Home and Community Care Support Services

Consolidated Annual Report: 2021-2022

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Ontario

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Consolidated Home and Community Care Support Services Annual Report 2021-22
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Message from the Board Chair

On behalf of the Home and Community Care Support Services Board of Directors, it is my pleasure to present our 2021-2022 Annual Report, our first as unified organizations. We began this journey together on April 1, 2021, when we officially became known as Home and Community Care Support Services. Then, on July 1, I began my tenure as Board Chair. Since that time, we have made major strides, not only in acting as one unit, province-wide, serving all people across Ontario, but in advancing the goals we set for ourselves in our first Annual Business Plan.

In that Plan, we laid out a set of Strategic Priorities designed to drive us towards fulfillment of our Mission and Vision. These Strategic Priorities—Drive Excellence in Care and Service Delivery; Accelerate Innovation and Digital Delivery; Advance Health System Modernization; and Invest in our People—have set us on a course that involves working with partners to ensure all patients receive the services they need, where and when they need them, as well as supporting the ongoing work of transforming home and community care to deliver equitable services across Ontario.

Over the past year we have worked with partners to fulfill the role set out for us by the Minister of Health in our priorities letter, striving to increase network collaboration, improve patient access to care, facilitate the successful integration of home and community care support services within the broader health system and innovate and improve service while maintaining constant vigilance on our spending. It is our progress across all these areas that you will find detailed within the pages that follow, and we are particularly proud of our organizations having made such strides all while continuing to operate within the complex reality of an ongoing global pandemic.

As we worked to deliver on these Strategic Priorities, we collaborated with health system partners, including long-term care homes, hospitals and primary care providers, to build a more connected, patient-centred health care system that is efficient and sustainable. And, as we committed to doing in our Annual Business Plan, we ensured this work was grounded in the principles of equity, inclusion, diversity and anti-racism, reflecting and responding to the needs of our diverse population. Ensuring that our services are culturally appropriate and safe for the Indigenous, Francophone, Black and other marginalized communities we serve is one of our top priorities, as is ensuring that all Ontarians, regardless of where they live, have access to the same high-quality care and services.

In this report you will read what we have accomplished to date in fulfilling our commitment as a Board to ensuring efficiency, effectiveness and value for money for patients and taxpayers in all that we do. It is a commitment that our organizations share, and one that we will carry forward with us as we continue working toward a better, more integrated health care system for all.

Joe Parker

Board Chair, Home and Community Care Support Services

Message from the Chief Executive Officer

As the recently appointed CEO of Home and Community Care Support Services, it has been my privilege to join the organization at a time when it was just embarking on a bold new vision for the future of home and community care services in Ontario. Now, it is my honour to be able to share with you the progress we have made in bringing our 14 geographies together to work as unified organizations to realize this vision. Within the pages of our first Annual Report, you will find details of the results we have achieved to date.

One of our first tasks as we came together was to articulate our new Mission and Vision. Our Mission—Helping everyone be healthier at home through connected, accessible, patient-centred care—and Vision—Exceptional care, wherever you call home—have served as the foundation for our work over the past year. Although we faced many challenges while delivering health care during an ongoing global pandemic, our dedicated team of nearly 8,600 health care professionals continued to not only provide exceptional care over the past year, but also embraced innovation. Drawing on their collective expertise and vast wealth of knowledge, our team has been hard at work, collaborating internally and with system partners to begin the work of realizing a future that ensures high-quality care and services, regardless of where you live in our geographically diverse province, and whether you reside in your own home, in long-term care or somewhere else in the community. Despite the seeming simplicity of this aim, our health care system is complex, and I am incredibly proud of the work our team has done to date towards achieving it.

Health care is centred on people, and Ontario is home to a richly diverse population with many different needs and from a range of cultural backgrounds. For this reason, we prioritized engaging with patients, families and caregivers to develop our annual business plan, and as we have begun to execute upon it, we have continued to ensure the patient voice is incorporated in everything we do—you will see this reflected in the pages that follow. Our goal is that patients, families, caregivers, staff and providers feel valued as partners in home and community care. The rich diversity of this province is also why we have dedicated ourselves to ensuring the care we deliver is culturally safe and appropriate, that our workplace is open and inclusive, and that our workforce is responsive to and reflective of the population it serves, and supported by a strong equity, inclusion, diversity, and anti-racism plan.

It is my pleasure to share our achievements to date with you, and I look forward to the work ahead as we continue this exciting journey to provide exceptional care, wherever people call home.

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

Introduction

In 2021-22, Home and Community Care Support Services was focused on making progress against the goals we set out to accomplish in our first Annual Business Plan (also known as our Interim Business Planning Document). It was a busy and productive year of operations, as we worked more seamlessly together across our 14 geographies to provide the best care possible to the people we serve, all while operating during an unprecedented—and ongoing—global pandemic.

As a key initial step, and in collaboration with our staff, patient and family advisors, health system partners and the people we serve, we completed the important work of articulating our organizational Mission, Vision and Values:

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

OUR VISION
Exceptional care – wherever you call home

OUR VALUES
Collaboration, Respect, Integrity, Excellence

With these critical pieces serving as the foundation for all that we do, we made great strides towards fulfilling the mandate set for us by the government as well as the strategic priorities we articulated for ourselves.

A significant component of our work over the last year has been the ongoing support of the province's evolving Ontario Health Teams. In December 2021, a province-wide steering committee was established to support the implementation of Ontario Health Teams and home care modernization. Since that time, Home and Community Care Support Services has played an increasingly significant role, providing both consultation and decision-making support on a range of components, including the development of business case criteria, an intake process and planning for testing home care service delivery within Ontario Health Teams.

Looking within our own organizations, Home and Community Care Support Services was also hard at work to develop and implement a People Strategy designed to attract, retain and engage a highly competent workforce. Our People Strategy is comprised of 19 initiatives that was created through engagement sessions with all staff, including the over 100 staff who have volunteered to participate in cross-functional project teams to plan and implement these initiatives. This work was key to ensuring our organization remains well positioned to support the critical work of health system modernization while at the same time continuing to provide high-quality care and services to those we serve.

During this critical year, not only did we continue to address the local needs within our 14 geographies while working more closely together as unified organizations that support and advance Ontario's health care system, but we continued to deliver high-quality care and services to the people we serve against the backdrop of an ongoing—and extremely disruptive—global pandemic. While some aspects of dealing with COVID-19 have been incorporated into our daily operations as we collaborate with health system partners to support restoration and recovery of our health care system, the past year also saw significant—and new—forms of pandemic-related disruptions.

While working collaboratively both internally and externally to deal with this and the many other challenges brought about by the COVID-19 pandemic, and at the same time to advance health system modernization, last year Home and Community Care Support Services staff

coordinated and/or delivered more than:

- **35,700,000 PSW hours**
(+13% from 2020-21)
- **7,900,000 Nursing visits**
(+1% from 2020-21)
- **27,000 Long-term care placements**
(+80% increase from 2020-21, due to COVID-19-related restrictions that limited placements that year)

We are extremely proud of the efforts of the entire Home and Community Care Support Services team during this time. Not only did we come together as unified organizations during a period of unprecedented challenges, we continued to excel at our core business of providing exceptional care to the people we serve, and the above is just a small, high-level sample of the achievements you will find on the pages that follow.

Population Profile

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

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

Area (km2)	908,699
Total Population	15,228,355
Population Age 65+	18.8%
Population Growth Rate	1.16%
Population Density	16.76/km2
Rural Population	17.2%
Indigenous Population	2.8%
Francophone Population (including IDF) *	4.7%
Low Income Population	14.4%

Health System Partners:

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

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

Sources:

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

Description of Activities Over the Year

In 2021-22, Home and Community Care Support Services received a mandate from the Minister of Health to focus on the following key priorities:

- COVID-19 pandemic response.
- Provision of home care services and long-term care placement.
- Advance health system transformation, including implementation of Ontario Health Teams.
- Advance home and community care modernization, including transition to successor legislative framework.
- Innovate ways to bring care coordination closer to frontline care.
- Consider a future long-term care home placement model.

Under one CEO and one Board of Directors, the 14 organizations came together to drive initiatives that benefit everyone in Ontario, while also maintaining a focus on local initiatives that support the diverse needs of individual communities.

COVID-19 Pandemic Response

The COVID-19 pandemic has dramatically affected all aspects of health care over the past two years. As each wave of the virus continues to impact long-term care homes, congregate settings and communities as a whole, each one of the 14 Home and Community Care Support Services geographies stepped up to help during an unprecedented time in health care delivery and make a difference for the communities they serve. This included engaging with Francophones to respond to and address concerns raised by those seeking COVID-19 information in French.

Vaccination and Testing Efforts through Redeployment and Homebound Vaccination Programs

As the new COVID-19 vaccines began rolling out to communities across Ontario in spring of 2021, Home and Community Care Support Services frontline staff were redeployed to vaccination clinics and testing centres to support provincial efforts in limiting the spread of COVID-19 and contributing to the overall safety of our communities.

In the North East, Home and Community Care Support Services staff worked with the five public health units within the widespread geography to ensure that vulnerable populations, including high-risk and homebound patients could benefit from mobile vaccination appointments. In the North West, staff were redeployed to support the Northwestern Health Unit's vaccination efforts in large-scale community vaccination clinics. Eleven North West staff assisted with 30 vaccination clinic shifts to administer much-needed vaccines and approximately 200 homebound patients received their vaccine at home.

Home and Community Care Support Services Central West continued to be actively involved in the COVID-19 pandemic response and maintained continuity of care and support for local hospitals. Between April and September 2021, Central West redeployed 17 staff, including care coordinators, nurses, managers and pharmacists to support discharge planning, direct care and Infection Prevention and Control initiatives. An additional 13 staff continued to operate and fully staff the Brampton Testing Centre, a community testing clinic, and support the Bolton Testing and Vaccination Clinic until the end of June 2021.

North Simcoe Muskoka partnered with service providers and a community paramedicine program to provide in-home COVID-19 vaccinations and booster doses for homebound patients.

More than 800 nursing visits were provided to patients who were at a high risk of falls, unable to physically get to a medical appointment, who were non-ambulatory or who had advanced cognitive impairment.

Waterloo Wellington staff were redeployed to congregate settings and vaccination clinics where roles ranged from providing hands-on care to supporting management in a variety of urgent tasks. In addition to supporting homebound vaccination efforts within the geography, Waterloo Wellington also implemented a procedure to support patients waiting for admission to long-term care homes to receive their first dose prior to admission.

In Toronto Central, 25 staff were redeployed to hospitals to support vaccination clinics and provide nursing support for inpatient units during the Delta wave. Care coordinators and Placement staff were also redeployed as part of the COVID-19 Response Team to support congregate settings to manage capacity, monitor outbreaks and health human resource pressures and to support mass testing in the community and in schools.

Remote COVID-19 Care

Remote COVID-19 monitoring programs were operating around the province to support primary care providers in monitoring COVID-19 positive patients as they isolated and recovered at home. For patients in South West, Home and Community Care Support Services continued to facilitate timely discharges to support hospital capacity pressures by optimizing programs such as community nursing clinics and remote COVID-19 patient monitoring – the latter supported 857 patients.

In Central East, the program was expanded in Wave 3 to provide remote monitoring of any patient isolating with symptoms in a home, community or cohort setting due to COVID-19 exposure. The program was operated by rapid response nurses and enabled patients to report symptoms on a smart device or by phone. The rapid response nurses then escalated and consulted as required with primary care or urgent care at partnering hospitals, reducing the likelihood of serious complications and hospitalizations. Central East's program supported 1,397 patients over the course of 2021-22. Similar programs were in effect for patients in Erie St. Clair, South West, North Simcoe Muskoka and Mississauga Halton.

In addition to remote monitoring, the COVID-19 Reconditioning Pathway in Mississauga Halton was designed for post long-stay patients who required additional rehab and/or other support for their transition to more formal outpatient rehabilitation programs. Serving nearly 550 patients since April 2021, the programs evolved to enable virtual care monitoring where appropriate and expanded to other patient populations, including those with Chronic Obstructive Pulmonary Disorder, Congestive Heart Failure and palliative care needs.

Provision of Home Care Services

Providing exceptional care wherever people call home is at the core of what we do, and despite the continuing pressures of an ongoing global pandemic, we at no time lost sight of this key fact. Throughout our first year operating as Home and Community Care Support Services, we not only continued supporting the people we serve through our existing services, we also launched new, innovative services, including several virtual offerings that ensured people were able to receive the care they need from the safety of their own homes.

High Intensity Supports at Home (HISH)

The High Intensity Supports at Home or HISH model supports patients across the province by providing a bundled model of care from existing service providers to support patients with complex or otherwise significant needs, including those waiting for long-term care placement. The HISH program supports the care that patients need, including personal support work, nursing or rehabilitative services up to 24 hours a day.

In Central East, a dedicated team works

collaboratively with community partners, including community support services, community paramedicine programs and service provider organizations, to keep patients safe at home. Together, this group conducts timely assessments and ensures customized individual care planning to facilitate patient transitions from hospital to home or congregate care settings. These patients also receive comprehensive system navigation and integrated wraparound care.

Through the HISH program, Home and Community Care Support Services Central supported over 377 patients, including 111 patients who successfully transitioned out of hospital. Of the patients who were discharged from hospital with enhanced rehabilitation services, over 70% were able to successfully transition to regular home care services after 16 weeks and resume activities of daily living. This cohort included frail elderly patients who benefited from integrated services planning and delivery.

In the North East, the HISH program expanded into Parry Sound, Timmins and Sault Ste. Marie where 226 patients and their families and caregivers were supported. Central West supported 320 individuals through the provision of HISH enhanced services, 174 of whom were transitioned from hospital into the community. Overall, there were 178,193 personal support hours, 536 personal support respite hours, 3,918 nursing visits, 382 occupational therapy visits and 1,450 physiotherapy visits during this fiscal year.

The HISH program was critical for all Home and Community Care Support Services organizations in supporting health system flow and helped transition patients safely home to rehabilitate or await long-term care placement while reducing unnecessary visits or admission to hospitals.

Ottawa Trucker Convoy – Mitigating Care Disruptions and Safety Risks

For four weeks in early 2022, during the Ottawa trucker "Freedom Convoy," Home and Community Care Support Services Champlain followed the emergency preparedness and response protocols. Actions included:

- Working with **more than 1,100 affected patients**, reviewing and revising contingency planning for the most vulnerable (including an option for them to relocate), prioritized and redistributed care, as needed, and
- Making **6,000+ connections with patients** – including wellness-checks by care coordinators to support patients' continued access to care, safety, food security, medications, pet supplies, etc.
- Establishing supply depots to ensure nurses had essential medical supplies, and
- For additional safety, establishing refuge locations for health care workers.

For the duration of the protest, all affected employees made exceptional efforts to mitigate care disruptions and ensure patient and provider safety and did so on top of their usual caseload and work.

Mental Health and Addictions Nurses

Closures due to the global pandemic had an impact on every aspect of society, including our children and teenagers as schools spent a considerable amount of time closed to in-person learning. These children struggled with isolation, social restrictions, modified online learning and continued global uncertainty during their formative years, which led to an increase in mental health issues and distress.

Home and Community Care Support Services Mental Health and Addictions Nurses across the province engaged with local school boards, community partners and school-aged children who were struggling with depression, addiction or other mental health issues. In Central, the team provided more than 3,800 video, telephone and in-person visits to 575 school-attending youth aged 4 to 21.

In Waterloo Wellington, the Mental Health and Addictions Nurses program strengthened the integration of roles and processes with primary care teams to support children in the community with mental health challenges. In South East, this team made every effort to continue seeing patients in-person to provide direct care, but virtual appointments allowed staff to monitor the best outcomes for the children when in-person care was not possible.

Mental Health and Addictions Nurses across the province provided support and medication management to children and youth transitioning back to school following a hospital admission with a critical focus on ensuring the continuity of care and flexible meeting options. Alternative meeting locations and virtual appointments enabled students across the province to thrive, cope and succeed during another unpredictable school year.

Community Nursing Clinics

In 2021-22, Home and Community Care Support Services worked to address capacity challenges across the province and as a result, placed a greater focus on community nursing clinics with a clinic-first philosophy.

Erie St. Clair initiated a Request for Information process to identify the best place for new nursing clinics based on patient populations and need. Three locations in Erie St. Clair were identified and contracts awarded to existing contracted service providers for clinics to open in downtown Windsor, Petrolia and Bothwell. Within a month of opening, the downtown Windsor clinic was serving between 18-23 patients per day, seven days a week.

Home and Community Care Support Services South West implemented an enhanced focus on community nursing clinics to maximize and stabilize care volumes. By partnering with service providers and system partners to support opportunities for clinic-based care, we increased resources and education to care coordination teams who are vital in managing our nursing resources.

Refocusing efforts on clinic-based care and using clinics to their full potential allowed for greater care capacity in the community through reduced travel times for clinic-based nurses and creating capacity for community nursing teams to see the more complex patients in their homes. It also allows patients to schedule their visits at times of the day that are most convenient for them.

With this enhanced focus, South West saw a 7% increase in clinic utilization from the previous year – which equaled 2,300 more patients served in a nursing clinic. This increase in clinic nursing capacity was critical for the community, especially with the health human resource challenges that have occurred throughout the pandemic.

Advance Health System Transformation

Home and Community Care Support Services is a key partner in our health system's efforts to innovate service delivery in order to create a more coordinated, patient-centred health care system. As a key component of this work, we have been working with the province's evolving Ontario Health Teams as they implement new models of care, including the seamless integration of home care delivery into Ontario Health Teams.

Seamless Care Optimizing the Patient Experience

Seamless Care Optimizing the Patient Experience (also known as SCOPE) promotes integrated and collaborative care between primary care, hospital services and community health partners to serve patients with complex needs through a single point of access – a SCOPE Nurse Navigator.

In 2021-22, Home and Community Care Support Services Mississauga Halton was a key partner in planning this work stream within the Connected Care Halton Ontario Health Team. We provided a nurse for the SCOPE Nurse Navigator role through a secondment, which started in July 2021 and will remain in place until March 31, 2023.

This role is critical to both testing the model and driving its further expansion and is the face or voice of SCOPE. To date SCOPE has registered 69 participating primary care providers, has had more than 120 contacts (calls and emails), has prevented more than 15 emergency department visits and avoided two hospital admissions.

In Toronto Central, where SCOPE has been an ongoing project for over a decade, we continued to provide in-kind care coordination support for complex patients with multiple chronic conditions who previously relied on the emergency department for care.

CHEO Transition

On September 20, 2021, Home and Community Care Support Services Champlain seamlessly transferred the pediatric home and community care patients, services, staff and funding to the Children's Hospital of Eastern Ontario (CHEO) after months of collaboration and by way of a Transfer Order issued by the Minister of Health. The genesis for this transfer was the 2017 Thrive report, which brought together representatives from CHEO and Home and Community Care Support Services Champlain, while under the name of the Champlain Local Health Integration Network.

It was a historic transfer and one that addressed the call from parents to integrate pediatric care in the region to simplify care delivery for children, youth and their families and caregivers. The goal of this unique and local initiative was to provide patients in the Champlain region with more seamless and coordinated care between acute and home care services. Regulatory changes were required to support the transfer, which resulted in the transition of more than:

- 700 complex pediatric patients, with no impact to their care as a result of the transfer;
- 50 staff including those who provide direct care such as therapists; and
- associated funding for the care provisions for pediatric patients.

Support for Ontario Health Teams

Home and Community Care Support Services has been an active partner in supporting the implementation of Ontario Health Teams across the province. In the North East, Home and Community Care Support Services staff worked closely with the existing Ontario Health Teams and prospective teams to improve Ontario Health Team coverage. All prospective teams are required to include home care partnerships. To this end, Home and Community Care Support Services North East is a core partner for prospective teams in the Cochrane District, Temiskaming Area, West Parry Sound and Sudbury-Espanola-Manitoulin-Elliott Lake areas. Additionally, North East is a Collaborative Partner for the Nipissing Wellness, Algoma and Muskoka and Area Ontario Health Teams.

In the North West, Home and Community Care Support Services worked closely with Ontario Health and other health care partners to improve the Ontario Health Team coverage of the North West area. Home and Community Care Support Services staff participated as core partners in the planning, development and virtual assessment of the Ontario Health Team applications for the Dryden, Sioux Lookout and Red Lake area and Thunder Bay District.

As part of the Hills of Headwaters Ontario Health Team priority pandemic response in 2021, Home and Community Care Support Services Central West partnered to plan, implement and participate in a successful Ontario Health Team-led integrated COVID, Cold and Flu clinic.

The clinic, located in the Town of Caledon, was one of the first integrated models of COVID-19 response, which was then replicated across the Central West geography.

Established, collaborative Ontario Health Team

partners from more than 10 different organizations, as well as local primary care providers, came together to support this initiative. The Central West community joined forces to provide staffing in both clinical and non-clinical roles, as well as volunteer supports to assist with the success of this population-health initiative.

Home and Community Care Support Services Central West leveraged the expertise of the direct nursing teams, pharmacists, care coordinators, and administrative supports to provide a robust clinic staffing contribution. Strong community awareness and trust contributed to the clinic being able to administer more than 15,000 vaccines to eligible populations and to administer more than 1,600 COVID tests between September 2021 and March 2022.

Waterloo Wellington worked with Ontario Health Teams, including Guelph Wellington Ontario Health Team, and service provider partners to identify data sets that describe shared patient populations with the goal of better identifying patients with complex needs and to support service provider alignment with integrated primary care teams.

In Waterloo Wellington, home care roles at Home and Community Care Support Services were integrated into the Guelph Wellington Interprofessional Primary Care Team. By integrating care coordinators, hospice palliative care nurse practitioners and mental health and addiction nurses, we moved towards the model of care delivery that will be at the centre of all Ontario Health Teams.

As a first step, Waterloo Wellington collaborated with the Kitchener, Waterloo, Wellesley, Wilmot and Woolwich (KW4) Ontario Health Team to launch an integrated care team approach for the refugee priority population.

Advance Home and Community Care Modernization

While continuing to drive improvements in the vital and essential home and community care services we deliver—such as wound care—our work over the past year included a focus on supporting the transition from the previous legislative framework for home and community care to the successor legislative framework enabled by the *Connecting People to Home and Community Care Act, 2020*.

New Legislation and Modernization

In early 2022, Home and Community Care Support Services organized around the work necessary to come into alignment with the new Ontario Regulation 187/22 under the *Connecting Care Act, 2019* scheduled for May and September 2022. Multiple work streams were established to focus on changes to care coordination practices, a revised Patient Bill of Rights, the inclusion of new services, updates to the complaints management process and other areas of regulatory change.

As part of the early work in meeting requirements, provincial policy, guidelines, protocols and templates were being developed and implemented at local Home and Community Care Support Services organizations. Home and Community Care Support Services organizations reviewed their existing policies to understand the degree of change required to come into compliance with the new regulatory framework. This work was underpinned by the development of a multi-faceted province-wide communications and education strategy. Home and Community Care Support Services continues to be subject to the *French Language Services Act, 1990*.

Additionally, several Home and Community Care Support Services organizations supported new transformative testing in home care delivery in the context of Ontario Health Teams and an evolving approach to integrated care.

Internal Ontario Health Team Steering Committee

Across the province, Home and Community Care Support Services made significant progress toward advancing the home care modernization plan, while supporting continuity of care. This progress

included supporting the implementation of Ontario Health Teams and the transition of home and community care service delivery to Ontario Health Teams.

An internal Ontario Health Team steering committee was established with representatives from all 14 Home and Community Care Support Services geographies with connections to the Ministry of Health and Ontario Health as we focused on planning and integration with Ontario Health Teams. We continued to work with approved Ontario Health Teams and remained actively engaged in supporting Ontario Health Team development. While the ministry continued to advance the framework for change through modernized legislation, procurement policies and setting the parameters for transition to Ontario Health Teams, Home and Community Care Support Services, Ontario Health and the Ontario Health Teams continued collaborating and preparing to test and evaluate new models of integrated care.

Wound Care

Focusing on wound care helps to increase patient and caregiver satisfaction while decreasing length of stay for home care nursing services and reducing emergency department and other unscheduled health care visits. Having proper wound care services in place is key as Ontario's population continues to age with increased medical complexities.

In October 2021, North Simcoe Muskoka introduced Wound Service Pathways to the short stay population and expanded the program in February 2022 to include long stay patients on the primary care, retirement home and congregate caseloads. Wound Service Pathways use intervals, which allows the total visits in a pathway to be spread out over time based on best practices and triggers the service provider and care coordinator when wound care reports are due and when the pathway ends.

Each Wound Service Pathway has defined services, total visits, focus of intervention and service plan goals, treatment orders and provider instructions, which will auto-populate into the patient EMR system when the Wound Service Pathway type is authorized. Care coordinators follow the patient's entire trajectory and draw on their clinical expertise and system navigation resources to support successful wound healing.

Since implementing this new wound care model, North Simcoe Muskoka has seen an overall improvement in wound reporting from service providers. The Wound Service Pathways model has also increased the awareness of wound care and the importance of wound care documentation with our primary care and retirement home care coordinators.

In Central East, a Wound Care Interprofessional Team was comprised of dedicated wound care experts from across the local health sector including those from Home and Community Care Support Services and contracted nursing service providers – all connected to each other and their patients with the Swift Skin and Wound app. With this wound management platform, the team was able to provide virtual and face-to-face wound care assessments, consultations and recommendations, ensuring patients received seamless, evidence-based, high-quality wound care for clinically complex and/or non-healing wounds.

Grow Your Own Program

As part of a larger plan to address personal support worker (PSW) capacity issues, the Grow Your Own HSW-PSW program was introduced in Erie St. Clair in 2019 with the goal of increasing PSW and home support worker (HSW) health human resource capacity by focusing on communities most in need.

Overall, this collaboration resulted in nearly 200 new personal support workers since the program began, with 120 new personal support workers in 2021-22. This past year we were able to leverage $2.5 million in funding to the Chatham-Kent

Employment and Social Services to support tuition,-and offset student costs such as travel and childcare.

The program was developed in partnership with service providers and partners, including Saint Elizabeth Career College of Health, Chatham-Kent Employment and Social Services, Ontario Works, the City of Windsor and County of Lambton. It took a systems approach where service provider partners, retirement homes and long-term care homes were all invited to participate in bringing more personal support workers into the community.

As a result of this program, Erie St. Clair has one of the lowest personal support waitlists in the province, hundreds of grateful graduates and ultimately better care for patients.

Partnership with Community Paramedicine Providers

In January 2022, Home and Community Care Support Services Central launched an eReferral program for Community Paramedicine in collaboration with three Emergency Management System (EMS) partners – Simcoe EMS, Toronto EMS and York Region EMS.

Through this program, care coordinators played a key role in assessing and referring eligible patients for additional support. Eligible patients included those awaiting long-term care placement or others who chose to age at home in their community. The Community Paramedicine program provided non-urgent support to medically complex, frail or elderly individuals to help keep them in a stable illness trajectory, so they could remain safely at home for as long as possible.

In the fourth quarter of 2021-2022, 30 patients were referred for Community Paramedicine support.

In Champlain, two programs with community paramedicine providers helped patients in the community to receive the care they needed in innovative ways.

In response to health human resource challenges, Home and Community Care Support Services Champlain partnered with community paramedicine providers in Prescott Russell to determine if they would be able to assist in the care of patients requiring IV infusions in the community. Work began in December 2020 and the first patients were navigated from Home and Community Care Support Services Champlain to community paramedicine providers in Prescott Russell as of July 2021. During the planning phase, community paramedicine providers and their medical director received training in the operation of the IV pumps used by Home and Community Care Support Services and how to care for peripherally inserted central catheter lines.

Being mindful that community paramedicine is not outlined under home care legislation, we worked with Agencies Legal to develop processes and education for Champlain staff and community paramedicine providers. To date, over 20 patients have been navigated to community paramedicine providers in Prescott Russell for support with their IV infusions, resulting in less hospital days, less trips to the ED for a patient to receive their care and the strengthening of the partnerships between Champlain and community paramedicine providers.

We saw improvements in our nursing capacity within Champlain– with less than 10 nursing gaps for visit nursing by the end of 2021-22.

Further to the IV Project, Home and Community Care Support Services Champlain established a partnership with the municipal community paramedicine provider chiefs to address increased health care demands during the pandemic. The partnership improved linkages with other organizations including primary care, Inner City Health and acute care hospitals, with the goal of addressing gaps in

services and to support patients waiting for admission to long-term care. In 2021-22, the program served more than 300 patients waiting for long-term care by providing them with enhanced services and support at home.

Community paramedicine providers brought their invaluable skills to the Home and Community Care Support Services care teams and became essential partners. Together, we leveraged our combined resources to keep patients safe at home and avoid unnecessary hospital visits. Among other activities, the community paramedicine providers checked in with patients at home, providing them with treatment and reassurance. Their support was especially important for those patients in need of assistance between care provider appointments, and who may have otherwise sought care at the hospital emergency department.

Innovate Ways to Bring Care Coordination Closer to Frontline Care

As a patient journeys through Ontario's health care system, they can access numerous services along the way that will impact both their experience and their health outcomes. Reducing the number of repetitive touchpoints by bringing care coordination closer to the front line of care has the potential to improve both patient satisfaction and health outcomes and has been a key focus for us over this past year. Our provincial Senior Leadership Team met weekly throughout the year, sharing progress on local initiatives and discussing opportunities to scale provincially.

One Client, One Plan Project

The One Client, One Plan project began as a way to improve the patient journey by removing duplication—and therefore potential confusion and frustration—patients experience when dealing with multiple providers. Driven by Home and Community Care Support Services North East and involving more than 60 home and community care service providers, this five-year project was completed in winter 2022.

Objectives for the project involved developing a single point of contact for clients, developing a standard process to identify services, removing duplication in home and community care assessments by improving data sharing among providers, and developing a standard approach to the coordination of services.

The completed deliverables included:

- Application of the No Wrong Door integrated service model that reduces client redirection.
- Launching northeastsupport.ca in summer 2021 to connect members of the community with more than 500 publicly-funded home and community care services (including meals and food security, home support, transportation services, day programs and respite, support groups) available in the North East.
- Standardization of Common Consent Language through a pilot that included the development of templates for agencies to use. Common consent language means less confusion for clients, ultimately allowing for information to be shared among partners in the circle of care.
- Expansion of eNotifications from Home and Community Care Support Services to all assisted living and low acuity providers across the North East.
- Standard use of assessments and application of the Integrated Assessment Record to assess patient needs through the provision of training to all community support service providers.

Another crucial component of this project involved working with Ontario Health to establish the Home and Community Support Innovation Centre, based at the Independence Centre and Network, which will now be responsible for sustaining the progress made.

Palliative Care Projects

In 2021-2022, Home and Community Care Support Services Central continued to advance the regionally established Palliative Care Hub Model, which brought together over 30 providers with expertise in palliative and hospice care. This collaborative team shared a common definition that palliative care is meant to relieve suffering and improve quality of life at all stages of a life limiting illness and embraced a holistic approach to treat the whole person and their family, not strictly a singular disease, condition or body part.

Reflective of increasing caseload and requests from patients and caregivers to stay out of hospitals for end-of-life care during the COVID-19 pandemic, the Palliative Care Hub Model partners focused on bringing care coordination closer to the front line through specialized, integrated palliative teams for 6,094 patients and their families and caregivers in 2021-2022, an increase of 500 patients from 2020-2021. Among the health human resources dedicated to this hub model were Home and Community Care Support Services Central's dedicated palliative care coordinators and nurse practitioners, as well as palliative physician teams, hospice palliative care teams and service provider organization nurses and personal support workers. This integrated team shared frequent virtual meetings to collaborate on patient cases and expected standards of care. Additionally, in adherence to federally mandated Medical Assistance in Dying (MAID) provisions, the team worked to implement a standardized MAID policy and procedure to enable fair, equitable and open access to MAID services, for all those eligible across the province.

In Mississauga Halton, Home and Community Care Support Services, Ontario Health, Ontario Health Teams and service providers came together to discuss and analyze current trends, issues, data and service provider capacity, and identified that patients, families and caregivers required more real-time clinical support and seamless access to palliative care.

In response, using an existing care coordinator role and the clinical skills and knowledge of a rapid response nurse, a new Blended Palliative Rapid Response Nurse/Care Coordinator role was created to provide integrated care planning as well as clinical hands-on nursing care.

Home and Community Care Support Services Mississauga Halton completed 38 visits through this new program since its launch in June 2021. Of the 38 visits, 36 resulted in avoiding the emergency department and two of the 38 visits allowed for MAID to be administered in the patient's place of choice. Ultimately, the patients and their families and caregivers received more timely clinical support.

Centralized Access to Care

In Toronto Central, Home and Community Care Support Services staff partnered with East Toronto Health Partners to co-design and plan the Thorncliffe Park Hub – a capital project to create a safe, accessible, multi-service community-centred space where Thorncliffe Park residents can access health and social services and community spaces. In 2021/2022, the project received approval to move into the design and implementation phase. The design included collaboration space for Home and Community Care Support Services staff to engage with community partners and space for future delivery of home and community care services to Thorncliffe Park residents.

Thorncliffe Park is one of the largest and most densely populated high-rise communities in Canada and a 2014 Health Care Gap Analysis of the neighbourhood determined that given the population's size, complexity and diversity, there are insufficient local health services available. Scheduled to open in 2023, the Hub will be designed to keep community members better connected to a portfolio of medical and social initiatives that will support residents in living a more optimal and well-balanced life.

After several years of planning, the Orléans Health

Hub opened in Champlain on June 24, 2021. The Hub is a partnership between Home and Community Care Support Services Champlain, Bruyère, Youth Services Bureau of Ottawa, CHEO, Eastern Ottawa Resource Centre, Hôpital Montfort, Ottawa Public Health and Geriatric Psychiatry Community Services of Ottawa.

Hôpital Montfort spearheaded a model that combines a range of specialized and community-based care under one roof; the centre allows Ottawa residents to benefit from integrated, seamless access to needs-based programs offered in both English and French, and close to home. On-site access to services from Home and Community Care Support Services Champlain is available, including a community nursing clinic, care coordination, system navigation and restorative care.

Primary Care Integration and Digital Strategies

Throughout 2021-22, Home and Community Care Support Services South East took an active role in expanding Primary Care Integration initiatives with additional alignment to support patients and improve access to care coordination in primary care settings.

Home and Community Care Support Services as a whole and the South East region in particular, remained committed through the past year to further implementation of digital health strategies, such as the Shared Health Integrated Information Portal (SHIIP) and ConnectingOntario initiatives with a focus on increasing frontline staff supports. Both SHIIP and ConnectingOntario provide key information that allowed staff to support patients, their families and caregivers through transitions in care, while also mitigating potential patient safety risks, especially following a hospital visit.

SHIIP is a digital health enabler developed with other regional system partners to provide a central tool for its Health Links Information Management Strategy. SHIIP supports the delivery of collaborative, coordinated care to complex and high-needs patients. With SHIIP, health care providers have timely access to information on patient encounters and access to shared electronic coordinated care plans in order to support their patients' health care needs, goals and outcomes.

Key benefits include:

- Access to information from hospitals, including discharge information, to support timely follow up with the patient and family.
- Current and historical information on utilization of hospital and community services to inform assessments and reassessments of care needs, as well as help guide more meaningful discussions with patients, families and caregivers.
- SHIIP in particular also offers real-time notifications to alert Care Coordinators and Team Assistants to transitions in care.

Primary Care integration remained a focus for other Home and Community Care Support Services organizations across the province in 2021-22. Champlain embedded care coordination in 11 primary care offices within the western Champlain region to ensure care coordination was integrated and the single point of contact. The care coordinator linked with primary care provided essential care coordination for shared and new patients and monitored each patient's care plan. Working with the primary care team and patients, the Care Coordinator connected the patient with various care and service options in the community while providing expertise in system navigation.

Care coordinators at Home and Community Care Support Services North East were working remotely during the pandemic, however, their caseloads remained closely aligned with primary care providers. Care coordinators were able to collaborate with primary care providers when necessary, allowing for a single point of contact to help resolve issues or concerns, or to discuss the

patient's care plan.

In Waterloo Wellington, home care roles, including Care Coordinator, Hospice Palliative Care Nurse Practitioner and Mental Health and Addictions Nurse, were integrated into the Guelph Wellington Interprofessional Primary Care Team to better support patient care in the region.

Toronto Central saw the expansion of Home and Community Care Support Services care coordinators into the Garrison Creek Family Health Team and the building of a liaison model with Vibrant Community Health Centre. In the past year, a dedicated care coordinator role was developed to support solo primary care practices to further a team approach and work collaboratively with community services. The team also developed a Primary Care Integration Framework and Playbook to advance the design and implementation of the primary care integration model with Home and Community Care Support Services Toronto Central staff and local partners. The playbook provided a foundation to convey a common vision among Toronto Central teams and partners, provided an overview of concepts to support staff through change, highlighted the key learnings to be applied from innovative testing of the primary care integrated models, leveraged tools to enable the implementation and set the stage for continuous model improvement.

Consider a Future Long-Term Care Home Placement Model

Ontario's Long-Term Care homes provide a vital health care service in support of our aging population, and Home and Community Care Support Services has an important role to play in both improving the model for placing patients in long-term care and improving care for the residents who live there.

Expanding Long-Term Care

As of June 8, 2022, across Ontario, there are 627 licensed long-term care homes with approximately 79,656 beds. A long-term care home is the primary home of its residents and is to be operated so that it is a place where they may safely live with dignity and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met. As the need for long-term care has grown in recent years, new long-term care homes opened in 2021-22 to support the needs of the communities we serve, with planning underway to increase assess to French language services.

In 2021-2022, Home and Community Care Support Services Central supported the opening of Mon Sheong Stouffville Long-Term Care Centre. This brand new 320-bed long-term care home was constructed with new technological features designed to maximize resident comfort and infection prevention and control. Special features included individual heating/cooling systems in each of the rooms, a real-time locating system, and infrared temperature screening.

In Central East, Lakeridge Gardens opened in March 2022 adding 320 long-term care beds to the Durham region. Located next to Lakeridge Health's Ajax Pickering Hospital, Lakeridge Gardens is a state-of-the-art home designed with evidence-informed infection prevention and control measures, a modern design and care planning that prioritizes residents' quality of life.

Fifty-one net-new long-term care beds were added in North Simcoe Muskoka when The Villa Care Centre's brand new, state-of-the-art facility in Midland opened in March 2022. Home and Community Care Support Services North Simcoe Muskoka worked closely with the Ministry of Long-Term Care and Villa Care Centre to plan for the opening and admission of patients in the Midland area.

Supporting Communities in Crisis

Long-term care homes among other congregate living environments were particularly impacted by the COVID-19 virus and the waves of infection that affected our communities across Ontario. In Champlain, Home and Community Care Support Services rose to meet the urgent needs of long-term care home residents and their families and caregivers. An interdisciplinary stakeholder team developed and disseminated Patient Decision Aids to long-term care home and retirement home residents across the region to support decision making regarding leaving a home during the pandemic.

In partnership with a group of scholars, Home and Community Care Support Services Champlain developed two Patient Decision Aids for retirement and long-term care home environments that were informed by decisional needs identified by public responses to media reports, pandemic regulations and guidance and recent systematic reviews.

Within three weeks of release, the Patient Decision Aids were downloaded more than 10,000 times by unique users with positive feedback.

The work to produce the aids was published in Medical Decision Making from SAGE journals and the aids were distributed across the province to support all Home and Community Care Support Services staff and patients as an example of how to approach difficult decision-making.

Creating Provincial Cohesion

Home and Community Care Support Services Toronto Central made strides over the 2021-22 year to align practices with the other 13 Home and Community Care Support Services organizations for long-term care referrals. Under the current model, Toronto Central is the only organization to refer patients using the Resource Matching & Referral tool while the rest of the province submits referrals using CHRIS (Client Health and Related Information System) where the referral is connected directly to the patient record.

In November 2021, Toronto Central received the formal approval to move forward with the transition and has since been mapping the data required to support the transition.

Once complete, the 35 long-term care homes in Toronto Central will join those in the rest of the province to provide patients with a clear and cohesive method for applying to long-term care and allow the placement coordinators at Home and Community Care Support Services Toronto Central to align with their colleagues across the province.

Community Engagement

As part of our commitment to building strong relationships with all the communities we serve—including Francophone, Indigenous, Black and other ethnic and marginalized populations—Home and Community Care Support Services is dedicated to public outreach, education, and two-way communication. Although in-person engagement was not possible this year, our highly knowledgeable and dedicated team met virtually with a variety of groups, including seniors, community groups, health system partners, educational institutions and patients, families and caregivers who wanted to know more about the services we provide, including long-term care placement.

In addition, Home and Community Care Support Services continued to seek educational, training and planning opportunities to better equip staff and leaders to have more meaningful engagements with patients, families, caregivers and communities when normal engagement activities are able to resume.

Engagement with Francophone Communities

Access to quality French language health services directly impacts the health of Franco-Ontarians. Home and Community Care Support Services is committed to engaging with the Francophone community to inform planning and integration of these services, while also understanding the diversity within this population, in accordance with the *French Language Services Act*. To that end, we have formed strong working partnerships with French Language Health Services Planning Entities across the province.

In Toronto Central, a dedicated French speaking Care Coordinator was hired to respond to the specific cultural and linguistic challenges Francophone patients and their caregivers encounter. This care coordinator supported 30 to 40 clients across the city at any given time. By providing culturally sensitive care to patients in their native language, the coordinator helped provide health equity in the community and gave patients a stronger sense of control over their care as they were able to discuss their needs in their preferred language.

Home and Community Care Support Services North West and North East partnered with the Réseau du Mieux-Etre Francophone du Nord de L ’Ontario to provide online training on the principle of active offer. The training ensured that both staff and leadership were clear on the theory, purpose and importance of active offer and how it ultimately leads to improved patient care and satisfaction for French speaking patients, families, caregivers and any other callers. With active offer, the onus is on health service providers to offer French Language Services at the first point of contact, rather than waiting for a request. About 78% of all North West staff have completed the training. The North East has a completion rate of approximately 98%. We also began work with the Réseau to develop a shorter, refresher training session that will improve staff awareness and confidence in implementing active offer in their day-to-day work.

In 2021-2022, Home and Community Care Support Services Central implemented additional actions to provide active offer for the 30,000 individuals who identify as Francophone in the local catchment area. Individuals who contacted the organization by telephone were greeted with an active offer message, with the option to access service/information in French in real-time. Additionally, a data field for French-speaking patients has been added to Client Health Record Information System (CHRIS), which prompts care coordinators to ask the patient or their caregiver if they would prefer service in English or French.

Champlain, which is French designated, continued to provide active offer services to French speaking callers.

In South East, Home and Community Care Support Services is a designated organization under the French Language Services Act with organizational policies created in partnership with Le Réseau including an Official Languages policy. In 2021-22, we developed a relationship with the Association Canadienne-Française de l 'Ontario Mille-Iles (ACFOMI) – a non-profit community group that represents more than 12,000 Francophones in the Thousand Islands region. Work began in March 2022 to add Home and Community Care Support Services to ACFOMI's directory of French language services and resources.

Engagement with Indigenous Communities

In 2021-22, Home and Community Care Support Services continued efforts to establish trust and strengthen relationships with First Nations, Métis and Inuit partners and communities to better understand and address the needs of Indigenous populations.

To recognize the importance of Truth and Reconciliation, the San'yas Indigenous Cultural Safety Training Program was available to all staff across the province. In addition to staff who previously completed this training, approximately 230 more staff, leaders and board members participated, which focused on addressing anti-Indigenous racism and promoting cultural safety for Indigenous people in Canada. This 8-week online course helped increase the knowledge, self-awareness and skills of participants so that they work more safely and effectively with First Nations, Métis and Inuit people.

In July 2021, the unexpected forest fire evacuation of Cat Lake First Nation in northwestern Ontario required a timely response to support evacuees coming to Peel Region. Nearly 350 residents of this First Nation were temporarily housed in a hotel near Toronto Pearson Airport. Home and Community Support Services Central West and Mississauga Halton partnered with more than 20 partners – including Ontario Health, emergency medical services, primary care providers, William Osler Health System, Anishnawbe Health Toronto, Canadian Mental Health Association, Wellfort Community Health Centre, Provincial Emergency Operations Centre and Cat Lake leadership – to establish an on-site Wellness Clinic to ensure holistic health needs were met. The Wellness Clinic conducted over 230 visits, supporting more than 100 community members over a three-week period. Reasons for visits included integrated harm reduction response, traditional healing, dental care, obstetrics care, mental health and chiropody. Organizations such as Anishnawbe Health Toronto, Barrie Area Native Advisory Circle and Windigo First Nation Council Crisis Team assisted in the effort to ensure support and services were provided in a culturally sensitive manner.

To improve how we engage with and understand the Indigenous population in Toronto Central, we collaborated with Saulteaux Traditional Healer Pete Keshane from Anishnawbe Health Toronto to provide a learning session for staff about traditional healing, what we need to know and how to access it for our Indigenous patients. This session created a greater awareness of traditional healing practices for nearly 270 attendees and established a contact for care coordinators to reach out to when considering care for our First Nations, Métis and Inuit patients.

In response to the COVID-19 pandemic, Home and Community Care Support Services Central's Information and Referral team provided administrative support to enable a centralized appointment booking process for multiple COVID-19 drive-thru testing clinics held in the Georgina area, which includes the Chippewas of Georgina Island First Nation, from October 2020 to July 2021. The community COVID-19 testing initiative, led by the Georgina Nurse Practitioner-Led Clinic with support from York Region Paramedic Services and the Town of Georgina, provided COVID-19 testing for Georgina area residents, Indigenous

communities, workers or visitors of long-term care homes, residents or workers in homeless shelters and farm workers.

Home and Community Care Support Services North East has been engaging with Maamwesying North Shore Community Health Services for several years on the needs of First Nations and urban Indigenous communities it serves with the goal of enhancing culturally appropriate home and community care service delivery. Maamwesying identified that home and community care continues to be an area where Indigenous people are at great risk. There continues to be significant confusion amongst service providers, issues with jurisdiction, systemic racism and inequities experienced by Indigenous patients and clients. In February 2019, Maamwesying submitted a formal business case to expand its mandate to take ownership of home and community care provision, with the goal of reducing locally identified risks with service delivery in First Nations communities and accelerating Indigenous health gains. This work culminated in September 2021, with the transition of services to Maamwesying through a contract to provide in-home nursing and personal support for patients who identify as First Nations, Métis and Inuit in the First Nations communities of Atikameksheng Anishnawbek, Sagamok Anishnawbek, Serpent River First Nation, Mississauga First Nation, Thessalon First Nation, Garden River First Nation, Batchewana First Nation and the urban Indigenous population within Sault Ste. Marie (for patients who have a primary care provider with the Indian Friendship Centre).

Engagement with Other Communities and Populations

In Toronto Central, family members of patients who are Black, Indigenous and/or from racialized communities participated on the local anti-racism steering committee. This included discussions that highlighted the lived experience of marginalization. It provided invaluable contributions to how staff think about patient care and prompted us to review our practices, including engaging patients in discussions around the Not Seen, Not Found policy – a protocol used when a patient is not home and cannot be found when a service provider attends a scheduled visit.

As well, leaders from Toronto Central engaged with Rekai Wellesley Long-Term Care Home to support the development of a 2SLGBTQ+ (Two-spirit, lesbian, gay, bisexual, transgender, queer or questioning) focused unit initiative. Located in the heart of Toronto's 2SLGBTQ+ village where support for this community has long been identified as a need, efforts involved engaging with community members on how best to launch the unit and associated services. These engagements identified the most effective ways to promote the unit and resulted in specific messaging developed for local care coordinators. The unit completed a soft launch in 2021-22 and officially opened during Pride Month (June) 2022.

Within Home and Community Care Support Services' Invest in our People strategic priority, we launched an Equity, Inclusion, Diversity and Anti-Racism (EIDAR) Committee and project team that developed a board-approved commitment statement, facilitated personal pronoun use in standardized email signatures, began the development of an EIDAR framework and established connection points with patient and family advisors. These initiatives helped us lay the foundation to embed a culture of equity and inclusivity so we can continue to build one strong, committed team to serve the people of Ontario.

Patient and Family Engagement

Patient and family engagement was an integral piece of many of our projects and initiatives across the province. To inform our new organizational Mission, Vision, Values and Strategic Priorities, two virtual sessions with 28 Patient and Family Advisors were held in August and September 2021. This resulted in an increased focus of these foundational pieces of work articulating our focus

on care being patient centred. Within the Drive Excellence in Care and Service Delivery priority, there was a specific commitment to "create new opportunities for patient, family and caregiver co-design to ensure that the patient voice is incorporated in everything we do." As such, 12 Patient and Family Advisors were involved in shaping the Quality Framework through participation on the working group which launched in March 2022.

The Quality Framework was developed to ensure a consistent and coordinated approach to delivering quality services and serves as a foundation to help staff and service provider organizations improve caregiver and patient care experience by providing safe, effective, reliable care, improving the health of populations by focusing on prevention and wellness, decreasing cost and improving the provider/staff and patient/caregiver experience of care provision. The framework includes six dimensions of quality – safe, effective, patient-centered, timely, efficient and equitable.

To bring an increased focus on the needs of patients, families and caregivers within the organization, nine Patient and Family Advisors participated in interview panels for the recruitment of several leadership positions, including the Chief Executive Officer. This involvement helped shape the initial stages of a dedicated organization-wide Community Engagement program that will be built out in 2022-23. Board Meetings throughout 2021-22 included patient and caregiver stories from across the province.

In Mississauga Halton, local Patient and Family Advisory Committee members and staff co-designed a Rapid Response Patient and Family Feedback process, to help inform patient communication materials during COVID-19. Members also shared their experiences through online engagement and identified insights that were incorporated into the planning of provincial level engagement sessions.

Champlain and North West continued to engage their local Patient and Family Advisory Councils, including members who are Francophone, on local implementation work.

Health System Performance

In 2021-22, Home and Community Care Support Services continued to provide care for home and community care patients as well as placement to long-term care. This occurred while continuing to support response and recovery efforts related to the pandemic and align with the government's plan for health system modernization outlined in the *Connecting Care Act, 2019*, including support for establishing Ontario Health Teams.

With these additional responsibilities, Home and Community Care Support Services maintained continuity of care for about 674,000 patients, however, challenges presented by the pandemic and a shortage of health human resources impacted our ability to meet our provincial targets for the performance indicators outlined below.

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

Our performance over the last two fiscal years has been dramatically impacted by the COVID-19 pandemic and the shortage of health human resources, including personal support workers and nurses, that was exacerbated by the pandemic. Despite these challenges, provincially, we improved our wait times from application to eligibility determination for long-term care home placements: from acute-care setting. Six Home and Community Care Support Services geographies met or exceeded the provincial target for: Percentage of home care clients who received their nursing visit within five (5) days of the date they were authorized for nursing services. Home and Community Care Support Services Central and North West met or exceeded the target for: 90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management). North West also met or exceeded the target for: Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services.

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

Indicator	Provincial Target	Provincial				
		2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Up to Q3)
1. Performance Indicators						
Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services	95.00%	87.80%	86.69%	85.63%	85.29%	81.81%
Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services	95.00%	96.25%	95.87%	95.66%	94.11%	91.58%
90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)	21 days	29.00	28.00	27.00	25.00	31.00
90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care	TBD	7.00	7.00	8.00	9.00	12.00
2. Monitoring Indicators						
Wait times from application to eligibility determination for long-term care home placements: from community setting	N/A	13.00	13.00	12.00	13.00	14.00
Wait times from application to eligibility determination for long-term care home placements: from acute-care setting	N/A	7.00	7.00	7.00	7.00	6.00

Challenges and Actions/Initiatives to Improve Performance

Indicator	Challenges	Actions/Initiatives to Improve Performance
Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services	Access to Personal Support services remained a challenge as a result of a continuing provincial PSW shortage. Many Home and Community Care Support Services geographies experienced a loss of home care PSWs employed by service provider organizations due to disparity in wages across health care sectors. For some geographies, patient preference to delay service or change/cancel the first visit due to concerns about the spread of COVID-19 continued to impact performance.	Home and Community Care Support Services staff continued to meet regularly with service provider organizations to review wait times metrics and discuss the PSW shortage and recruitment challenges. We continued to work with community support services agencies to transition low acuity patients to appropriate community services, creating PSW capacity for complex patients. We conducted reviews of instances where the first visit wasn't made within 5 days to look for trends / opportunities for improvement. Home and Community Care Support Services entered into new small service provider contracts to increase resources to support patients. The ministry wage enhancement and PSW training program announcements are expected to have a positive impact on PSW recruitment and retention.
Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services	Many Home and Community Care Support Services geographies experienced nursing shortages as a result of the pandemic, further	Several Home and Community Care Support Services geographies continued to actively increase referrals to nursing clinics, taking a "Clinic first" philosophy, in

	exacerbating existing retirement / recruitment issues. Recruitment has been an issue due to wage disparities across health care sectors. These issues contributed to existing struggles in some geographies to provide nursing services in rural areas. Low population density, large distances and inclement weather contributed to challenges to see patients in a timely manner.	addition to opening additional clinic locations. We began the process to evaluate the appropriateness of virtual nursing visits that were conducted during the pandemic to determine patient experience and to develop guidelines for care. Virtual visits were implemented as a pandemic response measure so we do not have previously established metrics. We regularly met with service provider agencies to discuss the shortage of community nurses and ongoing recruitment challenges. Home and Community Care Support Services geographies entered into new small service provider contracts to increase resources to support patients.
90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)	Challenges with personal support, nursing and therapy health human resources at service provider organizations had an impact on wait times across several Home and Community Care Support Services geographies. Patient preference to delay service or change/cancel the first visit due to COVID-related concerns, family member availability or other reasons impacted performance. Many geographies saw increased referrals as patients started re-engaging with their primary care physician. In	Home and Community Care Support Services continued to focus on process improvement initiatives including prioritizing initial assessments and working with providers to develop a scheduling strategy. We continued to work with community support services agencies to transition low acuity patients to appropriate community services, creating PSW capacity for complex patients. Virtual tools and other technologies to support new ways of delivering care were implemented where appropriate.

	addition, some patients hadn't visited their physician during the pandemic and had a higher level of acuity when referred. Challenges in some Home and Community Care Support Services geographies with Care Coordination resources affected timeliness of assessments.	We implemented new recruitment strategies such as expansion of job posting sites and more frequent new staff orientation to more quickly hire and onboard new care coordinators.
90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care	Challenges with personal support, nursing and therapy health human resources at service provider organizations had an impact on wait times across several Home and Community Care Support Services geographies. Wait lists at publicly funded physiotherapy clinics increased referrals in some areas. Resumption of surgeries increased the need for post-op home care, further straining under-staffed service provider organizations and impacting wait times. Public Health guidelines related to outbreaks in congregate settings delayed discharges, thus increasing time to first visit. Challenges in some geographies with care coordination resources affected timeliness of assessment. Volume and complexity of patients supported in the community due to LTC beds	Virtual tools and other technologies to support new ways of delivering care were implemented where appropriate. Advocacy to Public Health to develop guidelines to facilitate safe discharge to and from outbreak settings. Partnered with other agencies, such as Community Paramedicine, to help facilitate discharges and support patients in their homes. Home and Community Care Support Services developed programs, such as High Intensity Services in the Home and Rehab @ Home, to target high needs hospital patients. We implemented new recruitment strategies such as expansion of job posting sites and more frequent new staff orientation to more quickly hire and onboard new care coordinators.

	being closed created further challenges.	
Wait times from application to eligibility determination for long-term care home placements: from community setting	During the COVID-19 pandemic, patients/families/caregivers deferred completing applications and Home and Community Care Support Services staff prioritized requests based on urgency. Families were reluctant to have staff visit face-to-face during the pandemic due to concerns about spread of COVID-19. This caused significant delays in the Care Coordinators' ability to complete the assessments and determine eligibility. COVID-19 pressures also delayed Health Assessments, which affected the Care Coordinators' ability to determine eligibility. Patients in hospital waiting for long-term care were prioritized as needing urgent placement due to hospital pressures, which delayed the placement process in the community as a result.	As the health care system begins to stabilize and recover from the pandemic, this performance indicator is expected to improve and return to pre-pandemic levels. Authorization of video assessments was provided to help expedite assessment and eligibility determination for patients in the community. Rapid Response nurses were utilized to complete outstanding health assessments and continue to do so when physicians are not available. Caseload review days were established for Care Coordinators to review caseloads and outstanding assessments/eligibility in order to assist with prioritizing this work.
Wait times from application to eligibility determination for long-term care home placements: from acute-care setting	This performance indicator improved. There was a positive impact for hospital flow to LTC related to amendments to the regulations allowing for priority and incentives for hospital patients.	Home and Community Care Support Services will continue to monitor this indicator and look for further opportunities for improvement.

Annual Business Plan Indicators

In our 2021-22 Annual Business Plan (also known as the Interim Business Planning Document), we included several performance metrics to determine our progress in achieving our strategic priorities. These priorities were set in late summer 2021 and the below progress update is reflective of a nine-month period, ending on March 31, 2022. All of the work listed below continues in 2022-23 under that year's Annual Business Plan.

Note – while listed as measurements in our Annual Business Plan, we did not include wait time indicators for nursing or personal supports in the below chart as those metrics are already listed as part of the provincial performance indicators. Additionally, there have been differences in the way our 14 organizations have measured or tracked data over the years and therefore, data is not always available from all geographies. As we continue to work more closely together, we anticipate having greater consistency in reporting moving forward.

Strategic Initiative	**Performance**	**Comments**
Drive excellence in care and service delivery		
Measure and increase the opportunities/initiatives where patients, families and caregivers are engaged as equal partners to encourage co-design	N/A	Opportunities for patient engagement were ad hoc as required on interview panels and some strategic initiatives. Patient and family advisors were involved in the development of our Quality Framework, which includes principles for co-design. Increased patient, family and caregiver engagement as well as measurables will be determined in 2022-23 as part of the development of a Community Engagement Framework.
Caregiver distress rate for long-stay patients – % of long-stay patients whose caregiver has indicated experiencing caregiver distress	Community Independence – 20.04% Chronic – 41.19% Complex – 71.46% *(for Mar. 2022 – reported monthly)*	A care coordination report by Ontario Health in November 2021 showed caregiver distress had increased over the previous year. Home and Community Care Support Services teams noted that in 2021-22, the added stress on caregivers was due to less access to long-term care beds caused by changes in physical space limitations, an increased number of patients with cognitive needs, an increased number of young adults with developmental support needs and aging parents, a shortage of direct service provider health human resources and the elimination of convalescent care beds/short-stay respite beds related to the pandemic. Planning is underway to improve this metric in 2022-23.

Missed care – the incidence of care that is not provided in accordance with the Patient Care Plan because a visit is missed, or the Service Provider Organization (SPO) does not have the capacity to deliver the care	Nursing shift – 1.8% Nursing visit – 0.1% PSW hours – 0.6% Therapy – 0.4% *(Combined Q1 – Q4 2021-22)*	These rates have increased since the start of the pandemic due to ongoing shortages of health human resources amongst service provider organizations, particularly for personal supports and therapy. We are requiring providers to report all instances of missed care in advance to the care coordinator and patient or caregiver so they can initiate their contingency plan. When providers have limited staff, they are expected to prioritize care needs so that patients with high/complex needs receive care. Missed visits are to be rescheduled within the same week.
Percentage of complaints acknowledged to the individual who made a complaint within two, five and 10 business days	96.5% within 5 days *(Combined Q1 – Q4 2021-22)*	During this reporting period, eight Home and Community Care Support Services organizations tracked this measurement.
Percentage of complaints closed within 30 calendar days and 60 calendar days	59.2% within 60 days – of those, 49.6% within 30 days *(Combined Q1 – Q4 2021-22)*	During this reporting period, 12 Home and Community Care Support Services organizations tracked this measurement.
Accelerate innovation and digital delivery		
Support Ontario Health to identify opportunities for CHRIS (Client Health and Related Information System – our provincial patient management system that supports the delivery of home and community care and long-term care placement services) and its ecosystems for enhanced integration and functionality, driving consistency among partners including community support partners	N/A	We worked with Ontario Health throughout 2021-22 to research and develop groundwork to leverage CHRIS as a provincial asset for Ontario Health Teams. Some of this work included planning for regional profiles and identifiers. Work continues to align Toronto Central with the other 13 Home and Community Care Support Services organizations to manage referrals through CHRIS.
Advance health system modernization		
Establish integrated models of care coordination in partnership with Ontario Health Teams and	N/A	We worked with Ontario Health and the Ministry of Health to develop a plan and process aimed at testing home care delivery with Ontario Health Teams. Part of this planning

our Patient, Family and Caregiver Advisors		included a focus on involving patients and caregivers in co-designing these models of care.
% of Ontario Health Teams with embedded care coordination functions	N/A	Care coordination is a key element in developing new models of care, with some Ontario Health Teams proposing to leverage Home and Community Care Support Services care coordinators in those models. This indicator is in development.
Invest in our People		
Number of internal promotions vs. external hires	N/A	This indicator is in development.
Staff retention and turnover	0.69% voluntary turnover *(for Feb. 2022 – reported monthly)*	The ongoing ability of Home and Community Care Support Services to provide care to our patients is dependent on our ability to maintain a stable workforce. However, some level of voluntary turnover may be desirable to allow opportunity for organizational rejuvenation. To assist our retention and recruitment efforts, we developed a brand statement and associated marketing campaign to rollout in 2022-23.
Employee engagement score	N/A	In 2021-22, Home and Community Care Support Services worked with a procured vendor to develop an employee engagement survey for all staff to be rolled out in late spring 2022. The results of the survey will be shared with staff and leaders in 2022-23 and will be used to enhance employee satisfaction and organizational culture, while also assisting with recruitment efforts.

Appointees

A cross-appointed Home and Community Care Support Services Board of Directors was established on July 1, 2021. This highly skilled and diverse group oversees all Ontario's Home and Community Care Support Services organizations and supports the continued provision of high-quality home care services with a cohesive provincial vision in support of the government's plan to modernize home and community care.

Name of Appointee	Date First Appointed	Current Term Expiration	Renumeration
Joe Parker	March 5, 2021	December 31, 2024	$23,100
Glenna Raymond	July 1, 2021	June 30, 2023	$5725
Carol Annett	July 1, 2021	December 31, 2024	$5400
Anne Campbell	July 1, 2021	December 31, 2024	$5600
Eugene Cawthray	July 1, 2021	December 31, 2024	$4100
Stephan Plourde	July 1, 2021	June 30, 2023	$5100
Michael Dibden	July 1, 2021	June 30, 2023	$3700
Shanti Gidwani	February 17, 2022	February 16, 2025	$700
Kate Fyfe	February 17, 2022	February 16, 2025	$1000
John Beardwood	February 17, 2022	February 16, 2025	$700

Financial Analysis

Home and Community Care Support Services organizations were established as crown agencies under the *Local Health System Integration Act, 2006*. On March 17, 2021, the Ontario Minister of Health issued a transfer order to transfer specific assets, liabilities, rights and obligations to Ontario Health. The items transferred were primarily associated with health system planning, funding and integration of the local health system in each respective geography. In addition, certain staff positions were transferred to Ontario Health. We now have a focused mandate to deliver local health care services such as home and community care, access to community services and long-term care home placement.

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

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

Home and Community Care Support Services Erie St. Clair
Home and Community Care Support Services Erie St. Clair delivered on its mandate, receiving a Ministry of Health funding allotment of $174,601,469 for the full fiscal year 2021/22. Expenses were $174,601,469, which resulted in a balanced year-end position.

Home and Community Care Support Services South West
Home and Community Care Support Services South West delivered on its mandate, receiving a Ministry of Health funding allotment of $255,778,313 for the full fiscal year 2021/22. Expenses were $255,778,313, which resulted in a balanced year-end position.

Home and Community Care Support Services Waterloo Wellington
Home and Community Care Support Services Waterloo Wellington delivered on its mandate, receiving a Ministry of Health funding allotment of $186,277,042 for the full fiscal year 2021/22. Expenses were $186,277,042, which resulted in a balanced year-end position.

Home and Community Care Support Services Hamilton Niagara Haldimand Brant
Home and Community Care Support Services Hamilton Niagara Haldimand Brant delivered on its mandate, receiving a Ministry of Health funding allotment of $408,490,560 for the full fiscal year 2021/22. Expenses were $409,132,671, which generated a year-end deficit of $642,111 due to additional operating costs required to meet its mandate. In recognition of the year-end deficit, the ministry has directed Home and Community Care Support Services Hamilton Niagara Haldimand Brant to submit a plan to address the 2021-222 deficit.

Home and Community Care Support Services Central West
Home and Community Care Support Services Central West delivered on its mandate, receiving a Ministry of Health funding allotment of $190,789,466 for the full fiscal year 2021/22. Expenses were $190,789,466, which

resulted in a balanced year-end position.

Home and Community Care Support Services Mississauga Halton

Home and Community Care Support Services Mississauga Halton delivered on its mandate, receiving a Ministry of Health funding allotment of $246,174,742 for the full fiscal year 2021/22. Expenses were $246,174,742, which resulted in balanced year-end position.

Home and Community Care Support Services Toronto Central

Home and Community Care Support Services Toronto Central delivered on its mandate, receiving a Ministry of Health funding allotment of $302,527,028 for the full fiscal year 2021/22. Expenses were $302,689,930, which generated a year-end deficit of $162,902 due to additional operating costs required to meet its mandate. In recognition of the year-end deficit, the ministry has directed Home and Community Care Support Services Toronto Central to submit a plan to address the 2021-222 deficit.

Home and Community Care Support Services Central

Home and Community Care Support Services Central delivered on its mandate, receiving a Ministry of Health funding allotment of $439,024,058 for the full fiscal year 2021/22. Expenses were $440,854,486, which generated a year-end deficit of $1,830,410 due to additional operating costs required to meet its mandate. In recognition of the year-end deficit, the ministry has directed Home and Community Care Support Services Central to submit a plan to address the 2021-222 deficit.

Home and Community Care Support Services Central East

Home and Community Care Support Services Central East delivered on its mandate, receiving a Ministry of Health funding allotment of $405,372,049 for the full fiscal year 2021/22. Expenses were $405,372,049, which resulted in balanced year-end position.

Home and Community Care Support Services South East

Home and Community Care Support Services South East delivered on its mandate, receiving a Ministry of Health funding allotment of $137,570,602 for the full fiscal year 2021/22. Expenses were $135,570,602, which resulted in balanced year-end position.

Home and Community Care Support Services Champlain

Home and Community Care Support Services Champlain delivered on its mandate, receiving a Ministry of Health funding allotment of $294,776,414 for the full fiscal year 2021/22. Expenses were $294,776,414, which resulted in balanced year-end position.

Home and Community Care Support Services North Simcoe Muskoka

Home and Community Care Support Services North Simcoe Muskoka delivered on its mandate, receiving a Ministry of Health funding allotment of $124,721,402 for the full fiscal year 2021/22. Expenses were $124,721,402, which resulted in balanced year-end position.

Home and Community Care Support Services North East

Home and Community Care Support Services North East delivered on its mandate, receiving a Ministry of Health funding allotment of $167,334,647 for the full fiscal year 2021/22. Expenses were $167,334,647, which resulted in balanced year-end position.

Home and Community Care Support Services North West

Home and Community Care Support Services North West delivered on its mandate, receiving a Ministry of Health funding allotment of $ $62,988,867 for the full fiscal year 2021/22. Expenses were $62,988,867, which resulted in balanced year-end position.

Appendix 1: Population Profiles

HCCSS	Population Profile	
Erie St. Clair	Area (km²):	7,324
	Total Population:	667,818
	% of Ontario Population:	4.39%
	Population Age 65+:	21.93%
	Population Growth Rate:	0.39%
	Population Density:	91.2
	Rural Population:	22.50%
	Indigenous Population:	3.40%
	Francophone Population (including IDF) *:	3.30%
	Low Income Population	15.9%
South West	Area (km²):	20,915
	Total Population:	1,046,213
	% of Ontario Population:	6.87%
	Population Age 65+:	21.36%
	Population Growth Rate:	0.78%
	Population Density:	45.6
	Rural Population:	39.80%
	Indigenous Population:	2.40%
	Francophone Population (including IDF) *:	1.40%
	Low Income Population:	15.00%
Waterloo Wellington	Area (km²):	4,751
	Total Population:	854,417

	% of Ontario Population:	5.60%
	Population Age 65+:	17.22%
	Population Growth Rate:	1.12%
	Population Density:	179.8
	Rural Population:	14.00%
	Indigenous Population:	1.70%
	Francophone Population (including IDF) *:	1.60%
	Low Income Population:	11.60%
Hamilton Niagara Haldimand Brant	Area (km^2):	6,474
	Total Population:	1,565,460
	% of Ontario Population:	10.28%
	Population Age 65+:	21.17%
	Population Growth Rate:	0.99%
	Population Density:	241.8
	Rural Population:	13.80%
	Indigenous Population:	2.70%
	Francophone Population (including IDF) *:	2.30%
	Low Income Population:	13.50%
Central West	Area (km^2):	2,591
	Total Population:	1,073,759
	% of Ontario Population:	7.05%
	Population Age 65+:	14.57%
	Population Growth Rate:	1.81%
	Population Density:	414.4
	Rural Population:	6.10%

	Indigenous Population:	0.80%
	Francophone Population (including IDF) *:	1.50%
	Low Income Population:	12.40%
Mississauga Halton	Area (km^2):	1,054
	Total Population:	1,416,611
	% of Ontario Population:	9.30%
	Population Age 65+:	15.77%
	Population Growth Rate:	1.78%
	Population Density:	1344.0
	Rural Population:	1.60%
	Indigenous Population:	0.70%
	Francophone Population (including IDF) *:	2.30%
	Low Income Population:	12.40%
Toronto Central	Area (km^2):	192
	Total Population:	1,440,644
	% of Ontario Population:	9.46%
	Population Age 65+:	16.45%
	Population Growth Rate:	1.58%
	Population Density:	7503.4
	Rural Population:	0.00%
	Indigenous Population:	1.10%
	Francophone Population (including IDF) *:	2.90%
	Low Income Population:	19.00%
Central	Area (km^2):	2,731
	Total Population:	2,088,723

	% of Ontario Population:	13.72%
	Population Age 65+:	17.24%
	Population Growth Rate:	1.49%
	Population Density:	764.8
	Rural Population:	3.70%
	Indigenous Population:	0.60%
	Francophone Population (including IDF) *:	1.70%
	Low Income Population:	15.80%
Central East	Area (km^2):	15,395
	Total Population:	1,766,707
	% of Ontario Population:	11.60%
	Population Age 65+:	18.84%
	Population Growth Rate:	1.02%
	Population Density:	114.8
	Rural Population:	14.60%
	Indigenous Population:	1.80%
	Francophone Population (including IDF) *:	1.80%
	Low Income Population:	15.00%
South East	Area (km^2):	18,253
	Total Population:	518,893
	% of Ontario Population:	3.41%
	Population Age 65+:	25.23%
	Population Growth Rate:	0.45%
	Population Density:	28.4
	Rural Population:	55.80%

	Indigenous Population:	4.70%
	Francophone Population (including IDF) *:	3.10%
	Low Income Population:	14.60%
Champlain	Area (km^2):	17,723
	Total Population:	1,456,921
	% of Ontario Population:	9.57%
	Population Age 65+:	18.82%
	Population Growth Rate:	1.08%
	Population Density:	82.2
	Rural Population:	21.50%
	Indigenous Population:	3.20%
	Francophone Population (including IDF) *:	19.80%
	Low Income Population:	12.80%
North Simcoe Muskoka	Area (km^2):	8,449
	Total Population:	534,752
	% of Ontario Population:	3.51%
	Population Age 65+:	21.86%
	Population Growth Rate:	1.31%
	Population Density:	63.3
	Rural Population:	41.50%
	Indigenous Population:	5.00%
	Francophone Population (including IDF) *:	2.70%
	Low Income Population:	12.20%
North East	Area (km^2):	395,920
	Total Population:	559,845

	% of Ontario Population:	3.68%
	Population Age 65+:	24.02%
	Population Growth Rate:	-0.10%
	Population Density:	1.4
	Rural Population:	47.30%
	Indigenous Population:	13.40%
	Francophone Population (including IDF) *:	22.50%
	Low Income Population:	14.90%
North West	Area (km^2):	406,926
	Total Population:	237,591
	% of Ontario Population:	1.56%
	Population Age 65+:	21.27%
	Population Growth Rate:	-0.04%
	Population Density:	0.6
	Rural Population:	54.20%
	Indigenous Population:	24.80%
	Francophone Population (including IDF) *:	3.10%
	Low Income Population:	13.20%

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

Appendix 2: Performance Indicators

ONTARIO MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	Provincial							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36%	89.86%	87.80%	86.69%	85.63%	85.29%	81.81%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	96.07%	96.25%	95.87%	95.66%	94.11%	91.58%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	29.00	29.00	30.00	29.00	28.00	27.00	25.00	31.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	7.00	7.00	8.00	9.00	12.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	13.00	13.00	13.00	12.00	13.00	14.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	7.00	7.00	7.00	7.00	7.00	6.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

ERIE ST CLAIR LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.45%	90.54%	93.46%	95.51%	92.35%	88.52%	89.70%	86.90%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.04%	95.03%	95.88%	96.46%	96.01%	95.10%	95.30%	95.10%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	18.00	19.00	26.00	27.00	28.00	21.00	23.00	30.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	5.00	5.00	6.00	6.00	6.00	7.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	10.00	10.00	11.00	9.00	11.00	9.00	14.00	13.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	5.00	4.00	3.00	3.00	2.00	2.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

SOUTH WEST LHIN MLAA INDICATORS

2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	90.87%	88.95%	91.99%	88.90%	84.74%	79.87%	83.60%	81.50%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	92.59%	93.10%	93.69%	94.01%	93.16%	92.79%	89.40%	87.70%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	21.00	21.00	22.00	30.00	25.00	26.00	26.00	35.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	8.00	9.00	10.00	12.00	15.00	19.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	8.00	9.00	7.00	8.00	8.00	7.00	8.00	9.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	4.00	4.00	3.00	3.00	3.00	3.00	4.00	4.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

WATERLOO WELLINGTON LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	84.50%	85.66%	92.90%	95.32%	97.21%	95.57%	84.80%	76.50%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	94.77%	93.97%	95.98%	97.00%	96.11%	96.57%	94.30%	87.20%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	12.00	13.00	13.00	14.00	14.00	15.00	19.00	35.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	5.00	5.00	6.00	6.00	9.00	12.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	12.00	11.00	9.00	10.00	11.00	9.00	11.00	13.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	4.00	5.00	5.00	5.00	5.00	5.00	4.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

HAMILTON NIAGARA HALDIMAND BRANT LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	89.37%	90.28%	89.92%	88.63%	85.05%	86.03%	86.00%	79.30%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	92.67%	93.69%	95.97%	95.89%	95.79%	95.32%	93.90%	89.60%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	25.00	28.00	28.00	28.00	34.00	33.00	31.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	6.00	6.00	6.00	7.00	8.00	11.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	9.00	8.00	8.00	9.00	10.00	10.00	13.00	14.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	5.00	6.00	8.00	8.00	8.00	9.00	8.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

CENTRAL WEST LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.23%	88.97%	85.31%	82.61%	85.93%	82.73%	87.50%	85.50%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	96.52%	95.43%	95.17%	95.69%	96.48%	96.05%	95.90%	94.90%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	19.00	21.00	24.00	30.00	29.00	36.00	20.00	30.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	8.00	8.00	9.00	9.00	8.00	10.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	21.00	18.00	20.00	21.00	19.00	18.00	18.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	12.00	13.00	11.00	14.00	14.00	13.00	14.00	11.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

MISSISSAUGA HALTON LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.07%	91.48%	92.63%	90.81%	90.99%	90.91%	91.60%	88.30%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.22%	95.58%	96.69%	96.60%	95.99%	95.61%	94.10%	93.20%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	27.00	28.00	34.00	27.00	24.00	23.00	23.00	28.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	11.00	9.00	10.00	11.00	13.00	14.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	15.00	12.00	12.00	15.00	16.00	12.00	15.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	17.00	11.00	12.00	15.00	10.50	12.00	13.00	10.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

TORONTO CENTRAL LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.47%	85.03%	93.95%	95.57%	95.54%	96.40%	96.40%	94.90%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.64%	93.50%	96.19%	96.06%	96.46%	95.77%	95.70%	95.50%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	25.00	26.00	26.00	26.00	28.00	27.00	21.00	28.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	8.00	9.00	10.00	10.00	13.00	17.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	3.00	N/R***	N/R***	N/R***	N/R***	N/R***	N/R***	6.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	11.00	N/R***	N/R***	N/R***	N/R***	N/R***	N/R***	5.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

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

CENTRAL LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	84.35%	83.68%	92.39%	93.03%	94.12%	93.81%	94.50%	91.90%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	94.13%	94.23%	96.65%	96.41%	95.93%	96.09%	95.90%	95.10%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	31.00	33.00	33.00	22.00	22.00	20.00	16.00	20.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	6.00	6.00	5.00	6.00	5.00	6.00	7.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	17.00	22.00	19.00	21.00	21.00	20.00	22.00	21.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	6.00	4.00	5.00	4.00	3.00	5.00	4.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

CENTRAL EAST LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	87.88%	88.69%	90.64%	90.10%	87.75%	88.48%	88.60%	84.60%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.67%	95.84%	96.83%	96.51%	95.99%	96.27%	94.50%	92.30%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	30.00	49.00	41.00	39.00	31.00	23.00	27.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	13.00	10.00	9.00	9.00	10.00	12.00	12.00	15.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	21.00	20.00	17.00	20.00	20.00	16.00	25.00	21.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	10.00	10.00	8.00	8.00	9.00	8.00	11.00	8.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

SOUTH EAST LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	86.84%	84.62%	90.72%	88.12%	87.37%	80.26%	69.90%	73.70%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	92.70%	91.90%	96.14%	96.28%	95.04%	93.64%	89.10%	81.70%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	21.00	22.00	21.00	20.00	22.00	22.00	35.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	7.00	7.00	7.00	7.00	7.00	7.00	12.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	13.00	15.00	14.00	13.00	13.00	13.00	18.00	18.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	7.00	6.50	8.00	11.00	14.00	8.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

CHAMPLAIN LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	78.86%	77.03%	77.33%	71.39%	68.16%	66.12%	61.70%	59.30%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	91.70%	93.48%	96.04%	96.08%	95.29%	95.25%	92.60%	86.10%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	62.00	55.00	34.00	50.00	45.00	40.00	46.00	73.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	8.00	11.00	9.50	10.00	14.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	21.00	24.00	24.00	23.00	13.00	N/R***	N/R***
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	11.00	10.00	9.00	13.00	16.00	N/R***	N/R***	N/R***

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

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

NORTH SIMCOE MUSKOKA LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	69.53%	77.19%	89.20%	87.03%	86.56%	86.89%	87.50%	80.60%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	91.52%	93.08%	95.79%	97.62%	98.13%	97.75%	97.20%	96.40%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	69.00	67.00	51.00	41.00	32.00	27.00	27.00	27.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	7.00	8.00	6.00	8.00	9.00	12.00	12.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	19.50	15.00	15.00	14.00	13.00	14.00	20.00	20.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	13.00	15.00	24.00	28.00	34.00	29.00	20.00	12.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

NORTH EAST LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	86.06%	83.70%	96.05%	87.65%	85.99%	83.10%	79.80%	70.30%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.61%	94.09%	98.20%	98.49%	98.25%	98.50%	96.90%	96.20%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	70.00	48.00	39.00	31.00	28.00	24.00	22.00	30.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	11.00	9.00	7.00	7.00	8.00	7.00	8.00	9.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	8.00	8.00	7.00	7.00	7.00	7.00	3.00	4.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	9.00	11.00	9.00	9.00	8.00	7.00	9.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

NORTH WEST LHIN MLAA INDICATORS
2021/22 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN							
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result	2021/22 Fiscal Year Result (Year to Date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	76.43%	78.52%	83.92%	83.46%	85.23%	93.59%	94.50%	95.80%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	89.31%	88.32%	95.86%	96.09%	95.73%	97.38%	98.40%	97.40%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	35.00	28.00	30.00	26.00	23.00	22.00	18.00	20.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	5.00	5.00	5.00	5.00	5.00	6.00	6.00	7.00
2. Monitoring Indicators										
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	35.00	34.50	32.00	27.00	36.00	16.00	14.00	11.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	15.00	12.00	14.00	11.00	12.00	10.00	8.00	9.00

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2021/22 is based on the available data from the fiscal year (Q1-Q3, 2021/22)

Audited Financial Statements

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

Erie St. Clair
English French

South West
English French

Waterloo Wellington
English French

Hamilton Niagara Haldimand Brant
English French

Central West
English French

Mississauga Halton
English French

Toronto Central
English French

Central
English French

Central East
English French

South East
English French

Champlain
English French

North Simcoe Muskoka
English French

North East
English French

North West
English French