Unleashing the Potential in Home & Community Care
The aim of this goal is to deliver better coordinated and integrated care in the community, closer to home.

There are a multitude of challenges to overcome though, in achieving this transformation:

**Increasing demand**
- Aging demographics mean more seniors are and will be looking for supports to stay at home
- Pressures on other parts of the health system like hospitals and long term care mean patients are discharged quicker or kept out altogether

**Financial pressures**
- Increased costs of care delivery
- Wage increases and harmonization
- Funding and revenue from other sources unable to keep up or declining
- Increased need to ensure value for money

**Changing patient expectations**
- More patients want to remain at home as long as possible
- Technology changes in other industries are radically changing traditional ways of doing things and raising expectations for health care

**Traditional structures, relationships, & models of care**
- Ways of working, how agreements and contracts are set up, and how the health system itself is organized can:
  - Limit innovation, transparency, & availability of information
  - Provide disincentives to change and improve
  - Disconnect delivery organizations from the populations they serve

LHINs have a unique opportunity to significantly impact the operation of the health care system through optimization, capacity building, and further integration following CCAC transition into the LHINs.
On top of this, home care has lagged behind other industries in using technology

Leveraging the possibilities of current technology could radically change home care delivery, making it better for patients and providers and enabling LHINs to plan for future demand and capacity.

Provision of home care is a difficult, daily logistics challenge (MDVRPTW Problem^ to be exact) to provide the right care, at the right time, in the right place, by the right provider.

The current methods of managing this daily challenge leave significant room for improvement.
Homecare Intelligence (HCI) turns these home care challenges into opportunities

HCI up-ends the status quo by providing a “home care control tower” that is the most comprehensive and flexible technology in the business.

The control tower arms the home and community care system with solutions to combat its challenges.

**THE HCI OPPORTUNITY**

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<th>CHALLENGE</th>
<th>THE HCI OPPORTUNITY</th>
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<td>Increasing demand</td>
<td><strong>Free up system capacity</strong></td>
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<td>Financial pressures</td>
<td>• Optimize care provider utilization</td>
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<td>Changing patient expectations</td>
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<td>• Improve care provider satisfaction</td>
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<td>System structure, relationships, &amp; models of care</td>
<td><strong>Find system efficiencies</strong></td>
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<td>• Reduce care provider travel time &amp; travel costs</td>
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<td>• Reduce time &amp; resources for visit scheduling with better results</td>
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<td>• Free up dollars/people for other initiatives</td>
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<td>• More visits, more patients seen</td>
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<td>• Better match patient needs with provider skill sets</td>
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<td>• More time for patients</td>
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<td>• Increase continuity of care</td>
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<td>• Quicker response to urgent requests and unexpected events while minimizing disruption to patients</td>
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<td><strong>Exceed patient expectations</strong></td>
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<td>• Make patient communication and reminders more timely</td>
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<td>• Reduce missed visits</td>
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<td>• Increase compliance with care plans</td>
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<td>• Obtain near-real time patient feedback post-visit</td>
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<td><strong>Change structures, relationships, &amp; models</strong></td>
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<td></td>
<td>• Better match patient needs with provider skill sets at time of referral</td>
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<td>• More transparent information on home care system performance &amp; resources</td>
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<td>• Enable emerging models of care &amp; funding</td>
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<td>• Rapidly assign providers best matching patient need at lowest cost</td>
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<td>• More accurate measurement of existing indicators</td>
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<td>• Measure new indicators of system performance</td>
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<td>• Enable health human resource planning and mobilization</td>
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<td>• Rapidly respond to changes in referring organizations, populations served, geographic boundaries, and caseloads</td>
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HCI’s sophisticated scheduling, routing, & business intelligence technology transforms home & community care

Find best fit provider agency
- Patients are matched, at time of referral, to the provider organization best able to meet their needs and preferences, provide the best continuity of care, for the lowest cost
- Honour market share, award higher volumes created by efficiencies

Communicate with patients
- Automatically call patients the night before to confirm their next-day visit
- Send medication and other reminders to patients
- Call or survey patients after their visit to see how it went
- Patient engagement
- Machine Learning

Optimize provider schedules
- Assigns the team/individual provider best able to provide the best care
- Generate daily & weekly schedules for individual providers:
  - Match patient needs and preferences
  - Ensure continuity of care
  - Minimize travel times and distances
  - Build in provider constraints
- Adjust schedules quickly for urgent service requests and last-minute sick calls
- Route thousands of visits accurately in minutes

Adjust geographies quickly
- Generate flexible geographies for assigning caseloads and providers, and identifying sub-regions and neighbourhoods
- Takes into account a variety of factors including location of health care assets, patient population, workloads, etc.
- Team planning and workforce management

More Productive on the road
- Individual providers use their mobile devices to:
  - View visit calendars & visit details
  - See past and future visits (including those of other resources)
  - Order visits to honour timed visits, ensure completion, reduce drive time and distance
  - Check-in and check-out before and after visits
  - Realtime traffic routing and GPS

See the system
- Dashboards for SPO Managers help monitor performance and identify opportunities for improvement
- Collect more accurate and timely data on performance (for existing and new measures)
- See home care resources available to the system (for planning, emergency response):
  - Type and number of resources (RN, RPN, PSW)
  - Certifications and skillsets (palliative, wound)
  - Geographic location/base
A successful implementation at Visiting Nurse Health System Atlanta yielded measureable results:

**Efficient scheduling**
- 85% reduction in daily unassigned visits
- 99% reduction in weekend scheduling time
- 50% reduction in scheduling staff
- 18% increase in completed visits
- Easier to recruit & train new schedulers

**Patient & provider satisfaction**
- 20% reduction in clinicians per patient
- Increased patient satisfaction
- Reduction in clinicians’ daily scheduling & routing time
- Increased clinician satisfaction due to reduced drive time, reduced time sequencing visits, smaller patient clusters

**Better analysis**
- Faster management visibility to operational metrics
- Increased ability to adjust staffing levels in advance of need (e.g. holiday surge)
- New ability to target clinician recruitment in areas of greatest need
“...our staff have increased the valuable time they spend with patients.

We are providing more visits within the same staffing complement and we have reduced our travel costs. Innovation like this is an imperative in home care to ensure patients receive the best possible care and improve outcomes...”

Former CEO, Erie St. Clair CCAC

“...this product has revolutionized how we do business, while enhancing our patients’ satisfaction...and offering a better quality of life for our clinicians.”

CIO, Visiting Nurse Health System of Atlanta

“The HCI technology is a powerful tool that has revolutionized the way home care is delivered...

...Both public and private sector leaders can now drive better outcomes and minimize the labour intensive manual scheduling process. What took days or hours, now takes seconds with accuracy unachievable by standard means.”

Former CEO, Central West CCAC

“Best in class software, long overdue in home care.

Reduces strain on our valuable front line staff.

Cuts costs and improves care, an imperative technology for both Service Provider Organizations and CCACs/LHINs/Government.”

Former CEO, Central West CCAC
The potential in Ontario is transformational

By streamlining home care delivery in Ontario with HCI, there would be a significant reduction in travel time and travel costs, and better pairing of the right care provider with the right client. This improvement would significantly reduce wait times and travel reimbursement costs, and provide health care to thousands more clients every year (capitalizing on existing capacity).

<table>
<thead>
<tr>
<th>2015/16 Annual Ontario Home Care Expenditures &amp; Activity¹</th>
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<tr>
<td><strong>Contracted Out Services²</strong></td>
<td><strong>Care Coordination</strong></td>
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<tr>
<td>$1.7 billion spent by LHINs</td>
<td>$0.5 billion</td>
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<tr>
<td>8.5 million Visits³</td>
<td>0.7 million Visits</td>
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<tr>
<td>31.5 million Hours⁴</td>
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**HCI POTENTIAL**

- Reduced Costs
  - $31.8 million in Service Provider travel⁵
  - $35.6 million in Service Provider scheduling⁶

- Increased Capacity
  - 6.4 million more Service Provider visits⁷
  - 0.6 million hours clinician time freed up from visit confirmation calls⁸

- $0.4 million in Care Coordinator travel⁹
  - 127,000 more Care Coordinator visits¹⁰
  - 12,000 hours in visit confirmation time saved¹¹

See page 19 for endnotes
Innovation Adoption

“Innovation is new or better ways of doing valued things. An invention is not an innovation until it has been implemented in a meaningful extent. Innovating is not limited to products, but includes processes and new forms of business organization.”

If there are better ways to:

- improve patient outcomes
- improve patient experiences
- grow health human resource capacity
- improve working environments for clinicians
- Improve system capacity, and
- better utilize taxpayer dollars

as leaders and stewards of the health care system, are we not obligated to act?

“While an ‘innovation adoption deficit’ in the general economy hurts Canada’s economy and our prosperity, that deficit has profound impacts on our health and health care system. By failing to more quickly adopt new technologies, innovative processes and procedures, Canadian healthcare is becoming less and less efficient, more and more expensive”

Realizing the potential "moving as ONE"

With home care demand outpacing system capacity and increasing financial pressures to reduce system costs, there is an urgent imperative to transform the system—in a way that is sustainable and flexible enough to meet continually changing system needs. SPOs and LHINs need to work together.

A system approach means the system benefits:

The home care logistics problem is really about finding the best solution among all available options—fragmentation of the problem will cut into the power and efficiency benefits that optimization brings for the whole. ONE solution for the Province garners the greatest efficiencies. In this instance, the presence of multiple solution providers deeply hinders impact and gains.

Example: Implementing with individual Service Providers by multiple non-interoperable solutions limits critical mass efficiencies. By implementing a region-wide solution, savings are shared which drives up volumes; more visits and more care can be provided. Participating SPOs could realize ~15% volume growth which means all stakeholders—most notably patients—share in the benefits.

Corollary: OHIP Schedule of Benefits for procedures like cataract surgery, where physicians saw financial benefits of technology changes for procedures that significantly reduced surgery time and therefore increased volumes performed.

Optimization at the point of referral is crucial to system health and savings. We must move as “one” regionally to realize the greatest gains and prepare the system for growing demands.

Current referral processes from LHIN to Service Provider are based on market share, without regard to the resources available to each Service Provider and their skillsets, availability, and location. Optimizing at point of referral would reduce travel time drastically and reduce the number of declined referral offers and speed up the time to service offer acceptance.

Optimization could look across traditional LHIN geographic boundaries to find efficiencies, particularly in densely populated areas where LHIN boundaries converge (e.g. Greater Toronto Area).

HCI’s solution can be expanded to include other community services agencies and be used in implementing different funding and service models (e.g. hospital bundled care which includes out of hospital care, self-directed care, Price Report recommended primary care patient care groups, CSS sector).
Realizing the potential

Information for smarter decisions and ensuring value for money

HCl’s optimization tools can help LHINs to effectively and responsibly implement and manage potential changes like:
- PSW rate harmonization
- Direct reimbursement of Service Provider travel costs by LHINs

Without a means of tracking and managing these costs, there would be a significant impact:
- LHINs would incur all direct costs associated with suboptimal scheduling and routing
- LHINs would have no means to validate or control these costs
- LHINs would have no incentives for providers to keep those costs down

Personal and proprietary information should and can be protected. Stakeholder autonomy must be honoured. Co-Design / Collaboration.

Health human resource data within any solution should be anonymized when accessed by those from outside an employee’s home organization. SPOs must retain autonomy, ensure competitive advantages, and share in the benefits.

Ontario’s move to focus on:
- Sub-region populations
- Price Report recommended patient care groups in primary care

means more detailed, geographically-based information is needed to understand population health status and capacity.

Not to mention the ability to rapidly respond to changing health care needs by quickly mobilizing health human resources.

HCl’s solution uses census dissemination areas to create dynamic geographic boundaries to enable rapid redistribution of health resources in response to changing demand (e.g. caseload changes).

Coupled with the system’s ability to capture location of health care assets (e.g. primary care, long term care homes, etc.), HCl can provide LHINs with a regional view of health care supply and demand, enabling a response to “hot spots.”

HCl’s approach has been shown to be much more responsive, simple to use, and more effective than traditional geographic mapping approaches such as postal codes or CHRIIS geocoding functionality.
Homecare Intelligence Canada is a software technology company focused on improving operations for the home care and community health industry.

As the premier home care logistics company in Canada, our goal is to improve patient care and safety, patient and clinician experiences, and reduce systemic costs through the power of logistics science and other advanced technologies. HCI’s business value lies in the wise application of advanced technologies to the complex use case of home care delivery:

- Logistics
- Machine learning
- Business intelligence
- Geographic analysis

HCI’s founding team was able to crack the code for home care logistics by collectively leveraging their extensive experience in home care, consulting, software development, and provincial health care operations.

Our Team

Deborah Emerson
*President and Chief Executive Officer*

Eric Odom
*Chief Technology Officer*

Matt Willson
*Chief Financial Officer*

Iris Fung
*Vice President Operations*

Steve Pancino
*Director*

Our Partners

Currently HCI works with LHINs, Governments, Provinces, RHA’s, EHR’s, Service Provider Organizations, Innovation Centres, Patient advisors, Consultants, Associations, Academic Institutions, and a myriad of system stakeholders in an effort to ensure system-wide Provincial and regional efficiencies. Our aim is to work across and together with all system partners to coalesce around a single solution to ensure system sustainability, improve patient care, and support our important workforce as a whole.
To our knowledge there are no proven, mature, or tested VRP technologies working within the same home care ecosystem and providing similar outcomes.

To date a small number of companies continue to try to crack the vehicle routing problem for home care. However, these solutions are in ideation, research and development, or early development stages with theoretical designs.

These competitors are likely years away from offering a solution that is operationally usable and even farther away from a rigorously tested, scalable, and proven solution. Their solutions, even when developed, will likely face interoperability challenges given they are not necessarily backend-agnostic—so wide scale adoption is limited.

As a result, they have core competencies that lie outside the fleet scheduling, logistics, and business intelligence expertise that drives HCI. Claims about mileage savings are generally garnered by pointing their users to basic mapping applications to find shortest routes. This isn't a solution.

The HCI solution and mobile application, coupled with our team’s home care expertise, together provide many benefits in a single integrated solution:

- Geofencing for visit verification
- Visit completion and documentation
- Automated visit billing and mileage calculation
- Optimization of visit sequencing by clinicians
- Automated notification to patients (auto-call)
- Heuristics-based optimization of visit assignment over entire episodes of care
- Operational management dashboards and more

An additional benefit is assisting the LHIN and its partners in health human resource planning and mobilization in emergency or surge situations. This could include rerouting resources to assist in community disasters, floods, fires, hospital closures (all of which have happened in Ontario). We are not an EHR/EMR or enterprise solution. We do not propose sweeping vendor changes or aim to unseat any existing software systems in place. HCI simply optimizes and enhances what currently exists. We monetize our projects with actual savings.
For more info(read on or) find us at:
http://homecareintel.ca

Or Contact Us At:

E-mail: info@homecareintel.ca
Canada: (561) 506-4613
USA: 1 (800) 763-1957
UK: (+44) 7464-720798
What It’s All About—the “Why” Question

Innumerable studies have demonstrated that home care is one of the best and least expensive ways for a society to deliver needed care to an aging population. Few educated people question the key role for quality home care in any civilized health care system. Yet, the aging demographics that we all know too well present a seemingly insurmountable challenge. Human decency and compassion dictate that we must find a way to service the increasing demand for homecare without cutting services, taking more from our hard-working taxpayers, or unfairly penalizing other critical system players. In the same way that businesses innovate—reducing costs, adding value for customers, and improving productivity—so too must health systems innovate.

We at HCI share the vision of a health system where patients come first, and where all the stakeholders work together in good faith to build sensible, patient-centered, outcome-oriented processes. We believe the “rising tide” of innovation can “lift all ships” for the good of all parties involved.

So let’s be frank. HCI has cracked the code and solved an incredibly challenging “NP hard” problem in the realm of home care. Not only did we solve the problem mathematically, but we solved it operationally—in the real world. Our solution is in full production use in both Canada and USA and expanding in the UK. Data and case studies prove that the benefits of our technology are achievable in practice, not just in theory.

Coping with Change, Fear, and “Cheese Displacement”

Some of you may be familiar with the number one bestselling book, Who Moved my Cheese? by renowned author and physician Spencer Johnson (also author of The One Minute Manager). In it, Johnson urges the reader to view change not as the end of something, but rather as a new beginning. He says, “If you do not change, you can become extinct.” This is particularly true in home care, and Johnson, with a background in psychology, aptly arranges his theory of change around mice and cheese. Continuing his analogy, what we have before us is an opportunity to create more and better cheese for all entities of the system, especially patients, without increasing expenditure on cheese.

Let’s look at the question of health care change, from a couple different stakeholder perspectives:

- Sometimes Service Provider Organizations / Home Health Agencies (SPO’s) feel undervalued, questioned and over-managed. They often express a “disconnect” with Funders/Payors.
- Funders sometimes find it challenging to effect change given the multitude of demands, challenging procurement environments, and the pressure of ensuring sustainability of the greater system. They also work in complex policy and legislative environments, answer to many stakeholders, and wear many hats.

The current initiative brings together both groups in a dialogue to co-design a patient-centered, SPO-valued, Funder-supportive, continuously improving solution. This conversation bridges the public, private and academic divide, and leads to action on behalf of our citizen-patients.
Concept and Cost—the “How” Question

Can you imagine a world where UPS™ or FEDEX™, the trucking sector, busing sector, and many other “sectors” didn’t use algorithms and software to get food to your grocery store or the latest gadget to your door? Currently, our health system is delivering millions of care visits without the benefit of those same tools. Until now, there was no choice but to rely on human beings with limited tools, outdated methodologies, and imprecise practices—the technology to transform visit assignment did not exist.

In fact, the problem was long considered unsolvable due to its mathematical complexity. Perhaps you have heard of the “Traveling Salesperson Problem” or TSP. Home health clinician scheduling and routing is better compared to a more complex problem, known as Multi-Depot Vehicle Routing Problem with Time Windows (MDVRPTW)—that’s the most applicable version of the problem that is addressed in mathematical literature. Here are a couple of abstracts on the problem, even though home care is subject to still more constraints than addressed in the MDVRPTW models:

Now, equipped with innovations that never existed before, we are within arm’s reach of a systemic improvement in home care efficiency. All stakeholders can benefit from a “level up” in productivity of the system, acknowledging that the most efficient solutions to the problem encompass all the visits within the subject geographic area—taking into account more than just volume and market share.

Here’s one view from 30,000 feet, aligned to a similar jurisdiction in Europe but applicable to Ontario as well:

- In a single-payer health system, there are two primary levels of optimization necessary to achieve maximum efficiency and savings. Improved assignment of referrals (tier one optimization) is the first step in unlocking maximum impact. Instead of referring randomly and “ordering” visits sequentially after they are referred out, more efficiencies are gained if Funders view assets regionally and refer out to Providers that are known to have a clinician with the right skills, availability, and proximity while honouring market share and volume constraints.

- Second, after the initial ordering of referrals, SPOs still face operational issues such as sick calls, patient preferences/changes, in-services, FT staff assignment over PT, and continuous workflow disruptions which require post-referral optimization. These are finite adjustments; much of the heavy lifting is done back in the first step. And by finite adjustments, we mean click a few buttons and its done and pushed to our mobile app—fully re-optimized yet still allowing the clinician to re-order his/her day on the fly including changing her starting or ending locations if needed. The end user won’t perceive the massive and complex mathematical calculations completed instantly in the background, but he/she will see and feel the benefits.

- Keep in mind the algorithm accommodates any organizational or patient constraints like specialized skills, language and/or religious preferences, male or female providers, clinician constraints such as allergies to smoke, time preferences, FT vs PT weighting, and much more—all while prioritizing continuity of care over the entire episode of care. No human being (or team of humans) is capable of taking all these factors into account when creating a schedule of visit assignments. It can only be done through a computerized AI approach.
Opinion: The Opportunity Before Us

Naturally the next question is about cost-benefit and proposed model to maximize benefits to better serve all our citizen-patients. This conversation involves you—it’s a “co-design,” and any proposed model is just a starting point as we move through the project. Come to the table, we want to hear your voice. Speak up, talk about maintaining a competitive advantage, privacy, data security, organizational impact, change fatigue, “what’s in it for me,” Jedi mind tricks—reach out to us to find out how your organization can be heard.

Typical software business models are counterintuitive and in fact counterproductive to leveraging the power of a single payor system. These models create an environment where the purchaser must consider their ROI or try to “offset” a static cost. HCI works with existing budgets and constraints and prides itself on a unique and more stakeholder-focused monetization model. HCI’s business model is proudly unlike most software vendors, where seat or license fees are levied regardless of outcomes or promised efficiencies. We believe at heart that we’re all in it together, and we share risk and reward.

A system where visit assignment and optimization is shared throughout the entire region generates substantially more efficiencies and systemic benefits than a system where each provider or sub-region optimizes in isolation. Similar to managing pharmaceutical costs by purchasing as a single buyer to get the best possible price, acting as a single entity in a single payor home care system can garner similar outcomes.

Recognizing and honouring the unique objectives, goals, and strategies of each stakeholder as well as each entity’s important expertise, it is crucial to understand that operating in this unique ecosystem affords us all the opportunity to contribute and share in the savings and benefits garnered by close collaboration to best serve the patients.

Finding the Best Optimization Provider

The EHR software vendors meet a broad and important need, just like family doctors do. But when you have a serious heart problem, you visit a cardiologist, not a family doctor. In the same way, if you want a solution that delivers fully on the promise of productivity and optimization, you will better serve your organization and patients with a specialist in the area of home care logistics.

Aside from the issue of specialization, there is the obvious issue of interoperability and adoption. Multiple software vendors and multiple SPOs within a region are unlikely to share data or allow cross-integrations with each other, in order to support regional optimization. Clearly, a regional routing and optimization vendor should be and must be independent and back-end agnostic. It is a sector unto itself for that reason. Conversely, if all the existing software providers provide homegrown solutions and use widely varying optimization tools, so too will the outcomes vary widely. If the Funder uses one algorithm that pushes out the “most correct” recommendation, but sub-optimization is compromised by variant algorithms or no algorithm at all, how then can a broader system capitalize on truly maximized efficiencies?
Opinion: The Opportunity Before Us

HCI’s solution required years of software development and real-world testing with numerous home care agencies to deliver a flexible, high-performing, production version of our solution, purpose-built for the unique Canadian home care industry.

While many new entrants into this space are seeking funding to build or acquire a “like” technology in a market sector that HCI literally created, money isn’t the most salient aspect of solving the “NP-hard” MDVRPTW problem. The full equation is “time + money + talent + Canadian expertise.”

HCI has never replaced nor does it seek to replace a single EHR (they are important partners and a key component of the modernization of the Canadian Health system)—we integrate with EHRs to make the whole system better for everyone. Many Canadian and US EHR companies have engaged us to utilize our software; however, their objectives are incongruent with HCI’s notion of a patient- and system-first platform. The idea that optimizing in isolation is better for our patients is one we reject. However, in the absence of a broader geographic approach, any optimization must be pursued with vigor to the benefit of our patients. For those readers who may be contemplating a solution for optimization, we recommend that you engage a specialist in home care logistics, even if you feel you must move ahead with optimization in isolation. However, if you wish to share in the rewards of a regional solution (see above data in main document), we must collaborate together to the benefit of the region, putting patient interests first. A detailed consideration of broad and varying inputs will allow you to make an informed decision.

The Road Ahead

HCI is excited to continue our work with LHINs, SPOs, solution providers, patient advisors, and all stakeholders in the home care and community health system of Ontario. We bring a valuable innovation to the table, one that we believe will help create a “rising tide” for all stakeholders. It has been a privilege to be able to share our solution with innovative, forward-thinking leaders in Ontario whom we believe should be recognized for their excellence in leadership. Change is never easy, but having the courage to embrace it will leave a legacy of unparalleled excellence for all patients in the Province. Time is of the essence; while a unique opportunity is within reach, the longer the delay the greater the likelihood that localized, non-standardized, non-interoperable, and potentially suboptimal solutions may take hold—jeopardizing the advantages of a co-designed regional solution.

Let us work together and build a system that will be a point of reference for “like” health systems globally on the world stage. In collaboration, we can impact not only our health system, but our broader economy and also strengthen our commitment to Patients First.
1. Source: Ontario Ministry of Health & Long-Term Care (MOHLTC) Healthcare Indicator Tool (HIT).

2. Includes all nursing, personal support, therapies and other contracted out services costs.

3. Includes nursing, therapies and other visits.

4. Includes nursing shift, personal support and other hours.


6. Assume 50% scheduling cost reduction based on current customer performance measures. Actual scheduling costs estimated by service using percentages calculated in October 2013 Accenture report cited above for Supervision and Coordination applied against MOHLTC HIT CCAC data. Assume 40% of supervision and scheduling costs are for scheduling.

7. Assumes 18% increase in capacity based on current customer performance measures. Based on in-home visits only for nursing, personal support, therapies (assume 1 hour = 1 visit for personal support).

8. Based on in-home visits and in-home hours only. Assumes one, 1-minute call per visit, one personal support hour = 1 visit, six nursing shift hours = 1 visit.

9. Assumes 15% reduction in Care Coordinator travel reimbursement based on current customer performance adjusted for lower number of average number of daily visits. Actual travel reimbursement estimated assuming 0.1% of CCAC expenses are related to travel reimbursement (based on Auditor General of Ontario’s estimate of Care Coordinator travel and documentation costs as percent of total CCAC costs in *Special Report: Community Care Access Centres Financial Operations and Service Delivery 2015*, pg 30).

10. Assumes 18% increase in capacity based on current customer performance measures. Based on face-to-face visits for Care Coordinators.

11. Based on Care-Coordinator face-to-face visits. Assumes one, 1-minute call per visit made by Team Assistants.