HOME AND COMMUNITY CARE SUPPORT SERVICES

Business Plan

| 2022-23

Ontario

CONTENTS

Message from the Board **3**
Message from the CEO **4**
Introduction **5**
Our Partners 6
Listening to the People We Serve 6
Environmental Scan 7
Pandemic Response 7
Equity, Inclusion, Diversity and Anti-Racism 8
Business Plan at a Glance **9**
Our Engagement Approach 9
Strategic Priorities **10**
Drive Excellence in Care and Service Delivery 10
Accelerate Innovation and Digital Delivery 11
Advance Health System Modernization 12
Invest in our People 13
Performance Measurement **14**
Summary **16**
Appendix: By The Numbers **17**
Appendix: Risk and Mitigation Section **19**
Appendix: Communications & Engagement Plan **21**
Appendix: Financials **23**
Appendix: Health Human Resources **25**
Appendix: Acronyms Used **27**

MESSAGE FROM THE BOARD

On behalf of the Home and Community Care Support Services Board of Directors, it is my pleasure to present our 2022-2023 Business Plan, detailing how we will continue on the journey outlined in our 2021-2022 plan. Ensuring the highest quality care for the patients, families and caregivers we serve across the province remains our top priority, and to that end, this plan outlines what we will do to fulfil our critical mandate, while continuing to ensure equity, efficiency, transparency, effectiveness and value for money for patients and taxpayers in all that we do.

Key to achieving our goals will be working with all partners to ensure patients receive the services they need, where and when they need them, as we support the ongoing work of transforming home and community care services in Ontario. We will also be working with partners to consider and implement long-term care placement improvements and a future placement model. Our 14 organizations began functioning as one in July 2021, and since that time, we have made major strides in operating as a cohesive province-wide unit, preparing to integrate care within Ontario Health Teams and positioning to work with partners to provide unified and equitable care across the province.

The Minister of Health has given us an important system role—to work with partners to increase network collaboration, to improve patient access to care, to facilitate the successful integration of home and community care within the broader health care system and to innovate and improve service while being both vigilant and accountable with respect to spending.

To help guide us in the work ahead, Home and Community Care Support Services will continue following our Strategic Priorities, which are 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

Since delivering our last plan, we have made advances in each of these priorities, and as we continue to work to fulfil our important mandate, we will collaborate with health and service providers, including long-term care, hospitals and primary care, to build a more connected health care system that is integrated, seamless, affordable and sustainable.

We also highlight how we will improve access to care, making it more patient and family-centred, while improving health outcomes through enhanced care coordination and models of care that build on provincial learnings and best practices. We will ensure that everything we do is grounded in the principles of equity, inclusion, diversity and anti-racism. This plan also outlines our approach to measuring our performance and driving accountability during the 2022-23 timeframe. We look forward to the work ahead as we continue this exciting journey to provide exceptional care, wherever people call home.

Joe Parker
Board Chair,
Home and Community Care Support Services

MESSAGE FROM THE CEO

As the recently appointed CEO of Home and Community Care Support Services, it was my privilege to join the organizations at a time when home and community care is being modernized in Ontario and the long-term care placement process is being improved. Within these pages are our plans to ensure exceptional care, regardless of where you live in our geographically diverse province, and whether you reside in your own home, in long-term care or somewhere else in the community.

Health care is a service centred on people, and Ontario is home to a richly diverse population with many different needs and from a range of cultural backgrounds. For this reason, Home and Community Care Support Services are dedicated to ensuring the care we deliver is culturally safe and appropriate, that our workplace is open and inclusive, and that our workforce is responsive to and reflective of the population it serves, and supported by a strong equity, inclusion, diversity and anti-racism plan.

To ensure we met these aims, we engaged broadly in developing this plan. We spoke with our health care and service provider partners, as well as with our own staff—and their vast wealth of knowledge and expertise is visible on every page. Ultimately, though, this is a plan by and for the people of Ontario—it reflects the voices of the many patients, families and caregivers we engaged with from across the province in creating it, and patient and family co-design will also drive how we execute upon it, ensuring the patient voice continues to be incorporated in everything we do.

Our workforce has been and continues to be pivotal in the health care system. Our people strategy is designed to support our staff through growth, education and wellness opportunities so that they can achieve their full potential at the same time as they continue to support the system in its response to the COVID-19 pandemic and beyond.

We look forward to the work ahead as we continue this exciting journey to provide exceptional care, wherever people call home. This plan positions us well to both deal with the current realities and work towards a future where patients, families, caregivers, staff and providers feel valued as partners in home and community care. It is my pleasure to share it with you.

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

INTRODUCTION

WHO WE ARE

We help patients, families and caregivers when they need services, support and guidance to:


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


Leave the hospital and recover at home


Avoid visiting the emergency department, when possible


Die with dignity, in the setting of their choice


Find a family doctor or nurse practitioner


Find community services that support healthy, independent living


Transition to long-term care or supportive housing

On July 1, 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, with one Board of Directors and one CEO, funded and legislated by the Ministry of Health to deliver patient care services for their local communities. We actively support approximately 400,000 patients every month, many of whom are vulnerable and at-risk, have complex health conditions, and experience challenges accessing system resources. Acting as unified organizations, we will continue to work closely with Ontario Health, the Ministry of Health, the Ministry of Long-Term Care and other health care system partners. Together, we will 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 are actively working with Ontario Health Teams to improve patient experience and outcomes.

This Business Plan has been informed by the Quadruple Aim, an internationally-recognized framework for excellence in health care service delivery that will continue to inform our future decision-making. The four pillars of the Quadruple Aim and the foundation for this plan are:

1. **Enhancing patient experience**
2. **Improving population health**
3. **Enhancing provider experience**
4. **Improving value**

Our Partners

Across the province, Home and Community Care Support Services collaborates with a vast number of partners that are necessary for 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

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

Service Provider Organizations

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

Listening to the People We Serve

Ensuring the voices of those we serve are heard and reflected in our work is absolutely essential to Home and Community Care Support Services as patient-centred organizations. In embarking on the development of this Plan, we took the time to engage as broadly as possible, seeking input from patients, family members, caregivers and the organizations that represent them—including Francophone and Indigenous populations—through a combination of focus group sessions and surveys so that our plan is inclusive of a wide range of voices.

Meaningful engagement means not just listening to what people have to say, but taking the time to truly understand it; to probe for clarity when needed and to provide an opportunity for dialogue. Our consultation process was a two-way conversation that led us, over the course of many weeks, to develop and refine our Strategic Priorities and implementation plans.

We are grateful to the many people who participated in the process for their invaluable input. And, of course, our engagement will not end here. Community and partner engagement will continue to be a key component of our work as we move forward. We are in the process of creating an ongoing patient and family and caregiver engagement framework that will guide us in actively engaging in the co-design of our work, ensuring that we always continue to listen to—and truly understand—the voices of those we serve.

Environmental Scan

Our health care system has undergone tremendous change in the last few years. Digital health has become a key enabler in our system, improving connectivity through better integration of electronic health records for patients, families and caregivers, augmented by ongoing improvements in digital health platforms and virtual care. At the same time as these improvements are being made, the system is facing other challenges, including a shortage of health human resources which is affecting all areas of health care delivery, including home and community care. Shortages in health human resources paired with physical infrastructure shortages, such as beds in hospitals and long-term care, and an aging demographic with more diverse and complex needs, have increased demands for home and community care. With the ongoing health care system transformation, staff within home and community care services have experienced change fatigue, resulting in significant attrition risk for the sector.

Furthermore, the COVID-19 pandemic has exacerbated a shortage of health human resources throughout the province's health care system and increased the demand for home and community care services. Other factors such as reduced long-term care and respite capacity are placing significant pressure on home and community care resources to meet the needs of patients' in-home services. The pandemic and ongoing system pressures have also had considerable impact on caregiver distress as patients move from the hospital to the community.

Pandemic Response

Throughout the COVID-19 pandemic, Home and Community Care Support Services continued to provide consistent, high-quality home and community care, while also playing a key role in supporting the health care system's response to the pandemic. COVID-19 required us all to find ways to work and live differently, and Home and Community Care Support Services is no exception. Necessity led us to produce numerous innovations in how we deliver care, such as virtual care, which we continue to work with health care system partners to expand. The value of these and other innovations will be leveraged, both as the pandemic continues and in the future. And, as with the voices of the people we serve, the realities of the pandemic have also informed the development of this Plan.

During the earlier waves of the pandemic, demands for our services shifted. As the entire health care system pivoted to respond to the pandemic, some of our team members were redeployed to hospitals, long-term care homes and other community settings to help meet the increased demand for health human resources created by the pandemic. In addition, some home care teams provided outbreak response by conducting COVID-19 testing. A key focus for us during recent waves of the pandemic is on supporting vaccination efforts. Additionally, in partnership with primary care providers, we have continued to use unique in-home programs to support individuals with mild to moderate symptoms of COVID-19, preventing unnecessary hospitalization.

As we move forward, Home and Community Care Support Services will continue to help serve patients, families and caregivers in their homes, while also continuing to explore opportunities for innovation and in-home digital solutions, as well as ways to improve the long-term care placement process. The demand for home care is greater than ever and, in response, our home care teams across the province are actively reviewing service requests and looking for opportunities to:

- Support caregivers as they care for their loved ones
- Improve patient care experiences and outcomes
- Enhance care coordination response
- Closely monitor the availability of frontline home care providers
- Optimize the use of virtual care to provide care in the home setting

The people we serve remain our top priority, and we are focused on providing exceptional care, while maintaining stability and supporting efficient system flow.

Equity, Inclusion, Diversity and Anti-Racism

Home and Community Care Support Services recognizes that we contribute to better outcomes for patients, families and caregivers, and a healthier work environment for all people, when we build a culture that is grounded in a commitment to equity, inclusion, diversity, and anti-racism. This commitment starts by recognizing and addressing existing gaps and working to prevent them. We acknowledge that there are long-standing, systemic issues related to equity, inclusion, diversity, and racism in our system that must be addressed. We will work collaboratively to eliminate systemic barriers to under-represented, marginalized and racialized groups, and work towards a workforce that reflects the communities we serve, with the ultimate goal of optimizing patient, family and caregiver experiences and outcomes.

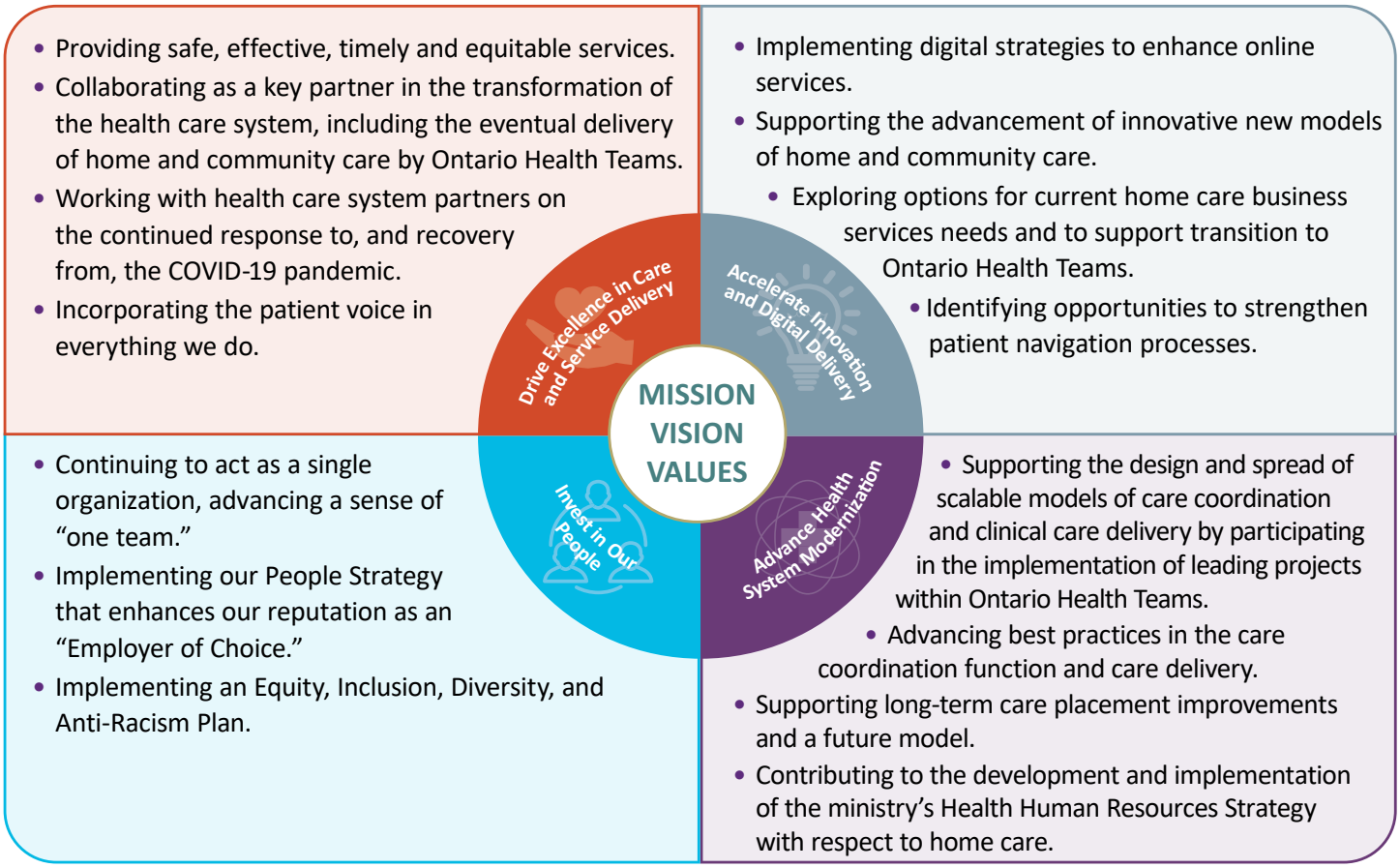
We will continue with the work of our provincial equity, inclusion, diversity, and anti-racism leadership group that is staff-led, supported by all levels of leadership, and actively informed by the patient voice through patient, family and caregiver representation. This provincial group will continue to work on implementing a plan that will:

- Leverage the work Home and Community Care Support Services has already begun by enabling the scale and spread of programs and supports across the province while also empowering initiatives within local geographies
- Engage all staff to identify gaps and draw people together to support improved service delivery for under-represented groups, with an initial focus on the impacts of anti-Black and anti-Indigenous racism
- Look at organizational policies and procedures with an equity, inclusion, diversity, and anti-racism lens

Through meaningful staff, patient, family and caregiver collaboration, we can ensure that a culture of equity, inclusion, diversity, and anti-racism is embedded in how we fundamentally operate as unified organizations.

BUSINESS PLAN AT A GLANCE

This Plan identifies the initiatives we will focus on to support a more patient and family-centred health care system that meets the needs of all those we serve. With people being our greatest strength, some initiatives are designed to support the employees of Home and Community Care Support Services. We strongly believe that cultivating a positive and healthy workforce drives better outcomes for the people we serve.



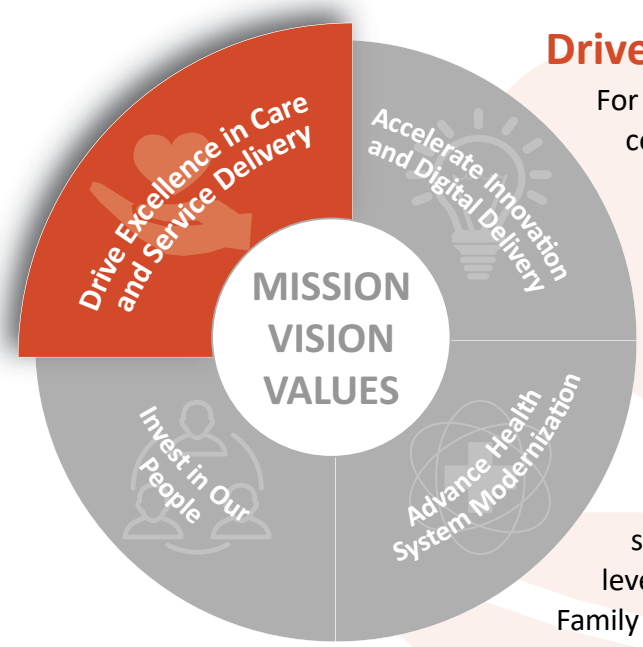
Our Engagement Approach

Our Board of Directors and CEO provided a clear mandate to engage with patients, families, caregivers, staff, leaders, service provider organizations and other key stakeholders on the path to creating a unifying Mission, Vision and Values, which was published in our 2021-22 Business Plan.

With a strengthened focus on patient- and family-centred care, we will continue our engagement efforts to capture the perspectives of the people we serve as we carry out the work necessary to achieve our Strategic Priorities.

STRATEGIC PRIORITIES

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



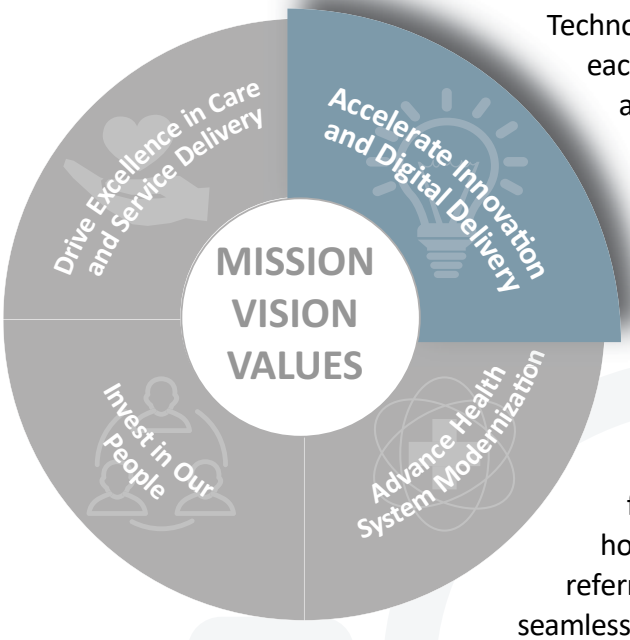
Drive Excellence in Care and Service Delivery

For decades, home and community care teams have been coordinating the delivery of in-home care across the province, including personal support services, home making, nursing care, occupational therapy, physiotherapy, palliative care, mental health and addictions supports, and dietetics. Our teams have also been coordinating long-term care placement. As we work to apply the learnings from the pandemic, we are actively looking for opportunities to improve access to consistent care and service delivery for those we serve including those in the long-term care sector. To ensure we continue to provide the best, most responsive supports possible to patients, families and caregivers, we will leverage the experiences and knowledge of our Patient and Family Advisors to guide our work into the future.

We Will Accomplish This By:

- Providing patient/caregiver-centred, high-quality home and community care services, long-term care home placement, and access to community services enabling safe, effective, timely and equitable services.
- Continuing to collaborate as a key partner in the transformation of the health care system, including supporting the implementation of the Ontario Health Team model and modernizing home care, ensuring better integration and navigation of services to improve patient outcomes and experiences.
- Continuing to work with health care system partners to respond to the COVID-19 pandemic, and supporting recovery activities.
- Creating new opportunities for patient, family and caregiver co-design to ensure that the patient voice, including voices from under-represented, marginalized and racialized groups, is incorporated in everything we do.

Accelerate Innovation and Digital Delivery



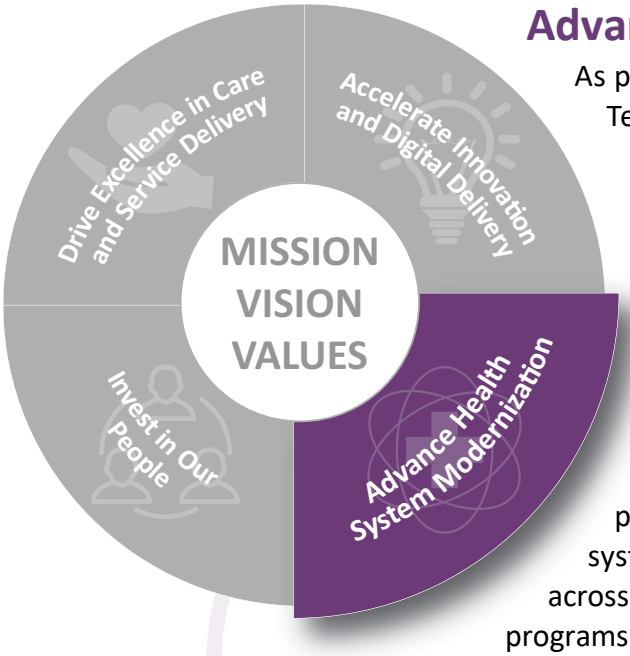
Technology has dramatically improved our ability to connect with each other, with other care providers, and with patients, with new advancements constantly emerging. Health care providers across the province have access to numerous technology solutions that they use on a daily basis to support patient care, and the benefits of these systems are significant—among other things, these solutions can enable faster access to care and smoother transitions between care settings. However, partners in care are often connected through technology solutions that could benefit from greater integration to help systems talk to each other, allowing providers greater ease of access to the information they need to support patients, families and caregivers. With this in mind, we are looking at how to help partners in care, including in-home services and our referral partners in hospital and the community, to connect more seamlessly and virtually with each other and with patients as they move through the health care system. We will work with Ontario Health to leverage CHRIS (Client Health and Related Information System) as a platform to enhance integration and drive consistency among partners including community support services partners.

As we move forward, we will be looking to enhance existing digital care delivery options to support high quality care. We are digitizing our paper forms to drive efficiency, while enhancing the security of our patients' data. This will reduce workload related to manual processes, increasing the amount of time available for direct patient care and thereby improving patient experiences. It will also help us to gather provincial data that can be used for modelling and planning at the local and provincial levels. A key design consideration will be how to effectively spread and scale best practices to benefit everyone, moving from individual pockets of local innovation to an integrated, province-wide system that ensures equitable access, regardless of where you live.

Additionally, we are developing cybersecurity mitigation plans, which include a partnership with Ontario Health and other health care partners to operationalize a provincial cybersecurity operating model that will ensure patients' information remains secure, while better enabling them to access the health care services they require.

We Will Accomplish This By:

- Partnering to implement digital strategies to enhance online services for patients that enable excellent clinical outcomes. These strategies will support care pathways and increase connections with—and seamless information exchange between—partners, including Ontario Health Teams.
- Supporting the advancement of innovative new models of home and community care that reflect the needs of our diverse communities.
- Exploring options for current home care business services needs as well as ongoing needs to support the transition of care coordination functions and the delivery of home care through Ontario Health Teams.
- Identifying opportunities to strengthen our patient navigation processes. This will include exploring links between our organizations and the provincial Health Care Navigation Service.

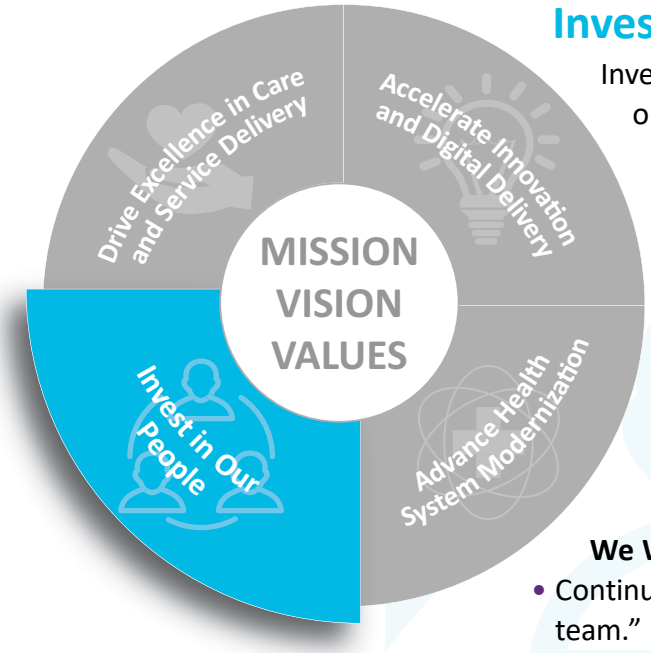


Advance Health System Modernization

As part of the evolution of the health care system, Ontario Health Teams are being created to provide a new way of organizing and delivering health care that is more connected for patients in their local communities, incorporating important learnings from the health, community and social services sectors. Home and Community Care Support Services is an integral partner of each Ontario Health Team across the province, and together we are working to support Ontario Health Teams to develop new models of integrated care and help to share best practices in care coordination with community and health care system partners. In addition, during the pandemic, we have learned a lot about how our health care system can work better together. We collaborated with partners across the system to help patients, families and caregivers to access programs and services to meet their care needs through care planning. Moving forward, we will leverage these learnings in our work with all partners as we continue to look beyond traditional health care, to address social determinants of health such as income disparity, food security, and housing in the care planning process.

We Will Accomplish This By:

- Continuing to collaborate with and supporting Ontario Health Teams in designing and spreading scalable models of care coordination and clinical care delivery. This includes supporting the implementation of leading projects within Ontario Health Teams. Advancing best practices in the care coordination function and care delivery while strengthening opportunities for collaboration with system partners.
- Working with the ministries of Health and Long-Term Care and Ontario Health to support placement improvements and consider a future long-term care home placement and services model in support of advancements in the long-term care sector.
- Contributing to the development and implementation of the Ministry of Health's Health Human Resources Strategy with respect to home care.



Invest in our People

Investing in our people will help improve patient experience and outcomes. By ensuring our team members feel safe in a work environment that promotes equity, diversity, inclusion and accessibility, we will continue to build one strong, committed team to serve the people of Ontario. We will also invest in our staff through a commitment to education and leadership development opportunities that support their growth and success. As well, we will support our leaders and actively engage staff using change management best practices to successfully drive the system changes necessary to support patients, now and in the future.

We Will Accomplish This By:

- Continuing to act as a single organization, advancing a sense of "one team."
- Implementing our ***People Strategy*** that cultivates a positive culture and a healthy and engaged workforce that feels supported to develop, enhancing our reputation as an "Employer of Choice."
- Implementing our *Equity, Inclusion, Diversity, and Anti-Racism Plan* that reflects the diverse communities we serve and supports our workforce by promoting an inclusive workplace.

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

To ensure our areas of successes and improvements are communicated to our Board of Directors and, ultimately, the Ministry of Health, we will be reporting on:

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

Additionally, we will measure progress on our strategic priorities through several performance metrics noted below. Since many of these are new measures, it will be important to establish a baseline initially.

Strategic Priorities and Performance Measurement

Drive excellence in care and service delivery

- Measure and increase the opportunities/initiatives where patients, families and caregivers are engaged as equal partners to encourage co-design
- Caregiver distress rate for long-stay patients – % of long-stay patients whose caregiver has indicated they are experiencing caregiver distress
- Missed care – 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 (SPO) does not have the capacity to deliver the care
- 5-day wait-time (personal support) – % of adult complex patients who receive their first personal support (PS) service within 5 days of patient available date
- 5-day wait-time (nursing) – % of adult patients who receive their first visit nursing service within 5 days of patient available date
- Volume of Open ALC Cases Related to HCCSS
  - This indicator measures the number of patients who are ready to be discharged from hospital (acute care) and whose discharge has been delayed because of lack of availability of care or services at their planned discharge destination. This includes patients being discharged to home (with or without home care and/or community services), convalescent care, assisted living or long-term care. It does not include other institutional or residential settings such as rehabilitation, palliative care, or mental health services.
- Community Crisis Patients Waiting for LTCH Placement – # of new home care referral admissions for the most recent period compared to the same period in the prior year
- Complaints
  - Percentage of complaints acknowledged to the individual who made a complaint within two, five and 10 business days
  - Percentage of complaints closed within 30 calendar days and 60 calendar days

Accelerate innovation and digital delivery

- Support Ontario Health to identify opportunities for CHRIS (Client Health and Related Information System – our provincial patient management system that supports the delivery of home and community care and long-term care placement services) and its ecosystems for enhanced integration and functionality, driving consistency among partners including community support partners

Advance health system modernization

- Establish integrated models of care coordination in partnership with Ontario Health Teams and our Patient, Family and Caregiver Advisors
- % of Ontario Health Teams with embedded care coordination functions

Invest in our people

- Number of internal promotions vs. external hires
- Staff retention and turnover
- Employee engagement score

Our progress with these metrics will be available in a variety of ways to internal and external audiences, and may include publication on our public-facing websites, as appropriate.

SUMMARY

Extensive health care system changes – ongoing implementation of Ontario Health Teams, the Ministry of Long-Term Care's plan to fix long-term care and the creation of Home and Community Care Support Services – have occurred while we have all been navigating the COVID-19 pandemic. Everything we do has had to evolve during this time. We take pride in the positive impact we have had during this period, and we will continue to deliver positive outcomes as we shift to supporting the recovery of our health care system.

National and international events have highlighted for our province, our communities and our organizations that much work lies ahead to ensure we have embedded a culture of equity, inclusion, diversity, and anti-racism. The development of our provincial leadership group, with representation from staff, patients, families and caregivers, will ensure this work is prioritized moving forward.

Our staff support the people we serve every day, wherever they call home. This uniquely positions us to deliver our mission of helping everyone to be healthier at home through connected, accessible, patient-centred care. As we strive to fulfill our important mission, we will also play an instrumental role in advancing health care system improvements by sharing decades of best practices in care coordination with community and health care system partners and supporting local system integration through Ontario Health Teams as well as improvement to long-term care placement and considering a future placement model. This wealth of experience will help us to drive excellence in care and service delivery, advancing new models of home and community care and long-term care placement that reflect the needs of our diverse communities and leveraging digital strategies to benefit patient outcomes.

To ensure we deliver on what we promise, our strategic priorities and initiatives will be supported by performance measurement reporting to our Board of Directors and the Ministry of Health and by regular risk assessment and monitoring. Our values will come to life as we meaningfully and proactively collaborate with patients, families, caregivers, staff, and system partners. This engagement will be pivotal to driving the initiatives outlined in this business plan.

Our vision is simple, but bold: to not just provide care, but to provide exceptional care to the people we serve, wherever they call home. We are confident that Home and Community Care Support Services can deliver on this. By cultivating a healthy and engaged workforce, building a cohesive team across the province, and enabling an inclusive workplace, we set the stage to deliver the best patient, family and caregiver experience.

Our plan is robust and forward thinking. The path ahead will be filled with an abundance of opportunities to further engage with patients, families and caregivers with the intention of bettering outcomes for those we serve. We are ready and committed to do this important work.

APPENDIX: BY THE NUMBERS

Across Ontario, Home and Community Care Support Services supports the delivery of 930,000+ home and community care services annually, and sends 5,400,000+ referrals and 3,900,000+ supporting medical documents to home care and long-term care annually. The services we provide are vital to patients across Ontario. They address the needs of people of all ages, including seniors, persons with physical disabilities and chronic diseases, children and others who require ongoing health and personal care to live safely and independently in the community. The patients we serve are some of the most vulnerable in the province.

Our organizations:

- Have a total funding allocation of $3.2B (as of July, 2021)
- Served 674,000 patients in 2020-2021
- Directly employ 8,600 staff positions (July, 2021)
- Purchase $2.1B services from over 150 Service Provider Organizations via approximately 400 contracts (this includes services such as nursing and personal support as well as hospices and medical vendors)

In addition:

- *Each day*, there are:
  - 22,000 nursing visits
  - 3,000 therapy visits
  - 85,000 PSW service hours
  - 8,300 interactions
- *Each day*, we operate 134 nursing clinics
- *Every month*, care coordinators collectively have 400,000 active patients on their caseload
- *Each quarter*, those nursing clinics receive more than 280,000 visits
- *Each year*, approximately 26,500 clients are placed in Long-Term Care homes

OUR ORGANIZATIONS:

$3.2B Funding

674,000 Patients

8,600 Staff

$2.1B Services

IN ADDITION

Each day
22,000 nursing visits
3,000 therapy visits
85,000 PSW service hours
8,300 interactions

Each day
we operate 134 nursing clinics

Each quarter
those nursing clinics receive more than 280,000 visits

400,000
active patients every month

26,500
Long-term care placements every year

Home care services reduce the need for hospital and long-term care, while supporting timely hospital discharge for acute care patients. The services also support people living with chronic conditions. Long-term care home placement provides equitable and appropriate access to long-term care homes, benefiting patients, residents, families and caregivers.

It is also important to note the unique services and functions Home and Community Care Support Services is responsible for delivering. We help patients navigate Ontario's health care system, understand their options, and connect with community-based resources.

Core services include:

- Needs assessment/reassessment and care plan development
- Care coordination
- Outcomes monitoring
- Home and community care services for post-acute, long stay and palliative patients
- Placement into long-term care homes, including specialized units, and transitional beds
- Information, referral, and navigation to other community services
- Direct care nursing for assessment and medication reconciliation
- Patient access 365 days per year
- Emergency response activities such as pandemic response and community, hospital and long-term care home evacuations for floods and forest fires

In-home Services

- Care coordinators assess client need and eligibility for home and community care services; support transitions from hospital and other places of care; develop, monitor and adjust plans of service as required, including supporting families and caregivers with contingency and future needs planning; and authorize services
- Coordinate access to nursing services, physiotherapy services, occupational therapy services, speech-language pathology services, dietetics services, pharmacy services, diagnostic and laboratory services, respiratory therapy services, social work services, personal support services and homemaking services
- Provide direct care such as Occupational Therapy, Physical Therapy, Speech Language Pathology Therapy, Dietetics, Primary Nurse Practitioners, Nursing Specialized in Wound, Ostomy and Continence, and Medical Assistance in Dying
- Provide additional support for clients who receive certain in-home professional health-services by purchasing or renting medical supplies and dressings, hospital and sickroom equipment, laboratory, and diagnostic services
- Train other persons, such as caregivers, to assist with or provide certain of the above services to a particular client
- Arrange for the provision of drug benefits to eligible persons

Admission to Long-Term Care Homes

- Assess need and determine eligibility for admission, and prioritize and manage the admission process to long-term care homes
- Provide support and information to both applicants and their families/caregivers prior to and during the admission process

School Services

- Assess need, determine eligibility, and provide or arrange nursing services, dietetics services, mental health and addictions services, and the medical supplies, dressings, and treatment equipment necessary for the provision of these services, as well as personal support services and the medical and personal equipment necessary for those services for children with special needs who require assistance in public schools
- Assess need, determine eligibility, and provide or arrange the services available for children in public schools, as well as occupational therapy services, physiotherapy services, speech-language pathology services and the medical supplies, dressings, and treatment equipment necessary for the provision of these services for children attending private schools and receiving home schooling

APPENDIX: RISK AND MITIGATION SECTION

Based on an environmental scan that examines the business environment in which we operate, this section outlines the key organizational risks facing Home and Community Care Support Services and the associated mitigation strategies. Over the course of this Business Plan's timeframe, we will develop appropriate province-wide frameworks and processes to effectively assess and monitor risks we face to avoid any potential risk to the patients we serve and staff who care for those patients.

Risks facing Home and Community Care Support Services	Existing Controls & Planned Mitigation Actions
Health Human Resources (HHR) Supply HHR shortages have been exacerbated by the COVID-19 pandemic and the demand for home care services has increased as a result of multiple factors including less long-term care and respite capacity, placing significant pressure on home and community care resources to meet the needs of patients' in-home services. Staff shortages result in negative patient outcomes and experience, and caregiver burnout	Work with the Ministry of Health, our service providers and the system to build and implement strategies to improve and optimize HHR capacity and service planning. Develop plans to communicate the value of working in the home and community care sector in order to help attract talent.

Risks facing Home and Community Care Support Services	Existing Controls & Planned Mitigation Actions
Staff Attrition and Change Fatigue Home and community care has been undergoing a prolonged transformation that has been further complicated by the pandemic over the past few years. As we work towards transferring care coordination functions to Ontario Health Teams and support consideration of a future long-term care placement model, change is perceived with uncertainty. This uncertainty may lead to attrition for the sector and in turn cause downstream negative impact on business continuity and the patients, families and caregivers who depend on Home and Community Care Support Services staff.	Develop and implement a change management plan, including education and training as required, to support staff through the system changes ahead. Develop and implement workforce stabilization strategies for Home and Community Care Support Services staff across the province. Develop and implement a communications plan that informs the public about the role and value provided by Home and Community Care Support Services and attracts prospective staff to the sector.
Digital Delivery Advancements and new technologies in electronic health records, digital health platforms and virtual care are increasingly being adopted and supported by the public, patients and partners. Part of our objective is to implement digital strategies to enhance services for patients to enable excellent clinical outcomes and exceptional experience. There may be limited of resources and timelines available to implement a robust ecosystem to support the seamless exchange of patient information across partners and allow patients to view their information.	Working with partners and government to develop adequate frameworks and agreements to allow for seamless data sharing across integrated systems and multiple partners.

APPENDIX: COMMUNICATIONS & ENGAGEMENT PLAN

Communications and engagement activities within Home and Community Care Support Services organizations will help us achieve our four key strategic priorities. Our Mission, Vision and Values, and commitment to high quality, patient-centred care, will guide the Communications team in developing plans and tactics that engage and inform our diverse audiences across Ontario.

Our Stakeholders

- All patients, families and caregivers
- Indigenous, Francophone, Black and other priority and marginalized communities
- All Home and Community Care Support Services staff across Ontario
- Service Provider Organizations, Health Service Providers, community partners and 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 services and how to access them
- Engage with patients, families, caregivers and our populations with diverse needs to further integrate the patient experience and voice into organizational decision-making and through co-design, ensure all outcomes meet the specific needs of our communities
- Build awareness and trusted relationships with all stakeholders, 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 – paying particular attention to the eventual transition to Ontario Health Teams and future long-term care placement models and keeping our community engaged and informed about any changes to their care delivery
- Keep staff informed about new (or changed) programs, initiatives and policies/processes that impact their jobs or the delivery of patient care
- Develop and implement communications strategies to support organizational programs and initiatives, and our four strategic priorities

Communications Tactics

- Streamlined and integrated communications efforts across Home and Community Care Support Services organizations 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 traditional, digital and other new and innovative communications products and delivery methods
- Strong media and external stakeholder relations
- An improved online experience, including user-friendly websites and engaging social media activity, while 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
- Ongoing engagement opportunities with patients, families, caregivers, service providers and our diverse communities

Engaging our Diverse Communities

Engaging and collaborating with patients, families, caregivers, service provider organizations, health care system partners and diverse communities across the province is vital in developing equitable home and community care for all.

Through meaningful engagement, we will learn from those with lived experience, as well as those representing Indigenous, Francophone, Black and other priority or marginalized communities, to gain a better understanding of people's wide-ranging experiences in our health care system and apply these learnings to improve care experiences and health outcomes.

Recognizing the importance of providing French language services to our patients, we will form a provincial French Language Services (FLS) Committee that will develop a consistent, inclusive, and equitable approach to the delivery of FLS so as to meet the diverse needs of our Francophone patients, their families and caregivers across our geographies. The committee will look for ways to improve the delivery of FLS and share best practices on implementing the principle of Active Offer, while also giving consideration to improving service offerings in other languages.

We will build a provincial Patient and Family Advisory framework that includes a robust plan for ongoing engagement, to reflect the voices of our diverse communities. We will design an engagement plan that captures patient, family and caregiver voices through in-person and virtual engagement sessions, surveys, embedding patient advisors in organizational projects and keeping two-way communication channels open.

By maintaining ongoing discussion with all stakeholders, we can appropriately address the needs of vulnerable communities to create a more integrated health care system that addresses health disparities and delivers excellent and equitable access, experience and outcomes for the people of Ontario.

As we engage, we commit to listening, to providing safe spaces for important conversations around all forms of racism, prejudice and discrimination, and to action necessary changes in our organizations and across our communities.

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:

Notes:

1. Planned Expenses cannot exceed the Ministry's Allocation.
2. Home Care/LHIN Delivered Services includes direct services as defined in Schedule 7, Table 1 of the 2015-18 Accountability Agreement between the Minister of Health and the LHINs operating as HCCSS.
3. Aggregated LHIN/HCCSS Operations includes:

   i. Regional Coordination Operations (formerly known as LHIN Operations). This is the residual funding related to the delivery of home care.

   ii. Regional Coordination Initiatives (formerly known as LHIN Operations Initiatives): This is funding for Quality Based Procedures.
4. Integrated Administration/Governance includes indirect costs such as administration and overhead expenses.

	2021/22 Estimated Actuals	2022/23 Allocation	2022/23 Planned Expenses[1]
Allocation: Home Care/LHIN Delivered Services[2]			
Salaries (Worked hours + Benefit hours cost)	$539,119,118		$579,461,043
Benefit Contributions	$142,727,125		$153,869,506
Med/Surgical Supplies & Drugs	$172,748,553		$179,981,475
Supplies & Sundry Expenses	$15,743,681		$20,978,100
Equipment Expenses	$28,361,202		$29,400,067
Amortization on Major Equip, Software License & Fees	$347,222		$259,161
Contracted Out Expenses	$2,341,401,070		$2,053,189,694
Buildings & Grounds Expenses	$570,507		$491,500
Building Amortization	$0		$0
TOTAL EXPENSES: Home Care	**$3,241,018,479**	**$3,017,630,546**	**$3,017,630,546**
Aggregated HCCSS Operations[3]			
Salaries (Worked hours + Benefit hours cost)	$0		$0
Benefit Contributions	$0		$0
Med/Surgical Supplies & Drugs	$0		$0
Supplies & Sundry Expenses	$0		$0
Equipment Expenses	$0		$0
Amortization on Major Equip, Software License & Fees	$0		$0
Contracted Out Expense	$0		$0
Buildings & Grounds Expenses	$0		$0
Building Amortization	$0		$0
Sub-total: Regional Coordination Operations			
Sub-total: Regional Coordination Initiatives			
TOTAL: Aggregated HCCSS Operations			
Allocation: Integrated Administration and Governance[4]			
Salaries (Worked hours + Benefit hours cost)	$70,993,846		$87,392,306
Benefit Contributions	$19,122,779		$23,594,970
Med/Surgical Supplies & Drugs	$0		$0
Supplies & Sundry Expenses	$11,823,898		$10,037,639
Equipment Expenses	$8,144,409		$8,427,244
Amortization on Major Equip, Software License & Fees	$1,185,538		$949,256
Contracted Out Expense	$1,065,508		$464,150
Buildings & Grounds Expenses	$27,473,085		$13,083,327
Building Amortization	$956,087		$705,027
TOTAL EXPENSES: Integrated Administration and Governance	$140,765,151	$144,653,919	$144,653,919
TOTAL: HCCSS SPENDING PLAN	$3,381,783,630	$3,162,284,465	$3,162,284,465

APPENDIX: HEALTH HUMAN RESOURCES

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

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

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

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

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

	2021/22 Actual	2022/23 Forecast
Home Care[2]		
MOS FTE	1858.10	1996.83
UPP FTE	4397.94	4753.46
NP FTE	121.77	118.35
Physician FTE	0.00	0.00
Total Home Care FTE	**6377.81**	**6868.64**
Regional Coordination Operations[3]		
MOS FTE	0.00	0.00
UPP FTE	0.00	0.00
NP FTE	0.00	0.00
Physician FTE	0.00	0.00
Total Regional Coordination Operations FTE	0.00	0.00
Regional Coordination Initiatives[4]		
MOS FTE	0.00	0.00
UPP FTE	0.00	0.00
NP FTE	0.00	0.00
Physician FTE	0.00	0.00
Total Regional Coordination Initiatives FTE	0.00	0.00
Integrated Administration and Governance[5]		
MOS FTE	330.98	413.82
UPP FTE	464.49	548.64
NP FTE	0.00	0.00
Physician FTE	0.00	0.00
Total Integrated Administration/Governance FTE	795.47	962.46
TOTAL FTE SUMMARY	7173.28	7831.10

*Note: Our internal headcount is nearly 8,600 people. This number refers to the **total** number of both full- and part-time employees in the 14 organizations, with each individual counting as “one,” regardless of the number of hours worked. The full-time equivalent or FTE number refers to the number of hours considered full-time (typically 7.5 hours per day, or 37.5 hours per week). For example, two part-time employees, each working 18.75 hours per week, would count as **two** headcounts, but only **one** full-time equivalent.

Notes:

1. One FTE equals 1950 hours per year and may be comprised of multiple staff.
2. Home Care/LHIN Delivered Services includes direct services as defined in Schedule 7, Table 1 of the 2015-18 Accountability Agreement between the Minister of Health and the LHINs operating as HCCSS.
3. Regional Coordination Operations (formerly known as LHIN Operations): This is the residual funding related to the delivery of home care.
4. Regional Coordination Initiatives (formerly known as LHIN Operations Initiatives): This is funding for Quality Based Procedures.
5. Integrated Administration/Governance includes indirect costs such as administration and overhead expenses.

APPENDIX: ACRONYMS USED

ACRONYM	MEANING
PFAC	Patient and Family Advisory Committee
HHR	Health Human Resources
SPO	Service Provider Organization
HIROC	Healthcare Insurance Reciprocal Of Canada
CHRIS	Client Health and Related Information System
ONA	Ontario Nurses Association
CUPE	Canadian Union of Public Employees
OPSEU	Ontario Public Service Employees Union
COPE	Canadian Office and Professional Employees