Home and Community Care Support Services Consolidated Annual Report: 2022/23

ISSN 2563-6545

Table of Contents

Central 11 Allstate Parkway, Suite 500 Markham, ON L3R 9T8	**Central West** 199 County Court Blvd. Brampton, ON L6W 4P3	**Mississauga Halton** 2655 North Sheridan Way, Suite #140 Mississauga, ON L5K 2P8
North Simcoe Muskoka 15 Sperling Dr., Suite 100 Barrie, ON L4M 6K9	**Central East** 920 Champlain Court Whitby, ON L1N 6K9	**South East** 470 Dundas St. E Belleville, ON K8N 1G1
Champlain 4200 Labelle St., Suite 100 Ottawa, ON K1J 1J8	**North East** 1164 Devonshire Ave. North Bay, ON P1B 6X7	**North West** 961 Alloy Dr. Thunder Bay, ON P7B 5Z8
Toronto Central 250 Dundas St. W, Suite 305 Toronto, ON M5T 2Z5	**Erie St. Clair** 180 Riverview Dr. Chatham, ON N7M 5Z8	**Hamilton Niagara Haldimand Brant** 211 Pritchard Rd., Unit #1 Hamilton, ON L8J 0G5
South West 356 Oxford St. W London, ON N6H 1T3	**Waterloo Wellington** 141 Weber St. S Waterloo, ON N2J 2A9	

Home and Community Care Support Services is committed to ensuring accessible services and communications to individuals with disabilities. To receive this annual report in an alternate format, please contact Home and Community Care Support Services' Communications Department at 310-2222, TTY 711 or by email at HCCSSInfo@hccontario.ca.

ISSN 2563-6545

Message from the Board Chair

On behalf of the Home and Community Care Support Services Board of Directors, it is my privilege to present our consolidated Annual Report for 2022/23.

Our 14 Home and Community Care Support Services organizations continued to deliver exceptional home and community care services over the last year, while updating or establishing new policies and practices to meet provincial legislation and regulations that came into effect during that time.

Throughout the year, Home and Community Care Support Services delivered on our commitment to support health system modernization and meet the priorities outlined in our mandate letter from the Minister of Health. We are particularly proud of the strides our 14 organizations made toward acting as one unit, province-wide, serving all people across Ontario.

In May 2022, Bill 175, the *Connecting People to Home and Community Care Act*, *2020* was proclaimed, and our teams acted quickly to ensure the appropriate policies were in place and staff equipped with the education needed to achieve our compliance with these regulatory provisions.

Our teams also worked diligently to implement Bill 7, the *More Beds, Better Care Act, 2022,* which amended the *Fixing Long-Term Care Act, 2021* and enabled the safe transfer of people who no longer require treatment in hospitals to temporary care arrangements in long-term care homes.

Our work supporting Ontario Health Teams continued with the establishment of a province-wide steering committee to support Ontario Health Team implementation and home care modernization. Home and Community Care Support Services was an active participant at Ontario Health Team tables across the province and identified by many as a crucial partner.

We experienced a shift in our COVID-19 journey, moving from pandemic response to restoration and recovery. Our work with partners on vaccination programs continued while our duties expanded to include the administration of antiviral medication in community and clinic settings. We also launched five capacity planning initiatives as part of our support for the Ministry of Health's *Plan to Stay Open: Our Health System Stability and Recovery.*

In 2022/23, our efforts to ensure all people in Ontario had access to the same high-quality care, regardless of where they live, continued by providing staff opportunities to strengthen their knowledge, awareness and skills to provide culturally safe service to Indigenous, Francophone, Black and other marginalized communities.

You will read about our progress in these areas and more within this report. You will find that our patients continue to be at the centre of everything we do. Together, we are committed to moving forward as high-performing organizations working to realize our unified vision of "exceptional care, wherever you call home."

Joe Parker
Board Chair, Home and Community Care Support Services

Message from the Chief Executive Officer

It remains my pleasure to lead Home and Community Support Services through so many successes and achievements during such a busy and pivotal time in health care.

In 2022/23, our work continued to be guided by our mission of helping everyone to be healthier at home through connected, accessible, patient-centred care. To ensure we were best positioned to achieve our goals, one of my top priorities this past year was the design of our organizational structure and the establishment of a streamlined leadership team. This included the appointment of five Chief positions joining me as our provincial Executive Leadership Team, and the establishment of a regional model that will provide our 14 organizations the opportunity to work more closely with nearby teams. Navigating the ever-evolving health care landscape is challenging work, and I'm grateful to be doing it alongside such skilled and dedicated leaders and staff.

As the COVID-19 pandemic evolved to a state of recovery, we were pleased to re-open our offices to staff, patients, caregivers and community members across the province. We now have staff working in a mix of locations through a hybrid workplace model, including community and clinical settings, patients' homes, on-site and remote. This model enabled us to effectively deliver face-to-face customer service and care to patients, their families and caregivers and to build strong relationships with our health system partners. It also enabled flexibility to be able to respond efficiently to the shifting landscape of the global pandemic and to ensure we are considering opportunities to reduce our physical footprint in line with guidance from Infrastructure Ontario.

We continued to support a diverse population of patients, each with unique circumstances, culture and health status. We remain committed to providing a respectful, accessible and inclusive environment for all patients, employees, partners and the public. I'm proud of the progress we've made in building a culture of equity, inclusion, diversity and anti-racism through education, training and process improvements focused on Black, Indigenous, Francophone, 2SLGBTQI+ and other marginalized communities. We will continue to improve patient outcomes and satisfaction by collaborating with system partners to eliminate systemic barriers.

Additionally, through our Equity, Inclusion, Diversity and Anti-Racism committee, we made strides in building a workforce that reflects the diverse communities we serve. We also engaged staff in a number of meaningful events and educational opportunities aimed at fostering a more comprehensive understanding of equity, inclusion, diversity and anti-racism to help guide them in their work. To continue to support the rollout of these important programs and initiatives, we created a new provincial position for the role of Manager of Equity, Inclusion, Diversity and Anti-Racism and invited members from our Community of Advisors to join the interview panel in order to ensure the candidate reflected the needs of the communities we serve.

I am pleased to share the details of these achievements and more within the pages of this report. I am proud of the work we have accomplished to date and excited for the work ahead as we continue to provide high-quality home care, long-term care placement and access to community services to patients across Ontario.

Cynthia Martineau
Chief Executive Officer, Home and Community Care Support Services

Introduction

In 2022/23, Home and Community Care Support Services focused on making progress against the goals outlined in our Annual Business Plan. It was a busy and productive year, as we worked more seamlessly together across our 14 organizations to provide the best care possible to the people we serve, all while supporting health system capacity and recovery efforts as the global pandemic began to wane.

With the *Connecting People to Home and Community Care Act, 2020* proclaimed into force in May 2022, Home and Community Care Support Services began to address the need for a number of new provincial policies to ensure all 14 organizations were compliant with the new regulations. The changes made across the province in compliance with the legislation, outlined in detail under the Description of Activities over the Year section of this report, pave the way for strengthened integration of home and community care services in a transforming health care system.

In August 2022, the Ministry of Health released its *Plan to Stay Open: Health System Stability and Recovery* to address Ontario's immediate needs and to stabilize the health and long-term care sectors for the future, and passed 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. As a key health care system stakeholder, Home and Community Care Support Services responded to the immediate priorities identified in Bill 7 by developing a comprehensive implementation and staff education plan for those involved in the long-term care placement process. In addition, and to support the larger system-wide goals identified in the Plan to Stay Open, we developed a multi-year Capacity Planning initiative that aligns with and supports the government's plan and provides for the implementation and expansion of the following initiatives:

- Targeted service provider organization incentives;
- Enhanced utilization of transitional care beds in retirement homes;
- Increased neighbourhood models of care;
- Maximize and expand community clinics; and,
- Optimization of direct care nursing and therapy staff.

The targeted implementation of these five initiatives began in 2022/23 and focused on our hard-to-serve and other specifically identified areas across the province, with the objective of sustaining and improving home care and system capacity.

A significant component of our work over the last year was the ongoing support for and participation in Ontario Health Teams. In 2022/23, Home and Community Care Support Services had the opportunity to support hospitals, primary care providers and other stakeholders to test innovation in home care delivery through our work with several Ontario Health Teams. We continue to inform working groups, consisting of Ontario Health, the Ministry of Health and Ontario Health Teams on critical functions, including care coordination, service provider selection and contracts, data sharing, privacy and evaluation.

At the organizational level, Home and Community Care Support Services was engaged in establishing a strategic organizational and leadership structure building on our efforts to work more seamlessly across our 14 organizations. With a provincial Executive Leadership Team and Senior Leadership Team in place, we had the opportunity for enhanced collaboration and consistency of care for the patients, families and caregivers we serve. The launch of our provincial website in September 2022, as well as the implementation of a provincial Guide to Placement into Long-Term Care Homes and Guide to our Home and Community Care Services, published in October 2022 and March 2023 respectively, ensure patients have access to the same comprehensive information regardless of where they reside in Ontario.

In 2022/23, we undertook a focused approach to organizational design to ensure our most valued asset, our people, are enabled to drive forward innovation and excellence in patient care. Following the initiation of our People Strategy in early 2022, several key initiatives were implemented in fiscal 2022/23. These initiatives included the development of a framework for a provincial wellness and well-being program and the implementation of an inaugural Employee Engagement Survey, the results of which were shared with staff provincially and locally as well as opportunities to inform action planning.

While working simultaneously to support health system capacity and recovery following two

disruptive years of dynamic pandemic response, aligning with new legislation and supporting health system modernization, last year Home and Community Care Support Services staff coordinated and/or delivered more than:

- **35,700,000** PSW hours (+3.2% from 2021/22)
- **10,000,000** Nursing visits (+5.2% from 2021/22)
- **28,700** Long-term care placements (+4.4% increase from 2021/22)

We are pleased to share our achievements over the 2022/23 fiscal year.

Population Profile

Below is a population profile of Ontario, which includes information on the number and type of health system partners across the province.

Population profiles for individual Home and Community Care Support Services organizations can be found in Appendix One.

Area (km^2)	908,699	Health System Partners: • 1000s of primary care providers • 680 community support agencies • 624 long-term care homes** • 150 hospital sites • 100+ service provider organizations • 100+ equipment and supply vendor sites • 72 school boards
Total Population	15,228,355	
Population Age 65+	18.8%	
Population Growth Rate	1.16%	
Population Density	16.76/km2	
Rural Population	17.2%	
Indigenous Population	2.8%	
Francophone Population (including IDF)*	4.7%	
Low Income Population	14.4%	

*IDF - Inclusive Definition of Francophones, including Francophones whose mother tongue is not French
** As of July 1, 2023

Sources:

- Ministry of Finance projections (2018-2041) via Ministry of Health Visual Analytics Site
- Statistics Canada 2016 Census via Ministry of Health Visual Analytics Site
- Home and Community Care Support Services Strategy, Decision Support departments

Description of Activities

COVID-19 PANDEMIC RESPONSE

The COVID-19 pandemic continued to have a dramatic effect on health care in 2022/23 with response and recovery efforts occurring simultaneously. All 14 Home and Community Care Support Services organizations were unwavering in their efforts to make a difference and to be there for the patients and families who have relied on us during this unprecedented time in health care, while also supporting our health system partners.

Vaccination and Homebound Anti-Viral Administration

At the start of the year, the 14 Home and Community Care Support Services organizations were focused on vaccination and testing efforts through redeployment and homebound vaccination programs. Toronto Central alone administered 736 influenza vaccines and 647 COVID-19 vaccines to homebound patients in 2022/23.

Home and Community Care Support Services began accepting referrals from primary care and hospitals for the administration of intravenous antiviral for individuals diagnosed with COVID-19 using the Health Canada approved Remdesivir, a broad-spectrum antiviral medication that, when administered within seven days of symptoms appearing, reduces the need for hospitalization of patients who are at high risk of developing severe COVID-19. This service was initially offered as an in-home nursing program, and after successful adoption, a pilot program to provide this treatment in clinic settings was introduced in several areas. Remdesivir was administered in-home to 60 patients in Central while 23 patients in Central West and 120 in Mississauga Halton received infusions in clinic settings. Aligned with the public health guidance, there are plans to further expand availability of this treatment in 2023/24.

Building Capacity Through Pandemic Response

COVID-19 continued to impact long-term care homes, congregate settings and communities as a whole. In response, Champlain introduced the Shift Model to 208 retirement homes within the region with the intent to limit the number of different personal support workers providing care within a single retirement home. Ensuring the efficient use of limited human resources, Champlain worked with patients and caregivers to create care plans that spread care-related activities across the day, rather than concentrated during peak hours. The shifts supported increased infection prevention and control practices which led to reduced risk of spreading infection. Additionally, Champlain's rapid response nurses worked jointly with the Ottawa Public Health Unit and Ottawa paramedics to assess, manage symptoms and escalate care to physicians for more than 500 residents in retirement homes during COVID-19 outbreaks. Also, the rapid response nursing remote care monitoring team followed 156 COVID-19 patients in their home.

In Waterloo Wellington, Home and Community Care Support Services supported increased resident admissions to long-term care as isolation beds re-opened and homes required enhanced communications and expedient information sharing to fill available beds quickly. At the peak of this work, in June 2022, 181 isolation beds were reopened in Waterloo Wellington.

A Partner in Care

Supporting hospital surge capacity and patient flow challenges, while monitoring alternate level of care patients were priorities for all 14 Home and Community Care Support Services organizations over the past year. In Hamilton Niagara Haldimand Brant, our COVID-19 work was so effective that the team received the 2022 Partnership in Protection Award from the Retirement Homes Regulatory Authority. This award is in recognition of our

unwavering commitment to resident protection and collaboration.

Our staff in the South East worked with local Ontario Health Teams to provide regular updates related to pandemic response and recovery efforts. Partner meetings occurred weekly, bi-weekly and in some cases daily. Barriers and action plans were identified and reviewed for all patients with longer standing alternate level of care to long-term care designations. Managers closely monitored bed offers and acceptance of alternate level of care to long-term care patients with ongoing communication at sites for patient transfer dates.

PROVISION OF HOME CARE SERVICES

Providing exceptional care wherever people call home is at the core of what we do. In addition to supporting the people we serve through connected, accessible, patient-centred care, we have continued to explore and implement new and innovative ways to support health system capacity.

In 2022/23, Home and Community Care Support Services supported over 650,000 patients across Ontario with health assessments, creation of individualized care plans and the delivery of services at home or in community nursing clinics, which included more than 35 million personal support visits or sessions. The team also managed the long-term care home assessment and placement process for over 28,700 individuals.

Supporting Hospital Capacity and Transitions

As health system recovery efforts were underway in 2022/23, Home and Community Care Support Services continued to develop partnerships to support timely and safe transitions from hospital to home or to long-term care, and to help ensure vital resources, like hospital beds, were available for those who needed them most.

In Central East, the Emergency Department Diversion Committee was relaunched with representation from Home and Community Care Support Services, hospitals, service providers and community paramedicine partners. The committee identified three immediate priorities, including the development of a Multidisciplinary Mobile Emergency Diversion team. Comprised of rapid response nurses, occupational therapists, physiotherapists and nurse practitioners as well as community paramedicine partners, the team assisted with immediate care needs, such as IV medication administration, wound care and home safety assessments until contracted services could be secured. This temporary and urgent hands-on care allowed patients to be discharged from hospital, and/or prevent a return trip to the emergency department. The Multidisciplinary Mobile Emergency Diversion team was first piloted in December 2022 in the Peterborough area, where health human resource shortages were pronounced. Since implementation, the team helped divert 92 emergency department visits within 120 days and provided care to 41 patients in the community.

A Stroke Care Coordinator role was developed in North Simcoe Muskoka to improve the transition from hospital to home and provide ongoing care for people who had experienced a stroke. Based out of Royal Victoria Regional Health Centre and supported by the Central East Stroke Network, the program helped increase the number of stroke patients admitted to the Home and Community Care Support Services Stroke Pathway and supported admissions to the pathway from all area hospitals since it launched in January 2023. Referrals to the Pathway program increased from 36 to 42 between Q3 and Q4 2022/23 and benefits include warm handoffs of patients transitioned from hospital to the community, reduction of hospital readmissions for stroke patients and improved integration between home care and outpatient programs.

In the “@home” model of care, hospitals and various health care partners work together to identify and provide eligible patients and their families with an integrated home care approach. Patients receive @home care for up to 16 weeks, after which many transition to Home and

Community Care Support Services for ongoing health care and personal supports. Care coordinators from Home and Community Care Support Services Central supported the safe transition of more than 360 patients through @home programs from five hospitals including through Humber River Heart@Home, MackenzieHelps, MSHCare@Home, NYGH@Home and Southlake@Home. Once safely at home, coordinated, enhanced or bundled care programs continued to bring together health care providers to meet the individual patient's needs, often with one or more services such as nursing, personal support, restorative or rehabilitation services and medical equipment and supplies. The majority of patients enrolled in the @home programs were seniors at significant risk for re-hospitalization. This model of care optimized patient recovery in a patient-centred approach, while helping address hospital capacity challenges.

The Central West Hospital to Home Direct Nursing Service, which focuses on palliative care, supports palliative patients through regular check-ins and symptom monitoring from a dedicated team of nurses. These nurses assess the patient and can provide appropriate patient care to avoid an emergency or acute care intervention. The Hospital to Home nurse completes weekly clinical assessments of the patient, their symptoms, the situation in the home, and provides education and resources to support the patient and their family so the patient can remain safely in their own home. In 2022/23, the program served 128 unique patients, with nurses providing 266 in-person visits, 243 telephone consultations and 366 virtual visits.

In 2022, Home and Community Care Support Services Mississauga Halton partnered with Trillium Health Partners, Schlegel Villages and Saint Elizabeth Rehab Health to address a persistent backlog of patients designated alternate level of care awaiting rehabilitation in hospital by repurposing transitional beds at Schlegel Villages. Through this pilot, Schlegel Villages' bed utilization rate increased from 78 to 95%. The care program lasts from two to eight weeks and provides intensive physiotherapy and occupational therapy to support patients to return home. Between December 1, 2022 and March 31, 2023, this transitional care approach enabled the transfer of 13 patients designated alternate level of care for an average 57-day length of stay. This helped free up much needed hospital capacity and provided patients with the rehabilitation services needed to return home safely and more quickly than if they had remained with an alternate level of care designation.

Wound Care

The Central East Wound Care Interprofessional Team worked together to provide virtual and face-to-face wound care consultations, ensuring patients throughout the region continued to receive seamless, evidence-based, integrated and high-quality wound care. In response to access challenges presented during the COVID-19 pandemic, a digital wound care solution was implemented to provide remote wound care access to patients with high-needs isolated in their homes and communities. In 2022/23, the Wound Care Interprofessional Team provided 682 expert wound consultations for 445 patients.

In 2022, Erie St. Clair introduced a Wound Nurse Practitioner program to support complex wounds within the community in a clinic setting. This initiative supported wound care specialization and hospital emergency department avoidance. Nurses worked in collaboration with primary care providers and prescribed intravenous antibiotics and renewals of prescriptions to support wound healing. This program supported 311 patients in fiscal 2022/23. Future expansion of this wound care initiative includes support and collaboration with Ontario Health Teams and the hospital lower limb preservation project.

In collaboration with contracted service provider organizations and community partners, Home and Community Care Support Services South East developed a Wound Care Interprofessional Team, consisting of specialized direct care and support staff. Launched in fall 2022, the Advance Practice

Nurse - Wound, Ostomy and Continence will provide direct nursing care for complex wounds as well as mentorship and support to wound care providers across the region. South East was excited to trial this new model of wound management on local and provincial wound care initiatives such as diabetic foot wounds, pressure ulcer formation and post-surgical dehiscence. In their first month, the Advance Practice Nurse – Wound, Ostomy and Continence visited more than 30 patients in the community using a collaborative model of care in partnership with local nursing providers.

Supporting Vulnerable Populations through Unique Partnerships

Through unique partnerships with community and health system partners, Home and Community Care Support Services provides targeted care to a variety of vulnerable populations in local communities, including children and youth struggling with mental health and addictions challenges, vulnerably housed individuals and high-risk senior populations.

Home and Community Care Support Services offers Mental Health and Addictions Nurses programming to support school-attending children and youth, aged 4 to 21 years, struggling with depression, addiction or other mental health issues. In 2022/23, Home and Community Care Support Services North East partnered with Algoma Family Services Care and Treatment Program and a local secondary school in Sault Ste. Marie to deliver a unique mental health and addictions program in a specialized classroom to support optimum function for students experiencing mental illness. The classroom is staffed with a teacher, an educational assistant, a social worker, care and treatment worker and a Home and Community Care Support Services North East mental health and addictions nurse to provide students with a safe space to discuss their mental health needs and support one another throughout their journey towards health and wellness. The mental health and addictions nurse supported the program twice a week through early identification, assessing and monitoring of mental health, medication management and education, addictions support, education to the program staff and liaising between families and physicians.

Home and Community Care Support Services Toronto Central partnered with the City of Toronto and Toronto Community Housing to develop an integrated service model for Toronto Seniors Housing. The model brought about new ways of supporting senior tenants so they can age in place with dignity and in comfort. The program aimed to increase access to health and community support services through enhanced integration of community housing staff with home and community care and other community services staff. More than 15,000 tenants, aged 59 years and older, live in 83 buildings across the city operated by Toronto Seniors Housing. At the end of 2022, all 83 Toronto Seniors Housing buildings were operating with the integrated service model.

Toronto Central care coordinators were assigned as liaisons to the 59 Toronto Seniors Housing buildings, housing approximately 13,000 tenants, located within the Toronto Central catchment area. Seniors services coordinators and care coordinators were attached to buildings and worked in integrated teams to provide wrap-around supports to the tenants. This included connecting them to home and community care as well as other community support services. The program was successfully implemented in the East, Mid-East and Mid-West sub-regions of Toronto Central with continued expansion planned in 2023/24.

In Champlain, we joined with community partners including community health centres, community paramedics, The Ottawa Hospital Cancer Centre and Inner City Health to create the Vulnerably Housed Working Group. The group aimed to improve access to services for the vulnerably housed population with significant chronic, complex and palliative needs. This collaboration helped inform the development of the Inclusion Team comprised of three care coordinators, team assistant and nurse practitioner to support individuals who are unsheltered, vulnerably housed

and/or who have a mental health issue that requires a different approach to conventional service delivery. With the hiring of team members still underway at the end of fiscal 2022/23, there will be more positive outcomes to report as the team is implemented in 2023/24.

Targeted Service Provider Organization Initiatives to Combat Health Human Resource Challenges

Home and Community Care Support Services Waterloo Wellington engaged in a comprehensive personal support service provision improvement strategy in response to ongoing system-level health human resource capacity challenges. The multi-pronged initiative which was implemented in October 2022 includes improvements such as enhanced service allocation guidelines, an enhanced approach to wait listing to support patients with complex needs to receive service in a timely manner, and a change in how service provider organizations interface with the wait list. As a result, 20% more people are receiving personal support services.

Home and Community Care Support Services South West implemented several successful palliative care initiatives. The Palliative Patient Population Guideline was updated and shared with contracted service providers to ensure widespread understanding and use. Additionally, an enhanced billing rate was initiated for service provider nurses who provide skilled palliative care. To support the retention of more palliative care nurses, South West utilized targeted funds to expedite specialized education including Fundamentals, Comprehensive Advanced Palliative Care Education and Learning Essential Approaches to Palliative Care courses. The success of these efforts is evident, with over 170 participants enrolling in palliative course offerings throughout the South West area. This means that more patients have access to nurses with specialized skills in palliative care, allowing for high-quality patient and family centered end-of-life care in their place of choice, home.

ESTABLISHMENT OF AN ORGANIZATIONAL STRUCTURE AND STREAMLINED LEADERSHIP TEAM

Developing a strategic organizational structure was crucial for effectively leveraging the strengths of our Home and Community Care Support Services teams as we continued to deliver high-quality patient care while also working to transform and modernize the home care model.

We developed organization design principles to guide our approach, which included:

- Moving with purpose toward a high performing single organization, ensuring no negative impact to patient care and stability of core operations;
- Creating greater efficiency and effectiveness while making sure our objectives are achieved at both the local and provincial level;
- Leveraging talent across our organizations, promoting collaboration and empowering staff; and
- Carefully considering changes in reporting relationships where it strengthens our ability to function effectively.

As a pillar of the health care system, establishing Home and Community Care Support Services' Executive Leadership Team was an important milestone for the evolution of our organization. In August 2022, to support and lead alongside with our Chief Executive Officer, we appointed five chief positions – Quality, Safety and Risk Officer; Patient Services Officer; Corporate Services Officer and CFO; Strategy, Transformation and Engagement Officer; and Human Resources Officer. These foundational roles provide the leadership necessary for the continued delivery of high-quality care, while developing and implementing our business and operational plans and supporting health system transformation and home care modernization through Ontario Health Teams.

With these roles in place, the focus turned to effectively aligning our provincial teams, filling gaps, and improving the way we work together locally and provincially to support our ability to deliver the best possible care for the patients we serve. To achieve broader organizational goals and objectives, Home and Community Care Support Services organizations were clustered into four regions – Central, East, North and West –respecting and including the local organizations. This regional model enables us to maximize our current resources, increase efficiencies and build consistency across the province. The overall organizational design reflects our provincial cohesion with the additional ability to adapt to reflect local nuances.

NORTH

- North West
- North East
- North Simcoe Muskoka

EAST

- Central East
- South East
- Champlain

CENTRAL

- Central West
- Mississauga Halton
- Toronto Central
- Central

WEST

- Erie St. Clair
- South West
- Waterloo Wellington
- Hamilton Niagara Haldimand Brant

With recognition of the great depth of experience and expertise across the province, realignment of the Vice President and Director teams has taken place to ensure our leadership structure is fully aligned to our strategy through new functional portfolios, where a number of vice presidents have regional and/or provincial responsibilities for specific initiatives and/or areas of expertise. This includes the implementation of Patient Services Regional Lead assignments for the West, Central, North and East regions. Similar alignment activities have occurred within the Human Resources, Finance, Communications and Strategy leadership teams to ensure a complementary structure is in place across the organizations. These roles are instrumental in advancing streamlined program planning, promoting fiscal responsibility and ensuring our strategic aims are met as outlined by the Ministry of Health and our Board.

As organizational design and realignment activities progressed through 2022/23, the Senior Leadership Team (comprised of the Executive Leadership Team and Vice Presidents) remained committed to supporting staff across the organization through regular updates and through transparent and effective communication including regular People Leaders meetings and All Staff Town Halls. Home and Community Care Support Services is at the threshold of transformation and these organizational design changes support us to deliver on our mandate.

ADVANCE HEALTH SYSTEM TRANSFORMATION

Home and Community Care Support Services is a key partner in advancing health system transformation through the development of Ontario Health Teams across the province and their development of local integrated care delivery networks, including the strengthened integration of home and community care services and the modernization of service delivery.

All 14 Home and Community Care Support Services organizations across Ontario have been actively partnering with most Ontario Health Teams and supporting those still in the development phase. We established a province-wide steering committee to support the implementation of Ontario Health Teams, home care modernization and a standardized Ontario Health Teams Participation Agreement to promote greater consistency as planning progresses, in alignment with our role as crown agencies.

Leading Projects

As part of an evaluation process supported by Ontario Health, Home and Community Care Support Services helped select seven Ontario Health Team leading projects that will inform provincial planning related to home and community care modernization. Through this work, Home and Community Care Support Services organizations are supporting hospitals, primary care and other stakeholders to test innovation in home care delivery, while also maintaining stability in the home care system as a whole.

Thorncliffe Park Community Hub, a leading project through the East Toronto Health Partners Ontario Health Team, services a high-needs population and is available as a safe, accessible, community-centred space where residents can access health and social services and programs. Home and Community Care Support Services Toronto Central is collaborating with the partners to co-design the hub as a full-service community space. Throughout 2022/23, the Hub served as a COVID-19 mass immunization clinic serving the residents of Thorncliffe Park, which was designated a COVID-19 hotspot. After conducting an environmental scan of nursing clinic sites across the city, as well as the home care service utilization rates for Thorncliffe Park residents, Home and Community Care Support Services Toronto Central identified a need for a nursing clinic in Thorncliffe Park to improve patient outcomes. As a result, four nursing beds in the Thorncliffe Park Community Hub are now being supported.

Central East is supporting the Durham Ontario Health Team leading project - an integrated system of care for the residents of the Downtown Oshawa Neighbourhood. The health status of the residents that fall within that catchment area is significantly below that of the rest of the Durham Region and results in higher utilization of emergency, community and social services along with higher rates of chronic conditions when compared to the regional average. Additionally, located within the Downtown Oshawa Neighbourhood is a mid-rise 10-storey apartment building with 150 residents who are 60 years of age and older with rent geared-to-income and socio-economic challenges. Through the Downtown Oshawa Neighbourhood integrated model of care, patients can access care through various providers on-site including care coordinators, community paramedicine partners, Lakeridge Health Mental Health Services, Community Care Durham and contracted service provider organizations. Care may also be accessed through self-referrals and primary care referrals. The patient pathway is premised on the principle of "no wrong door" to care and services. In time, the Downtown Oshawa Neighbourhood model of care will be scaled to support the entire region.

Outside of this work, Home and Community Care Support Services organizations partnered with Ontario Health Teams in focused areas such as system navigation, reducing the number of patients designated alternate level of care, access and flow, emergency department diversion and hospital admission avoidance. We continued to collaborate with health system partners in the advancement of

innovative system level improvement in order to enhance the patient experience and build system capacity while also supporting Ontario Health Teams to advance toward maturity.

Access and Flow

Home and Community Care Support Services Central has been an active member of the North York Toronto Health Partners Ontario Health Team, which brings together a continuum of care providers, including 22 core partners, more than 30 alliance partners, a Patient and Caregiver Health Council and a Primary Care Network with over 200 primary care physicians. Home and Community Care Support Services Central helped design and implement a new transitional care program to support patients with medical and/or social complex needs. North York CARES (Community Access to Resources Enabling Support) provides integrated, multi-disciplinary care, including high intensity home and community supports to identified patients. Based on patient satisfaction and successful outcomes, the program doubled in enrollment size in 2022/23, enabling more than 60 at-risk seniors to remain safely at home.

Integrated Patient Care Teams

The Guelph-Wellington Ontario Health Team established Integrated Patient Care Teams in 2022/23. Home and Community Care Support Services Waterloo Wellington co-led the design and implementation work and embedded care coordinators and a mental health and addictions nurse in primary care teams. The model focused on enhanced information exchange and innovation in digital health and enabling technology. To this end, care coordinators within the Guelph-Wellington Ontario Health Team Integrated Patient Care Teams have access to the primary care electronic medical record and add notes and send messages to team members, improving communication across the team. Improving communication with primary care partners means better coordination of services for patients and more seamless care across different sectors.

Emergency Department Diversion

Home and Community Care Support Services Mississauga Halton provided staffing for the nurse navigator role within the Seamless Care Optimizing the Patient Experience (SCOPE) program, which promotes integrated and collaborative care between primary care, hospital services and community health partners to serve patients with complex needs. Through a partnership between Connected Care Halton Ontario Health Team, Halton Healthcare, and Community Paramedicine, this role was extended to March 29, 2024 and expanded into the Remote Care Management program in Mississauga Halton. SCOPE initiatives, like the nurse navigator, contributed to an average 60% emergency department avoidance. As of March 31, 2023, the program had monitored and supported 161 patients with an average length of enrollment of 43.6 days. The program had a reported satisfaction rate of 81%.

ADVANCE HOME AND COMMUNITY CARE MODERNIZATION

In May 2022, the *Connecting People to Home and Community Care Act, 2020* (Bill 175) was proclaimed. Most regulatory provisions under Bill 175 came into force immediately, with others following in September 2022. Accordingly, Home and Community Care Support Services began to address the need for a number of new provincial policies to align practice changes across our 14 organizations in compliance with the new regulations.

Several workstreams were established to develop policies accompanied by guidance documents and education materials in support of local change implementation. Areas of focus included care coordination, transition planning, Patient Bill of Rights, patient complaints management and incident management protocols, French language services and the provision of personal support workers in long-term care.

All 14 organizations were engaged in the provincial review and development of the policies,

procedures and resources developed in alignment with the legislation. Additionally, all organizations conducted thorough reviews of existing local policies and procedures to ensure alignment and compliance.

Each Home and Community Care Support Services organization worked closely with contracted service provider organizations to achieve compliance with requirements around the Patient Bill of Rights, abuse prevention and complaints management along with other aspects of the regulatory provisions.

Implementation of the modernized Patient Bill of Rights

Patient care is the core function of Home and Community Care Support Services. Patients, caregivers and families are key partners in care and a Patient Bill of Rights sets the foundation for how they can expect to interact with, and be treated by, each Home and Community Care Support Services employee, as well as contracted service providers. The rights outlined in Section 9(1) of Ontario Regulation 187/22 under the *Connecting Care Act, 2019* are closely aligned with our mission, vision and values, as well as our strategic priorities, and will continue to be promoted, respected and upheld through our dedication and commitment to the patients and families we serve.

A provincial policy was developed and rolled out in May 2022 to support the implementation of the updated Patient Bill of Rights outlining our responsibilities for promoting and distributing this information to staff, contracted service provider organizations and patients, families, caregivers or substitute decision makers. Under the policy, and in alignment with the regulation, the modernized Patient Bill of Rights is displayed prominently in all Home and Community Care Support Services offices, on our website, as well as in the offices and clinics of contracted service providers.

The Patient Bill of Rights is available in both official languages as well as Arabic, Chinese, Greek, Italian, Portuguese, Russian, Spanish, Tagalog and Tamil, and is available in other accessible formats such as large print and audio to support the diverse patient populations within Ontario.

Care Coordination Policies

New provisions included within the regulation expanded the scope of home and community care services and created more flexibility in how care is delivered. These provisions related to care coordination required us to develop new provincial policies and procedures to support consistent compliance across the province with the goal of standardizing guidelines and procedures, wherever possible, across all 14 Home and Community Care Support Services organizations. These policies were in effect as of May 1, 2022. While some Home and Community Care Support Services organizations had existing policies that covered these areas, these now better align with the requirements in the new regulation and are now consistent across the province.

A new provincial **Transition Plan Policy** provides direction to ensure a patient's seamless transition from Home and Community Care Support Services following discharge from our services. Care coordinators routinely provide a written transition plan for all patients with chronic and complex conditions with two or more active services in the final six months prior to discharge from our services, upon request by the patient or at the care coordinator's clinical discretion. The policy indicates the care coordinator must ensure the patient is prepared for transition through early planning with clear, timely and accurate communication. Additionally, the care coordinator promotes self-management skills and the need to secure other appropriate or alternative resources, such as contact information for community and social supports.

The provincial **Personal Support Services in Long-Term Care policy** clearly defines the circumstances under which patients transitioning to a long-term care home and/or residents residing in a long-term care home would be eligible for personal support

services funded by Home and Community Care Support Services.

Additional provincial policies developed or standardized included a Care Coordination Services policy, a Care Plan policy, Eligibility Criteria for End-of-Life Services for Out-of-Province Patients policy and Service Allocation policy.

Accessible Formats for Patients and Member of the Community Policy

Actions were taken across the province to support compliance and consistent application of the requirements under Section 3 of Regulation 187/22 related to the availability of information to patients and substitute decision-makers in a clear and accessible format. In January 2023, a provincial policy was developed and implemented across our organizations that outlines our commitment to upholding the right for patients to receive clear and accessible information about their home and community care services. This commitment was also enshrined within the modernized Patient Bill of Rights. Additionally, this requirement aligns with our existing responsibilities under the *Accessibility for Ontarians with Disabilities Act, 2005*.

To support awareness of, and compliance with, the above requirement, Home and Community Care Support Services developed an Accessibility Statement that acts as a declaration of our commitment to the *Accessibility for Ontarians with Disabilities Act, 2005* and Ontario Regulation 187/22. This statement is included within the new policy with the expectation that it is to be adopted/embedded into local policies and procedures. A provincial email address for accessibility related enquiries was also created (HCCSSAccessibility@hccontario.ca) and listed on our website to support public requests for accessible documents.

French Language Services Policy

In alignment with our obligations as crown corporations under the *French Language Services Act*, and Section 29.1 of Ontario Regulation 187/22 under the *Connecting Care Act, 2019* to actively offer our services in both official languages, a new provincial French Language Services policy was developed and implemented across the Home and Community Care Support Services organizations in September 2022. The policy enabled a consistent, inclusive and equitable approach to the provision of French language services in meeting the needs of Francophone patients, families and caregivers. Fundamental to the policy is the concept of active offer, meaning that services in French are to be offered to the patient upon first contact and throughout the patient journey.

Patient Abuse Prevention, Recognition and Response

Under Section 28 of Ontario Regulation 187/22, all Home and Community Care Support Services organizations are required to have a plan for preventing, recognizing and addressing physical, sexual, mental, emotional, verbal and financial abuse of persons who receive home and community care services. The abuse prevention plan must provide, among other things, for the education and training of both staff and volunteers in methods of preventing, recognizing and addressing the above types of abuse. Home and Community Care Support Services must also ensure contracted service provider organizations have a plan.

Home and Community Care Support Services developed a provincial plan to support a consistent approach to preventing, recognizing and responding to abuse and neglect of Home and Community Care Support Services patients. The provincial plan included a policy and a resource manual for prevention, recognition and response to patient abuse. The plan is intended to support staff in dealing with suspected or witnessed abuse of a patient by any individual in the patient's home, including care providers. Standardized education was rolled out to all staff across the province as well as contracted service provider organizations to support a consistent and timely response.

Patient Complaints and Appeal Management

In alignment with Section 30 of Ontario Regulation 187/22 and the Patient Bill of Rights, all Home and Community Care Support Services' patients have the right to raise concerns or recommend changes in connection with the home and community care service(s) they receive and in connection with policies and decisions that affect their interests without fear of interference, coercion, discrimination or reprisal.

To support a consistent approach across our organizations, a provincial Patient Complaints and Appeal Management policy was developed to ensure we have effective, transparent and patient-centred complaint management processes that comply with relevant legislation. The changes made across the province in compliance with the legislation, paved the way for strengthened integration of home and community care services in a transforming health care system.

Additional work started in 2022/23 related to the new legislation included the establishment of a provincial framework for patient assessments, service planning and allocation of service hours and the use of virtual care modalities.

IMPROVEMENTS TO LONG-TERM CARE AND PLACEMENT

Home and Community Care Support Services remained a key health care partner in strengthening the future of long-term care in Ontario. In 2022/23, Home and Community Care Support Services transitioned 28,759 individuals into long-term care homes – 13,348 from the community, 12,953 from hospitals and transferred 2,458 patients between long-term care homes across the province. Our teams also engaged with thousands of residents, family members and caregivers, hospitals, rehabilitation centres, primary care providers and the operators and staff of long-term care homes to fill isolation beds, convalescent care beds and respite care beds as these resources returned to the system post pandemic.

More Beds, Better Care

On August 31, 2022, the Ontario government passed Bill 7: *More Beds, Better Care Act, 2022* to facilitate the admission of eligible Alternate Level of Care patients who no longer require treatment in hospital to an appropriate long-term care home, thereby providing these patients with a better quality of life and the right care for their needs while they wait for their preferred long-term care home. To prepare staff for these changes, all care coordinators involved in the long-term care application process across Ontario participated in provincial education sessions about ethical decision-making, supporting challenging conversations and frequently asked questions about Bill 7.

From the day the amendments to the bill came into force on September 21, 2022, to the end of the fiscal year, Home and Community Care Support Services Central West had 56 unique patients with care coordinator-selected long-term care home choices. No patients refused a bed in a care coordinator-selected home. In the North East, care coordinators supported 408 patients in hospital to select additional long-term care home choices and a further 72 patients had their care coordinator select additional long-term care home choices on their behalf. In the North West, 200 patients in hospital made additional long-term care home choices. Also in the North West, 130 patients in hospital have had care coordinator-selected long-term care home choices added related to Bill 7. In the North West, Bill 7 expedited the discharge of 34 patients from hospital into care coordinator-selected long-term care home choices where these patients waited in an appropriate venue for transfer to their preferred long-term care home.

This collaborative effort across the province resulted in more timely discharge of medically stable patients from hospital, while maintaining a supportive relationship with the family. By prioritizing compassionate communication and

partnership, we made significant progress in ensuring the best possible outcomes for patients as they navigated transitions in care.

Expanding Long-Term Care

As of July 1, 2023, across Ontario, there are 624 long-term care homes and 80,481 beds. These are specially designed facilities where people can live safely and comfortably with access to onsite nursing care and assistance with personal care on a 24/7 basis.

To increase capacity across the province, Home and Community Care Support Services Central helped plan the opening and admissions process for two new long-term care homes offering 640 new beds, significantly increasing long-term care capacity across local communities. Mon Sheong Stouffville Long-Term Care Centre, located in York Region, opened with 320 new beds, while Humber Meadows Long-Term Home in North York will be home to 320 residents by the end of 2023. In Central East, Lakeridge Gardens opened in spring 2022, adding 320 long-term care beds to the Durham region, including a specialized behavioural support unit with access to a secure rooftop terrace. In South West, Home and Community Care Support Services supported the opening or redevelopment of five different long-term care homes, including the redevelopment of Ritz Lutheran Villa and Mitchell Nursing Home to create the upgraded West Perth Village, the construction of new homes for Southbridge in Owen Sound and London and the redevelopment of Country Terrace, Chelsey Park and Meaford.

Additionally, during Pride Month celebrations in June 2022, the Rekai Centres opened North America's first long-term care wing dedicated to supporting the 2SLGBTQI+ (Two-spirit, lesbian, gay, bisexual, transgender, queer or questioning) community at its Wellesley Central Place location in Toronto Central. Located steps from the Church and Wellesley Village, the Rainbow Wing is a 25-bed unit focused on creating a safe space for the older adult 2SLGBTQI+ community. Current estimates show there are more than 65,000 individuals who identify as being part of the 2SLGBTQI+ community over the age of 65 – a number that will only grow as the population ages. As of March 31, 2023, the wing was fully occupied.

Supporting future growth

Given the number of new long-term care homes opening across the province, Home and Community Care Support Services Central, Central East, Erie St. Clair and North Simcoe Muskoka came together to create a standardized provincial Guide for Opening New Long-Term Care Homes. The guide provides a consistent framework and approach to support our role in the opening of new long-term care homes in Ontario, including recommended steps, templates and timelines to plan and execute patient notification along with admission and waitlist management. This guide will be applied consistently across the province to support future new home openings.

Building Capacity

To further alleviate pressures on the hospital system, Home and Community Care Support Services North West worked with St. Josephs Care Group to implement three new short-stay respite beds to replace the previous one that was housed in a local long-term care home. Effective September 2022, 32 beds were made available in Willow Place, a temporary transitional care environment, of which three were allocated to be short-stay respite beds, preserving the one long-term care bed, therefore increasing the access to both long-term care beds and short-stay respite service for hospital and community patients.

Community Engagement

Community engagement is an important planning and evaluation tool that helps Home and Community Care Support Services achieve its mission, vision and values while improving the patient experience by hearing from, and speaking with, the unique communities we serve across the province.

Home and Community Care Support Services co-designed and implemented a provincial Community Engagement Framework to guide our engagement program with input from 67 patient and family advisors from our legacy organizations, 75 staff, 25 leaders and 10 community partners. An engagement guide was developed to establish best practices and clear processes for supporting and coaching staff, engagement training was added to new staff orientation and content was developed for our website to promote community engagement to the public. Through this foundational work, by the end of 2022/23, we launched a call for nominations for our first Above and Beyond Caregiver Recognition event.

As part of our ongoing commitment to public outreach and education, Home and Community Care Support Services participated in community and health fairs and presentations to provide information about the organization's programs and services. With the easing of COVID-19 restrictions, we saw an increase in the number of requests for in-person presentations and events, as well as others that continued to be offered virtually. Throughout the year, our knowledgeable staff attended 160 engagements to a variety of stakeholders including patients and families, health system partners, community organizations and groups, mental health and addictions providers and service users including students, educational facilities, health fairs and seniors' expos to name a few.

We also focused on engaging with priority populations, including Francophone and Indigenous communities, and other marginalized communities to identify potential risks and implement targeted tactics to improve access to appropriate and culturally safe care.

ENGAGEMENT WITH FRANCOPHONE COMMUNITIES

Home and Community Care Support Services remains committed to engaging with the Francophone community to better plan for and understand this diverse population. In 2022/23, and in accordance with the *French Language Services Act*, we built on our commitment to French language services and strengthened relationships with French Language Health Services Planning Entities across the province.

Provincially, Home and Community Care Support Services established a French Language Services Committee comprised of staff, leaders, patient and family advisors and representatives from French Language Health Services Planning Entities to oversee efforts to strengthen our commitment to Francophone patients, families, caregivers and health system partners.

The committee led work to develop our first provincial French Language Services policy, supported by an education module, for staff across all 14 organizations. Through this policy, we developed a guidance document to support active offer of services in French upon a patient's first contact – a requirement under Ontario's French Language Services strategy for all government ministries and crown agencies. Through the Réseau du mieux-être francophone du Nord de l'Ontario, active offer training was provided to all staff across the province and we had the opportunity to showcase this policy by providing a presentation to the Forum for Long-Term Care for Francophones in the Greater Toronto Area.

Locally in 2022/23, Home and Community Care Support Services Central implemented additional actions to provide active offer for the 22,000

individuals who identify as Francophone in the local catchment area. Individuals who contacted our organizations by telephone were greeted with an active offer message, and had the option to access services/information in French in real time. Additionally, a data field was added in the province-wide Client Health and Related Information System (CHRIS) to prompt care coordinators to ask the patient or their caregiver if they would prefer service in English or French.

The North East and North West areas continued to engage with the Réseau du mieux-être francophone du Nord de l'Ontario to further enhance education on the principles of active offer. In 2022/23, North West achieved a 74% compliance rate from all staff and North East achieved 100% compliance of new staff receiving active offer training and a 97% compliance rate from all staff who have taken active offer training. Additionally, Home and Community Care Support Services North East partnered with the Réseau du mieux-être francophone du Nord de l'Ontario to offer short interactive French Language Services refresher sessions for intake staff on how to implement active offer of French language services.

Across the province, Home and Community Care Support Services continued to engage with respective French language health services networks to enhance a greater understanding of the challenges and opportunities faced by Francophone patients, including engaging the Entities in the development of our 2023/24 Annual Business Plan. We also engaged in biannual meetings with the Fédération des aînés et des retraités francophones de l'Ontario.

Home and Community Care Support Services North West engaged with Francophone seniors through La Fédération des aînés et des retraités francophones de l'Ontario, including at its North West Collaboration table. Additionally, in Champlain, we participated as a panel member on a virtual Seniors Collaborative Roundtable which focused on Living Well at Home. Approximately 50 Francophone seniors attended and wanted to know more about community services and their availability in French. We also provided two presentations about our services in French to more than 30 people at Champlain's Alzheimer Society.

Home and Community Care Support Services South West was a supporting partner of the local Francophone Service Hub, Accès Franco-Santé London, located at Carrefour Communautaire Francophone de London. The hub is a central point of access for information, referral and navigation of the health and social systems for Francophones in Middlesex-London. Partners included Ontario Health, Addiction Services of Thames Valley, London InterCommunity Health Centre, Vanier Children's Mental Wellness, Entité de planification des services de santé en français and Canadian Mental Health Association Middlesex.

ENGAGEMENT WITH INDIGENOUS COMMUNITIES

In 2022/23, Home and Community Care Support Services continued to focus on establishing trust and strengthening relationships with First Nations, Métis and Inuit partners and communities to better understand and address the needs of Indigenous populations. This included providing staff the opportunity to increase knowledge, awareness and skills to work with and provide culturally safe service to Indigenous people and communities.

All Home and Community Care Support Services staff across the province were invited to participate in Indigenous Cultural Safety Training provided by San'yas. Covering topics such as the social determinants of health in relation to Indigenous people, gaps in health equity for Indigenous people and how racism, discrimination and stereotyping impacts Indigenous peoples in health care contexts, this training fosters safe and effective health services for Indigenous people. In 2022/23, over 300 employees across the province participated in this training; this is in addition to staff trained in previous years.

In the South East, a local working group was established to identify staff already San'yas

educated and develop a strategy to identify and enable priority staff groups to take the Indigenous Cultural Safety Training. Currently within the South East, 21% of active staff have completed the training and many staff are enrolled for the next cohort. Additionally, 24% of self-identified Indigenous patients are matched to a care coordinator who has completed this valuable education.

In 2022/23, Home and Community Care Support Services Hamilton Niagara Haldimand Brant, along with other health system partners in the Niagara Ontario Health Team - Équipe Santé Ontario Niagara (NOHT-ÉSON), was gifted with a Pendleton blanket on behalf of the Indigenous Health Network. The blankets hold profound and diverse cultural significance for Indigenous Peoples and are considered integral in many systems and practices. The gift of a blanket has important meaning and is symbolic as a treaty blanket, representing a commitment to working collaboratively and respectfully with Indigenous Peoples in Niagara to improve access to care. It also represents an acknowledgement of the partners' work toward reconciliation and understanding the barriers to health and wellbeing outcomes for Indigenous Peoples.

Home and Community Care Support Services North East continued to partner and engage with Indigenous communities along the James and Hudson Bay coasts to support the evacuation of community members due to spring flooding. Many communities along this coastal area are prone to flooding nearly every year during the spring ice break-up, with flood risk typically lasting from late April through the middle of May. We worked with Kashechewan First Nation, Fort Albany First Nation and Attawapiskat First Nation communities to obtain required patient information to coordinate placement to long-term care homes or other community supports as required. In 2022/23, more than 1,600 community members from these communities evacuated to seven host communities across Ontario including Hearst, Toronto, Kapuskasing, Thunder Bay, Cochrane, Timmins and Val-Rita. We also supported 16 long-term care placements to three long-term care homes.

In September 2022, a new two-bed palliative eShift ward model was launched as a result of a shared vision between Six Nations Health Services and Home and Community Care Support Services Hamilton Niagara Haldimand Brant. The purpose of this model was to provide culturally appropriate end-of-life care for patients within the Six Nations community. Six Nations Health Services provided cultural knowledge to the care teams and identified personal support workers to be trained in enhanced palliative care services. CarePartners, a contracted service provider organization, provided directing registered nurses, who direct care virtually supporting designated palliative care technicians in the home. The directing registered nurses shared education and mentorship to the Six Nations personal support workers. As a result, the personal support workers became specially-trained palliative technicians able to work alongside the directing registered nurses. During the first six months, this program successfully supported six Indigenous patients to pass away at home - their preferred setting. Similarly, a virtual eShift model for palliative services was developed in Erie St. Clair in collaboration with Aamjiwnaang First Nation, Kettle and Stony Point First Nation and the Victorian Order of Nurses, with service beginning soon.

Provincially, Home and Community Care Support Services engaged with a number of Indigenous health partner organizations to inform the development of the 2023/24 Annual Business Plan, Quality Framework and to inform our Engagement Strategy. Partners included Chiefs of Ontario, Southwest Ontario Aboriginal Health Access Centre, Gizhewaadiziwin Health Access Centre, the Mohawks of the Bay of Quinte and an Indigenous patient and family advisor.

ENGAGEMENT WITH SPECIFIC COMMUNITIES AND POPULATIONS

In 2022/23, Home and Community Care Support Services further delivered on its commitment to equity, inclusion, diversity and anti-racism as part of our Invest in our People strategic priority. This included posting a new provincial position for Manager of Equity, Inclusion, Diversity and Anti-Racism to provide direct leadership for the roll out of related initiatives across the province. In 2023/24, this individual with extensive and diverse experience as well as lived experience will collaborate with key stakeholders to lead the development and implementation of our Equity, Inclusion, Diversity and Anti-Racism plan, a key deliverable in our 2023/24 People Strategy, which will also involve a fulsome review of our Human Resources policies, practices and programs with a goal to eliminate systemic barriers to under-represented and racialized groups, and work towards a workforce that reflects the diverse communities we serve.

Several equity, inclusion, diversity and anti-racism activities were held throughout the year to provide staff with opportunities to increase their awareness and understanding of the unique populations we serve across the province. This included presentations to staff by experts in anti-Black racism and Black history, all staff events and resources for Indigenous History Month and National Day of Truth and Reconciliation and special activities and resources provided throughout Pride Month. While we rolled out the use of pronouns in staff email signatures the previous year, in 2022/23, we updated our patient record system, CHRIS, to include pronouns and gender identity for all patients.

Pride Month in June 2022 saw the creation of the first provincial staff-led Home and Community Care Support Services Pride Committee to recognize and plan Pride Month education and activities. The group developed the Home and Community Care Support Services Pride page to house a collection of resources, learning opportunities and events to help support frontline staff in providing 2SLGBTQI+ safe, patient-centred health care. The team also hosted special events throughout the month, including local Pride trivia or the Pride Month Book Club where staff from across the province read, reflected and learned about the issues facing the 2SLGBTQI+ community through honest, open discussions.

Also as part of Pride Month, we met Shoshana Pellman, a trans woman from Toronto whose story shed a light on the barriers and discrimination individuals identifying as 2SLGBTQI+ may experience in accessing health care and social services. As a result of Shoshana's story, staff were empowered to seek change to better support patients in the 2SLGBTQI+ community.

In celebration of Black History Month, Home and Community Care Support Services Erie St. Clair was honored to have a Telehomecare nurse present her path to nursing as a successful woman of colour. Hosted by Chatham-Kent Children's Services, One Vision One Voice Committee and Buxton's Next Generation, several other community agencies and programs were represented at the panel to help youth understand some of the barriers faced by local citizens to reach the success they achieved today.

Home and Community Care Support Services Central West delivered three presentations for members of racialized communities including a Health Care Forum organized by the Goan Charitable Organization, a Community Wellness Fair for Black, African and Caribbean communities and the Black Professionals of Dufferin-Peel Conference. These events provided us with an opportunity to connect directly with these communities and share specialized information about our programs and services.

In Mississauga Halton, a working group was created to establish an integrated primary care and social services hub within Peel Region with a focus on serving the Black, African and Caribbean communities. In partnership with Roots Community Services, LAMP Community Health Centre, the

Black Health Alliance, Partners Community Health and Ontario Health, this hub model will serve the unique health and social needs of the Black Community in Peel.

In Champlain, Home and Community Care Support Services supported 71 patients through a Neighbourhood Integrated Care Model – a care team approach including an interdisciplinary team of care coordinators, nurse practitioners, social and health partners working collaboratively to provide support to compromised individuals in apartment buildings. Partners have identified these residents as high-need, based on significant use of emergency services with significant chronic, complex needs that can vary at any given point of time. The core team worked together with residents to ensure access and services were well coordinated and consistent with a range of primary care, nursing, personal care and homemaking. Positive outcomes included eliminating waitlists for services in the area, reduction of missed care, fewer providers in the home leading to more consistent care and increased patient satisfaction.

Home and Community Care Support Services South West participated in London's Homeless Prevention and Housing Initiative, a partnership with the city, health and social service system partners. A dedicated care coordinator was assigned to support the needs of people experiencing homelessness, supporting 60-80 patients at any one time throughout the year. Additionally, work began on the creation of a dedicated provider model, with one service provider aligned to this model of care so far. We also began working with the City of London to explore opportunities to add personal support and nursing services within its Community Service Hub model which supports those experiencing homelessness.

ENGAGEMENT WITH COMMUNITY OF ADVISORS

Through the development of our Community Engagement Framework, we launched our first provincial Community of Advisors consisting of 57 members selected through established criteria and a clear role description.

By getting to know the advisors' interests, skills and experiences, we closely matched them to 37 different engagement opportunities across our organizations, representing over 400 hours of participation in 2022/23. A Community of Advisors stamp of approval was developed to be placed on materials reviewed or advised on by its members.

The Community of Advisors supported recruitment efforts throughout 2022/23, including taking part in key hiring panels for vice president, director and manager level positions, while taking part in committees to shape organizational strategies, priorities and policies for items such as our quality framework, annual business plan, virtual care services, French language services, opioid safety, community nursing clinics, website, branded materials and community presentations.

In Waterloo Wellington, advisors reviewed the care conference template and communication material to ensure they aligned with our values of collaboration and respect. This process allowed us to ensure the physical and psychological safety of both our staff and patients, and better equipped us to provide the highest quality care to our patients, while also supporting the well-being of our care providers. Advisors also reviewed key messages, developed in collaboration with service provider organizations, to support discussions with patients, particularly related to bridging care plans when nursing isn't available due to ongoing health human resources challenges.

Locally, advisors also supported the Central East Quality Improvement Committee, Mississauga Halton Clinic Optimization project, South West Palliative Care Reform, South West Basic Wound Care Kit Document review, North East Retirement Home cluster, Hamilton Niagara Haldimand Brant Palliative Quality & Safety Committee and Hamilton Niagara Haldimand Brant Diabetes Pathway sessions.

Health System Performance

In 2022/23, Home and Community Care Support Services continued to coordinate in-home and community-based care for thousands of patients across the province each day. This occurred in addition to our activities to support health system recovery and achieve targets outlined within the Minister's Mandate letter and our Annual Business Plan. Other key priorities and activities focused on ensuring alignment with the government's plan for health system modernization, outlined in the *Connecting Care Act, 2019*, including collaboration and support for Ontario Health Teams, and with compliance efforts related to new legislative requirements under the *Fixing Long-Term Care Act, 2021,* the *More Beds, Better Care Act, 2022* and the *Connecting People to Home and Community Care Act, 2020*. Finally, to align with and support the system-wide goals identified in Ontario's *Plan to Stay Open: Our Health System Stability and Recovery*, Home and Community Care Support Services developed and began implementing a multi-year capacity planning initiative with five key priority areas, focused on sustaining and improving home care and system capacity.

Even with these additional responsibilities, in 2022/23 Home and Community Care Support Services was able to maintain continuity of care for over 650,000 patients across Ontario, providing more than 35 million hours of personal support services (+3.2% from 2021/22) and over 10 million nursing visits (+5.2% from 2021/22), an increase from the previous fiscal year. Despite this increase in our ability to provide more services, ongoing challenges presented by the pandemic, including the province-wide health human resources shortage, impacted our ability to meet our provincial targets for the performance indicators outlined below.

The provincial targets for performance and monitoring indicators were developed as a benchmark for Home and Community Care Support Services, with the expectation of continuous improvement toward achieving the targets. Population, socio-economic, geographic and demographic circumstances in different parts of the province vary and have an impact on health care delivery.

In spite of health human resource challenges, Home and Community Care Support Services Toronto Central exceeded the provincial target for 'Percentage of home care clients with complex needs who received their personal support visit within five (5) days of the date they were authorized for personal support services', and North Simcoe Muskoka and North East increased their performance on the same indicator from the previous fiscal year. Additionally, North Simcoe Muskoka exceeded the provincial target for 'Percentage of home care clients who received their nursing visit within five (5) days of the date they were authorized for nursing services', North East met the provincial target and three other areas nearly met the target. Home and Community Care Support Services Central East and North East saw a reduction in their '90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care'.

Home and Community Care Support Services Central East reduced their 'Wait times from application to eligibility determination for long-term care home placements from community setting' and Waterloo Wellington and North West saw a reduction in their 'Wait times from application to eligibility determination for long-term care home placements from the acute-care setting'.

Results for each Home and Community Care Support Services organization can be found in Appendix 2.

No.	Indicator	Provincial target	Provincial				
			2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators							
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	86.69%	85.63%	85.29%	81.14%	78.24%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.87%	95.66%	94.11%	91.08%	89.70%
3	90th Percentile Wait Time (days) from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	28.00	27.00	25.00	33.00	43.00
4	90th Percentile Wait Time (days) from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	8.00	9.00	12.00	14.00
2. Monitoring Indicators							
17 (a)	Median wait time (days) from application to eligibility determination for long-term care home placements: from community setting**	NA	13.00	12.00	13.00	14.00	15.00
17 (b)	Median wait time (days) from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	7.00	6.00	7.00

*For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

Challenges and Actions/Initiatives to Improve Performance

Indicator	Challenges	Actions/Initiatives to Improve Performance
Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services	Access to personal support services remained a challenge as a result of a continuing provincial health human resources shortage. Many Home and Community Care Support Services organizations experienced a loss of home care personal support workers employed by service provider organizations due to disparity in wages across health care sectors. For some areas, patient preference to delay service or change/cancel the first visit continued to impact performance.	Staff continued to meet regularly with service providers to review wait times and strategize to mitigate the impact of the personal support worker shortage and recruitment challenges. On behalf of the Ministry of Health, Home and Community Care Support Services continued to facilitate the Personal Support Wage Enhancement and fuel top up for travel with the intent of increasing recruitment and incentivizing home care workers. Within our Capacity Plan launched in September 2022, we focused on the scale and spread of neighbourhood models of care (three were established in the latter part of 2022/23). Three different incentives to help service providers stabilize their staffing models were implemented in Q4 and evaluation is underway. We aim to increase the utilization of existing Home and Community Care Support Services-funded transitional care beds to a level of 90%. We continue to work with community support services agencies to transition low acuity patients to appropriate community services, creating personal support worker capacity to support patients with complex needs.

		We continue to review trends and opportunities for improvement and staff re-education to ensure first visit dates align with patient availability for service. In order to increase resources to deliver care, Home and Community Care Support Services continues to enter into new contracts (that do not include guaranteed volumes) with additional service providers who demonstrate capacity. New business intelligence reports were created with defined metrics to support effectiveness of models including service provider organization incentives, neighbourhood models and hard-to-serve areas.
Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services	Many Home and Community Care Support Services organizations continued to experience nursing shortages. This sector has not yet fully recovered from the pandemic and recruitment challenges continue. Recruitment of home care nursing staff continues to be an issue due to wage disparities across health care sectors, health human resource issues, nurse burnout and early retirement. These issues contributed to existing challenges in some areas to provide nursing services in rural areas. Low population density, large distances between communities and inclement weather have traditionally	Several Home and Community Care Support Services organizations continued to actively increase referrals to nursing clinics in addition to opening additional clinic locations, focusing on hard-to-serve areas and providing service provider organization incentives. We refreshed and re-launched our "Clinic First" approach to care – nurses can see more patients in a day in clinic versus home. In Q3 and Q4, three additional clinics were opened in areas which did not have geographic access to this model of care previously, with more planned for 2023/24. In multiple areas, we expanded or further optimized Home and Community Care Support Services-employed direct care roles to

	created barriers to seeing patients in a timely manner.	assist in offsetting capacity challenges with service providers. We implemented and expanded existing Telehomecare models and remote care monitoring with pathways to support COVID and surgical support to bridge the gap for nursing services and assist with emergency department diversion. An interprofessional wound care digital skin and wound application was leveraged to support seamless and specialized wound consultations which has provided efficiencies, and drives excellent data analytics to support nursing interventions and our ability to monitor visits, supplies and wound healing. We leveraged community paramedicine programs to augment in-home nursing, where appropriate. In order to increase resources to deliver care, Home and Community Care Support Services continues to enter into new contracts (that do not include guaranteed volumes) with additional service providers who demonstrate capacity.
90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)	Challenges with service provider organizations with personal support, nursing and therapy health human resources had a direct impact on wait times across several Home and Community Care Support Services organizations. Patient preference to delay service or change/cancel the first visit due to COVID-related	Home and Community Care Support Services continued to focus on process improvement initiatives including prioritizing initial assessments and working with service providers to develop a scheduling strategy. Planning for a refreshed standardized intake model to generate process improvements leading to reduced wait times is underway.

	concerns, family member availability or other reasons impacted performance. Many areas saw increased referrals as patients started re-engaging with their primary care physician. In addition, some patients hadn't visited their physician during the pandemic and had a higher level of acuity when referred. Care coordination resource challenges in some Home and Community Care Support Services organizations affected timeliness of assessments.	Through continued collaboration with Ontario Health, we are reviewing current community support service models/funding to take on lower needs patients in the community. We implemented a service provider incentive focused on a shift model of care that guaranteed full-time employment for personal support workers. We implemented new recruitment strategies such as expanding use of job posting sites and increasing the frequency of new staff orientation to onboard new care coordinators more quickly. Key performance indicators have been created to monitor patient satisfaction, acceptance rate, retention and recruitment. Utilization of virtual platforms such as eRehab, which supports a rehab assistant in the home tethered to a therapist in real time, helped us carry out the therapy treatment regime.
90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care	In order to increase resources to deliver care, Home and Community Care Support Services continues to enter into new contracts (that do not include guaranteed volumes) with additional service providers who demonstrate capacity. Increased volume of patients discharged from hospital requiring complex care planning and high intensity supports has added to the time to service initiation in the community. This population is not eligible for the	Planning began for a refreshed standardized discharge planning model to strengthen process improvements leading to reduced wait times based on alternate level of care best practices. We partnered with other agencies, such as community paramedicine, to help with discharges and support patients in their homes. Home and Community Care Support Services continued to evaluate, refine and contemplate spread of programs to facilitate

	emerging hospital @home models.	the discharge of high needs hospital patients. We are operationalizing our People Strategy framework to increase and expand staff retention and recruitment strategies. Creation of a direct-hire strategy that enables Home and Community Care Support Services staff to provide direct care when service providers are unable to. Utilization of virtual platforms such as eRehab, which supports a rehab assistant in the home tethered to a therapist in real time, helped us carry out the therapy treatment regime. We supported timely discharges through remote care monitoring programs for Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, surgical patients and COVID patients. Business intelligence reports have been created to monitor referral trends and assist with monitoring and opportunities for quality improvement.
Wait times from application to eligibility determination for long-term care home placements: from community setting	Home and Community Care Support Services relies on information from other sources, including family, hospital records, health report, etc. to determine eligibility for long-term care placement. Delays often result due to information not submitted to Home and Community Care Support Services in a timely manner.	Work is underway to develop and implement an online application for long-term care placement. This will automate the application submission process to provide patients with an online option. It will Include secure functionality on the Home and Community Care Support Services website where applications can be completed and submitted by the

	Additional assessments, such as behavioural, are required for patients with dementia and/or behaviours.	patient/Substitute Decision Maker and retrieved by staff online. Functionality would also include electronic notification of application status. Standardization of long-term care application form(s) across the 14 organizations will ensure consistent process and technology enablers, including integration with CHRIS and Privacy.
Wait times from application to eligibility determination for long-term care home placements: from acute-care setting	An increase in the number of new long-term care applications from hospital patients resulting from amendments to the *Fixing Long-Term Car Act, 2021* and Ontario Regulation 246/22 that enables ALC patients waiting in hospital for long-term care to be placed in category 1 (crisis/highest category) has impacted this indicator. We are seeing an increase in the numbers of transitions to long-term care from hospital patients. Home and Community Care Support Services relies on information from other sources, including family, hospital records, health report, etc. to determine eligibility for long-term care placement. Delays often result due to information not submitted to Home and Community Care Support Services in a timely manner. Additional assessments, such as behavioural, are required for patients placed from hospital into long-term care due to increased complex care needs often coupled with behaviours.	Work is underway to develop and implement an online application for long-term care placement. This will automate the application submission process to provide patients with an online option. It will include secure functionality on the Home and Community Care Support Services website where applications can be completed and submitted by the patient/Substitute Decision Maker and then retrieved by staff online. Functionality would also include electronic notification of application status. Standardization of long-term care application form(s) across the 14 organizations will ensure consistent process and technology enablers, including integration with CHRIS and Privacy.

Annual Business Plan Indicators

Our 2022/23 Annual Business Plan included several performance metrics to measure our progress in achieving our strategic priorities. The priorities, initially set in our 2021/22 Annual Business Plan, were adjusted in 2022 with input from key partners including patients, families, caregivers, health system partners, Indigenous partners, French Language Health Planning Entités and our staff and health system partners. Below is the 2022/23 progress update.

Note – while listed as measurements in our Annual Business Plan, we did not include wait time indicators for nursing or personal supports in the below chart as those metrics are already listed as part of the provincial performance indicators.

Strategic Initiative	**Performance**	**Comments**
Drive excellence in care and service delivery		
Measure and increase the opportunities/initiatives where patients, families and caregivers are engaged as equal partners to encourage co-design	On-boarded 57 new members to the Community of Advisors. Advisors were engaged in 37 different projects, representing 400 hours of volunteer time. Average # of Advisors involved per month: 22 Average # of hours volunteered per month: 33	Co-designed and implemented a Community Engagement Framework to guide our engagement program. Embedded patient, family, caregiver voice into various levels of decision making across the organizations, including organizational strategies, priorities, policies, hiring panels, committees and working groups, at both the local and provincial level.
Caregiver distress rate for long-stay patients – % of long-stay patients whose caregiver has indicated experiencing caregiver distress	Overall: 47% Community Independence: 18% Chronic: 42% Complex: 72% *(Combined Q1 – Q4 2022/23)*	Of note, there has not been much change over the months or past couple of years. Performance on this indicator continues to be impacted as a result of increased caregiver burden during the pandemic, coupled with ongoing barriers to access and availability of community supports due to health human resource challenges in the sector.

Volume of open alternate level of care cases related to Home and Community Care Support Services – number of patients ready to be discharged from hospital (acute care) and whose discharge has been delayed due to lack of availability of care or services at planned discharge destination	3,539 *(for Feb. 2023 – reported monthly)*	Alternate level of care volumes remained stable, even while hospitals ramped up surgeries, amidst health human resources shortages and high emergency department volumes.
Community Crisis Patients Waiting for long-term care home placement – number of new home care referral admissions for the most recent period compared to the same period in the prior year	2,238 *(for Mar. 2023 – reported monthly)*	Patients designated priority 1 has decreased from March 2022 by approximately 12%. This is an improvement over the year in balancing between hospital and community crisis patients.
Percentage of complaints acknowledged to the individual who made a complaint within two, five and 10 business days	Acknowledged within 2 days – 94.1% Acknowledged within 5 days – 2.9% Acknowledged within 10 days – 1.4% *(Combined Q1 – Q4 2022/23)*	All 14 organizations adopted a new provincial Patient Complaints and Appeals Management Framework including technical updates to capture the acknowledgement times in their Event Reporting Systems. A new provincial Complaints and Appeals policy was developed in consultation with Agencies Legal to align the provisions in regulation 187/22 s.30 with the complaints management in home and community care provincially. All staff were required to complete a mandatory learning module to ensure consistent application.
Percentage of complaints closed within 30 calendar days and 60 calendar days	Closed within 30 days – 42.5% Closed within 60 days – 18.3% *(Combined Q1 – Q4 2022/23)*	All 14 organizations modified their Events Reporting Systems to capture complaints closing times. The data analysis of patient complaints in 2022/23 reveals that, on average, 60.8% of complaints are closed within 60 days or less. A quality improvement project was initiated to enhance patient outcomes

		related to complaints closure times. This project aims to achieve 90% of complaints being closed within 60 days or less by the end of 2023/24.
Accelerate innovation and digital delivery		
Support Ontario Health to identify opportunities for CHRIS (Client Health and Related Information System – our provincial patient management system that supports the delivery of home and community care and long-term care placement services) and its ecosystems for enhanced integration and functionality, driving consistency among partners including community support partners		We continued to work with Ontario Health in fiscal 2022/23 to advance integration of CHRIS with other systems, advance patient access to their health record, participate in readiness to deploy new technologies and to strengthen our protection of patients' personal health information. This included implementing eNotification from acute care hospitals, to notify us when home care patients are discharged from hospital, including from The Ottawa Hospital, Deep River and District Hospital, Kemptville District Hospital and Winchester District Memorial Hospital. In Central East, we implemented eReferral for all local acute care hospitals who use the EPIC system, to facilitate referrals for patients being discharged to Home and Community Care Support Services. Also in Central East, we implemented eNotification for Durham Region emergency medical services, to notify Home and Community Care Support Services when a home care patient is transported to hospital. CHRIS releases introduced more detailed audit logs to meet Bill 188 requirements which outline enhanced event audit logs under the Personal Health Information Protection Act. We enhanced our privacy auditing capability by utilizing the new events audit logs in our auditing processes. This enhanced functionality

		supports protection of patients' personal health information.
Advance health system modernization		
Establish integrated models of care coordination in partnership with Ontario Health Teams and our Patient, Family and Caregiver Advisors	N/A	We continue to work with Ontario Health and the Ministry of Health to support the planning for, and development of, integrated models of care through Ontario Health Teams (OHT). Throughout the ongoing OHT Leading Projects planning work, a continued focus has been placed on including patients and caregivers in co-designing these models of care.
% of Ontario Health Teams with embedded care coordination functions	N/A	The implementation planning stage is currently underway with Ontario Health Team Leading Project, Ontario Health and Ministry of Health and the model for embedding care coordination functions is still being determined. We continue to operate with care coordinators embedded in family health teams and hospitals. We are awaiting direction from the ministry on indirect care coordination which may impact how we embed care coordination functions in Ontario Health Teams.
Invest in our People		
Internal Management Promotions	N/A	The ability of Home and Community Care Support Services to develop leadership capacity amongst our staff demonstrates success in developing our leadership capability and supports the organizations' goal of offering rewarding careers. Some level of external management hiring may be needed to support leadership during times of transformation and transition. Data collection commenced on April 1, 2023.
Staff retention and turnover	10.22% voluntary turnover	The ongoing ability of Home and Community Care Support Services to

	(as of February 2023)	provide care to our patients is dependent on our ability to maintain a stable workforce. However, some level of voluntary turnover may be desirable to allow opportunity for organizational rejuvenation. We continue to be on track to achieve our target voluntary turnover rate of 10.5%.
Employee engagement score	76% engagement index for November 2022 Employee Engagement Survey 78% target for 2023/24	Our employee engagement is near the benchmark average (79%), with a number of positive indicators including the almost unanimous desire for success, a strong belief in the mission, vision and values and a very low level of disengagement. Strong employee engagement is highly correlated with better employee productivity, employee retention and organizational performance.

Appointees

Name of Appointee	Date First Appointed	Current Term Expiration	Remuneration
Joe Parker	March 5, 2021	December 31, 2024	$16,476.00
Glenna Raymond**	July 1, 2021	June 30, 2023	$9,514.28
Carol Annett	July 1, 2021	December 31, 2024	$5,157.14
Anne Campbell	July 1, 2021	December 31, 2024	$5,600.00
Michael Dibden	July 1, 2021	June 30, 2023	$4,328.57
Eugene Cawthray*	July 1, 2021	December 31, 2024	$5,400.00
Stephan Plourde**	July 1, 2021	June 30, 2023	$6,732.84
Shanti Gidwani*	February 17, 2022	February 16, 2025	$4,657.14
Kate Fyfe	February 17, 2022	February 16, 2025	$6,800.00
John Beardwood	February 17, 2022	February 16, 2025	$3,385.71

* The following two (2) board members resigned from the Board:
- Eugene Cawthray, effective May 17, 2023; and
- Shanti Gidwani, effective June 15, 2023

** The following two (2) board members were reappointed to the Board:
- Glenna Raymond, effective July 1, 2023 until June 30, 2024
- Stephan Plourde, effective July 1, 2023 until June 30, 2024

Financial Analysis

Home and Community Care Support Services organizations were established as crown agencies under the *Local Health System Integration Act, 2006*, and have a focused mandate to deliver local health care services such as home and community care, access to community services and long-term care home placement.

Home and Community Care Support Services organizations are funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement (MLAA) and have entered into Memorandums of Understanding which provide the framework for accountabilities and activities.

In accordance with the MLAA, Home and Community Care Support Services organizations are required to be in a balanced budget position at year end. Any funding received in excess of expenses incurred is required to be returned to the Ministry of Health and any deficits are required to be repaid the following fiscal year. Detailed finances can be found in the Audited Financial Statements found at the end of this report and posted to our websites.

Home and Community Care Support Services Erie St. Clair
Home and Community Care Support Services Erie St. Clair delivered on its mandate, receiving a Ministry of Health funding allotment of $182,251,066 for the full fiscal year 2022/23. Expenses were $182,251,066, which resulted in a balanced year-end position.

Home and Community Care Support Services South West
Home and Community Care Support Services South West delivered on its mandate, receiving a Ministry of Health funding allotment of $256,221,989 for the full fiscal year 2022/23. Expenses were $256,221,989, which resulted in a balanced year-end position.

Home and Community Care Support Services Waterloo Wellington
Home and Community Care Support Services Waterloo Wellington delivered on its mandate, receiving a Ministry of Health funding allotment of $187,037,247 for the full fiscal year 2022/23. Expenses were $187,037,247, which resulted in a balanced year-end position.

Home and Community Care Support Services Hamilton Niagara Haldimand Brant
Home and Community Care Support Services Hamilton Niagara Haldimand Brant delivered on its mandate, receiving a Ministry of Health funding allotment of $425,859,431 for the full fiscal year 2022/23. Expenses were $425,217,320, which generated a year-end surplus of $642,111. This surplus will be used to offset last year's (fiscal 2021/22) deficit of the same amount, in line with Ministry of Health directives to Home and Community Care Support Services Hamilton Niagara Haldimand Brant to address its prior year deficit.

Home and Community Care Support Services Central West
Home and Community Care Support Services Central West delivered on its mandate, receiving a Ministry of Health funding allotment of $199,708,818 for the full fiscal year

2022/23. Expenses were $199,708,818, which resulted in a balanced year-end position.

Home and Community Care Support Services Mississauga Halton

Home and Community Care Support Services Mississauga Halton delivered on its mandate, receiving a Ministry of Health funding allotment of $248,951,491 for the full fiscal year 2022/23. Expenses were $248,951,491, which resulted in a balanced year-end position.

Home and Community Care Support Services Toronto Central

Home and Community Care Support Services Toronto Central delivered on its mandate, receiving a Ministry of Health funding allotment of $322,388,201 for the full fiscal year 2022/23. Expenses were $322,225,299, which generated a year-end surplus of $162,902. The surplus will be used to offset last year's (fiscal 2021/22) deficit of the same amount, in line with the Ministry of Health's requirement of Home and Community Care Support Services Toronto Central to address the prior year deficit.

Home and Community Care Support Services Central

Home and Community Care Support Services Central delivered on its mandate, receiving a Ministry of Health funding allotment of $478,086,116 for the full fiscal year 2022/23. Expenses were $476,255,706, which generated a year-end surplus of $1,830,410. The surplus will be used to offset last year's (fiscal 2021/22) deficit of the same amount, in line with the Ministry of Health's requirement of Home and Community Care Support Services Central to address the prior year deficit.

Home and Community Care Support Services Central East

Home and Community Care Support Services Central East delivered on its mandate, receiving a Ministry of Health funding allotment of $415,879,121 for the full fiscal year 2022/23. Expenses were $415,879,121, which resulted in a balanced year-end position.

Home and Community Care Support Services South East

Home and Community Care Support Services South East delivered on its mandate, receiving a Ministry of Health funding allotment of $140,794,133 for the full fiscal year 2022/23. Expenses were $140,794,133, which resulted in a balanced year-end position.

Home and Community Care Support Services Champlain

Home and Community Care Support Services Champlain delivered on its mandate, receiving a Ministry of Health funding allotment of $303,992,644 for the full fiscal year 2022/23. Expenses were $303,992,644, which resulted in a balanced year-end position.

Home and Community Care Support Services North Simcoe Muskoka

Home and Community Care Support Services North Simcoe Muskoka delivered on its mandate, receiving a Ministry of Health funding allotment of $127,347,134 for the full fiscal year 2022/23. Expenses were $127,347,134, which resulted in a balanced year-end position.

Home and Community Care Support Services North East

Home and Community Care Support Services North East delivered on its mandate, receiving a Ministry of Health funding allotment of $173,698,373 for the full fiscal year 2022/23. Expenses were

$173,698,373, which resulted in a balanced year-end position.

Home and Community Care Support Services North West

Home and Community Care Support Services North West delivered on its mandate, receiving a Ministry of Health funding allotment of $63,778,592 for the full fiscal year 2022/23. Expenses were $63,778,592, which resulted in a balanced year-end position.

Appendix 1 – Population Profiles

HCCSS	Population Profile	
Erie St. Clair	Area (km^2):	7,324
	Total Population:	666,780
	% of Ontario Population:	4.50%
	Population Age 65+:	20.90%
	Population Growth Rate:	-0.17%
	Population Density:	91.0
	Rural Population:	17.46%
	Indigenous Population:	3.52%
	Francophone Population (including IDF):	2.86%
	Low Income Population	11.16%
South West	Area (km^2):	20,915
	Total Population:	1,062,646
	% of Ontario Population:	7.17%
	Population Age 65+:	20.20%
	Population Growth Rate:	1.08%
	Population Density:	0.6
	Rural Population:	25.63%
	Indigenous Population:	2.52%
	Francophone Population (including IDF):	1.35%
	Low Income Population:	11.29%
Waterloo Wellington	Area (km^2):	4,751
	Total Population:	868,902

	% of Ontario Population:	5.86%
	Population Age 65+:	15.82%
	Population Growth Rate:	1.08%
	Population Density:	182.9.8
	Rural Population:	9.92%
	Indigenous Population:	1.68%
	Francophone Population (including IDF):	1.46%
	Low Income Population:	8.87%
Hamilton Niagara Haldimand Brant	Area (km^2):	6,474
	Total Population:	1,529,162
	% of Ontario Population:	10.31%
	Population Age 65+:	20.43%
	Population Growth Rate:	0.75%
	Population Density:	236.2
	Rural Population:	11.25%
	Indigenous Population:	2.70%
	Francophone Population (including IDF):	2.04%
	Low Income Population:	9.78%
Central West	Area (km^2):	2,591
	Total Population:	1,088,751
	% of Ontario Population:	7.34%
	Population Age 65+:	13.54%
	Population Growth Rate:	1.19%
	Population Density:	420.2
	Rural Population:	4.76%
	Indigenous Population:	0.58%

	Francophone Population (including IDF):	1.06%
	Low Income Population:	7.19%
Mississauga Halton	Area (km^2):	1,054
	Total Population:	1,280,668
	% of Ontario Population:	8.64%
	Population Age 65+:	15.12%
	Population Growth Rate:	0.34%
	Population Density:	1215.1
	Rural Population:	1.55%
	Indigenous Population:	0.52%
	Francophone Population (including IDF):	1.68%
	Low Income Population:	8.48%
Toronto Central	Area (km^2):	2,731
	Total Population:	1,341,754
	% of Ontario Population:	9.05%
	Population Age 65+:	16.38%
	Population Growth Rate:	-0.55%
	Population Density:	6988.3
	Rural Population:	0.00%
	Indigenous Population:	0.83%
	Francophone Population (including IDF):	2.56%
	Low Income Population:	13.41%
Central	Area (km^2):	2,731
	Total Population:	1,989,578
	% of Ontario Population:	13.42%
	Population Age 65+:	16.81%

	Population Growth Rate:	0.36%
	Population Density:	728.5
	Rural Population:	3.50%
	Indigenous Population:	0.46%
	Francophone Population (including IDF):	1.12%
	Low Income Population:	10.58%
Central East	Area (km^2):	15,395
	Total Population:	1,708,098
	% of Ontario Population:	11.52%
	Population Age 65+:	18.12%
	Population Growth Rate:	0.69%
	Population Density:	111.0
	Rural Population:	13.18%
	Indigenous Population:	1.83%
	Francophone Population (including IDF):	1.52%
	Low Income Population:	9.57%
South East	Area (km^2):	18,253
	Total Population:	517,098
	% of Ontario Population:	3.49%
	Population Age 65+:	24.58%
	Population Growth Rate:	0.25%
	Population Density:	28.3
	Rural Population:	43.83%
	Indigenous Population:	5.10%
	Francophone Population (including IDF):	3.15%
	Low Income Population:	10.84%

Champlain	Area (km^2):	17,723
	Total Population:	1,441,525
	% of Ontario Population:	9.72%
	Population Age 65+:	18.03%
	Population Growth Rate:	0.87%
	Population Density:	81.3
	Rural Population:	17.55%
	Indigenous Population:	3.41%
	Francophone Population (including IDF):	18.21%
	Low Income Population:	9.18%
North Simcoe Muskoka	Area (km^2):	8,449
	Total Population:	520,632
	% of Ontario Population:	3.51%
	Population Age 65+:	21.18%
	Population Growth Rate:	1.71%
	Population Density:	61.6
	Rural Population:	30.41%
	Indigenous Population:	5.14%
	Francophone Population (including IDF):	2.49%
	Low Income Population:	8.78%
North East	Area (km^2):	395,920
	Total Population:	573,049
	% of Ontario Population:	3.87%
	Population Age 65+:	22.81%
	Population Growth Rate:	0.02%
	Population Density:	1.4

	Rural Population:	35.42%
	Indigenous Population:	14.27%
	Francophone Population (including IDF):	21.05%
	Low Income Population:	12.31%
North West	Area (km^2):	406,926
	Total Population:	237,633
	% of Ontario Population:	1.60%
	Population Age 65+:	20.05%
	Population Growth Rate:	-0.56%
	Population Density:	0.6
	Rural Population:	40.36%
	Indigenous Population:	26.19%
	Francophone Population (including IDF):	2.83%
	Low Income Population:	13.69%

Appendix 2 – Performance Indicators

ONTARIO MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	Provincial								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36%	89.86%	87.80%	86.69%	85.63%	85.29%	81.14%	78.24%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	96.07%	96.25%	95.87%	95.66%	94.11%	91.08%	89.70%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	29.00	29.00	30.00	29.00	28.00	27.00	25.00	33.00	43.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	7.00	7.00	8.00	9.00	12.00	14.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	13.00	13.00	13.00	12.00	13.00	14.00	15.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	7.00	7.00	7.00	7.00	7.00	6.00	7.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

ERIE ST CLAIR LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.45%	90.54%	93.46%	95.51%	92.35%	88.52%	89.70%	87.76%	87.09%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.04%	95.03%	95.88%	96.46%	96.01%	95.10%	95.30%	95.15%	94.63%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	18.00	19.00	26.00	27.00	28.00	21.00	23.00	30.00	42.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	5.00	5.00	6.00	6.00	6.00	8.00	9.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	10.00	10.00	11.00	9.00	11.00	9.00	14.00	13.00	15.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	5.00	4.00	3.00	3.00	2.00	3.00	3.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

SOUTH WEST LHIN MLAA INDICATORS

2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	90.87%	88.95%	91.99%	88.90%	84.74%	79.87%	83.60%	80.45%	72.97%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	92.59%	93.10%	93.69%	94.01%	93.16%	92.79%	89.40%	87.24%	85.06%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	21.00	21.00	22.00	30.00	25.00	26.00	26.00	36.00	47.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	8.00	9.00	10.00	12.00	15.00	20.00	25.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	8.00	9.00	7.00	8.00	8.00	7.00	8.00	10.00	12.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	4.00	4.00	3.00	3.00	3.00	3.00	4.00	4.00	5.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

WATERLOO WELLINGTON LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	84.50%	85.66%	92.90%	95.32%	97.21%	95.57%	84.80%	75.04%	60.79%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	94.77%	93.97%	95.98%	97.00%	96.11%	96.57%	94.30%	84.60%	74.20%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	12.00	13.00	13.00	14.00	14.00	15.00	19.00	42.00	70.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	5.00	5.00	6.00	6.00	9.00	12.00	19.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	12.00	11.00	9.00	10.00	11.00	9.00	11.00	12.00	12.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	4.00	5.00	5.00	5.00	5.00	5.00	4.00	3.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

HAMILTON NIAGARA HALDIMAND BRANT LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	89.37%	90.28%	89.92%	88.63%	85.05%	86.03%	86.00%	77.27%	68.77%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	92.67%	93.69%	95.97%	95.89%	95.79%	95.32%	93.90%	88.71%	86.89%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	25.00	28.00	28.00	28.00	34.00	33.00	30.00	35.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	6.00	6.00	6.00	7.00	8.00	11.00	14.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	9.00	8.00	8.00	9.00	10.00	10.00	13.00	15.00	17.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	5.00	6.00	8.00	8.00	8.00	9.00	9.00	13.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

CENTRAL WEST LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.23%	88.97%	85.31%	82.61%	85.93%	82.73%	87.50%	85.18%	83.64%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	96.52%	95.43%	95.17%	95.69%	96.48%	96.05%	95.90%	94.75%	92.98%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	19.00	21.00	24.00	30.00	29.00	36.00	20.00	31.00	28.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	8.00	8.00	9.00	9.00	8.00	10.00	12.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	21.00	18.00	20.00	21.00	19.00	18.00	17.00	22.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	12.00	13.00	11.00	14.00	14.00	13.00	14.00	12.00	15.50

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

MISSISSAUGA HALTON LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.07%	91.48%	92.63%	90.81%	90.99%	90.91%	91.60%	88.36%	85.03%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.22%	95.58%	96.69%	96.60%	95.99%	95.61%	94.10%	92.67%	92.62%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	27.00	28.00	34.00	27.00	24.00	23.00	23.00	28.00	36.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	11.00	9.00	10.00	11.00	13.00	14.00	15.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	15.00	12.00	12.00	15.00	16.00	12.00	16.00	21.50
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	17.00	11.00	12.00	15.00	10.50	12.00	13.00	12.00	20.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

TORONTO CENTRAL LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.47%	85.03%	93.95%	95.57%	95.54%	96.40%	96.40%	94.79%	96.30%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.64%	93.50%	96.19%	96.06%	96.46%	95.77%	95.70%	95.47%	94.52%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	25.00	26.00	26.00	26.00	28.00	27.00	21.00	30.00	71.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	8.00	9.00	10.00	10.00	13.00	18.00	22.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	3.00	0.00	0.00	0.00	0.00	0.00	1.00	3.00	8.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	11.00	9.00	7.00	7.00	7.00	7.00	11.00	5.00	5.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

NOTE: due to different data collection system used in Toronto Central LHIN and different business rule WT in TC LHIN may not be comparable to other LHINs

CENTRAL LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	84.35%	83.68%	92.39%	93.03%	94.12%	93.81%	94.50%	92.17%	88.96%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	94.13%	94.23%	96.65%	96.41%	95.93%	96.09%	95.90%	94.82%	93.55%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	31.00	33.00	33.00	22.00	22.00	20.00	16.00	21.00	24.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	6.00	6.00	5.00	6.00	5.00	6.00	7.00	8.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	17.00	22.00	19.00	21.00	21.00	20.00	22.00	21.00	23.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	6.00	4.00	5.00	4.00	3.00	5.00	4.50	5.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

CENTRAL EAST LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	87.88%	88.69%	90.64%	90.10%	87.75%	88.48%	88.60%	82.56%	78.16%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.67%	95.84%	96.83%	96.51%	95.99%	96.27%	94.50%	92.16%	91.54%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	30.00	49.00	41.00	39.00	31.00	23.00	29.00	44.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	13.00	10.00	9.00	9.00	10.00	12.00	12.00	14.00	12.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	21.00	20.00	17.00	20.00	20.00	16.00	25.00	21.00	17.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	10.00	10.00	8.00	8.00	9.00	8.00	11.00	8.00	9.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

SOUTH EAST LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	86.84%	84.62%	90.72%	88.12%	87.37%	80.26%	69.90%	72.22%	65.65%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	92.70%	91.90%	96.14%	96.28%	95.04%	93.64%	89.10%	80.47%	75.53%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	21.00	22.00	21.00	20.00	22.00	22.00	38.00	57.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	7.00	7.00	7.00	7.00	7.00	7.00	12.00	13.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	13.00	15.00	14.00	13.00	13.00	13.00	18.00	20.00	21.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	7.00	6.50	8.00	11.00	14.00	9.00	13.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

CHAMPLAIN LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	78.86%	77.03%	77.33%	71.39%	68.16%	66.12%	61.70%	58.88%	57.20%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	91.70%	93.48%	96.04%	96.08%	95.29%	95.25%	92.60%	85.56%	88.22%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	62.00	55.00	34.00	50.00	45.00	40.00	46.00	83.00	93.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	8.00	11.00	9.50	10.00	15.00	16.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	21.00	24.00	24.00	23.00	13.00	7.00	7.00	7.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	11.00	10.00	9.00	13.00	16.00	7.00	0.00	0.00	0.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

NOTE: due to business procss change in Champlian LHIN since 2019, WT after 2019 may not be comparable to previous years and also not comparable to other LHINs

NORTH SIMCOE MUSKOKA LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	69.53%	77.19%	89.20%	87.03%	86.56%	86.89%	87.50%	81.27%	85.98%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	91.52%	93.08%	95.79%	97.62%	98.13%	97.75%	97.20%	95.88%	95.47%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	69.00	67.00	51.00	41.00	32.00	27.00	27.00	27.00	30.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	7.00	8.00	6.00	8.00	9.00	12.00	13.00	12.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	19.50	15.00	15.00	14.00	13.00	14.00	20.00	21.00	27.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	13.00	15.00	24.00	28.00	34.00	29.00	20.00	13.00	19.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

NORTH EAST LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	86.06%	83.70%	96.05%	87.65%	85.99%	83.10%	79.80%	71.98%	83.33%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.61%	94.09%	98.20%	98.49%	98.25%	98.50%	96.90%	96.20%	95.80%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	70.00	48.00	39.00	31.00	28.00	24.00	22.00	31.00	35.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	11.00	9.00	7.00	7.00	8.00	7.00	8.00	11.00	14.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	8.00	8.00	7.00	7.00	7.00	7.00	3.00	4.00	4.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	9.00	11.00	9.00	9.00	8.00	7.00	10.00	14.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

NORTH WEST LHIN MLAA INDICATORS
2022/23 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN								
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result (Year to Date)
1. Performance Indicators											
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	76.43%	78.52%	83.92%	83.46%	85.23%	93.59%	94.50%	95.79%	92.59%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	89.31%	88.32%	95.86%	96.09%	95.73%	97.38%	98.40%	97.16%	94.33%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	35.00	28.00	30.00	26.00	23.00	22.00	18.00	21.00	23.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	5.00	5.00	5.00	5.00	5.00	6.00	6.00	7.00	7.00
2. Monitoring Indicators											
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	35.00	34.50	32.00	27.00	36.00	16.00	14.00	11.00	11.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	15.00	12.00	14.00	11.00	12.00	10.00	8.00	9.00	8.00

**For No. 1-4, FY 2022/23 is based on the available data from the fiscal year (Q1-Q3, 2022/23)

**For No. 17(a) and 17(b), 2022/23 is based on full fiscal year, Q1-Q4

Appendix 3: Audited Financial Statements

The Audited Financial Statements for each of our 14 Home and Community Care Support Services organizations can be found on our website at:

Erie St. Clair	**Central**
South West	**Central East**
Waterloo Wellington	**South East**
Hamilton Niagara Haldimand Brant	**Champlain**
Central West	**North Simcoe Muskoka**
Mississauga Halton	**North East**
Toronto Central	**North West**