Annual Business Plan

2025/26

Ontario Health

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Executive Summary

Since being formed in 2019, Ontario Health has worked with patients, providers and delivery partners to ensure high-quality services are available to Ontarians across the continuum of care. We have worked closely with the Ministry of Health (MOH), the Ministry of Long-Term Care (MLTC) and our health service provider partners to drive system integration through the implementation of the government's ambitious transformation agenda. As a result, more Ontarians are receiving the right care in the right place at the right time, driving better outcomes and patient care. Additionally, we have focused on supporting health care workers to ensure the capacity to deliver quality, patient-centred care.

The Ontario health system continues to adapt to meet growing pressure across the continuum of care. Factors contributing to this challenge include Ontario's rapidly growing and aging population, more Ontarians living with chronic disease (especially those with multi-morbidity) and an increase in the "social morbidity" of patients – such as those experiencing homelessness. Taken together, Ontario Health continues to prioritize patient access, care, quality and outcomes in several critical areas:

- More Ontarians are receiving primary care services than ever before, and more teams have been added to communities in need of primary care capacity.
- Health811 continues to expand its role in supporting patient access to care by offering 24/7 navigation, health advice, and digital services, helping Ontarians connect more easily to primary care and pharmacist-led assessments.
- Emergency departments (ED) have received support to continue operating across the province and investments in more community care have reduced the number of people with lower-urgency care needs going to the ED.
- More Ontarians are accessing critical support services for depression and anxiety-related disorders through the Ontario Structured Psychotherapy (OSP) program.
- Surgical volumes have increased, waitlists have been reduced, and Ontario is providing more Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans than ever before.

In addition, this Annual Business Plan (ABP) marks the first year that Ontario Health is formally working with the home care sector to improve the access, quality and integration of home care within the province. In Fall 2024, Ontario Health administered the expansion of the Hospital-to-Home (H2H) program with funding from the MOH. Now implemented across 49 hospitals, the program delivers better, faster and more integrated home care to patients returning home from the hospital. In the coming year, we will work with the MOH and delivery partners to expand this program for all Ontarians.

We are excited to build on these successes and continue advancing the government's priorities though the work identified in the 2025/26 ABP. The priorities in this plan reflect the priorities outlined by the government and the three pillars in *Your Health: A Plan for Connected and Convenient Care,* as well as Ontario Health's foundational priorities reflective of our objects in the *Connecting Care Act, 2019*.

Introduction

Ontario Health was established through the *Connecting Care Act, 2019* with a mandate to connect, coordinate and modernize our province's health care system. Ontario Health oversees the delivery and quality of clinical services, manages funding and accountability for parts of the health system and measures how the system is performing. Collectively, this work will ensure that Ontarians receive the best possible patient-centred care when and where they need it.

Our Annual Business Plan (ABP) is a critical planning document that sets out our overarching goals, priorities and key activities for the next three years. The 2025/26 ABP outlines how we will work with our delivery partners to achieve the priorities in the Ministry of Health (MOH)'s Letter of Direction and the Strategic Priorities Letter from the Ministry of Long-Term Care (MLTC), both of which are grounded in the government's health strategy, *Your Health: A Plan for Connected and Convenient Care*, and its three pillars: The Right Care in the Right Place, Faster Access to Care and Hiring More Health Care Workers.

Our work continues to be guided by our vision, mission and values. Collectively, this outlines what we want to be as a health organization, why we exist and what we believe in, and a set of principles that will define how we will operate within the health care system with our partners and for the people of Ontario.

OUR VISION

Together, we will be a leader in health and wellness for all.

OUR MISSION

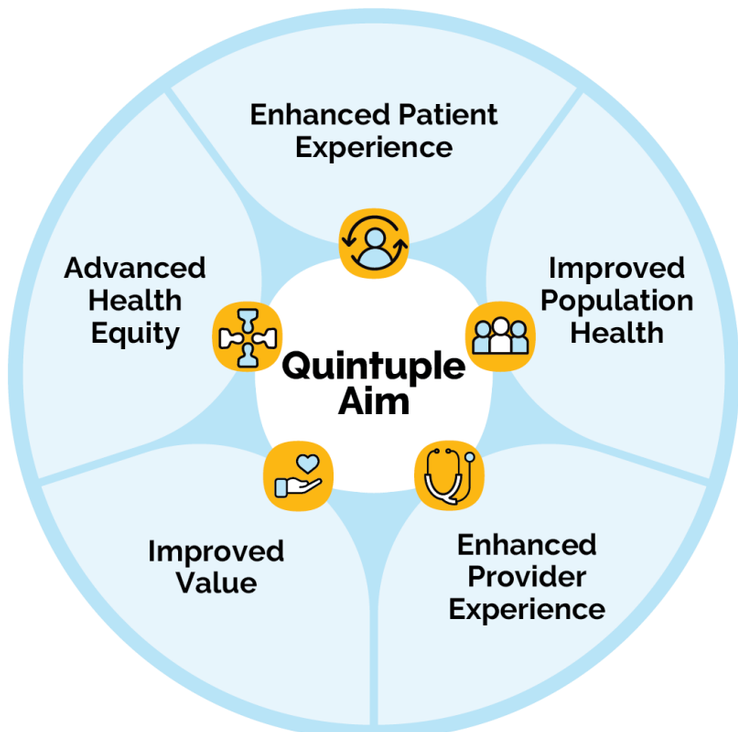
To connect the health system to drive improved and equitable health outcomes, experiences and value.

OUR VALUES

Integrity, Inspiration, Tenacity, Humility, Care

The Quintuple Aim is also central to health system planning at Ontario Health. We are firmly committed to the five goals it sets for the design and delivery of an effective health care system:

- Enhancing patient experience.
- Improving population health outcomes.
- Improving value.
- Enhancing frontline and provider experience.
- Advancing health equity.



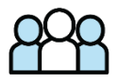
Strategic Priorities

Our work is framed by strategic priorities, which represent the most critical things that the organization must undertake to fulfill its mandate and the government's transformation agenda.

Reducing health inequities: All the work we do is through the lens of reducing health inequities. In this ABP, we will continue improving care with and for those who need it most across the continuum of care.

Advancing the *Your Health* plan's focus on the right care in the right place by transforming care with the person at the centre: We advance health system transformation, integration and care for patients and care partners at the centre of all our efforts.

Advancing the *Your Health* plan's focus on faster access to care and supporting health care workers. We achieve this through health system operational management, coordination, performance measurement and management, and integration: We improve the experience of Ontarians accessing time-sensitive care and support the frontline with a continuous focus on access and flow.



Enhancing clinical care and service excellence: We deliver best-in-class clinical and population-based care through our well-established clinical programs and strong partnerships with delivery partners.

Maximizing system value by applying evidence: We strengthen our capacity to collect, share and analyze data to support evidence-driven and high-quality care.

Strengthening Ontario Health's ability to lead: We will strengthen our organizational culture to unify and empower our team members across Ontario Health.

ONTARIO HEALTH

Impact Achieved

EQUITY & QUALITY IS *EMBEDDED* IN EVERYTHING WE DO

Ontario Health connects, coordinates and continues to modernize our province's health care system.

Since its formation, Ontario Health has integrated the system and improved access and outcomes for Ontarians across the health care continuum.

ONTARIO HEALTH WITH DELIVERY PARTNERS

Primary Care

- Since the launch of Health811, the service has provided 24/7 access to health information, **supporting over two million patient encounters.**
- With the MOH, we expanded access to primary care for **over 300,000 patients** through 66 new or expanded Interprofessional Primary Care Teams.

Screening

- The **Ontario Breast Screening Program expanded** to individuals aged 40 to 49.
- Screening volumes for breast and colorectal cancers reached all-time highs, helping screen **over 120,000 people monthly.**

Diagnosis

- Overall access to MRI/CT was expanded with **268,000 additional MRI and CT patients** year over year. Furthermore, **23 new MRI machines** were introduced with over 40,000 new hospital operating hours.

Equity

- **Over 29,000 Indigenous Relationship and Cultural Awareness Course**s have been completed by members of the public, health care professionals, medical students and Ontario Health staff since 2023.
- Close to **3,000 individuals from Black and racialized communities** accessed new community-driven and culturally relevant wellness and preventative care programs.

Quality

- **Over 1,003 (99.7%)** organizations submitted **quality improvement plans** promoting a focus on transparency by sharing change ideas, performance and measuring progress.

ONTARIO HEALTH

Impact Achieved (con't)

ONTARIO HEALTH
WITH DELIVERY PARTNERS

Mental Health & Addictions Centre of Excellence

- Since the Ontario Structured Psychotherapy program launched in 2017, **more than 90,000 Ontarians** have accessed this free, evidence-based service.

Emergency Department & Acute Care

- Between 2018 and 2023, there was a **3% decrease** in the annual total **volume of ED visits** – a difference of **180,000 ED visits.**
- Lower-acuity ED visits have **dropped by 30% over the past five years** due to increased investment in community care programs, ED diversion clinics and alternatives such as Health811.
- **Over 12,000 health care providers** across Ontario can now refer patients electronically to health services, speeding up access to care.
- The ED Locum Program supported **over 27,200 physician coverage days** to ensure coverage in rural and remote areas.

Surgery

- Increased capacity and coordination for surgical care has ensured that **80% of patients requiring surgery are treated within recommended clinical timeframes.**
- The number of people waiting too long for surgery has **dropped by 39%** since 2022.
- Despite increased demand due to an aging population, same-day hip and knee replacements have **increased 14-fold.**
- Donor transplants **saved 1,465 lives.**
- O**ver 2,600 new nurses** were added to hospitals, long-term care homes, and home and community care organizations through the Community Commitment Program for Nurses.

Rehab & Community

- In 2024, more Ontarians received care in the comfort of their homes as home care volumes reached an all-time high.
- The Hospital-to-Home model **expanded to 49 hospitals**, providing faster and more seamless transitions for an estimated 12,000 initial patients and their families.
- O**ver 1,300 personal support workers** were attracted to long-term care homes and home and community care organizations through incentive programs.

Spotlight – Primary Health Care

Primary health care focuses on providing accessible, continuous, coordinated and comprehensive care which focuses on prevention, early detection and chronic disease management. A strong primary health care system enhances the overall well-being of the population and helps alleviate pressure on hospitals and emergency services, ensuring urgent care can be provided quickly to those who need it most and contributing to a more efficient health care system.

Improving access to primary health care in the province has been a top priority for the government. The magnitude of this is reflected in the Ontario government's historic, transformative investment of $1.8 billion to connect two million more people to a family doctor or a nurse practitioner who practices in a publicly funded primary care team, which will achieve the government's goal of connecting everyone in the province to primary health care. Ontario's Primary Care Action Team, which is led by Dr. Jane Philpott, will partner with Ontario Health, Ontario Health Teams (OHTs) and others to implement an action plan that leverages best-in-class models. This will include connecting people to interprofessional care teams, supporting primary care providers (PCPs), and making primary care more connected and convenient for Ontarians.

Where We Are:

Working with the MOH, Ontario Health has already supported:

- The investment of $90 million to expand or create new interprofessional primary care teams (IPCTs) in 2024/25. This initial funding resulted in 78 new or expanded interprofessional care teams that will connect over 300,000 new patients to primary health care services.
- The development of provincial guidance for establishing Primary Care Networks (PCNs) within OHTs to improve the coordination of primary health care services locally and enhance the integration of primary health care services within the broader health care system.
- The launch of an integrated quality improvement report for family physicians. This newly integrated report is sent to over 9,000 family physicians and provides them with insights to improve care for their patients.
- The expansion of Health811, now serving over 60,000 Ontarians each month, providing care guidance and navigation to primary health care services.

What's Ahead:

Ontario Health will play a critical role in implementing this transformative agenda. We will work with the MOH on implementing the Primary Care Action Plan. In 2025, Ontario Health will initiate the following deliverables:

- The expansion of IPCTs.
- Support OHTs and PCNs to facilitate local geographic attachment.
- Modernize Health Care Connect, leverage Health811 to facilitate access to primary care, enhance digital tools to reduce administrative burden for primary care and much more.

Spotlight – Emergency Care

Emergency care is a critical component of Ontario's health care system. In fiscal year 2022/23, there were over 5.5 million visits to Ontario's 163 emergency departments (ED) and hospitals are serving more people than ever before. The ED is a complex environment that requires comprehensive, specialized skills and processes to quickly assess, triage, intervene and collaborate to provide 24/7 unscheduled and urgent care to patients of all ages, with all forms of illness/injuries, and all clinical and social care needs.

Ontario Health is dedicated to improving health outcomes, overseeing the quality and coordination of emergency care services, and enhancing the experience for patients, families and providers, despite an increasing demand on the system than ever before. We will continue working with partners to systematically address broader health system issues affecting ED performance and improve the stability and delivery of emergency care. We are committed to accessible, exceptional and sustainable emergency care for all Ontarians.

Where We Are:

We have taken major steps with our hospital partners in continuously improving access to care in EDs in Ontario. Some highlights include:

- Enhancing hospital/ED performance measurement and monitoring to improve ED performance.
- Implementing the ED Nursing Education, Retention, and Workforce Program, in partnership with the MOH, to increase ED nurse access to virtual training and specialized education curriculum for all 163 EDs in Ontario.
- Providing ED shift closure coverage through close monitoring and collaboration with system partners, resulting in significant decreases in ED shift closures in 2024.
- Providing 24/7 support and clinical advice to rural and remote ED physicians through the ED Peer-to-Peer Program.

What's Ahead:

In 2025, Ontario Health will:

- Continue improving Ontario's EDs through strong collaboration with hospital partners focused on performance improvement and system integration.
- Reduce variation in hospital performance across the province.
- Spread best practices from the best hospital performers to those that need to improve through a Provincial ED Community of Practice.
- Expand the ED Peer-to-Peer Program.
- Continue keeping EDs operating when faced with health human resources (HHR) challenges.
- Provide strategic and operational directions for programs to support ED nurse recruitment with strategies to onboard and prepare new ED nurses.

Spotlight – Surgery & Medical Imaging

Ontario Health has been working continuously with the MOH, hospital partners and integrated community health services centres (ICHSCs) to continue expanding timely access to diagnostic imaging and surgery.

Progress To Date:

- Ontario Health administered the $30-million Surgical Innovation Fund (SIF), focused on hospital-led surgical recovery projects and processes from 2021 to 2023. Funded by the MOH, more than 100 SIF projects kickstarted surgical expansion in hospitals across the province, where specialized training, new hires, extended hours, new equipment, renovations, unique partnerships and surgical efficiency programs brought more patients into operating rooms and improved flow from surgery booking to recovery.
- Incremental Surgical Recovery (ISR) Funding is a provincial initiative launched in FY 2021/22 and aims to improve access and reduce wait times for prioritized surgical procedures. With ISR, the MOH invested funds with an emphasis on procedures with wait times that extended beyond clinically recommended targets. This investment, combined with other long waiter strategies, has supported the continued reduction in patients waiting beyond clinically recommended targets in the province.
- Since 2021/22, the Ontario government has invested $40 million in annual base funding to support the operations of 50 new MRI machines in 43 hospitals, increasing MRI capacity and managing increasing wait times. Ontario Health has worked with delivery partners to operationalize 31 of the 50 MRI machines to date.
- Ontario Health implemented a new model of imaging funding, with case-based funding provided in three clinical areas (image-guided lung biopsy, cardiac MRI, prostate MRI plus MR-informed biopsy) tied to patient-outcome related quality indicator reporting.
- Ontario Health expanded the number of sites providing specialized Positron Emission Tomography (PET) scanning and innovative image-guided therapy (transarterial radioembolization) services.
- From 2020 to 2024, through the Surgical Recovery Strategy, the government added an additional 379,000 one-time operating hours for hospital-based MRI and CT machines, ensuring better and more equitable access to medical imaging services.

Where We Are:

Despite growing pressure on Ontario's health system in recent years, the investments and innovations made have resulted in many accomplishments:

- Hospitals and ICHSCs have increased overall MRI and CT volumes by 27% since 2018, helping 780,000 more patients receive these imaging services.
- Five additional PET centres now provide specialized PET scans for prostate cancer indications, including two ICHSCs, bringing the provincial total of PET centres offering this service to ten.
- Provincial capacity and patient access to transarterial radioembolization has improved, with seven additional hospitals (ten total) now offering this treatment for patients where standard therapies, such as surgery, are not suitable.
- The annual number of same-day hip and knee replacements increased by 5,840% (knee) and 4,260% (hip) between 2018 and 2023.
- The number of people waiting for surgery (long waiters) has decreased by 15% over the last three years, because of Ontario Health's development and execution of regional strategies.
- In one year (November 2023 to November 2024), the number of patients waiting for a cardiac surgical procedure (Wait 2 waitlist) decreased by 15.5%.

What's Ahead:

As we move into a new fiscal year, Ontario Health will build on its achievements and, working with health service providers, will:

- Establish Regional Surgical Networks aimed at optimally allocating surgical volumes across providers to improve patient access, reduce wait times and maximize efficient use of funding.
- Increase system coordination and reduce heterogeneity of wait times through planning, alignment and implementation of central intake hubs for priority surgical and diagnostic imaging pathways.
- Complete the review of MRI and CT funding models, including rates, and provide recommendations to the MOH on an implementation plan for the adoption of any proposed changes to reflect current service delivery cost drivers.
- Leverage expansion of ICHSCs to improve access to surgical and medical imaging procedures in a community setting, increasing timely hospital access for more acute patients.
- Establish minimum standard for vascular ultrasounds (VUS) in Ontario to improve quality and consistency, reducing need for repeated imaging and saving resources for those needing it most.
- Continue focusing on decreasing the number of patients waiting beyond clinically-recommended wait time targets.

Measuring Clinical Excellence and Health System Performance

This plan aims to improve clinical outcomes and integrated health system performance.

Ontario Health will continue taking a data-driven approach to identifying and addressing areas of improvement that matter to Ontarians and that reduce health inequities. By linking strategic priorities to key system indicators, we can measure our impact. Our performance domains include those listed to the right. Additional KPIs are tracked by OH and reviewed regularly to support continuous improvement.

Key performance indicators within these domains will be used to establish targets, track system performance over time and compare our performance to other jurisdictions. This will be shared regularly with the Ministry of Health.

Quality Domains	Description of Key System Indicators
Timely Access	• Increased attachment to primary health care and team-based care.* • Reduced wait time to home and community care services and supports for people waiting for long-term care.* • Reduced wait time to diagnostic, surgical and emergent care, and within clinically-recommended times (including for pediatrics). • Improved experience, navigation and flow across the continuum of care.
Safety and Effectiveness	• Improved outcomes for mental health and addictions (MHA) and chronic diseases.
Efficiency	• Matching capacity with demand across the continuum of care. • Enhanced data, digital and virtual care access and integration.
A Strong Ontario Health	• A diverse, engaged and healthy workforce partnering with communities, health service providers and Ontario Health Teams (OHTs).
Equity and Patient Centredness	• Reducing inequities across all domains. • Focusing on quality in all we do.

* Requires collaboration with MOH and MLTC given ministry accountabilities, as well as Ontario Health atHome for placement services

Stakeholder, Partner and Community Engagement

Ontarians from across the province, including patients, caregivers, clinicians and health system leaders, were engaged in the development of Ontario Health's Annual Business Plan. This plan is informed by Ontarians to support a health system that is for Ontarians.

We will continue building and supporting our patient and family engagement program, focusing on proactively advancing equity, inclusion and a person-centred approach to health care planning and quality improvement. This includes creating multiple opportunities for health system users to share their experiences and insights through regional patient and family advisory councils, the Ontario Health CEO Patient and Family Advisory Group, and a wide range of Ontario Health strategic initiatives.

We will continue our commitment to advancing the quality of engagement through the Patient and Family Engagement Committee which focuses on sharing best practices, setting standards and fostering knowledge exchange. We continue collaborating with the Minister of Health's Patient and Family Advisory Council to support meaningful patient engagement across health transformation initiatives.

We recognize the importance of First Nations, Inuit, Métis and urban Indigenous (FNIMUI) partnerships and will continue establishing a partnership approach to our engagements. Our work together to develop and implement a FNIMUI Health Plan will include a process for engagement and relationship development with FNIMUI leadership, organizations, health tables and communities. This process will have a clear focus on respecting governance structures, relevant protocols and political agreements. The FNIMUI Health Plan will emphasize coordination across Ontario Health to avoid duplication and added burden on FNIMUI organizations and communities. We will continue to work closely with FNIMUI leadership to align priorities and ensure that we work with established Indigenous health tables to seek guidance and build health system capacity to address Indigenous needs respectfully, transparently and in a culturally safe manner. We will continue to take guidance from the Joint Ontario Indigenous Health Committee and Indigenous leaders, communities and organizations across Ontario on the work that Ontario Health leads. In alignment with provincial work, regional-level planning is also underway through the region's Indigenous health staff, working closely with FNIMUI health services and the Indigenous Health team to create and implement regional Indigenous health plans. Regional-level goals include operationalizing funding opportunities to improve access and attachment to Indigenous-led wholistic health services, supporting cultural safety and anti-racism work, and supporting partnership development between Indigenous health services and non-Indigenous health services, including hospitals, community health organizations and Ontario Health Teams (OHTs).

We will continue engaging regularly with health system partners to ensure transparency, build partnerships and foster collaboration. Regional all-partner meetings, chaired by Chief Regional Officers, will continue occurring throughout the year. The CEO Health System Advisory Council, comprised of senior leaders from across the province and all health sectors, will continue meeting regularly to provide input and guidance on Ontario Health programs and initiatives to ensure all sectors' requirements are considered. To improve access to health care services for Francophone people in each region, we will continue to engage and collaborate with key Francophone partners, including the French Language Health Planning Entities, as part of Ontario Health's overall engagement program, consistent with the *Connecting Care Act, 2019*.

Implementation Plan and Strategic Map

Reduce Health Inequities

Through discrete strategies and across all that we do:

1.1 Improve equitable outcomes and experiences for First Nations, Inuit, Métis, urban Indigenous and equity-deserving communities

- Black communities
- Francophone populations
- People living with disabilities
- Communities with geographic disparities in access to care
- Newcomers
- 2SLGBTQIA+ communities
- Older adults

1.2 Improve access to health supports in housing

- Home care
- Supportive housing
- Assisted living
- Long-term care

1.3 Advance whole person care experiences and outcomes

- Enhance prevention and a population health approach
- Scale effective models of service delivery
- Improve health care navigation

Transform care with the person at the centre

Advance the Right Care in the Right Place Through:

2.1 Primary health care
2.2 Mental health and addictions care
2.3 Home and community care
2.4 Long-term care and aging
2.5 Access and flow
2.6 Integrated care delivery
2.7 Chronic disease care
2.8 Ontarians' access to digital information and services

Health System Operational Management, Coordination, Performance Measurement & Management, and Integration

Support Faster Access to Care Through:

3.1 Emergency care and surge responses
3.2 Integration of diagnostics and surgical care
3.3 Provider access to digital tools
3.4 Digital and data system integration, standardization and security
3.5 Use of data and analytics services

Support Health Care Workers Through:

4.1 Workforce training and optimization
4.2 Recruitment, retention and distribution
4.3 Integrated capacity planning

Enhance Clinical Care and Service Excellence

5.1 Expand provincial genetic services
5.2 Improve access and quality in cancer care
5.3 Improve access and quality in renal care
5.4 Increase life-saving organ and tissue donations and transplants
5.5 Improve access and quality in cardiac, vascular and stroke care
5.6 Transform and improve access and quality in palliative care
5.7 Expand Ontario Laboratory Medicine Program

Maximize System Value by Applying Evidence

6.1 Advance high-quality and safe care through evidence and continuous quality improvement
6.2 Strengthen system supports and accountabilities

Strengthen Ontario Health's Ability to Lead

7.1 Continue enhancing Ontario Health's organizational effectiveness through a strong, engaged, connected, diverse and accountable workforce
7.2 Support the government's plans for supply chain centralization

GOALS

Reducing Health Inequities

1.1 Improve equitable outcomes and experiences for FNIMUI and equity-deserving communities

1.2 Improve access to health supports in housing

1.3 Advance whole person care experiences and outcomes

1.1 IMPROVE EQUITABLE OUTCOMES AND EXPERIENCES FOR FIRST NATIONS, INUIT, MÉTIS, URBAN INDIGENOUS AND EQUITY-DESERVING COMMUNITIES

Our priorities reflect our commitment to reducing health inequities. Ontario Health aims to dismantle barriers, leverage local solutions, promote culturally responsive health services and utilize evidence-based planning. Over the next three years, our overarching goals are to:

- Build capacity to address discrimination and racism in the system.
- Advance collaboration and community-led strategies for First Nations, Inuit, Métis and urban Indigenous (FNIMUI) communities and equity-deserving communities.
- Expand and scale locally driven population health initiatives.
- Strengthen equity and data analytics to identify and address gaps.
- Ensure compliance with legislation requiring the active offering of French-language health services.
- Support emerging areas of health inequities across Ontario aligned with provincial priorities to ensure adaptive and responsive health service delivery.

This work is dynamic and integrated with activities throughout this implementation plan. While these activities are listed here, reducing inequities remains a priority across all areas.

Key measures expected to achieve:

- Number of initiatives aimed at providing equitable access, experiences and health equity outcomes, with specific efforts to address racism in the health sector affecting FNIMUI and equity-deserving populations.
- Number of signed Relationship Agreements between Ontario Health and FNIMUI partners

YEAR ONE 2025/26

First Nations, Inuit, Métis and Urban Indigenous Populations

1.1.1 Build and strengthen relationships across all regions with FNIMUI leaders, communities and organizations. Formalize relationships as requested, addressing issues and concerns identified by FNIMUI partners.

1.1.2 Identify and work to address existing barriers to funding with and for FNIMUI-led organizations in collaboration with the MOH.

1.1.3 Develop the First Nations, Inuit, Métis and Urban Indigenous Health Plan in partnership with FNIMUI communities/organizations, local Indigenous health tables and health system partners.

1.1.4 Implement the fifth First Nations, Inuit, Métis and Urban Indigenous Cancer Strategy (2024-28) in partnership with FNIMUI communities/organizations and health system partners.

1.1.5 Develop and improve the Indigenous Data Governance Matters process with FNIMUI communities and partners.

Locally Driven Population Health Models

1.1.6 Build on the successes of the High Priority Communities Strategy by expanding locally driven population health models (LDPHM), formalizing partnerships with OHTs and enhancing the role of community ambassadors to drive tailored, community-responsive health care solutions.

1.1.7 Determine key areas of support and needs for people living with disability in Ontario and use these insights to inform the planning of responsive initiatives.

Black Health Plan

1.1.8 Continue engaging community members, health system leaders and providers to inform and advance Black Health Plan implementation deliverables.

1.1.9 Monitor and demonstrate the impact of Black Health Plan-funded programs and identify areas to improve outcomes for Black populations.

Francophone Populations

1.1.10 Continue engaging with French-language sector partners to support and inform annual planning, address French Language Services (FLS) needs, improve the health system and implement health system programming.

1.1.11 Implement the government's strategy to enhance FLS access across the continuum of care, including evidenced-based French Language Health Services (FLHS) planning, design, delivery and evaluation.

1.1.12 Advance equitable access to health services in French:

- Increase the number of organizations identified and designated to provide services in French, with a focus on primary care.
- Continue providing support to Health Services Providers (HSPs) to develop and implement health services available in French via an active offer.
- Organize active offer training sessions to support HSPs.
- Strengthen support in priority areas, including primary care, to ensure equitable health care services for French-speaking populations.
- Develop best practice FLS navigation support for French-speaking people.

1.1.13 Continue building awareness and bilingual capacity within Ontario Health by promoting team member education through Francophones, Cultural and Linguistic Sensitive Care training.

- People Leaders to complete mandatory tri-annual training in 2026/27 to support the provision and delivery of FLHS offered and supported by the organization.

1.1.14 Work with the MOH to:

- Implement the government's direction, once determined, to modernize Ontario's FLS engagement and planning model.

Note: Work captured as part of 1.1.14 will support advancing priorities within LOD #68-71, 73.

2SLGBTQIA+ Communities

1.1.15 Launch 2SLGBTQIA+ action plan with distinct areas of work and commitments.

1.1.16 Continue working with Rainbow Health Ontario to strengthen 2SLGBTQIA+ inclusive health care capacity and support broader implementation of the 2SLGBTQIA+ action plan.

1.1.17 Begin implementation of Gender-Affirming Care for Transgender, Two-Spirit and Nonbinary Adults Quality Standards.

1.1.18 Coordinate funding of Mental Health and Addiction (MHA) supports and services tailored to 2SLGBTQIA+ children and youth.

Refugee, Asylum-Seeking and Housing-Insecure Populations

1.1.19 Continue enhancing primary care access to refugees and asylum-seeking groups through culturally responsive interventions.

1.1.20 Continue providing tailored community investments aimed at housing-insecure populations, leveraging data and evolving community insights.

YEAR TWO 2026/27

First Nations, Inuit, Métis and Urban Indigenous Populations

- Continue advancing prior year's deliverables related to building relationships with FNIMUI leaders, communities and organizations, addressing funding barriers, advancing the FNIMUI health plan and cancer strategy, and improving the Indigenous Data Governance Matters process.

Locally Driven Population Health Models

- Illustrate the impact of LDPHM on diverse populations by promoting and expanding inclusive care practices to additional areas in North Regions.
- Work with people living with disability and key partners to develop an action plan that addresses their needs and identifies service delivery gaps to reduce health disparities and guides future recommendations.
- Enhance the implementation of the Core Sociodemographic Data Standard within Ontario Health and utilize encounter-based data on disability for planning purposes.

Black Health Plan

- Continue implementing initiatives and securing sustainable funding to advance equitable health and social outcomes for Black and underserved populations.

Francophone Populations

- Continue engaging with French-language sector partners to support and inform annual planning, address FLS needs, improve the health system and implement health system programming.
- Continue implementing the government's strategy to enhance FLS access across the continuum of care, including evidenced-based FLHS planning, design, delivery and evaluation.
- Continue advancing equitable access to health services in French.
- Continue building awareness and bilingual capacity within Ontario Health.

2SLGBTQIA+ Communities

- Improve the cultural competency of Health811 services for 2SLGBTQIA+ communities.
- Continue advancing our work with Rainbow Health Ontario to strengthen 2SLGBTQIA+-inclusive health care capacity and support the broader implementation of 2SLGBTQIA+ action plan.
- Continue leveraging province-wide relationships to improve intersectional and ongoing engagement with 2SLGBTQIA+ communities and support the implementation of a broader 2SLGBTQIA+ action plan.

Refugee, Asylum-Seeking and Housing-Insecure Populations

- Evaluate the impact of community investments on housing-insecure populations and refine strategies based on data and community feedback to enhance program effectiveness.

YEAR THREE 2027/28

First Nations, Inuit, Métis and Urban Indigenous Populations

- Report on and sustain established relationship protocols with FNIMUI partners.
- Monitor funding processes to ensure seamless access to funding opportunities for FNIMUI organizations, in collaboration with the MOH.
- Continue advancing prior years' deliverables related to the implementation and advancement of the FNIMUI Health Plan, FNIMUI Cancer Strategy and Indigenous Data Governance Matters initiative.

Locally Driven Population Health Models

- Expand LDPHMs to advance culturally-responsive care system-wide by identifying areas for joint impact and co-planning between OHTs and LDPHM lead agencies.
- Enhance care access for people living with disability in Ontario by implementing immediate priorities from the action plan to address inequities.

Black Health Plan

- Embed the Black Health Plan priorities in provincial strategies with a particular focus on preventative care and primary care. Spread and scale culturally-responsive models in prevention and service delivery.

Francophone Populations

- Continue advancing prior years' deliverables.

2SLGBTQIA+ Communities

- Align the 2SLGBTQIA+ action plan with provincial priorities of advancing key areas of prevention, primary care and MHA.
- Continue our work with Rainbow Health Ontario to provide 2SLGBTQIA+-inclusive health care capacity building and support broader implementation of 2SLGBTQIA+ action plan.

Refugee, Asylum-Seeking and Housing-Insecure Populations

- Explore opportunities to work with shelter organizations to potentially scale best practices and improve outcomes and access for housing-insecure populations.

1.2 IMPROVE ACCESS TO HEALTH SUPPORTS IN HOUSING

Ontario Health collaborates with partners across the province to support care delivery in community settings, including at home. Increasing access to these services will allow people across Ontario to receive care where and when they need it, while maintaining their existing support networks. As access to good-quality, stable housing becomes an increasing challenge in Ontario, we are committed to working locally and regionally with housing corporations, municipalities, other funding providers and provincially with ministries to develop collaborative solutions that meet the needs of equity-deserving groups, including people without housing.

Key measure expected to achieve:

- Reduced Alternate Level of Care (ALC) numbers and length of stay for patients waiting for community care.

YEAR ONE 2025/26

1.2.1 Co-develop a health supports in housing model to establish consistency in care across the province, covering the full range of housing-based supports including community support services (CSS), home and community care, MHA and supports for those who are underhoused or without housing.

1.2.2 Develop a phased strategy for expansion of capacity across the continuum of health supports in housing (community and home-based support), with a focus on improving patient flow through the health system.

1.2.3 Work with housing corporations, municipalities, other ministries and other funding providers, and local delivery partners to develop a shared understanding of current housing models and the health supports required for priority populations.

YEAR TWO 2026/27

- Continue expanding capacity across the continuum of health supports in housing (community and home-based support), with a focus on improving patient flow through the health system.
- Build on the established partnership between housing and health, including expanding data collection, reporting, evaluation and capital planning.

YEAR THREE 2027/28

- Continue expanding capacity across the continuum of health supports in housing (community and home-based support), with a focus on improving patient flow through the health system.
- Contributing continued capital and system planning across the health supports in housing sector.

1.3 ADVANCE WHOLE PERSON CARE EXPERIENCES AND OUTCOMES

As part of our commitment to the Quintuple Aim, our activities include a focus on improving health system navigation and enhancing the collection and use of holistic outcome and experience measures. Deliverables to support this work are included in several different areas of focus within the ABP, including:

YEAR ONE 2025/26

1.3.1 Enabling whole person care through comprehensive relationship-based primary care (section 2.1).

1.3.2 Improving people's ability to navigate the health system and the implementation of a provincially-coordinated strategy of patient-reported outcome and experience measurements (PROMs/PREMs) (section 2.6).

YEAR TWO 2026/27

- Continue advancing prior year's deliverables.
- Enhancing Health811 to enable people to more easily access streamlined information, navigate through the health care system and view their health data via secure access (section 2.8).

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

GOALS

Advancing the Right Care in the Right Place Through:

Transforming Care with the Person at the Centre

2.1 PRIMARY HEALTH CARE

Ontario Health is focused on improving access to comprehensive team-based primary health care for more of the population. We will continue leading the implementation of the MOH plan to expand interprofessional primary care teams (IPCTs) with a focus on improving equitable access. Aligned with this focus, we will also continue advancing the implementation of Primary Care Networks (PCNs) that will connect the local primary care sector within an Ontario Health Team (OHT), ensuring clinicians are key members of improving local care delivery. We are committed to leveraging data-driven frameworks for planning, performance measurement and quality improvement, alongside the expansion of team-based primary care and the implementation of PCNs.

Key measures expected to achieve:

- Increased number of new or expanded IPCTs.
- Increased number of new patients served by the new and expanded IPCTs; increased attachment to primary care.

YEAR ONE 2025/26

2.1.1 Support the allocation of the $235 million primary care investment and implement the 80 additional primary care teams, who will attach up to 300,000 patients.

2.1.2 Implement an evidence-based primary care planning framework that could inform planning, health human resources (HHR), equity of access, funding allocations for primary care programs and integration. Launch of regional planning data tool.

2.1.3 Implement a provincial and regional performance management process for team-based primary care models, which includes performance standards and indicators, quality supports and escalation pathways.

2.1.4 Implement the provincial approach to primary care quality measurement and embed the primary care report within electronic medical records (EMRs) to ensure clinicians have access.

2.1.5 Support the modernization of the Health Care Connect user and provider experience.

2.1.6 Support the MOH to clear the Health Care Connect waitlist, which will include identifying approaches for OHTs and PCNs to facilitate attachment.

2.1.7 Work with clinical stakeholders to review and update the clinical content in the MyPractice Primary Care Plus report to align with the Primary Care Strategy, which provides data to practitioners to support evidence-based care and quality improvement. This will include (but is not limited to) additions, removals or changes to indicators and/or methodologies.

YEAR TWO 2026/27

- Continue implementing and evaluating provincial expansion of team-based primary care with a focus on improving equity.
- Further refine the primary care planning framework and evaluate the regional data tool.
- Continue implementing a provincial and regional performance management process for team-based primary care models.
- Continue refining accountability agreements in consultation with the primary care sector. This will be achieved through provider oversight and accountability, contract management and performance monitoring of interprofessional care teams.
- Continue advancing the primary care data strategy and embed the primary care integrated report into EMRs to promote greater clinician engagement with the report.

YEAR THREE 2027/28

- Continue advancing the evaluation and implementation of the provincial expansion of team-based primary care to increase attachment and access, with a focus on equity.
- Explore expanded application of primary care planning framework to OHTs/PCNs and provide OHTs access to the regional planning data tool to support local capacity and resource planning, including HHR.
- Continue implementing a provincial and regional performance management process for team-based primary care models, including performance standards and indicators, quality supports and escalation pathways.
- In consultation with the primary care sector, continue refining accountability agreements.
- Continue advancing the primary care data strategy and improving primary care data infrastructure to strengthen reporting back to IPCTs, enhancing accountability and quality improvement.

2.2 MENTAL HEALTH AND ADDICTIONS CARE

Ontario Health's Mental Health and Addictions Centre of Excellence (MHACoE) plays a central role in advancing a comprehensive, connected and high-quality mental health and addictions (MHA) system across Ontario. In partnership with clinical experts, service providers and people with lived and living experience, the MHACoE is committed to enhancing system management, supporting quality improvement initiatives, disseminating best practices and evidence, and establishing clear service expectations. The focus remains on ensuring MHA services are more accessible, integrated and responsive to meet the diverse needs of Ontarians.

Key measures expected to achieve:

- Increased number of people accessing Ontario Structured Psychotherapy (OSP).
- Increased percentage of clients with reliable improvement through the OSP program.
- Implement provincial foundations (data collection, coordinated access, program expectations).

YEAR ONE 2025/26

2.2.1. Increase access to the OSP program, while improving and measuring quality of the program.

2.2.2. Advance ongoing implementation and begin performance measurement of in-person and virtual provincial programs for people experiencing depression and anxiety-related disorders, schizophrenia and psychosis, eating disorders and substance use disorders.

2.2.3. Advance and monitor performance of the multi-year implementation of provincially-coordinated access to MHA services.

2.2.4. Begin implementing the MHA core services framework including resourcing impact analysis.

2.2.5. Further advance the implementation of a standardized provincial system for the collection, use and reporting of community MHA data in Ontario.

2.2.6. Build and sustain partnerships and processes with FNIMUI organizations and communities, implement initial recommendations related to depression and anxiety-related disorders and co-develop deliverables for substance use disorders needs.

2.2.7. Finalize the multi-year system plan for MHA, in alignment with the priorities listed above and the *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System.*

2.2.8. Support the implementation of the Homelessness and Addictions Recovery Treatment (HART) Hubs, including establishing a Community of Practice, and the development of Program Operational Guidelines and shared best practices and processes.

YEAR TWO 2026/27

- Continue increasing access to OSP, while improving and measuring quality of the program.
- Continue implementation, performance measurement and monitoring of in-person and virtual provincial programs for people experiencing depression, anxiety-related disorders, schizophrenia, psychosis, eating disorders and substance use disorders.
- Advance and monitor performance of the multi-year implementation of provincially-coordinated access to MHA services.
- Continue implementation of the MHA core services framework and impact analysis resourcing.
- Implement outstanding recommendations related to depression and anxiety-related disorders identified through consultations with FNIMUI organizations and communities and implement initial recommendations and deliverables related to substance use disorders needs.
- Further develop and implement a standardized provincial system for the collection, use and reporting of community MHA data in Ontario.
- Advance the multi-year system plan for MHA, in alignment with the *Roadmap to Wellness*.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

2.3 HOME AND COMMUNITY CARE

Ontario Health will collaborate with Ontario Health atHome, the MOH and MLTC, OHTs and other HSPs to continue integrating the home and community care sector with the broader health care system, ensuring quality home and community care services and long-term care home placements across the province. Our organization will continue spreading best practice home care delivery models and evolving the digital and service contract infrastructure to support ongoing sector modernization. We will recommend investments at both the local and regional levels to ensure programs and initiatives reflect local needs. *See Appendix A: Ontario Health atHome Annual Business Plan 2025/26.*

Key measures expected to achieve:

- Increased home care access and reduced wait times.
- Increased volume of individuals served through the HSP-led Hospital-to-Home (H2H) programs.

YEAR ONE 2025/26

2.3.1. Provide oversight of Ontario Health atHome performance.

2.3.2. Work with delivery partners, the MOH, the MLTC and Ontario Health atHome to identify opportunities to improve the appropriate discharge of Alternate Level of Care patients to community settings or long-term care homes by working collaboratively with key system partners, including leveraging home and community care services where appropriate.

2.3.3. Lead the establishment of a digital platform that supports an integrated home and community care sector and best practice models of integrated care.

2.3.4. Continue advancing the spread and scale of new or proven home care models, such as the H2H program, Leading Projects and models for equity deserving communities.

2.3.5. Continue advancing a new provincial contracting model that supports high-quality home care delivery.

YEAR TWO 2026/27

- Sustain and continue expanding home care delivery models in response to system and local needs.
- Implement a new digital platform that supports an integrated home and community care sector.
- Transition to new provincial contracting model.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

2.4 LONG-TERM CARE AND AGING

Ontario Health continues to focus on enhancing the experience of care and quality of life of all older Ontarians. Working in collaboration with the MOH, the MLTC, the Ministry of Seniors and Accessibility (MSAA), Ontario Health atHome, OHTs and delivery organizations, we are committed to supporting seniors to receive the right care in the right place with more timely access to the services.

Key measures expected to achieve:

- Decrease in avoidable ED visits from long-term care residents.
- Increase support for people seeking long-term care home placement.

YEAR ONE 2025/26

2.4.1. Conduct long-range planning of aging care (including dementia, with a focus on those exhibiting responsive behavioural symptoms of neurological conditions) and impact on services and capacity.

2.4.2. Continue advancing support efforts to improve long-term care home resident access to clinical and diagnostic services, including by building clinical capacity within homes, and through key partnerships to prevent avoidable transfers to the ED.

2.4.3. In partnership with the MLTC, identify and implement strategies to optimize and maximize existing capacity within long-term care homes, mitigating temporary and permanent bed losses.

2.4.4. Establish a comprehensive care partner support strategy addressing respite care and care partner resources to alleviate burden. This includes ongoing collaboration with system partners to define and support the development and implementation of roles, training and supports for essential care partners in hospitals and long-term care homes with expansion to additional sectors.

YEAR TWO 2026/27

- Continue advancing prior year's deliverables.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables

For more details about the Ontario Health atHome implementation plan and deliverables, please see Ontario Health atHome's 2025-26 ABP

2.5 ACCESS AND FLOW

Good access and flow allow patients to receive the right care in the right place at the right time across the health system. Ontario Health is dedicated to optimizing access by ensuring quality care, allocating appropriate resources and fostering care integration among health providers. This approach emphasizes delivering more community-based care to decrease unnecessary ED visits and hospitalizations, while minimizing hospital stays for patients that can be cared for in more appropriate care settings.

Key measures expected to achieve:

- Reduced wait times for care in more appropriate settings (lower ALC length of stay).
- Fewer open ALC volumes.

Year One 2025/26

2.5.1. Support continued implementation of Alternate Level of Care (ALC) Leading Practices and Home First actions across the health system.

2.5.2. Develop and implement an integrated capacity plan with a focus on key priority service areas. Implement strategies to address gaps identified in sector-based capacity plans, evaluate and address pressures in the long-term care sector and broader health system to facilitate access to the most appropriate care setting, with a focus on improving patient access to care in community and home-based settings.

2.5.3. Expand the provincial bed management system to support a shared understanding of capacity across all sectors and make well-informed decisions to enhance patient flow and system capacity.

2.5.4. Evaluate and scale promising ED diversion models.

2.5.5. Develop and implement a standardized community paramedicine model of care which allows for local variation, including development of Indigenous care models. Implement tools and resources to support optimization of community paramedicine.

YEAR TWO 2026/27

- Continue advancing prior year's deliverables.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

2.6 INTEGRATED CARE DELIVERY

Ontario Health Teams (OHTs) take an integrated approach to organizing and coordinating care delivery, ensuring stronger connections for patients within their local communities. Through OHTs, health care and community providers (including those in hospitals, primary care, local public health agencies and home and community care) work as one coordinated team – regardless of where they provide care. OHTs are tasked with advancing a population health management approach to improve how Ontarians experience and access care. Ontario Health is focused on supporting OHTs to deliver high-quality integrated care for all Ontarians. In collaboration with the MOH, we play a critical role in supporting the development and maturity of OHTs. This includes our role in setting and overseeing the key clinical and digital priorities for OHTs to advance in alignment with the MOH's Path Forward policy direction and regional contexts.

Key measure expected to achieve:

- The number of patients in the Health Care Connect program referred to a provider within the OHT population.

YEAR ONE 2025/26

2.6.1. Support all OHTs to establish and advance their Primary Care Networks through toolkits and supports.

2.6.2. Enable further optimization, standardization and spread and scale of high-impact remote care management (RCM) programs for chronic conditions, surgical transitions and ALC/frailty. Continue implementation of RCM Provincial Solution.

2.6.3. Finalize recommendation to the MOH regarding an aligned provincial approach for virtual primary care models. Continue funding, optimization and alignment of existing virtual primary care models for unattached patients and those without timely access to primary care.

2.6.4. Advance supports to OHTs including data sharing, information management, population health planning, enabling integrated funding strategies and digital guidance.

2.6.5. Advance clinical maturity of existing heart failure, chronic obstructive pulmonary disease (COPD) and lower limb preservation ICPs in support of the chronic disease prevention and management priority for OHTs.

2.6.6. Support OHTs and PCNs in advancing the government's goal of 100% primary care attachment for all Ontarians by leading the development of new or expanded interprofessional primary care team (IPCT) proposals and attaching patients registered with the Health Care Connect Program.

YEAR TWO 2026/27

- Advance OHT performance improvement activities including refreshing performance measures, leading OHT performance reporting and improvement processes, evaluating patient and provider experience measures, and aligning OHT collaborative Quality Improvement Plans (cQIPs).
- Support the establishment, advancement and maturation of PCNs with toolkits and supports.
- Continue spread and scale of high-impact virtual care programs (RCM, virtual primary care, etc.)
- Continue supporting OHTs in their planning for home care delivery, in alignment with the MOH policy direction.
- Continue supporting OHTs and PCNs in advancing the government's goal of 100% primary care attachment for all Ontarians.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

2.7 CHRONIC DISEASE CARE

With Ontarians living longer than ever before, reducing incidence and improving outcomes of chronic disease are critical to improving quality of life and building a sustainable health care system. Chronic disease programs will improve access to prevention, early detection and management services.

YEAR ONE 2025/26

2.7.1. Improve access to preventive care for equity-deserving and FNIMUI communities.

2.7.2. Improve access to early detection and Diabetes Education Programs through program enhancements, integration, performance management and working with partners, including Public Health Ontario.

Deliverables to support this work are also included in different areas of focus throughout the ABP, such as Integrated Care Delivery (2.6). This work also pertains to launching abdominal aortic aneurysm screening for individuals who are 65+ and maturing existing integrated care pathways in support of chronic disease management.

YEAR TWO 2026/27

- Continue advancing prior year's deliverables related to improvements to chronic disease programs.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables related to improvements to chronic disease programs.

2.8 ONTARIANS' ACCESS TO DIGITAL INFORMATION AND SERVICES

Ontario Health prioritizes providing Ontarians with digital access to health information and services. Despite some successful initiatives across the province, many Ontarians still lack consistent digital access to health services. As the digital landscape evolves rapidly and citizens' expectations for seamless, efficient services rise, Ontario Health is committed to connecting the digital landscape for the benefit of patients, care partners and the frontline.

Key measures expected to achieve:

- Health811 user satisfaction and utilization.
- Number of Ontarians registered as users of the Provincial Patient Viewer.
- Number of unique logins by registered users to Provincial Patient Viewer.
- Number of total logins by registered users to Provincial Patient Viewer.
- Number of sites accessing Provincial Clinical Viewers.
- Number of providers with access to the provincial clinical viewer (acute, community, primary care) (pilot)
- Number of users actively using the provincial clinical viewer (acute, primary care, community) (pilot)

YEAR ONE 2025/26

2.8.1 Continue advancing Health811 services based on user experience and needs.

2.8.2 Roll out the Provincial Patient Viewer to Ontarians, in alignment with the Integrated Patient Access (IPA) Program, executing on the roadmap for the Patient Viewer and enabling greater patient access to their personal health information.

YEAR TWO 2026/27

- Continue advancing prior year's deliverables related to Health811.
- Advance patient access roadmap and integrate additional priority digital health services.
- Continue rolling out the Provincial Patient Viewer to Ontarians, in alignment with the IPA Program and execution of the roadmap, including the decommissioning of legacy clinical viewers.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

GOALS

Supporting Faster Access to Care Through:

Health System Operational Management, Coordination, Performance Measurement & Management and Integration

3.1 Emergency care and surge responses

3.2 Integration of diagnostics and surgical care

3.3 Provider access to digital tools

3.4 Digital and data system integration, standardization and security

3.5 Use of data and analytics services

3.1 EMERGENCY CARE AND SURGE RESPONSES

Working with our delivery, public health and ministry partners, we have established a strong foundation of provincial and regional emergency management and surge response. This foundation continues to be operationally embedded through our regional model of health system coordination and management and is applied to ongoing seasonal surges. Provincially, we will build on this through our work to improve access to high-quality ED care and the development of an integrated critical care system. Our goal is to ensure all Ontarians have access to life- and limb-saving emergency care by developing standards and guidelines, fostering knowledge exchange (e.g., communities of practice), implementing digital and virtual solutions to advance ED care, and continuously measuring, monitoring and reporting performance.

Key measures expected to achieve:

- Reduction in 90th percentile ED wait time to physician initial assessment.
- Keeping EDs open across the province.
- Decreased number of no-bed admits.
- Filling urgent ED physician shifts through the Emergency Department Locum Program.
- Maintaining critical care bed capacity and safe occupancy levels.

YEAR ONE 2025/26

3.1.1. Improve performance of outlier hospitals (including pediatrics) through performance measurement, monitoring and reporting, and the identification and spread of best practices and learnings from leading hospital sites.

3.1.2. Launch an ED Community of Practice to sustain knowledge exchange, highlight best practices and support system cohesion.

3.1.3. Support EDs through ongoing improvements to programming (ED nurse recruitment, virtual education, Specialty Training Fund and ED Peer-to-Peer).

3.1.4. Lead system change management, communication and knowledge transfer to the amendments from the Pay-for-Results (P4R) Program review. Develop, deliver tools, governance and methodologic amendments to enhance and sustain this program.

3.1.5. Engage stakeholders to further refine and implement the comprehensive plan for the critical care system that encompasses critical care bed capacity, related HHR supports, trauma, burns, long-term ventilation, neurosurgery and other critical care services and programs.

3.1.6. Work with the MOH and MLTC to maintain and support province-wide monitoring, planning and response to both planned and emerging disruptions affecting the health system.

3.1.7. Collaborate with the MOH, Public Health Units and Public Health Ontario to improve access to and uptake of publicly funded vaccines, including COVID-19 and the administration of RSV immunizing product to infants and high-risk children.

YEAR TWO 2026/27

- Continue providing strategic and operational direction to improve ED performance.
- Continue advancing previous year's deliverables related to critical care services in Ontario.
- Support a comprehensive strategic plan for critical care including bed capacity, trauma, burns, long-term ventilation, neurosurgery and related services.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables related to critical care.

3.2 INTEGRATION OF DIAGNOSTICS AND SURGICAL CARE

Ontario Health is focused on reducing surgical and diagnostic imaging wait times by prioritizing care within clinically-recommended timeframes and addressing prolonged wait times, particularly in historically underserviced areas. While continuing to improve access to surgery, imaging, procedures and long-range planning, we will also support the expansion and integration of Integrated Community Health Service Centres (ICHSCs) into broader system planning. We will promote collaboration and increase the use of existing infrastructure, such as rapid access clinics (RACs) and centralized intake mechanisms.

Key measures expected to achieve:

- Percentage of surgeries completed within clinically-recommended wait times for pediatrics and adults.
- Percentage of priority 2-4 MRI and CT scans completed within wait time targets for adults and pediatrics.
- Volumes of CT and MRI scans for pediatrics and adults.
- Total MRI/CT operating hours for adults and pediatrics.

YEAR ONE 2025/26

3.2.1. Strengthen system capacity and integration by embedding the ICHSCs into system planning, capacity-building, performance processes and digital integrations, including into the Wait Time Information System (WTIS). Continue collaborating with the MOH on expansion initiatives and work closely with Accreditation Canada to uphold and enhance quality and safety standards within these ICHSCs.

3.2.2. Continue improving access to surgery and reducing surgical wait times to meet clinically determined targets and establish a long-range provincial surgical plan aimed at enhancing capacity, quality and performance (adults and pediatrics).

3.2.3. Expand system stewardship for medical imaging, strengthening proactive system-level planning and supports, and broadening scope of imaging modalities to address prioritized gaps impacting patient care.

3.2.4. Complete review of MRI and CT funding models, including rates, and provide recommendations to the ministry on an implementation plan for adoption of any proposed changes to reflect current service delivery cost drivers.

3.2.5. Establish Regional Surgical Networks aimed at shifting surgical volumes between providers to improve patient access, reduce wait times and maximize efficient use of funding.

Note: Deliverables within this area of focus will support advancing clinical priorities within LOD #30.

YEAR TWO 2026/27

- Continue advancing prior year's deliverable pertaining to surgery, diagnostic imaging, ICHSCs and the pediatric recovery plan.
- Potential further expansion of RACs to be considered.

YEAR THREE 2027/28

- Continue advancing prior years' deliverable pertaining to surgery, diagnostic imaging, ICHSCs and the pediatric recovery plan.

3.3 PROVIDER ACCESS TO DIGITAL TOOLS

Patients before Paperwork (Pb4P) aims to deliver safer, timely and more equitable care for Ontarians. Our objective is to streamline and simplify administrative processes, freeing providers from unnecessary paperwork and empowering patients to actively engage in their health care journey. By increasing the adoption, utilization and connection of digital products, we are committed to enhancing the patient experience and significantly reducing the administrative burden on providers.

Key measures expected to achieve:

- Increased number of providers with access to eReferral.
- Increased volume of eReferrals sent.

YEAR ONE 2025/26

3.3.1. Reduce the administrative burden on primary care by expanding integrations of eConsult services to point-of-care systems and increasing access to digitized administrative forms via the eForms platform.

3.3.2. Support adoption of lab test e-ordering in community and primary care sectors and build point-of-care functionality in Ontario Laboratories Information Systems (OLIS)-Mobile Order Results Entry (OLIS-MORE). Facilitate lab-to-lab referrals and redirects between Public Health Ontario, community and hospital labs via OLIS.

3.3.3. Determine Ontario's solution for digital prescribing and integration with provincial electronic health record (EHR) assets in alignment with the Pb4P initiative.

3.3.4. Increase adoption of electronic referral tools including Provincial eReferral Forms, enabling seamless and timely transitions for patients between providers. Ensure that barriers to accessing digital health tools are identified and addressed for FNIMUI-led organizations.

3.3.5. Support the implementation of Central Intake Hubs for equitable referral distribution in orthopedics, cataracts, MRI and CT services across Ontario.

YEAR TWO 2026/27

- Continue advancing prior year's deliverables and expanding central intake and e-referral services.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables and expanding central intake and e-referral services.

3.4 DIGITAL AND DATA SYSTEM INTEGRATION, STANDARDIZATION AND SECURITY

Significant progress has been made in developing a provincial system that allows thousands of health care providers in hospitals, family practices, long-term care homes and pharmacies to quickly access lab results, publicly-funded and monitored drugs, digital images (e.g., x-rays and MRIs), hospital discharge summaries and more. However, this work is far from complete. When separate systems cannot share records or be easily accessed, clinicians face limited access to patient health information. This can lead to repeated tests or poor patient outcomes due to decisions made with incomplete information. Relying on patient recollection and communication results in sub-optimal experiences and quality for both patients and providers.

Ontario Health is prioritizing efforts to digitally unite providers and existing data stores containing billions of patient records critical to high-quality and timely care. These efforts are supported by essential provincial cyber and privacy measures that Ontario Health will continue to mandate and scale to ensure security across the health care system.

Key measure expected to achieve:

- Total number of HSPs supported by the Cyber Security Operating Model.

YEAR ONE 2025/26

3.4.1. Add new critical datasets to the provincial EHR to help clinicians with decision-making, such as better access to medication data, primary care data and genetic lab results/data from labs at the point of care.

3.4.2. Enhance registries and repositories to support the contribution of new data that will support clinical decision-making.

3.4.3. Continue strengthening the foundation for interoperability and information exchange between systems via the Digital Health Information Exchange (DHIEX) program.

3.4.4. Increase cyber security resiliency across the health system by advancing the provincial Cyber Security Operating Model (CSOM) strategy and expanding coverage across the system, supporting the established Local Delivery Groups (LDGs) and operationalizing provincial platforms.

3.4.5. Work to establish sophisticated points of regional digital integration and standardization through an expanded scope for LDGs.

YEAR TWO 2026/27

- Continue prior year's deliverables including addition of critical datasets to the provincial EHR and enhancements to registries and repositories to support clinical decision making.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

3.5 USE OF DATA AND ANALYTICS SERVICES

Accessing data for analytics and insights to improve system coordination and care delivery is central to Ontario Health's daily operations. The objectives outlined for Ontario Health in the *Connecting Care Act, 2019* are achieved through the collection and responsible use of data. To meet our priorities, Ontario Health is collaborating with the MOH and Information Privacy Commissioner (IPC) to establish a modernized data authority model. This includes establishing a harmonized authority model and aligning our secure information management practices, which integrate technology, people and processes.

Our efforts focus on expanding the insights we generate to drive timely improvements in equity, clinical and quality outcomes, timely access to care, health system integration and provider performance.

Key measures expected to achieve:

- New datasets and information assets added to the Analytics Data Hub and utilized for planning, informing quality and clinical improvements, improving timely access and flow, and maintaining oversight and performance management of the health system.
- Provision of quality improvement information to delivery organizations.
- Rationalized Data Sharing Agreements with providers.
- Increased number of rationalized and streamlined data feeds within Ontario Health.

YEAR ONE 2025/26

3.5.1 Continue working with the MOH and MLTC to implement the health data and digital strategy to "collect data once, use many times," aligned with the Provincial Health Data and Digital Services (PHDDS), improving patient care and health system delivery while reducing issues and burden for the health care system. This includes working with the ministry to realize harmonized Ontario Health Authorities, unified data governance includes establishing a Data Governance Framework across OH authorities, and unified Ontario Health technologies to enhance the responsible use of data and reduce data siloes.

3.5.2 Continue expanding Ontario Health's Analytics Data Hub including incorporating new tenancies, data assets, information products, capabilities/functionalities and overall governance.

3.5.3 Drive purpose-driven access to data and insights in internal and external Ontario Health reporting through the Health System Insights platform.

3.5.4 Strengthen our governance frameworks for artificial intelligence (AI) and assess our health system and electronic health record (EHR) data assets for their readiness and value for powering development of AI solutions. Work with health system partners to identify and assess high-value AI use cases for spread and scale, leveraging our provincial data infrastructure.

3.5.5 Continue working with the ministry to provision high-quality and timely data to support ministry program and decision-making.

3.5.6 Continue expanding sociodemographic data collection, use and governance into new programs at Ontario Health. Socialize and share our resources and internal successes in improving internal equity with external audiences.

YEAR TWO 2026/27

- Continue advancing prior year's work to implement the health data and digital strategy to "collect data once, use many times."

YEAR THREE 2027/28

- Continue advancing prior year's deliverable related to the health data and digital strategy. Advance priorities consistent with Ontario Health's objectives and government and system priorities.

GOALS

Supporting Health Care Workers Through:

Health System Operational Management, Coordination, Performance Measurement & Management and Integration

4.1 WORKFORCE TRAINING AND OPTIMIZATION

Access to the right health care services from the right providers is essential to the health and well-being of Ontarians. Ontario Health offers select provincial programs aimed at supporting delivery partners in building a health workforce in areas of the greatest need. This reflects the diversity of Ontario's population and promotes the sharing and uptake of innovative ideas around how to deliver health care effectively and efficiently.

Key measures expected to achieve:

- Number of Personal Support Worker (PSW) learners supported through the PSW Incentive Program.
- Number of family medicine medical residents who received transition to practice supports.
- Number of new externs matched to hospitals to strengthen HHR capacity.

YEAR ONE 2025/26

4.1.1 Improve the efficient and effective delivery of care across settings by identifying, spreading and scaling HHR best practices and innovative HHR models that enable health care professionals to practice to their full scope.

4.1.2 Increase access to culturally safe care for FNIMUI and equity-deserving populations by facilitating cultural safety training for locum physicians and leading recruitment initiatives that foster a diverse health workforce.

4.1.3 Create opportunities for health care trainees and learners in high-need clinical areas to access experiential learning, early career supports, mid-career professional development and upskilling opportunities.

4.1.4 Continue working with the Ontario Caregiver Organization (OCO) to define and support the development and implementation of roles, training and supports for essential care partners in hospitals, long-term care homes, primary care, home and community care, and OHTs with expansion to community support services (CSS).

YEAR TWO 2026/27

- Continue advancing prior year's deliverables.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

4.2 RECRUITMENT, RETENTION AND DISTRIBUTION

To ensure that all people living in Ontario have access to health care when and where they need it, Ontario Health continues to deliver programs that enhance the size of Ontario's health workforce and its equitable distribution across the province. Through a multitude of initiatives and partnerships, Ontario Health increases the number of health care professionals practicing in high-need professions, helps internationally educated health care providers to practice in Ontario faster, and provides urgent, responsive support to rural, remote and Northern Ontario communities where it is needed most.

Key measures expected to achieve:

- Number of internationally educated health professionals integrated/recruited into the health care system.
- Number of days of physician coverage provided to communities in need.

YEAR ONE 2025/26

4.2.1 Protect patient access to care in rural and Northern communities by delivering immediate-term initiatives including physician locum programs and supporting the ministry in its short-, medium- and long-term implementation of the Northern and Rural Strategy for Health and Human Resources (HHR).

4.2.2 Enhance the size and equitable distribution of Ontario's health workforce through the increased integration of internationally educated health professionals into priority areas of the health system, including supporting expedited pathways for registration, centralized support and employment opportunities.

4.2.3 Strengthen capacity, recruitment, retention and distribution within Ontario's health workforce by attracting health care providers to the sectors and communities where they are needed most.

YEAR TWO 2026/27

- Continue advancing prior year's deliverables.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

4.3 INTEGRATED CAPACITY PLANNING

Maintaining and expanding access to health care services now and into the future relies on the health system's ability to monitor the number, types, practice locations of health care professionals, and types and volumes of care across the health system. By improving the availability of timely and relevant data, Ontario Health supports health care investments and health workforce growth in the communities, sectors and professions that need it most, providing health system partners with important information for planning and decision-making.

Key measure expected to achieve:

- Enhancements to data inputs, including health workforce data.

YEAR ONE 2025/26

4.3.1 Support the implementation of an integrated capacity and HHR plan in Ontario by enhancing the ability to monitor health care delivery, health workforce data and identify trends across sectors.

YEAR TWO 2026/27

- Enable decision-makers across the health system to access and use robust health trend data to implement strategic priorities captured within a provincial integrated capacity and HHR plan.

YEAR THREE 2027/28

- Facilitate the ongoing monitoring and enhancement of an integrated capacity and HHR plan in Ontario by strengthening the accessibility of increasingly robust datasets for decision-makers.

GOALS

Enhance Clinical Care and Service Excellence

5.1 EXPAND PROVINCIAL GENETIC SERVICES

Ontario Health's Provincial Genetics Program (PGP) is building a comprehensive and connected system for clinical genetic testing and services across Ontario. This work enhances access to timely, high-quality genetic services for the best possible health outcomes and to ensure health care professionals have the tools and resources they need to provide effective and coordinated genetic services across the health system. PGP will also position Ontario as a leader by bringing new genetic and digital technologies into clinical practice to benefit patients and families and improve the health care system.

Key measures expected to achieve:

- Increased number of cancer tests performed (comprehensive biomarker and hereditary).
- Increased number of rare and inherited genetic tests performed.
- Decreased average wait time for accessing routine genetic counsellor-led assessments across Ontario.
- Increased number of sites contributing genetic test results to OLIS.

YEAR ONE 2025/26

5.1.1 Continue improving the delivery and management of comprehensive, coordinated, evidence-based genetic services for rare and inherited conditions.

5.1.2 Initiate the implementation of a digital solution to support system planning, monitoring and performance management of genetic services, including genetic testing.

5.1.3 Initiate the scoping and planning to institute provincial genomic data storage and sharing as part of system planning for genetic services.

YEAR TWO 2026/27

- Continue advancing prior year's deliverables.
- Finalize the implementation of genetic testing results into OLIS.
- Begin development of a provincial genomic data storage and sharing system for genetic services.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

5.2 IMPROVE ACCESS AND QUALITY IN CANCER CARE

Half of Ontarians will develop cancer in their lifetime, and about 266 new cancer cases are expected to be diagnosed every day. Cancer can have devastating effects on individuals and their loved ones. Cancer was the leading cause of death in Ontario in 2020, and mortality rates are predicted to grow over the next 10 years. As of March 2023, Ontario had over 750,000 cancer survivors – the highest number to date. Ontario Health's vision is to remain a leader in cancer care by advancing initiatives that improve the quality, safety and accessibility of cancer services from prevention to long-term follow-up and end-of-life care. Focusing on cancer screening, cancer care and survivorship programs aims to reduce the number of cancer diagnoses, detect cancers earlier and improve patient outcomes and experience.

Key measures expected to achieve:

- Increased cancer screening participation rates (colorectal, cervical, breast).
- Increased percentage of positive self-collected HPV results associated with low-grade and high-grade cytology results.
- Reduced wait time between a self-collected elevated-risk cervical screening test result and the follow-up colposcopy among Ontario screen-eligible people, who underwent colposcopy.
- Radiation ready to treat to treatment within wait time target.
- Systemic referral to consult within wait time target.
- Radiation referral to consult within wait time target.

YEAR ONE 2025/26

Cancer Care Program

5.2.1 Begin the second year of the Ontario Cancer Plan 6 (2024-2028) initiatives, including identifying gaps, barriers and opportunities to:

- Build capacity as a learning health system;
- Reduce variation in care to improve cancer outcomes and quality of life;
- Plan for integrated survivorship services to improve patient and care partner experience; and
- Refresh Master Pricing Agreements for Radiation Therapy Systems and PET/CT scanners to ensure ongoing access to the best pricing for new and replacement equipment and software.

5.2.2 As part of Ontario Cancer Plan 6, continue the scoping and planning work for Building Enhanced Assessment for Cancer in Ontarians with Non-specific and Specific High-risk Symptoms (BEACON) - integrated diagnostic services that improve navigation and access, ultimately enhancing the diagnostic experience for our patients.

5.2.3 Continue improving and expanding access to specialized imaging and related procedures (e.g., theranostics, advanced PET scanning, MR/CT procedures).

5.2.4 Continue expanding eClaims to improve operational efficiencies for CAR T-cell therapy and PET scans, streamlining administration and access.

5.2.5 Continue efforts to mitigate the patient and health system impact of cancer drug shortages.

5.2.6 Maintain improvements to the New Drug Funding Program by reducing timelines to implement the Ministry's decisions to fund new cancer therapies and submit quarterly updates for drug utilization costs based on actuals. Collaborate with the Ministry to explore options to provide individuals in Ontario with improved access to publicly funded take-home cancer drugs.

Note: Deliverables within this area of focus will support advancing clinical priorities within LOD #30.

Cancer Screening

5.2.7 Develop multi-year plan to replace the information system that supports the Ontario Breast Screening Program.

5.2.8 Expand access to the Ontario Lung Screening Program by onboarding five more hub hospitals (Level 1 and 2 thoracic cancer surgery centres). Continue onboarding spoke sites to expand access at existing sites.

5.2.9 Stabilize and initiate evaluation of HPV testing in Ontario and continue expanding HPV testing self-collection.

5.2.10 Complete Digital Correspondence (DC) build, testing, end-to-end integration and initiate security testing.

5.2.11 Onboard new lab and test system vendors for Fecal Immunochemical Test (FIT) in ColonCancerCheck and complete system enhancements.

YEAR TWO 2026/27

- Continue advancing prior year's deliverables and begin the third year of the Ontario Cancer Plan 6 initiatives.
- Initiate implementation of intake clinics for integrated cancer diagnostic services as part of the BEACON project.
- Expand availability of HPV testing self-collection sites and prepare lab system to support an at-home self-collection model (e.g., conduct procurement or validation studies).
- Launch DC phase 1 for ColonCancerCheck program participants. Initiate portal enhancements and program expansion.
- Launch new vendors for screening with FIT in the ColonCancerCheck, including program enhancements to improve provider and participant experience.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables and begin the fourth year of the Ontario Cancer Plan 6 initiatives.
- Complete build/upgrade and plan for deployment of initiatives in Ontario Cancer Plan 6.
- Complete build, privacy impact assessment, testing, end-to-end-integration and security testing as part of Integrated Client Management System (ICMS) replacement and develop a deployment strategy.
- Implement DC portal enhancements and plan for expansion.

5.3 IMPROVE ACCESS AND QUALITY IN RENAL CARE

More than 13,000 people in Ontario have advanced chronic kidney disease and an additional 12,500 require dialysis. Living with this disease can present tremendous challenges to patients and their care partners. Ontario Health advises the government on chronic kidney disease and the renal care system, while also funding, coordinating and providing clinical guidance on the delivery of services to people with chronic kidney disease. Through collaborative efforts, we are committed to advancing a high-quality and person-centred system of care for Ontarians with chronic kidney disease.

Key measures expected to achieve:

- Increase the percentage of living or deceased donor kidney transplants to end-stage renal patients.
- Increase the percentage of chronic dialysis patients on a home dialysis modality.
- Increase the percentage of documented Goals of Care conversations with chronic dialysis patients.

YEAR ONE 2025/26

5.3.1 Implement the second year of Ontario Renal Plan 4 (2024-2028), focusing on quality improvement initiatives, health equity, Indigenous kidney health and critical capacity infrastructure to drive excellence in renal care.

5.3.2 Realize a more person-centred and integrated kidney transplant system to increase equitable access to kidney transplantation, with a focus on increasing the number of living kidney donor transplants.

YEAR TWO 2026/27

- Implement the third year of Ontario Renal Plan 4.
- Enable a collaborative and adaptive kidney transplant system to increase equitable access to kidney transplantation, with a focus on increasing the number of living kidney donor transplants.

YEAR THREE 2027/28

- Implement the final year of Ontario Renal Plan 4.
- Develop Ontario Renal Plan 5 to establish future priorities for the renal system. Engage extensively with stakeholders and identify opportunities to reduce disparities through partnerships.
- Continue advancing prior years' deliverables.

5.4 INCREASE LIFE-SAVING ORGAN AND TISSUE DONATIONS AND TRANSPLANTS

Ontario Health is responsible for coordinating and delivering organ and tissue donation and transplantation services across the province. Approximately 1,400 people in Ontario are waiting for an organ transplant. Ontario Health helps save and enhance lives by maximizing organ and tissue donations in partnership with our stakeholders. Our public education and awareness initiatives support efforts to increase donor registration rates by encouraging Ontarians to register their consent for donation.

Key measures expected to achieve:

- New donor registrations.
- Increased number of deceased organ donors.
- Increased number of ocular donors.
- Increased number of multi-tissue donors.
- Increased organ yield.
- Increased total living and deceased donor transplants.

YEAR ONE 2025/26

5.4.1 Identify and operationalize system-level improvements to maximize organ and tissue donation, recovery and transplantation.

5.4.2 In partnership with Ornge, drive improvement strategies for air transportation processes.

5.4.3 Advance transplant system modernization through continued enhancements and integration of the Organ Allocation and Transplant System (OATS) with transplant hospitals and labs.

5.4.4 Advance new and leading practices for expanded organ and tissue donation.

5.4.5 Improve support for patient care before, during and after transplant by refining the new kidney transplant funding model, continuing the work for living donation and pediatrics, and preparing to extend the model toother organ transplants.

YEAR TWO 2026/27

- Continue advancing prior year's deliverables related to maximizing organ and tissue donation, recovery and transplantation.
- Continue advancing prior year's efforts to drive improvement strategies for air transportation processes in partnership with Ornge.
- Continue working with transplant hospitals and human leukocyte antigen (HLA) labs on integration between OATS and their EMR/lab systems.
- Continue advancing new and leading practices for expanded organ and tissue donation.
- Continue advancing prior year's deliverable related to patient care through the expansion of the new transplant funding model across other organ transplants.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

5.5 IMPROVE ACCESS AND QUALITY IN CARDIAC, VASCULAR AND STROKE CARE

Ontario Health provides clinical leadership to improve equitable access to, and quality of, cardiac, stroke and vascular care for all Ontarians. Our efforts focus on developing standards and guidance, defining evidence-based clinical pathways and models of care, delivering knowledge transfer and exchange, developing strategies to reduce variations in services, assessing capacity and informing funding policy, and implementing performance measurement, monitoring and reporting frameworks.

Key measures expected to achieve:

- Reduce heart failure admissions per 100 heart failure patients.
- Increase Endovascular Treatment (EVT) for ischemic stroke.
- Reduce non-traumatic major lower limb amputation (per 100,000).

YEAR ONE 2025/26

5.5.1 Submit recommendations to the MOH and begin implementation of a service expansion plan to build local/regional capacity for appropriate access to hyperacute stroke services over the next five years.

5.5.2 Improve access to high-quality stroke unit care through regional consolidation of stroke volumes, updating stroke quality-based procedures, and development and implementation of a performance measurement and monitoring framework. This framework will evaluate the quality of care provided by stroke units and inform future quality improvement opportunities.

5.5.3 Develop, advance and sustain strategies to reduce variation in community stroke rehabilitation services that promote standardized programming, performance evaluation and align with the Model of Care (MOC).

5.5.4 Implement and evaluate a model structure for strengthened accountability and system performance improvement in stroke care that aligns the Stroke Networks to Ontario Health priorities for greater impact on access, quality of care and outcomes.

5.5.5 Provide strategic and operational support that will enable clinically appropriate access to provincial cardiac surgery. Work collaboratively with the MOH and Michener Institute to continue efforts to stabilize the perfusion workforce.

5.5.6 Monitor uptake of Coronary Computed Tomography Angiography (CCTA) funded volumes and capacity, including recommendation for redistribution of CCTA hours, as required, and ongoing quality improvements.

5.5.7 Implement the newly released standards and pathway for the management of Chronic Limb Threatening Ischemia in Ontario.

5.5.8 Implement the newly released Common Core Standards for Vascular Ultrasound (VUS) in Ontario and identify opportunities to enhance adoption to improve VUS care for patients.

5.5.9 Launch the first phase of abdominal aortic aneurysm (AAA) screening for people aged 65 and complete supporting digital enhancements.

Note: Deliverables within this area of focus will support advancing clinical priorities within LOD #30

.

YEAR TWO 2026/27

- Continue providing strategic and operational direction to improve cardiac, stroke and vascular care.

YEAR THREE 2027/28

- Continue advancing previous year's deliverables.

5.6 TRANSFORM AND IMPROVE ACCESS AND QUALITY IN PALLIATIVE CARE

Ontario Health's provincial palliative care program plays a central role in advancing a comprehensive, connected and high-quality palliative care system across Ontario for people living with a serious illness, their families and their care partners. We are committed to enhancing system management, supporting quality improvement initiatives and disseminating best practices. With the advice of the Ontario Palliative Care Network, we will ensure palliative care services are more accessible, integrated and responsive. By implementing the community MOC, over 150 organizations across the province will strengthen health care providers'

ability to meet palliative care needs through the deployment of Clinical Coaches.

Key measures expected to achieve:

- Increase in number of community organizations/long-term care homes implementing the MOC recommendations for adults in the community.
- Increase in the number of health care professionals who received coaching to be able to better meet patients' palliative needs.
- Increase in number of Indigenous organizations implementing self-determined approaches to meet palliative care needs of their communities.

YEAR ONE 2025/26

5.6.1 Promote adoption of the MOC for adults receiving palliative care in hospital settings, and the MOC for children receiving palliative care across all settings.

5.6.2 Collaborate with Indigenous communities and organizations to implement self-determined approaches for the MOC for adults receiving palliative care in community settings and co-develop distinctions-based MOC recommendations for FNIMUI adults receiving palliative care in hospital settings and FNIMUI children receiving palliative care across all settings.

5.6.3 Expand implementation of the MOC for adults receiving palliative care in community settings, including long-term care homes.

YEAR TWO 2026/27

- Finalize co-development of distinctions-based MOC recommendations for FNIMUI adults receiving palliative care in hospital settings and FNIMUI children receiving palliative care across all settings.
- Establish implementation plans for the MOC for adults receiving palliative care in hospital settings and the MOC for children receiving palliative care across all settings.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

5.7 EXPAND ONTARIO LABORATORY MEDICINE PROGRAM

The Ontario Laboratory Medicine Program (OLMP), at maturity, will implement a unified provincial plan for laboratory medicine across the health system that is patient-centred, innovative, sustainable and delivers the greatest value for Ontarians. Working with system partners, the OLMP leverages the expertise of its clinical and scientific advisory groups, focuses on equitable and coordinated access to testing (including point-of-care testing), fosters innovation and system responsiveness, supports digital integration, and enables high-quality laboratory diagnostics for providers, patients and system surveillance

Key measures expected to achieve:

- Improved end-to-end turnaround times of select provincial laboratory medicine/testing programs (e.g., HPV, FIT, Respiratory Viruses, etc.)

YEAR ONE 2025/26

5.7.1 Expand upon OLMP's target areas of focus, which include monitoring specimen collection and ensuring equitable access to testing, leveraging expert advice and evidence to ensure lab tests are appropriate and coordinated, fostering innovation and system responsiveness, enabling digital integration across the testing continuum and working with health system partners to support point-of-care testing.

5.7.2 Implement recommendations to reduce the specimen collection gaps in Northern and rural communities.

5.7.3 Enhance access by implementing the Point-of-Care Testing Framework for non-hospital sites.

5.7.4 Identify key tests of provincial significance for provincial monitoring based on expert advice.

5.7.5 Advance e-ordering initiatives for primary care and long-term care.

5.7.6 Advance initiatives for lab-to-lab integration for orders and results across the province.

YEAR TWO 2026/27

- Continue advancing OLMP targeted areas of expansion
  and prior year’s deliverables.
- Establish laboratory testing innovation pathway based on
  expert advice.

YEAR THREE 2027/28

- Continue advancing OLMP targeted areas of expansion and prior years’ deliverables.

GOALS

Maximize System Value by Applying Evidence

6.1 Advance high-quality and safe care through evidence and continuous quality improvement

6.2 Strengthen system supports and accountabilities

6.1 ADVANCE HIGH-QUALITY AND SAFE CARE THROUGH EVIDENCE AND CONTINUOUS QUALITY IMPROVEMENT

Quality is a critical tenet of a high-quality health system and central to all we do at Ontario Health. The goal is for Ontario's health system to lead in delivering the best outcomes across all six dimensions: safety, effectiveness, patient-centred, timeliness, efficiency and equity. To achieve these goals, Ontario Health works with patients, families, providers and organizations across the health system to improve outcomes, promote health equity and patient safety, standardize care, and enhance patient and provider experience. Improving outcomes requires capacity for continuous improvement and knowledge transfer.

Key measures expected to achieve:

- Increased rate of implementation/adoption of accepted health technology assessment recommendations.
- Percentage of organizations that are showing year-over-year improvement in at least one indicator recommended by Ontario Health within their annual quality improvement plans.

YEAR ONE 2025/26

6.1.1 Work with Delivery Organizations and other providers to facilitate the development and implementation of clinical and quality standards to address variation, gaps and inequities in care (experience and/or outcomes), including Sickle Cell Disease, Delirium, Hip Fracture, Menopause, Transitions between Hospital and Home, Pressure Injuries, and care for gender-diverse and Indigenous people.

6.1.2 Advance clinical adoption of evidence-based care through the provincial spread and scale of Evidence2Practice tools that embed quality standards into EMRs and hospital information systems.

6.1.3 Deliver 2026/27 Quality Improvement Plan (QIP) guidance and support to delivery organizations participating in the program, driving a system-wide integrated and collaborative culture of continuous quality improvement.

6.1.4 Deliver clinical quality programs that improve patient outcomes and experiences including through the Ontario Surgical Quality Improvement Network (ONSQIN), General Medicine Quality Improvement Network (GeMQIN), and Never Events hospital reporting.

6.1.5 Continue working with the MOH and partners to jointly design and implement a Health Innovation Pathway program, incorporating the existing Health Technology Assessment program, that proactively identifies, reviews and enables the adoption of promising health technologies and services across the health system. Once implemented, deliver the Health Innovation Pathway program on an ongoing basis.

YEAR TWO 2026/27

- Continue advancing prior year's deliverables related to the development and implementation of clinical and quality standards to address variation, gaps and inequities in care.
- Continue to implement and deliver the Health Innovation Pathway program to enable adoption of promising health technologies and services across the health system and advance high-quality care using evidence-based health technology assessments.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

6.2 STRENGTHEN SYSTEM SUPPORTS AND ACCOUNTABILITIES

In addition to coordination and clinical guidance, Ontario Health uses service accountability agreements, funding approaches, and performance measurement, monitoring, and management to continuously improve and connect the health system. Continued refinement of these levers is central to Ontario Health's ability to lead.

Key measures expected to achieve:

- Effective integration of Transfer Payment Agreements (TPAs) transferred from the ministry and other organizations to Ontario Health.
- Enhanced health system accountability and multi-year planning through updated Service Accountability Agreements (SAAs), supporting tools, performance measures and frameworks that are aligned with system goals and performance management processes.

YEAR ONE 2025/26

6.2.1 Work with the MOH to advance the government's transformation agenda by overseeing programs and TPAs selected for transfer from the ministry and other organizations to Ontario Health, supporting an integrated, high-quality health care system.

6.2.2 Continue enhancing Ontario Health's health system accountability through the development of updated SAAs and supporting tools and ensuring performance measures are aligned with system goals and performance management processes.

6.2.3 Continue working with the MOH on the expansion of the Ontario Case Costing Program in up to 20 new facilities (including the Home Care sector) by FY 27/28, and operationalizing the Centre of Excellence & Community of Practice to effectively measure performance and savings, and support health system funding models.

6.2.4 In partnership with the MOH and hospital sector, continue implementing an efficiency and performance framework to drive continuous improvement and support sector planning. Work with the ministry on strategies to support greater ongoing financial oversight, hospital pressures, manage risks (e.g., cash failure), plan for appropriate service changes, develop a community of practice, and implement innovative funding policies and models.

6.2.5 Implement and embed the new health service provider performance management framework across Ontario Health, ensuring alignment with organizational priorities and facilitating consistent, effective performance monitoring and improvement.

6.2.6 Work with the MOH to implement a renewed policy framework, accountabilities and processes for hospital multi-year planning and sector performance.

YEAR TWO 2026/27

- Refine and advance system performance expectations within SAAs.
- Continue advancing prior year's deliverables.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables.

GOALS

Strengthen Ontario Health's Ability to Lead

7.1 Continue enhancing Ontario Health's organizational effectiveness through a strong, engaged, connected, diverse and accountable workforce

7.2 Support the government's plans for supply chain centralization.

7.1 CONTINUE ENHANCING ONTARIO HEALTH'S ORGANIZATIONAL EFFECTIVENESS THROUGH A STRONG, ENGAGED, CONNECTED, DIVERSE AND ACCOUNTABLE WORKFORCE

We are committed to engaging, equipping and inspiring individuals to help them do their best work. We will continue investing in our people through professional development and workplace wellness programs that support individual growth and team performance, and foster a *One Ontario Health* culture, bringing our values to life in how we work and how we serve people and communities.

We will recognize the achievements of our people through internal and external channels and promote a unified culture of pride in Ontario Health's impact through compelling communications.

Key measures expected to achieve:

- Maintain strength in our key workforce metrics.

YEAR ONE 2025/26

7.1.1 Plan pipelines and attract external talent for current and future needs, including an early careers program, a diversified candidate pipeline and an improved talent acquisition process.

7.1.2 Develop and build internal talent and leadership capability for sustained success.

7.1.3 Engage and retain talent through a compelling employee value proposition, engagement plan and a program to combat workplace discrimination.

7.1.4 Continue delivering on Ontario Health's internal Equity, Inclusion, Diversity and Anti-Racism (EIDA-R) plan, including implementing any outstanding diversity survey action plan items and identify any additional identified priorities.

7.1.5 Continue expanding Communities of Inclusion (COIs) and support their success by building formal processes and raising their profile across Ontario Health.

7.1.6 Ontario Health will continue supporting the Ministry of Health with planning, implementation and reporting on priority operational work that advances the health system, its integration, and care for Ontarians. *Note: This deliverable will include the Letter of Direction priorities such as LOD# 13, 14, 26, 51-53, and 63*

YEAR TWO 2026/27

- Develop a compelling Employee Value Proposition to attract and retain Ontario Health talent.
- Implement an Employee Referral Program to leverage the existing Ontario Health workforce as a source of new talent.
- Formalize a Talent Review process to identify the next generation of organizational leaders, including succession planning.
- Create a Leadership Development Program to support capability development of the next generation of Ontario Health leaders.
- Establish cadence of diversity survey for future years along with an action plan.
- Demonstrate impact and report major achievements of COIs internally.

YEAR THREE 2027/28

- Determine diversity survey analysis and report back on findings to staff with actions.
- Continue advancing prior years' deliverables.

7.2. SUPPORT THE GOVERNMENT'S PLANS FOR SUPPLY CHAIN CENTRALIZATION

Ontario Health's supply chain plays a critical role in delivering vendor-based solutions and services that drive improved health care outcomes in various key programs such as screening, capital purchases for medical equipment and digitally-enabled solutions. We will continue collaborating with key stakeholders, such as the MOH, the Ministry of Public and Business Service Delivery and Procurement, and Supply Ontario to enhance value for money through best procurement contract outcomes.

Key measure expected to achieve:

- Vendor performance is measured and monitored through key vendor contract management mechanisms (e.g. service levels) to better ensure service expectations are being met.

YEAR ONE 2025/26

7.2.1 Develop a sourcing strategy in collaboration with Supply Ontario for radiation therapy systems and PET/CT scanners for the province to continue building upon the previous successful provincial procurement.

7.2.2 Provide clinical guidance and leverage Ontario Health's regional structure to respond to health care supply shortages.

7.2.3 Establish a multi-year sourcing plan with the MOH and Supply Ontario.

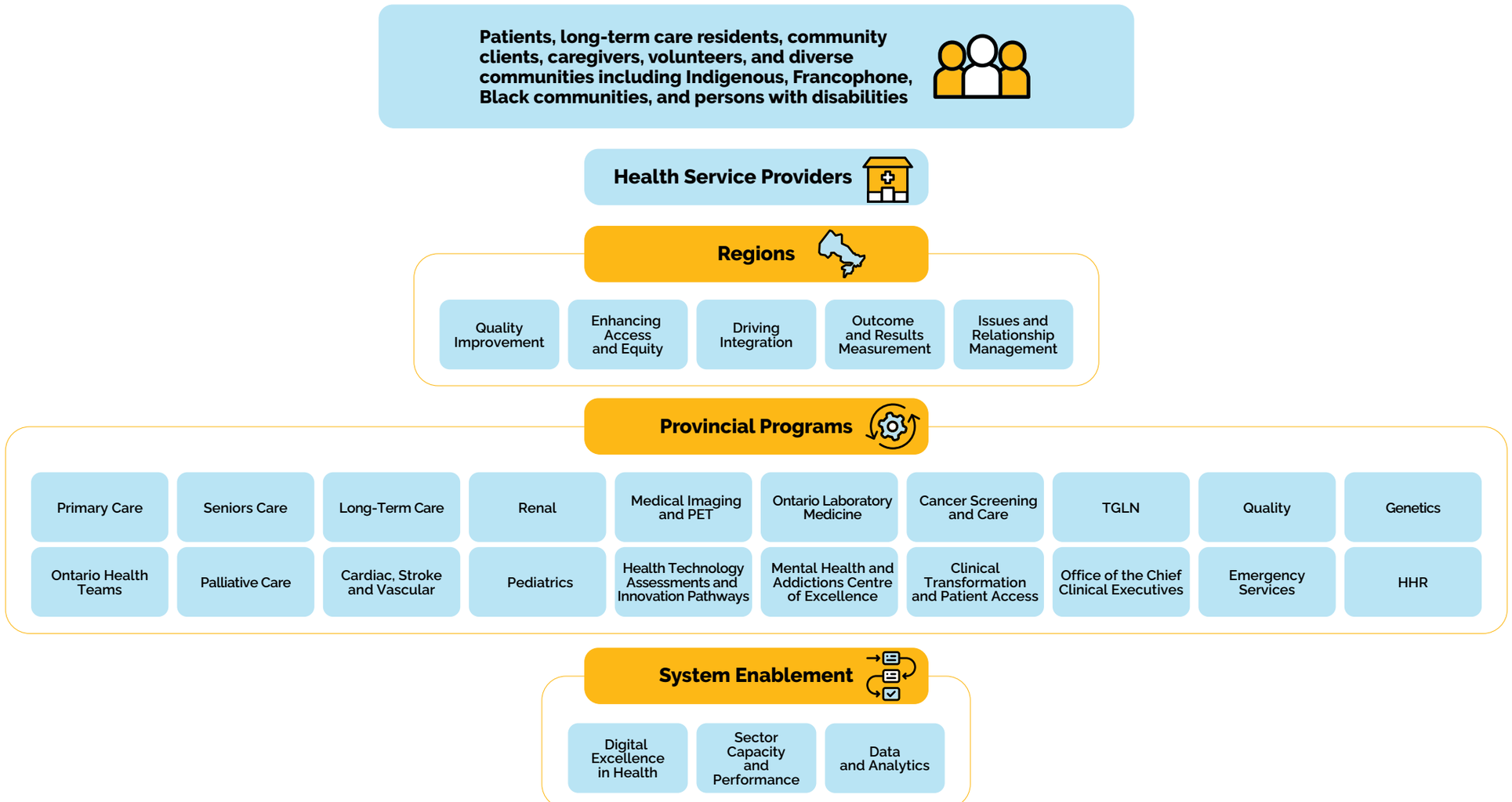
YEAR TWO 2026/27

- Continue advancing prior year's deliverables related to health care supply shortages.

YEAR THREE 2027/28

- Continue advancing prior years' deliverables related to health care supply shortages.

Operating Model



The Ontario Health Board of Directors provide strategic guidance and oversight for Ontario Health and is directly accountable to the government through the Minister of Health.

Board of Directors

The Board currently have five committees:

Finance, Audit and Risk	Oversees Ontario Health's financial management and the review of financial results, Ontario Health's Enterprise Risk Management Program and Compliance Program, and reviews external and internal auditors' reports and recommendations.
Governance and Nominating	Advises the Board on matters relating to Board operations, nominations and corporate governance functions, as well as selection, supervision and succession planning for the CEO.
Human Resources and Compensation	Advises the Board on matters relating to the effective administration of human resources functions and to satisfy itself that Ontario Health has appropriate HR policies and practices in place for recruitment, compensation, performance and retention of its employees in compliance with applicable laws, regulations and government directives.
Innovation and Technology	Achieves Ontario Health's corporate objectives and drives patient-focused strategies efficiently and cost effectively by leveraging information, communication and digital technologies; also drives adoption of emerging, transformative technologies that advance patient-focused strategies including effective and high-quality care.
Quality	Advises on health system performance measurement and management, evaluation, monitoring and reporting, as well as health system quality improvement, and clinical and quality standards development for patient care and safety.

Provincial Demographics by Region

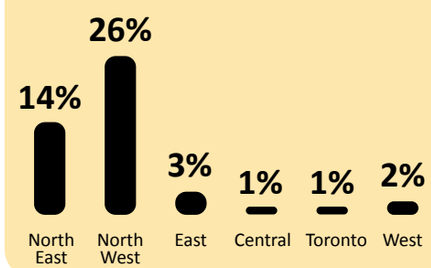
PROJECTED POPULATION GROWTH OVER NEXT TEN YEARS

North East	North West	East	Central	Toronto	West
+2%	+3%	+14%	+13%	+7%	+12%

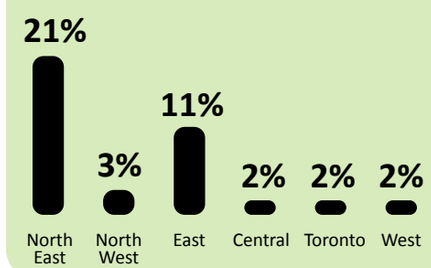
THE NUMBER OF RESIDENTS OVER 65 YEARS OF AGE IS PROJECTED TO INCREASE DRAMATICALLY OVER THE NEXT TEN YEARS

	North East	North West	East	Central	Toronto	West
projected	27%	24%	23%	21%	19%	22%
current	149,287	53,830	685,225	731,164	534,179	904,545

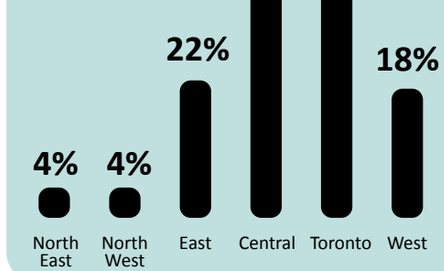
POPULATION THAT IDENTIFIES AS INDIGENOUS



POPULATION THAT IDENTIFIES AS FRANCOPHONE



POPULATION THAT IDENTIFIES AS RACIALIZED GROUP



HEALTH SERVICE PROVIDERS*

Community Mental Health and Addictions	Community Support	Community Health Centres	Public Hospitals
472	670	82	140

Indigenous Primary Healthcare Organizations*	Long-term Care Homes	Family Health Teams
23	613	183

Nurse Practitioner-led Clinics	Regional Renal Programs	Regional Cancer Centres	Transplant Centres
27	27	14	8

*formerly Aboriginal Health Access Centres

The statistics in the demographics and regional profile sections were leveraged from a variety of sources, which include Statistics Canada, Ministry of Finance, Ministry of Health and projections from regional teams. Please see the End Notes for the specific sources.

Central

4,214,487
(population)

Projected population growth over the next ten years

13%

Projected population over age of 65 in ten years

21%
(currently 17%)

Number of approved Ontario Health Teams

12

1%
Identify as Indigenous

2%
Identify as Francophone

51%
Identify as a Racialized Group

42%
Immigrant Population

196
Service Accountability Agreements

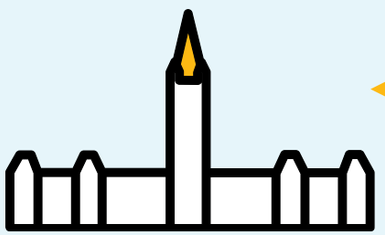
3
Designated French-Language Service Areas

Health Service Providers

Community Mental Health and Addictions	Community Support	Community Health Centres	Public Hospitals	Indigenous Primary Health Care Organizations	Long-Term Care Homes
46	79	8	14	1	99

Family Health Teams	Nurse Practioner-Led Clinics	Designated Agencies for French Language Services	Regional Renal Programs	Regional Cancer Centres	Transplant Centres
23	4	2	6	3	0

East



3,352,724
(population)

Projected population growth over the next ten years

14%

Projected population over age of 65 in ten years

23%
(currently 20%)

Number of approved Ontario Health Teams

12

3%
Identify as Indigenous

11%
Identify as Francophone

22%
Identify as a Racialized Group

19%
Immigrant Population

272
Service Accountability Agreements

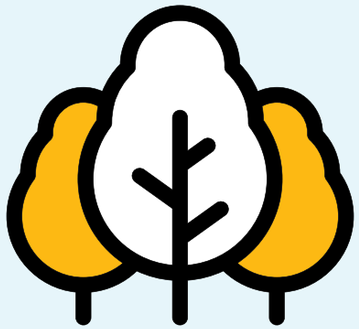
8
Designated French-Language Service Areas

Health Service Providers

Community Mental Health and Addictions	Community Support	Community Health Centres	Public Hospitals	Indigenous Primary Health Care Organizations	Long-Term Care Homes
75	113	21	33	3	142

Family Health Teams	Nurse Practioner-Led Clinics	Designated Agencies for French Language Services	Regional Renal Programs	Regional Cancer Centres	Transplant Centres
46	6	38	5	3	3

North East



636,290
(population)

Projected population growth over the next ten years

2%

Projected population over age of 65 in ten years

27%
(currently 23%)

Number of approved Ontario Health Teams

7

14%
Identify as Indigenous

21%
Identify as Francophone

4%
Identify as a Racialized Group

5%
Immigrant Population

175
Service Accountability Agreements

41
Designated French-Language Service Areas

Health Service Providers

Community Mental Health and Addictions	Community Support	Community Health Centres	Public Hospitals	Indigenous Primary Health Care Organizations	Long-Term Care Homes
49	86	8	24	9	40

Family Health Teams	Nurse Practioner-Led Clinics	Designated Agencies for French Language Services	Regional Renal Programs	Regional Cancer Centres	Transplant Centres
28	7	7	4	1	0

North West

250,614
(population)

Projected population growth over the next ten years

3%

Projected population over age of 65 in ten years

24%
(currently 21%)

Number of approved Ontario Health Teams

4

26%
Identify as Indigenous

3%
Identify as Francophone

4%
Identify as a Racialized Group

7%
Immigrant Population

96
Service Accountability Agreements

2
Designated French-Language Service Areas

Health Service Providers

Community Mental Health and Addictions	Community Support	Community Health Centres	Public Hospitals	Indigenous Primary Health Care Organizations	Long-Term Care Homes
39	57	2	12	6	12

Family Health Teams	Nurse Practioner-Led Clinics	Designated Agencies for French Language Services	Regional Renal Programs	Regional Cancer Centres	Transplant Centres
14	1	0	1	1	0

Toronto

3,255,595
(population)

Projected population growth over the next ten years

7%

Projected population over age of 65 in ten years

19%
(currently 16%)

Number of approved Ontario Health Teams

8

1%
Identify as Indigenous

2%
Identify as Francophone

56%
Identify as a Racialized Group

47%
Immigrant Population

224
Service Accountability Agreements

1
Designated French-Language Service Areas

Health Service Providers

Community Mental Health and Addictions	Community Support	Community Health Centres	Public Hospitals	Indigenous Primary Health Care Organizations	Long-Term Care Homes
156	157	22	16	2	80

Family Health Teams	Nurse Practioner-Led Clinics	Designated Agencies for French Language Services	Regional Renal Programs	Regional Cancer Centres	Transplant Centres
21	2	5	6	2	3

West

4,701,906
(population)

Projected population growth over the next ten years

12%

Projected population over age of 65 in ten years

22%
(currently 19%)

Number of approved Ontario Health Teams

15

2%
Identify as Indigenous

2%
Identify as Francophone

18%
Identify as a Racialized Group

20%
Immigrant Population

426
Service Accountability Agreements

6
Designated French-Language Service Areas

Health Service Providers

Community Mental Health and Addictions	Community Support	Community Health Centres	Public Hospitals	Indigenous Primary Health Care Organizations	Long-Term Care Homes
107	178	21	41	2	240

Family Health Teams	Nurse Practioner-Led Clinics	Designated Agencies for French Language Services	Regional Renal Programs	Regional Cancer Centres	Transplant Centres
51	7	4	5	4	2

Environmental Scan

EXTERNAL FACTORS

Fiscal Environment and Economic Outlook

- Health care comprises a significant portion of the overall Ontario budget. The government must balance economic environments and growth with increasing demand for health care across the province. Ontario Health's business plan continues to consider new ways to create value for finite public health investments.
- Ontario's commitment of almost $50 billion in hospital infrastructure over the next 10 years and their investments of $6.4 billion in long-term care since 2019 have been essential to increasing the capacity of our health care system while simultaneously improving the reliability and quality of care.[1]

Legislative, Regulatory and Policy Changes

- Ontario Health is working with the MOH on several files that require policy, regulatory or legislative amendments. Notable work includes the need to resolve Ontario Health's fragmented data authorities to enable Ontario Health to utilize data to improve the quality of health care as well as work to enable patient's digital access to their personal health care information.

HHR Constraints

- The MOH has developed an Integrated Capacity and Health Human Resources (HHR) plan focusing on the recruitment, retainment and value optimization of HHR. Ontario Health will advise the MOH on strategies to improve the state of HHR across the province.

Population Growth and Trends

- In 2025, Ontario's population is projected to reach 16.4 million, reflecting a growth rate of 1.61% from 2024. From July 2023 to July 2024, the population increased by over 500,000, largely driven by international migration. During the same time span, Ontario experienced a natural population increase of just over 10,000, with approximately 140,000 births and 130,000 deaths.[2] Population growth naturally adds demand to the health system. Ontario Health will continue working with the MOH to enumerate this impact within the MOH's integrated and long-term capacity plan for the health system.
- In 2025, individuals aged 65 and older are projected to account for 19% of Ontario's population. This demographic is projected to increase to 22% in 2035, driving a growing demand for high-quality home care and long-term care services. Ontario Health is working with the MOH and the MLTC to improve access and capacity through various modernization efforts, by informing immediate and longer-term investment strategies, and by increasing access to primary health care, clinical services and community care.

Technology Modernization

- Ontario Health is taking an active role in supporting the evolving landscape of artificial intelligence (AI) and recognizes its immense potential in shaping the future of health care in the province. To advance clinical innovation and improve health service delivery and efficiencies, Ontario Health is working in close collaboration with the MOH and health system partners to ensure the benefits of AI for health are realized across the province in a transparent, responsible, equitable and accountable manner, while preserving privacy rights and proactively managing risks associated with adopting new AI-related technology. In addition, Ontario Health is establishing AI governance, risk management processes, infrastructure and operational capabilities in alignment with the Ontario Government's Responsible Use of Artificial Intelligence Directive for programs and services that are augmented with AI. This includes maintaining, disclosing and reporting the inventory of Ontario Health AI use cases, making sure AI use is justified and proportionate and is ultimately used to benefit the people of Ontario. Ontario Health has aligned and supported the implementation of Bill 194 to ensure compliance with the Strengthening *Cyber Security and Building Trust in the Public Sector Act, 2024* by integrating robust cybersecurity measures and fostering trust within the healthcare system.

- The Patients Before Paperwork (Pb4P) initiative seeks to enable health care professionals to dedicate more time to patient care by streamlining processes, minimizing unnecessary paperwork and enhancing the overall operational efficiency of our health system. By supporting the continued implementation of electronic health records, digital forms, patient portals and integrated scheduling systems, Ontario Health continues to utilize innovative technologies to improve health care delivery in the province.

SOCIO-CULTURAL AND SOCIAL DETERMINANTS OF HEALTH FACTORS

Mental Health and Addictions

- Over one million people in Ontario experience a mental health or addictions challenge requiring care each year, exacerbated by social determinants of health, including food security, housing, income, etc.[3]
- Ontario's mental health and addictions (MHA) landscape is comprised of hundreds of organizations varying in size and scope of services. Significant effort is underway to connect these services and ensure providers are contributing data that helps us understand overall access and quality of care.
- This ABP outlines the ways we are improving timely access to high-quality MHA care in alignment with the government's Roadmap to Wellness initiative. Ontario Health will continue advising the MOH on high-value, targeted investments to improve equitable access to MHA care.

Chronic Disease

- Cancers, cardiovascular disease, chronic lower respiratory disease and diabetes cause approximately two thirds of all deaths in Ontario.[4]
- The main modifiable risk factors for chronic disease – commercial tobacco use, vapour product use, alcohol consumption, physical inactivity and unhealthy eating – are highly prevalent in Ontario, especially among Indigenous populations, those with low socioeconomic status and those with poor mental health.[5]
- From 2012 to 2022, the number of Ontarians living with at least one chronic condition has increased by 12% (700,000 people), while the number of people living with two or more chronic diseases increased by 16% (480,000). People with chronic disease make up the highest cost users of the health system. Ontario Health is working to develop integrated clinical pathways that will help improve care delivery and care capacity for individuals with chronic diseases.

Inflation and Cost of Living

- The elevated interest rates throughout 2023 resulted in the largest recorded increase in the mortgage interest cost index. Combined with rising demand, this has significantly increased the cost of accessing adequate housing across the province.[6] Additionally, escalating food prices have further strained the ability of many individuals and families to meet basic needs. As a result, a growing number of people are struggling to maintain their health, as they face barriers in accessing nutritious food, secure housing and essential health care services.
- Inflation and the impacts of a rising cost of living are disproportionally felt by the most vulnerable members of society, furthering issues of health inequity and diminishing access to care due to rising ancillary out-of-pocket costs.

INTERNAL FACTORS

Ontario Health Expansion of Mandate

- The *Convenient Care at Home Act*, *2023*, which amended the *Connecting Care Act*, *2019*, was proclaimed into force in June 2024. This legislation consolidated the 14 Home and Community Care Support Services organizations into a single entity, Ontario Health atHome, tasked with supporting the modernization of home and community care, managing long-term care home placements and providing operational support to Ontario Health Teams (OHTs). Ontario Health will oversee this subsidiary, ensuring accountability for its designated responsibilities.
- In October 2024, the government of Ontario appointed Dr. Jane Philpott to serve as chair of a new primary care action team, which has been tasked with a historic mandate to connect **every person** in Ontario to a family doctor or nurse practitioner working in a publicly funded team, within five years. This initiative builds upon the expansion of team-based primary health care being led by Ontario Health, and the plan developed by Dr. Philpott and her team is expected to significantly influence the future activities of Ontario Health's Primary and Community-Based Care portfolio. The primary care action team is being supported by the MOH and Ontario Health.

Value-for-Money Audits

- Ontario Health is managing six value-for-money/performance audits for which Ontario Health is expected to collaborate with other health system partners to address Office of the Auditor General of Ontario (OAGO) recommendations.

Risk Identification, Assessment and Mitigation

CYBER SECURITY

As Ontario Health continues to advance and rely on digital health platforms and infrastructure to enable the delivery of patient-centred care, the organization is inherently subject to increasing cyber security threats from external sources, resulting in potential operational, financial, legal and reputational impacts and downstream effects on patient care. Delivery partners have similar reliance on digital health platforms and may have differing approaches to cyber and information security management. Ontario Health is implementing a plan to advance standardized elements to cyber security programs that will ultimately drive ongoing advancement in collective cyber security maturity across the province.

Likelihood and Impact

Likelihood: ***Possible***, given the persistent and evolving external threat landscape.

Impact: ***Critical***, given the impact on various aspects of Ontario Health business and partners.

Mitigation

Ontario Health periodically reviews and validates its privacy and security programs. A robust cyber security program is in place, incorporating people, process and technology controls to prevent, detect and respond to cyber threats, complemented by continuous sharing of cyber intelligence with partners. A Zero Trust Architecture plan is being implemented which will enable the organization to counter evolving threats.

Ontario Health has established a provincial cyber security operating model (CSOM) in partnership with the MOH and Ministry of Public Business Service Delivery and Procurement. The model aims to enhance collective cyber security resilience in the provincial health care sector and support all health service providers (HSPs) across the province. Local Delivery Groups (LDGs) have been formed to establish cyber security shared services and support HSPs within their region.

HEALTH SYSTEM CAPACITY

Ontario's health system has experienced sustained upward pressure arising from annual respiratory surges, population growth and demographic shifts including an increasing prevalence of chronic and social morbidity. Sustained pressures risk negatively impacting equitable health service delivery and patient care, increasing operational costs and diminishing public trust in timely access to care. As patient volume and complexity continues to rise, HHR capacity and health system access and flow challenges have been noted as some of the underlying systemic issues contributing to capacity pressures. Unanticipated health emergency events in the future may further exploit this health system vulnerability.

Likelihood and Impact

Likelihood: ***Likely***, given the complexity and systemic nature of the risk.

Impact: ***Critical***, given direct impact on timely, equitable and appropriate patient access to health care in Ontario.

Mitigation

Ontario Health is supporting the MOH and MLTC in executing *Your Health: A Plan for Connected and Convenient Care* through strategies and actions described in various sections of this ABP. Some highlights include:

- **Investments in more primary health care** to support new and expanded Interprofessional Primary Care Teams (IPCTs). Additional actions to expand access to primary health care are detailed in the Primary Care Transformation risk section.
- **Improving system access and flow** by implementing cross-sectoral and community-focused interventions to improve patient flow and reduce the number of ALC patients in acute and post-acute care hospitals.
- **Preventing Emergency Department (ED) closures** due to HHR challenges by deploying capacity balancing techniques within and across hospitals, expanding the ED Peer-to-Peer Program, leveraging new education investments, mentorship and guidance, and experiential learning opportunities to maximize the impact of medical and nursing learners, and implementing locum programs to ensure clinicians are deployed, particularly in rural and northern settings.

- **Stabilizing and increasing the health workforce capacity through targeted HHR infrastructure and knowledge sharing supports,** such as greater integration of internationally educated health professionals, working with professional regulatory colleges to simplify registration for health professionals seeking licensure, spreading and scaling innovative approaches to care, directing new funding to support critical areas and prioritizing the equitable distribution of HHR in rural, northern and remote Ontario communities.
- **Reducing waitlists** by deploying funding to maximize surgical volumes, exploring partnerships to augment capacity (particularly for low acuity procedures), identifying opportunities for surgical innovation and enhancing reporting processes to support health service provider planning.
- **Advising the MOH and MLTC** on broader HHR capacity needs across health sectors through the implementation of an HHR data strategy, with a particular focus on hospitals, primary care, home and community care, a long-term care continuum and mental health and addictions services.
- **Addressing long-term care home capacity** challenges by working with the MLTC to deliver recruitment and retention programs, support initiatives to stabilize and increase bed capacity, such as Hospital to Home (H2H), Home First and alternate level of care (ALC) diversion strategies, and supporting long-term care home applicants and other seniors in the community by facilitating access to the most appropriate care setting.

HEALTH SYSTEM RESILIENCY AND EMERGENCY MANAGEMENT

In recent years, Ontario Health has had to significantly increase operational resiliency by improving its ability to resist, absorb, recover or adapt to emergent business disruption events both within the organization as well as those experienced by HSPs and other delivery partners across the province. Business disruption events take many different forms, including natural disasters, infectious diseases, cyber incidents, supply chain disruptions, disruptive geo-political scenarios such as tariff impacts on economies and industries, etc. The health system needs to be prepared for such scenarios and minimize the impact on health service delivery and patient care across the province.

Likelihood and Impact

Likelihood: ***Possible***, given the large range of external factors that have the ability to affect business operations of Ontario Health and/or HSPs across the province.

Impact: ***Critical***, given the potential disruption that could be caused to health service delivery and patient care.

Mitigation

Ontario Health will continue working with the ministries and provincial partners on health emergency management priorities, including readiness for seasonal and pandemic respiratory pathogens, mass casualty, chemical, biological, radiological or nuclear events, and ongoing response and recovery to health system emergencies and disruptions.

Ontario Health will further operationalize and mature its Enterprise Business Continuity Management System through training and education, ensuring ongoing operations of its most time-sensitive services, capacity development, as well as continuing to support HSPs and communities in planning for and responding to business disruptions events.

PRIMARY CARE TRANSFORMATION

Ontario's Primary Care Action Team, led by Dr. Jane Philpott, announced a Primary Care Action Plan supported by the government's historic investment of $1.8 billion to connect two million more people to a publicly funded family doctor or primary care team within four years, which will achieve the government's goal of connecting everyone in the province to a family doctor or primary care team. Achieving this goal will improve health outcomes for the population, particularly for those at most risk of inequitable outcomes such as equity-deserving communities, FNIMUI communities and people with complex medical needs without access to regular primary care providers. As a result, system pressures experienced across the health system, notably in emergency departments, will be reduced. In contrast, lack of access to primary care will exacerbate risk to population health and associated health system costs, and hinder efforts to optimize system access and flow for appropriate and timely patient care.

Key risks to achieving this goal include HHR scarcity, workforce recruitment and retention challenges due to intersectoral wage competition, the need for mature and coordinated data infrastructure, and variable accountability and performance approaches.

Likelihood and Impact

Likelihood: ***Likely***, given that these challenges are being experienced during the $90 million IPCT expansion.

Impact: ***Critical***, given the importance of patient access to primary care in achieving goals related to the Quintuple Aim.

Mitigation

Ontario Health is working closely with the MOH and the new Primary Care Action Team to address these challenges.

ARTIFICIAL INTELLIGENCE

Artificial Intelligence (AI) for health is an area of growing importance, with vast potential to advance clinical innovation, improve health service delivery and drive operational efficiencies. In the evolving landscape of modern health care systems, AI applications can provide valuable solutions to improve both individual clinical health outcomes and support broader population health management initiatives. Failure or delay by Ontario Health to adopt and appropriately implement AI-related infrastructure, governance and solutions poses the risk of missed opportunities for both Ontario Health and the provincial health system, with a risk that Ontario's performance will lag behind that of other jurisdictions that are nimbler and more aggressive in their adoption of AI. This risk of inaction must be balanced by a careful approach to the development and adoption of AI-related capacities, policies and solutions that realize benefits while preserving public trust, privacy, and promoting a shared responsibility for proactive risk management.

Likelihood and Impact

Likelihood: ***Likely***, given the proliferation of rapidly evolving AI tools and technologies, along with our drive to innovate and improve operational efficiency.

Impact: ***Major***, given the widely recognized potential for AI in health and Ontario Health's pivotal role in promoting its provincial uptake and appropriate use.

Mitigation

Ontario Health is working with provincial partners, including the MOH, to advance the equitable provincial adoption of high-value AI solutions for health and to build AI readiness across sectors and organizations. Ontario Health is also enhancing and evolving its data governance structures to embed and ensure clear governance, oversight and risk management for AI and AI-related use cases, in alignment with the Government's *Responsible Use of Artificial Intelligence Directive* and other applicable legal and privacy requirements. With this balanced approach, Ontario Health will ensure the transparent, responsible and accountable use of AI to harness our considerable provincial health data assets in pursuit of achieving our strategic objectives.

Artificial Intelligence

The landscape of artificial intelligence (AI) in Ontario's health sector is evolving quickly, with rapidly emerging technologies and a growing array of health system use cases, coupled with the introduction of new policy frameworks, legislation and regulation governing AI use. Ontario Health performs several roles in this emerging space, and we are poised to expand our role over the course of the year. As the connector and operator of the health system, Ontario Health must play a leadership role in driving equitable system-wide adoption of high-value AI technologies. As a data utility, Ontario Health collects and manages datasets essential for powering AI development, while ensuring responsible governance and use of AI. Ontario Health is building its own capabilities to develop and deploy AI solutions for better managing the health system, including development of a machine learning-based solution for optimizing surgical and diagnostic imaging referral routing and employing natural language processing for analyzing cancer pathology data to improve patient outcomes.

In the coming year, Ontario Health will continue building its AI capabilities while advancing collaborative efforts with the MOH and other system partners to ensure strategic alignment with provincial priorities. This strategic approach will position Ontario Health as a trusted provincial leader in the governance and safe use of AI, while ensuring transparency, accountability and ethical responsibility in all AI-related initiatives.

These efforts will be anchored in the principles of strong governance and responsible AI use, adhering to the reporting requirements set forth in the Ontario government's Responsible Use of Artificial Intelligence Directive, prioritizing public safety, innovation and trust. Through this directive, Ontario Health will strengthen risk management, transparency, governance and proper documentation of AI usage, beginning with the development of a consolidated inventory of AI-related initiatives organization-wide. In parallel, Ontario Health will work closely with the MOH to ensure alignment with regulatory requirements under Bill 194.

Ontario Health AI Use Cases

- AI-enabled improvements to Ontario Health's cyber security defense capabilities and response speed.
- Generative AI-enabled enhancements to assist with coding and responding to questions.
- AI Scribe adoption activities in primary care.
- Machine learning-enabled modeling of ED wait times.
- Machine learning-based forecasting for dialysis capacity planning.
- AI optimization for diagnostic imaging and surgical referral routing.
- Machine learning-enabled algorithm for predicting lower limb amputation risk.
- Natural language processing-enabled advancements in cancer pathology to enhance detection, automate extraction of relevant information and support staging.
- Natural language processing for anonymization and redacting identifiable information in free text datasets.

Human Resources

We are committed to engaging, equipping and inspiring individuals to enable them to do their best work. We will continue investing in our people through professional development and workplace wellness programs that support individual growth and team performance and foster a One Ontario Health culture that brings our values to life in how we work and serve patients and communities.

HUMAN RESOURCES PRIORITIES AND DELIVERABLES

In support of Ontario Health's strategic priority to *Deliver the Ontario Health Mission through an aligned, effective, capable organization, and an engaged, diverse and accountable workforce*, we have established our Human Resources strategy.

Plan and Attract: external talent pipelines for current and future needs.

FY 2025/26 priorities include:

- Introducing a Workforce Planning protocol to capture resource requirements tied to the achievement of the ABP;
- Developing an Early Careers Program to establish sustainable talent pipelines from key Ontario post-secondary programs;
- Diversifying the candidate pipeline by removing internal hiring barriers and developing external sourcing and partnership strategies; and
- Implementing enhancements to the talent acquisition process to improve the hiring manager and candidate experience and accelerate time to fill.

Develop and Build: internal talent and leadership capability for sustained success.

FY 2025/26 priorities include:

- Implementing the People Leader (PL) Enablement Model, including delivery of the PL Foundations Curriculum (Phase I);
- Building a Leadership Capability Model for multiple levels of Ontario Health leadership;
- Reviewing current learning assets against individual development needs and emerging leadership capability models to ensure alignment; and
- Developing an approach to assess Ontario Health talent for implementation in FY 2026/27.

Engage and Retain: through a compelling Employee Value Proposition.

FY 2025/26 priorities include:

- Leading and facilitating the One Ontario Health culture journey through delivery of the organization-level Employee Engagement Action Plan;
- Delivering an Employee Engagement pulse check survey to gauge progress and momentum on key indices;
- Developing and implementing an employee recognition program aligned to Ontario Health values;
- Delivering a multi-pronged program to combat workplace discrimination and realize the goals of the organization's Respectful Workplace policy;
- Developing a toolkit of policies and programs to support employees with navigating their careers within Ontario Health (Phase I); and
- Expanding the Wellness Program to focus on team health, organizational health and psychological safety.

Align and Reward: to deliver results aligned with our mandate.

FY 2025/26 priorities include:

- Monitoring the external market for trends with an emphasis on a premium pay strategy for scarce skills roles;
- Implementing PDP improvements introduced in FY 2024/25 and identifying opportunities to continuously improve and evolve the program; and
- Conducting an annual review of the benefits plan to ensure it remains cost-effective, competitive and aligned with team members' needs.

Equip and Support: for individual success and organization effectiveness.

FY 2025/26 priorities include:

- Delivering actionable insights to our leadership through enhanced HR analytics to drive data-driven decision-making;
- Conducting a market review of collective bargaining trends to inform future bargaining mandates; and
- Implementing integrated mandatory training program with enhanced, role-based governance.

Ontario Health Workforce Demographics

Ontario Health Workforce Profile – Overall

As of December 31, 2025

Demographics[1]	Total
Full-Time Equivalent (FTE)	3337
Executive FTE	14
Management FTE	510.30
Employees FTE	2812.77
% Female Workforce	62.88%
% Women in Leadership	62.79%
Average Age (in Years)	43.96
% Unionized Workforce FTE (CUPE, SEIU, AMAPCEO)	4.70%
% Non-union Workforce FTE	95.30%
Contract Staff FTE	128.58
Consultant FTE	0.25
Average Tenure (in Years)	7.57
% Part-Time Workforce FTE	1.65%
% Full-Time Temporary Workforce FTE	3.66%

Total active headcount - **3396**

[1] aligned to December 31, 2025 provincial eAgency reporting.

Financial Budget

Financials for 2025-26 onwards are forecasted based on assumed ministry funding commitments and are not a projection of program need or ultimate utilization. Actual funding, including in outyears, may differ and will be reported through the Annual Report.

(in 000's)	2024/25 Budget	2025/26 Budget	2026/27 Budget	2027/28 Budget
Revenue	**$44,782,786**	**$46,382,070**	**$50,815,740**	**$51,965,007**
Gov of Ontario (MOH, MLTC)	$44,778,883	$46,374,596	$50,808,239	$51,957,507
Other Recoveries and Revenues	$3,902	$7,501	$7,501	$7,501
Expense	**$44,782,786**	**$46,382,070**	**$50,815,740**	**$51,965,007**
Health Service Provider transfer payments:	$35,338,722	$36,284,164	$38,106,498	$38,614,129
Acquired Brain Injury	$67,821	$67,821	$68,121	$68,121
Addictions Program	$381,253	$393,988	$349,350	$347,680
Assisted Living	$381,092	$394,592	$381,343	$381,343
Community Health Centres	$570,316	$566,120	$705,438	$660,623
Community Mental Health	$1,112,680	$1,177,446	$1,169,800	$1,166,772
Community Support Services	$728,060	$750,919	$744,189	$744,189
Home and Community Care	$296,950	$341,447	$295,400	$295,400
Hospital	$26,379,067	$26,684,404	$26,989,741	$27,546,886
Initiatives	$392,522	$503,132	$388,286	$388,286
Long-Term Care	$5,028,961	$5,404,293	$7,014,830	$7,014,830
Transfer Payments	$8,666,977	$9,210,421	$11,703,037	$12,342,689
Salary and Benefits	$421,854	$474,071	$482,903	$483,628
Information Technology	$117,432	$130,741	$142,935	$142,935
Purchased Services	$199,926	$242,608	$339,680	$340,939
Amortization	$9,214	$11,659	$11,659	$11,659
Office Space	$10,319	$9,370	$9,370	$9,370
Administration, Supplies and meeting expenses	$13,350	$13,969	$14,615	$14,615
Travel and Accommodation	$1,696	$1,770	$1,748	$1,748
Patient Ombudsman Office	$3,296	$3,296	$3,296	$3,296
NET	**$0**	**$0**	**$0**	**$0**

IT and Electronic Service Delivery Plan

Ontario Health manages a comprehensive technology infrastructure that supports our products, managed services and data repositories. The ongoing operation of this infrastructure is a substantial undertaking, critical to the seamless operation of systems and the provision of care across Ontario. Below are the initiatives that support the ongoing operations of the technology infrastructure, as well as those that support the MOH's Digital First for Health Strategy, ensuring a robust, efficient and forward-thinking health care system for all Ontarians.

DIGITAL SERVICES FOR ONTARIANS

Patient Navigation, Digital Access and Virtual Care

- Operating and enhancing digital tools used by patients to better navigate the system, such as Ontario's Health811 services.
- Managing digital access to health care services using a single, reusable set of credentials, reducing or eliminating the need for multiple passwords and reconfirming identity each time.
- Modernization and operationalization of the existing provincial virtual visit infrastructure and development, and implementation of verification standards for virtual solutions across the province.

Clinical Care Supports Cancer Care, Screening and Prevention

- Operation of cancer care, screening and prevention systems and products for electronic communications, screening forms, drug adjudication tools, patient information systems and administrative systems enabling critical cancer care services, chemotherapy administration, diagnostic imaging and data collection.
- Management and operation of the cardiac care digital system that manages cardiac surgical wait times and procedure efficiencies.

DIGITAL SUPPORTS FOR PROVIDERS

- **Enable Patient Access Across Providers (Putting Patients Before Paperwork):** Oversee the operation and enhancement of tools and services that streamline and simplify administrative processes, freeing providers from unnecessary paperwork and empowering patients to actively engage in their health care journey. This includes increasing the adoption and utilization of digital products for provider communications, provider consults, secure document exchange, electronic referrals, assessments, lab orders, notifications and discharge reports.
- **Provider Technical Support and Change Management:** Provide support services for providers enrolling in Ontario Health digital products and viewing clinical data assets.
- **Home Care:** Conduct operation of the provincial digital system for home care services, enabling the management of four million patient records and integrations with other digital assets and point-of-care systems.
- **Renal Care:** Operation of the Ontario Renal Reporting System supporting the provision of renal care.
- **Organ Donation and Transplant:** Operation and support for systems enabling the provincial organ allocation and donation system, such as the Organ Allocation and Transplant System (OATS) and the Donor Management System (DMS).

SYSTEM CONNECTIVITY AND CAPACITY

- **Provincial Electronic Health Record:** Maintenance and support of the Provincial Electronic Health Record (EHR) housing billions of records in provincial data repositories that are critical to care at the bedside. This includes datasets, directories and registries like the Ontario Laboratories Information System (OLIS), Digital Health Drug Repository (DHDR), Diagnostic Imaging Repositories (DIRs), Acute and Community Clinical Data Repository (acCDR), Provincial Client Registry (PCR), Provincial Provider Registry (PPR), and the provider identity services, data feeds, viewing applications and other access channels.

- **Data and Analytics for System, Capacity, Practice and Waitlist Management:** Operation and modernization of Ontario Health's 160 data assets, ensuring secure storage and appropriate sharing for capacity and system planning, practice and waitlist management, and quality improvement.
- **Provincial Interoperability Standard Services**: Select, define, implement and develop provincial health information standards for Digital Health assets, based on business requirements, provincial architecture, strategic alignment and subject matter expertise to ensure the interoperability of information across the province. This includes assessments and implementation guides for internal and external use.
- **Network:** Administer, modernize and optimize the security and consolidated Information Technology operations of Ontario Health, ensuring business continuity, seeking efficiencies and savings, and reducing technical debt.
- **Cyber Security:** Provide leadership in cyber security within the provincial health sector, assisting and supporting providers to enhance their overall cyber security posture, as well as strengthening internal cyber security at Ontario Health.
- **Cloud Migration Strategy and Data Centre Consolidation:** Migrate data to the cloud and consolidate data centres to reduce hosting and maintenance costs and enhance efficiency across the organization.
- **Emergency Department Support:** Operation and support for products enabling Emergency Department operations, patient triaging and appropriate levels of care.
- **Enterprise IT Services & Solutions:** Enhance the operations and productivity of Ontario Health team members by providing comprehensive support for hardware, software and corporate functions. This includes ensuring reliable access to tools and resources and maintaining efficient technological and administrative processes.

Communications Plan

Communications is a core strategic enabler for Ontario Health to deliver on its mandate and priorities.

Ontario Health's communications strategy is guided by a set of principles that underpin all communications and are to be used as a touchstone to reference as tactics are developed and implemented. They are:

Timely: Inform and engage target audiences early and provide information when they are most receptive and able to take action.

Equitable: Prioritize plain language and ensure communications are inclusive, equitable and meet our French Language Services mandate.

Trusted: Ensure credibility by communicating with integrity and honesty and as one unified organization, internally and externally.

Distinct: Showcase Ontario Health's important role and value within the health care system.

Integrated: Ensure consistency and coordination across all audiences and channels by integrating communications.

Informed: Reflect evidence-based best practice and internal and external feedback from partners, providers and patients as required.

Measurable: Assess the effectiveness of communications through qualitative and quantitative data to evaluate progress towards goals.

OVERARCHING GOALS

Ontario Health's goals for communications over the next three years are to:

Goal 1: Drive a focused, proactive communication strategy that supports system optimization and performance, promoting Ontario Health's role as a leader and the operator of an integrated health care system.

Goal 2: Promote a culture of unity and pride aligned to our values within Ontario Health by celebrating our collective impact.

Goal 3: Build standardized and aligned processes, tools and channels that support equitable outcomes.

STRATEGIC APPROACH

Our communications objectives and goals will be reached over a three-year period, with each year having its own focus.

Year 1 (2023-24): Drive

Develop a proactive communications plan reinforcing our role in the system. Build a unified brand for Ontario Health, consolidating and enhancing existing communication channels.

Year 2 (2024-25): Strengthen

Through measurement and feedback, strengthen communications channels including the development and implementation of an integrated Ontario Health website, continue improving upon consistency, frequency and efficiency. Refresh annual communications plans.

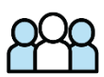
Year 3 (2025-26): Evolve

Re-evaluate and optimize all communications channels to ensure best practice communications with target audiences.

MEASUREMENT

To measure our communication strategy against each major initiative and organization objective, we will use various tools including, but not limited to:

- Survey insights
- Web analytics
- Event/webinar evaluations
- Media coverage
- Employee engagement surveys



TARGET AUDIENCE

Ontario Health has identified the following primary and secondary audiences for communications.

Primary Audiences:

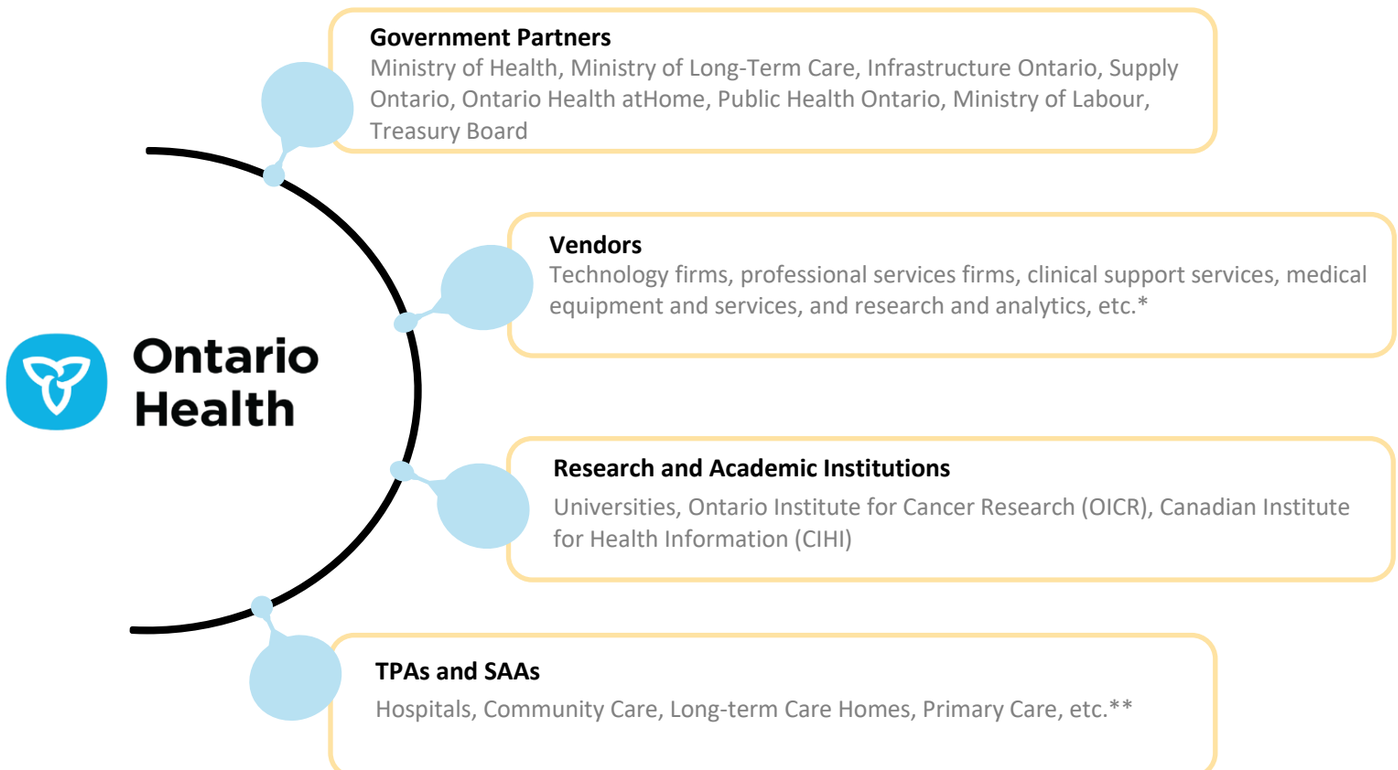
- Health care partners – associations, groups, people and institutions that operate within the health care system
- Health care providers and organizations
- Ontario Health team members
- Government of Ontario

Secondary Audiences:

- Patients, families and care partners

Initiatives Involving Third Parties

This section provides an overview of the various types of organizations Ontario Health works with for the successful delivery of our evidence driven programs and services. This requires collaboration with our clinical, academic and other professional partners. When funds are provided to third party organizations, it is done in accordance with the applicable directives (e.g. Transfer Payment Accountability Directive).



*Furthermore, Ontario Health is currently engaged with over 800 vendors and there are nearly 1,400 active contracts

** Ontario Health holds just under 1400 (1398) SAAs across the province across the hospital, long-term care and community sector. As of FY23/24, there were 1532 active TPAs in place with health service organizations across Ontario, including hospitals, ICHSCs, long-term care homes, home and community care support service organizations, community health service providers, universities, municipalities, family health teams, nurse practitioner-led clinics, community labs and, Indigenous health service

Glossary

ABBREVIATION	DEFINITION
AAA	Abdominal Aortic Aneurysm
ABP	Annual Business Plan
ACCDR	Acute and Community Clinical Data Repository
AI	Artificial Intelligence
ALC	Alternate Level of Care
BEACON	Building Enhanced Assessment for Cancer in Ontario
CCTA	Coronary Computed Tomography Angiography
CIHI	Canadian Institute for Health Information
COIS	Communities of Inclusion
COPD	Chronic Obstructive Pulmonary Disease
CQIPS	Collaborative Quality Improvement Plans
CSOM	Cyber Security Operating Model
CSS	Community Support Services
CT	Computed Tomography
DASH	Delirium Aware Safer Health Care
DHDR	Digital Health Drug Repository
DHIEX	Digital Health Information Exchange
DIR	Diagnostic Imaging Repositories
ED	Emergency Department
EHR	Electronic Health Record

ABBREVIATION	DEFINITION
EIDA-R	Equity, Inclusion, Diversity and Anti-Racism
EMR	Electronic Medical Record
EVT	Endovascular Treatment
FHT	Family Health Team
FIT	Fecal Immunochemical Test
FLHS	French Language Health Services
FLS	French Language Services
FNIMUI	First Nations, Inuit, Metis and Urban Indigenous
FTE	Full Time Equivalent
GEMQIN	General Medicine Quality Improvement Network
H2H	Hospital to Home
HHR	Health Human Resources
HLA	Human Leukocyte Antigen
HSPS	Health Service Providers
ICHSC	Integrated Community Health Services Centres
ICMS	Integrated Client Management System
ICPS	Integrated Clinical Pathways
IPA	Integrated Patient Access
IPC	Information Privacy Commissioner

ABBREVIATION	DEFINITION
IPCT	Interprofessional Primary Care Teams
ISR	Incremental Surgical Recovery
LDG	Local Delivery Group
LDPHM	Locally Driven Population Health Models
LTC	Long-Term Care
MHA	Mental Health and Addictions
MHACOE	Mental Health and Addictions Centre of Excellence
MLTC	Ministry of Long-Term Care
MOC	Model of Care
MOH	Ministry of Health
MRI	Magnetic Resonance Imaging
MSAA	Ministry of Seniors and Accessibility
NPLCS	Nurse Practitioner-Led Clinics
OATS	Organ Allocation and Transplant System
OCO	Ontario Caregiver Association
OHTS	Ontario Health Teams
OICR	Ontario Institute for Cancer Research
OLIS	Ontario Laboratory Information System
OLIS-MORE	Ontario Laboratories Information Systems – Mobile Order Results Entry
OLMP	Ontario Laboratory Medicine Program

ABBREVIATION	DEFINITION
ONSQIN	Ontario Surgical Quality Improvement Network
OSP	Ontario Structured Psychotherapy
P4R	Pay for Results
Pb4P	Patients before Paperwork
PCN	Primary Care Network
PCP	Primary Care Provider
PCR	Provincial Client Registry
PET	Positron Emission Tomography
PGP	Provincial Genetics Program
PHDDS	Provincial Health Data and Digital Services
PPR	Provincial Provider Registry
PREMS	Patient-Reported Experience Measures
PROMS	Patient-Reported Outcome Measures
PSWS	Personal Support Workers
QIP	Quality Improvement Plan
RAC	Rapid Access Clinic
RCM	Remote Care Management
SAA	Service Accountability Agreement
SIF	Surgical Innovation Fund
SPP	Strategic Planning Process
TPA	Transfer Payment Agreement
TPAWTIS	Transfer Payment Agreement Wait Time Information System
VUS	Vascular Ultrasound

Endnotes

Sources leveraged to support the Provincial Demographics and Regional Profiles:

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2. MOH - Health Analytics and Insights Branch (HAIB) - Ontario Health Region Inclusive Definition of Francophone Population Counts Report: The report provides counts of the French-speaking population of Ontario, according to the Inclusive Definition of Francophones (IDF) for Ontario Health (OH) Regions, HCCSS Areas and Public Health Units (PHUs) by age group. Counts are based on a Special Tabulation prepared for HAIB by Statistics Canada (2021 Census of Canada).

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Sources referenced in the Environmental Scan:

1. Ministry of Finance. *2024 Ontario Budget – In Brief.* Toronto: Ontario Government; 2024 Apr [cited 2024 Nov]. Available here: 2024 Ontario Budget | In Brief

2. Ministry of Finance. *Ontario Demographic Quarterly: highlights of second quarter.* Toronto: Ontario Government; 2024 Oct 7 [cited 2024 Nov]. Available here: Ontario Demographic Quarterly: highlights of second quarter | ontario.ca

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Ontario
Health atHome

Business Plan

2025-28

Contents

Message from the CEO and the Board

Anna Greenberg
Chief Executive Officer

Carol Annett, Board Chair

It is our pleasure to present the first Business Plan for Ontario Health atHome, a new organization that carries a long history within Ontario's health care system. On June 28, 2024, through the *Convenient Care at Home Act, 2023,* the 14 Home and Community Care Support Services organizations across Ontario amalgamated into one single service organization called Ontario Health atHome.

This was a key step in the government's plan to modernize home care for all residents of Ontario. While our name has changed, our services remain the same. As a subsidiary of Ontario Health, we are now one provincial organization that coordinates local home and community care services and long-term care home placement, and we also connect people to services in their communities.

As OHTs mature, health care partners including Ontario Health atHome, will work more closely together to explore innovative models of care delivery. This means patients will experience more integrated care with improved outcomes.

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

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

Since introducing these strategic priorities in 2021-2022 as 14 Home and Community Care Support Services organizations, we've made notable progress. In the 2024-25 fiscal year, we expanded Family-Managed Home Care and standardized this service, building capacity while exploring additional caregiver supports. By centralizing teams and streamlining processes, we are optimizing resources to have the greatest impact on patient care. Initiatives like standardizing the hospital discharge process help create a more equitable, high-quality health care system with improved consistency across the province. Additionally, we re-launched the Caregiver Voice Palliative Care survey to gather direct feedback from caregivers, allowing us to further refine and expand palliative care services as a strategic priority over the next three years.

We will continue to foster collaboration with the Ministry of Health, Ontario Health, health system partners and the communities we serve. Our active collaboration with OHTs has enabled us to share our expertise and work alongside partners to enhance care pathways.

Since 2009, we have helped 670,000+ patients in finding primary care providers through the Health Care Connect program. Over the next three years, we will deepen our partnerships with primary care providers across Ontario and enhance our efforts to help residents access the care they need. Aligning with the government's direction on the Primary Care Action Team to support the goal of connecting every person in Ontario to primary health care, our aim is to empower primary care providers by enhancing their capacity through better system navigation and comprehensive care coordination.

We will leverage valuable resources to address the needs of patients and caregivers across Ontario while simultaneously advancing our efforts in equity, inclusion, diversity and anti-racism to effectively respond to the specific needs of the communities we serve.

Our people are our greatest asset, and none of our accomplishments would be possible without the dedication and commitment of our incredible staff, especially during a time of significant change. In 2024-25, we focused on investing in our people, providing the support they need to excel in their roles as we completed our transition to Ontario Health atHome. As we continue this work over the next three years, we are committed to advancing our **People Strategy,** understanding that investing in our workforce is key to achieving better outcomes for the patients we serve.

We look forward to the opportunities ahead and we are confident this plan equips us to address the challenges of today while shaping the future of care. It paves the way for a more modern health care system where patients, families, caregivers, staff and providers feel valued and supported as true partners in home and community care.

Anna Greenberg
Chief Executive Officer

Carol Annett
Board Chair

Introduction

Who we are

Ontario Health atHome coordinates home and community-based care for thousands of patients across the province every day.

We assess patient care needs and deliver home and community-based services to support health and wellbeing. We also provide access and referrals to other community services and manage Ontario's long-term care home placement process. We will continue to coordinate home care services through designated Ontario Health Teams as they assume responsibility for the delivery of home care.

Our mission is to help everyone to be healthier at home through integrated and equitable care in partnership with the communities we serve. We help patients of all ages and diverse backgrounds, their families and caregivers when they need services, support and guidance to:

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

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

Attend school with complex health problems and disabilities

Access mental wellness strategies and addictions support while at school

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

Recover at home after a hospital stay

Find a family doctor or nurse practitioner

Find community services that support healthy, independent living

Access respite and resources to support caregiving

Transition to long-term care or supportive housing

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

Each year, 9,200+ staff serve and support 669,800+ patients of all ages, including enabling approximately 26,800+ long-term care home placements. Every day, Ontario Health atHome provides approximately 29,500+ nursing visits, 4,400+ therapy visits and 112,400+ hours of personal support care.

MISSION

Helping everyone to be healthier at home through integrated and equitable care in partnership with the communities we serve.

VISION

Exceptional care – wherever you call home.

VALUES

Collaboration

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

Integrity

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

Respect

We engage with kindness, empathy, gratitude and compassion

Excellence

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

Our Partners

Across the province, Ontario Health atHome collaborates with a vast number of partners that are vital to the successful delivery of home care services, either directly or indirectly:

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

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

Service Provider Organizations

We have patient care contracts with more than 150 service provider organizations who deliver care.

We maintain oversight of these services to uphold quality and deliver the best possible patient experience. Our focus is on delivering safe care, improving consistency in performance management across the province and fostering a shared understanding of service provider performance expectations, all with the ultimate goal of providing exceptional care to patients.

Listening to the People We Serve

Your voice, your care, wherever you call home. Listening to, and learning from, the people we serve is essential to the work we do and a core value of Ontario Health atHome. Engagement is a crucial component to delivering high-quality care, reflective of the needs of those we serve. By working together with patients, family members, caregivers and the community, we can meet these goals.

Our Community Engagement program enables us to harness unique insight from those with lived experience to help guide us in the development of patient-centred programs, services and policies. This approach helps make our services more **relevant, beneficial and reflective of patient needs, priorities and values,** while also enhancing the support we offer.

> **"The team has done a fantastic job with meeting structures/topics so far, and I feel like I'm a valued advisor. This is not easy to do, and I'm very appreciative of the work that staff have put into working with patient and caregiver advisors."**
>
> — Advisor, General Engagement Program

Environmental Scan

Health System Transformation

In December 2023, Bill 135, the *Convenient Care at Home Act, 2023*, received Royal Assent, establishing Ontario Health atHome as a new single service organization and subsidiary of Ontario Health. On June 28, 2024, the 14 former Home and Community Care Support Services organizations officially amalgamated under the Ontario Health atHome name.

Ontario Health atHome will continue to deliver home and community care services, as well as long-term care home placement.

In collaboration with Ontario Health and OHTs, we are implementing new models of home and community care that strengthen connections among all health system partners involved in a patient's circle of care, including hospitals and primary care providers. This enhanced collaboration aims to offer patients more integrated care tailored to their needs.

While we embrace our identity as a newly unified organization, our commitment to delivering exceptional care remains steadfast as we currently support approximately 344,500+ patients monthly and 669,800+ patients annually, and plan to serve a growing number of people in Ontario with increasingly complex needs into the future. We are dedicated to advancing health care system

integration, promoting equity and ensuring consistent access to care across the province. At the same time, we acknowledge the unique needs of patients within their local communities and the importance of partnering with Ontario Health and OHTs to enhance patient experiences and outcomes.

Responding and Planning for Ongoing Health System Needs

Ontario's health system continues to face increasing pressure, with seasonal illnesses overlapping with evolving COVID-19 patterns, which is driving higher demand for care. Projections also show that Ontario's senior population, who require more health care services and community support to remain healthy as they age, will increase in the coming years. Patients and families are also seeking more convenient, personalized and high-quality care, with many preferring the option to age in the place of their choosing.

To further stabilize Ontario's health and long-term care sectors for the future, we are committed to delivering the right care in the right place, alleviating pressure on hospitals. A key priority is improving the flow of patients from hospitals to their homes, long-term care or other community settings. We continue to support the implementation of the *More Beds, Better Care Act, 2022* and *Your Health: A Plan for Connected and Convenient Care* by automating the long-term care home application process and expanding capacity-building initiatives to better serve patients and families.

Like the rest of Canada, Ontario is struggling with a shortage of health human resources, particularly in rural and remote regions, while facing rising demand for home and community care services with increasingly complex needs. The government's *Your Health: A Plan for Connected and Convenient Care*, includes a commitment to increasing the number of health human resources and improving access to care.

Ontario Health atHome is committed to developing innovative care models, including strengthening partnerships with primary care networks to expand capacity and improve transitions between health care providers. Additionally, we are prioritizing internal staff retention, recruitment and maximizing the scope of practice for health care professionals to provide patients with more timely and accessible care.

The health care system is continually advancing, particularly in the areas of technology, but with these advancements come increasing cyber security threats. Tackling these challenges is essential to protecting sensitive information and maintaining a secure and efficient experience for both staff and patients. In May 2024, the Ontario government introduced ***The Strengthening Cyber Security and Building Trust in the Public Sector Act, 2024***, which, if passed, will provide public services, including health care, with innovative tools to improve cyber security.

We are committed to strengthening our defenses by investing in advanced strategies that safeguard operations, protect personal health information and maintain the continuity of patient care.

Artificial Intelligence

The integration of artificial intelligence (AI) into Ontario's health care system is advancing rapidly, bringing transformative opportunities to how care is delivered and managed. This growth is driven by the emergence of innovative technologies, expanding health system use cases and the introduction of new policy frameworks, legislation and regulations governing AI usage.

Ontario Health atHome is committed to being at the forefront of this evolution by aligning with the Ministry of Health's Digital Strategy, Ontario's *Strengthening Cyber Security and Building Trust in the Public Sector Act*, 2024 and Responsible Use of Artificial Intelligence Directive. In support of this commitment, we have embedded the directive's principles into our organizational policies and processes, with a particular focus on privacy, security and performance monitoring for critical systems and applications. These measures prioritize ethical considerations, safeguard patient confidentiality and maintain transparency in data handling.

Looking forward, we plan to adopt advanced IT tools to enhance security, privacy monitoring and application performance. These innovations, combined with our compliance policy and robust governance measures, will position Ontario Health atHome as a leader in responsible AI adoption within the health care sector.

CURRENT AI USE CASES

Operational Efficiency in IT Systems

- AI enhances operations by monitoring access, optimizing IT performance, identifying security risks and automating maintenance. Our Service Desk software uses machine learning to streamline support ticketing. Microsoft Copilot, embedded in Microsoft 365 applications like Word, Excel and Teams, boosts productivity by automating tasks, generating content and analyzing data efficiently.

Operational Efficiency in IT Systems and Privacy Use

- Our Privacy Team uses Splunk for Client Health and Related Information System (CHRIS) patient record system auditing and compliance, with AI enhancing access control, user analytics, automated alerts, anomaly detection and reporting. AI also supports data analysis, incident investigations and overall platform effectiveness, strengthening auditing, compliance and operational efficiency.

Equity, Inclusion, Diversity and Anti-Racism

Ontario Health atHome is committed to a culture of equity, inclusion, diversity and anti-racism (EIDAR). We will work collaboratively to remove systemic barriers for underrepresented and racialized groups, striving to build a workforce that reflects the diversity of the communities we serve. Our goal is to enhance patient and family outcomes through this inclusive approach.

In 2024-25, we focused on continuing to build a strong foundation to support meaningful and sustainable progress. With staff and advisor input, we developed an EIDAR Framework to guide our ongoing efforts in fulfilling our EIDAR commitment. This Framework outlines our initial priorities and areas of action, serving as a roadmap for how we will address and advance our commitment moving forward.

Ontario Health atHome is committed to a culture of equity, inclusion, diversity and anti-racism.

We will work collaboratively to eliminate systemic barriers to underrepresented and racialized groups, and work towards a workforce that reflects the diverse communities we serve, with the goal of optimizing patient and family outcomes. We will have an initial focus on the impacts of anti-Indigenous and anti-Black racism.

As we continue to act on our EIDAR commitment over the next three years, we will measure the impact of our efforts and use that understanding to refine our approach and maximize our impact. EIDAR questions are now part of our Employee Engagement Survey. Additionally, an EIDAR Dashboard has been created to aggregate data from the Client Health and Related Information System (CHRIS) patient record system, helping us better understand disparities in patient experiences and enhance our approach to delivering culturally safe care.

Learning and development remains a priority to support our progress. Throughout 2024-25, in collaboration with Employee Resource Groups (see further down to learn more about ERGs), we recognized Black History Month, National Day for Truth and Reconciliation, Pride Month, National Accessibility Week and other periods of significance. Through these engagements, we helped staff expand their knowledge and understanding of critical issues and EIDAR topics and connect them to the work we do at Ontario Health atHome. Staff continued to engage in foundational EIDAR training, with over 4,200 employees completing the "Pronouns Matter" eLearning module, which supports using the CHRIS functionality related to gender identity and pronouns. Demonstrating their ongoing commitment to enhancing EIDAR knowledge and skills, staff made EIDAR-related opportunities a priority.

We have made significant progress in embedding EIDAR into all aspects of our work by offering strategic guidance on key projects. To foster transparency and demonstrate the impact of EIDAR, we share quarterly updates with all staff, highlighting EIDAR metrics and summarizing the initiatives we've supported. This helps employees recognize the importance of EIDAR in our organization.

> **"It is very clear what the priorities of EIDAR are and how they will be followed to ensure the anticipated outcome is realized."**
>
> — Advisor, EIDAR Framework Engagement

Our responsibility to act on our EIDAR commitment is shared across all functional areas. In the first year of this plan, we will introduce an EIDAR policy to promote an inclusive, equitable and anti-racist culture while guiding EIDAR contributions. Key contributors, alongside the EIDAR team, include the EIDAR Advisory Committee for strategic guidance, Employee Resource Groups for project insights and grassroots leadership and Community Advisors for input on core initiatives.

Building on our successes, there is important work ahead to improve equity, inclusion, diversity and anti-racism for all those we work with and serve. Moving forward, we remain committed to collaborating with staff, families, patients and caregivers, and will continue to rely on their insights and guidance to drive our progress. Over the next three years, we will prioritize efforts to strategically embed EIDAR throughout Ontario Health atHome and empower staff to actively contribute to meaningful progress on culturally safe care. Key actions will include:

- Prioritizing EIDAR in key organizational initiatives;
- Developing strategies to implement the EIDAR Framework Priorities;
- Strengthening our approach to EIDAR measurement;
- Building organizational capacity to strategically implement EIDAR; and
- Harmonizing resources to strengthen inclusive, equitable and anti-racist staff interactions.

> **"I definitely found the EIDAR Framework to be a blueprint for real and effective change."**
>
> — Advisor, EIDAR Framework Engagement

Business plan at a glance

Our Engagement Approach

Guided by our **Community Engagement Framework**, the Community Engagement program employs two distinct approaches to foster collaboration and inclusivity. First, the Community of Advisors consists of volunteer patients, families and caregivers who provide valuable insights. Second, we maintain broad engagement with system partners such as primary care providers, community support services, long-term care homes, hospitals, hospices and contracted service provider organizations. Additionally, we engage with priority populations and communities, including French Language Health Planning Entités and Ontario Collaborative for Aging Well to ensure diverse perspectives are considered in our decision-making.

Since the program's inception in 2021, our Community of Advisors has contributed 1,132 hours of meaningful engagement. The Community Engagement program is dedicated to creating inclusive and accessible spaces that recognize and address the diverse needs of Advisors.

Our commitment to inclusion extends to both the Community of Advisors and our broader engagement efforts, where we intentionally reach out to historically excluded communities. This includes Indigenous, Francophone, racialized, 2SLGBTQIA+, disabled and other underserved groups, ensuring their voices are heard in shaping health care programs and services.

To support the strategic priorities outlined in the 2025-28 Business Plan, Advisors and health system partners continue to have opportunities to contribute to the improvement of programs and services for the populations we serve. Advisors play a co-design role, being integrated into project work alongside project sponsors at various stages of the project lifecycle, from initial information gathering to better understand patient experiences and opportunities, to testing approaches and developing patient and family materials. As these projects progress, Advisors will have ongoing opportunities to support standardization efforts across the province.

> **"It is wonderful to have the opportunity to share thoughts, concerns and praise, knowing the message is safely passed on where it might make a positive difference. We are glad and honoured to be a helpful part of our provincial health care team."**
>
> — Advisor, General Engagement Program

> **"Thank you for listening and for genuinely seeking input to improve home care. My legacy to my husband is to help create a stronger health care system to provide better care for others."**
>
> — Advisor, General Engagement Program

Strategic Priorities at a Glance

OBJECTIVES

- Provide high-quality, patient- and caregiver-centred home and community care services, facilitate long-term care home placements and improve access to community services, promoting safe, effective, timely and equitable care.
- Optimize organizational capacity to support equitable service planning and implement activities to respond to ongoing system needs in alignment with Ontario's *Your Health: A Plan for Connected and Convenient Care.*

INITIATIVES

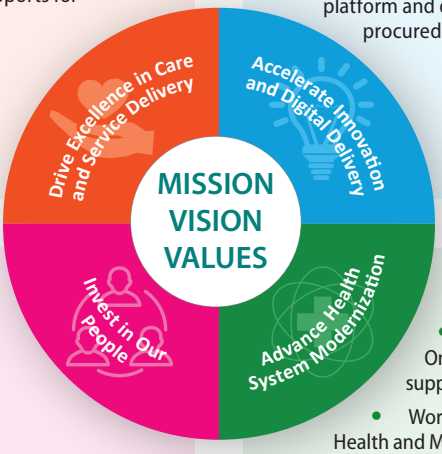
- Continue the implementation of improved efficiency and system capacity initiatives that began in 2022-23 in collaboration with service provider organizations, including engagement with these organizations to review performance and quality and assess risks.
- Build new capacity through expansion and standardization of Family-Managed Home Care, while exploring additional supports for caregivers.
- Implementation of standardized quality and safety processes and outcome measures.
- Continued standardization of business support services for increased efficiency and effectiveness.

OBJECTIVES

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

INITIATIVES

- Implement a Digital Plan in alignment with the Ministry of Health's Digital Strategy to increase efficiency, effectiveness and improve patient experience and outcomes.
- Collaborate with Ontario Health to procure a digital wound care platform and develop a plan to lead the implementation of the procured platform.



OBJECTIVES

- Recognizing the health human resources challenges across the system, continue to focus on attracting and retaining staff to evolve the organization as we prepare for organizational transformation to serve Ontario Health Teams.
- Leverage the full potential of all staff to create a workforce that is skilled, motivated and passionate to deliver best in class service as we evolve to a service organization.

INITIATIVES

- Continue to implement our People Strategy, focusing on:
  - **Employee Wellness, Wellbeing and Health and Safety Programming:** Create a positive, healthy and engaged workforce that supports people to care for themselves and each other.
  - **Build an Effective Team Culture:** continue to establish a high-performance mindset and culture of mutual respect and kindness.
  - **Provide Rewarding Careers:** Recognize the incredible work of our talented team, stabilize our workforce and attract, develop and retain exceptional people.
  - **Equity, Inclusion, Diversity and Anti-Racism (EIDAR):** Advance a culture of equity, inclusion, diversity and anti-racism and work to eliminate systemic barriers to under-represented racialized groups.
- Apply the *Public Sector Labour Relations Transition Act, 1997* (PSLRTA) to define new bargaining units and determine union representation for Ontario Health atHome.

OBJECTIVES

- Plan and organize internal resources to position Ontario Health atHome to effectively provide operational supports to Ontario Health Teams.
- Work collaboratively with Ministry of Health, Ontario Health and Ministry of Long-Term Care to improve long-term care home placement in alignment with the Ministry of Long-Term Care direction, including planning for the future state model of long-term care placement functions.
- Advance the spread and scale of new models of home care delivery with health service providers.
- Work with Ontario Health, OHTs, health service providers and service provider organizations to implement the Ministry of Health's direction to update the service provider selection process and service contracts, with the goal of enhancing quality and spreading new models of home care delivery.

INITIATIVES

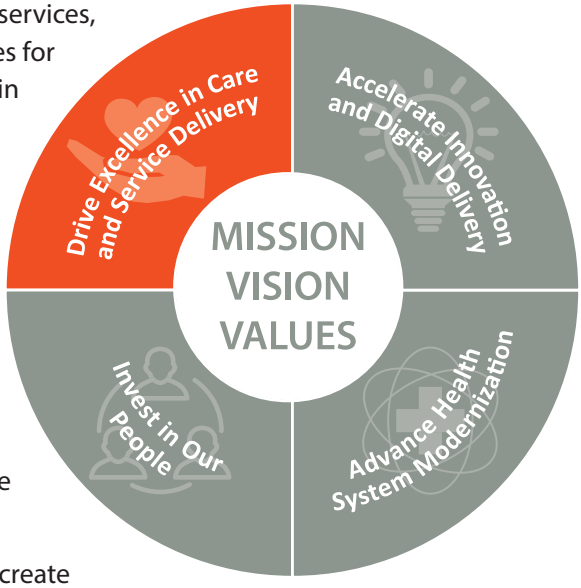
- Develop and implement a service model and change plan for Ontario Health atHome to provide operational supports, including care coordination supports, to client providers, enabling them to provide home and community care services to the patients they serve.
- Support and implement innovative service models and clinical pathways in collaboration with OHTs, Ontario Health and other health system partners so patients receive exceptional care.
- Continue to streamline and standardize key operational processes, including hospital discharge, intake, information & referral and navigation across the province in collaboration with system partners.
- Continue to standardize long-term care home placement practices, policies and procedures to improve transitions to long-term care homes and implement future state models of care.
- With system partners, plan and implement home care integration with Primary Care.

Strategic priorities

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

Priority 1: Drive Excellence in Care and Service Delivery

We remain focused on improving home and community care services, long-term care placements and access to community resources for patients, families and caregivers, while navigating challenges in the health care system and responding to emerging needs. By actively engaging with our Community of Advisors, we incorporate the patient voice into everything we do.



In 2024-25, we made significant progress in standardizing the Family-Managed Home Care program to provide patients, families and caregivers with consistent access to services, experiences and outcomes, wherever they live in Ontario. A key part of this initiative was introducing a single-funding model giving patients and families greater flexibility and control over their care. Areas with this model in place have seen significantly higher patient and family satisfaction.

Additionally, we developed provincial tools and guidelines to create a uniform approach to Family-Managed Home Care administration. In collaboration with the Ministry of Health, we launched a secure digital portal that streamlines processes while protecting patient information, along with a standardized agreement template for all patients. These efforts are enhancing the quality of care, empowering families and improving overall patient outcomes.

In alignment with Ontario's ***Plan for Connected and Convenient Care,*** we have prioritized efforts to stabilize the health care system and expand our capacity to deliver home and community care to eligible patients, particularly in small, rural communities and areas facing challenges in accessing timely care. Over the past year, we have made significant progress through key initiatives to expand and operationalize community nursing clinics, implementing neighbourhood models of care and optimizing the use of transitional care beds.

As we continue to evolve as a single service organization, we've put essential policies and protocols in place, including infection prevention and control and an ethics framework to guide our actions and decisions. Patient safety and quality of care remains our top priority, and we introduced provincial policies for reporting, managing, analyzing and responding to patient complaints and safety incidents.

Additionally, we launched two key surveys to gather valuable feedback: the monthly Patient and Caregiver Experience Evaluation survey, sent to approximately 9,000 patients each month, and the Caregiver Voice palliative care survey, which reaches approximately 1,000 caregivers each month. The feedback from these evaluations will directly inform our strategies to continuously improve patient outcomes across Ontario.

We streamlined our business supports and provided frontline teams with the tools and resources necessary for delivering exceptional care. By consolidating resources and standardizing processes, we have empowered our teams to enhance patient care across the province.

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

- Provide high-quality, patient- and caregiver-centred home and community care services, facilitate long-term care home placements and improve access to community services, promoting safe, effective, timely and equitable care.
- Optimize organizational capacity to support equitable service planning and implement activities to respond to ongoing system needs in alignment with Ontario's *Your Health: A Plan for Connected and Convenient Care*.

We will undertake the following strategic initiatives:

1. **Continue the implementation of improved efficiency and system capacity initiatives that began in 2022-23 in collaboration with service provider organizations, including engagement with service provider organizations to review performance and quality and assess risks.**

   YEAR ONE 2025-26:
   A continued effort will be made to optimize and expand capacity within the home and community care sector, particularly as increasing pressure from seasonal illnesses overlaps with evolving COVID-19 patterns, driving higher demand for care. Our focus will be on the evaluation of neighbourhood models of care, expansion of shift nursing and leveraging new nursing supplies to create additional nursing capacity in the community. Additionally, annual fall preparedness activities, such as emergency department diversion, hospital admission avoidance and discharge planning, will continue to create focused support for patients and system partners during a time when it is needed the most. Looking to the future, Ontario Health atHome will further embrace a proactive approach to delivering the right care in the right place to help alleviate pressure on hospitals and addressing surges in demand for our services.

   YEAR TWO 2026-27:
   - Build on initiatives to reduce unnecessary emergency department visits, support timely hospital discharges and enhance access to services.

   YEAR THREE 2027-28:
   - Continue to build on initiatives to create additional patient and caregiver supports.

> **"Managing expectations is important – share what can and cannot be offered in the community so families can access their own resources (if possible). Wait times for services and/or devices is important to share."**
>
> — Advisor, Hospital to Home, Discharge Planning Engagement

2. **Build new capacity through expansion and standardization of Family-Managed Home Care, while exploring additional supports for caregivers.**

YEAR ONE 2025-26:

Through the Family-Managed Home Care program, patients and their substitute decision-makers receive funding to purchase home care services or hire care providers. This approach offers greater flexibility and choice, allowing them to select their caregivers, determine how and when care is delivered and manage all related administrative tasks. As Ontario, like the rest of Canada, faces a shortage of health human resources, particularly in rural and remote regions, this program provides an important alternative for patients who may otherwise experience challenges accessing home care services.

Recognizing the importance of this program, we are implementing standardized processes within Family-Managed Home Care to provide all patients and caregivers across the province with access to the program and deliver a consistent care experience.

We have actively listened to caregivers through surveys and other feedback channels, gaining a deeper understanding of the challenges and stresses they face. Guided by this valuable input, we will explore additional support options to enhance both patient and caregiver satisfaction, foster greater control over care and promote a consistent, high-quality experience. Listening and acting on feedback remains central to shaping our approach and addressing caregiver needs effectively.

To assess our impact on the patient and caregiver experience, we will implement a patient experience survey specifically for the Family-Managed Home Care program. This survey will help us understand how we can improve the patient experience. Additionally, we will measure staff satisfaction levels to evaluate improvements in overall program operations. Our goal is to transition 100% of existing Family-Managed Home Care patients to the single, consistent model introduced in the 2024-25 year.

YEAR TWO 2026-27:

- Engage patients and caregivers in the design of initiatives to provide caregiver support and ease caregiver responsibilities.

YEAR THREE 2027-28:

- Use patient and caregiver experience data to guide improvements and establish caregiver support systems.

3. **Implementation of standardized quality and safety processes and outcome measures.**

YEAR ONE 2025-26:

Everyone in Ontario deserves the same high-quality care, no matter where they live. As projections show that Ontario's senior population, who require more health care services and community support to remain healthy as they age, will increase in the coming years, the demand for home and community care will continue to grow. Patients and families are also seeking more convenient,

personalized and high-quality care, with many preferring the option to age in the place of their choosing.

We remain committed to leading, co-leading and supporting the standardization of best practices in continuous quality improvement and risk management across our organization. This commitment will continue as our role evolves as a service organization supporting OHTs.

In the coming year, we will build on key initiatives recently launched. These include establishing a professional practice framework and implementing a province-wide approach to the collection, analysis and response to wound care data. Addressing inconsistencies in wound care will be a key focus, as practices and resources vary across the province, leading to inequities in access to specialized care. To address this, we will develop and implement a provincial wound care framework.

These efforts will remain a priority as we drive continuous improvements in care quality, enhance patient experiences and promote equitable access to expert care across the province.

YEAR TWO 2026-27:

- Complete accreditation process through an external review to promote transparency and quality improvement.
- Act on patient and caregiver experience survey responses.

YEAR THREE 2027-28:

- Embed continuous improvement strategies to enhance ongoing excellence in care delivery.

4. **Continued standardization of business support services for increased efficiency and effectiveness.**

YEAR ONE 2025-26:

Standardizing our business support services is essential to providing our frontline teams with the support they need to excel in their important work within a service organization. This includes implementing an organizational design that strengthens our operations. These efforts are key to creating a cohesive and efficient organization that enhances care delivery.

YEAR TWO 2026-27:

- Enhance coordination among teams to improve the delivery of care provided to patients and services provided to OHTs.

YEAR THREE 2027-28:

- Continue to make improvements to service delivery models.

What does this mean for patients?

When 92-year-old Javier* was diagnosed with dementia, his family was faced with the task of finding the right care to meet his needs. They wanted him to stay at home, where he was comfortable, but they knew he needed specialized support.

Through the Family-Managed Home Care program, Javier's family was able to handpick a small, consistent team of service providers to visit their home. This provided them with greater control over who was entering their home and made sure that Javier always saw familiar faces—a crucial factor for someone with dementia.

Each member of his care team received ample orientation to understand Javier's specific needs and preferences, allowing them to build therapeutic relationships with him over time. The consistency of the team meant that Javier bonded with his providers, who soon became trusted companions.

This stability gave Javier a sense of security and familiarity, reducing his anxiety and confusion. His family noticed a significant improvement in his overall wellbeing.

The Family-Managed Home Care program not only supported Javier's health, but also gave his family peace of mind, knowing he was in caring, capable hands.

* Javier is a composite of patients we have heard from, and his story illustrates how Family-Managed Home Care is empowering patients and caregivers to receive personalized, compassionate care that enhances their quality of life.

How will we know that we are making a difference?

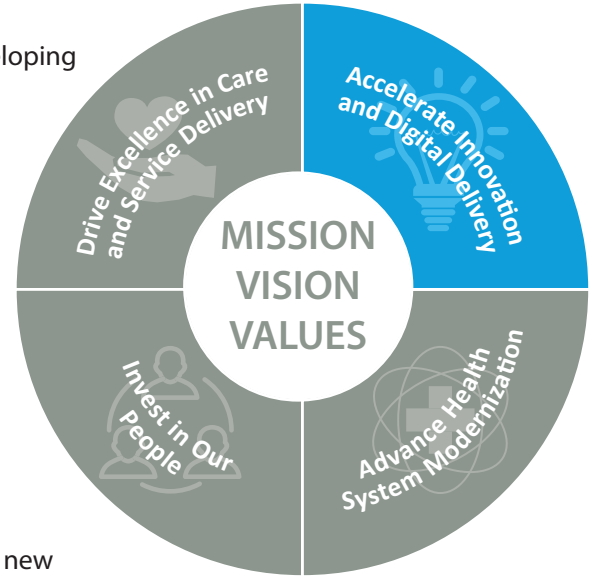
Measuring the impact of our initiatives is crucial to making sure they address patient needs and support system stabilization. Our key performance indicators will track metrics such as incomplete visits and the time taken to accept service offers.

Additionally, we will monitor the percentage of patients on waitlists and the percentage of initial service offers accepted by the first provider. For the Family-Managed Home Care program, we'll evaluate patient experience and staff satisfaction, as well as the successful transition of all existing patients to the new funding model.

To assess the quality and safety of our care, we will track the percentage of complaints resolved within 30 days and the percentage of abuse allegations addressed within 10 days. We will also use data from the Patient and Caregiver Experience Evaluation survey and the Caregiver Voice palliative care survey to further inform the effectiveness of our initiatives and their impact on patient and caregiver experiences.

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

Priority 2: Accelerate Innovation and Digital Delivery



Digital health remains a cornerstone of health care system modernization. Ontario Health atHome is committed to developing a unified digital infrastructure, processes and systems to improve patient and provider experiences, provide seamless transitions of care and realize health care system efficiencies. We are continuing to digitize our paper forms, while enhancing the security of patient data. This has reduced the workload related to manual processes, increasing the amount of time available for direct patient care and improving patient experiences.

We are advancing digital solutions to support integrated home health care delivery, including improving the functionality of the Client Health and Related Information System (CHRIS), the provincial tool used for home and community care and long-term care home placement. In our new role supporting OHTs, we have developed a standardized approach to facilitate the use of CHRIS and other digital tools for OHTs, to allow for health system partner messaging. A common platform now allows health system partners to share information about palliative patients more efficiently, bringing the circle of care closer together.

Over the past year, we've made significant progress in implementing digital initiatives to enhance patient care, including completing the Integrated Decision Support System initiated last year. We also successfully completed the CARE pilot program, which uses technology to send referrals for hospice services. This program speeds up patient access to care while reducing the risk of privacy breaches.

Digital technology has created new opportunities for delivering care in non-traditional settings, such as allowing patients to receive care in the safety and comfort of home in their preferred language. Over the past year we explored the benefits of remote care monitoring systems through our Telehomecare programs, which combine monitoring with nurse coaching. We finalized eligibility criteria and standardized tools and equipment. We also established baseline data for our Telehomecare program, measuring the number of Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) patients receiving care through the program.

Continuous engagement and collaboration with our health care partners, as well as Ontario Health and the Ministry of Health, is critical to maintaining seamless patient experiences and for planning and implementing new models of care delivery as we support OHTs. As we build on what we have accomplished, we will focus on the following strategic objectives:

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

We will undertake the following strategic initiatives:

1. **Implement a Digital Plan in alignment with the Ministry of Health's Digital Strategy to increase efficiency, effectiveness and improve patient experience and outcomes.**

   YEAR ONE 2025-26:

   We are committed to driving the growth, expansion and enhancement of a wide range of digital solutions, as part of our organization's comprehensive Digital Plan. This includes advancing priority digital initiatives and collaborating closely with Ontario Health and the Ministry of Health to introduce new, innovative platforms. Key efforts will focus on improving efficiency, integration and patient care across the province.

   As part of this plan, we will implement privacy best practices to comply with the *Personal Health Information Protection Act, 2004* (PHIPA) and enhance data sharing capabilities. We also aim to adopt and expand digital tools to further streamline operations and improve service delivery.

   One of our primary initiatives is the implementation of a digital wound care solution that will standardize wound care management across Ontario. This will provide equitable access to care, particularly for patients in rural and remote areas, reducing the need for emergency department visits and hospital admissions.

   In addition, we plan to enhance the CHRIS system to support consistency with Ontario Health Teams, including integration with OCEAN e-referral, expanding geographic information system (GIS) capabilities, medical equipment and supplies modernization and other key improvements. We also plan to implement an Information Management Plan to support the Ministry of Health's data analytics requirements.

YEAR TWO 2026-27:

- Explore and pilot more effective ways to integrate health system portals, digital interfaces and other digital tools to improve the patient experience.

YEAR THREE 2027-28:

- Refine and promote the use of digital tools to support integrated care to improve patient experiences and interactions between patients and service providers.

2. **Collaborate with Ontario Health to procure a digital wound care platform and develop a plan to lead the implementation of the procured platform.**

YEAR ONE 2025-26:

Since the successful implementation of a digital wound care solution in 2021 in Central East, we've seen significant cost reductions, improved patient outcomes and enhanced patient experiences. Building on this success, we aim to expand this solution across Ontario to create a province-wide, integrated wound care system that ensures consistent care and equitable access to specialized consultations for all patients, no matter where they live.

Through digital tools, patients will receive virtual wound assessments and expert recommendations from inter-professional wound care teams in their homes, supported by standardized care pathways for common wound types like diabetic foot ulcers, pressure injuries and venous leg ulcers. This approach will be reinforced by advanced data analytics to continuously monitor, evaluate, and improve care quality.

Our goal is to implement this digital solution province-wide, enabling high-quality wound imaging, virtual consultations and seamless collaboration among the patient's care team. This will result in timely expert care, reduced healing times, fewer emergency visits and improved quality of life for patients, while supporting hospital capacity by preventing unnecessary admissions. This transformation will elevate wound care in Ontario, delivering expert care wherever it's needed.

YEAR TWO 2026-27:

- Implement province-wide plan for a digital wound care platform.

YEAR THREE 2027-28:

- Evaluate the impact of the digital wound care platform by collecting qualitative and quantitative feedback from health care providers and patients.

What does this mean for patients?

At 62 years old, Mark* was navigating the challenges of life after cancer surgery. Recently undergoing a procedure to remove a tumor, he faced complications with a persistent surgical wound that wouldn't heal. Living in a rural area made accessing specialized care a struggle, and with ongoing chemotherapy treatments, Mark was concerned about how his wound would affect his health and recovery.

Recognizing these challenges, Mark was referred to the Ontario Health atHome Digital Wound Care program, which facilitates virtual consultations and collaboration among an Interprofessional Wound Care Team using high-quality images and standardized assessments.

A wound champion visited Mark at home to discuss the program and obtain his consent for photography. They conducted a thorough assessment of his wound, capturing detailed images that were uploaded to a secure dashboard, allowing his care team to collaborate and provide expert guidance.

With his wound information available to nurses and specialists, the team quickly developed a comprehensive approach to his care. Regular visits from service provider nurses meant Mark was never managing his wound alone. They assisted with dressing changes and monitored his progress, discussing how his ongoing chemotherapy treatments might affect his healing.

The program also included advanced technology like thermography to detect the presence of bacteria in the wound. This capability allowed the team to identify effective treatment strategies tailored to Mark's needs.

As Mark progressed in his recovery, his wound began to heal, allowing him to resume chemotherapy treatments. The support and collaboration provided by the Digital Wound Care program made a significant difference in his healing journey. With the worry of his wound behind him, Mark felt empowered to focus on his health and regain his strength.

Thanks to the comprehensive care offered through the program, Mark was able to continue his cancer treatment with renewed confidence, knowing he had support every step of the way.

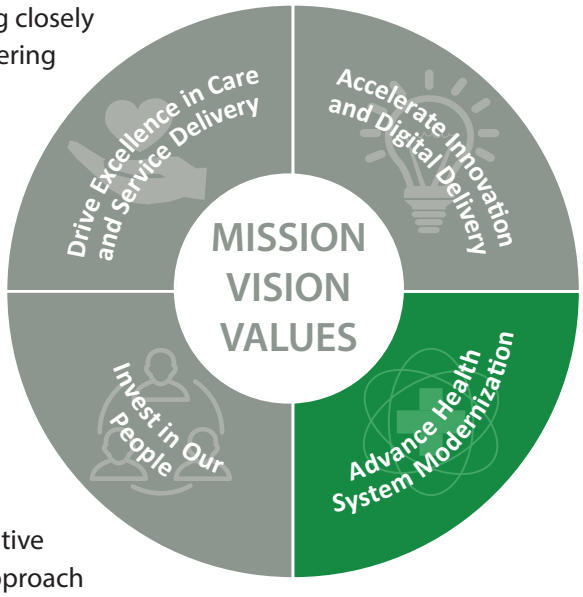
* Mark is a composite of patients we have heard from, and his story illustrates how the Digital Wound Care program empowers individuals to manage their wounds with support from wound care experts.

How will we know that we are making a difference?

Measuring the effectiveness and impact of our digital initiatives is critical to ensuring they are producing results as intended, to enhance system modernization and improve patient experiences and outcomes.

We are tracking how many areas have access to and are using our digital wound care solution and the related impacts to health outcomes with the goal of having it accessible and implemented province-wide. To see a more comprehensive list of indicators that will be used for this priority, please refer to the 'Performance Measurement' section of the plan.

Priority 3: Advance Health System Modernization



To advance health system modernization, we are collaborating closely with partners to develop new, connected approaches to delivering health care in local communities. This effort aligns with the *Convenient Care at Home Act, 2023*, as we transitioned to Ontario Health atHome, a single service organization that will continue to coordinate all home care and placement services across the province through OHTs.

On June 28, 2024, the 14 legacy Home and Community Care Support Services organizations successfully amalgamated into Ontario Health atHome.

Building on our commitment to collaborate, we will share best practices in care coordination with OHTs and support the development of innovative models for integrated care for all patients, particularly in mental health and addictions, palliative and end-of-life care and chronic disease management. This approach supports teams in delivering proactive, evidence-based care that meets the diverse needs of patients, families and caregivers. We remain actively involved in implementation planning for OHT models of care and will continue to provide support as these initiatives are rolled out. In collaboration with OHTs, Ontario Health and the Ministry of Health, we are refining our shared services to support OHTs. We continued to share provincial policies, procedures and host knowledge transfer sessions to support operational readiness. A key element in transforming service delivery for OHTs has been the implementation of a client relationship service model. This model aims to enhance interactions between Ontario Health atHome and our OHT clients by fostering long-term, positive relationships through personalized service, efficient communication and tailored solutions.

Foundational elements for modernizing home care and enhancing long-term care home placement involve a consistent and equitable service delivery approach across the province.

This past year, we made significant progress in standardizing and streamlining long-term care placement policies and procedures. We successfully completed our work related to automating the placement process for patients, making it more efficient and easier to navigate. Additionally, we standardized reporting and patient forms to create equitable access and consistent experiences for all patients.

We now operate under a provincial long-term care home standard and follow provincial guidelines, including those for opening new homes, specialized units, redevelopment and closures. Our provincial reporting mechanisms also track long-term care homes in outbreak status, as well as the placement dashboard and bed availability.

While consistency in accessing care is essential, our approach must also prioritize equity by accommodating local variations in cultural, linguistic and geographic needs. As we work to improve long-term care placement in accordance with regulations and community needs, we recognize the importance of engaging with Indigenous patients, families and caregivers. We understand that these consultations may evoke trauma from past experiences. To better serve these communities, we will continue to engage in dialogue with Indigenous groups, exploring their needs and experiences, including the principles of trauma-informed care, to enhance the support we provide for Indigenous patients seeking long-term care and hospice services.

This past year, we made significant strides in developing a more equitable personal support service framework that creates greater equity across the province. As a result, waitlists for personal support services have been significantly reduced and service provider organizations are prioritizing high needs patients for service. We have heard widespread appreciation for the standardized waitlist process, which facilitates seamless transitions for adult personal support service patients moving from one area of the province to another. Additionally, acceptance rates among service provider organizations have risen and the average time patients spend on waitlists has decreased. We are planning to move to a standardized provincial waitlist sharing platform, gathering valuable insights for future projects to support organizational transformation.

Modernization has also involved refining our internal practices so that patients receive consistent, high-quality care and services, wherever they call home. We have improved our patient intake process to create a seamless experience for patients, families, caregivers and health system partners. Over the past year, significant planning efforts have been underway to create a single entry point and phone number to simplify navigation to the appropriate provider, service or OHT. Through patient engagement, we have designed a more patient-centred phone system that addresses inquiries promptly and effectively. Additionally, we have established standardized provincial eligibility, information and referral policies to support provincial harmonization. We also implemented teletypewriter (TTY) Bell Relay services, guidelines for unable to contact situations, patient letters and definitions for referral priority ratings.

Over the past year, we've focused on improving the transition from hospital to home by streamlining the discharge process. A hospital principles document and standards of work for care coordinators and team assistants have been developed, incorporating patient feedback. A draft staffing algorithm for hospital support has also been developed. Work continues to develop tools for team members, patients and caregivers to support a "Home First" approach, reducing handoff gaps between care providers.

> **"From my perspective, it feels like I've called multiple numbers and I'm left wondering, 'Which one is the right one?' One of the key benefits I hope to see from a unified approach is streamlined communication. If it were simpler, like 'go to this site' or 'call this number first,' it would make the whole process so much easier to follow and understand."**
>
> — Advisor, Central Intake and Referral Project, One Number Engagement

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

- Plan and organize internal resources to position Ontario Health atHome to effectively provide operational supports for client providers.
- Work collaboratively with Ministry of Health, Ontario Health and Ministry of Long-Term Care to improve long-term care home placement in alignment with the Ministry of Long-Term Care direction, including planning for the future state model of long-term care placement functions.
- Advance the spread and scale of new models of home care delivery with health service providers.
- Work with Ontario Health, OHTs, health service providers and service provider organizations to implement the Ministry of Health's direction to update the service provider selection process and service contracts, with the goal of enhancing quality and support spreading new models of home care delivery.

We will undertake the following strategic initiatives:

1. **Develop and implement a service model and change plan for Ontario Health atHome to provide operational supports, including care coordination supports, to client providers, enabling them to provide home and community care services to the patients they serve.**

   YEAR ONE 2025-26:
   Ontario Health atHome provides services to patients, and supporting the provision of home care requires collaboration with partners across the health care system, including our service provider organizations, to develop a service model and establish an operating structure that aligns seamlessly with it. This initiative aims to enhance the ability of the service organization to support health system partners, including primary care providers, fostering the modernization of the health care system. As part of this initiative, we will develop a client relationship management model and a comprehensive service catalogue for Ontario Health atHome to provide operational supports, including care coordination, to client providers and health system partners to support them in delivering exceptional care.

   YEAR TWO 2026-27:
   - Implement client relationship management model and service catalogue.

   YEAR THREE 2027-28:
   - Evaluate and enhance client relationship management model and service catalogue.

> **"An optimal transition from the hospital... necessitates careful planning and thorough discussion involving all relevant parties. This becomes particularly crucial when the patient's medical condition is highly complex. A well-structured process should be in place, incorporating medical insights from various treatment departments to ensure a comprehensive and coordinated approach to the transition process."**
>
> — Advisor, Hospital to Home, Discharge Planning Engagement

2. **Support and implement innovative service models and clinical pathways in collaboration with OHTs, Ontario Health and other health system partners so patients receive exceptional care.**

YEAR ONE 2025-26:

By working with Ontario Health Teams and other health system partners, including long-term care, we will support and implement innovative service models to better serve patients, families and caregivers. In collaboration with the Ministry of Health, Ontario Health and OHTs we will develop integrated team-based approaches to deliver palliative home care services through members of OHTs. We will support OHTs through operational supports as outlined in a Master Support Agreement between Ontario Health atHome and client providers. We will continue to engage as an active partner in planning for the implementation of accelerated OHTs.

YEAR TWO 2026-27:

- Continue to advance innovative models and work to advance clinical pathways in collaboration with system partners.

YEAR THREE 2027-28:

- Advance efforts to support innovative models and implement clinical pathways.

3. **Continue to streamline and standardize key operational processes, including hospital discharge, intake, information & referral and navigation across the province in collaboration with system partners.**

YEAR ONE 2025-26:

We will continue to leverage best practices to ensure greater consistency in processes and service planning guidelines to provide equitable access to care for everyone in Ontario. This includes:

- Standardizing and streamlining our intake, information and referral/ navigation processes across the province for newly referred patients and integrating these services into OHTs to improve the patient experience, ensuring they meet our commitment to equity, inclusion, diversity and anti-racism.
- Streamlining the hospital discharge process across the province in alignment with the Home First Operational Guidelines released by Ontario Health in August 2024. This allows for a smooth transition from hospital to home, with a focus on timely access to home care services for patients ready for discharge.

YEAR TWO 2026-27:

- Refine and advance the implementation of standardized processes to enhance the patient experience.

YEAR THREE 2027-28:

- Evaluate the impact and effectiveness of standardized processes, refining them to improve the patient experience.

4. **Continue to standardize long-term care home placement practices, policies and procedures to improve transitions to long-term care homes and implement future state models of care.**

YEAR ONE 2025-26:

We will work actively with the Ministry of Long-Term Care and the Ministry of Health to align our initiatives with government policies, supporting patient care and adapting our services to meet health care priorities across the province. In the first year of our business plan, aligned with the timing of the pilot program, we will work closely with the Ministry of Long-Term Care to evaluate and enhance access for culturally diverse patients to long-term care homes primarily serving people of a particular ethnic, religious or linguistic origin, addressing their unique needs effectively. Additionally, we will incorporate feedback from Patient and Caregiver Experience Evaluation surveys to drive continuous improvement, helping our services evolve to better meet the needs of the communities we serve.

YEAR TWO 2026-27:

- Refine the standardization of long-term care placement practices, policies and procedures.

YEAR THREE 2027-28:

- Evaluate the impact and effectiveness of the standardized practices and future state models.

5. **Plan and implement home care integration with primary care and other system partners.**

YEAR ONE 2025-26:

To transform care effectively, collaboration is essential. Aligning with the government's direction on the Primary Care Action Team to support the goal of connecting every person in Ontario to primary health care, we are committed to deepening partnerships with primary care providers and enhancing strategies to connect individuals with comprehensive support.

Interprofessional care teams are vital in addressing complex patient needs. Our goal is to empower primary care providers by enhancing their capacity through improved system navigation and comprehensive care coordination.

We are making significant strides by expanding and standardizing our approach to aligning care coordinators within primary care settings. Currently, over 500 care coordinators are either fully embedded or aligned with family health teams. Feedback from physicians indicates these models allows them to support patients more effectively and we are committed to working together with them to expand them.

We also remain dedicated to enhancing primary care attachment through Ontario Health atHome Care Connectors. Through our Health Care Connect program, our care connectors play a crucial role matching unattached patients to primary care providers who can best meet their health care needs. Unattached patients can register by phone or online, consent to participate and complete a health questionnaire. Patients are then prioritized on a waitlist based on their health needs. Since launching in 2009, the Health Care Connect program has matched more than 670,000 unattached patients with a primary care physician.

We are working closely with Ontario Health Teams, the Ontario Medical Association, Ontario Health and the Ministry of Health to improve communication and integration with primary care. We aim to enhance understanding of care coordination and address regulatory requirements while focusing on refining intake processes, optimizing hospital discharge and preventing avoidable emergency department visits. By enhancing communication and collaboration between primary care and care coordination, we aim to provide comprehensive care that meets diverse patient needs.

YEAR TWO 2026-27:

- Build on the progress made in integrating home care and primary care, advancing efforts to ensure comprehensive support for patients.

YEAR THREE 2027-28:

- Continue to build on progress made in collaboration with primary care.

> **"[Patients] are able to be better served. We're able to respond to crisis a lot more quickly than we would if [care coordinators] weren't here in our offices. Mostly because we're able to communicate much more easily and clearly with them."**
>
> — Dr. Jason Sutherland, Family Physician, City of Lakes Family Health Team

What does this mean for patients?

At 61 years old, Rita was a retired teacher living in the suburbs, known for her active and independent lifestyle. She enjoyed her morning walks, tended to her garden and was an active member of her community.

However, Rita began experiencing frequent dizziness and fatigue. After a sudden fall at home, she was rushed to the hospital where she was diagnosed with a respiratory illness.

From the moment she was admitted, her journey was guided by a structured process designed for a smooth transition from hospital to home. Before her discharge, Rita underwent a thorough assessment, and her care coordinator developed a personalized care plan tailored specifically to her needs. This plan included medication management, physical therapy exercises to help regain her strength and regular follow-ups with a nurse.

Rita's medications were meticulously reviewed, and adjustments were made to minimize side effects and interactions, providing her with a greater sense of security. Throughout her hospital stay and recovery, her care coordinator worked diligently to keep her primary care physician informed about her condition and treatment plan, providing continuity of care. Regular communication among all team members made her transition home as seamless as possible.

Over time, Rita grew more confident in managing her condition. She appreciated knowing that a dedicated team of professionals was focused on her wellbeing, including her care coordinator and her primary care physician, and felt empowered by the consistent care and clear communication.

Six months later, Rita's health had stabilized significantly. She had not experienced any further falls or emergency room visits. Rita felt comfortable navigating her care with the support of her health care team, knowing she could count on them whenever she needed assistance.

For Rita, this journey wasn't just about recovering from a fall or managing a diagnosis. It was about feeling seen, heard and cared for every step of the way. It was about receiving a high standard of care and support, no matter where she lived. Most importantly, it was about finding comfort and confidence in her ability to live independently again, surrounded by a system that truly cared.

* Rita is a composite of patients we have heard from, and her story illustrates how a structured hospital-to-home transition, personalized care planning and ongoing support from a dedicated health care team empower individuals to recover safely and regain their independence.

How will we know that we are making a difference?

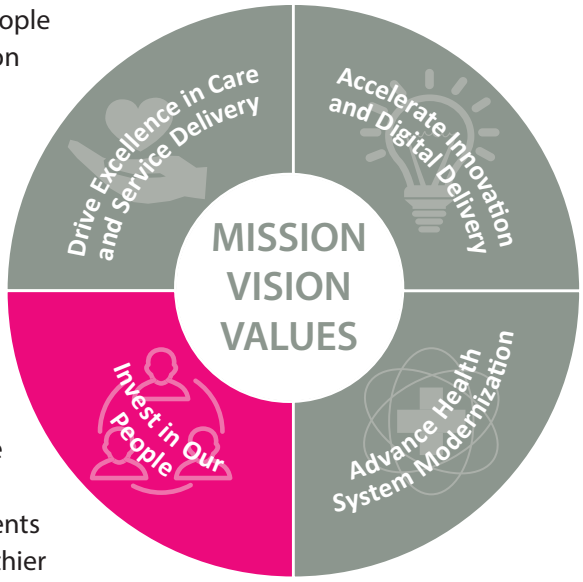
We will track the percentage of patients receiving nursing care within five days of their available date and the percentage of complex patients obtaining personal support services within the same timeframe to facilitate a smooth transition from hospital to home. Additionally, we will monitor the time taken to complete initial intake eligibility assessments and identify opportunities for improvement to minimize waiting times.

To assess the effectiveness of our service model and our commitment to being client-focused, we will implement metrics to evaluate relationships and experiences with our Ontario Health Team clients, brand awareness and service response levels.

For a complete list of indicators associated with this priority, please refer to the 'Performance Measurement' section.

Priority 4: Invest in our People

Guided by our strategic priority to invest in our people, the People Strategy is grounded in Ontario Health atHome's mission, vision and values and is our roadmap, shaping the way we lead, engage and develop our people to enhance the organization. Together, we have embarked on this journey so our people may lead and learn, partner and connect, care and be cared for as our organization faced significant change. We recognize that our people are our greatest asset and together we are helping everyone to be healthier at home through integrated and equitable care in partnership with the communities we serve.



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

Last year, Ontario Health atHome served 669,800+ people, providing care that wouldn't have been possible without the dedication of our team. From the care coordinator who met patients in the hospital or at their primary care office, to the team assistant's friendly voice on the phone keeping patients connected, to the IT professional who resolved critical network issues - each person played a vital role.

Guided by our organizational values of collaboration, respect, integrity and excellence, we are committed to helping each exceptional employee reach their full potential. This commitment is focused on four key pillars. Within each pillar, we have made significant strides forward in the third year of implementing our People Strategy:

WELLNESS, WELLBEING AND HEALTH AND SAFETY

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

Over the past year, we launched an Employee Wellness and Wellbeing initiative that introduced a Healthy Workplace Framework to guide our organization with harmonized health and safety resources and policies. Simultaneously, the Wellness Supports Change Action Team has been actively developing wellness resources for both leaders and staff as part of our Transformation change management efforts. These resources include wellness check-in guides, strategies for fostering connection and belonging within teams and various tools designed to help staff reach their full potential during this period of change. Our aim is to ensure that all employees have equitable access to wellbeing resources and support.

EFFECTIVE TEAM CULTURE

We are growing our high-performance mindset and culture of mutual respect and kindness. High-performing teams deliver exceptional results, and by creating an environment where everyone feels empowered to share their expertise and make decisions, we will achieve our goals. With the right resources in place, we can empower our teams to be more creative and focus on impactful work that benefits the patients, families and caregivers we serve.

To enhance organizational design, we have aligned roles within each portfolio with the new organizational structure. As we continue to evolve, these roles will adapt to meet emerging needs. This alignment fosters strong leadership and flexibility, creating an effective and efficient organization that supports our teams in delivering exceptional patient care.

Over the past year, we have made significant progress in harmonizing our performance and development program for non-union staff. Planning has been initiated for a standardized performance and development program for unionized employees, reflecting our commitment to continuous growth at all levels. A cross-functional team from Human Resources, Organizational Development and EIDAR, along with representatives from various departments and functions, led this initiative.

Starting in July 2024, we began the program design phase, focusing on creating a framework and practical tools that facilitate ongoing feedback, goal-setting and professional development for unionized employees. We deployed a survey to gather insights from the initial phase with non-unionized employees to inform and enhance the design for unionized staff.

We've made significant progress in harmonizing non-union total compensation, including wages and leave entitlements, to improve equity, recruitment and retention. The next phase includes implementation of a provincially harmonized benefit plan for non-union staff and moving all benefits plans to the new carriers.

Additionally, the Employee Engagement Survey project held focus groups in June 2024 to analyze themes from pulse survey results related to communication, transparency, support and resources. The insights gained will inform an action plan, which will be shared with all staff. A second and third pulse survey will be conducted to further gauge workforce engagement and perceptions during the transformation phase of our journey as Ontario Health atHome.

We've worked closely with leaders across the organization to align our teams with the six geographic regions of Ontario Health, supporting both regional coordination and provincial objectives.

REWARDING CAREERS

As the health care system continues to evolve at a rapid pace, we need to be ready to meet the needs of patients now and in the future. Being an employer of choice that attracts, develops and retains top talent will allow us to be agile, innovative and responsive to the health care needs of the communities we serve.

The Leader Education Change Action Team was created in connection with the Build Leadership Capacity project within the People Strategy to deliver a series of leadership education sessions aimed at enhancing leadership capabilities. This training equips leaders to navigate transformation, manage and lead other change initiatives.

The organization is now on a harmonized Collaborative Recruitment Initiative contract, and all areas are utilizing the iCIMS Applicant Tracking System platform.

Crucial Conversations is a leading practice, research-based standard in effective communication and is a longstanding high-demand program for staff. The implementation of this gold-standard training program will continue, with a focus on frontline patient-facing staff and people leaders.

The HR Exit Interview Program successfully transitioned to operations in April 2024, using confidential surveys and interviews to gather employee feedback. Quarterly reports deliver aggregated insights and recommendations to leadership, supporting improvements aligned with organizational goals.

EQUITY, INCLUSION, DIVERSITY AND ANTI-RACISM

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

We have made significant strides in fostering a safe and inclusive work environment. We have established a robust EIDAR structure that includes an advisory committee and Employee Resource Groups (ERGs), or staff led teams, who are actively engaged in embedding the EIDAR principles into all of our work.

Comprehensive reviews of our EIDAR framework were conducted with the support of this robust structure. Anti-Black Racism was affirmed as a starting priority with our employee-led group of Black staff and staff of African descent. Additionally, reconciliation and Indigenous inclusion have been recognized as foundational priorities.

Active relationship-building continues through significant events and speaker engagements. Internal campaigns have been organized to celebrate Indigenous History Month, National Day for Truth and Reconciliation, Pride Month and Black History Month. Staff are encouraged to enhance their knowledge and skills for effectively serving Indigenous communities through educational initiatives like the San'yas Indigenous Cultural Safety Training Program. Cultural safety training will continue, and options for Trauma-Informed Care for frontline staff will be explored.

We also recognize the importance of stabilizing and expanding the bilingual workforce to reflect both official languages while optimizing the distribution of French-speaking staff across the province to enhance access to French language services for patients in their preferred language.

Positioning us for the future

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

- Recognizing the health human resources challenges across the system, continue to focus on attracting and retaining staff to evolve the organization as we prepare for organizational transformation to serve Ontario Health Teams.
- Leverage the full potential of all staff to create a workforce that is skilled, motivated and passionate to deliver best in class service as we evolve to a service organization.

1. **The People Strategy 2024-25 has positioned Ontario Health atHome well to continue delivering on its strategic priority to invest in its people and we will continue to focus on our four pillars.**

   YEAR ONE 2025-26:

   Employee Wellness, Wellbeing and Health and Safety Programming: Create a positive, healthy and engaged workforce that supports people to care for themselves and each other.

   We are dedicated to providing a safe, healthy workplace by implementing consistent safety practices and policies, supported by our Occupational Health and Safety Centre of Excellence. Our commitment to employee wellness and wellbeing includes a structured Wellness Program and a guiding Healthy Workplace Framework ensuring a supportive environment that enhances staff wellbeing.

   Build an Effective Team Culture: continue to establish a high-performance mindset and culture of mutual respect and kindness.

   We are committed to fostering an effective team culture through a standardized performance and development program, focusing on growth, leadership education and sustainability. By streamlining our benefits under a unified plan, we ensure equity for non-union staff, enhancing our appeal as an employer of choice. Regular pulse surveys will capture employee feedback to guide ongoing change and engagement efforts, while our organizational design work will focus on optimizing teams to better support our services. This alignment of compensation, benefits and practices will continue through 2025-26.

Provide Rewarding Careers: Recognize the incredible work of our talented team, stabilize our workforce, and attract, develop and retain exceptional people.

Building on the foundations of LEADS and Change Leadership education from 2024-25, we will enhance leadership development through customized training, timely tools, resources and interventions. These initiatives will empower leaders to support their teams throughout our transformation journey.

We are committed to attracting and retaining top talent to effectively support health system modernization and service OHTs across the province. As we navigate organizational changes, we will equip leaders to lead the change and encourage staff engagement

Our People Strategy centers on positioning our workforce where we are needed most.

Equity, Inclusion, Diversity and Anti-Racism (EIDAR): Advance a culture of equity, inclusion, diversity and anti-racism and work to eliminate systemic barriers to under-represented racialized groups.

In 2025-26, we will enhance our strategic implementation of EIDAR across the organization while empowering staff to drive progress. We will prioritize foundational EIDAR actions and initiatives that will promote the sustainability of our efforts, including:

- Developing strategies to address anti-Black and anti-Indigenous racism
- Building organizational capacity for effective EIDAR implementation
- Strengthening our measurement approach to track EIDAR progress
- Harmonizing resources to promote inclusive, equitable and anti-racist interactions

Our EIDAR Framework drives our commitment to equity, inclusion, diversity and anti-racism across all aspects of our work. Through education, resource development and leadership support, we aim to embed EIDAR in daily interactions and decision-making, fostering an inclusive culture. Progress will be measured and refined based on feedback from staff, patients, families and caregivers to ensure sustainable, impactful change.

YEAR TWO 2026-27:

- Refresh and communicate the People Strategy for the new fiscal year ensuring alignment with organizational goals.
- Identify and launch new initiatives that align with the strategy.
- Continue advancing initiatives that span multiple fiscal years maintaining progress and evaluating their impact.
- Monitor Human Resources, Organizational Development and EIDAR metrics using established dashboards to inform decision-making and ensure continuous improvement.

YEAR THREE 2027-28:

- Refresh and communicate the People Strategy for the new fiscal year ensuring alignment with organizational goals.
- Identify and launch new initiatives that align with the strategy.
- Continue advancing initiatives that span multiple fiscal years maintaining progress and evaluating their impact.
- Monitor Human Resources, Organizational Development and EIDAR metrics using established dashboards to inform decision-making and ensure continuous improvement.

2. **Apply the *Public Sector Labour Relations Transition Act, 1997* (PSLRTA) to define new bargaining units and determine union representation for Ontario Health atHome.**

YEAR ONE 2025-26:

In the coming year, we will continue to apply the processes provided for in the *Public Sector Labour Relations Transition Act, 1997* (PSLRTA) following the creation of Ontario Health atHome as a single organization. This development triggers the need to establish new bargaining units and determine which unions will represent each unit. The process has already begun and will involve close collaboration with unions and other involved groups to support a smooth and effective transition. As we proceed with PSLRTA activities, we will focus on transparent communication and cooperation to facilitate the restructuring and meet the requirements of the Act throughout the year.

YEAR TWO 2026-27:

- Continue to work through each phase of the PSLRTA process

YEAR THREE 2027-28:

- Continue to work through each phase of the PSLRTA process

What does this mean for patients?

Sam*, a 52-year-old Two-Spirit member of a remote First Nations community in Northern Ontario, whose pronouns are they/them, had long embraced their cultural heritage and role in the community. However, seeking medical care outside the reserve had often been isolating. The health care system didn't always recognize their Two-Spirit identity or traditional beliefs, making Sam hesitant to seek treatment for chronic pain and diabetes.

This changed when Sam was connected with an Indigenous care coordinator from Ontario Health atHome who understood both clinical and traditional healing practices. From the start, Sam felt respected and supported. Sam's patient record in CHRIS respected their Two-Spirit identity and the care plan incorporated both Western medicine and traditional healing, with guidance from local Elders.

The care coordinator collaborated with Two-Spirit Elders to create a culturally safe space for Sam to discuss their health and identity. This blend of cultural support and medical care empowered Sam, as their identity and traditions were honored throughout their treatment.

Six months into the program, Sam's health had improved significantly. Their blood sugar levels were stable, and their chronic pain was more manageable. More importantly, they felt a deep sense of belonging and safety within the health care system for the first time. Sam knew they could rely on their care team, who honored both their medical needs and their cultural identity.

For Sam, this journey wasn't just about managing diabetes or easing pain—it was about receiving care that truly respected their whole being. They had found a path forward that balanced tradition and modern care, allowing them to thrive in their community and live a life of dignity, health and cultural pride.

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

How will we know that we are making a difference?

Supporting our workforce is essential to delivering high-quality health care services, which is why we prioritize tracking the effectiveness of our initiatives to ensure they achieve the intended results and contribute to workforce stabilization. We will continue to monitor key metrics, such as voluntary turnover due to retirement or resignation, and use insights from Employee Engagement Surveys to shape actionable plans with measurable outcomes.

For a comprehensive list of indicators related to this priority, please refer to the 'Performance Measurement' section of the plan. Key metrics include voluntary turnover rate and the employee engagement index.

Performance measurement

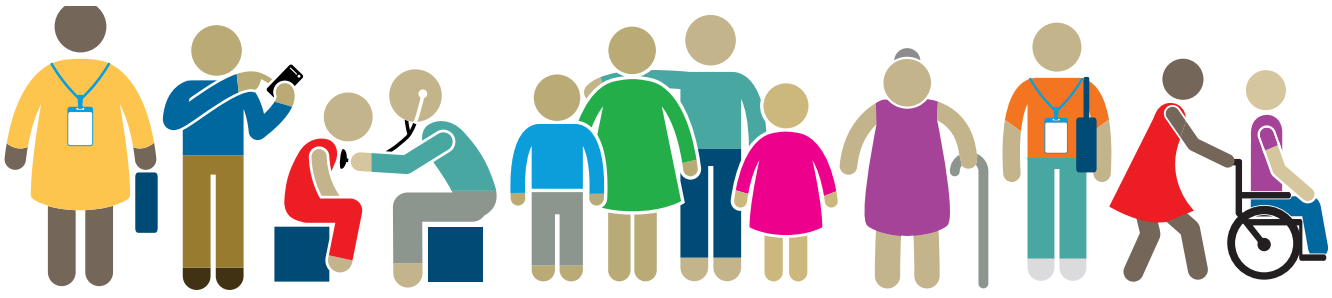
As a critical part of the health care system, we are accountable to the partners, patients, families and caregivers we serve daily. To drive continuous improvement and support the quintuple aim of improving population health, enhancing the care experience, reducing costs, addressing clinician burnout and advancing health equity, we use performance measures as a baseline with clear targets to assess how well we meet our organizational goals. Each initiative under our strategic priorities is monitored using performance indicators to track progress.

Delivering high-quality home and community care, as well as long-term care home placement, is crucial. To maintain consistent care standards across Ontario, we adhere to the Ontario Health atHome – Ontario Health Service Accountability Agreement, which sets performance and quality benchmarks. Additionally, the provincial Client Services Contract Performance Framework defines standards for all partner service providers, with contracts specifying the performance targets they must meet. To support improved patient outcomes, Ontario Health atHome engages with leadership from service provider organization to review performance and quality and assess risk within the system.

By adhering to these frameworks, we can measure and improve the quality of care delivered across the province. Our continuous monitoring and reporting will focus on:

- Patient and caregiver experience in accessing and receiving care.
- How we care for the patients we serve and support caregivers in their role.
- How we leverage digital technologies to provide care.
- Wait times for providing patient care in various home and community settings.
- How we support our workforce in delivering quality health care services.

(Chart on next page.)



Improvement Direction Arrows:
We are committed to improving all our priorities by working toward the targets we have set for each metric. An upward-pointing arrow indicates that we are aiming to increase that metric, while a downward-pointing arrow indicates that improvement is achieved by reducing that metric.

Strategic Priorities and Performance Measurement

Drive excellence in care and service delivery

Indicator	Baseline	Target	Improvement Direction
Caregiver Distress – Percentage of long- stay patients whose caregiver has indicated experiencing caregiver distress, broken out by adult long-stay patient populations (community independence, chronic and complex).	FY 24/25 Q3 (Avg) Complex: 74.9 % Chronic: 45.4% Community Independence: 18.6%	Monitor Results	
Service Waitlists – The volume and percentage of patients waitlisted compared to total patients authorized for service, by service type (nursing, personal support and therapy).	FY 24/25 Q3 YTD (Dec. 31, 2024 Snapshot) Nursing: 285 (0.3% of all Nursing) PSS: 1,585 (1.1% of all PSS) Therapy: 6,820 (12.8% of all Therapy) Combined: 8,690 (3.9% of all combined services)	Monitor Results	
Missed Care – Measures the incidence of care that is not provided in accordance with the patient care plan because a visit is missed or the service provider organization does not have the capacity to deliver the care, broken out by service type (nursing visits, nursing shift, personal support hours and therapy visits).	FY 24/25 Q3: Visit Nursing: 0.03% Shift Nursing: 0.60% PSS: 0.20% Therapy: 0.04%	0.05%	
Patient and Caregiver Experience Survey – Overall assessments of the care and services provided to patients, as well as the support available to caregivers.	FY 24/25 Q3: Patient Experience Score: 92% Caregiver Experience Score: 63%	Establish Baseline	
Caregiver Voice Palliative Care Survey – Overall assessments of the care and services provided to patients receiving palliative care in the final three months of life. Surveys completed by bereaved caregivers.	FY24/25 Q3 Overall score: 92%	Establish Baseline	

Accelerate Innovation and Digital Delivery

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

Advance Health System Modernization			
Indicator	**Baseline**	**Target**	**Improvement Direction**
5 Day Wait Time - Personal Support for Complex Patients – Percentage of adult complex patients who receive their first personal support service within 5 days of patient's available date.	FY 24/25 Q3 87.0%	95%	↑
5 Day Wait Time - Nursing Visits – Percentage of adult patients who receive their first nursing visit within 5 days of patient's available date.	FY 24/25 Q3 90.7%	95%	↑
Crisis-Designated Patients as a Percentage of All Patients Waiting for LTC Placement – Crisis designated patients as a percentage of all patients waiting for long-term care placement from community, hospital and long-term care.	FY 24/25 Q3 YTD (Dec. 31, 2024 Snapshot) Community – 7.1% (3,084 of 43,149) Hospital – 42.7% (2,632 of 6,158) Long Term Care – 5.2% (1,070 of 20,457) Combined – 9.7% (6,786 of 69,764)	Monitor Results	↓
Percentage of Crisis-Designated Patients Waiting for LTC Placement from Community, Hospital and Long-Term Care – The percentage of crisis-designated patients waiting for long-term care placement, split by patients from community, hospital and long-term care.	FY 24/25 Q3 (Dec. 31, 2024 Snapshot) Community 45.5% (3,084 of 6,786) Hospital 38.8% (2,632 of 6,786) Long Term Care 15.8% (1,070 of 6,786)	Monitor Results	To be determined
Volume of Open ALC Cases with a Home Discharge Destination – The number of patients waiting in an inpatient hospital bed who do not require the intensity of resources/services provided in that care setting whose discharge is delayed due to lack of availability of resources/services at their discharge destination.	FY 24/25 Q3 430 (11.8% of all open ALC cases)	500 or 10% of all open ALC cases	↓
Average Length of Stay in ALC for Patients Designated ALC Waiting for Home Care – Measures the average Length of Stay (LOS) for ALC Open Cases from ALC designation date to a specified point in time (e.g. last day of the reporting month)	FY 24/25 Q3 25 Days	To be determined	↓
OHT customer experience feedback survey	To be determined	To be determined	To be determined

Invest in Our People			
Indicator	**Baseline**	**Target**	**Improvement Direction**
Voluntary Turnover – Percentage of employees who leave the organization voluntarily, either through retirement or resignation.	FY23/24 Year-end 8.8%	10.5% Year-end target	↓
Employee Engagement Index – comprised of six questions from the Employee Engagement Survey.	FY23/24 Q4 72%	78%	↑

** **Monitoring indicators:** Targets have not been set for indicators where performance is shared across multiple system partners. These measures are monitored to support accountability for Ontario Health atHome's role and to inform continuous improvement.

Summary

We remain dedicated to meeting the evolving needs of patients, families and caregivers within Ontario's health care system. Following our successful transition to Ontario Health atHome, this plan outlines how we will work closely with partners, our Community of Advisors and staff throughout transformation to become a world-class service organization.

Our strategic priorities will guide our efforts to fulfill our mandate, aligning with our organization's mission and vision. Our core values will drive us to engage meaningfully and proactively with patients, families, caregivers, staff and system partners. This collaborative approach has resulted in a robust and innovative plan that reflects the voices and experiences of those we serve.

As we continue to navigate the evolving health care landscape, we remain committed to providing exceptional care for all patients, wherever they call home. Our focus will be on enhancing the quality of care by partnering with OHTs, so that patients, family and caregivers receive the support they need.

Appendix:
By the numbers

Ontario Health atHome supports 669,800+ home and community care patients annually. The services we provide are vital to patients across the province. They address the needs of people of all ages, including seniors, persons with physical disabilities and chronic diseases, children and others who require ongoing health and personal care to live safely and independently in the community. The patients we serve are some of the most vulnerable in the province.

Our organization:

- Has a total funding allocation of **$4.3B**.
- Served **669,800+** patients in 2024-25.
- Directly employ **9,200+** staff positions.
- Purchase **$3B services** from over **150 service provider organizations** via approximately **400 contracts** (this includes services such as nursing and personal support, as well as hospices and medical vendors).

In addition:

- **Each day,** there are 10,600+ care coordinator interactions, comprised of face-to-face, telephone and virtual connections.
- **Each day,** we operate 140+ nursing clinics that receive more than 348,100+ visits per quarter (three-month period).
- **Each day,** there are more than 29,500+ nursing visits, 4,400+ therapy visits and 112,400+ personal support worker (PSW) service hours delivered to patients across the province.
- **Each month,** care coordinators collectively have 344,500+ active patients on their caseload.
- **Each year,** through our services, approximately 26,800+ people are placed in long-term care (LTC) homes.

OUR ORGANIZATION:

$4.3B
Funding

669,800+
Patients

9,200+
Staff

$3B
Services

IN ADDITION:

Each day
29,500+ nursing
4,400+ therapy visits
112,400+ PSW service hours

Each day
140+ nursing clinics
Each quarter
348,100+ patient visits to the clinics

Each Month
344,500+ patients

Each Year
approximately 26,800+ LTC home placements

Appendix: Risk and mitigation

This section outlines the key organizational risks facing Ontario Health atHome in delivering on our plan and the associated mitigation strategies. Over the course of the 2025-26 fiscal year, we will continue to develop appropriate province-wide frameworks and processes to effectively assess and monitor hazards we face to avoid any potential risk to the patients we serve and staff who care for those patients.

Risks Facing Ontario Health atHome	Existing Controls and Planned Mitigation Actions
Ontario Health atHome organizational change impacts to workforce and patient care Operations face significant risk due to recruitment and retention challenges, which could compromise patient care and quality. These challenges stem from uncertainties about role changes as we transform into a provincial shared service organization with an evolving mandate. Recruitment is further hindered in some geographic regions by limited workforce availability. Additionally, staff workload pressures and change fatigue are affecting the ability to perform at optimal levels. Voluntary exits across all levels of the organization are contributing to vacancies, which are often challenging to fill, putting additional strain on remaining staff and service delivery. While staffing challenges are improving, there remains a risk that the organization may still struggle to optimally support Ontario Health Teams. Limited capacity to efficiently manage operations and allocate resources to Ontario Health Teams may hinder our ability to fully leverage economies of scale, affecting overall effectiveness and efficiency.	We aim to mitigate this risk by advancing key initiatives from our People Strategy, focusing on workforce stabilization, prioritizing change management and supporting staff through the transformation of Ontario Health atHome. Our efforts will target recruitment, a robust retention campaign and staff recognition through an employee engagement action plan and the continuous application of change management strategies. Proactively assessing staffing needs, ensuring dedicated resources and implementing appropriate structures will be critical for a smooth transition to a service organization that benefits both staff and the patients, families and caregivers we serve. To address resource limitations, we will also consider contracting for essential services as demand escalates, ensuring continuity of care and operational effectiveness. Ongoing engagement with the Ministry of Health, Ontario Health and Ontario Health Teams, alongside with a strong communication and engagement plan, will help meet partner expectations throughout transformation.
Annual fall/winter surge cycle Each year, the health care system navigates the challenges of the fall and winter surge, facing increased pressures on capacity due to flu, RSV and COVID. A limited supply of long-term care beds means many patients designated as alternative level of care (ALC) remain in hospital, adding to the demand for home care to support patients outside acute settings. At the same time, health human resources constraints in hospitals, coupled with capacity and clinical specialization challenges among service providers in some regions, create a potential risk. The widespread surge across numerous acute care hospitals could impact the ability to maintain the same level of care, potentially affecting home care patients who rely on these essential services.	To manage increased pressures on the health care system during the fall and winter surge, a coordinated approach is implemented across hospitals, long-term care and home care. Surge field documents support hospital leadership and front-line staff, providing guidance on leadership processes, optimizing LTC placements for ALC patients and maintaining situational awareness. Service provider organizations discharge stable patients who have met their goals of care to create additional capacity, while community care coordinators review and confirm long-term care crisis designations and discharge community patients who no longer require services, particularly in areas with waitlists. Hospitals leverage high intensity supports at home and enhanced service programs to transition patients home, prioritize long-term care admissions for ALC patients and support families and caregivers in selecting long-term care homes with short waitlists, in alignment with Bill 7 legislation. These strategies help reduce strain on acute care settings, enhance home care capacity and support patients in receiving the right care in the right place.

Risks Facing Ontario Health atHome	Existing Controls and Planned Mitigation Actions
CHRIS degradation with potential for failures and outages CHRIS is the primary information hub for Ontario Health atHome and is set to expand to the seven leading projects. With the continued growth in patient care and system users, including increased staffing, there is a risk of system degradation or outages, which could impact the ability to sustain effective and critical patient service operations. As a legacy system, identifying and addressing the root cause of functionality issues, degradation or outages can be complex, making proactive monitoring and mitigation essential to maintaining seamless care delivery.	The CHRIS system is essential to delivering patient care services, particularly during surge periods when stable system performance is critical to maintaining smooth patient flow from hospital to home and supporting home and community care referrals. As reliance on CHRIS continues to grow, along with the upcoming onboarding of OHTs, we are prioritizing the development of a formalized Business Continuity and Disaster Recovery Plan. This plan will incorporate robust failover measures to safeguard operations, minimize service disruptions for Ontario Health atHome and ensure a seamless transition for future OHT integrations. We are also collaborating with Ontario Health to support the development of a digital roadmap that will strengthen and modernize our digital infrastructure for the future.
Ongoing risk of cyber security and privacy breaches in the health care industry Ontario Health atHome faces significant cyber security risks due to the sensitive nature of patient data and the increasing reliance on technology, digital health platforms and further integration of digital health systems.	To mitigate this risk, we continue to implement robust strategies and security controls across the province, continually strengthening existing processes for security monitoring, incident identification and management. We continue to enhance and support the growth and maturity of our Security Program concurrently promoting a cyber-security awareness and training culture. We continue to work with our health system partners to ensure that appropriate security controls and agreements are in place to allow for seamless and safe data sharing across integrated digital platforms.

Appendix: Communications & engagement plan

Our communications and engagement activities are essential for achieving the goals outlined in our four strategic priorities and supporting the transformation of Ontario Health atHome as a service organization. Dedication to our mission, vision and values, and a strong commitment to high-quality patient-centred care, will guide our communications activities as we engage with diverse communities across the province and maintain our strong commitment to equity, inclusion, diversity and anti-racism in all that we do.

Targeted engagement opportunities will support the development of a unified vision and service model for Ontario Health atHome. This work will be driven by a comprehensive engagement plan that harnesses innovative and transformative ideas from key partners, including internal staff, Community of Advisors and partners from Francophone and Indigenous communities, as well as the broader health system. The insights gathered will shape Ontario Health atHome's structure and operating model, positioning us to effectively meet the needs of Ontario Health Teams and the patients and communities we serve together.

OUR PARTNERS

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

COMMUNICATIONS OBJECTIVES

- Provide patients, families and caregivers with relevant and timely information about services from a trusted source.
- Raise awareness of our services and how to access them, while navigating "who we are" throughout home care transformation.
- Keep staff, patients, families, caregivers, service providers and other health system partners informed as we transform into a single service organization that coordinates home care delivery.
- Focus on communicating continuity of care for all home care patients, families and caregivers throughout transformation and in general, the government's plan for home care modernization.
- Engage with patients, families, caregivers and populations with diverse needs to further integrate the patient experience and voice into organizational and transformational decision-making and through co-design, ensure all outcomes meet the specific needs of the communities we serve.
- Build awareness and trusted relationships with all community members and partners, particularly patients, families, caregivers and priority or marginalized populations.
- Uphold our commitment to be open, transparent and accessible to the public on all Ontario Health atHome priorities and initiatives, while keeping our community engaged and informed about any changes to their home care delivery.
- Keep staff informed about new (or changed) programs, initiatives and policies/processes that impact their jobs or the delivery of patient care while promoting our transition to a single service organization.
- Develop and implement communications and change management strategies to support organizational programs and initiatives, our four strategic priorities and home care transformation.
- Engage and collaborate with the Ministry of Health, Ontario Health and Ontario Health Teams to produce and distribute consistent communications materials and messaging.
- Attract and recruit staff through our Employment Brand strategy, as well as support workforce stabilization.
- Develop and implement an effective process for the identification, assessment and mitigation of reputational risk.

COMMUNICATIONS TACTICS

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

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

ENGAGEMENT PLAN

Community engagement is a fundamental function and core value of Ontario Health atHome, playing a vital role in delivering high-quality care that aligns with the needs of the populations we serve.

The goal of community engagement is to "positively shape exceptional patient-centred home and community care programs, services and policies through purposeful collaboration and partnership among patients, families, caregivers and staff." By fostering collaboration and actively involving individuals with lived experience, we can achieve these objectives and guarantee that our services remain **relevant, beneficial and aligned with the needs, priorities and values of the patients we serve.**

In 2023-24, our Community of Advisors contributed 338 hours of volunteer participation through 38 unique engagement activities, including focus groups, surveys, one-on-one interviews and the inaugural Ontario Health atHome Priorities Panel. This panel facilitated discussions between leadership and Advisors on system transformation and hospital-to-home discharge planning, a strategic initiative that remains a key focus.

Guided by our **Community Engagement Framework,** and with the Community Engagement program now in its third year, the Community Engagement plan will focus our efforts on the following:

- **Supporting Strategic Initiatives:** Continue to support system transformation and strategic initiatives as outlined in the ABP
- **Community of Advisors:** Expand our roster of volunteer Advisors with an emphasis on recruiting underrepresented communities
- **Strengthen Relationships:** Explore opportunities to strengthen relationships with community groups and partners, including Indigenous Health Networks and French Language Health Planning Entités

Through our engagement efforts, we are committed to listening to vulnerable communities. This approach allows us to build a more responsive, patient-centred organization that effectively addresses health disparities while providing excellent and equitable access, experiences and outcomes for the people of Ontario.

The 2025-26 fiscal year will bring a renewed focus on developing lasting relationships with Indigenous leaders and communities as we set out to build our self-awareness and connection with Indigenous peoples. We will focus on listening, learning and building trust over the coming year to better understand the unique challenges faced by Indigenous communities. This will be a collaborative effort with key members of Ontario Health atHome, including leadership and EIDAR staff. We will continue to engage with Francophone communities to gain insights into their unique needs and challenges. To support this effort, we will maintain active offer training and reporting to facilitate access to care in patients' first language throughout their entire health care journey.

Appendix: Financials

The following spending plan identifies the resources, including financial and capital, that Ontario Health atHome will use to meet our goals and objectives:

	2024-25 Estimated Actuals	2025-26 Ministry Allocation (via Ontario Health)	2025-26 Planned Expenses[1]	2026-27 Planned Expenses[1]	2027-28 Planned Expenses[1]
Home Care[2]					
Salaries (Worked hours + Benefit hours cost)	$634,824,264	$689,774,018	$689,774,018	$690,261,900	$729,718,000
Benefit Contributions	$182,405,736	$198,194,594	$198,194,594	$208,438,100	$220,334,000
Med/Surgical Supplies & Drugs	$191,165,000	$194,849,900	$194,849,900	$209,330,000	$230,263,000
Supplies & Sundry Expenses	$16,033,006	$16,033,006	$16,033,006	$19,989,068	$22,158,820
Equipment Expenses	$32,237,093	$32,812,193	$32,812,193	$35,692,213	$39,256,470
Amortization on Major Equip, Software License & Fees	-	-	-	-	-
Contracted Out Expense	$3,243,145,000	$3,451,369,397	$3,451,369,397	$3,742,800,000	$3,992,281,000
Buildings & Grounds Expenses	-	-	-	-	-
Building Amortization	-	-	-	-	-
TOTAL: Home Care	**$4,299,810,099**	**$4,583,033,108**	**$4,583,033,108**	**$4,906,511,281**	**$5,234,011,290**
Integrated Administration / Governance[3]					
Salaries (Worked hours + Benefit hours cost)	$89,934,451	$75,045,136	$75,045,136	$83,444,900	$83,444,900
Benefit Contributions	$25,085,949	$20,932,784	$20,932,784	$24,525,100	$24,525,100
Med/Surgical Supplies & Drugs	-	-	-	-	-
Supplies & Sundry Expenses	$26,659,917	$16,067,449	$16,067,449	$15,020,700	$15,020,700
Equipment Expenses	$17,463,624	$10,525,010	$10,525,010	$3,257,000	$3,257,000
Amortization on Major Equip, Software License & Fees	$598,820	$359,054	$359,054	$323,553	$323,553
Contracted Out Expense	$1,123,166	$1,129,576	$1,129,576	$0	$0
Buildings & Grounds Expenses	$26,003,165	$30,409,053	$30,409,053	$27,685,716	$27,685,716
Building Amortization	$625,511	$375,057	$375,057	$566,149	$566,149
TOTAL: Integrated Administration/ Governance	**$187,494,602**	**$154,843,119**	**$154,843,119**	**$154,823,119**	**$154,823,119**
TOTAL: OH atHome SPENDING PLAN	**$4,487,304,701**	**$4,737,876,227**	**$4,737,876,227**	**$5,061,334,400**	**$5,388,834,409**

Financials for 2025-26 onwards are forecasted based on assumed Ministry funding commitments and are not a projection of program need or ultimate utilization. Actual funding, including in outyears, may differ and will be reported through the Annual Report.

1. Planned Expenses cannot exceed the Ministry's Allocation.
2. Home Care Delivered Services includes direct services as defined in the MOH-OH amending agreement 289 where funds were transferred from MOH to OH.
3. Integrated Administration/Governance includes indirect costs such as administration and overhead expenses.

Appendix:
Health human resources

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

In addition, our staffing is comprised of both non-union and union employees, who are represented under 27 unique collective agreements across the province. There are five bargaining agents that represent these employees including Ontario Nurses' Association (ONA), Canadian Union of Public Employees (CUPE), Ontario Public Service Employees Union (OPSEU), Canadian Office and Professional Employees (COPE) and UNIFOR.

We want to support our staff with growth and development opportunities as we continue to navigate change, transform and evolve as a single service organization. Our People Strategy is the roadmap that keeps us focused on meeting the immediate and long-term requirements of staff throughout our transformation. Some of the priorities of the plan include:

- Redesigning and implementing an organizational structure that enables us to function effectively as one provincial team and a single service organization;
- Renewing our focus on attracting and retaining a talented workforce;
- Implementing an Organizational Development Strategy to ensure staff and change management support through transformation;
- Strong focus on labour relations as the *Public Sector Labour Relations Transitions Act, 1997* is enacted for our transition to Ontario Health atHome;
- Integrating Ontario Health atHome staff with Ontario Health Teams to promote the success of new integrated team-based care models;
- Fostering and advancing a culture of equity, diversity, inclusion and anti-racism;
- Creating engagement opportunities for our staff; and
- Supporting education and growth opportunities.

Agencies and Appointments Directive (AAD) Head Count FTE

In alignment with the AAD, Ontario Health atHome reported Active FTE as of December 31, 2025:

Executive:		5.0
Management:		594.93
Employee:		7411.23
Total		**8011.16**
Consultant:		0.0
Based upon the above data Active FTE:		
Unionized staff (approx.)	88%	7049.82
Non-Union staff (approx.)	12%	961.34

Appendix:
Three year plan overview

Strategic Priority 1: Drive Excellence in Care and Service Delivery		
Year 1 (2025-26)	**Year 2 (2026-27)**	**Year 3 (2027-28)**
Continue the implementation of improved efficiency and system capacity initiatives that began in 2022-23 in collaboration with service provider organizations, including engagement with these organizations to review performance and quality and assess risks.	• Build on initiatives to reduce unnecessary emergency department visits, support timely hospital discharges and enhance access to services	• Continue to build on initiatives to create additional patient and caregiver supports
Build new capacity through expansion and standardization of Family-Managed Home Care, while exploring additional supports for caregivers to ensure patients and caregivers across the province have access to the program and a consistent care experience and to transition the program to a single funding model introduced in 2024.	• Engage patients and caregivers in the design of initiatives to provide caregiver support and ease caregiver responsibilities.	• Use patient and caregiver experience data to guide improvements and establish caregiver support systems.
Implement standardized quality and safety processes rooted in best practices and outcome measures to support timely and equitable delivery of care. Foster collaboration with service provider organizations on quality improvement and risk mitigation strategies to promote patient safety while incorporating the voice of the patient.	• Complete accreditation process through an external review to promote transparency and quality improvement. • Act on patient and caregiver experience survey responses.	• Embed continuous improvement strategies to enhance ongoing excellence in care delivery.
Continue standardization of business support services for increased efficiency and effectiveness to support timely and equitable delivery of care considering broad system level impact of any potential changes aligned to the future model of care through the OHTs.	• Enhance coordination among teams to improve the delivery of care provided to patients and services provided to OHTs.	• Continue to make improvements to service delivery models.

Strategic Priority 2: Accelerate Innovation and Digital Delivery		
Year 1 (2025-26)	**Year 2 (2026-27)**	**Year 3 (2027-28)**
Implement a Digital Plan in alignment with the Ministry of Health's Digital Strategy to increase efficiency, effectiveness and improve patient experience and outcomes.	• Explore and pilot more effective ways to integrate health system portals, digital interfaces and other digital tools to improve the patient experience.	• Refine and promote the use of digital tools to support integrated care to improve patient experiences and interactions between patients and service providers.
Collaborate with Ontario Health and health system partners to procure a digital wound care platform and develop a plan to lead the implementation of the procured platform.	• Implement province-wide plan for a digital wound care platform.	• Evaluate the impact of the digital wound care platform by collecting qualitative and quantitative feedback from health care providers and patients.

Strategic Priority 3: Advance Health System Modernization		
Year 1 (2025-26)	**Year 2 (2026-27)**	**Year 3 (2027-28)**
Develop and implement a service model and change plan for Ontario Health atHome to provide operational supports, including care coordination supports, to client providers to enable them to provide home and community care services to their own patients.	• Implement client relationship management model and service catalogue	• Evaluate and enhance client relationship management model and service catalogue
Support and implement innovative service models and clinical pathways in collaboration with OHTs, Ontario Health and other health system partners so patients receive exceptional care.	• Continue to advance innovative models and work to advance clinical pathways in collaboration with system partners.	• Advance efforts to support innovative models and implement clinical pathways.
Continue to streamline and standardize key operational processes, including hospital discharge, intake, information & referral and navigation across the province in collaboration with system partners by leveraging best practices to ensure consistency and improve the patient experience considering broad system level impact of any potential changes aligned to the future model of care through the OHTs.	• Refine and advance the implementation of standardized processes to enhance patient experience.	• Evaluate the impact and effectiveness of standardized processes, refining them to improve the patient experience.
Continue to standardize long-term care home placement practices, policies and procedures to improve transitions of persons to long-term care homes and implement future state models of care. Support efforts to evaluate and improve access for cultural patients to culturally designated long-term care homes in collaboration with the Ministry of Long-Term Care.	• Refine the standardization of long-term care home placement practices, policies and procedures.	• Evaluate the impact and effectiveness of the standardized practices and future state models.
With system partners such as the Ministry of Health, Ontario Health, OHTs and the Ontario Medical Association, plan and implement Home Care Integration with Primary Care through deepened relationships with primary care providers and enhance strategies to connect individuals with comprehensive support. Align with the government's Primary Care Action Team to further efforts towards ensuring everyone in Ontario has access to primary health care.	• Build on the progress made in integrating home care and primary care, advancing efforts to ensure comprehensive support for patients	• Continue to build on progress made in collaboration with primary care.

Strategic Priority 4: Invest in Our People		
Year 1 (2025-26)	**Year 2 (2026-27)**	**Year 3 (2027-28)**
Continue to implement the four pillars of our People Strategy: **Wellness, Wellbeing Health and Safety** Create a positive, healthy, and engaged workforce that supports people to care for themselves and each other. **Effective Team Culture** Continue to establish a high-performance mindset and culture of mutual respect and kindness. **Rewarding Careers** Recognize the incredible work of our talented team, stabilize our workforce, and attract, develop and retain exceptional people. **Equity, Inclusion, Diversity and Anti-Racism (EIDAR)** Advance a culture of equity, inclusion, diversity and anti-racism and work to eliminate systemic barriers to under-represented racialized groups.	• Refresh and communicate the People Strategy for the new fiscal year ensuring alignment with organizational goals. • Identify and launch new initiatives that align with the strategy. • Continue advancing initiatives that span multiple fiscal years maintaining progress and evaluating their impact. • Monitor Human Resources, Organizational Development and EIDAR metrics using established dashboards to inform decision-making and ensure continuous improvement.	• Refresh and communicate the People Strategy for the new fiscal year ensuring alignment with organizational goals. • Identify and launch new initiatives that align with the strategy. • Continue advancing initiatives that span multiple fiscal years maintaining progress and evaluating their impact. • Monitor Human Resources, Organizational Development and EIDAR metrics using established dashboards to inform decision-making and ensure continuous improvement.
Apply the *Public Sector Labour Relations Transition Act, 1997* (PSLRTA) to define new bargaining units and determine union representation for Ontario Health atHome.	• Continue to work through each phase of the PSLRTA process	• Continue to work through each phase of the PSLRTA process

Appendix:
Acronyms used

ACRONYM	MEANING
AI	Artificial Intelligence
ALC	Alternate Level of Care
CHRIS	Client Health and Related Information System
CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
COPE	Canadian Office and Professional Employees
CUPE	Canadian Union of Public Employees
EIDAR	Equity, Inclusion, Diversity and Anti-Racism
ERG	Employee Resource Group
GIS	Geographic information system
LTC	Long-term care
OHT	Ontario Health Team
ONA	Ontario Nurses Association
OPSEU	Ontario Public Service Employees Union
PHIPA	Personal Health Information Protection Act
PSLRTA	Public Sector Labour Relations Transition Act

Exceptional care – wherever you call home.

Ontario Health atHome coordinates in-home and community-based care for thousands of patients across the province every day.

For information and referrals related to home and community care or to learn more about long-term care home placement services, please call 1-833-515-1234.

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