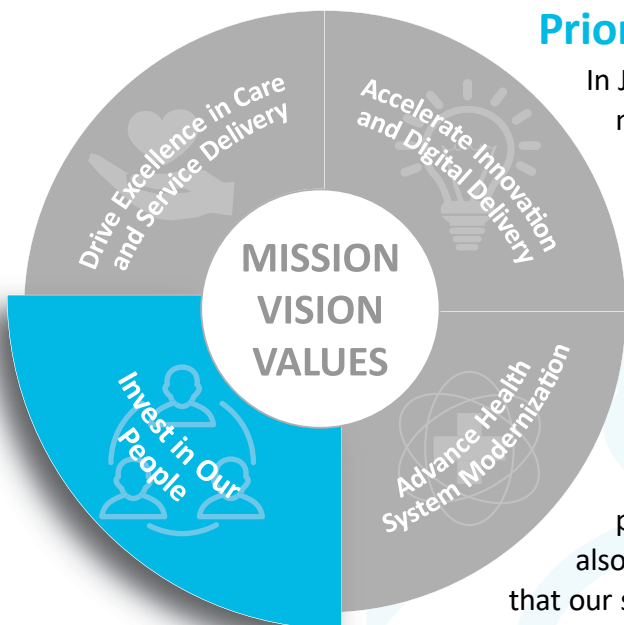
Care Support Services and Ontario Health Teams, you can expect your home care coordinator to be working with your local hospital teams, paramedic services, primary care providers, and other members to best support your needs, right in your community.

*Ryan and Kaylee are a composite of patients we have heard from, and their story illustrates how our work internally and with system partners can improve the experience of the patients we serve.

How will we know that we are making a difference?

We will measure the number of patients who are waiting in an inpatient hospital bed (no longer requiring acute care) for discharge to their home, community setting or long-term care home, where this is delayed due to a lack of availability of services and resources required to support the patient's needs at their discharge destination. Additionally, we will continue to measure the time it takes to complete an initial intake assessment and make improvements where possible. Given the importance of medical equipment and supplies for our home care patients, we continue to monitor the proportion of deliveries that are regularly scheduled and successfully completed, as well as identifying deliveries that need to be expedited. To see a more comprehensive list of indicators that will be used for this priority, please refer to the 'Performance Measurement' section of the plan.





Priority 4: Invest in our People

In January of 2022, we launched our People Strategy, after months of preparation and planning. Guided by our strategic priority to “Invest in Our People,” and rooted in our mission, vision, and values, the [People Strategy](#) shapes the way we lead, engage and develop our people. We are investing in strategies focused on supporting staff, enabling professional growth, while retaining and attracting top talent. Through purposeful, transparent, and consistent communications with staff using a variety of channels, including a new provincial intranet site, weekly newsletter, and monthly town halls, we are staying connected and promoting a one team culture across the province. We are also exploring opportunities for learning and development so that our staff can continue to provide high quality care.

“Front line staff are the jewels in your crown.”

– Patient/Family Advisor
(November 2022)

In its first year, more than 145 staff members, led by eight executive sponsors, came together to implement the People Strategy through defined projects and initiatives. Over the course of the year, we have engaged our staff and leadership, our community of advisors, and external partners in various initiatives.

Within each pillar we have made significant strides forward in the first year of implementing our People Strategy:



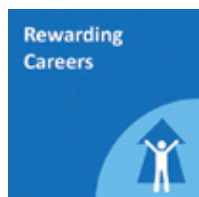
We have drafted a framework for a provincial wellness and wellbeing program, and have renewed our commitment to provide a safe and healthy workplace for our staff, paving the way to creating consistent practices and policies that help us reduce risks and hazards that could result in any form of employee injury and illness.



To better understand how our staff are feeling, we gathered information through an organization-wide Employee Engagement Survey, the results of which have been shared with all staff. In an effort to ensure all voices are heard to inform policies and decision-making, staff have participated in action planning sessions. These will inform the development of an organizational action plan to make Home and Community Care Support Services a great place to work.

High-performing teams want to be recognized for their work. Earlier this year, we offered staff an opportunity to tell us how they want to be recognized for their work. This input will allow us to create a new Employee Recognition Program to celebrate the success of our talented employees.

A strong, effective team culture also depends on establishing a clear organizational structure, which we are developing with careful consideration.



The development of our Employment Brand was a significant milestone. Our employment brand is not just our marketing message to external candidates, it is our career promise to staff – our commitment to inclusion, celebrating diversity, equitably serving communities, driving innovation and having a positive impact on all that we do.

We developed two new Human Resource policies to bolster Home and Community Care Support Services as a competitive employer in this post-pandemic hybrid workforce. The hybrid workforce model enables Home and Community Care Support Services to maximize productive work time, contributes to employee wellbeing and morale, supports recruitment and retention of our workforce enabling the provision of exceptional care to our patients.

We also wanted to enhance leadership capabilities and create a coaching and mentorship program for all staff. Along the same lines of learning and development, we strive to enhance professional capabilities for all, and ultimately establish a clear and consistent process for learning and development opportunities.



We have made progress in creating a safe, inclusive work environment. (Please see our EIDAR section, on page 8)

Education and awareness are foundational to this pillar and on top of implementing personal pronouns to our email signatures and creating a centralized EIDAR intranet page, we have held several speaking events – on Emancipation Day, Black History Month, National Day for Truth and Reconciliation and for Pride Month.

As part of our EIDAR work, we acknowledge the need for enhanced training and education around Indigenous and Black communities and population health needs. We will continue cultural safety training and exploring options for Trauma-Informed Care for our front-line staff.

We also acknowledge the importance of stabilizing and building our bilingual (French and English speaking) workforce as well as optimizing the distribution of French-speaking staff across the province to improve access to French Language services in our patients' language of need.

“Home and Community Care Support Services staff provide high-quality care.”

– Patient/Family Advisor (November 2022)

As we build on what we have accomplished, we will prioritize the following strategic objectives:

- Recognizing the health human resources challenges across the system, continue to focus on attracting and retaining staff.
- Utilize front-line staff and their roles to their full potential, including providing opportunities to use their clinical skillsets to provide more comprehensive clinical patient care services.

We will undertake the following strategic initiative:

- **Build on the accomplishments of our People Strategy to support workforce stabilization and help prepare staff for the future.**

This will include achieving an employee engagement index of 78% and a voluntary turnover rate of 10.5%, along with continued progress in the four pillars of the People Strategy:

- Equity, Inclusion, Diversity, and Anti-Racism (EIDAR) Plan that supports our workforce and reflects the diverse communities we serve
- Employee Wellness, Wellbeing and Health and Safety Programming
- Building an Effective Team Culture
- Providing Rewarding Careers

What does this mean for our patients?

Meet Kelly*

Kelly, a high school student who uses the pronouns they/them, has been finding this year challenging. Their dad recently reconnected with his birth mother; he was part of what is known as the “Sixties-Scoop,” a period that began in the 1960s and continued into the 1980s, when a disproportionate number of Indigenous children were taken from their families by child protection agencies and placed with middle-class Euro-Canadian families. Kelly’s not sure what it means and the connection to some of the challenges they are facing at school. Recently, Kelly met with a Mental Health and Addictions Nurse from Home and Community Care Support Services at their school who talked to them about wellness strategies and also connected them to an Indigenous health care provider in their community who specializes in a Trauma-Informed approach. The Home and Community Care Support Services nurse had recently received training on this form of strengths-

based, person and community-centred care. While she wasn’t an expert on this type of practice, she knew people who could help Kelly and the importance of this type of approach.

Supporting the wellbeing of our staff will improve their ability to care for patients and their loved ones within the community and across the system. Protecting and enhancing the diversity of our staff directly affects our ability to care for our patients unique and diverse needs. We recognize that compassion fatigue and burnout are increasing, and we must look after the care team so that they can look after patients. Our employment brand statement, “Care and be Cared for” captures the caring attitude our staff bring to the job, and our organization’s commitment to ensuring our staff are cared for too, so that they are ready to serve every person in Ontario who needs our services.

*Kelly is a composite of patients we have heard from, and their story illustrates how our work internally and with system partners can improve the experience of the patients we serve.

How will we know that we are making a difference?

Supporting our workforce is critical to delivering quality health care services, therefore we understand the importance of measuring the effectiveness of our initiatives to ensure they are producing results as intended; to enhance workforce stabilization. We will continue to measure the percentage of employees who leave the organization voluntarily, through either retirement or resignation. We are committed to using the results of our Employee Engagement Survey to inform action plans that will result in tangible plans. To see a more comprehensive list of indicators that will be used for this priority, please refer to the ‘Performance Measurement’ section of the plan.

The following are examples of key indicators that will measure improvements in our organizational stability: voluntary turnover rate and employee engagement index.

PERFORMANCE MEASUREMENT |

As an integral member of our health care system, we are accountable to the partners, patients, families and caregivers we serve every day. As we strive for continuous improvement, we look to use a series of performance measures that will be used as a baseline with appropriate associated targets to measure our ability to meet our organizational goals. The initiatives under each of the strategic priorities will be measured using performance indicators to ensure progress is being consistently monitored.

The provision of high-quality home care and long-term care placement is essential. To ensure consistent, high quality care for the people we serve, regardless of where in the province they live, we follow a stringent provincial Client Services Contract Performance Framework. This Framework sets out the standards that all health service providers we partner with must follow, and the contracts with these providers set out the performance targets they must meet. With these obligations clearly stated, we are able to measure the quality of care that is delivered across Ontario.

To ensure our areas of successes and improvements are measured, we will be reporting on:








- How we support caregivers to care for loved ones at home
- How we leverage digital technologies to provide care
- Wait times for providing patient care in various home and community settings
- How we measure quality of care provided to patients within Home and Community Care Support Services organizations as well as service providers







(Chart on next page.)



Improvement Direction Arrows:

We are committed to driving improvement in all our priorities by working towards the targets we have set for each metric. The arrow's point (up or down) indicates the direction of improvement we are working towards with the metric.

| Strategic Priorities and Performance Measurement | | | |
|---|--|--|---|
| Drive excellence in care and service delivery | | | |
| Indicator | Baseline | Target | Improvement Direction |
| Service Offer Time to Acceptance (% Accepted within 60 minutes) – The percentage of service offers that have been accepted within 60 minutes. | Dec 2022 Nursing Visit: 56.1% PSS: 41.9% Rehab: 50.9% | Nursing Visit: 60% PSS: 45% Rehab: 60% |  |
| Volume of Open ALC Cases with a Home Discharge Destination - The number of patients waiting in an inpatient hospital bed who do not require the intensity of resources/services provided in that care setting whose discharge is delayed due to lack of availability of resources/ services at their discharge destination. | End of Month Snapshot Nov 2022 500 | 470 |  |
| Caregiver Distress Rate for Long-Stay Patients - Percentage of long-stay patients whose caregiver has indicated experiencing caregiver distress, broken out by adult long-stay patient populations (community independence, chronic and complex). | December 2022 48% | 47 % |  |
| Number of patients receiving Caregiver Respite per 10,000 Long Stay patients (Monthly) - Number of clients who are receiving Caregiver Respite services as a ratio to all long-stay patient populations (community independence, chronic and complex). | Dec 2022 3.37 | 4.40 |  |
| 5 Day Wait Time – Personal Support for Complex Patients - Percentage of adult complex patients who receive their first personal support service within 5 days of patient available date. | Dec 2022 77.2% | >90% |  |
| 5 Day Wait Time – Nursing Visits - Percentage of adult patients who receive their first nursing visit within 5 days of patient available date. | Dec 2022 88.0% | >90% |  |
| Missed Care - Measures the incidence of care that is not provided in accordance with the Patient Care Plan because a visit is missed or the Service Provider Organization does not have the capacity to deliver the care, broken out by service type (nursing visits, nursing shift, personal support hours and therapy visits). | FY 2022/23-Q2 Nursing Visit: 0.071% Nursing Shift: 1.201% PSS: 0.785% Rehab: 0.114% | < 0.05% |  |

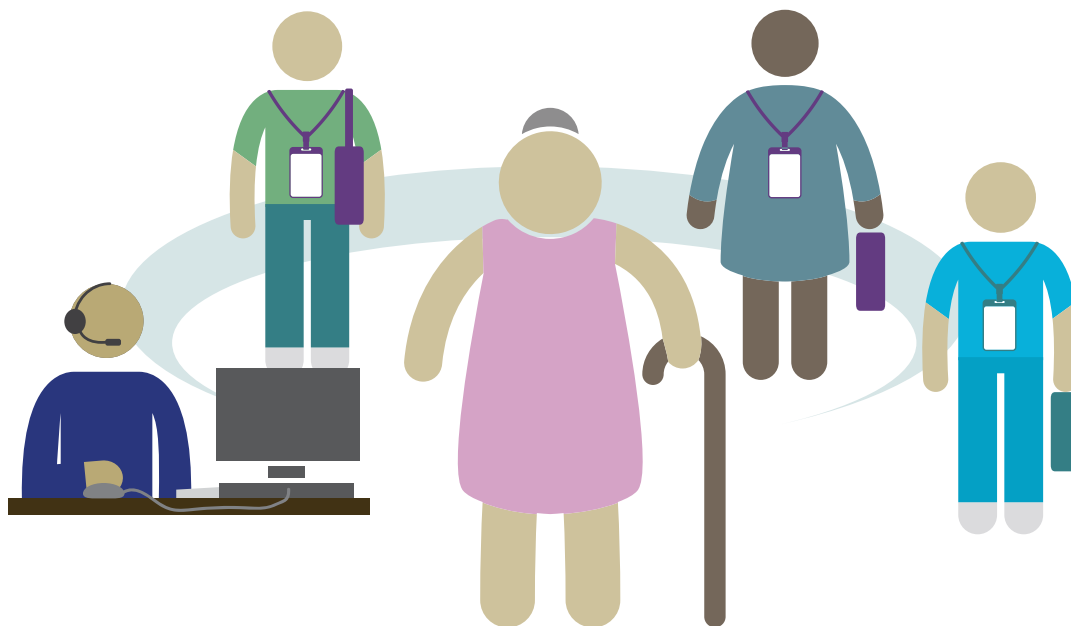
| Client and Caregiver Experience Surveys – Home and Community Care Support Services is currently going through a procurement process to develop a provincial approach for assessing client and caregiver experience. | | | |
|--|--|---|---|
| Accelerate Innovation and Digital Delivery | | | |
| Indicator | Baseline | Target | Improvement Direction |
| Virtual Visits Service Percent – A monitoring indicator showing the percentage of service provided virtually in the reporting period, broken out by nursing visits and therapy visits. | Nov 2022 Nursing: 2% Rehab: 16% | Maintain or increase performance where appropriate until clinical standards developed |  |
| Telehomecare Visits Service Volumes – Percentage of CHF and COPD patients on Telehomecare programs (Monthly) | Dec 2022 5.1% | 8.0% |  |
| Advance Health System Modernization | | | |
| Indicator | Baseline | Target | Improvement Direction |
| Community Crisis Applications Waiting for Long-Term Care Home (LTCH) Placement - Number of community applications on the LTCH placement wait list with in priority 1 category (crisis) and living in the community as of the end of the month. | Month End Snapshot Dec 2022 2,333 (6.5% of wait list) | 1,530 (4.5% of wait list) |  |
| Volume of Open Alternate Level of Care (ALC) Cases Related to LTCH Placement - The number of patients waiting in an inpatient hospital bed who do not require the intensity of resources/ services provided in that care setting whose discharge is delayed due to lack of availability at an appropriate LTCH destination. | End of Month Snapshot Nov 2022 1,712 | 1,712 |  |
| Invest in Our People | | | |
| Indicator | Baseline | Target | Improvement Direction |
| Voluntary Turnover - Percentage of employees who leave the organization voluntarily, either through retirement or resignation. | Year End Mar 2022 10.8% | 10.5% |  |
| Employee Engagement Index - comprised of six questions from the Employee Engagement Survey. | March 2022 76% | 78 % |  |

SUMMARY |

Home and Community Care Support Services remains committed to responding to the ever-evolving needs within the Ontario health care system to ensure we meet the needs of our patients, families and caregivers. This plan outlines how we will work closely with our health system partners, community of advisors and staff to prepare for a transition to a more stable and modernized health system where people will be better supported at home.

Our strategic priorities guide our actions to achieve our mandate as set out by the Minister of Health and support our organization's mission and vision. Our values will come to life as we meaningfully and proactively collaborate with patients, families, caregivers, staff, and system partners.

Together, we've developed a plan that is robust and innovative, grounded in the voices and experiences of our people and partners. As the health care landscape continues to evolve over the next year, we will continue to engage with all of our partners with the intention of ensuring exceptional care, wherever our patients call home, through our important work.



APPENDIX: BY THE NUMBERS

Across Ontario, Home and Community Care Support Services supports 640,000+ home and community care patients annually. The services we provide are vital to patients across Ontario. They address the needs of people of all ages, including seniors, persons with physical disabilities and chronic diseases, children and others who require ongoing health and personal care to live safely and independently in the community. The patients we serve are some of the most vulnerable in the province.

Our organizations:

- Have a total funding allocation of \$3.4B (as of Dec., 2022)
- Served 640,000+ patients in 2021-2022
- Directly employ 8,946 staff positions (Feb., 2023)
- Purchase \$2.1B services from over 150 Service Provider Organizations via approximately 400 contracts (this includes services such as nursing and personal support as well as hospices and medical vendors)

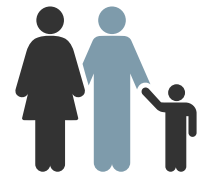
In addition:

- *Each day*, there are 10,800 care coordinator interactions, comprised of face to face, telephone and virtual connections.
- *Each day*, we operate 135 nursing clinics that receive more than 300,000 visits per quarter (three month period).
- *Each day*, there are more than 26,900 nursing visits, 5,600 therapy visits, and 100,000 personal support worker (PSW) service hours delivered to patients across the province.
- *Each month*, care coordinators collectively have 336,000 active patients on their caseload.
- *Each year*, through our services more than 27,270 people are placed in long-term care (LTC) homes.

OUR ORGANIZATIONS:



\$3.4B Funding



640,000+ Patients



8,940+ Staff



\$2.1B Services

IN ADDITION



Each day
26,900+ nursing visits
5,600+ therapy visits
100,000+ PSW
service hours



Each day
135 nursing clinics
Each quarter
300,000+ patient
visits to the clinics



Each Month
336,000 patients



Each Year
27,270+ LTC home
placements

APPENDIX: RISK AND MITIGATION SECTION

This section outlines the key organizational risks facing Home and Community Care Support Services in delivering on our plan and the associated mitigation strategies. Over the course of the 2023-24 year, we will develop appropriate province-wide frameworks and processes to effectively assess and monitor risks we face to avoid any potential risk to the patients we serve and staff who care for those patients.

| Risks Facing Home and Community Care Support Services | Existing Controls and Planned Mitigation Actions |
|--|---|
| <p>Service Provider Organization (SPO) partners’ health human resource strain</p> <p>Health human resource shortages have disproportionately affected the home and community care sector. The ongoing COVID-19 pandemic and threat of other viruses such as influenza and respiratory syncytial virus (RSV) will increase the risk of further health human resource shortages across the health system.</p> <p>The increased demand for home and community care services, the aging population and increased complexity of care required will continue to add strain to a health system that is already facing capacity issues.</p> | <p>In hard-to-serve areas, strategies will be implemented to increase capacity and improve access to care for patients in those regions.</p> <p>We will continue, where appropriate, to increase the number of service provider organization contracts to try to increase capacity within the system. We will also continue to conduct provincial analyses that looks at capacity indicators such as waitlist volume per specialty (e.g. personal care, nursing, occupational therapy, etc.), missed care, percentage of service authorizations, initial service offer acceptance rate, and service offer time to completion to determine hard-to-serve areas across Ontario.</p> <p>In hard-to-serve areas of the province or in areas where there is insufficient service provider organization capacity, we will increase opportunities for our front-line staff to deliver clinical patient care.</p> |

| Risks facing Home and Community Care Support Services | Existing Controls & Planned Mitigation Actions |
|--|---|
| <p>Home and Community Care Support Services workforce uncertainty</p> <p>Uncertainty about the future of home and community care has impacted staff retention and recruitment. This has led to challenges in attracting qualified staff.</p> | <p>We plan to mitigate this risk by advancing the initiatives outlined in the People Strategy that focus on efforts towards workforce stabilization. Specifically, our efforts to prioritize recruitment, retention, and recognition of our staff and leverage the insights gained from our Employee Engagement survey.</p> |
| <p>Ongoing risk of cybersecurity and privacy breaches in the digital health environment</p> <p>There has been an increased use of digital health platforms and further integration of digital health systems, resulting in the potential risk of experiencing a cybersecurity attack.</p> | <p>To mitigate this risk, a cybersecurity plan is being implemented across the province including an updated cybersecurity training program for all staff. We continue to work with our health system partners to ensure that appropriate frameworks and agreements are in place to allow for seamless and safe data sharing across integrated digital platforms.</p> |

APPENDIX: COMMUNICATIONS AND ENGAGEMENT PLAN

Communications and engagement activities will help us to accomplish our goals within our four strategic priorities. Dedication to our mission, vision and values, and a strong commitment to high quality patient-centred care, will guide our communications activities as we engage with diverse communities across the province and maintain our strong commitment to equity, inclusion, diversity and anti-racism in all that we do.

Our Partners

- All patients, families and caregivers
- Indigenous, Francophone, Black and other priority and marginalized communities
- All Home and Community Care Support Services staff across Ontario
- Service Provider Organizations
- Health Service Providers (such as hospitals, long-term care homes, community support service providers, mental health and addiction providers, primary care providers)
- Community Partners (such as school boards, emergency services, and public health units)
- Health Care Professionals
- Ontario Health Teams
- Municipal, regional and provincial government, including the Ministry of Health and the Ministry of Long-Term Care
- Local and provincial media
- General public

Communications Objectives

- Provide patients, families and caregivers with relevant and timely information about services from a trusted source
- Raise awareness of who we are, our services and how to access them
- Engage with patients, families, caregivers and our

populations with diverse needs to further integrate the patient experience and voice into organizational decision-making and through co-design, ensure all outcomes meet the specific needs of our communities

- Build awareness and trusted relationships with all community members and partners, particularly patients, families, caregivers and priority or marginalized populations
- Uphold our commitment to be open, transparent and accessible to the public on all Home and Community Care Support Services priorities and initiatives, while keeping our community engaged and informed about any changes to their home care delivery
- Keep staff informed about new (or changed) programs, initiatives and policies/processes that impact their jobs or the delivery of patient care while promoting the connectivity of Home and Community Care Support Services to operate as one organization across the province
- Develop and implement communications strategies to support organizational programs and initiatives, and our four strategic priorities
- Attract and recruit staff through our Employment Brand strategy, as well as support workforce stabilization

Communications Tactics

We will achieve our communications objectives through the development and implementation of a variety of communications tactics, including:

- Streamlined and integrated communications efforts across Home and Community Care Support Services to deliver consistent and timely information
- Customized communications plans to meet the needs of each project or initiative, including key messages, memos, promotional materials, media releases, engagement opportunities, etc.
- External promotion through various means, including

news media, social media and advertising, as appropriate

- Leverage digital and other new and innovative communications products and delivery methods to augment traditional communications
- Strong media and external stakeholder relations
- Continue to improve the online experience by continual improvement to an updated patient-centred website and engaging social media activity, while still maintaining traditional communications methods
- An internal communications program that engages staff and builds a positive culture that reassures them of the value of their work now and in the future – resulting in high-quality patient care
- Ensure a continued focus on equity, inclusion, diversity and anti-racism in all communications practices
- Ongoing engagement opportunities with patients, families, caregivers, service providers and our diverse communities

Engagement Plan

Our new [Community Engagement Framework](#) provides continued vision, direction, and inspiration for our engagement approach over the coming year. The development of this Framework involved hearing from close to 200 patients, families, caregivers, staff, leaders, and system partners. Co-designing the Framework sets a collaborative vision where those who provide care and those who receive it partner together through purposeful engagement. The Framework outlines what, why, how and when we will engage people using our programs, services, and community partners. It also demonstrates our collective commitment to listening to, and learning from, those who we serve.

The Framework helps to ensure local and provincial work embeds lived experience of patient advisors into our programs, service, and policies. Central to this is our Community of Advisors, a newly formed group of patients, families, and caregivers who have used our services within the last five years. Our goal with this group is to be reflective of the diversity of Ontario to ensure we hear from diverse geographies,

backgrounds, culture, experiences, identities, skills, interests and racialized communities. These Advisors receive support, orientation and training about the home and community care sector to ensure they are empowered to actively participate and provide informed input. Sharing opportunities through our new online engagement portal will ensure timely responses and ease of navigation for our Advisors.

Home and Community Care Support Services supports the Advisors to ensure they are clear on engagement best practices and approaches. Customized engagement planning, method selection, matching with Advisors, preparation, engagement delivery, follow-up and evaluation ensures that engagement is designed in a fashion to yield important and relevant insights from our Advisors lived experiences. We also train staff on engagement best practices and how to engage with purpose. We will support the Advisors and empower their ability to engage underrepresented communities. This is supplemented with resources and guidance to ensure staff are knowledgeable and comfortable with setting up engagement opportunities for success.

The coming year will also bring a renewed focus on building lasting relationships with Indigenous leaders and communities as we set out to build learning, reflection, and dialogue with Indigenous peoples. We will focus on listening, learning, and building trust over the coming year to ensure that we better understand the unique challenges faced by Indigenous communities. With this, we will work towards greater support of their needs. We will also be working to engage Francophone communities to better understand and address their unique needs and challenges receiving Active Offer of care throughout their patient journey in their first language.

As we engage all of our audiences, we commit to listening to, and learning from the people we serve. Through all of our engagement work, we remain committed to hearing from vulnerable communities. This will allow us to create a more resilient and patient-centred organization that addresses health disparities and delivers excellent and equitable access, experience and outcomes for the people of Ontario.

APPENDIX: FINANCIALS

The following spending plan identifies the resources, including financial and capital, that Home and Community Care Support Services will utilize to meet our goals and objectives:

| | 2022/23 Estimated Actuals | 2023/24 Ministry Allocation | 2023/24 Planned Expenses ¹ |
|--|---------------------------------|-----------------------------------|---|
| Allocation: Home Care/LHIN Delivered Services² | | | |
| Salaries (Worked hours + Benefit hours cost) | \$567,784,030 | \$555,747,789 | \$555,747,789 |
| Benefit Contributions | \$151,001,923 | \$157,268,037 | \$157,268,037 |
| Med/Surgical Supplies & Drugs | \$175,333,134 | \$182,232,623 | \$182,232,623 |
| Supplies & Sundry Expenses | \$15,987,287 | \$18,565,935 | \$18,565,935 |
| Equipment Expenses | \$30,354,181 | \$33,724,830 | \$33,724,830 |
| Amortization on Major Equip, Software License & Fees | \$261,577 | \$228,277 | \$228,277 |
| Contracted Out Expense | \$2,454,856,929 | \$2,315,649,486 | \$2,315,699,486 |
| Buildings & Grounds Expenses | \$491,500 | \$459,800 | \$459,800 |
| Building Amortization | \$0 | \$0 | \$0 |
| TOTAL: Home Care | \$3,396,070,560 | \$3,263,876,777 | \$3,263,926,777 |
| Aggregated HCCSS Operations³ | | | |
| Salaries (Worked hours + Benefit hours cost) | \$72,408,875 | \$77,506,095 | \$77,506,095 |
| Benefit Contributions | \$19,973,425 | \$22,858,200 | \$22,858,200 |
| Med/Surgical Supplies & Drugs | \$0 | \$0 | \$0 |
| Supplies & Sundry Expenses | \$18,349,363 | \$12,238,752 | \$12,238,752 |
| Equipment Expenses | \$11,131,992 | \$9,527,070 | \$9,527,070 |
| Amortization on Major Equip, Software License & Fees | \$885,509 | \$571,805 | \$571,805 |
| Contracted Out Expense | \$588,009 | \$504,780 | \$504,780 |
| Buildings & Grounds Expenses | \$27,967,543 | \$20,616,839 | \$20,616,839 |
| Building Amortization | \$756,009 | \$830,377 | \$830,377 |
| TOTAL: Integrated Administration/Governance | \$152,060,724 | \$144,653,918 | \$144,653,918 |
| TOTAL: HCCSS SPENDING PLAN | \$3,548,131,284 | \$3,408,530,695 | \$3,408,580,695 |

Notes:

1. Planned Expenses cannot exceed the Ministry's Allocation.
2. Home Care/LHIN Delivered Services includes direct services as defined in Schedule 7, Table 1 of the 2015-18 Accountability Agreement between the Minister of Health and the LHINs operating as HCCSS.
3. Integrated Administration/Governance includes indirect costs such as administration and overhead expenses.

APPENDIX: | HEALTH HUMAN RESOURCES

As organizations that provide services over a 12-hour day, with after hours on-call service available seven days a week, 365 days a year to address urgent patient needs, our health human resources are critical to our success. Providing this kind of coverage requires a large, flexible workforce, including a mix of full- and part-time employees, which enables us to be nimble and responsive to patient needs.

In addition, our staffing is comprised of non-unionized employees and those who are represented under 26 unique collective agreements across the province. There are five bargaining agents that represent these employees including ONA, CUPE, OPSEU, COPE and UNIFOR. We want to support all our staff with growth and development as we continue to navigate change. Our People Strategy will help us focus on meeting the immediate and long-term needs of our staff and our organizations. Some of the priorities of the plan include:

- Designing an organizational structure that allows us to function effectively as one team
- Stabilizing and retaining a talented workforce
- Fostering a culture of equity, diversity, inclusion and anti-racism
- Creating engagement opportunities for our staff
- Supporting education and growth opportunities



The following spending plan identifies the staffing resources that Home and Community Care Support Services will utilize to meet our goals and objectives:

HCCSS Consolidated Staffing Plan (Full-Time Equivalents¹)

| | 2022/23 Actual | 2023/24 Forecast |
|---|---------------------------|-----------------------------|
| Home Care² | | |
| Management and Operational Support (MOS) FTE | 1,780.55 | 1,788.19 |
| Unit Producing Personnel (UPP) FTE | 4,435.04 | 4,567.93 |
| Nurse Practitioner (NP) FTE | 128.82 | 139.37 |
| Physician FTE | 0.00 | 0.00 |
| Total Home Care FTE | 6,344.41 | 6,495.49 |
| Regional Coordination Operations³ | | |
| MOS FTE | 328.86 | 358.84 |
| UPP FTE | 440.52 | 467.89 |
| NP FTE | 0.00 | 0.00 |
| Physician FTE | 0.20 | 0.19 |
| Total Integrated Administration/Governance FTE | 769.58 | 826.92 |
| TOTAL FTE SUMMARY | 7,113.99 | 7,322.4 |

Notes:

1. One FTE equals 1950 hours per year and may be comprised of multiple staff.
2. Home Care/LHIN Delivered Services includes direct services as defined in Schedule 7, Table 1 of the 2015-18 Accountability Agreement between the Minister of Health and the LHINs operating as HCCSS.
3. Integrated Administration/Governance includes indirect costs such as administration and overhead expenses.

APPENDIX: ACRONYMS USED

| ACRONYM | MEANING |
|---------|--|
| ALC | Alternate Level of Care |
| CHF | Chronic Heart Failure |
| CHRIS | Client Health and Related Information System |
| COPD | Chronic Obstructive Pulmonary Disease |
| COPE | Canadian Office and Professional Employees |
| CUPE | Canadian Union of Public Employees |
| EIDAR | Equity, inclusion, diversity and anti-racism |
| HCCSS | Home and Community Care Support Services |
| HIROC | Healthcare Insurance Reciprocal Of Canada |
| HPG | Health Partner Gateway |
| LHIN | Local Health Integration Network |
| LTC | Long-term care |
| ONA | Ontario Nurses Association |
| OPSEU | Ontario Public Service Employees Union |
| SPO | Service Provider Organization |