HOME AND COMMUNITY CARE
SUPPORT SERVICES

Business Plan

2024-2025

Ontario

CONTENTS

MESSAGE FROM THE BOARD

Our fourth Annual Business Plan, since our inception in July of 2021, builds on our accomplishments to date, while also focusing on our future transition into a new organization and role within the health care system.

The recently passed legislation, the *Convenient Care at Home Act, 2023*, if proclaimed will amalgamate 14 Home and Community Care Support Services organizations into a single service organization called Ontario Health atHome in 2024. In addition to continuing to deliver our current services as Ontario Health atHome, we will also work towards a new mandate that includes advancing home and community care modernization and supporting Ontario Health Teams as they continue to build capacity, ensuring every patient gets the care they need, when and where they need it.

The care and well-being of patients, families and caregivers remains our number one priority throughout this transition and beyond. To improve access and ensure equitable services for patients, we have been standardizing and streamlining processes across our 14 geographies, with a focus on patient safety and quality care.

We remain committed to strong partnerships built across the health care sector. Our collaborative approach ensures that patients receive needed services where and when appropriate, while supporting the ongoing work of transforming home and community care to a more integrated and equitable future state. Over the past year, we have been active participants at Ontario Health Team tables across the province, sharing our expertise and collaborating with partners to improve pathways to care.

To help guide our work, we will continue to focus on our four strategic priorities, detailed later in this plan:

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

We have already made significant advancements within these priorities since they were first introduced in our 2021-2022 Annual Business Plan. Some notable accomplishments include the implementation of a Patient Abuse Prevention, Recognition and Response Plan, the development of Personal Support Service Guidelines that support equitable services across the province, and continued collaboration with contracted service provider organizations to build health care system capacity through initiatives such as our Clinics First approach.

As we plan to transition to a single service organization, we will continue to collaborate with health care system partners and the people we serve. We will modernize our service provider contracts in order to better serve patients and support a more efficient and integrated system of care. We will make the most of valuable resources to meet the needs of patients and caregivers across Ontario. At the same time, we will advance progress on equity, inclusion, diversity and anti-racism as we respond to the needs of Ontario's diverse population.

We look forward to the work ahead while continuing to help everyone be healthier at home through connected, accessible, patient-centred care.

Joe Parker
Board Chair

MESSAGE FROM THE CEO

I am pleased to present our 2024-25 Annual Business Plan, which outlines how we advance progress and leverage our existing strategic priorities to guide us as we transition from 14 organizations into a new service organization, called Ontario Health atHome.

Through the transition to Ontario Health atHome, we will adopt a new, yet critical role in the health care system that includes the continued delivery and coordination of home and community care services, as well as support for Ontario Health Teams to deliver and transform home care. At the same time, we will continue to engage with our health care system partners and the people we serve to help shape our new organization and ensure a seamless transition and continuity of care, so that patients continue to receive the services they need, wherever they call home.

Everything that we do is centred on the needs of patients, families and caregivers. This is reflected in our work this past year to implement a Framework for Supporting Ethical Practice, which helps our employees provide exceptional care. In 2023, we also launched our inaugural Above and Beyond Caregiver Recognition Program to formally acknowledge the vital role unpaid caregivers have in supporting their loved ones. With more than 100 submissions, we heard inspiring stories of courage and innovation; exemplifying how caregivers of all ages are supporting people at home and in the community, and making a meaningful difference.

We serve a diverse population of patients, each with unique circumstances, culture and health status. We have created a new leadership position focused on Equity, Inclusion, Diversity, and Anti-Racism (EIDAR), responsible for developing and operationalizing our provincial EIDAR strategy and for the provision of education, guidance and support in the advancement of EIDAR both internally and externally. We look forward to furthering our commitment to providing a respectful, accessible and inclusive environment for all patients, families, caregivers, employees, partners and the public.

Within Home and Community Care Support Services, our people are our greatest asset, and none of our accomplishments would be possible without our tremendous staff. This past year, we focused on investing in our people to ensure they have the support they need to do their best work as we transition into Ontario Health atHome. This includes a new employee recognition program, an employee wellbeing and wellness program, as well as training on Indigenous cultural safety and the active offer of French Language Services. We will continue to build on the accomplishments of our People Strategy as we know that investments in our staff will lead to positive outcomes for patients. This strategy has received national recognition through the Canadian HR Awards with an excellence awardee in five categories and receiving the HR Champion award for Chief Executive Officer.

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

Cynthia Martineau
Chief Executive Officer

INTRODUCTION

WHO WE ARE

We are here to help and ready to serve people across Ontario who need our services. Ontario's 14 Home and Community Care Support Services organizations work together as one team to coordinate home and community-based care for thousands of patients across the province every day. Over the course of this year, we will transition into a new service organization, called Ontario Health atHome. While our name and structure will change, the exceptional care we provide to patients, families and caregivers will continue seamlessly without interruption.

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

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

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

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

Attend school with complex health problems and disabilities

Access mental wellness strategies and addictions support while at school

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

Find a family doctor or nurse practitioner

Find community services that support healthy, independent living

Access respite and resources to support caregiving

Transition to long-term care or supportive housing

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

Recover at home after a hospital stay

Each year, 9,200+ staff serve or support more than 651,850 patients of all ages, including approximately 28,750 long-term care home placements. Every day, Home and Community Care Support Services provides approximately 27,490+ nursing visits; 4,200+ therapy visits; and 100,570+ hours of personal support care.

Our Partners

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

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

We also work with an extensive number of system stakeholders including public health units, mental health and addictions providers, Ontario Health, Ontario Health Teams, as well as the Ministry of Health, the Ministry of Long-Term Care and Ministry of Children, Community and Social Services.

Service Provider Organizations

We have patient care contracts with more than 150 service provider organizations who deliver care. We maintain oversight of these services to ensure quality and an optimal patient experience. Service provider organization performance is aligned with our provincial Contract Performance Framework and the Contract Management Guidelines. The intent is to ensure safe delivery of care, increase provincial consistency regarding performance management and to create a shared understanding of performance expectations with the ultimate goal of exceptional care for patients.

"Being a caregiver is an important role that a family member can take on - it doesn't need to be a stressful one, as long as they are included in the care team and both they and their loved one are supported to experience optimal health and well-being."

– Community Advisor, Caregiver Wellbeing Focus Group (Aug. 24, 2023)

Listening to the People We Serve

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

We regularly consult with our Community of Advisors, who bring the perspective of patients, families and caregivers. We also build relationships with Indigenous and Francophone communities to understand what matters to them. In 2023-24, we developed a new Community Engagement Strategy to build on the foundation of our program. The strategy, guided by our Community Engagement Framework, outlines our approach to further supporting our advisors and our colleagues to enable greater connection points and ensure people feel heard, valued and respected. This includes our work to develop a Priorities Advisors Panel to help shape our thinking and priority-setting.

As we embark on the initiatives that advance our strategic priorities, we are committed to ongoing engagement with partners and the people we serve to ensure we stay focused on the right priorities and maintain an understanding of preferences and how people expect to be treated. We are grateful to the people who engage with us throughout the year. Their ideas, experiences and values ensure we are focused on what matters most.

Environmental Scan

Health System Transformation

Our health care system continues to evolve, with modernization that requires ongoing adaptability and innovative solutions. In 2021, the 14 separate agencies delivering home and community care in Ontario came together under a refocused mandate and new business name, Home and Community Care Support Services, led by one Chief Executive Officer and Board of Directors. We actively support approximately 344,560+ patients every month, with a total of 651,850+ patients each year. Acting as a unified organization, we strive to advance health care system integration, drive equity and enable consistent access to care across the province. At the same time, we recognize the unique needs of patients in their local geographies and the necessity to work with Ontario Health Teams to improve patient experience and outcomes.

In October 2023, the government introduced Bill 135, *Convenient Care at Home Act, 2023*, which if proclaimed will establish a new, single service organization called Ontario Health atHome. The act proposes to amalgamate the 14 Home and Community Care Support Services organizations into a single organization called Ontario Health atHome to provide a strong and centralized foundation to support stability of long-term care placement services and home care services now, and as home care is delivered through Ontario Health Teams in the future. Ontario Health atHome will continue to coordinate and deliver care, providing continuity of the services Home and Community Care Support Services delivers today. Through these changes, continuity of patient care is paramount. Careful planning will ensure consistent patient care as we assume our new role supporting Ontario Health Teams.

Responding and Planning for Ongoing Health System Needs

The health care system continues to evolve with the help of innovative technology. We remain committed to implementing digital solutions that ensure home care service delivery and long-term care placement is timely, equitable, accessible and responsive. Working to increase the use of digital platforms such as virtual care and remote patient monitoring, we will improve access to care to improve timely and convenient access to patient care. As risks for cyber security and privacy breaches continue to be a threat within our health care sector and across the globe, we remain committed to investing in strategies that maintain safe and secure operations to avoid disruption to patient care and ensure security of personal health information.

To address the pressures facing the health care system, and to further stabilize the health and long-term care sectors for the future, we are focused on providing the right care in the right place and easing pressure on emergency departments. Supporting the improved flow of patients from hospital to a location that best meets their care needs – whether that be at home, in long-term care, or another setting in the community – is a key priority for us. There are several ways we will continue to facilitate admissions to long-term care and support the implementation of the *More Beds, Better Care Act 2022* and the government's *Your Health: A Plan for Connected and Convenient Care*, including our work with alternate level of care (ALC) patients, automating our long-term care application process, and expanding our capacity building initiatives.

Ontario, much like other provinces across Canada, continues to face a shortage of health human resources and an increased demand for home and community care services, with increasing complexity of care needs. Ontario's *Your Health: A Plan for Connected and Convenient Care* outlines the necessary actions to bolster Ontario's health care workforce, including adding more domestic and internationally trained nurses and other health care professionals. While emphasizing health care system stability, Home and Community Care Support Services has, and will continue to expand innovative models of care to build new capacity and explore innovative support for caregivers, as well as a focus on internal staff retention and recruitment so that patients receive faster access to care.

Equity, Inclusion, Diversity and Anti-Racism

Home and Community Care Support Services recognizes that through our commitment to equity, inclusion, diversity and anti-racism (EIDAR), we contribute to better outcomes for patients, families, caregivers and a healthier work environment for all. We continue to make meaningful progress using our board endorsed EIDAR commitment statement as a guide:

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

In July 2023, we hired an EIDAR leader to guide and support our commitment across the province. To better facilitate staff contributions, we refreshed the EIDAR structure to include an EIDAR Steering Committee and Employee Resource Group supports. A valuable component of growing inclusion, staff launched three new resource groups this past year: a Staff Against Anti-Semitism group, Disability Accessibility employee group, and a Muslim employee group, where staff can find community, resources and connect with other groups. Previously established employee driven groups – a Pride Committee, an Indigenous working group and a group focused on Black Anti-Racism, Inclusion, Social Justice and Equity (ARISE) – continue to offer meaningful opportunities for staff to learn and reflect, including developing programming for National Day for Truth and Reconciliation, Black History Month and Pride Month.

We continued to build EIDAR awareness and capacity through education and process changes. More than 700 staff received training offered through the Canadian Diversity Initiative in the San'Yas Anti-Racism Indigenous Cultural Safety Training Program. In addition, we launched the Pronouns Matter eLearning module. Led by the Pride Committee, with community advisor guidance, the eLearning module supports new functionality around gender pronouns in our Client Health and Related Information System (CHRIS). By asking patients their preferred pronouns and recording them in CHRIS, we can support culturally safer care. We've also activated a Microsoft Teams feature enabling staff to add their pronouns to their profile to contribute to a more inclusive organization.

We recognize that EIDAR is a long-term commitment. This year, we released an EIDAR Plan to organize upcoming efforts and are developing an EIDAR Framework to guide our long-term priorities. In the coming year, we will prioritize foundational EIDAR actions that will promote the sustainability of our efforts, including:

- Providing opportunities to increase staff knowledge and skills, including adding to an EIDAR Toolkit;
- Creating an EIDAR Policy to guide behaviours and contribute to a more inclusive and equitable organization;
- Review of targeted policies, procedures and resources;
- Seeking community advisor and staff input to inform the EIDAR Framework and contribute to EIDAR efforts; and
- Leveraging in 2024 our upcoming Employee Engagement Survey and Patient and Caregiver Experience Evaluation results to inform future efforts.

EIDAR is meant to be done through intentional collaboration and with the advice of community members. We plan to seek valuable input from community advisors and staff, with the goal of advancing EIDAR in ways that reflect the diversity of the people we employ and serve. While we have made meaningful progress, there are important actions that we have yet to take. We are committed to working collaboratively to eliminate systemic barriers experienced by underrepresented, marginalized and racialized groups, and to building a workforce that reflects the communities we serve.

BUSINESS PLAN AT A GLANCE

Our Engagement Approach

To inform our 2024-25 Business Plan, we reflected on engagement conducted with key partners to build the 2023-24 Business Plan, including patients, families and caregivers, Indigenous partners, French Language Health Planning Entités, our staff and health care system partners, including primary care providers, community support services, long-term care homes, hospitals and our contracted service provider organizations.

In addition, we continued to engage throughout the past year with our Community of Advisors, a collection of patients, families and caregivers of diverse backgrounds and demographics from across the province with home and community care experience. Through 37 engagement activities, our advisors provided more than 400 hours of volunteer participation including ongoing feedback related to our current priorities; providing a lens to drive further improvement and focus. Their voices are highlighted in quotes throughout this plan.

"We need to meaningfully engage with family caregivers throughout the patient's care journey to improve connections and information sharing about the patient's care and facilitate supports that address patient and families' needs and interests."

– Community Advisor, Caregiver Wellbeing Focus Group (Aug. 24, 2023)

We appreciate the opportunity to be able to incorporate the feedback from both our partners and the people we serve in the 2024-25 plan and in our work moving forward.

Mission

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

Vision

Exceptional care – wherever you call home.

Values

COLLABORATION

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

RESPECT

We engage with kindness, empathy, gratitude and compassion

INTEGRITY

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

EXCELLENCE

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

Strategic Priorities at a Glance

Drive Excellence in Care and Service Delivery

Objectives

- Provide patient, family and caregiver-centric, high-quality home and community care services, long-term care home placement, and access to community services enabling safe, effective, timely and equitable services.
- Optimize organizational capacity to support the best service and plan, develop and implement activities to respond to ongoing system needs in alignment with Ontario's Your Health: A Plan for Connected and Convenient Care.

Initiatives

- Continue the implementation of improved efficiency and system capacity initiatives that began in 2022-2023 in collaboration with service provider organizations.
- Build new capacity through expansion and standardization of Family Managed Home Care while exploring additional supports for caregivers.
- Continue the implementation of standardized quality and safety processes and outcome measures.
- Continue the standardization of business support services for increased efficiency and effectiveness.

Accelerate Innovation and Digital Delivery

Objectives

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

Initiatives

- Implement a Digital Plan in alignment with the Ministry of Health's Digital Strategy to increase efficiency, effectiveness and improve patient experience and outcomes.
- Expand the use of virtual care through Telehomecare.

MISSION
VISION
VALUES

Invest in Our People

Objectives

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

Initiatives

- Continue to implement our People Strategy with focus on:
  - Equity, Inclusion, Diversity and Anti-Racism (EIDAR): Advance a culture of equity, inclusion, diversity and anti-racism and work to eliminate systemic barriers to under-represented racialized groups.
  - Employee Wellness, Wellbeing and Health and Safety Programming: Create a positive, healthy and engaged workforce that supports people to care for themselves and each other.
  - Build an Effective Team Culture: Lay the foundation to establish a high-performance mindset and culture of mutual respect and kindness.
  - Provide Rewarding Careers: Recognize the incredible work of our talented team, stabilize our workforce, and attract, develop and retain exceptional people.

Advance Health System Modernization

Objectives

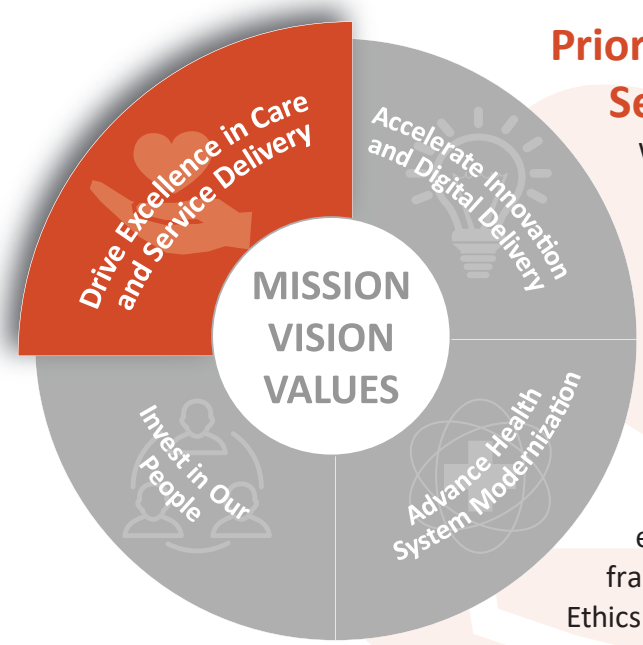
- Transition resources, functions and responsibilities of Home and Community Care Support Services agencies to Ontario Health atHome, ensuring continuity of care.
- Implement improvements in long-term care home placement in alignment with the Ministry of Long-Term Care direction.
- Support new models of care delivery enabled by Ministry regulations in collaboration with the Ministry and Ontario Health, including updating service provider organization selection process and contracts.

Initiatives

- Develop and implement a transition plan to consolidate 14 agencies into one single service organization – Ontario Health atHome.
- Develop and implement a service model and change plan for the new service organization – Ontario Health atHome.
- Support and implement innovative service models in collaboration with Ontario Health Teams and other health care system partners including Leading Projects.
- Continue to streamline key processes, including: wait list management and service guidelines, hospital discharge, intake, information/referral, and navigation across the province in collaboration with system partners.
- Develop and implement a streamlined long-term care placement process including the completion of the online application implementation for placement.
- Continue to implement a provincial Medical Equipment and Supplies structure to support a provincial service provider contract modernization plan.

STRATEGIC PRIORITIES

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



Priority 1: Drive Excellence in Care and Service Delivery

We continue to focus our efforts on delivering improved patient, family and caregiver-centred home and community care services, long-term care placement and access to community services, while navigating health care system pressures and responding to health care system needs. To ensure that the patient voice guides our work, we continue to engage with our community of advisors.

To promote ethical, safe, effective, high-quality and equitable service delivery, we have implemented a framework for supporting ethical practice. A Provincial Ethics Steering Committee was also established to direct and sustain our Ethics Program, supporting high-quality patient care and organizational decisions across the province. This steering committee has endorsed a performance measurement framework that leverages key qualitative and quantitative metrics to inform ethics education and resource allocation based on emerging ethical issues. This work is supporting patient safety and high-quality care. Additionally, we have continued to leverage our Quality Framework and Provincial Quality Toolkit to strengthen our commitment to creating a culture of continuous quality improvement.

Supporting Ontario's *Plan for Connected and Convenient Care*, we have focused on ways to stabilize our health care system and increase our capacity to provide home and community care to eligible patients, including in small, rural communities and communities experiencing difficulties accessing timely care. Some examples of progress made over the past year include:

"Having more seamless sharing of information among the family members and care team would help with responsiveness to urgent needs. The transition from hospital to home could also be improved."

– Community Advisor, Caregiver Wellbeing Focus Group (Aug. 24, 2023)

- Implementing plans to make the most efficient use of health human resources and ensure better integration of services to improve patient outcomes and experiences, including initiatives targeting hard-to-serve communities.
- Expanding our number of community nursing clinics from 135 to 140 and increasing utilization of these clinics from 65% to 74%.
- Increasing the number of our Neighbourhood Models of Care to improve our ability to coordinate patient care within local communities.
- Achieving our target to increase transitional care bed utilization from 84% to 90% to help keep patients out of hospital emergency departments while they prepare to be well enough to go home.

In addition, this past year, we have standardized our business supports to ensure that our frontline teams are able to provide the best care possible to patients. We are leveraging tried and tested initiatives, developed in the different geographies, as best practices to be scaled and spread across the province.

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

- Provide patient and caregiver-centric, high-quality home and community care services, long-term care home placement, and access to community services enabling safe, effective, timely and equitable services.
- Optimize organizational capacity to support the best service delivery and plan, develop and implement activities to respond to ongoing system needs in alignment with Ontario's Your Health: A Plan for Connected and Convenient Care.

We will undertake the following strategic initiatives:

1. **Continue the implementation of improved efficiency and system capacity initiatives that began in 2022-23 in collaboration with service provider organizations.**
   We will continue to expand and operationalize the five initiatives – Community Nursing Clinics, Service Provider Organization Incentives, Neighbourhood Models, Transitional Care Bed Utilization, and Optimizing Internally Employed Clinical Roles – currently underway to support more coordinated care, closer to home, and increase health care system capacity. Other programs considered for further scale and spread across the province to improve system efficiency and capacity include the eRehabilitation program and the Emergency Department (ED) Diversion program, for patients who do not require emergency care and might be better served through other services. Data analytics will continue to play an important role in determining whether an area needs further help in building capacity so that the needs of patients, families and caregivers are met.

"I appreciate there are clinics that are easier to get to for people who are mobile. Care and care coordination has got a lot better as I've had more issues. What I value is that you get to know the person who you talk to regularly - the same nurses get to know your situation."

– Community Advisor, Care Coordination Focus Group (Oct. 20, 2023)

2. **Build new capacity through expansion and standardization of Family-Managed Home Care, while exploring additional supports for caregivers.**
   Through the Family-Managed Home Care program, patients or their substitute decision-makers receive funding to purchase home care services or employ care providers. This offers greater flexibility and choice as they are able to choose who will care for them, determine how and when the care plan is delivered and handle all related administrative tasks. Recognizing the importance of this program, we will work towards expanding and standardizing the processes within the Family-Managed Home Care program so that patients across the province can access it with a consistent experience. We've heard from caregivers about the challenges and stresses they face. With this in mind, we will explore further ways of supporting caregivers to improve patient and caregiver satisfaction and control over care, and ensure a consistent experience across the province. To ensure we're making a difference in improving the patient and caregiver experience, we'll use the patient and caregiver experience survey and caregiver distress data to monitor and better understand their needs.

3. **Continued implementation of standardized quality and safety processes and outcome measures.**
   All Ontarians should receive the same high-quality care, wherever they call home. Standardizing quality and safety processes includes the implementation of the Healthcare Insurance Reciprocal of Canada's (HIROC's) Risk Assessment Checklist program, with a three-year implementation timeline. The checklist is an innovative tool enabling health care organizations to systematically self-assess compliance with evidence-based strategies for top risks related to patient safety. The program allows organizations to conduct analysis of patient safety and critical incidents to proactively assess risks, improve quality and build a culture of safety.
   We are currently in our second year of implementation. The provincial standardization of management of complaints and safety events will enable the timely response and closure of complaints. Implementation of standardized processes to address patient harm, such as documenting a response to allegations of abuse within 10 days, will ensure a harmonized provincial approach to addressing potential abuse situations. Implementation of standardized diabetic foot ulcer outcome indicators will provide visibility into provincial performance of diabetic foot ulcer treatment and inform opportunities to improve outcomes that promote healing within 12 weeks.
   To ensure we continue to provide the best, most responsive supports possible to patients, families and caregivers, we are relaunching our patient experience survey along with a new one geared to caregivers. We are calling this combined approach the Patient Caregiver Experience Evaluation. Together, both evaluations will inform our decisions as we strive to continue improving patient health outcomes across Ontario. The surveys will be mailed to 9,000 randomly selected patients or their caregivers each month. The bilingual surveys (in English and French), will also be available in an additional seven languages for patients. Once those surveys are launched, we will focus on refreshing the VOICES palliative care survey, releasing it later in the 2024-25 fiscal year.

4. **Continue the standardization of business support services for increased efficiency and effectiveness.**
   Standardization within our business support services ensures our frontline teams are well supported to be successful in completing their important work throughout transition and into the future as we take on our new role as Ontario Health atHome. All parts of corporate services are needed to support our patient services teams as we work collectively to become a single service organization. This work includes recruitment for leadership positions within information technology and business analytics, as well as the development of standardized provincial policies and processes.

What does this mean for patients?

For Sam*, the simple act of preparing dinner one evening turned into a months-long ordeal. While cutting raw chicken, Sam sliced her finger. At first it seemed like a minor cut, but within a week an infection took hold, and Sam found herself in the Emergency Department of her local hospital.

Sam required ongoing intravenous antibiotic treatments and was referred to one of Home and Community Care Support Services Community Nursing Clinics, where qualified, registered nurses and health care professionals provide clients with a variety of services.

As a busy hockey mom with a full-time job, Sam was looking for the most convenient way to receive care. With 140 clinics in highly accessible locations, often close to public transit and accessible parking, Sam chose the clinic location closest to her home and worked with our team to arrange nursing care that fit her schedule, even giving her the opportunity to stop in on her way home from work in the evening.

*Sam is a composite of patients we have heard from, and her story illustrates the efficiency and convenience of Nursing Clinics and supports the need for program expansion.

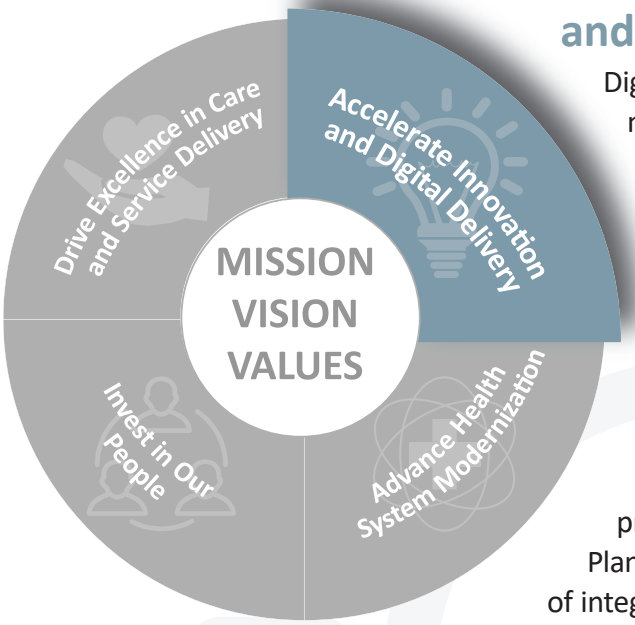
Community nursing clinics are by appointment only and are not the same as visiting a walk-in medical clinic. Sam appreciated the way the nurses were all familiar with her care plan and provided seamless services, no matter who was working that day. And, with Sam's consent, clinic nurses and care coordinators were also able to provide her family doctor with updates, saving her even more time.

How will we know that we are making a difference?

We know how important it is to measure the impact of our initiatives, to ensure they are addressing the needs of patients and supporting system stabilization. Key performance indicators include wait times for nursing visits, therapist visits and personal support service visits, as well as those incidents where visits were not completed. In addition, we will measure our nursing clinic utilization rates, occupancy rate of transitional care beds and offer time to accept service offers. To evaluate the quality and safety of our care, we will measure the percentage of complaints closed within 30 days and percentage of allegations of abuse that were responded to within 10 days. We also are looking to leverage the results of our patient and caregiver experience survey, once available, to inform the impact of our initiatives.

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

Priority 2: Accelerate Innovation and Digital Delivery



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

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

Over the past year, we have made progress in the implementation of digital initiatives to enhance patient care, including our digital solution for wound care with the completion of our Wound Care Framework, progress on wound pathways and implementation of Interprofessional Wound Care teams. Additionally, we are considering a digital Wound Care solution. We have also initiated our Integrated Decision Support System and our Geographical Information System to leverage enhanced geocoding functionality to improve process efficiency and access to timely patient care.

"I favour the use of technology where there is integrated reporting and scheduling that allows me to have a cohesive view of what is going on with my condition and its treatment. It would also give me reassurance that my different health care professionals all have access to this information."

– Community Advisor, Care Coordination Focus Group (Oct. 20, 2023)

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

Digital technologies have enabled new opportunities for care in non-traditional settings, such as providing patients the ability to receive health care from the comfort and safety of their homes in their preferred language. We are continuing to explore the benefits of electronic remote care monitoring systems, combined with coaching, through our Telehomecare programs. Over the past year, we have introduced the COVID-19 remote care monitoring pathway and will be working towards making it accessible to patients across the province to ensure patients have standardized and consistent care to treat and manage COVID-19 from the comfort of their homes.

Continuous engagement and collaboration with our health care system partners is critical to ensuring there is no disruption to patient care throughout our transition to a single service organization and beyond to support the delivery of care through Ontario Health Teams. We continue to plan for the implementation of new models of care delivery through Ontario Health Teams in collaboration with Ontario Health and the Ministry of Health.

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

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

We will undertake the following strategic initiatives:

1. **Implement a Digital Plan in alignment with the Ministry of Health's Digital Strategy to increase efficiency, effectiveness and improve patient experience and outcomes.**
   This year we will foster the growth, augmentation and enhancement of a wide range of digital solutions and further mobilize our existing digital-based initiatives as part of an organizational Digital Plan. The plan encompasses the following progression of digital initiatives: consistent wound care management across the province and equitable opportunity for specialized wound consultations; enhancing our CHRIS system to enable consistency with Ontario Health Teams (integration with OCEAN e-referral, GIS expansion, etc.); implement an information management plan to support the Ministry of Health's data analytics requirements; work with Ontario Health to implement privacy best practices to ensure the handling of personal health information is done in accordance with the Personal Health Information Act; and moving our organization's data centre to the cloud in partnership with Ontario Health to promote improved data sharing, elimination of duplication and improved internal efficiencies for our staff through integration and the use of a single software system across the province. Additionally, we will enhance patients' confidence in managing their health and health care with access to their electronic health records through ONE Access, which will provide enhanced clinical data to providers and serve as the patient portal for Ontario where patients are able to access their own health record. We will share required information and support Ontario Health with a comprehensive privacy review.

2. **Expand the use of virtual care through Telehomecare.**
   Telehomecare combines remote sensing technology with coaching by a nurse to help patients learn to self-manage symptoms related to chronic disease management. Through the program, changes in a patient's health can also be relayed to their primary care provider. Virtual care employs video conferencing, by both care providers and our service provider organizations, with eligible patients and caregivers. Both options can be accessed by patients who are comfortable learning or employing these technologies. Where it's appropriate, we will

ensure that Telehomecare is offered to patients who have chronic heart failure and chronic obstructive pulmonary disease. We will also continue to provide access throughout the province to COVID-19 Telehomecare monitoring, and explore an innovative stroke pathway as work continues on the development of this program.

What does this mean for patients?

Meet Stanley*

At 64 years old, Stanley was recently diagnosed with chronic obstructive pulmonary disease (COPD). Since he and his spouse live in a remote northern community without a hospital nearby, both were concerned about how he would get the care needed and learn to manage this disease. They certainly didn't want to move away from their community to which they have a deep cultural connection, and long drives back and forth to the nearest hospital would be stressful and time consuming, especially in the winter when northern road conditions can be unpredictable.

Recognizing his challenges, Stanley's primary care provider referred him to Home and Community Care Support Services' Telehomecare program, which enables patients to become partners in their own care, right in their own homes, using technology as the enabler.

Stanley was provided with all the equipment he needed to manage his condition. He also received coaching on how to check his own blood pressure, weight, heart rate and pulse. With a touchscreen tablet provided through the program, he was able to send his results, along with the answers to a few simple health check questions, to his Telehomecare nurse, who follows his progress closely. In addition to remotely monitoring his results, Stanley was particularly impressed with the way his nurse provided weekly health coaching geared to his needs, including advice and encouragement on diet, exercise and other factors to help improve his overall health.

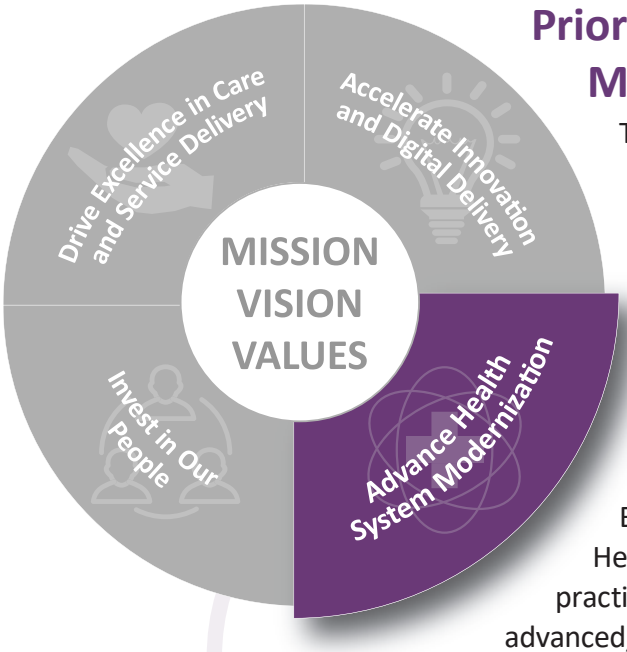
It brings both Stanley and his spouse comfort to know that if any of his readings were to fall outside of normal range, his nurse is alerted and can respond as needed, and will also communicate directly with his primary care provider so that everyone in his circle of care is aware of any potential issues.

Since joining the Telehomecare program, not only has his physical health improved, but both he and his spouse's mental health has benefited from being able to self-manage his care in his own home and community where he feels most comfortable.

* Stanley is a composite of patients we have heard from, and his story illustrates how Telehomecare is helping patients self-manage chronic diseases.

How will we know that we are making a difference?

Measuring the effectiveness and impact of our digital initiatives is critical to ensuring they are producing results as intended, to enhance system modernization and improve patient experiences and outcomes. We will continue to obtain and assess patient feedback on Telehomecare as we continue to develop the program, including the establishment of baseline performance measurements to improve the patient experience and outcomes. We are also tracking how many regions have access to our Wound Care solution with the goal of having it accessible and implemented province-wide. To see a more comprehensive list of indicators that will be used for this priority, please refer to the 'Performance Measurement' section of the plan.



Priority 3: Advance Health System Modernization

To further advance health care system modernization, we continue to work closely with partners to enable new ways of organizing and delivering health care that is more connected for patients in their local communities. This is in alignment with the Convenient Care at Home Act, 2023, to establish a new, single service organization, called Ontario Health atHome, that will coordinate all home care services and manage placement services across the province through Ontario Health Teams.

Building on our commitment to collaborate with Ontario Health Teams, we will continue to share knowledge of best practices regarding care coordination and explore new models of advanced, integrated and seamless care for patients across the full care continuum in the areas of mental health and addictions, palliative and end-of-life care and chronic disease management. This supports teams in delivering proactive evidence-based care that meets the needs of patients, families and caregivers.

Foundational elements to informing home care modernization and the future state model for long-term care placement include both a consistent and equitable approach to service delivery across the province. While consistency in accessing care is needed, our approach must also reflect the tenets of equity by allowing for flexibility and local variations, including cultural, linguistic and geographic needs. As we focus on making improvements to long-term care placement in alignment with regulations and needs for all communities across the province, we also acknowledge the importance of consulting with patients, families and caregivers from Indigenous communities, and that this process may trigger trauma from past experiences. We will continue to have conversations and explore options with Indigenous communities to gain a better understanding of their needs and experiences, including Trauma-Informed Care, so we can better serve these communities, including Indigenous patients, families and caregivers seeking long-term care placement and hospice care.

"If there is a stronger partnership between my various care providers across the system, I think that would make a difference for family caregivers, knowing that they are partners. The relationship between providers needs improvement to feel like it is a team approach."

– Community Advisor, Primary Care Focus Group (March 31, 2023)

Home and community care services modernization also involves refining and reviewing our processes, so that patients can access the same high-quality care, services and equipment wherever they call home. This includes making improvements in our patient intake process so that we offer a consistent patient, family, caregiver and partners experience through our service, communication and information. This is accomplished by offering a single-entry point and phone number that will help navigate patients to the appropriate provider, service or Ontario Health Team. We have heard from our partners and patients that the journey from hospital to home needs improvement, and we will

continue to explore ways to streamline this process so that patients don't experience gaps during the handoff between health care providers.

We are streamlining and standardizing processes related to ordering and delivery of medical equipment and supplies. Through a modernized approach, home and community care patients across Ontario will have access to the high-quality medical equipment and supplies they need, regardless of where they live. Ordered through a provincial formulary, all the products will have been reviewed by a team of clinicians to ensure quality, safety and performance standards are met, resulting in better patient outcomes. A stronger, more robust supply chain will also reduce or eliminate avoidable delays, so that patients and families can rely on their medical equipment and supplies to arrive on time.

We recognize the effort to amalgamate 14 Home and Community Care Support Services agencies into Ontario Health atHome and we will build on the work that started in 2023-24 to ensure consistency in service delivery across the province to successfully transition to a single service organization, and the while ensuring continued excellent care for the patients we serve.

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

- Transition resources, functions and responsibilities of Home and Community Care Support Services agencies to Ontario Health atHome, ensuring continuity of care.
- Implement improvements in long-term care home placement in alignment with the Ministry of Long-Term Care direction.
- Support new models of care delivery enabled by the new legislative framework and regulations that came into effect in 2022, in collaboration with the Ministry of Health and Ontario Health, including updating service provider organization selection process and contracts.

"More coordination and collaboration among different health care providers is required and there has to be a point person to help you navigate through all these resources especially when you are stuck at home."

– Community Advisor, Care Coordination Focus Group (Oct. 20, 2023)

We will undertake the following strategic initiatives:

1. **Develop and implement a transition plan to consolidate 14 agencies into Ontario Health atHome.**
   In 2024-25, transition and transformation efforts will continue to establish Ontario Health atHome while maintaining patient care operations and ensuring no disruption to care or service delivery. The 14 Home and Community Care Support Services organizations each have unique policies, processes and systems that will need to be consolidated and standardized to effectively support operations. We will continue to work with the Ministry of Health, Ontario Health and the Ministry of Long-Term Care to design and implement the scope, services and structure to operationalize and achieve the future state and vision for Ontario Health atHome.

2. **Develop and implement a service model and change plan for the new service organization - Ontario Health atHome.**
   Establishing Ontario Health atHome as a single service organization providing services to patients and supporting the provision of home care by Ontario Health Teams will involve engaging with partners across the health care system to shape a service model and institute an operating structure that aligns seamlessly with the service model. This initiative aims to enhance the ability of the service organization to support Ontario Health Teams and stakeholders, including primary care providers, fostering the modernization of the health care system. As part of this initiative, we will develop a client relationship management

service model and a service catalogue for Ontario Health atHome that support health system partners in delivering exceptional care to patients including through care coordination and back-office supports.

3. **Support and implement innovative service models in collaboration with Ontario Health Teams and other health care system partners including Leading Projects.**
   By working with Ontario Health Teams and other health care system partners, we will support and implement innovative service models to better serve patients, families and caregivers. We will continue to engage as an active partner in Leading Project planning in three key areas: service provider organization selection and contracting care services; CHRIS access, privacy and information management; and care coordination. We have developed internal processes and mechanisms to ensure that all Ontario Health Team requests are supported.

4. **Continue to streamline key processes, including: wait list management and service guidelines, hospital discharge, intake, information/ referral, and navigation across the province in collaboration with system partners.**
   With the consolidation of 14 Home and Community Care Support Services organizations into a single organization, we will leverage best practices to ensure greater consistency in processes and service planning guidelines to provide equitable access to care for all Ontarians. This includes:
   - Creating a provincial Adult Personal Support Service Eligibility, Care Planning and Waitlisting Framework. By standardizing our waitlisting framework, we will ensure that the process is consistent for all adult personal support service and eligibility guidelines is unified across the province, ensuring the same access to care for all Ontarians waiting to receive these services.
   - Streamlining the hospital discharge process across the province to leverage best practices and create a smooth transition from hospital to home, ensuring timely access to home care services for patients ready for discharge. The goals include: increasing the percentage of patients receiving nursing home care within 5 days of discharge; enhancing access for complex patients to Personal Support Services within the same timeframe; and engaging the care coordinator within 48 hours of referral receipt.
   - Standardizing the intake, information and referral/navigation processes across the province for newly referred patients from the community and integrating these processes with Ontario Health Teams to improve the patient experience, ensuring that it meets our commitment to equity, inclusion, diversity and anti-racism.

5. **Develop and implement a streamlined long-term care placement process including the completion of the online application implementation for placement.**
   To drive provincial equity of access and consistency in practice, we will identify key principles for placement practices, implement consistent policies and procedures and key quality improvement initiatives across the province. Also, some families and patients have shared with us that applying online would streamline the application process to long-term care homes. Based on this feedback, in 2023-24 we developed an online process that offers improved access while also safeguarding patient privacy. For those who do not have proficiency or access to technology, we will continue to offer a paper-based application process. In 2024-25, we will automate additional aspects, forms and add new functionalities to further improve access.

6. **Continue to implement a provincial Medical Equipment and Supplies structure to support a service provider contract modernization plan.**
   By reviewing every aspect of our current system and implementing a modernized structure, we will continue to ensure medical equipment and supplies are ordered and arrive on time

– increasing efficiency to our processes that improve the experience for patients and partners. As part of this multi-year initiative, all medical equipment and supplies available through a provincial formulary have been reviewed by a team of clinicians to ensure quality, safety and performance standards are met, resulting in better health outcomes. Through this initiative, provincial buying power will be leveraged to generate savings that can be reinvested into improving direct patient care.
As the work evolves, we will establish indicators aligned with the five new provincial contracts that will be implemented from a system and aligned process perspective. Policies associated with the medical equipment and supplies will be updated and revised to ensure a standardized approach across the province.

What does this mean for patients?

Meet Minnie*

Minnie's health has been declining for several years. Home and Community Care Support Services visits have helped Minnie, who lives alone, manage her chronic conditions and dementia. However, when walking to the mailbox in only slippers and a bathrobe on a cold day in February, Minnie took a bad fall breaking her hip. Minnie has been in hospital for a few weeks now with new health complications and much frailer overall health.

Her two children, who live in different parts of the province, have visited but aren't able to remain with Minnie. After speaking with her care coordinator, who assessed Minnie's health, they feel it's time to start the process of applying to long-term care.

Minnie would like to go to a long-term care home on Manitoulin Island, where she lives. Her children would also like her to live closer to them. With the help of her care coordinator, they were able to work together to choose a number of homes based on Minnie's preferences using a new long-term care online application form, which made it easier as they live in different communities. While they may disagree on where Minnie should live (they all want their mother to live closer to them), her children agree that the most important thing is that Minnie get out of the hospital as soon as possible, as she no longer needs acute care, and into a long-term care home, where she can feel at home and get back to some of the activities she enjoys. It also helped to have her care coordinator talk to them about wait times at each of the homes and other factors to consider like her cultural needs.

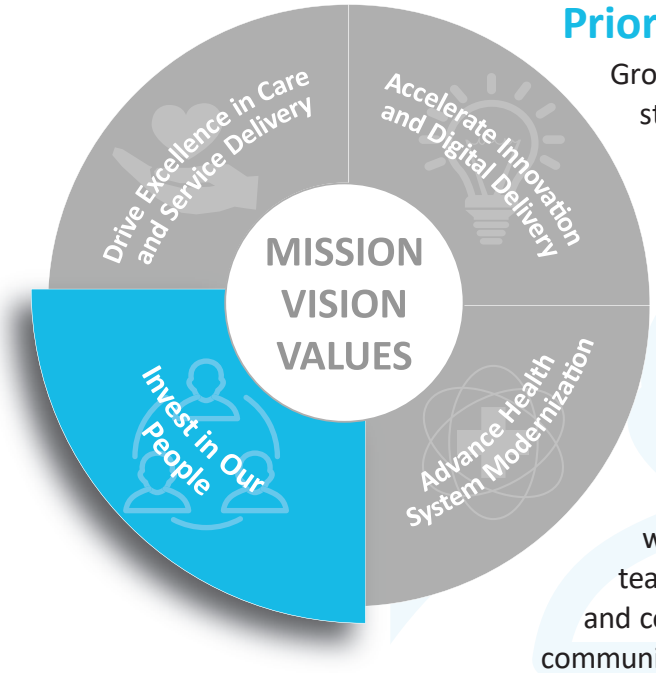
* Minnie is a composite of patients we have heard from, and her story illustrates how modernized, online application forms are helping patients and families navigate the process of applying to long-term care.

How will we know we are making a difference?

We will measure the percentage of patients who receive nursing care within five days of patient's available date and the percentage of complex patients who receive personal support services within five days of patient's available date to ensure a seamless transition from hospital to home. Additionally, we will continue to measure the number of days to complete initial intake eligibility assessment and make improvements where possible to reduce the number of days waiting. Given the importance of medical equipment and supplies for home care patients, we continue to monitor the proportion of deliveries that are regularly scheduled and successfully completed, as well as identifying deliveries that need to be expedited.

To evaluate the implementation of our service model and our ability to be client focused, we will introduce metrics to measure the client relationships, client experience, brand awareness and service response levels.

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



Priority 4: Invest in our People

Grounded in our mission, vision and values, and guided by our strategic priority to invest in our people, the People Strategy is our road map, shaping the way we lead, engage and develop our people to enhance the organization. Together, we have embarked on this journey so our people may lead and learn, partner and connect, care and be cared for. Our people are our greatest asset and together we are helping everyone to be healthier at home through connected, accessible, patient centered care.

Our People Strategy was in part born out of a need to stabilize our Home and Community Care Support Services workforce in a rapidly changing health care environment. Our teams are in the community every day, working with patients and connecting with our partners, to achieve one goal: a healthier community for all.

The 651,850+ people served by Home and Community Care Support Services last year received care that would not have happened without our people – from the care coordinator who met them in hospital, to the team assistant/patient care assistant who ordered their medical supplies, to the information technology professional who solved a network connectivity issue. Guided by our organizational values of collaboration, respect, integrity and excellence, we are helping each of our exceptional employees unlock their full potential by focusing on four pillars. Within each pillar, we have made significant strides forward in the second year of implementing our People Strategy:

"I wish to express my sincere and genuine appreciation to the staff and nurses who assist us through Home and Community Care Support Services. Without their help – their listening and hearing our concerns, and providing suggestions that are sometimes not services included under their umbrella of care – we would all be lost. Thank you all for everything you do!"

- Community Advisor, Primary Care Focus Group (March 31, 2023)

We are creating a work environment that promotes wellness and that is safe, positive and healthy. This will empower us to be our best selves, do our best work and deliver the best possible patient experience.

We are committed to providing a safe and healthy workplace for our staff, paving the way to creating consistent practices and policies that help us reduce risks and hazards that could result in any form of employee injury and illness and accompanying lost time. After an extensive review of existing health and safety policies, programs and best practices, we have implemented four new provincial occupational health and safety policies and procedures with the upcoming launch of additional harmonized policies and procedures in the coming months. We have harmonized the Employee and Family Assistance Program provider and package of services across Home and Community Care Support Services, ensuring that all employees have equitable access to this wellbeing support.

We are establishing a high-performance mindset and culture of mutual respect and kindness. High performing teams produce great results, and developing a culture where everyone is empowered to share their expertise and make decisions will help us achieve our goals. With the right resources in place, we can empower our teams to be more creative and focus on doing important work with the greatest impact. To advance organizational design, roles within each portfolio have been aligned with the new organizational structure and will continue to evolve as we transition to Ontario Health atHome. This ensures strong leadership, flexibility and an effective and efficient organization through which our teams are supported and are able to perform to the best of their abilities to deliver exceptional patient care.

A new harmonized provincial non-union compensation system has been implemented that is pay equity compliant. A provincial job evaluation committee has also been established to maintain and administer the system.

Work towards implementing a common benefits carrier and a harmonized non-union benefits plan is well underway. Alignment under one benefits broker and carrier along with harmonization of the non-union benefits plan is an important step in achieving a consistent total compensation offering across the province for all non-union staff.

"Reducing staff turnover and increase staff retention is key so that loved ones do not have to go without care."

– Community Advisor, Caregiver Wellbeing Focus Group (Aug. 24, 2023)

We've also introduced a new multi-faceted Employee Recognition program. Anchored in our values, the Share the L.O.V.E. (Living Our Values Everyday) program is accessible to all staff and leaders. The program has had a positive impact in building a workplace culture of recognition. A number of tools and resources have been created to support staff and leaders in recognizing their colleagues.

A standardized Performance and Development Program was launched for leadership and non-union employees. This includes an updated policy and standardized plan to support the development of individual performance/developmental goals, tracking and assessment of ongoing progression and identification of supports and developmental opportunities.

As the health care system continues to evolve at a rapid pace, we need to be ready to meet the needs of patients now and in the future. Being an employer of choice that attracts, develops and retains top talent will enable us to be agile, innovative and responsive to the health care needs of the communities we serve. We have developed a new standardized way for staff across the province to request learning and development opportunities, so as to build and improve skills and capabilities, as well as support professional growth. This will form the basis for measuring and evaluating learning and development activities.

To build leadership capacity, we've pursued several initiatives including undertaking the LEADS in A Caring Environment Leadership Capabilities Framework and launching the Harvard ManageMentor, a digital learning platform to support new leaders and to promote leadership development as we work towards transition.

Monitoring the overall health of our workforce is needed to support retention and attraction of top talent. An exit interview project, currently underway, is part of this work. In addition, through the establishment of workforce health metrics, a Human Resources Dashboard has been created and a strategy is under development to positively influence performance.

Home and Community Care Support Services is committed to furthering initiatives to support equity, inclusion, diversity and anti-racism (EIDAR). We are building a culture of inclusion and belonging that will culminate in improved service delivery for under-represented groups.

We have made progress in creating a safe, inclusive work environment. Following a rigorous recruitment and selection process across the province, the new leader for EIDAR has been on-boarded. This role is responsible for developing and operationalizing our organizational EIDAR strategy and supporting the provision of education, guidance and support in the advancement of EIDAR both internally and externally. Home and Community Care Support Services has achieved a monumental milestone, launching mandatory 2SLGBTQIA+ and gender diversity training for all staff, aligned with our enhanced intake process and the inclusion of patient pronoun fields in CHRIS. This training aims to help our staff deliver safe, respectful care to 2SLGBTQIA+ patients and caregivers.

Internal campaigns were launched to recognize and celebrate Indigenous History Month, National Day for Truth and Reconciliation, Pride Month and Black History Month. As part of our EIDAR work, we acknowledge the need for enhanced training and education around Indigenous and Black communities and population health needs. Home and Community Care Support Services continues to actively encourage staff to strengthen their knowledge, awareness and skills for working with and providing service to Indigenous people and communities through educational programs such as the San'Yas Anti-Racism Indigenous Cultural Safety Training Program. We will continue cultural safety training and exploring options for Trauma-Informed Care for our front-line staff.

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

Positioning us for the future

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

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

The People Strategy 2023/24 has positioned Home and Community Care Support Services well to continue to deliver on its strategic priority to invest in its people and we will continue to focus on our four pillars:

1. **Equity, Inclusion, Diversity and Anti-Racism (EIDAR): Advance a culture of equity, inclusion, diversity and anti-racism and work to eliminate systemic barriers to under-represented racialized groups.**
   In 2024-25 and beyond, we will prioritize foundational EIDAR actions that will promote the sustainability of our efforts, including:
   - Support the weaving of EIDAR into strategy and engagement.
   - Establish practices and policies to guide behaviors to support and align with our EIDAR commitment.
   - Establish a fundamental level of EIDAR knowledge across our organization.
   - Develop an approach to measure EIDAR progress moving forward.

2. **Employee Wellness, Wellbeing and Health and Safety Programming: Create a positive, healthy and engaged workforce that supports people to care for themselves and each other.**
   This will include encouraging and supporting the development of staff-led wellness committees. There will also be continued development of a provincial occupational health and safety program.

3. **Build an Effective Team Culture: Lay the foundation to establish a high-performance mindset and culture of mutual respect and kindness.**
   The Employee Engagement Survey delivered in the 2023-24 fiscal year will yield valuable insights and feedback to form an actionable plan. There will be continued work on organizational design as we transition to Ontario Health atHome.

4. **Provide Rewarding Careers: Recognize the incredible work of our talented team, stabilize our workforce, and attract, develop and retain exceptional people.**
   An Organizational Development Centre of Excellence will be established to support organizational design, change management and advance employee and leadership learning and development. There will be further purposeful planning to monitor, report and action performance on key workforce metrics.
   With a renewed focus on attracting and retaining staff, Home and Community Care Support Services will have the best team in place to support health system modernization and prepare to transition to Ontario Health atHome. With organizational and system change in view, we are equipping and empowering our leaders to lead the change, and our staff to participate and have a voice in the change. Change management strategies, development opportunities, as well as communications and engagement strategies and supports are planned as we prepare for the upcoming organizational transition and transformation.

   Underpinning our People Strategy is a commitment to ensure that our people are positioned to be where they are needed most. We will carefully align to Ontario Public Service human resources and accommodation strategies while doing our work.

What does this mean for patients?

Meet Denis*

Denis, a young Francophone, was recently diagnosed with bowel cancer. His level of anxiety felt very high, with many fears about his new diagnosis, compounded by feeling anxious about his recent move to Ontario and his struggles with communicating in English. Following surgery to remove a tumor and the insertion of a colostomy bag, Denis required short-term nursing care.

When a Home and Community Care Support Services care coordinator called Denis to schedule his care, Denis was pleasantly surprised to find that the care coordinator not only actively offered services in French, but asked him his preferred pronouns. As an ally and advocate for the 2SLGBTQIA+ community, Denis immediately felt at ease that the care coordinator had created an inclusive, open and caring environment for him. Throughout his care journey, he received his nursing services in French, which alleviated much of his anxiety. He understood his care plan and was able to express his symptoms and concerns in his first language. Feeling safe, respected and valued as a person, this allowed Denis to actively participate in his care.

Denis' care coordinator had recently received active offer training as well as gender diversity training, with a focus on the importance of pronouns. She also had access to a variety of resources and supports to further develop the skills required to incorporate her learnings into her daily practice.

Supporting staff through education and development opportunities ensures everyone has the required skills and knowledge to excel in their role thus improving their ability to provide safe, inclusive, connected, patient-centred care. Through our efforts to increase equity, inclusion, diversity, and anti-racism (EIDAR) education and awareness, we are contributing to better health outcomes for patients, families and caregivers, and a healthier work environment for staff.

* Denis is a composite of patients we have heard from, and his story illustrates how investing staff training is helping patients receive inclusive, person-centred care.

How will we know that we are making a difference?

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

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

PERFORMANCE MEASUREMENT

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

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

To ensure our areas of successes and improvements are measured, we will continue to report on:

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

(Chart on next page.)

Improvement Direction Arrows:

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

Strategic Priorities and Performance Measurement

Drive excellence in care and service delivery

Indicator	Baseline	Target	Improvement Direction
Caregiver distress – Percentage of long-stay patients whose caregiver has indicated experiencing caregiver distress, broken out by adult long-stay patient populations (community independence, chronic and complex).	FY 23/24 YTD Complex: 72.5% Chronic: 41% Community Independence: 16.5%	Complex: 72.5% Chronic: 41% Community Independence: 16.5%	↓
Service Waitlists – The total volume of waitlists for all services (full or partial) that patients are waiting for.	FY 23/24 Q2 (Snapshot) 15,638	Monitor Results	↓
Missed care – Measures the incidence of care that is not provided in accordance with the patient care plan because a visit is missed or the service provider organization does not have the capacity to deliver the care, broken out by service type (nursing visits, nursing shift, personal support hours and therapy visits).	FY 23/24 – Q2 Visit Nursing: 0.042% Shift Nursing: 0.739% PSS: 0.443% Rehab: 0.108%	0.05%	↓
Patient and Caregiver Experience Survey – Home and Community Care Support Services is currently going through a procurement process to develop a provincial approach for assessing patient and caregiver experience.	Pending	Establish Baseline	To be determined

Accelerate Innovation and Digital Delivery

Indicator	Baseline	Target	Improvement Direction
Telehomecare Visits – Percentage of patients with Chronic Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) that receive care through Telehomecare programs (monthly).	Pending	Establish Baseline	↑
Wound Care – Home and Community Care Support Services is considering procurement of a provincial digital solution to monitor and improve wound care outcomes for patients with the use of technology.	Pending	Establish Baseline	To be determined

Advance Health System Modernization			
Indicator	**Baseline**	**Target**	**Improvement Direction**
5 day wait time - personal support for complex patients – Percentage of adult complex patients who receive their first personal support service within 5 days of patient's available date.	FY 23/24 YTD (Avg) 80.9%	95%	↑
5 day wait time - nursing visits – Percentage of adult patients who receive their first nursing visit within 5 days of patient's available date.	FY 23/24 YTD (Avg) 91.7%	95%	↑
Community crisis applications waiting for long - term care home (LTCH) placement – Number of community applications on the LTCH placement wait list within priority 1 category (crisis) and living in the community as of the end of the month.	FY 23/24 YTD (Avg) 2,762 Oct: 2,999 [4.6% of all applications to LTCH]	Monitor Results	↓
Volume of open Alternate Level of Care (ALC) cases related to LTCH placement – The number of patients waiting in an inpatient hospital bed who do not require the intensity of resources/ services provided in that care setting whose discharge is delayed due to lack of availability at an appropriate LTCH destination.	FY 23/24 YTD (Avg) 2,023 Oct: 2,252 [45.2% of all open ALC cases]	Monitor Results	↓
Volume of open ALC cases with a home discharge destination – The number of patients waiting in an inpatient hospital bed who do not require the intensity of resources/services provided in that care setting whose discharge is delayed due to lack of availability of resources/ services at their discharge destination.	FY 23/24 YTD (Avg) 488 Oct: 513 [10.3% of all open ALC cases]	500 or 10% of all open ALC cases	↓
Invest in Our People			
Indicator	**Baseline**	**Target**	**Improvement Direction**
Voluntary turnover – Percentage of employees who leave the organization voluntarily, either through retirement or resignation.	YTD 2023 10.6%	10.5% Year end target	↓
Employee engagement index – comprised of six questions from the Employee Engagement Survey.	March 2022 76%.	78%	↑

SUMMARY

Home and Community Care Support Services remains committed to responding to the ever-evolving requirements within the Ontario health care system to ensure we meet the needs of patients, families and caregivers. This plan outlines how we will work closely with our health care system partners, our community of advisors and staff to transition to Ontario Health atHome with a mandate to support Ontario Health Teams to deliver exceptional care to patients, families and caregivers, and transform home and community care.

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

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

APPENDIX: BY THE NUMBERS

Across Ontario, Home and Community Care Support Services supports 651,850+ home and community care patients annually. The services we provide are vital to patients across the province. They address the needs of people of all ages, including seniors, persons with physical disabilities and chronic diseases, children and others who require ongoing health and personal care to live safely and independently in the community. The patients we serve are some of the most vulnerable in the province.

Our organizations:

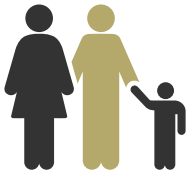
- Have a total funding allocation of $3.8B.
- Served 651,850+ patients in 2022-23.
- Directly employ 9,200+ staff positions.
- Purchase $2.7B services from over 150 service provider organizations via approximately 400 contracts (this includes services such as nursing and personal support as well as hospices and medical vendors).

In addition:

- *Each day*, there are 10,600+ care coordinator interactions, comprised of face-to-face, telephone and virtual connections.
- *Each day*, we operate 140 nursing clinics that receive more than 313,400+ visits per quarter (three month period).
- *Each day*, there are more than 27,490+ nursing visits, 4,200 therapy visits, and 100,570+ personal support worker (PSW) service hours delivered to patients across the province.
- *Each month*, care coordinators collectively have 344,560+ active patients on their caseload.
- *Each year*, through our services, approximately 28,750 people are placed in long-term care (LTC) homes.

OUR ORGANIZATIONS:

$3.8B Funding



651,850+ Patients

9,200+ Staff

$2.7B Services

IN ADDITION

Each day
27,490+ nursing visits
4,200+ therapy visits
100,570+ PSW service hours

Each day
140 nursing clinics

Each quarter
313,400+ patient visits to the clinics

Each Month
344,560+ patients

Each Year
approximately 28,750 LTC home placements

APPENDIX: RISK AND MITIGATION

This section outlines the key organizational risks facing Home and Community Care Support Services in delivering on our plan and the associated mitigation strategies. Over the course of the 2024-25 fiscal year, we will continue to develop appropriate province-wide frameworks and processes to effectively assess and monitor hazards we face to avoid any potential risk to the patients we serve and staff who care for those patients.

Risks Facing Home and Community Care Support Services	Existing Controls and Planned Mitigation Actions
Service provider organization partners' health human resource strain/pressures/challenges Health human resource shortages have disproportionally affected the home and community care sector. The COVID-19 recovery efforts and threat of other viruses such as influenza and respiratory syncytial virus (RSV) will increase the risk of further health human resource shortages across the health care system. The increased demand for home and community care services, the aging population and continued increased complexity of care required will add further strain to a health care system that is already facing capacity issues. The following statistics speak to the demographic shift that has begun and is predicted to continue: • There has been a 33% increase in new referrals from the community for our services since 2020, with more patients requiring supportive and complex care at home. • The number of people age 85 or older, counted as 861,000 (2021), has more than doubled since 2001 (Statistics Canada); • Over the next 25 years, the population aged 85 and older could triple to almost 2.5 million people making it one of the fastest growing age groups; and • Ontario's seniors' population is predicted to increase by 15 per cent in just the next five years.	In hard-to-serve areas, strategies will continue to be implemented to increase capacity and improve access to care for patients in those regions. We will continue, where appropriate, to increase the number of service provider organization contracts to try to increase capacity within the system. We will also continue to conduct provincial analyses that looks at capacity indicators such as waitlist volume per specialty (personal care, nursing, occupational therapy, etc.), missed care, percentage of service authorizations, initial service offer acceptance rate, and service offer time to completion to determine hard-to-serve areas across Ontario. We will also look to build new capacity through expansion and standardization of Family-Managed Home Care while exploring greater supports for caregivers. Other programs considered for further capacity building within the health care system include, eRehab and ED diversion to support more coordinated care closer to home, as well as increasing use of Telehomecare and virtual care, where appropriate. In addition, we will continue to increase our capacity through optimizing community clinics and neighbourhood models of care to improve our ability to coordinate patient care within local communities.

Risks Facing Home and Community Care Support Services	Existing Controls and Planned Mitigation Actions
Home and Community Care Support Services organizational change impacts to workforce and patient care Continuous evolution within the home and community care sector has led to change and transition fatigue, which continues to impact staff retention, organizational turnover rates and recruitment. This has led to challenges in attracting qualified staff. Transition to a single service organization (Ontario Health atHome) and taking on a new operating and service delivery model will be a significant endeavor for our staff as we continue to meet the needs of our health care system partners, while also maintaining patient care operations to ensure no disruption to the people we serve.	We plan to mitigate this risk by advancing the initiatives outlined in the People Strategy that focus on workforce stabilization, as well as prioritizing change management and supporting our staff through the transition to Ontario Health atHome. Specifically, our efforts to prioritize recruitment, development of a robust retention campaign and recognition of our staff through the development of an employee engagement action plan and ongoing change management strategies. We also plan to proactively assess staffing needs to effectively manage this change, with appropriate dedicated resources and structures in place for a successful and seamless transition to a single service organization not only for our staff but for the patients, families and caregivers we serve. Ongoing engagement with the Ministry of Health and Ontario Health Teams, as well as a robust engagement and communication plan, will be key in ensuring health system partner expectations are met throughout transition and beyond.
Ongoing risk of cyber security and privacy breaches in the health care industry Home and Community Care Support Services faces significant cyber security risks due to the sensitive nature of patient data and the increasing reliance on technology, digital health platforms and further integration of digital health systems.	To mitigate this risk, we continue to implement robust strategies and security controls across the province, continually strengthening existing processes for security monitoring, incident identification and management. We continue to enhance and support the growth and maturity of our Security Program concurrently promoting a cyber security awareness and training culture. We continue to work with our health care system partners to ensure that appropriate security controls and agreements are in place to allow for seamless and safe data sharing across integrated digital platforms.

APPENDIX: COMMUNICATIONS AND ENGAGEMENT PLAN

Communications and engagement activities will help us to accomplish the goals within our four strategic priorities, as well as support our transition to a single service organization (Ontario Health atHome) with a new role in the health care system. Dedication to our mission, vision and values, and a strong commitment to high-quality patient-centred care will guide our communications activities as we engage with diverse communities across the province and maintain our strong commitment to equity, inclusion, diversity and anti-racism in all that we do.

Additional and targeted engagement opportunities will support the development of a shared vision and service model for Ontario Health atHome. This work will be guided by an overarching engagement plan that channels innovative and transformative thinking from key audiences including internal staff, community advisors, Francophone, Indigenous and health system partners. This input will inform Ontario Health atHome's structure and operating model, enabling us to meet the needs of Ontario Health Teams and the patients and communities we collectively serve.

Our Partners

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

Communications Objectives

- Provide patients, families and caregivers with relevant and timely information about services from a trusted source.
- Raise awareness of our services and how to access them, while navigating "who we are" throughout our transition from 14 Home and Community Care Support Service organizations to one single service organization.
- Keep staff, patients, families, caregivers, service providers and other health care system partners informed as we transition from 14 organizations to one and transform into a single service organization that coordinates home care delivery for Ontario Health Teams.
- Focus on communicating continuity of care for all home care patients, families and caregivers throughout our transition, transformation and in general, the government's plan for home care modernization.
- Engage with patients, families, caregivers and populations with diverse needs to further integrate the patient experience and voice into organizational and transformational decision-making and through co-design, ensure all outcomes meet the specific needs of our communities.

- Build awareness and trusted relationships with all community members and partners, particularly patients, families, caregivers and priority or marginalized populations.
- Uphold our commitment to be open, transparent and accessible to the public on all Home and Community Care Support Services priorities and initiatives, while keeping our community engaged and informed about any changes to their home care delivery.
- Keep staff informed about new (or changed) programs, initiatives and policies/processes that impact their jobs or the delivery of patient care while promoting the consolidation of Home and Community Care Support Services into one single service organization.
- Develop and implement communications and change management strategies to support organizational programs and initiatives, our four strategic priorities and our transition to a single service organization.
- Engage and collaborate with the Ministry of Health, Ontario Health and Ontario Health Teams to produce and distribute consistent communications materials and messaging.
- Attract and recruit staff through our Employment Brand strategy, as well as support workforce stabilization.
- Develop and implement an effective process for the identification, assessment and mitigation of reputational risk.

Communications Tactics

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

- Streamlined and integrated communications efforts across Home and Community Care Support Services to deliver consistent and timely information.
- Customized communications plans to meet the needs of each project or initiative, including key messages, memos, promotional materials, media releases, engagement opportunities, etc.
- External promotion through various means, including news media, social media and advertising, as appropriate.
- Leverage digital and other new and innovative communications products and delivery methods to augment traditional communications.
- Strong media and external stakeholder relations.
- Continue to improve the online experience by continual improvement to an updated patient-centred website and engaging social media activity, while still maintaining traditional communications methods.
- An internal communications program that engages staff and builds a positive culture that reassures them of the value of their work now and in the future – resulting in high-quality patient care.
- Collaborate with other internal teams on change management planning that supports staff throughout our transition and transformation.
- Ensure a continued focus on equity, inclusion, diversity and anti-racism in all communications practices.
- Ongoing engagement opportunities with patients, families, caregivers, service providers and our diverse communities.

Engagement Plan

Community engagement provides a real-time connection between the people we serve and our organization. It is a two-way dialogue with patients, families and caregivers as they share how their experiences, suggestions and values can guide all facets of our work. This work purposefully invites people into our work while we are in the process of improving, discussing priorities and exploring options that yield insights gained only by seeing our services through the eyes of those who use them. By working with those we serve, unique improvement opportunities become visible, and it better positions our organization to offer programs and services that meet user needs and values. By doing this, we focus on patient experiences and outcomes by better understanding barriers and reducing assumptions.

In 2023-24, the focus of the Community Engagement Program was to build a foundation. This was accomplished by setting a guiding Framework, building a team, designing processes to support engagement opportunities and launching our Community of Advisors. This resulted in supporting over 37 unique engagement activities throughout the year with over 400 hours of volunteer participation from advisors.

Our Community Engagement Strategy builds on our foundation to bring in more voices into our work while continuing to focus on coaching our colleagues about the value that engagement can bring into their work. Guided by our Community Engagement Framework, this strategy sets our path to achieve the overall objective for our program "to positively shape exceptional patient-centred home and community care programs, services and policies through purposeful collaboration and partnership between patients, families, caregivers and staff."

As we move forward, our Community Engagement Strategy is focused on achieving two key strategic objectives:

Expand the range of program areas we support:

- Continue to coach and support staff on individual engagement opportunities.
- Build the Home and Community Care Support Services Priorities Advisors Panel.
- Offer drop-in sessions to staff to overview core concepts.

Expand our roster of advisors:

- Work with patient-facing staff to connect with potential advisors.
- Provide ongoing stewardship.
- Set up opportunities for ongoing networking and recognition.

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

The 2024-25 fiscal year will bring a renewed focus on developing lasting relationships with Indigenous leaders and communities as we set out to build our self-awareness and connection with Indigenous peoples. We will focus on listening, learning and building trust over the coming year to ensure we better understand the unique challenges faced by Indigenous communities and work towards greater support of their needs. We will also continue to engage Francophone communities to better understand and address their unique needs and challenges receiving active offer of care in their first language throughout their patient journey.

APPENDIX: FINANCIALS

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

	2023/24 Estimated Actual	2024/25 Ministry Allocation	2024/25 Planned Expenses[1]
Allocation: Home Care/LHIN Delivered Services[2]			
Salaries (Worked hours + Benefit hours cost)	$572,065,731	$562,848,306	$562,848,306
Benefit Contributions	$161,099,515	$161,769,373	$161,769,373
Med/Surgical Supplies & Drugs	$176,143,924	$176,143,924	$176,143,924
Supplies & Sundry Expenses	$16,010,723	$16,010,723	$16,010,723
Equipment Expenses	$29,508,872	$29,508,872	$29,508,872
Amortization on Major Equip, Software License & Fees	$178,449	$26,675	$26,675
Contracted Out Expense	$2,726,731,254	$2,691,773,306	$2,691,773,306
Buildings & Grounds Expenses	$372,300	$372,300	$372,300
Building Amortization	$0	$0	$0
TOTAL: Home Care	**$3,682,110,769**	**$3,638,453,478**	**$3,638,453,478**
Aggregated HCCSS Operations[3]			
Salaries (Worked hours + Benefit hours cost)	$76,687,217	$73,708,964	$73,708,964
Benefit Contributions	$20,896,081	$20,554,153	$20,554,153
Med/Surgical Supplies & Drugs	$0	$0	$0
Supplies & Sundry Expenses	$18,261,052	$18,161,152	$18,161,152
Equipment Expenses	$11,897,368	$11,897,368	$11,897,368
Amortization on Major Equip, Software License & Fees	$625,331	$587,828	$587,828
Contracted Out Expense	$1,043,357	$1,043,357	$1,043,357
Buildings & Grounds Expenses	$26,447,684	$25,647,584	$25,647,584
Building Amortization	$576,813	$576,813	$576,813
TOTAL: Integrated Administration/Governance	**$156,434,902**	**$152,177,219**	**$152,177,219**
TOTAL: Home and Community Care Support Services spending plan	**$3,838,545,671**	**$3,790,630,697**	**$3,790,630,697**

Notes:

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

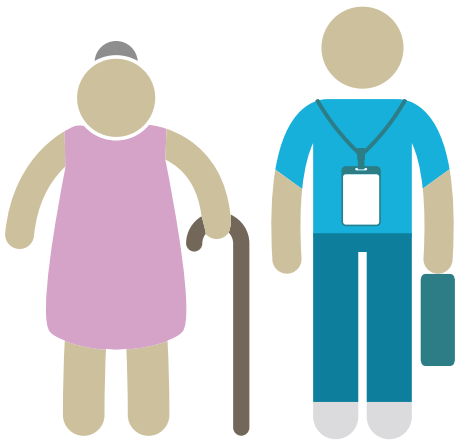
APPENDIX: HEALTH HUMAN RESOURCES

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

In addition, our staffing is comprised of both non-union and union employees, who are represented under 26 unique collective agreements across the province. There are five bargaining agents that represent these employees including Ontario Nurses' Association (ONA), Canadian Union of Public Employees (CUPE), Ontario Public Service Employees Union (OPSEU), Canadian Office and Professional Employees (COPE) and UNIFOR.

We want to support our staff with growth and development opportunities as we continue to navigate change and transition to a single service organization. Our People Strategy is our roadmap to ensure we stay focused on meeting the immediate and long-term requirements of staff as we transition to Ontario Health atHome. Some of the priorities of the plan include:

- Redesigning and implementing an organizational structure that allows us to function effectively as one provincial team and a new single service organization;
- Renewing our focus on attracting and retaining a talented workforce;
- Implementing an Organizational Development Strategy to ensure staff and change management support through transition;
- Strong focus on labour relations as the Public Sector Labour Relations Transitions Act is enacted for transition;
- Integrating Home and Community Care Support Services staff with Ontario Health Teams to promote the success of new integrated team-based care models;
- Fostering and advancing a culture of equity, diversity, inclusion and anti-racism;
- Creating engagement opportunities for our staff; and
- Supporting education and growth opportunities.



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

Consolidated Staffing Plan – Full-Time Equivalents[1] (FTE)

	2023/24 Actual	2024/25 Forecast
Home Care[2]		
Management and Operational Support (MOS) FTE	1,916.3	1,797.5
Unit Producing Personnel (UPP) FTE	4,710.4	4,455.5
Nurse Practitioner (NP) FTE	126.5	130.1
Physician FTE	0.00	0.00
Total Home Care FTE	**6,753.2**	**6,383.2**
Regional Coordination Operations[3]		
MOS FTE	369.2	369.2
UPP FTE	475.6	475.6
NP FTE	0.00	0.00
Physician FTE	0.1	0.1
Total Integrated Administration/Governance FTE	**844.9**	**844.9**
TOTAL FTE SUMMARY	**7,598.1**	**7,598.1**

Notes:

1. One FTE equals 1,950 hours per year and may be comprised of multiple staff.
2. Home Care/LHIN Delivered Services include direct services as defined in Schedule 7, Table 1 of the 2015-18 Accountability Agreement between the Minister of Health and the LHINs operating as Home and Community Care Support Services.
3. Integrated Administration/Governance includes indirect costs such as administration and overhead expenses.

APPENDIX: ACRONYMS USED

ACRONYM	MEANING
ALC	Alternate Level of Care
CHRIS	Client Health and Related Information System
COPD	Chronic Obstructive Pulmonary Disease
COPE	Canadian Office and Professional Employees
CUPE	Canadian Union of Public Employees
ED	Emergency Department
EIDAR	Equity, inclusion, diversity and anti-racism
HIROC	Healthcare Insurance Reciprocal of Canada
LHIN	Local Health Integration Network
LTCH	Long-term care home
ONA	Ontario Nurses Association
OPSEU	Ontario Public Service Employees Union
PSW	Personal support worker
RSV	Respiratory Syncytial Virus