Ontario Health atHome

Consolidated Home and Community Care Support Services Annual Report, 2023/24 + Q1 2024/25

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Message from the Board Chair and CEO

In such a transformational time in health care in Ontario, it is our pleasure to present the Consolidated Annual Report for Home and Community Care Support Services for 2023/24 and Q1 of 2024/25.

As a result of the *Convenient Care at Home Act, 2023* being proclaimed into force on June 28, 2024, 14 Home and Community Care Support Services organizations were amalgamated into a single service organization called Ontario Health atHome. As a unified provincial organization, Ontario Health atHome provides consistent, high-quality home care services to patients across the province while supporting Ontario Health Teams (OHTs) as they begin to take on responsibility for home care.

While amalgamation planning activities happened throughout the course of this reporting period, Home and Community Care Support Services delivered on commitments outlined in our Letter of Direction from the Minister of Health. We are proud of the pivotal role we played in supporting the modernization of home and community care while continuing to deliver high-quality care to 670,000 patients across Ontario.

We balanced priorities related to internal organizational realignment and standardization of processes with our vision to provide patients with exceptional care, wherever they call home.

We worked to improve access to equitable, safe and high-quality services across the province. Through capacity planning initiatives, we standardized care models and processes, modernized service provider contracts and made significant progress in standardizing long-term care placement.

We actively participated in the development and growth of OHTs, sharing expertise and collaboration in supporting OHT progress on the delivery of home care.

As part of our commitment to continuous quality improvement and responsive support for patients, families and caregivers, we relaunched our Patient and Caregiver Experience Evaluation survey, which will help enhance patient health outcomes and contribute to consistent experiences across Ontario.

We continued to strategically embed Equity, Inclusion, Diversity and Anti-Racism (EIDAR) in our work, recognizing that through this commitment, we contribute to better outcomes for patients, families, caregivers and a healthier work environment for staff. Recognizing EIDAR is a long-term commitment, we prioritized foundational EIDAR actions that will promote the sustainability of our efforts.

Within the pages of this report, you will find details of these achievements and more. We are incredibly proud of our people and teams, who even in the face of so much change, continue to draw upon our core values to guide their work and remain dedicated in their commitment to the people we are here to serve.

As this report represents our last as Home and Community Care Support Services, and as we welcome a new Ontario Health atHome Board of Directors, we would be remiss if we did not acknowledge and thank the tremendous contribution of our previous board members, who were instrumental in overseeing the first phase of our transition from 14 organizations to one.

We look forward to our expanded role as a service organization supporting health system partners and to working collaboratively with them in the delivery of integrated and accessible home and community care services. We know that system transformation on this scale can be daunting, but we also recognize the tremendous opportunities for improvement that will be driven by the people who we are privileged to partner with through this journey – our terrific staff, service providers, volunteers, board members, funders and patient and family partners.

Carol Annett
Board Chair, Ontario Health atHome

Cynthia Martineau
Chief Executive Officer, Ontario Health atHome

Introduction

In 2023/24 and Q1 2024/25, Home and Community Care Support Services focused on delivering on our mandate, while making progress in achieving our Annual Business Plan goals. We refined and streamlined processes in anticipation of our amalgamation to form a unified organization.

Supporting Ontario's *Plan for Connected and Convenient Care*, we focused on increased capacity to provide home and community care to patients, including those living in rural communities and communities experiencing difficulties accessing timely care.

- We implemented plans to make the most efficient use of health human resources and enable better integration of services to improve patient outcomes and experiences;
- We expanded our number and utilization of community nursing clinics;
- We increased the number of neighbourhood models of care to improve coordination within localized communities;
- We achieved our target to increase transitional care bed utilization to help keep patients out of hospital emergency departments while they prepare to go home; and,
- We supported the safe transition of patients who no longer require treatment in hospitals to temporary care arrangements in long-term care homes while they wait for placement in a preferred home

To advance health care system modernization, we continued to work closely with partners to enable new ways of organizing and delivering connected health care to patients. A significant component of our work included ongoing support for, and participation at, OHT planning tables across the province. This included active engagement as a partner planning the implementation of seven OHT Leading Projects. We shared knowledge of best practices regarding care coordination and explored new models of advanced, integrated and seamless care for patients across sectors including mental health and addictions, palliative and chronic disease management.

Our staff are our most valuable resource. As such, through the four pillars of our People Strategy – the roadmap that shapes the way we lead, engage and develop our people – we invested in our teams to enable them to do their best work throughout the transition to Ontario Health atHome, ensuring continued positive patient experience and outcomes. This included launching a new employee recognition program, an employee wellbeing and wellness program, as well as providing access to training for Indigenous cultural safety and the active offer of French Language Services. Our People Strategy received national recognition through the Canadian HR Awards with an excellence awardee in five categories and we received the HR Champion award for Chief Executive Officer.

As we worked with the Ministry of Health, Ministry of Long-Term Care and Ontario Health to operationalize and achieve the future state and vision for Ontario Health atHome, we maintained our keen focus on delivering high-quality home and community care services. In fact, last year we coordinated and/or delivered more than:

- 40,867,936 PSW hours (+11.6% from 2022/23)
- 10,691,852 Nursing visits (+7.2% from 2022/23)

Q1 of 2024-25 saw further service increases:

- PSW hours increased 10% from Q1 2023/24
- Nursing visits increased 4.8% from Q1 2023/24

The following pages of this report demonstrate our achievements, as well as the significant progress to standardize and centralize services and processes. The Health System Performance section of this report lists performance, targets and achievements by Ministry of Health and Annual Business Plan priority.

Population Profile

Below is a population profile of Ontario, which includes information on the number and type of health system partners across the province. Population profiles for individual Home and Community Care Support Services organizations can be found in Appendix One.

Area (km^2)	892,411
Total Population	15,109,416
Population Age 65+	18.4%
Population Growth Rate	2.0%
Population Density	5.4/km^2
Rural Population	13.2%
Indigenous Population	2.8%
Francophone Population (including IDF)*	4.1%
Low Income Population	10.1%

Health System Partners:

- 1000s of primary care providers
- 680 community support agencies
- 618 long-term care homes
- 150 hospital sites
- 100+ service provider organizations
- 100+ equipment and supply vendor sites
- 72 school boards

*IDF - Inclusive Definition of Francophones, including Francophones whose mother tongue is not French

Sources:

- Ministry of Finance projections (2018-2041) via Ministry of Health Visual Analytics Site
- Statistics Canada 2021 Census via Ministry of Health Visual Analytics Site
- Home and Community Care Support Services Strategy, Decision Support departments

Description of Activities

Health Care Recovery

Following a shift from two disruptive years of pandemic response to the early stages of health system restoration in 2022/23, we continued to support health system capacity and recovery efforts through our work on vaccination programs, including the expansion of access to Remdesivir in the community, and launched a multi-faceted capacity planning initiative.

Access to Remdesivir in the Community

In preparation for the 2023/24 fall/winter surge in respiratory illnesses, we worked collaboratively with the Ministry of Health and Ontario Health to provide COVID-19 treatments, including Remdesivir, to patients in the community. We developed and implemented a provincial Remdesivir policy, enabling patients to receive infusions at one of over 140 community nursing clinics across the province. Patients not eligible for nursing clinics received their treatment at home.

In 2023/24, Home and Community Care Support Services supported 1,460 patients with Remdesivir infusions in the community, helping to divert patients from unnecessary hospital or emergency department visits.

Supporting health system recovery through multi-year Capacity Planning initiative

The Ministry of Health introduced A Plan for Connected and Convenient Care in 2023, which laid the groundwork for implementing, monitoring and evaluating the multi-year capacity plan for Home and Community Care Support Services. Five strategic initiatives were deployed in hard-to-serve areas and other regions across the province. These initiatives were designed to strengthen and maintain health system capacity.

As part of the capacity planning initiative, we developed guides and successfully implemented these strategic initiatives across the province.

1. **Targeted service provider organization incentives**
   To support our service provider organizations with recruitment and retention of frontline staff and stabilization of health human resources capacity, particularly in hard-to-serve areas, we provided incentives to 28 service provider organizations (up from 24), that enabled them to provide guaranteed shifts and travel stipend for frontline staff.
2. **Enhanced utilization of transitional care beds in retirement homes** We implemented several strategies to increase use of transitional care beds in retirement homes for alternate level of care (ALC) patients who no longer require acute care in a hospital. Through these strategies, we successfully increased our transitional care beds occupancy rate to 88% (up from 78% in Q4 of 2022/23).
3. **Increased neighbourhood models of care**
   We use the neighbourhood model of care to better support patients while maximizing the use of health human resources and creating more patient touchpoints. It provides for a clustering of services to patients within neighbourhoods and improves efficiency in care delivery. In 2023/24, we expanded this model of care to 167 neighbourhoods across the province (up from 59 the previous year).
4. **Optimization of direct care nursing and therapy staff**
   We optimized direct care nursing and therapy staff to provide in-home care in areas where there are service provider

gaps and patients would otherwise not receive the care they require. The goal of this initiative is to enhance services typically delivered by service provider nurses and therapy staff.

5. **Maximize and expand community clinics** We continued to expand the number of community nursing clinics available to Home and Community Care Support Services patients across the province. We now operate 140 clinics where we offer high-quality and specialized nursing services within a clean and safe environment, including wound care, intravenous therapy urinary catheter care and other nursing treatments. Additionally, to raise awareness about our Clinic First approach and increase utilization of our clinics, we refreshed educational resources about our community clinics for staff, patients/caregivers and health system partners – including primary care providers, hospital partners and Ontario Health Teams. In 2023/24 we achieved an 11.1% increase in nursing clinic utilization. The increased utilization continued into Q1 2024/25 with more than 45,500 patients receiving service through 368,000 visits, or an increase of 22.4% when compared to Q1 2023/24.

Fall/Winter Surge Planning

As part of our annual fall/winter surge planning, we worked collaboratively with Regional Planning Tables that included health system partners to support local emergency department diversion strategies and the transition of alternate level of care (ALC) patients to home and community settings. Surge planning initiatives included leveraging community paramedicine programs, optimizing opportunities for remote care monitoring, deploying mobile teams and ensuring maximization of occupancy in transitional care beds in retirement homes.

In addition to ongoing participation at the Operations Executive Table, our Patient Services leaders continued to meet with Ontario Health's Access and Flow leaders to monitor and proactively plan for projected hospital surge and related system impacts of influenza, COVID and respiratory syncytial virus (RSV).

We prioritized home visits for palliative, complex patients and patients with multiple recent emergency department visits; maximized the use of internal programs such as community nursing clinics and intensive hospital to home and neighbourhood care models; and facilitated timely admissions to long-term care homes.

We continue to observe respiratory illness trends across the country, province and within our organization and we continue to work with the Ministry of Health, Public Health Ontario and Chief Medical Officer of Health to ensure alignment with the latest scientific evidence and guidance.

Provision of Home Care Services

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

In 2023/24, Home and Community Care Support Services supported 670,000 patients across Ontario with health assessments, creation of individualized care plans and the delivery of services at home or in community nursing clinics, which included more than 40 million personal support visits or sessions. The team also managed the long-term care home assessment and placement process for nearly 27,000 individuals.

Supporting Hospital Capacity and Transitions

With health system recovery efforts underway in 2023/24, we continued to develop partnerships with other health service providers, including community support services agencies and community paramedicine partners, to support timely and safe transitions from hospital to home or to long-term care, and to help ensure vital resources, like hospital beds, were available for those who needed them most.

Rapid Response Nurses

Our rapid response nurses support patients and families dealing with complex conditions and high care needs, with an aim to ensure smooth transitions from hospital to home and reduce risk of hospital readmission or avoidable emergency department visits. Rapid response nurses work collaboratively with the care team, including hospital staff, primary care providers, community paramedicine programs and community support services agencies. In 2023/24, rapid response nurses completed 48,800 visits, a 22.7% increase when compared to the previous fiscal year.

Emergency Department Diversion

Through various programs and strategies, we worked in collaboration with other health system partners and community support service agencies, playing an important role in supporting hospital and health system capacity by diverting patients from unnecessary emergency department visits and supporting them to receive the right care in the right place.

In 2023/24, the Central East Emergency Department Diversion Committee continued to build on three innovative initiatives originally implemented in 2022/23:

1. Through the implementation of an enhanced emergency department diversion protocol, a tool that helps identify patients with high emergency department and 911 usage and that provides guidance for staff to support the patient through assessment and intervention, 166 patients were identified in Q1 2024/25, and 68% saw a reduction in emergency department and 911 utilization post intervention.
2. Following the success of a pilot program with the Region of Durham for eNotification from paramedic services, the program was expanded to the Peterborough and Kawartha areas in 2023/24. Through this program, we receive a notification when a patient calls 911 and is seen by a paramedic but is not transported to hospital. In Q1 2024/25, 988 eNotifications were received from paramedic partners with 85% of patients avoiding any visits to the emergency department within seven days of the 911 call where intervention was completed by a care coordinator.
3. The Mobile Emergency Diversion team pilot was expanded across the Central East geography in 2023/24. An innovative and collaborative model, these multidisciplinary teams are comprised of registered nurses, occupational therapists, nurse practitioners and community paramedicine partners. The teams provide urgent nursing and therapy services for patients at a high risk of returning to the emergency department. In 2023/24, 270 patients received service through the expanded program and 409 emergency department visits were diverted.

Community Nursing Clinics

Community nursing clinics provide high-quality specialized nursing services, including wound care, intravenous therapy and urinary catheter care, to support patients on their road to wellness, recovery and independence. Clinics are by appointment only, in accessible locations and offer flexibility for patients to schedule their nursing care at times that fit their schedule, with options including extended hours and evenings and weekends. Across the province, we opened five new community nursing clinics and provided care to nearly 111,000 patients through 1.4 million visits.

In 2023/24, two new clinics opened in the Campbellford and Minden areas. These clinics are unique as they feature an innovative partnership for shared operation between two service providers, enabling the most effective use of health human resources and helping patients to receive the right care in the right place. Home and Community Care Support Services Central opened its eighth community nursing clinic in Keswick. Aligned with our province-wide borderless approach for our community nursing clinics, neighbouring Home and Community Care Support Services organizations can refer patients to this new clinic location as appropriate.

Community nursing clinics free up visiting nursing capacity for patients who absolutely need in-home care. A nurse in a community clinic can see 2-3 patients in an hour while a visiting nurse can see one patient in 1.5 to 2 hours due to travel time.

Collaborating with Partners to Respond to Emergencies

In addition to providing care and services to 670,000 patients each year as part of our regular operations, we played an integral role in local emergency management and response efforts. These emergency situations can arise from a variety of sources, such as weather-related incidents like ice storms, extreme heat warnings, wildfires and flooding or through technology and infrastructure incidents like power outages and Information Technology (IT) disruptions. We responded to a number of emergency situations in 2023/24, including:

Northern First Nations Communities Flooding Preparation and Response

Beginning in early spring 2023, we supported the precautionary evacuation of community members from Kashechewan and Fort Albany First Nations in the face of a high flooding risk. These remote fly-in communities, only accessible by ice-roads in the winter are prone to flooding nearly every year during the spring ice break-up, with flood risk typically lasting from late April through the middle of May. As a result of this, more than 700 community members were evacuated to eight host communities across Ontario – Timmins, Cochrane, Kapuskasing, Val Rita, Thunder Bay, Toronto, Mississauga and Niagara Falls. Additionally, eight community members were moved to long-term care homes in Thunder Bay.

Home and Community Care Support Services North East worked with the Kashechewan and Fort Albany communities to obtain the required patient information to coordinate placement to long-term care homes or referrals to other community supports as required. To ensure those who required care were able to receive it in a timely manner, care coordinators were on standby to assess individual resident needs. Beginning in May, repatriation began of Kashechewan, Attawapiskat and Fort Albany First Nations residents, with all residents, including the eight who were moved to long-term care facilities, returning safely to their homes.

Supporting Emergency Preparedness for Patients impacted by Wildfires

In summer 2023, Home and Community Care Support Services Erie St. Clair partnered with health care providers to set up a pop-up clinic in Windsor to welcome residents from northern Ontario communities where forest fires had forced their evacuation. The Erie St. Clair team played a vital role in coordinating the delivery of medical supplies and equipment including walkers, wheelchairs, bath benches and commodes, urgently needed for people arriving by plane. The Erie St. Clair Intake team was also on standby to process any patients that required medical referrals for nursing care. This collaborative effort received recognition and thanks from leadership at the Southwest Ontario Aboriginal Health Access Centre.

In addition to responding to emergencies as they occur, we also engaged in emergency preparedness and risk mitigation activities, including counseling patients on the importance of having contingency plans in place if care is interrupted in an emergency. In 2023/24, staff monitored the needs of patients with homes near the wildfire in the western Champlain geography. While no evacuations were necessary, care coordinators and service providers worked with identified patients in the area to ensure they had a contingency plan in place should they need to evacuate their homes, considering their medication supply and needed medical equipment such as oxygen supply and sufficient battery backup.

Supporting Patients Affected by Ice Storm Outages

In April 2023, an ice storm left more than a million people in Ontario and Quebec without power – some for a few hours and others for days. Among those were nearly 1,300 of the most vulnerable people we serve across Champlain. The situation was especially concerning for patients who live at home and depend on electricity, including those needing ventilators to breathe and air mattresses to prevent skin breakdown.

To minimize disruption to patient care, Home and Community Care Support Services Champlain activated its Emergency Response Team in advance of the storm. Data from the local Business Intelligence team identified affected patients, and care coordinator teams made hundreds of phone calls over the course of the outage to check-in with patients to ensure they were safe and remind them to activate their contingency plans, if needed.

Supporting Vulnerable Populations

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

Telehomecare

Telehomecare combines remote sensing technology with coaching by a nurse to help patients learn to self-manage symptoms related to chronic disease management. In 2023/24 and Q1 2024/25, we monitored an average of 348,900 patients each month with an average of approximately 48,200 new home care and school referrals per month.

This past year, the Telehomecare program expanded to include a COVID+ pathway for patients in all areas of Ontario supported by the Telehomecare program. In addition to the new COVID+ pathway, two primary pathways for congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD) were available to support patients for up to 16 weeks. In 2023/24 and Q1 2024/25, we standardized the program eligibility and reporting criteria for each of these pathways to ensure consistent

patient support in all areas of Ontario and to create better continuity of data reporting within CHRIS to create opportunities for future improvement.

Mental Health and Addictions Nursing

The Mental Health and Addictions Nursing program consists of specialized nurses working in the community and in schools to assist students who have various mental health and addictions challenges requiring early intervention, psychoeducational support and therapeutic strategies.

In 2023/24, mental health and addictions nurses across the province completed more than 58,200 visits, an 8.6% increase compared to the previous fiscal year. This increase in service continued to trend upwards with almost 18,000 visits completed in Q1 2024/25, a 4.7% increase when compared to Q1 2023/24.

Self-Management Program

The Self-Management Program offered a Living a Healthy Life series that included workshops and supports focused on chronic pain, diabetes and chronic conditions. The team, along with 58 highly skilled, lived experience volunteer facilitators, empowers people living with health conditions to take charge of their health, improve their health literacy and live healthier and more fulfilling lives. Through its Powerful Tools for Caregivers workshop, caregivers develop a wealth of self-care tools to reduce personal stress, communicate their needs to family members and health care or service providers and make tough caregiving decisions. In 2023/24, the program hosted 46 Living a Health Life workshops and 31 Powerful Tools for Caregivers workshops for a combined total of 552 participants.

The Health Care Professional training program offered workshops targeted to those who have a role in motivating individuals to make healthy changes. The workshops are focused on self-management support interventions and developing communication skills to motivate patients. In 2023/24, the Self-Management program hosted 17 Health Care Professional workshops, with 195 participants.

Collaborating to Support Vulnerably Housed Individuals in the Champlain area

To address a growing need for health and wellness supports for vulnerably housed individuals in the Champlain area, we collaborated with service provider organizations to connect patients with appropriate community resources to support their needs.

In 2023/24, we partnered with local community support service agencies, community mental health charities and other local organizations to optimize home environments and prevent the loss of stable housing and support patients' basic needs and facilitate overall wellbeing. The team also acted as a liaison with the Oasis program at Sandy Hill Community Health Centre, Neighbourhood Integrated Care Model project and Ottawa Inner City Health to support vulnerable clients requiring intensive care management.

We also partnered with and supported The Royal Ottawa Outreach and various community health centres across the city to address mental health challenges and diagnoses, serving an average of 50 patients monthly.

Caregiver Distress and Supports

Over the past few years, significant pressures such as the COVID-19 pandemic and the resulting impact on health human resources, combined with limited access to long-term care, social supports and increased financial strain have resulted in elevated caregiver distress rates across the province. According to Caregiver Distress Indicator results from fiscal year 2018/19 to 2022/23, the percentage of caregivers of complex and chronic patient

populations in distress increased from 64% to 72% and from 37% to 41% respectively.

To better understand the key contributors to the elevated caregiver distress rates, Home and Community Care Support Services produced a Caregiver Distress Report for submission to the Quality Committee of our Board.

In developing this report, an opportunity was presented to engage with caregivers and hear their firsthand accounts. Through a facilitated focus group and subsequent survey with members of our Community of Advisors, caregivers who were/are supporting someone on service with Home and Community Care Support Services, shared their experiences, reflections and recommendations.

The resulting report explored key themes, including caregiver health and wellbeing, health care needs of patients and caregivers and access to health care. In addition, initiatives across the health care system supporting caregiver wellness were identified and opportunities to expand and enhance existing Home and Community Care Support Services programs and to adopt new programs and approaches were outlined, including:

- Designing and executing models of care that leverage efficiency in care delivery, including Community Transitional Care Bed programs, the expansion of nursing clinics, expanding the neighbourhood model of care and creating direct service contracts with retirement home settings.
- Providing staff with caregiver distress education and training to support early identification of caregiver distress and mitigation strategies.
- Sharing active leading practice initiatives with regions that are experiencing higher distress rates, such as elder mediation and respite and relief programs.

To ensure we are making a difference in improving the patient and caregiver experience, we relaunched the Patient and Caregiver Experience Evaluation (PCEE) survey, which will help us enhance patient health outcomes and consistent experiences across Ontario. We will use the caregiver portion of the survey, along with caregiver distress data (one of our Annual Business Plan indicators), to monitor and better understand the needs of caregivers and inform further ways of supporting them with the goal of improving patient and caregiver satisfaction and control over care.

Streamlining Organizational Structures, Systems and Processes

Building on our work in 2022/23 to establish a strategic organizational structure and streamlined leadership team, we continued to focus on effectively aligning our teams, filling gaps and improving the way we work together provincially throughout as we prepared to amalgamate to become Ontario Health atHome. We accomplished this by aligning and standardizing programs, policies and processes to build a strong and centralized foundation to support stability of home care services now, and in the future. These actions to align our people, processes and technology will support us to deliver on our new mandate as a service organization supporting Ontario Health Teams.

While activities to prepare for transition were underway for much of 2023/24, a tremendous amount of work was accomplished in Q1 2024-25, including:

- Rebranding to Ontario Health atHome, including redesigning all promotional materials, forms, letters, public-facing website, etc. to reflect our new name, logo and visual identity.

- Preparing formal communication to staff, our service providers and vendors, our Community of Advisors and health system partners, including hospitals and long-term care homes regarding the official proclamation of the *Convenient Care at Home Act, 2023*, continuity of care and operations.
- Streamlining and aligning our systems, tools and technology, including migrating to our new @ontariohealthathome.ca email domain, updating our website domain to reflect ontariohealthathome.ca and continuing to prepare for our eventual transition to SharePoint Online as our provincial collaborative workspace and official business record repository for Ontario Health atHome.
- Equipping staff for a successful transition day through the development of a Staff Transition Guide, which included important guidance for updating email addresses and signatures and phone greetings and voicemails. Additionally, actions were taken to ensure staff received rebranded lanyards and ID badges to begin wearing immediately, particularly patient-facing staff.

Unified Leadership

Our organizational design project has made significant progress over the past three years, steering us toward a provincial focus and structure.

After previously establishing a single Executive Leadership Team for all 14 organizations, work began in 2023/24, and continued through Q1 2024/25, to formalize the functional portfolios into provincial and/or regional operating models, aligned to improve the way we work together to support our ability to deliver the best possible care for the patients we serve, and to support OHTs in the future. This approach focuses on building specialized expertise and developing high-performing teams across Ontario.

To optimize our alignment with Ontario Health and support our effectiveness as a service organization supporting OHTs, Patient Services has regionally organized to match the six geographic regions of Ontario Health. This ensures that our services are tailored to the specific needs and characteristics of each region. This step also supports data reporting processes and our participation in regional planning tables.

Quality, Safety and Risk is also organizing with this structure, thereby ensuring the highest quality standards are maintained and to effectively manage risk in collaboration with Patient Services.

Building a Strong and Resilient Team Through the Expansion of Key Initiatives Under our People Strategy

In 2023/24, and continuing into Q1 2024/25, we made significant advancements in alignment with the four pillars of our People Strategy to enhance the organization. The People Strategy work focused on wellness, wellbeing, health and safety; cultivating an effective team culture; embedding the principles of equity, inclusion, diversity and anti-racism into every aspect of our organization; and building rewarding careers, emphasizing the importance of these areas for our staff and those we serve. We accomplished this by:

- Establishing province-wide leads to drive standardized practices and policies, such as the development and implementation of six harmonized occupational health and safety policies;
- Ensuring staff is supported and has access to wellness and mental health programs and initiatives by offering complementary

virtual wellness workshops in partnership with the Canadian Mental Health Association;

- Launching a refreshed Employee Engagement Survey that features three annual pulse surveys, designed to gather frequent feedback during our transformation to Ontario Health atHome and to ensure employee feedback is translated into tangible outcomes;
- Standardizing and launching a unified non-union Performance and Development Program, with plans to design a consistent program for unionized staff in 2024/25;
- Harmonizing non-union total compensation practices and establishing a provincial non-union compensation structure and associated policies;
- Introducing a provincial Learning and Development policy and standardized request and approval process, providing staff with access to opportunities that build and improve their skills and capabilities and support their professional growth;
- Implementing the LEADS in a Caring Environment capabilities framework; and
- Creating a new leadership position dedicated to developing and operationalizing our organizational EIDAR strategy and upholding our commitment statement.

Standardizing Patient Care to become Ontario Health atHome

Over the last year, we took deliberate steps to implement 18 standardized provincial policies and 20 education modules to support staff training. We aligned internal practices in the following areas to create standardized forms, guidelines and processes to ensure a consistent experience no matter where someone lives in the province:

- Long-Term Care Placement
- Centralized Access, Intake & Navigation
- Palliative Care
- Telehomecare
- Children's Health
- Clinical Intervention
- Family-Managed Home Care
- Hospital and Community

Navigation, Access and Intake

Our Information and Referral teams provided health system navigation support through nearly 2.1 million calls from patients, caregivers and other health system partners in 2023/24. Additionally, from April 1, 2023 to June 30, 2024, our online health services directory – thehealthline.ca – which offers nearly 45,000 service profile listings, was accessed over 10.1 million times.

A multi-year initiative began to standardize our Patient Services access, intake and navigation procedures, beginning with an environmental scan of current state, identified opportunities for standardization and established the following five work streams:

- Standardized Eligibility Criteria
- Centralized Access (One number)
- Standardized Intake and Information & Referral Processes

- Intake and Information & Referral Team
- Integration with Ontario Health Teams

Standardized Provincial Adult Personal Support Services Framework

To add greater consistency and equity for patients, we developed a standardized provincial adult personal support services framework for the provision of eligibility, care planning and waitlisting processes based on patient assessment outcomes. This work aimed to support fairness and equity, streamline waitlist management, improve patient experience for waitlisted patients, improve access to personal support services for adult patients with high care needs, and navigate patients with low and moderate care needs to community support services agencies.

By the end of August 2023, all 14 geographies completed robust readiness assessments to inform a staggered implementation across the province, which was completed by the end of June 2024.

Early success indicators include improved access to care as evidenced by a decrease in waitlisted adult personal support services patients, service provider organizations consistently selecting patients according to priority sequence criteria and increased acceptance rates overall.

Improving Family-Managed Home Care

More than 1,300 families across Ontario are enrolled in the Family-Managed Home Care program, which empowers patients and their families to manage care independently by providing funding directly to patients or their substitute decision-makers to hire care providers and purchase necessary services.

Over the last year, a provincial working group formed to standardize the Family-Managed Home Care program so patients, families and caregivers have access to the same services, experiences and outcomes regardless of where they reside. This group created a program model and developed provincial tools, guidelines and processes that include the introduction of a single-funding model province-wide that allocates a lump-sum amount at the beginning of each month, enabling patients and families to manage their funds as needed throughout that period. Those geographies that adopted this payment method have reported significantly higher patient and family satisfaction.

Standardizing Hospital Discharge Process

In alignment with our 2023/24 Annual Business Plan, we worked to improve and streamline the discharge process from hospital to home, with a goal of ensuring patients experience a smooth and safe transition no matter where they are in the province.

This extensive, multi-year initiative involves working closely with partners, patients, families and caregivers to address variances amongst the 14 geographies to enhance and standardize the hospital discharge process across the province.

Over the course of 2023/24 and into Q1 2024/25, a comprehensive analysis of current discharge processes across more than 230 hospital sites was conducted, resulting in the creation of a provincial set of principles to guide the development of the Hospital Standard Work Document. This document will be implemented in a phased approach beginning in the fall 2024.

Standardizing Caseload Reviews to Support Best Possible Patient Outcomes

Patient caseload reviews are an important strategy to validate data integrity, ensure optimal service utilization and review current care plans to support best possible patient outcomes. We developed standardized provincial caseload review guidelines and processes to support consistency across all 14 organizations.

All Patient Services teams now complete two caseload reviews each year – in May and October. For fiscal year 2024/25, the first caseload review was completed in Q1 resulting in file updates, patient re-assessments and data quality enhancements. Using a standardized provincial caseload review checklist, all caseloads were reviewed by the primary care coordinator/placement coordinator (caseload holder), including specialty, palliative, Family-Managed Home Care, child and family and long-term care placement-only files.

Ensuring consistent clinical assessments for equitable access to care

We coordinated care planning and the provision of services based on the completion of patient assessments using interRAI clinical assessment instruments.

Following an environmental scan across the province, three new provincial policies to support consistency were developed and introduced:

- Standardization of the interRAI clinical assessment instruments used for adult long-stay and palliative patients.
- Introduction of mandatory interRAI competency evaluations to ensure the consistent application of coding standards.
- Establishment of employee standards for the activities and skills required to complete the patient assessment process accurately, effectively, and efficiently.

Improving Palliative Care: Early access for patients in need

Hospice palliative care supports patients and their loved ones to improve their quality of life at all stages of a life-limiting illness. This care enables people to remain at home or support a transition to a hospice residence or other preferred location.

In 2023/24, we standardized our palliative and oncology care eligibility and tools, including the development of standard criteria and the creation of an adapted version of the Gold Standards Framework Prognostic Indicator Guidance tool to help staff identify (as early as possible) patients appropriate for palliative care.

Aligned with Ontario Palliative Care Network best practice guidelines and the Ontario Health Reporting Standards, the oncology and palliative policies were enhanced to ensure equitable access to and delivery of palliative care across the province.

Enhancing Patient Services Operations Through Standardization of Key Quality, Safety and Risk Policies and Procedures

Provincial Ethics Program

To promote ethical, safe, effective, high-quality and equitable service delivery, we launched the Ethics Program in July 2023, which included the implementation of a standardized policy, framework, education and tools for supporting ethical practice across the province.

The Ethics Program provides staff with a consistent and coordinated approach to delivering quality, ethical services using a single set of expectations and guidelines that meet patient and government expectations. A Provincial Ethics Steering Committee was established to direct and sustain the program. An Ethics Community of Practice comprised of local ethics leads, committee members and champions provides opportunities to share experiences, learn and support one another, and local Ethics Committees build capacity for ethical practice at the local level.

A provincial bioethicist was hired to provide leadership in further developing and promoting the ethics program and to provide consultation

on ethical decision-making across the organization.

Medical Equipment and Supplies

In 2023/24, as part of our Annual Business Plan, we undertook an initiative to modernize contracts through the procurement and implementation of a provincial Medical Equipment and Supplies structure – a project co-led with Ontario Health.

A crucial step in 2023/24 was the procurement of five streams of services:

1. Negative Pressure Wound Therapy
2. Wound Care and Medical Supplies
3. Fulfillment Services (pick, pack, and ship)
4. Infusion Services
5. Medical Equipment

Full implementation is planned for March 2025, using a phased approach.

Infection Prevention and Control

In 2023/24, work began on developing a provincial Infection, Prevention and Control (IPAC) program. A Provincial IPAC Lead was appointed and a detailed scope and action plan for the program was developed based on national and provincial standards.

Additionally, a new provincial multi-disciplinary IPAC committee was established to serve as an oversight and advisory body to guide the IPAC program's development and maintenance. The committee oversaw the implementation of a work plan that established a comprehensive, integrated IPAC program based on best-practice standards, and ensured alignment with the broader health care community as we moved toward becoming a service organization.

Advance Home and Community Care Modernization

In 2023/24, we continued to develop and implement a number of new provincial policies and practices to align our 14 organizations with O. Reg. 187/22 (Home and Community Care Services), which came into force on May 1, 2022 under the *Connecting Care Act, 2019*.

Patient Abuse Prevention, Recognition and Response

On its website, Elder Abuse Prevention Ontario states "…studies indicate that between 8% to 10% of older adults experience some form of abuse. Based on Census data (2020), there are currently 2 million older adults over the age of 65 residing in Ontario, which translates to over 200,000 older adults in Ontario alone, experiencing, or at-risk of elder abuse."

In fiscal year 2022/23, a provincial plan was developed to support the establishment of a consistent approach to abuse management. Critical work continued in 2023/24, building on the foundational elements of that plan, which focused on the prevention, identification and response to instances of abuse. In response to strengthened direction in legislation, and in the interest of the wellbeing of our patients, a comprehensive Abuse Management Framework was developed and implemented and includes standardized policies and procedures rooted in best practice, educational materials and response guidelines.

Patient Complaints and Appeal Management

In 2022/23, we developed a provincial Patient Complaints and Appeal Management policy to support a consistent approach across our organizations with an effective, transparent and patient-centred complaint management processes that comply with legislation. Work continued in 2023/24, with focus on the development and implementation of two

frameworks – Patient Complaints and Safety Incident Management. The frameworks align with legislative direction and include a focus on definitions, severity rankings, decision trees and associated metrics. Implementation of the frameworks, which will continue throughout 2024/25, supports a provincially standardized approach in compliance with legislation and enables monitoring and benchmarking of data and response development across the province. Work also began to develop standardized scenario-specific protocols for responding to complaints.

Increased awareness and adoption of the patient complaint framework as well as improved adoption across the 14 organizations to the new 30-day target for closure of complaints had a positive influence on complaints metrics in 2023/24, with the percentage of complaints acknowledged to the individual who made a complaint within two and five business days experiencing notable improvements, from 94.1% acknowledged within two days and 97.1% acknowledged within 5 days in 2022/23 to 97.3% and 99.1% respectively. Similarly, notable improvements were seen in the percentage of complaints closed within 30 calendar days and 60 calendar days from 42.5% closed within 30 days and 60.8% closed within 60 days in 2022/23 to 54.4% and 71.4% respectively.

The full standardization of our approach to complaints and incidents management will be actualized through the procurement of a province-wide software system to support an aligned approach to capturing and responding to complaints and incidents and will better support data capture and analysis across the entire province.

Home and Community Care Support Services and Service Provider Organization Forum

In winter 2023, a new, monthly provincial Home and Community Care Support Services and Service Provider Organization (SPO) Forum to enhance collaboration and two-way communication and information sharing was launched. The monthly Forums provide an opportunity to:

- Share information affecting the home and community care sector;
- Consult co-operatively to identify potential risks that may affect patients and the sector;
- Support improved efficiency and system capacity; and
- Identify opportunities for sector improvement and modernization.

For example, data concerning patient complaints and patient safety incidents across the province was reviewed. The review was made possible by a provincial framework that harmonized reporting practices across our 14 organizations. Feedback was also sought on the development and membership of a new SPO Capacity Planning Working Group. The meeting also provided time to answer questions regarding reporting requirements under the government's Personal Support Workers and Direct Support Workers Permanent Compensation Enhancement Program.

Service Provider Risk Assessment

In collaboration with Ontario Health, we introduced an interim and one-time risk assessment process for all service provider organizations. In the past, service providers completed a more comprehensive prequalification – a requirement under the Ministry's Client Services Procurement Policy (2007). Last completed in 2021, work to

modernize the prequalification process was undertaken and in the interim, service providers completed the risk assessment.

This assessment was intended to ensure standards were met related to privacy, cybersecurity, experience and capacity to deliver services, as well as safeguards focused on patient safety and quality of care in alignment with requirements related to Abuse Prevention as outlined in Regulation 187/22. Across the province, the risk assessments have been reviewed and work continues with the service providers on their plans to support compliance with these standards.

Improvements to Long-Term Care and Placement

From April 1, 2023 to June 30, 2024, we transitioned nearly 33,000 individuals into long-term care homes – about 14,600 from the community, approximately 15,600 from hospitals and transferred nearly 2,800 patients between long-term care homes across the province.

Expanding Long-Term Care

Across Ontario, as of October 2024, there are 618 long-term care homes and 80,492 beds. These are specially designed facilities where people can live safely and comfortably with access to onsite nursing care and assistance with personal care on a 24/7 basis.

In 2023/24, more than 1,500 new long-term care beds were opened provincially. This included opening 978 new beds in the Central region, adding much needed capacity into the health care system. Specific examples included 320 beds at Humber Meadows Long-Term Care Home, which opened in June 2023. In the Mississauga Halton area, Wellbrook Place East and Wellbrook Place West opened in fall 2023, adding 632 beds.

Behavioural Support Transitional Units

Behavioural Support Transitional Units (BSTU) are designed for individuals expressing responsive behaviours (generally associated with dementia) to receive transitional, specialized support to stabilize their behaviours before they return to their community or long-term care. While the anticipated length of stay is 120 days, it is not a fixed period and depends on the resident and their ability to safely transition to other care. BSTUs help prevent unnecessary and avoidable emergency room visits and potential hospitalizations of current long-term care home residents and enhance the quality of life for residents and their care partners.

In September 2023, through a partnership involving Home and Community Care Support Services and the Ministry of Long-Term Care, Lakeridge Gardens in Durham Region began accepting patients to a 16-bed specialized BSTU pilot and Peel Manor in Brampton added 26 BSTU beds in fall 2023.

Achieving Efficiencies and Streamlining the Long-Term Care Application Process

Long-Term Care Placement in Toronto Central

January 2024 marked the end of a multi-year project as Toronto Central completed the migration of all long-term care applications onto CHRIS and Health Partner Gateway (HPG). Moving all long-term care applications into CHRIS aligned placement processes and practices in Toronto Central with the rest of the province, leading to a streamlined process. The change cleared an application backlog and created a better, more efficient system for processing of long-term care applications. This change led to significant data improvements and gave Toronto Central staff access to more accurate and timely data.

Standardizing Long-Term Care Placement

To ensure all patients and families applying for long-term care have a similar placement experience no matter where they begin their journey, and in support of our future operational model as Ontario Health atHome, work began to develop a *Long-Term Care Placement Standard Work Document*. This work included standardized and patient-centred policies and procedures that adhere to the latest legislation and regulations. Work continues to support patients in crisis, including standardized crisis definitions and guidelines for practice, a crisis override guide and a handout for community crisis patients.

The following long-term care-related guides were developed in 2023/24 to support province-wide consistency:

- Guide for Opening New Long-Term Care Homes
- Guide for Long-Term Care Home Closure
- Guide for Long-Term Care Home Redevelopment
- Guide for Opening a Specialized Unit in a Long-Term Care Home

In addition, patient-facing materials were standardized across the province and four new long-term care capacity evaluation eLearning modules to support ongoing staff education were developed.

A review of long-term care home waitlists was undertaken to ensure patient choices were current. This work included more than 16,500 phone calls to waitlisted patients resulting in more than 5,300 or 22% of patients residing in long-term care homes choosing to remove their names from the waitlist. During the same timeframe, the overall number of patients on the long-term care waitlist decreased by 3% or approximately 1,900 residents. This work enhanced efficiency for cross-geography documentation, reduced duplication, streamlined the bed offer process and supported greater data accuracy.

Reinstatement of Pre-Pandemic Regulatory Requirements

At the height of the COVID-19 pandemic, several measures were put in place to increase the safety of long-term care home residents. With the Government of Ontario declaring the public health emergency over, amendments were made to the *Fixing Long-Term Care Act, 2021* to address current conditions and support the reinstatement of pre-pandemic regulatory requirements. Effective July 1, 2024:

- Care coordinators are required to complete a full eligibility assessment for placement, including interRAI-HC and Health Assessment. They would no longer complete assessments based only on the information available in the current situation;
- All acceptance or refusal decisions are to be communicated in writing;
- All community applicants who refuse a bed offer will be removed from all waiting lists and required to wait 12 weeks before reapplying, unless there's a significant change to their condition. Patients would no longer be able to refuse a bed due to the pandemic and remain on the waitlist;
- Residents moving out of a long-term care home must reapply to return and will be placed in the appropriate category. Patients would no longer be able to request a discharge from a home due to the pandemic and be re-admitted under the readmission category;
- The language was revised to offer greater flexibility in designating "imminent home closure," either before or after the actual closure date;

- Simplified admission processes were extended to a new, connected or reopened home operated by a different licensee when suitable; and
- Long-term care staff would not have to conduct a full resident assessment for admission, saving time, reducing administrative burden and ensuring continuity of care.

In Q1 2024/25, in advance of the reinstatement of pre-pandemic regulatory requirements, our staff received detailed information and education to support this shift.

Advance Health System Transformation

Home and Community Care Support Services is a partner with Ontario Health and the Ministry of Health in advancing health system transformation. 2023/24 saw the continued support for the development of OHTs across the province, particularly as they prepare to take on responsibility for home care delivery over time.

OHT Leading Projects

In 2023/24, Home and Community Care Support Services played a key role in advancing home care modernization and testing innovative care delivery models in partnership with the Ministry of Health, Ontario Health and OHTs through seven Leading Projects. The Leading Projects are two-year tests of change that are being planned in partnership between the Ministry of Health, Ontario Health, Ontario Health atHome and the OHTs in the following areas:

Ontario Health Team	Home and Community Care Support Services Geography	Leading Project Model of Care
Frontenac Lennox & Addington	South East	Health Home Model
Durham	Central East	Primary and Community Care Hub
East Toronto Health Partners	Toronto Central	Interprofessional Neighbourhood Home Care Team
Mississauga	Mississauga Halton	Palliative integrated model with service providers, primary care, hospice & hospital
Nipissing Wellness	North East	Builds on High Intensity Supports at Home (HISH)
Chatham-Kent	Erie St. Clair	Palliative care team linked to primary care, hospice & service providers
Guelph Wellington	Waterloo Wellington	Integrated Primary Care Team (IPCT) Model

The Leading Projects present opportunities to explore different approaches to further integrate home care within OHTs. In 2023/24, we provided input and subject matter expertise to three critical work streams for the Leading Projects:

- **Service Provider Organization Selection, Contracting & Care Services** – test chosen selection and contracting approach to support implementation of Leading Projects, including care services funding and contract development.
- **CHRIS, Privacy, Information Management (and other digital enablers)** – ensure access to CHRIS and other digital enablers for SPOs are in alignment with existing privacy requirements.
- **Care Coordination Transformation** – develop the framework for care coordination within new models of care.

We have continued to support planning for the Leading Projects, which are expected to go live in 2024/25.

Transition to Ontario Health atHome

On June 28, 2024, the *Convenient Care at Home Act, 2023* was proclaimed into force, and the province's 14 Home and Community Care Support Services organizations amalgamated into a single service organization called Ontario Health atHome.

With a focus on the eventual delivery of high-quality home care through OHTs, patients, families and caregivers can expect more integrated and patient-centred care across health system partners. Significant work throughout fiscal year 2023/24 and Q1 2024/25 occurred to prepare for a seamless transition for staff, as well as patients, families and caregivers.

Collaboration between the ministries of Health and Long-Term Care, Ontario Health and Home and Community Care Support Services was pivotal in planning for our amalgamation to become Ontario Health atHome. These efforts laid the groundwork for a successful transition to a new single entity with no disruption to patient care.

Developing a Service Model for Ontario Health atHome

As we prepare for the next phase in our transformation to become a service organization supporting OHTs, planning work is underway in collaboration with the Ministry of Health, Ontario Health and OHTs to develop a service catalogue to support OHTs. This will be supported by a robust client relationship service model and operating model.

Community Engagement

Community engagement is an important planning and evaluation tool that helps us achieve our mission while improving the patient experience by hearing from, and speaking with, the unique communities we serve across the province.

We participated in more than 200 events across the province, reaching an estimated 7,500 members of the public. Staff subject matter experts typically focused on providing general information about home and community care services and about long-term care placement. This included attending health fairs and delivering presentations to seniors and community groups such as Georgian Bay Cancer Centre, Centre Francophone du Toronto and Mon Sheong Foundation; health system partners such as North West Toronto Ontario Health Team, York Region Paramedic Service, Parkinson Society and the Canadian National Institute for the Blind; municipalities such as the Town of Grimsby and Region of Peel; and educational institutions such as University of Ottawa and McMaster University.

To recognize, celebrate and support caregivers who make it possible for people to live their lives in their communities despite the impacts of age, illness or disability, our team established the Above and Beyond Caregiver Recognition Program. To celebrate these inspiring individuals, the inaugural recognition event was launched May 10, 2023, with in-person celebrations in five locations as well as being live streamed across the province. We received 106 nominations from across the province with six recipients honoured in specific categories such as caring and sharing and partner in care.

The 2024 event was held on National Caregiver Day (April 2, 2024). The event honoured nine category recipients and a total of 110 nominees. More than 200 people attended the online event which represented a 35% increase from the previous year. Recognizing the incredible sacrifices that caregivers make to support their loved ones and the challenges and barriers they encounter, we introduced a focused engagement session where caregivers had the opportunity to share their experiences and learn from one another, including where to go for further support. These learnings, as well as additional caregiver resources were shared back with all attendees and posted on our website with plans to expand this offering in 2024/25.

Feedback from the events was overwhelmingly positive, with one caregiver recipient who shared, “it was an incredibly inspiring and moving event. We feel very grateful to be part of it.”

Engagement with Community of Advisors

Involving those with lived experience brings unique insight, helps guide us in the development of patient-centred programs, services and policies and further ensures our services are relevant, beneficial, reflective and supportive of patient needs, priorities and values.

We continued our Community of Advisors program in 2023/24 and Q1 2024/25, with approximately 60 active advisors from across the province who are reflective of the people we serve. These advisors provided more than 330 hours of engagement, supporting key organizational initiatives such as hospital to home discharge planning, patient safety disclosure meetings, family-managed home care and the development of our Equity, Inclusion, Diversity and Anti-Racism (EIDAR) Framework. They also shared their lived experiences through patient stories to our Board of Directors and took part in various events for Indigenous Peoples Day, Pride Month and Black Experience Week.

Advisors were engaged in work across multiple organizational and functional areas, including Organization and Governance, Quality, Safety and Risk, and Patient Care Programs and Services, ensuring the patient and caregiver perspective was embedded in the most critical and meaningful aspects of our work.

Engagement with Francophone Communities

We remain committed to engaging with the Francophone community to better plan for, and understand, this diverse population. In 2023/24 and Q1 2024/25, and in accordance with the *French Language Services Act*, we built on our commitment to French language services and strengthened relationships with French Language Health Services Planning Entities across the province.

Our provincial French Language Services Committee continued its work throughout 2023/24 and Q1 2024/25, highlighted by the establishment of a standard provincial French Language Services policy which was fully implemented in February 2024.

In recognition of our commitment to the active offer of French Language Services, in May 2024, the Réseau du mieux-être francophone du Nord de l'Ontario presented us with a certificate to acknowledge 100% staff completion of “The Active Offer of French Language Health Services: Why it matters and How to Put It Into Practice” training.

In April 2024, a number of staff attended l'Assemblée de la francophonie de l'Ontario conference in Toronto, which focused on Francophone experiences of care (Journée de réflexion en santé en français 2024).

Home and Community Care Support Services Hamilton Niagara Haldimand Brant collaborated with Centre de santé communautaire Hamilton and introduced a new Francophone clinical care coordinator position. This position is embedded within the community health centre and supports patient care needs in the community related to care coordination and system navigation. The clinical care coordinator also assists with nursing assessments which can support emergency department avoidance. This role also enabled us to engage with French speaking active patients in Hamilton, outside of the community health centre, to offer care coordination services in their desired language.

In the Niagara community, a new French speaking patient services assistant position was introduced to enable individuals and partners calling into the office to speak to a Francophone administrative staff in their preferred language.

Home and Community Care Support Services South West continued to match a dedicated French speaking care coordinator with a Francophone caseload in the London area to better serve and understand the needs of that community. Additionally, the South West geography continued to be a supporting partner of the local Francophone Service Hub, Accès Franco-Santé London, located at Carrefour Communautaire Francophone de London. It is a central point of access for information, referral and navigation of the health and social systems for Francophones in Middlesex-London. Partners include Carrefour Communautaire Francophone de London, Ontario Health, Addiction Services of Thames Valley, London InterCommunity Health Centre, Vanier Children’s Mental Wellness, Entité de planification des services de santé en français and Canadian Mental Health Association Middlesex.

In Central East, a French language services care coordinator in Scarborough attended the Special Education Advisory Committee of the Conseil Scolaire Catholique MonAvenir in May and June 2024.

Engagement with Indigenous Communities

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

All Home and Community Care Support Services staff across the province were invited to participate in Indigenous Cultural Safety Training provided by San'yas. Covering topics such as the social determinants of health in relation to Indigenous people, gaps in health equity for Indigenous people and how racism, discrimination and stereotyping impacts Indigenous peoples in health care contexts, this training fosters safe and effective health services for Indigenous people. Building on the large number of staff who have already taken this training, more than 150 more staff participated during 2023/24 and Q1 2024/25.

To contribute to our collective reconciliation efforts, more than 1,100 staff took part in a presentation by the National Centre for Truth and Reconciliation. Participants learned about intergenerational trauma, its impacts on communities and the importance of a trauma-informed approach across the board for service providers. Additionally, Kathy MacLeod Beaver shared a presentation with more than 1,300 staff about her role as an Indigenous Navigator for the Central East Regional Cancer Program and provided actions for them to take away and use in their practice with Indigenous communities.

Representatives from our EIDAR and Community Engagement teams attended a National Indigenous People Day event in Oakville on June 21, 2024 to honour, celebrate and reflect on the history, resilience and impact of First Nations, Inuit and Métis Peoples. The event featured Six Nations Smoke Dancers, Butterfly Spirit Drummers and concerts and reflections from musicians. Throughout these performances, the power and importance of oral history/storytelling and tradition was at the forefront.

Each week in September 2023, Indigenous Working Group members shared information to help staff learn more about Indigenous culture and the issues that continue to face Indigenous communities today, including the four sacred medicines, the Qikiqtani Truth Commission and how to be an effective ally. Together, we recognized the rich history, heritage, resilience and diversity of First Nations, Inuit and Métis Peoples across Canada.

In Erie St. Clair, Home and Community Care Support Services supported the Aamjiwnaang First Nation community, located in Sarnia, with the opening of a new hospice-like space, Ganigiiwe. In consultation with the First Nations community, we provided a dedicated care coordinator to support referrals from this new location. Providing a consistent point of contact for care coordination supports improved transitions of care when patients choose to move from their home in their final weeks of life.

Home and Community Care Support Services Erie St. Clair also collaborated with VON, Kettle and Stony Point First Nation and Aamjiwnaang First Nation communities to expand the eShift model of care by securing a dedicated First Nations on-site personal support worker to provide care for patients, while working directly with VON directing registered nurses. This expansion enabled more care to be provided directly in the First Nations' communities with more equitable and culturally sensitive care.

Home and Community Care Support Services Hamilton Niagara Haldimand Brant held

quarterly meetings with Six Nations and Mississaugas of the Credit First Nations. The group collaborates on a number of initiatives to support First Nations communities in the Brant area. This included dedicating care coordinators to support the communities and continued support for end-of-life care with a culturally appropriate Palliative eShift program with Six Nations home care personal support workers trained as the eShift technicians.

Home and Community Care Support Services South West continued to align care coordinator caseloads to Indigenous communities, supporting care for over 150 Indigenous patients, demonstrating its long and proud commitment to better support relationships with Indigenous communities across the region. In addition, staff regularly attended community health events and fairs at Saugeen First Nation.

In Central East, a dedicated care coordinator served the Indigenous communities of Curve Lake and Hiawatha First Nations.

Staff in Waterloo Wellington benefitted greatly from the expertise of the Southwest Ontario Aboriginal Health Access Network which opened a location in Waterloo Wellington. In addition, Home and Community Care Support Services staff at Cambridge Memorial Hospital participated in smudging ceremonies on site and received support with a palliative approach to care for those who identify as Indigenous.

Engagement with Specific Communities and Populations

In 2023/24 and Q1 2024/25, we further delivered on our commitment to equity, inclusion, diversity and anti-racism (EIDAR) as part of our strategic priority to Invest in our People. Several activities were held throughout the year to provide staff with opportunities to increase their awareness and understanding of the unique populations we serve across the province.

Building on this commitment and to deliver on our EIDAR Framework, an EIDAR Advisory Committee – a group of EIDAR-informed staff to provide guidance and advice on key EIDAR projects and support quality EIDAR efforts – was established. Additionally, Employee Resource Groups – provincial level staff-created groups for employees of shared experiences/identities to connect, make recommendations and run EIDAR initiatives at their discretion – were introduced.

Further, an EIDAR Collaboration Committee was established. This committee is a group made up of the EIDAR Manager, Communications staff and leads from each Employee Resource Group (ERG):

- Accessibility Disability ERG (for staff living with a disability)
- Anti-Semitism ERG (for Jewish staff)
- Anti-Racism, Inclusion, Social Justice and Equity (ARISE) ERG (for Black staff and staff of African descent)
- Muslim ERG (for Muslim staff)
- Pride ERG (for 2SLGBTQIA+ staff and allies)

Together, members of the EIDAR Collaboration Committee coordinate efforts, facilitate ERG collaboration and support ERG alignment with provincial efforts. Throughout 2023/24 and Q1 2024/25, ERGs led staff engagement and education initiatives and provided key insights for projects including the EIDAR Framework and EIDAR strategy.

To support staff understanding of anti-Black racism, the Anti-Racism, Inclusion, Social Justice and Equity (ARISE) ERG for Black staff and staff of African Descent, led a focused discussion on what Emancipation Day is, its importance and what it means for us today.

Nearly 1,200 staff took part in a Black Health Equity Panel that brought together Joanne Robinson, a caregiver with experience caring for Black seniors and seniors of African descent personally and through her nonprofit; Shelly Laforest, a registered nurse and the founder and Executive Director for Ontario Black Nurses' Network; and Sharon Stanley, a staff member in our South West geography and member of the National Racial Justice Committee for CUPE. The panelists discussed how Black health equity is relevant to the work we do, why it is important, the role they play in supporting it and the actions they can take.

Additionally, the Black Health Alliance provided a presentation to children and family and mental health and addictions teams in 13 of our geographies to support how we interact and support the mental health of Black children, youth and families. After the presentation, staff were provided with a tool to find culturally safe mental health resources for this population.

To support cultural safety for 2SLGBTQIA+ communities, we added functionality in our CHRIS system to document a patient's pronouns and developed and assigned Pronouns Matter Training to all staff. The training explores what pronouns are, why they are important and how to use them appropriately. More than 4,200 staff have completed the training.

Seven hundred course bundles were purchased from the Canadian Diversity Initiative for the online modules LGBTQ2+ Diversity and Inclusion Training for Workplaces, Unconscious Bias In The Workplace and Respect and Inclusion in the Workplace. More than 30% of staff completed all the courses in 2023/24.

In Champlain, we facilitated connections between individuals and the Centretown Community Health Centre in Ottawa for mental health support related to gender diversity. We also collaborated with the Youth Services Bureau and various housing care managers to identify appropriate housing options for individuals identifying as 2SLGBTQIA+.

Health System Performance

We continued to coordinate in-home and community-based care for thousands of patients across the province each day, while simultaneously preparing for our transition to a single service organization under the name Ontario Health atHome. At the same time, activities to support health system recovery and achieve the targets outlined within the Minister's Letter of Direction and our Annual Business Plan continued.

Key priorities and activities focused on ensuring alignment with the government's plan for health system modernization, as outlined in the *Connecting Care Act, 2019*, included collaboration and support for OHTs, and with compliance efforts related to legislative requirements under the *Fixing Long-Term Care Act, 2021* and the *Connecting People to Home and Community Care Act, 2020*. To align with and support system-wide goals identified in Ontario's *Plan to Stay Open: Our Health System Stability and Recovery*, we continued to implement strategies and initiatives related to the multi-year capacity planning initiative with five key priority areas, focused on sustaining and improving home care and system capacity:

1. Targeted service provider organization incentives.
2. Enhanced utilization of transitional care beds in retirement homes.
3. Increased neighbourhood models of care.
4. Optimization of direct care nursing and therapy staff.
5. Maximize and expand community clinics.

While addressing these additional responsibilities, we maintained continuity of care for approximately 670,000 patients, provided more than 40 million hours of personal support services and over 10 million nursing visits (an increase of 11.6% and 6.2% from the previous fiscal year). While continued challenges presented by the pandemic and health system recovery efforts, including the ongoing shortage of health human resources, impacted our ability to meet provincial targets for the performance indicators outlined below, the majority of our 14 organizations saw a marked improvement in their performance results in 2023/24 when compared to the previous fiscal year. Provincial results demonstrate improvement for all performance indicators and stability for all monitoring indicators.

The provincial targets for performance and monitoring indicators were developed as a benchmark. While there is an expectation of continuous improvement toward achieving the targets, variations in population, socio-economic, geographic and demographic circumstances in different parts of the province impact health care delivery.

In spite of province-wide health human resource challenges, Home and Community Care Support Services Toronto Central exceeded the provincial target for 'Percentage of home care clients with complex needs who received their personal support visit within five (5) days of the date they were authorized for personal support services' for the second year in a row, with 12 other geographies increasing their performance on this indicator from the previous fiscal year (of note, in Hamilton Niagara Haldimand Brant there was an increase of eight percentage points.)

Additionally, North Simcoe Muskoka, North East and North West exceeded the provincial target for 'Percentage of home care clients who received their nursing visit within five (5) days of the date they were authorized for nursing services,' Erie St. Clair met the provincial target and two other geographies nearly met the target. Although they did not meet the

provincial target for this indicator, Home and Community Care Support Services Waterloo Wellington saw a significant improvement in their performance with an increase of nearly 10 percentage points from the previous fiscal year.

Home and Community Care Support Services North West met the provincial target for '90th Percentile Wait Time from community for Home Care Services – Application from Community Setting to first Home Care Service' and 10 other areas saw improvement under this indicator, with South West, South East, Waterloo Wellington and Toronto Central seeing a significant reduction in wait time of 10, 14, 23 and 35 days respectively. Eight geographies saw a reduction in their '90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care,' with Waterloo Wellington seeing the most significant reduction in wait time of five days.

Home and Community Care Support Services Hamilton Niagara Haldimand Brant, North Simcoe Muskoka and Central East reduced their 'Wait times from application to eligibility determination for long-term care home placements: from community setting' with Central East continuing to trend down to its lowest wait time since before the pandemic. Five geographies reduced their 'Wait times from application to eligibility determination for long-term care home placements: from acute-care setting' with South East reducing their total wait time by 3 days in 2023/24 and Waterloo Wellington achieving its lowest wait time to date at just 2 days from application to eligibility determination.

Results for each geography can be found in Appendix 2.

Ontario MLAA Indicators
2023/24 Annual Report Data

Performance Indicators

No.	Indicator	Provincial Target	2018/19 Fiscal Year Target	2019/20 Fiscal Year Target	2020/21 Fiscal Year Target	2021/22 Fiscal Year Target	2022/23 Fiscal Year Target	2023/24 Fiscal Year Target	2024/25 Q1 Result
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	86.69%	85.63%	85.29%	81.14%	78.30%	81.60%	84.8%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.87%	95.66%	94.11%	91.08%	90.00%	91.40%	92.0%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	28.00	27.00	25.00	33.00	44.00	39.00	39.0
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	8.00	9.00	12.00	14.00	13.00	Not Available Yet

Ontario MLAA Indicators
2023/24 Annual Report Data

Monitoring Indicators

No.	Indicator	Provincial Target	2018/19 Fiscal Year Target	2019/20 Fiscal Year Target	2020/21 Fiscal Year Target	2021/22 Fiscal Year Target	2022/23 Fiscal Year Target	2023/24 Fiscal Year Target	2024/25 Q1 Result
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	13.00	12.00	13.00	14.00	14.00	14.00	Not Available Yet
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	7.00	6.00	7.00	7.00	Not Available Yet

Challenges and Actions/Initiatives to Improve Performance

Indicator: Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services

Challenges: Although performance improvement was realized, access to personal support services remained a challenge in some geographies due to continuing province-wide health human resources shortages.

Personal support workers are employed by service provider organizations and many Home and Community Care Support Services organizations experienced a loss of home care personal support workers due to disparity in wages across health care sectors.

For some areas, patients' preference to delay service or change/cancel the first visit continued to impact performance.

Actions/Initiatives to Improve Performance: Staff continued to meet regularly with service provider organizations to review wait times and strategize to mitigate the impact of the personal support worker shortages and recruitment challenges. On behalf of the Ministry of Health, Home and Community Care Support Services continued to facilitate the contract rate increases with the intent of increasing recruitment and Incentivizing home care workers.

Within the multi-year capacity planning initiative, the scale and spread of neighbourhood models of care continued to be focused upon.

In 2023/24, the North implemented three different incentives to help service providers stabilize their staffing models: guaranteed shift model; stipend for travel in hard to service areas; and increase in the time for service.

Ongoing support to achieve 90% occupancy of existing Home and Community Care Support Services-funded transitional care beds was also provided. These initiatives continue to be monitored and expanded to support increased capacity.

The Personal Support Services Framework was implemented to standardize personal support service across the province and ensure equity of care for patients wherever they live in Ontario. Work continues with community support services agencies to transition low acuity patients to appropriate community services, creating capacity for personal support workers to support patients with complex needs.

Trends and opportunities for improvement and staff re-education to ensure first visit date alignment with patient availability for service continue to be reviewed. To increase resources to deliver care, Home and Community Care Support Services continues to enter new contracts with additional service providers who demonstrate capacity.

New business intelligence reports were created with defined metrics to support effectiveness of models including service provider organization incentives, neighbourhood models and hard-to-serve areas. Sharing relevant data with internal staff and external partners has built the foundation for action planning and strategy setting with a goal of moving performance in a positive direction.

A focus on service capacity planning has been enhanced, targeting several key areas: optimizing and expanding nursing clinics as needed, maximizing the use of existing transitional care beds, improving the efficiency of employed clinical staff, exploring incentives to help SPOs meet demand—especially in rural areas—and expanding the neighbourhood model where appropriate and operational capacity allowed. These initiatives, plus the work done by service providers to build their health human resourcing, resulted in notable and sustained improvement in indicators of capacity.

Indicator: Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services

Challenges: Many Home and Community Care Support Services organizations continued to experience nursing shortages. While improvement is showing in some areas of the province, this sector has not yet fully recovered from the pandemic and continues to face recruitment challenges.
Recruitment of home care nursing staff continues to be an issue due to wage disparities across health care sectors, health human resource issues, nurse burnout and early retirement.

These issues compounded the existing challenges of delivering nursing services in rural areas. Low population density, large distances between communities and inclement weather have traditionally created barriers to seeing patients in a timely manner.

Actions/Initiatives to Improve Performance:
The Clinic-First approach to care was refreshed and relaunched. In a day, nurses can see more patients in-clinic versus in-home. In 2023/24, additional clinics were opened to expand this model of care, including two unique clinics in Central East that feature an innovative partnership for shared operation between two service providers, enabling the most effective use of health human resources. Additional clinics are planned to open in 2024/25.

In multiple areas, expansion or further optimization of Home and Community Care Support Services-employed direct care roles was undertaken to assist in offsetting capacity challenges with service providers.

Existing Telehomecare models and remote care monitoring (with pathways to support COVID and surgical support to bridge the gap for nursing services and assist with emergency department diversion) were implemented and expanded

A digital wound care application was introduced in Central East that enabled improved assessment of wounds and enhanced monitoring of healing progress. The application provided data analytics that supported optimized nursing interventions.

Where appropriate community paramedicine programs were leveraged to augment in-home nursing.

To increase resources to deliver care, new contracts (with no guaranteed volumes) with additional service providers who demonstrate capacity were negotiated. These new contractors primarily addressed service gaps in shift nursing and pediatric nursing.

Enhanced focus on service capacity planning, targeting several key areas including optimizing and expanding nursing clinics as needed, maximizing the use of existing transitional care beds, improving the efficiency of employed clinical staff, exploring incentives to help SPOs meet demand—especially in rural areas—and expanding the neighbourhood model where appropriate and operational capacity allowed was undertaken. These initiatives, in conjunction with work by SPOs to build their health human resourcing, resulted in notable and sustained improvement in indicators of capacity.

Indicator: 90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)

Challenges: Continued challenges with health human resources in personal support, nursing and therapy within service provider organizations had a direct impact on wait times across several Home and Community Care Support Services organizations.

Patient preference to delay service or change/cancel the first visit due to residual COVID-related concerns, family member availability or other reasons impacted performance.

Many areas experienced a rise in referrals as patients became more engaged with their primary care physicians. In addition, delayed visits with primary care physicians meant some patients were presenting with higher levels of acuity when referred.

Care coordination resource challenges in some Home and Community Care Support Services organizations affected timeliness of assessments.

Actions/Initiatives to Improve Performance: A focus on process improvement initiatives, including prioritizing initial assessments and working with service providers to develop a scheduling strategy continued. Planning for a refreshed standardized intake model to generate process improvements to reduce wait times is underway.

Through continued collaboration with Ontario Health, a review of current community support service models/funding to take on lower needs patients in the community was undertaken.

A service provider incentive focused on a shift model of care that guaranteed full-time employment for personal support workers was implemented.

New recruitment strategies such as expanding use of job posting sites and increasing the frequency of new staff orientation to onboard new care coordinators more efficiently was implemented.

Key performance indicators have been created to monitor patient satisfaction, acceptance rate, retention and recruitment.

Utilization of virtual platforms such as eRehab, which supports a rehab assistant in the home tethered to a therapist in real time, helped carry out the therapy treatment regimen.

An enhanced focus on service capacity planning, targeting several key areas: optimizing and expanding nursing clinics as needed, maximizing the use of existing transitional care beds, improving the efficiency of employed clinical staff, exploring incentives to help SPOs meet demand—especially in rural areas—and expanding the neighbourhood model where appropriate and operational capacity allowed. These initiatives, plus the work done by service providers to build their health human resourcing, resulted in notable and sustained improvement in indicators of capacity.

Indicator: 90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care

Challenges: Increased volume of patients discharged from hospital requiring complex care planning and high intensity supports has added to the time to service initiation in the community. This population is not eligible for the available hospital @home models of care, which involve hospitals and various health care partners working together to identify and provide eligible patients and their families with an integrated home care approach.

Actions/Initiatives to Improve Performance: To increase resources to deliver care, Home and Community Care Support Services continued to enter into new contracts (with no guaranteed volumes) with additional service providers who demonstrate capacity.

Work began for a refreshed standardized discharge planning model to strengthen process improvements leading to reduced wait times based on alternate level of care best practices.

We partnered with other agencies, such as community paramedicine, to help with discharges and support patients in their homes.

We continued to evaluate, refine and contemplate the spread of programs to facilitate the discharge of high needs hospital patients.

We continued to work within our People Strategy framework to increase and expand staff retention and recruitment strategies.

Creation of a direct-hire strategy enabling Home and Community Care Support Services staff to provide direct care when service providers are unable to do so has been instituted.

Utilization of virtual platforms such as eRehab, which supports a rehab assistant in the home tethered to a therapist in real time, helped us carry-out the therapy treatment regimen. We supported timely discharges through remote care monitoring programs for CHF, COPD, surgical patients and COVID patients.

Business intelligence reports have been created to track referral trends and assist with monitoring and opportunities for quality improvement. Sharing relevant data with internal staff and external partners has built the foundation for action planning and strategy setting with a goal of moving performance in a positive direction.

A focus on service capacity planning, targeting several key areas was enhanced: optimizing and expanding nursing clinics as needed, maximizing the use of existing transitional care beds, improving the efficiency of employed clinical staff, exploring incentives to help SPOs meet demand—especially in rural areas—and expanding the neighbourhood model where appropriate and operational capacity allowed. These initiatives, plus the work done by service providers to build their health human resourcing, resulted in notable and sustained improvement in indicators of capacity.

Indicator: Wait times from application to eligibility determination for long-term care home placements: from community setting

Challenges: Home and Community Care Support Services relies on information from other sources, including family, hospital records, health reports and others to determine eligibility for long-term care placement. Delays often result due to information not submitted to Home and Community Care Support Services in a timely manner.

Additional assessments, such as behavioural, are required for patients with dementia and/or responsive behaviours.

Actions/Initiatives to Improve Performance: To ensure all applicants have the same experience, no matter where they begin their long-term care journey, significant work to develop a long-term care placement Standard Work Document was undertaken. This work includes standardized policies and procedures that are patient-centred and adhere to the latest legislation and regulation.

Work continued to develop and implement an online application for long-term care placement. This will automate the application submission process to provide patients with an online option. It will Include secure functionality on our website where applications are completed and submitted by the patient/Substitute Decision Maker and retrieved by staff online. Functionality will also include electronic notification of application status.

Standardization of long-term care application form(s) across the 14 Home and Community Care Support Services organizations will ensure consistent process and technology enablers, including integration with CHRIS and Privacy.

Indicator: Wait times from application to eligibility determination for long-term care home placements: from acute-care setting

Challenges We rely on information from other sources, including family, hospital records, health report, etc. to determine eligibility for long-term care placement. Delays often result due to information not submitted to us in a timely manner.

Additional assessments, such as behavioural, are required for patients placed from hospital into long-term care due to increased complex care needs often coupled with behaviours.

Actions/Initiatives to Improve Performance: To ensure all applicants have the same experience, no matter where they begin their long-term care journey, we undertook significant work to develop a long-term care placement Standard Work Document. This work includes standardized policies and procedures that are patient-centred and adhere to the latest legislation and regulation.

Work continued to develop and implement an online application for long-term care placement. This will automate the application submission process to provide patients with an online option. It will Include secure functionality on our website where applications are completed and submitted by the patient/Substitute Decision Maker and retrieved by staff online. Functionality will also include electronic notification of application status.

Standardization of long-term care application form(s) across the 14 Home and Community Care Support Services organizations will ensure consistent process and technology enablers, including integration with CHRIS and Privacy.

Home and Community Care Support Services Annual Business Plan Indicators

The 2023/24 Annual Business Plan included several performance metrics, established by Home and Community Care Support Services, to measure progress in achieving our strategic priorities. As we strive for continuous improvement, we use a series of performance measures as a baseline with appropriate associated targets to measure our ability to meet our organizational goals. The initiatives under each of our strategic priorities are measured using performance indicators to ensure progress is being consistently monitored.

Setting our Priorities and Measuring Performance

The priorities that we initially set for our 2022/23 Annual Business Plan were adjusted in 2023/24, with input from key partners and with consideration of our ongoing focus on standardization across the province and ensuring data is accurate and representative.**

Reviewing and refining our Annual Business Plan indicators is an important process undertaken each year, with consideration given to our various legislated agreements and requirements, as well as internal operational goals and measures. This includes adhering to the Ontario Health atHome – Ontario Health Service Accountability Agreement (still in development during this reporting period), which sets performance and quality benchmarks and the provincial Client Services Contract Performance Framework, which defines standards for all partner service providers, with contracts specifying the performance targets they must meet. By adhering to these frameworks, we can measure and improve the quality of care delivered across the province.

Additionally, we align our priorities to those set out in the Minister's Letter of Direction and other government priorities and regulations, including the *Connecting Care Act, 2019, Fixing Long-Term Care Act, 2021, Connecting People to Home and Community Care Act, 2020, Ontario Regulation 187/22: Home and Community Care Services* and Ontario's *Plan to Stay Open: Our Health System Stability and Recovery.*

We continue to hone the collection, collation and sharing of relevant data as we look forward to our 2024/25 Annual Business Plan and our new mandate as Ontario Health atHome.

We are committed to driving improvement in all our priorities by working toward the targets we have set for each metric. The below progress update is reflective of a 15-month period, ending on June 30, 2024.

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

Drive Excellence in Care and Service Delivery

Indicator: First Service Offer Acceptance Rate

The percentage of service offers that have been accepted on first attempt.

Performance

Provincial Target: >=94%

2023/24 Fiscal Year Result:

- Nursing: 77.8%
- PSS: 76.9%
- Therapies: 72.5%

Comments

The priorities that we initially set for our 2022/23 Annual Business Plan were adjusted in 2023/24, with input from key partners and with consideration of our ongoing focus on standardization across the province and ensuring data is accurate and representative.

This indicator was added in 2023/24 as a replacement for *Service Offer Time to Acceptance (% accepted within 60 minutes)*. This is a contracted indicator, which aligns with Ontario Health monitoring.

In 2023/24, we enhanced our focus on service capacity planning, targeting several key areas: optimizing and expanding nursing clinics as needed, maximizing the use of existing transitional care beds, improving the efficiency of employed clinical staff, exploring incentives to help service providers meet demand—especially in rural areas—and expanding the neighbourhood model where appropriate and operational capacity allowed. These initiatives, plus the work done by service providers to build their health human resourcing, resulted in notable and sustained improvement in indicators of capacity. Work continues to meet our provincial target of >=94% in 2024/25.

Indicator: 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.

Performance

Provincial Target: <=470

2023/24 Fiscal Year Result: 372

Q1 2024/25 Result: 363

Comments

A combination of hospital @home bundle programs, High Intensity Supports at Home programs, Family-Managed Home Care and increased transitions to long-term care due to the *More Beds, Better Care Act, 2022*, led to a reduction in the number of ALC cases waiting in hospitals. As a result, our target for open cases was exceeded by 20% at the end of 2023/24 and by 23% at the end of Q1 2024/25.

Indicator: Caregiver Distress Rate for Long-Stay Patients

Percentage of long-stay patients whose caregiver has indicated experiencing caregiver distress, broken out by adult long-stay patient populations (community independence, chronic and complex).

Performance

Provincial Target:

- Community Independence: <=18%
- Chronic: <=40%
- Complex: <=72%

2023/24 Fiscal Year Result

- Community Independence: 18.0%
- Chronic: 43.1%
- Complex: 73.2%

Q1 2024/25 Result

- Community Independence: 19.4%
- Chronic: 45.6%
- Complex: 75.0%

Comments

There was a slight increase of distress reported amongst chronic and complex populations compared to the previous year, and a further increase amongst all three population groups in Q1 2024/25.

Performance on this indicator continues to be impacted as a result of increased caregiver burden following the pandemic, coupled with ongoing barriers to access and availability of community supports due to health human resource challenges in the sector. In 2023/24, our focus on service capacity planning, targeting several key areas was enhanced: optimizing and expanding nursing clinics as needed, maximizing the use of existing transitional care beds, improving the efficiency of employed clinical staff, exploring incentives to help service providers meet demand—especially in rural areas—and expanding the neighbourhood model where appropriate and operational capacity allowed. To support our service provider organizations with recruitment and retention of frontline staff and stabilization of health human resources capacity, particularly in hard-to-serve areas, we provided incentives to 28 service provider organizations (up from 24), that enabled them to provide guaranteed shifts and travel stipend for frontline staff. These initiatives may result in a positive impact to this indicator in 2024/25.

Indicator: 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).

Performance

Provincial Target: <= 0.05%

2023/24 Fiscal Year Result:

- Nursing: 0.09%
- PSS: 0.38%
- Therapies: 0.12%

Comments

We are committed to driving improvement in all our priorities by working toward the targets we have set for each metric.

Performance for this indicator has seen minor improvement, though health human resource challenges have continued to impact the home and community care sector, with COVID-19 recovery efforts and the threat of other viruses such as influenza and respiratory syncytial virus (RSV) adding to 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 adds further strain to a health care system that is already facing capacity issues.

In 2023/24, our focus on service capacity planning, targeting several key areas was enhanced: optimizing and expanding nursing clinics as needed, maximizing the use of existing transitional care beds, improving the efficiency of employed clinical staff, exploring incentives to help service providers meet demand—especially in rural areas—and expanding the neighbourhood model where appropriate and operational capacity allowed. These initiatives, plus the work done by service providers to build their health human resourcing, resulted in notable and sustained improvement in indicators of capacity.

Advance Health System Modernization

Indicator: 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.

Performance

Provincial Target

<=1,530 (4.5% of total waitlist)

2023/24 Fiscal Year Result March 31, 2024: 2,659 (3.9% of total waitlist)

Q1 2024/25 - June 30, 2024: 2,929 (4.4% of total waitlist)

Comments

We are committed to driving improvement in all our priorities by working toward the targets we have set for each metric.

There are many variables that contribute to challenges with performance for this indicator, including external factors beyond our control. This includes an increased focus on hospital ALC patients designated crisis.

There are several ways we continue to facilitate admissions to long-term care and support the government's Your Health: A Plan for Connected and Convenient Care, including our work with automating our long-term care application process and expanding our capacity building initiatives.

To ensure all applicants have the same experience, no matter where they begin their long-term care journey, we undertook significant work to develop a long-term care placement Standard Work Document. This work includes standardized policies and procedures that are patient-centred and adhere to the latest legislation and regulation.

Work continued to develop and implement an online application for long-term care placement. This will automate the application submission process to provide patients with an online

option. It will include secure functionality on our website where applications are completed and submitted by the patient/Substitute Decision Maker and retrieved by staff online. Functionality will also include electronic notification of application status.

Standardization of long-term care application form(s) across the 14 Home and Community Care Support Services organizations will ensure consistent process and technology enablers, including integration with CHRIS and Privacy.

Indicator: 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.

Performance

Provincial Target: <=1,712

2023/24 Fiscal Year Result March 31, 2024: 2,204

Q1 2024/25 June 30, 2024: 2,296

Comments

We are committed to driving improvement in all our priorities by working toward the targets we have set for each metric.

We have seen some improvement in performance for this indicator when compared to 2022/23. There are a number of factors impacting this indicator, including from sources external to Ontario Health atHome.

Supporting 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 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 ALC patients, automating our long-term care application process and expanding our capacity building initiatives.

To ensure all applicants have the same experience, no matter where they begin their long-term care journey, we undertook significant work to develop a long-term care placement Standard Work Document. This work includes standardized policies and procedures that are patient-centred and adhere to the latest legislation and regulation.

Work continued to develop and implement an online application for long-term care placement. This will automate the application submission process to provide patients with an online option. It will include secure functionality on our website where applications are completed and submitted by the patient/Substitute Decision Maker and retrieved by staff online. Functionality will also include electronic notification of application status.

Standardization of long-term care application form(s) across the 14 Home and Community Care Support Services organizations will ensure consistent process and technology enablers, including integration with CHRIS and Privacy.

Invest in Our People

Indicator: Voluntary turnover

Percentage of employees who leave the organization voluntarily, either through retirement or resignation.

Performance

Provincial Target: <=10.5%

2023/24 Fiscal Year Result: 8.78%

Comments

There was significant improvement in the past fiscal year for the voluntary turnover metric, achieving 8.78% ending March 2024 against the target of 10.5%. In the prior fiscal year, the result was 10.61%. As such, there were 136 more employees retained with the organization in fiscal 2023/24 compared to fiscal 2022/23.

Indicator: Employee engagement index

Comprised of six questions from the Employee Engagement Survey.

Performance

Provincial Target: >=78 %

2023/24 Fiscal Year Result: 72%

Comments

The provincial target of 78% stems from our inaugural Employee Engagement Survey result in 2022 where a result/score of 76% was achieved. Following consultation with the project team, it was felt we could aim to increase our employee engagement result by 2%, resulting in the establishment of a provincial target of 78%. 72% is the result/score from “Pulse Survey 1” (instead of one large survey, we are administering three shorter surveys as we move through transformation - These are referred to as “Pulse Surveys”)

While a result of 72% is considered a strong engagement score, as confirmed by the third party survey vendor who supported this work, a decline is not surprising considering the current level of organizational change. The organization is implementing change action initiatives to support our transformation and maintain employee engagement.

Upcoming Q3 and Q4 2024/25 Pulse Surveys will provide updated results.

**The following indicators were removed in the 2023/24 Annual Business Plan (as compared to 2022/23): *Service Offer Time to Acceptance (% accepted within 60 minutes)* was removed with focus instead on the contracted indicator of Initial Service Acceptance rate, which aligns with Ontario Health monitoring; *Number of patients receiving Caregiver Respite per 10,000 Long Stay patients (Monthly)* was removed as it was a developmental indicator for a developmental program which changed direction and focus. Focus was shifted to prioritize broader Personal Support Service SPO capacity; *Telehomecare Visits Service Volumes* was removed as the indicator and business processes are being redesigned. Previous data deemed not to be as valid, due to provincial inconsistencies; *Virtual Visits Service Percent* was removed as it was originally established for COVID, but has not been assessed for appropriateness of care.

Appointees

Name of Appointee	Date First Appointed	Term Expiration	Remuneration
Joe Parker	March 5, 2021	June 27, 2024	$13,125.00
Glenna Raymond	July 1, 2021	June 27, 2024	$11,642.80
Anne Campbell	July 1, 2021	June 27, 2024	$6,200.00
Carol Annett	July 1, 2021	June 27, 2024	$5,300.00
Kate Fyfe	February 17, 2022	June 27, 2024	$6,800.00
Linda Franklin	July 27, 2023	June 27, 2024	$4,000.00
Stephan Plourde	July 1, 2021	June 27, 2024	$7,276.26
John Beardwood	February 17, 2022	June 27, 2024	$3,000.00
Michael Dibden	July 1, 2021	June 30, 2023	$1,000.00
Shanti Gidwani	February 17, 2022	June 15, 2023	$-
Eugene Cawthray	July 1, 2021	May 17, 2023	$-

Financial Analysis

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

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

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

In 2023-24, we experienced a 3% increase in patient volumes and a 10% increase in services delivered. Funding received by Home and Community Care Support Services was used to coordinate and/or deliver patient services and programs – accounting for 96% of spending. The remaining 4% of funding was used to cover operational and administrative costs.

As Home and Community Care Support Services ceased to exist on June 28, 2024, we are also including financial analysis for Q1 2024-25. By the end of this period, all 14 Home and Community Care Support Services organizations were in a balanced budget. No funding was returned to the Ministry of Health as a result.

Home and Community Care Support Services Erie St. Clair

Home and Community Care Support Services Erie St. Clair delivered on its mandate, receiving a Ministry of Health funding allotment of $207,751,816 for the full fiscal year 2023/24. Expenses were $207,751,816 which resulted in a balanced year-end position.

For Q1 of fiscal 2024-25, Home and Community Care Support Services Erie St. Clair delivered on its mandate, receiving a Ministry of Health funding allotment of $57,813,737 for the period April 1 to June 27, 2024. Expenses were $57,813,737 which resulted in a balanced position for the period.

Home and Community Care Support Services South West

Home and Community Care Support Services South West delivered on its mandate, receiving a Ministry of Health funding allotment of $302,112,790 for the full fiscal year 2023/24. Expenses were $302,809,256 which generated a year-end deficit of $696,466 due to additional operating costs required to meet its mandate.

For Q1 of fiscal 2024-25, Home and Community Care Support Services South West delivered on its mandate, receiving a Ministry of Health funding allotment of $74,624,341 for the period April 1 to June 27, 2024. Expenses were $73,927,875 which resulted in a surplus of $696,466, ensuring that South West met its obligation to generate a surplus covering its year-end deficit from 2023-24.

Home and Community Care Support Services Waterloo Wellington

Home and Community Care Support Services Waterloo Wellington delivered on its mandate, receiving a Ministry of Health funding allotment of $216,807,155 for the full fiscal year 2023/24.

Expenses were $216,807,155 which resulted in a balanced year-end position.

For Q1 of fiscal 2024-25, Home and Community Care Support Services Waterloo Wellington delivered on its mandate, receiving a Ministry of Health funding allotment of $57,530,064 for the period April 1 to June 27, 2024. Expenses were $57,530,064 which resulted in a balanced position for the period.

Home and Community Care Support Services Hamilton Niagara Haldimand Brant

Home and Community Care Support Services Hamilton Niagara Haldimand Brant delivered on its mandate, receiving a Ministry of Health funding allotment of $495,041,377 for the full fiscal year 2023/24. Expenses were $500,730,980 which generated a year-end deficit of $5,689,603 due to additional operating costs required to meet its mandate.

For Q1 of fiscal 2024-25, Home and Community Care Support Services Hamilton Niagara Haldimand Brant delivered on its mandate, receiving a Ministry of Health funding allotment of $145,649,188 for the period April 1 to June 27, 2024. Expenses were $139,959,585 which resulted in a surplus of $5,689,603, ensuring that Hamilton Niagara Haldimand Brant met its obligation to generate a surplus covering its year-end deficit from 2023-24.

Home and Community Care Support Services Central West

Home and Community Care Support Services Central West delivered on its mandate, receiving a Ministry of Health funding allotment of $226,717,885 for the full fiscal year 2023/24. Expenses were $226,717,885 which resulted in a balanced year-end position.

For Q1 of fiscal 2024-25, Home and Community Care Support Services Central West delivered on its mandate, receiving a Ministry of Health funding allotment of $58,584,804 for the period April 1 to June 27, 2024. Expenses were $58,584,804 which resulted in a balanced position for the period.

Home and Community Care Support Services Mississauga Halton

Home and Community Care Support Services Mississauga Halton delivered on its mandate, receiving a Ministry of Health funding allotment of $284,520,002 for the full fiscal year 2023/24. Expenses were $284,520,002 which resulted in a balanced year-end position.

For Q1 of fiscal 2024-25, Home and Community Care Support Services Mississauga Halton delivered on its mandate, receiving a Ministry of Health funding allotment of $72,467,870 for the period April 1 to June 27, 2024. Expenses were $72,467,870 which resulted in a balanced position for the period.

Home and Community Care Support Services Toronto Central

Home and Community Care Support Services Toronto Central delivered on its mandate, receiving a Ministry of Health funding allotment of $374,070,226 for the full fiscal year 2023/24. Expenses were $374,070,226 which resulted in a balanced year-end position.

For Q1 of fiscal 2024-25, Home and Community Care Support Services Toronto Central delivered on its mandate, receiving a Ministry of Health funding allotment of $94,487,350 for the period April 1 to June 27, 2024. Expenses were $94,487,350 which resulted in a balanced position for the period.

Home and Community Care Support Services Central

Home and Community Care Support Services Central delivered on its mandate, receiving a Ministry of Health funding allotment of $546,693,278 for the full fiscal year 2023/24. Expenses were $546,693,278 which resulted in a balanced year-end position.

For Q1 of fiscal 2024-25, Home and Community Care Support Services Central delivered on its mandate, receiving a Ministry of Health funding allotment of $139,073,312 for the period April 1 to June 27, 2024. Expenses were $139,073,312 which resulted in a balanced position for the period.

Home and Community Care Support Services Central East

Home and Community Care Support Services Central East delivered on its mandate, receiving a Ministry of Health funding allotment of $478,517,717 for the full fiscal year 2023/24. Expenses were $478,517,717 which resulted in a balanced year-end position.

For Q1 of fiscal 2024-25, Home and Community Care Support Services Central East delivered on its mandate, receiving a Ministry of Health funding allotment of $122,118,384 for the period April 1 to June 27, 2024. Expenses were $122,118,384 which resulted in a balanced position for the period.

Home and Community Care Support Services South East

Home and Community Care Support Services South East delivered on its mandate, receiving a Ministry of Health funding allotment of $156,207,988 for the full fiscal year 2023/24. Expenses were $156,207,988 which resulted in a balanced year-end position.

For Q1 of fiscal 2024-25, Home and Community Care Support Services South East delivered on its mandate, receiving a Ministry of Health funding allotment of $41,200,167 for the period April 1 to June 27, 2024. Expenses were $41,200,167 which resulted in a balanced position for the period.

Home and Community Care Support Services Champlain

Home and Community Care Support Services Champlain delivered on its mandate, receiving a Ministry of Health funding allotment of $352,575,572 for the full fiscal year 2023/24. Expenses were $352,575,572 which resulted in a balanced year-end position. For Q1 of fiscal 2024-25, Home and Community Care Support Services Champlain delivered on its mandate, receiving a Ministry of Health funding allotment of $89,956,825 for the period April 1 to June 27, 2024. Expenses were $89,956,825 which resulted in a balanced position for the period.

Home and Community Care Support Services North Simcoe Muskoka

Home and Community Care Support Services North Simcoe Muskoka delivered on its mandate, receiving a Ministry of Health funding allotment of $142,565,382 for the full fiscal year 2023/24. Expenses were $142,565,382 which resulted in a balanced year-end position.

For Q1 of fiscal 2024-25, Home and Community Care Support Services North Simcoe Muskoka delivered on its mandate, receiving a Ministry of Health funding allotment of $36,834,258 for the period April 1 to June 27, 2024. Expenses were $36,834,258 which resulted in a balanced position for the period.

Home and Community Care Support Services North East

Home and Community Care Support Services North East delivered on its mandate, receiving a Ministry of Health funding allotment of $192,488,798 for the full fiscal year 2023/24. Expenses were $192,488,798 which resulted in a balanced year-end position.

For Q1 of fiscal 2024-25, Home and Community Care Support Services North East delivered on its mandate, receiving a Ministry of Health funding allotment of $50,389,085 for the period April 1 to June 27, 2024. Expenses were $50,389,085 which resulted in a balanced position for the period.

Home and Community Care Support Services North West

Home and Community Care Support Services North West delivered on its mandate, receiving a Ministry of Health funding allotment of $71,998,630 for the full fiscal year 2023/24. Expenses were $71,998,630 which resulted in a balanced year-end position.

For Q1 of fiscal 2024-25, Home and Community Care Support Services North West delivered on its mandate, receiving a Ministry of Health funding allotment of $20,708,813 for the period April 1 to June 27, 2024. Expenses were $20,708,813 which resulted in a balanced position for the period.

Appendix 1 – Population Profiles

Erie St. Clair

Area (km^2):	7,324
Total Population:	679,441
% of Ontario Population:	4.50%
Population Age 65+:	21.12%
Population Growth Rate:	1.91%
Population Density:	92.8
Rural Population:	17.46%
Indigenous Population:	3.52%
Francophone Population (including IDF):	2.86%
Low Income Population	11.16%

South West

Area (km^2):	20,915
Total Population:	1,091,179
% of Ontario Population:	7.22%
Population Age 65+:	20.36%
Population Growth Rate:	2.42%
Population Density:	0.6
Rural Population:	25.63%
Indigenous Population:	2.52%
Francophone Population (including IDF):	1.35%
Low Income Population:	11.29%

Waterloo Wellington

Area (km^2):	4,751
Total Population:	895,918
% of Ontario Population:	5.93%
Population Age 65+:	15.85%
Population Growth Rate:	3.15%
Population Density:	188.6
Rural Population:	9.92%
Indigenous Population:	1.68%
Francophone Population (including IDF):	1.46%
Low Income Population:	8.87%

Hamilton Niagara Haldimand Brant

Area (km^2):	6,474
Total Population:	1,556,926
% of Ontario Population:	10.30%
Population Age 65+:	20.61%
Population Growth Rate:	1.68%
Population Density:	240.5
Rural Population:	11.25%
Indigenous Population:	2.70%
Francophone Population (including IDF):	2.04%
Low Income Population:	9.78%

Central West

Area (km^2):	2,591
Total Population:	1,118,101
% of Ontario Population:	7.40%
Population Age 65+:	13.81%
Population Growth Rate:	3.02%
Population Density:	431.5
Rural Population:	4.76%
Indigenous Population:	0.58%
Francophone Population (including IDF):	1.06%
Low Income Population:	7.19%

Mississauga Halton

Area (km^2):	1,054
Total Population:	1,292,791
% of Ontario Population:	8.56%
Population Age 65+:	15.45%
Population Growth Rate:	1.33%
Population Density:	1226.6
Rural Population:	1.55%
Indigenous Population:	0.52%
Francophone Population (including IDF):	1.68%
Low Income Population:	8.48%

Toronto Central

Area (km^2):	192
Total Population:	1,364,920
% of Ontario Population:	9.03%
Population Age 65+:	16.49%
Population Growth Rate:	2.36%
Population Density:	7109.0
Rural Population:	0.00%
Indigenous Population:	0.83%
Francophone Population (including IDF):	2.56%
Low Income Population:	13.41%

Central

Area (km^2):	2,731
Total Population:	2,019,890
% of Ontario Population:	13.37%
Population Age 65+:	17.22%
Population Growth Rate:	1.83%
Population Density:	739.6
Rural Population:	3.50%
Indigenous Population:	0.46%
Francophone Population (including IDF):	1.12%
Low Income Population:	10.58%

Central East

Area (km^2):	15,395
Total Population:	1,743,342
% of Ontario Population:	11.54%
Population Age 65+:	18.35%
Population Growth Rate:	2.21%
Population Density:	113.2
Rural Population:	13.18%
Indigenous Population:	1.83%
Francophone Population (including IDF):	1.52%
Low Income Population:	9.57%

South East

Area (km^2):	18,253
Total Population:	526,443
% of Ontario Population:	3.48%
Population Age 65+:	24.97%
Population Growth Rate:	1.49%
Population Density:	28.8
Rural Population:	43.83%
Indigenous Population:	5.10%
Francophone Population (including IDF):	3.15%
Low Income Population:	10.84%

Champlain

Area (km^2):	17,723
Total Population:	1,464,940
% of Ontario Population:	9.70%
Population Age 65+:	18.33%
Population Growth Rate:	1.70%
Population Density:	82.7
Rural Population:	17.55%
Indigenous Population:	3.41%
Francophone Population (including IDF):	18.21%
Low Income Population:	9.18%

North Simcoe Muskoka

Area (km^2):	8,449
Total Population:	534,510
% of Ontario Population:	3.54%
Population Age 65+:	21.46%
Population Growth Rate:	2.43%
Population Density:	63.3
Rural Population:	30.41%
Indigenous Population:	5.14%
Francophone Population (including IDF):	2.49%
Low Income Population:	8.78%

North East

Area (km^2):	395,920
Total Population:	582,700
% of Ontario Population:	3.86%
Population Age 65+:	23.18%
Population Growth Rate:	1.43%
Population Density:	1.5
Rural Population:	35.42%
Indigenous Population:	14.27%
Francophone Population (including IDF):	21.05%
Low Income Population:	12.31%

North West

Area (km^2):	406,926
Total Population:	238,315
% of Ontario Population:	1.58%
Population Age 65+:	20.60%
Population Growth Rate:	0.21%
Population Density:	0.6
Rural Population:	40.36%
Indigenous Population:	26.19%
Francophone Population (including IDF):	2.83%
Low Income Population:	13.69%

Appendix 2 – Performance Indicators

Ontario MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36%	89.86%	87.80%	86.69%	85.63%	85.29%	81.14%	78.30%	81.60%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	96.07%	96.25%	95.87%	95.66%	94.11%	91.08%	90.00%	91.40%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	29.00	29.00	30.00	29.00	28.00	27.00	25.00	33.00	44.00	39.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	7.00	7.00	8.00	9.00	12.00	14.00	13.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	13.00	13.00	13.00	12.00	13.00	14.00	14.00	14.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	7.00	7.00	7.00	7.00	7.00	6.00	7.00	7.00

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Erie St. Clair LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.45%	90.54%	93.46%	95.51%	92.35%	88.52%	89.70%	87.76%	87.40%	88.60%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.04%	95.03%	95.88%	96.46%	96.01%	95.10%	95.30%	95.15%	94.60%	95.00%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	18.00	19.00	26.00	27.00	28.00	21.00	23.00	30.00	44.00	49.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	5.00	5.00	6.00	6.00	6.00	8.00	9.00	9.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	10.00	10.00	11.00	9.00	11.00	9.00	14.00	13.00	15.00	16.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	5.00	4.00	3.00	3.00	2.00	3.00	3.00	5.00

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South West LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	90.87%	88.95%	91.99%	88.90%	84.74%	79.87%	83.60%	80.45%	74.90%	77.50%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	92.59%	93.10%	93.69%	94.01%	93.16%	92.79%	89.40%	87.24%	86.40%	89.40%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	21.00	21.00	22.00	30.00	25.00	26.00	26.00	36.00	47.00	37.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	8.00	9.00	10.00	12.00	15.00	20.00	24.00	23.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	8.00	9.00	7.00	8.00	8.00	7.00	8.00	10.00	12.00	12.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	4.00	4.00	3.00	3.00	3.00	3.00	4.00	4.00	5.00	6.00

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Waterloo Wellington LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	84.50%	85.66%	92.90%	95.32%	97.21%	95.57%	84.80%	75.04%	62.30%	68.80%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	94.77%	93.97%	95.98%	97.00%	96.11%	96.57%	94.30%	84.60%	75.90%	84.80%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	12.00	13.00	13.00	14.00	14.00	15.00	19.00	42.00	71.00	48.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	5.00	5.00	6.00	6.00	9.00	12.00	19.00	14.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	12.00	11.00	9.00	10.00	11.00	9.00	11.00	12.00	12.00	13.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	4.00	5.00	5.00	5.00	5.00	5.00	4.00	3.00	2.00

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Hamilton Niagara Haldimand Brant LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	89.37%	90.28%	89.92%	88.63%	85.05%	86.03%	86.00%	77.27%	70.00%	78.10%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	92.67%	93.69%	95.97%	95.89%	95.79%	95.32%	93.90%	88.71%	87.20%	88.30%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	25.00	28.00	28.00	28.00	34.00	33.00	30.00	35.00	32.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	6.00	6.00	6.00	7.00	8.00	11.00	15.00	13.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	9.00	8.00	8.00	9.00	10.00	10.00	13.00	15.00	17.00	15.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	5.00	6.00	8.00	8.00	8.00	9.00	9.00	13.00	13.00

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Central West LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.23%	88.97%	85.31%	82.61%	85.93%	82.73%	87.50%	85.18%	84.10%	87.30%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	96.52%	95.43%	95.17%	95.69%	96.48%	96.05%	95.90%	94.75%	93.20%	94.40%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	19.00	21.00	24.00	30.00	29.00	36.00	20.00	31.00	29.00	34.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	8.00	8.00	9.00	9.00	8.00	10.00	12.00	11.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	21.00	18.00	20.00	21.00	19.00	18.00	17.00	22.00	25.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	12.00	13.00	11.00	14.00	14.00	13.00	14.00	12.00	15.00	21.00

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Mississauga Halton LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.07%	91.48%	92.63%	90.81%	90.99%	90.91%	91.60%	88.36%	85.50%	87.10%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.22%	95.58%	96.69%	96.60%	95.99%	95.61%	94.10%	92.67%	92.40%	92.80%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	27.00	28.00	34.00	27.00	24.00	23.00	23.00	28.00	35.00	29.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	11.00	9.00	10.00	11.00	13.00	14.00	14.00	15.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	15.00	12.00	12.00	15.00	16.00	12.00	16.00	21.00	23.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	17.00	11.00	12.00	15.00	10.50	12.00	13.00	12.00	20.00	19.00

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Toronto Central LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.47%	85.03%	93.95%	95.57%	95.54%	96.40%	96.40%	94.79%	96.20%	97.70%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.64%	93.50%	96.19%	96.06%	96.46%	95.77%	95.70%	95.47%	94.60%	94.50%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	25.00	26.00	26.00	26.00	28.00	27.00	21.00	30.00	75.00	40.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	8.00	9.00	10.00	10.00	13.00	18.00	21.00	17.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	3.00	0.00	0.00	0.00	0.00	0.00	1.00	3.00	5.00	7.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	11.00	9.00	7.00	7.00	7.00	7.00	11.00	5.00	4.00	6.00

***NR - data have not been reported due to concerns with data quality

NOTE: due to a different data collection system used in Toronto Central LHIN, and different business rules, Wait Times in Toronto Central LHIN may not be comparable to other LHINs. This has since been addressed following amalgamation in June.

If you require this information in an accessible format, please email your request to **accessibility@ontariohealthathome.ca**

Central LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	84.35%	83.68%	92.39%	93.03%	94.12%	93.81%	94.50%	92.17%	89.00%	92.40%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	94.13%	94.23%	96.65%	96.41%	95.93%	96.09%	95.90%	94.82%	93.50%	93.30%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	31.00	33.00	33.00	22.00	22.00	20.00	16.00	21.00	24.00	24.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	6.00	6.00	5.00	6.00	5.00	6.00	7.00	8.00	8.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	17.00	22.00	19.00	21.00	21.00	20.00	22.00	21.00	22.00	23.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	6.00	4.00	5.00	4.00	3.00	5.00	4.50	5.00	5.00

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Central East LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	87.88%	88.69%	90.64%	90.10%	87.75%	88.48%	88.60%	82.56%	78.60%	82.30%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.67%	95.84%	96.83%	96.51%	95.99%	96.27%	94.50%	92.16%	91.80%	92.00%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	30.00	49.00	41.00	39.00	31.00	23.00	29.00	43.00	39.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	13.00	10.00	9.00	9.00	10.00	12.00	12.00	14.00	12.00	14.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	21.00	20.00	17.00	20.00	20.00	16.00	25.00	21.00	17.00	15.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	10.00	10.00	8.00	8.00	9.00	8.00	11.00	8.00	9.00	8.00

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South East LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	86.84%	84.62%	90.72%	88.12%	87.37%	80.26%	69.90%	72.22%	66.50%	69.00%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	92.70%	91.90%	96.14%	96.28%	95.04%	93.64%	89.10%	80.47%	75.90%	79.80%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	21.00	22.00	21.00	20.00	22.00	22.00	38.00	57.00	43.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	7.00	7.00	7.00	7.00	7.00	7.00	12.00	14.00	13.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	13.00	15.00	14.00	13.00	13.00	13.00	18.00	20.00	21.00	21.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	7.00	6.50	8.00	11.00	14.00	9.00	13.00	10.00

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Champlain LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	78.86%	77.03%	77.33%	71.39%	68.16%	66.12%	61.70%	58.88%	56.00%	58.90%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	91.70%	93.48%	96.04%	96.08%	95.29%	95.25%	92.60%	85.56%	87.90%	91.00%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	62.00	55.00	34.00	50.00	45.00	40.00	46.00	83.00	98.00	97.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	8.00	11.00	9.50	10.00	15.00	16.00	13.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	21.00	24.00	24.00	23.00	13.00	7.00	7.00	7.00	8.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	11.00	10.00	9.00	13.00	16.00	7.00	0.00	0.00	0.00	0.00

***NR - data have not been reported due to concerns with data quality

NOTE: due to a business process change for Champlain LHIN since 2019, Wait Times after 2019 may not be comparable to previous years, and also not comparable to other LHINs.

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North Simcoe Muskoka LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	69.53%	77.19%	89.20%	87.03%	86.56%	86.89%	87.50%	81.27%	86.00%	88.50%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	91.52%	93.08%	95.79%	97.62%	98.13%	97.75%	97.20%	95.88%	95.90%	96.20%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	69.00	67.00	51.00	41.00	32.00	27.00	27.00	27.00	31.00	28.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	7.00	8.00	6.00	8.00	9.00	12.00	13.00	12.00	8.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	19.50	15.00	15.00	14.00	13.00	14.00	20.00	21.00	27.00	25.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	13.00	15.00	24.00	28.00	34.00	29.00	20.00	13.00	18.50	17.00

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North East LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	86.06%	83.70%	96.05%	87.65%	85.99%	83.10%	79.80%	71.98%	80.20%	78.90%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.61%	94.09%	98.20%	98.49%	98.25%	98.50%	96.90%	96.20%	95.90%	96.50%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	70.00	48.00	39.00	31.00	28.00	24.00	22.00	31.00	37.00	47.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	11.00	9.00	7.00	7.00	8.00	7.00	8.00	11.00	15.00	15.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	8.00	8.00	7.00	7.00	7.00	7.00	3.00	4.00	4.00	6.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	9.00	11.00	9.00	9.00	8.00	7.00	10.00	14.00	14.00

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North West LHIN MLAA Indicators
2023/24 Annual Report Data

No.	Indicator	Provincial target	Provincial									
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result	2022/23 Fiscal Year Result	2023/24 Fiscal Year Result
1. Performance Indicators												
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	76.43%	78.52%	83.92%	83.46%	85.23%	93.59%	94.50%	95.79%	87.00%	87.50%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	89.31%	88.32%	95.86%	96.09%	95.73%	97.38%	98.40%	97.16%	94.60%	97.00%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	35.00	28.00	30.00	26.00	23.00	22.00	18.00	21.00	23.00	21.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	5.00	5.00	5.00	5.00	5.00	6.00	6.00	7.00	7.00	7.00
2. Monitoring Indicators												
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	35.00	34.50	32.00	27.00	36.00	16.00	14.00	11.00	11.00	11.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	15.00	12.00	14.00	11.00	12.00	10.00	8.00	9.00	8.00	10.00

If you require this information in an accessible format, please email your request to accessibility@ontariohealthathome.ca

Appendix 3 – Audited Financial Statements

Erie St. Clair

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

South West

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

Waterloo Wellington

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

Hamilton Niagara Haldimand Brant

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

Central West

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

Mississauga Halton

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

Toronto Central

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

Central

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

Central East

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

South East

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

Champlain

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

North Simcoe Muskoka

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

North East

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)

North West

April 1, 2023-March 31, 2024 Stub Period (April 1-June 27, 2024)