HSPN Health System Performance Network

Ontario Health Team Leading Projects

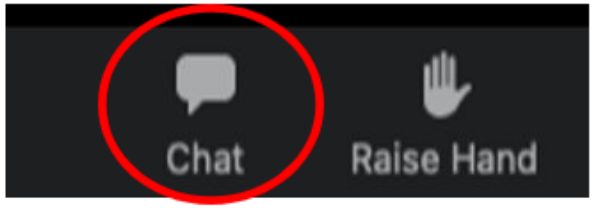
Learnings from (an ongoing) Realist Rapid-cycle Evaluation

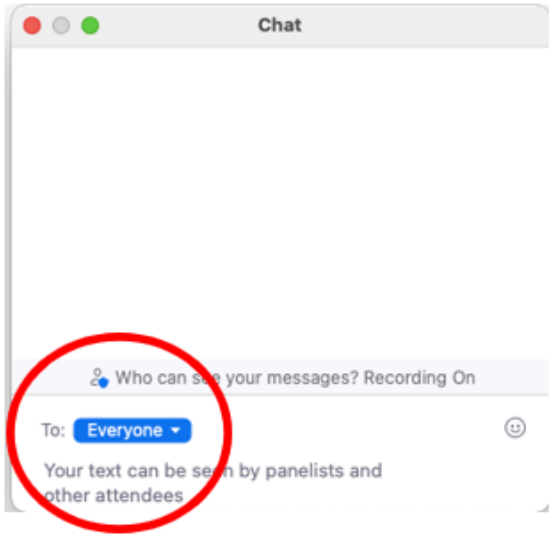
HSPN Monthly Webinar

March 25, 2025

Welcome & thank you for joining us!

Please let us know who you are by introducing yourself (name & OHT or other org)





➢Open Chat

➢Set response to everyone in the chat box

Land Acknowledgement

We wish to acknowledge this land on which the University of Toronto operates. For thousands of years it has been the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

Poll 1

Have you joined us for an HSPN webinar previously?

- Yes. I have participated previously
- No. This is my first event

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HSPN Health System Performance Network | ONTARIO SPOR SUPPORT UNIT | CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

For Patients, Caregivers, Citizens

JOIN US FOR A COMMUNITY DISCUSSION:

WHAT'S HEALTH GOT TO DO WITH IT?

How can patient and caregiver experience best be captured and used to inform health system improvements? Come join us to share your ideas as we explore recent research findings and engage in discussions.

Thursday March 27th
9:30 – 11:30 PST
12:30 - 14:30 EST
13:30 – 15:30 AST

Register Now

bitly

Ontario SPOR SUPPORT Unit (OSSU)

10-Year Milestone at Research Day 2025

Thursday, April 10, 2025

This year's conference will include:

- Updates from OSSU's research centres and initiatives
- Examples of equity-focused patient-oriented research in practice
- Discussions on impacts in mental health and addictions research
- Approaches to sustaining patient and caregiver partnerships through organizations such as the Patient Advisors Network
- Perspectives on advancements in care through artificial intelligence and digital health

Online Registration Only

Register at: https://ossu25.swoogo.com/OSSU25

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Today's event
Leading Projects

Learnings from a Realist Rapid-cycle Evaluation

Host

Dr. Walter Wodchis
Principal Investigator
HSPN

Presenters

Dr. Kaileah McKellar
Co-Lead
Leading Project Evaluation
HSPN

Jessica Morgan
HSPN Research Assistant
ICES Appointed Analyst

Dr. Gaya Embuldeniya
Cultural Anthropologist
HSPN Investigator

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March 25, 2025

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Special Guests

Lindsay Wingham-Smith
Co-Chair
Integrated Home Care Committee

Jon Kwok
Nipissing OHT

Jenine Theben
Lead
OHT Implementation

Meaghan Cunningham
Director
OHT Implementation

Nisha Singh
Project Director
OH

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March 25, 2025

Poll 2

What is your relationship with the Leading Projects in Home Care

a) I am involved in a Leading Project for Home Care
b) I am watching closely as an initial 12 OHT (participating in Integrate Home Care Committee)
c) I am generally interested as a (non-i12) OHT participant
d) I am an interested non-OHT observer
e) I am just here for the ride…I hope it's a good one !

The Leading Projects Evaluation

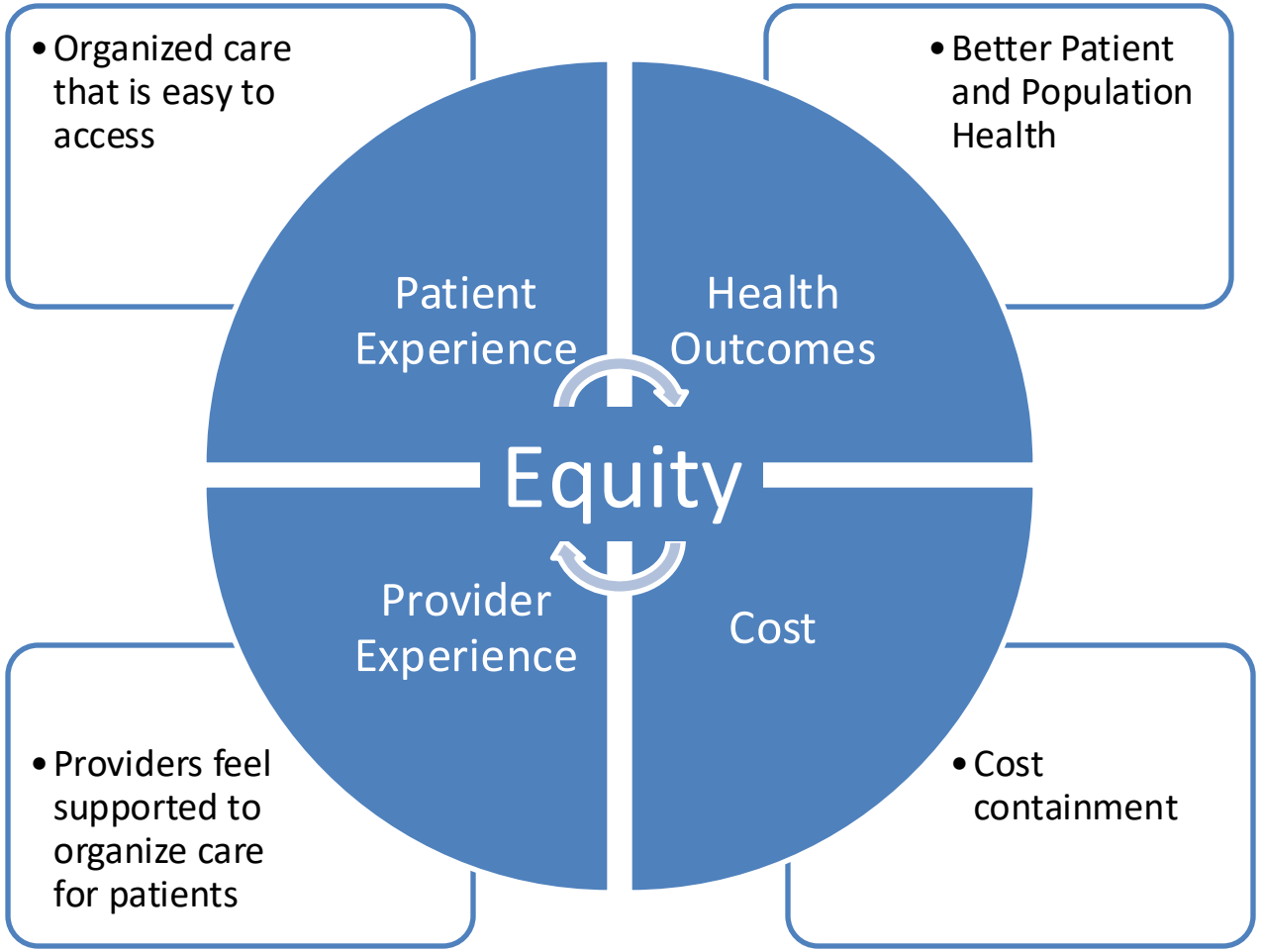
1. To understand what changes are (reliably) implemented in the leading projects.
2. To understand the effects of the leading projects on client, provider and system outcomes.
3. To assess the conditions necessary for scale and spread of successful models.

Evaluation Approach: Realist & RE-AIM

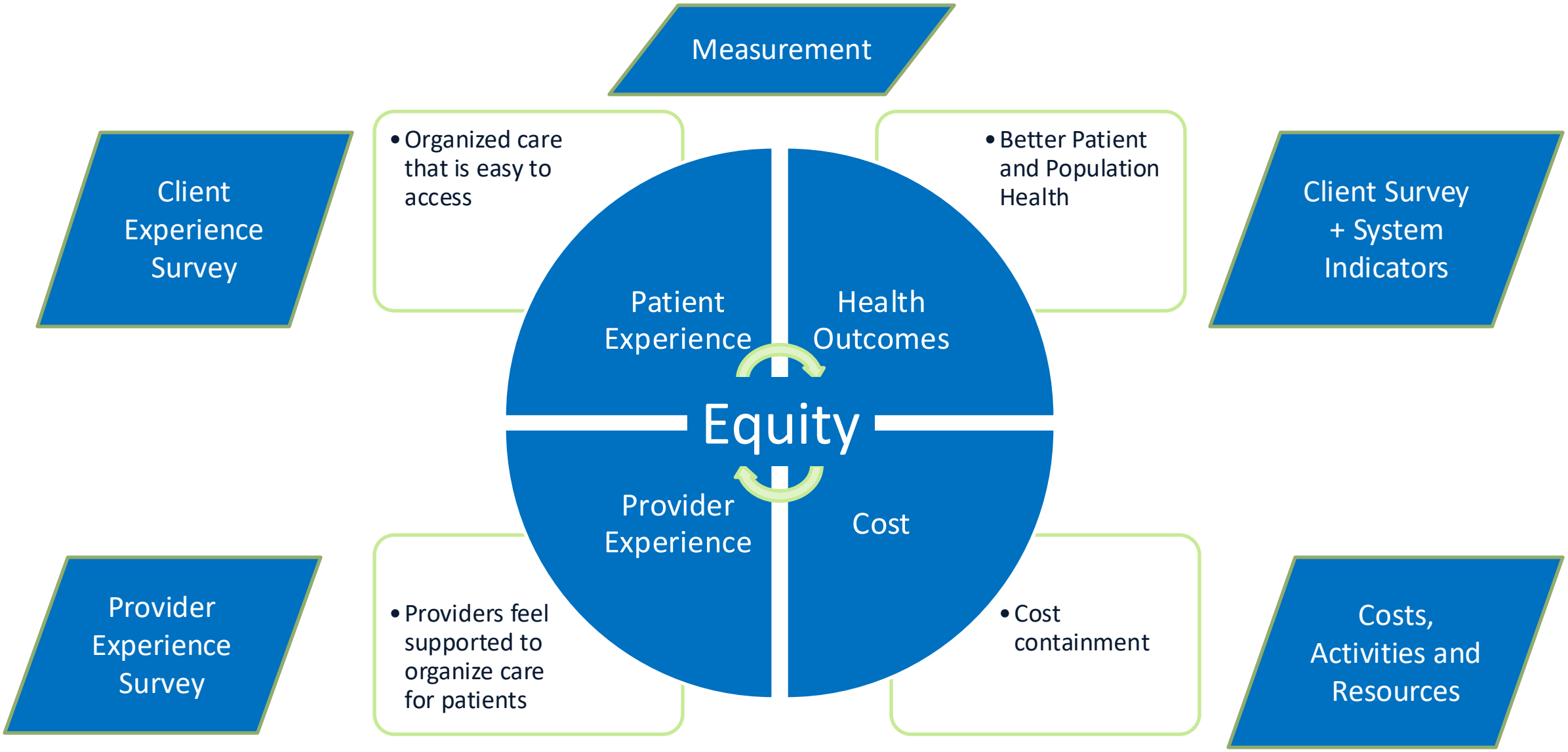
Realist Evaluation:

What works,
for whom,
in what context ?

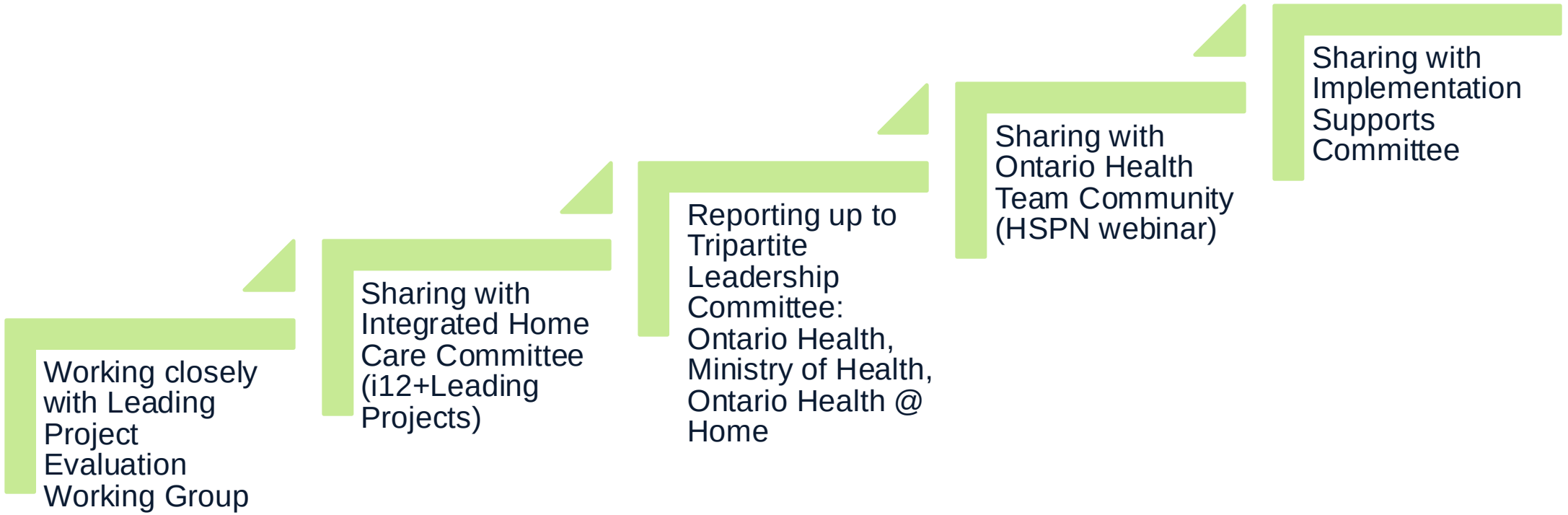
Evaluation Framework: Quintuple Aim



MEASURING QUINTUPLE AIM FRAMEWORK & EQUITY



Reporting and Engagement



Agenda and Overview

1. How we are approaching the Leading Projects Evaluation
2. What are the Leading Projects?
3. How are we measuring quantitative changes using health system indicators?
4. How are we measuring client/caregiver experience?
5. How are we measuring provider experience?
6. What are we learning qualitatively?

7. Some reflections from Leading Projects and Ontario Health

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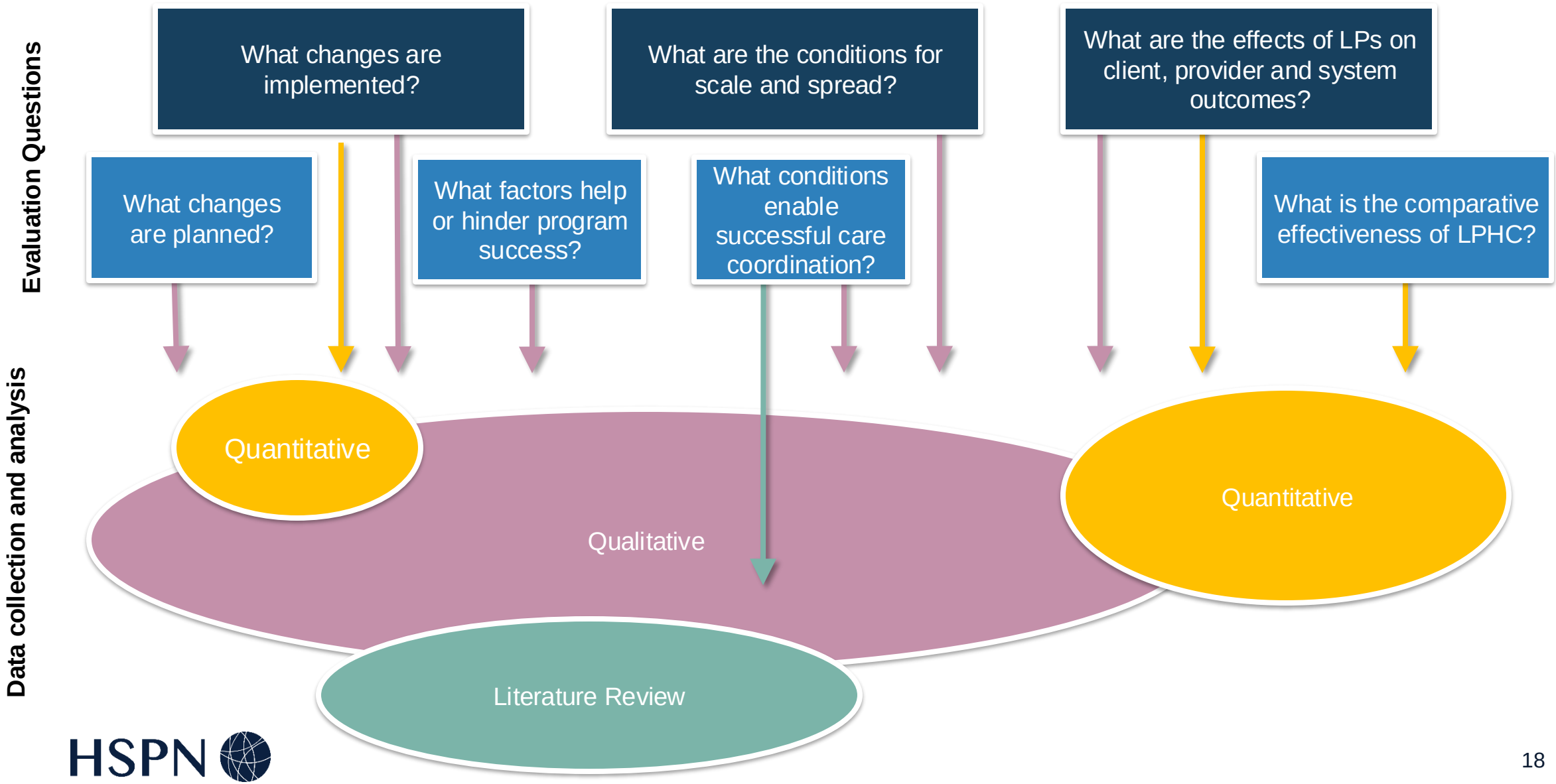
Evaluation Overview

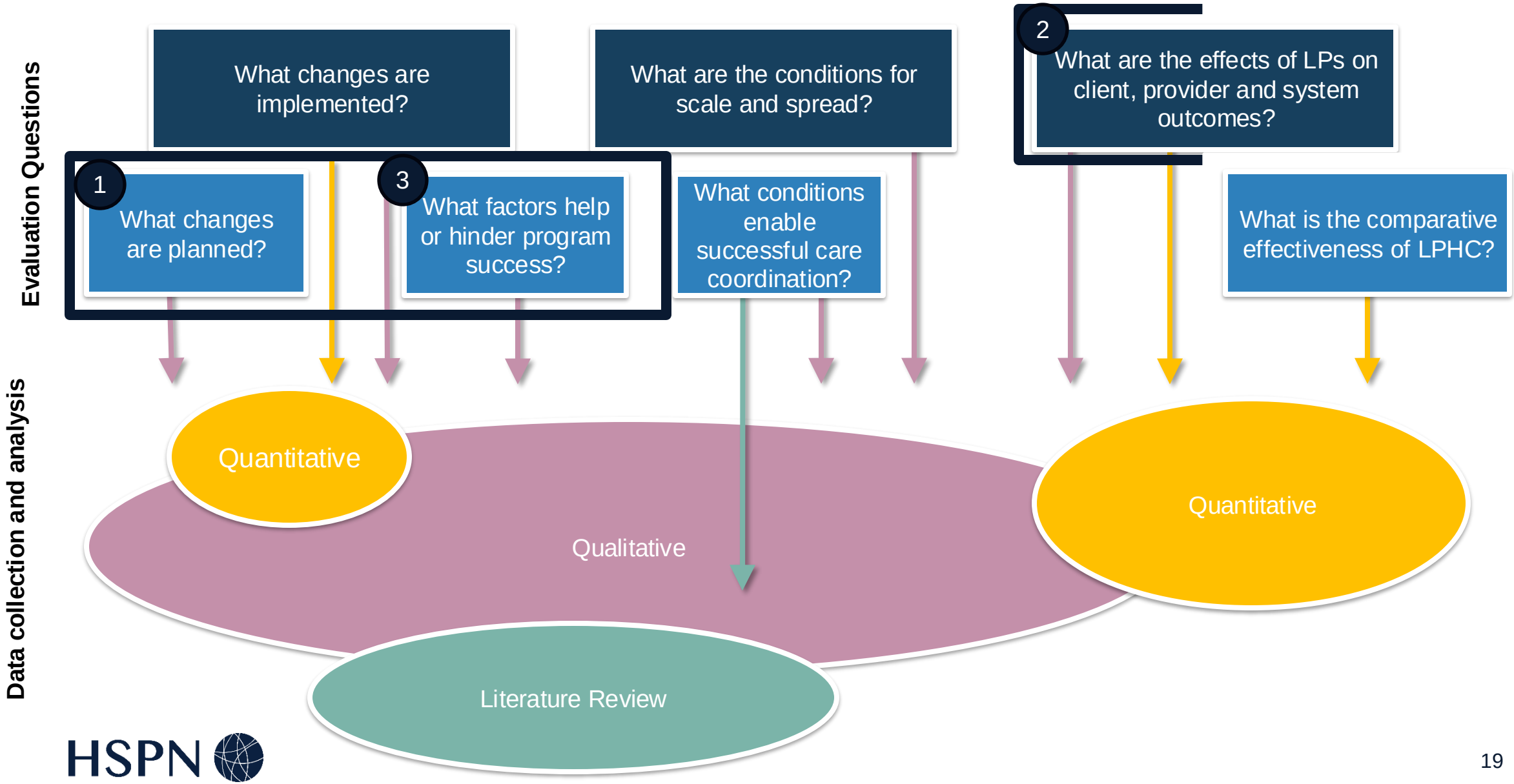
Evaluation Approach

- Evaluation is undertaken **in partnership;** Co-designed with Leading Projects
  - *Measures identified through LP logic models, ranked by EWG*
- We are interested in supporting **learning and development**
  - *Leading Projects, Ontario Health, Ontario Health atHome, Ministry of Health, as well as future work of i12, and all OHTs*
- Evaluation is **flexible, engaging and interactive**
  - *Ongoing opportunity adapt approach to local contexts, to discuss results, and tailor reporting to stakeholder's interests*

Evaluation Methods Map



Evaluation Methods Map: Today's Focus



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LP Overview

Home Care Leading Projects

Seven Ontario Health Team-led Leading Projects have been launched to model innovations in integrated home care services within OHTs. Project objectives include:

1) Test and evaluate OHT-led home care models that improve care integration, access, and patient outcomes and experience

2) Build OHT capacity for home care planning, delivery, and integration

LP Overview

OHT	Model Type	Implementation Site(s)	Scale Y2 Clients	Population/ Aim
East Toronto Health Partners (ETHP)	Neighbourhood	2 neighborhoods	1368	To enable more integrated home care access for short stay & community-complex clients in two neighbourhoods
Durham (D)	Neighbourhood	Priority areas in Downtown Oshawa	700	To integrate services provided to residents within the Downtown Oshawa area through a coordinated team of service providers
Guelph Wellington (GW)	Primary Care	6 Integrated Patient Care Teams (FHT or FHT practice sites)	1489	Integrates services into primary care to provide comprehensive and holistic care to the patients served by that primary care team, with attention to high-needs patients.
Frontenac, Lennox & Addington (FLA)	Primary Care	1 FHT	450	Integrate services into the health home framework, ensuring that patients receive the appropriate level of services and linkages based on their support needs—minimum, moderate, or maximal. Care Coordinators & Care Integrator embedded within Primary Care.
Chatham Kent (CK)	Palliative Care	1 FHT, 1 CHC * *primary care)	400	Shifting services from end of life to using early identification to offer services earlier in the palliative care journey. Improving palliative capacity. Palliative home care embedded within primary care.
Mississauga (M)	Palliative Care	Initially 2 sites, later full geography (*neighbourhood)	2000 (Y1=800)	Implement a new integrated model of palliative care, beginning with home care transformation in phase 1
Nipissing Wellness (NW)	Community Crisis	Community & hospital	150	Supporting crisis patients in community awaiting LTC placement & ALC acute care patients with discharge destination of LTC

Key Transformation Ideas

Across Leading Projects

- Changes in how teams work together
  - Consistent **team structure**, working together more with huddles, rounds or shared care plan, relationship-focus
  - Reconceptualizing **care coordination function**
- Development of **IT platform/ digital tools t**o facilitate team collaboration & information sharing
- **Procurement – Chosen SPO** with dedicated service providers for patients
- **Payment model**, changing fee for services to capitated rate (e.g., salaried home care teams)

Neighbourhood

- Centralizing services in neighbourhoods
  - Co-location

Primary Care

- Embedding designated care coordinators and HC providers for each practice site
- Population segmentation/streaming, with higher needs receiving more complex care

Palliative Care

- Early identification of palliative care patients
- Enhancement of palliative care competencies

Community Crisis

- Focus on high-risk/needs patients (e.g., waiting for LTC)
- Care coordinator with expanded geriatric expertise

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Program Components

	Model Component	ETHP	D	GW	FLA	CK	M	NW
Patient-facing Change	Shared care plan	✓	✓	✓	✓	✓	✓	✓
	Rounds/ Case conferencing	✓	✓	Site-dependent	✓		✓	✓
	24/7 navigation			✓		✓	✓	
	Client or community education		✓		✓			
Structural Change	Early identification of clients		✓			✓	✓	
	Identifying complex patients	✓		✓	✓			✓
	Provider training (non-tech)	✓				✓	✓	
	Created new roles	✓			✓	✓		✓
	Change management lead(s)	✓		✓	✓			
	Neighbourhood focused integration	✓	✓				✓	
	Primary care focused integration			✓	✓	✓		
	Reconceptualizing care coordination	✓	✓	✓	✓	✓	✓	✓
	Enhancing digital communication/tools	✓	✓	✓	✓	✓	✓	✓
	Funding model changes	✓	✓	✓	✓	✓	✓	✓

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Leading Projects Baseline Results

Quantitative Indicators

March 2025

Population definition

General criteria: Individuals who were enrolled in home care and received home care services in the fiscal year 2022/23.

Specific program criteria were used defining the baseline comparator populations (e.g. geography, palliative, affiliated with primary care team).

Individuals receiving palliative care were included/excluded based on a comprehensive definition, extending beyond home care services as these programs are expected to expand home-based palliative care to new patient populations.

Baseline Quantitative Indicators

Cross-Project Indicators:
(a few additional measures in evaluation)

- Service time per client-month
- Time in home care
- Wait time
- Change in health status
- Monthly government spending
- Unplanned hospitalizations
- Caregiver Distress

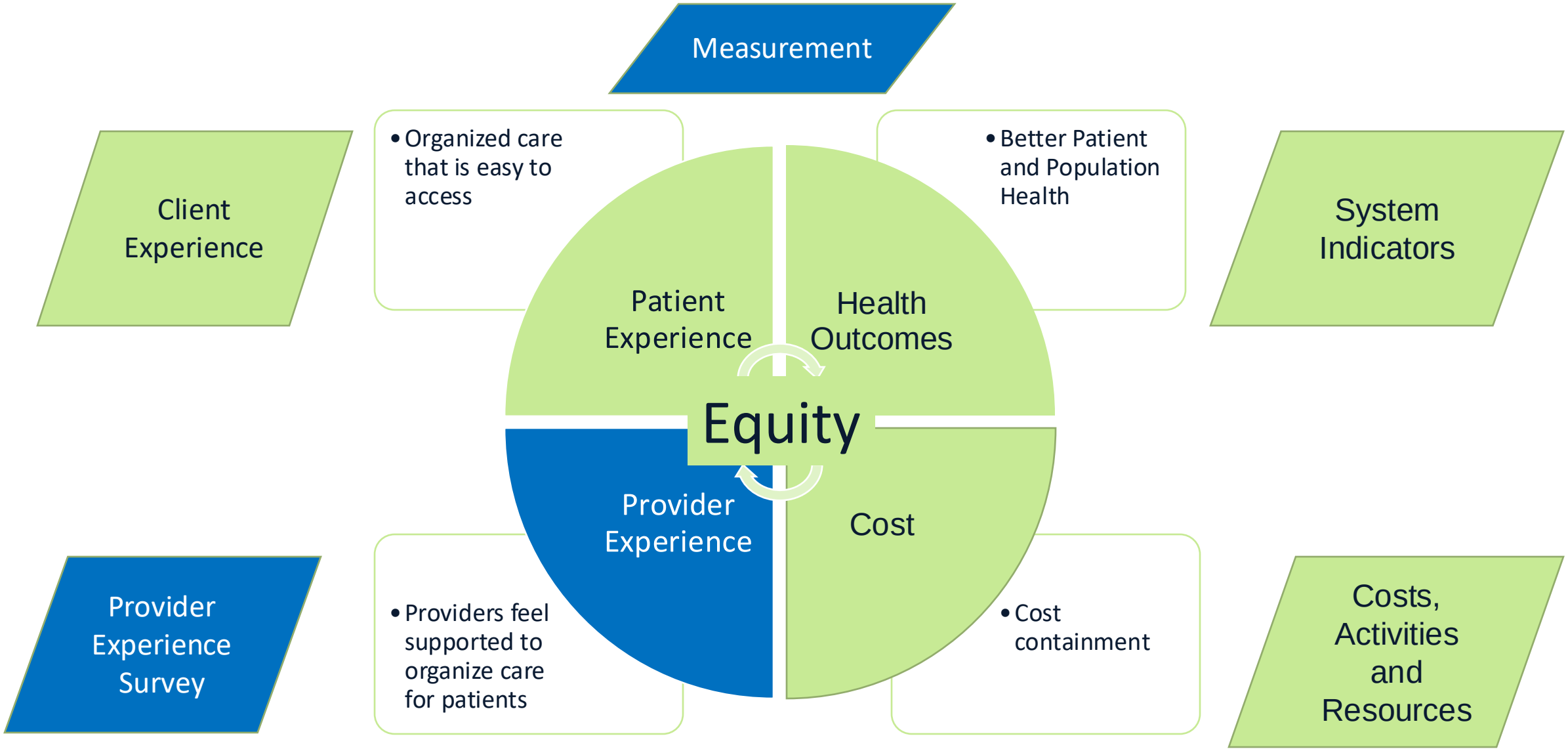
Palliative Indicators:

- ED visits in last 30 days of life
- Decedents receiving home care service in last 90 days
- Days spent at home in last 180 days of life
- Deaths in hospital

Demographic/Equity Stratifiers:

- Age & Sex
- Material Deprivation/Socio Economic Status

MEASURING QUINTUPLE AIM FRAMEWORK & EQUITY



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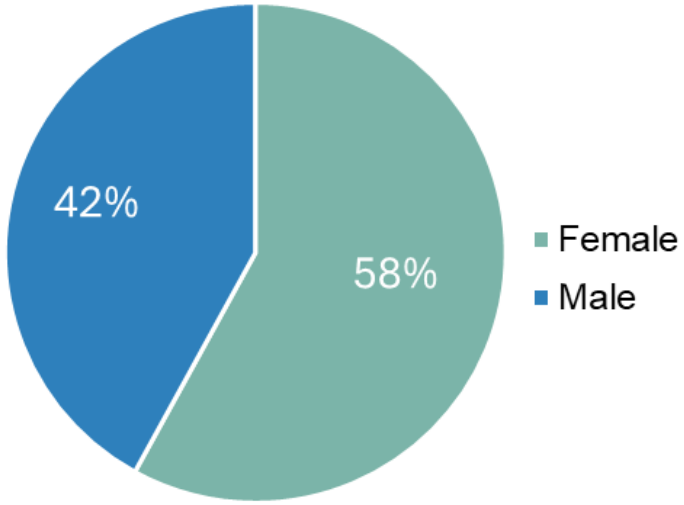
Demographics & Equity Stratifiers

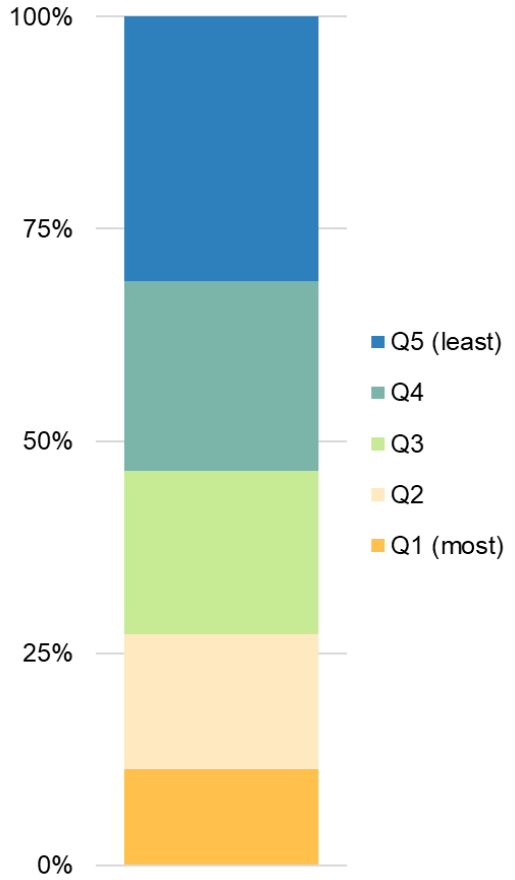
Age (n=6,772)

Mean (SD): 75.6 (14)
Median (IQR): 78 (68-86)

Sex (n=6,772)



Access to material resources (n=6,743)



Interpretation:
Q1 would be living in neighbourhoods with the most access to material resources and Q5 with the least access.

Here we see that there is a tendency toward low SES/high material deprivation

Based on Ontario Marginalization Index – Material Resources Scale.

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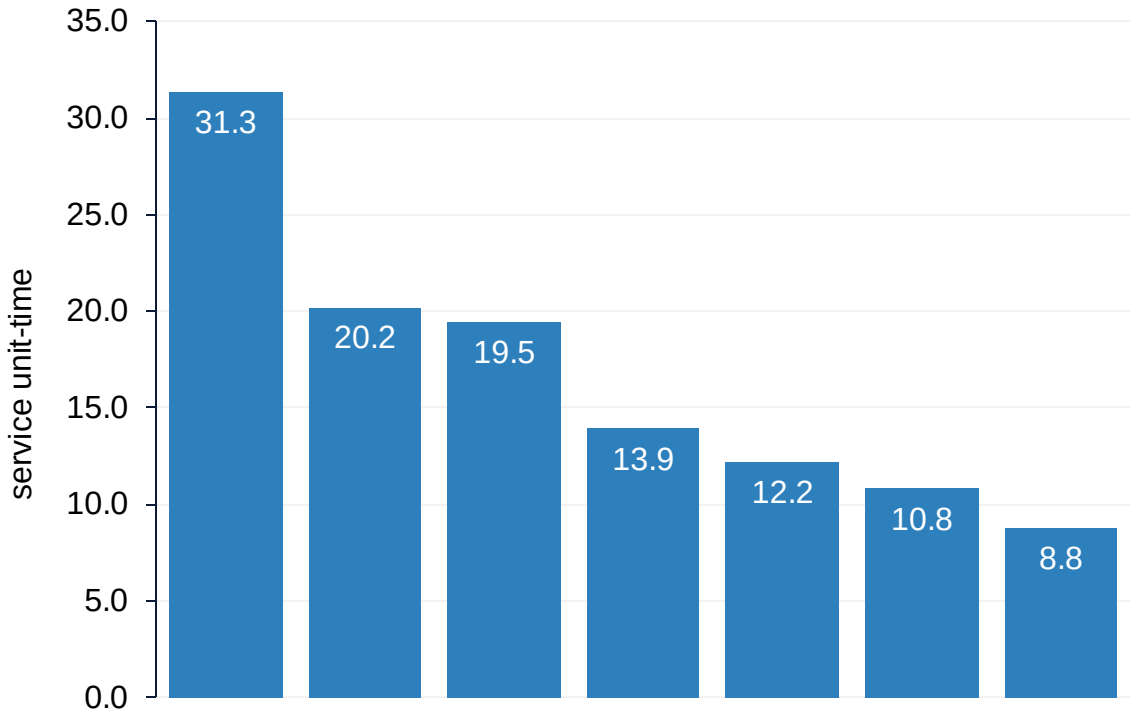
PROGRAM ACTIVITY MEASURES

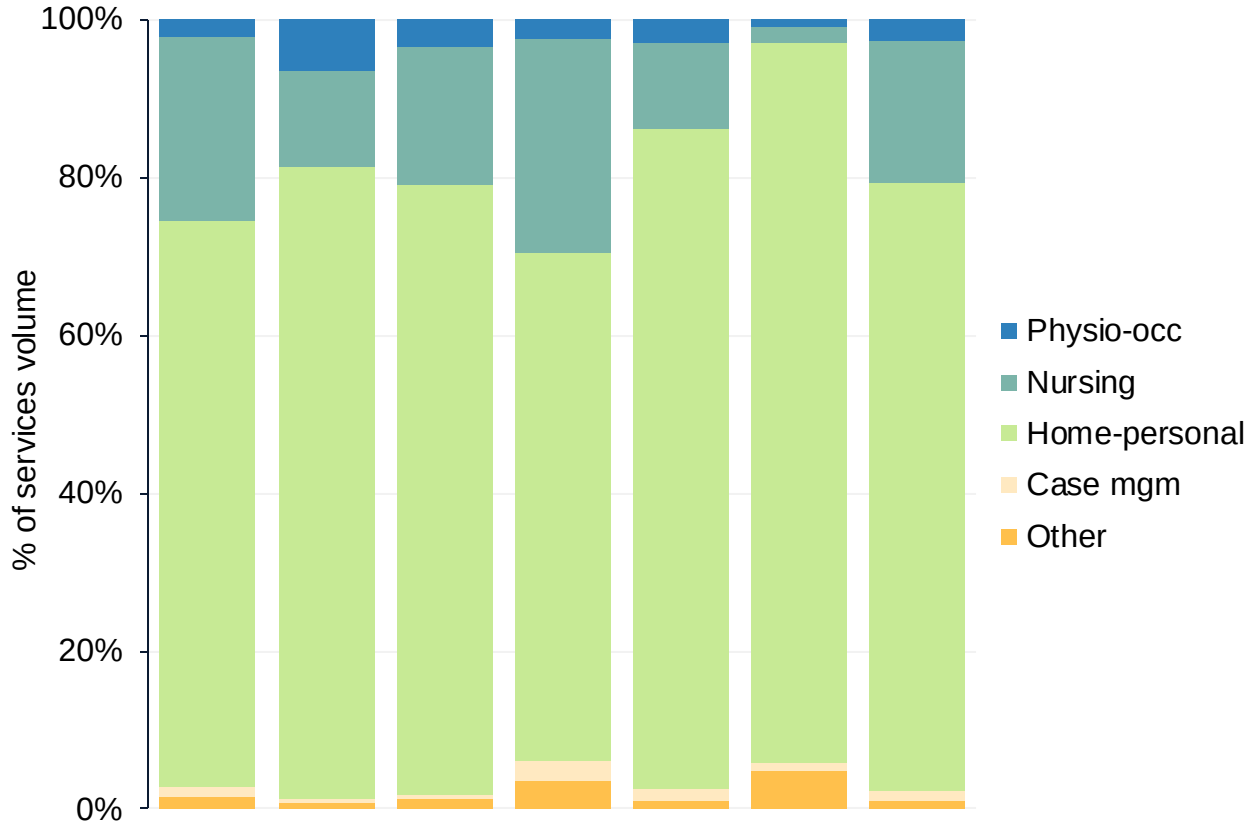
Service time per client-month



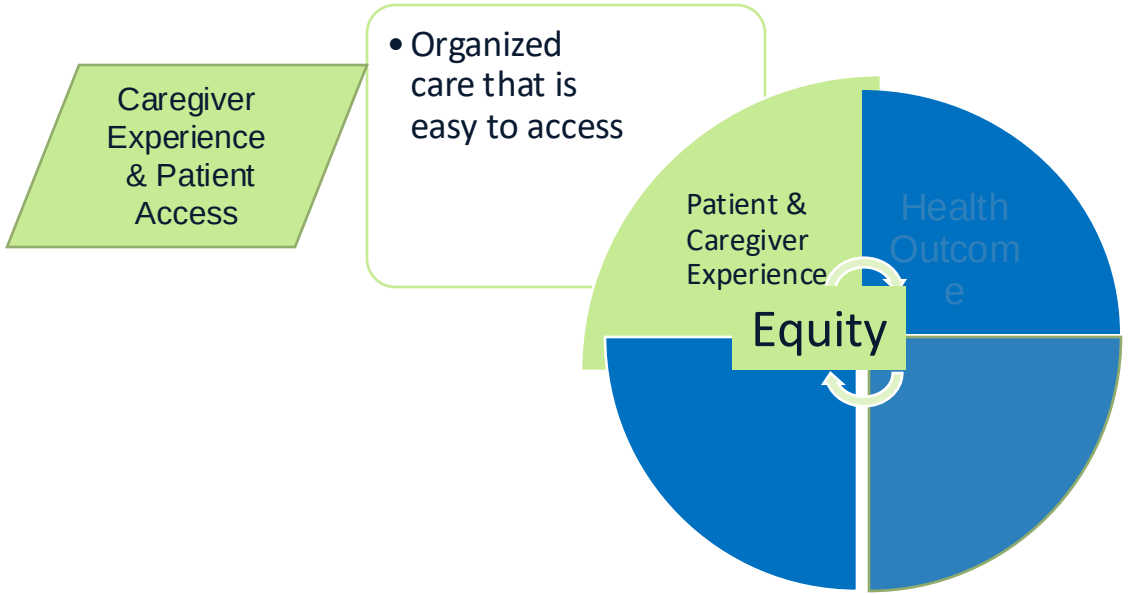
Average service unit-time per month in home care.

Visits have been counted as equivalent to 1 hour.

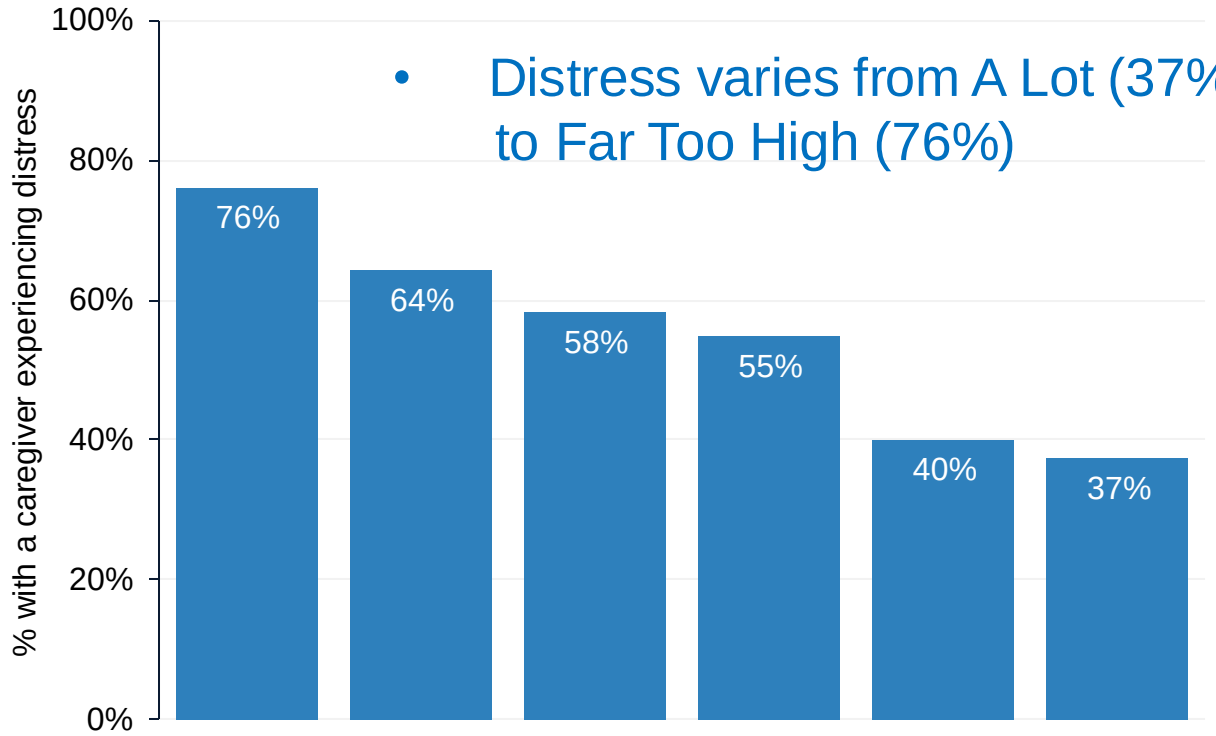
Proportion of service volume by type



Reporting categories:
Nursing: Service = 1 (visit), 2 (hours)
Physio or occupational therapy: Service = 5, 6 (visit)
Social work or case management: 8, 10, 14 (visit)
Personal services, homemaking, or both: 11, 12, 13 (hours)
Other: all other codes



Caregiver distress

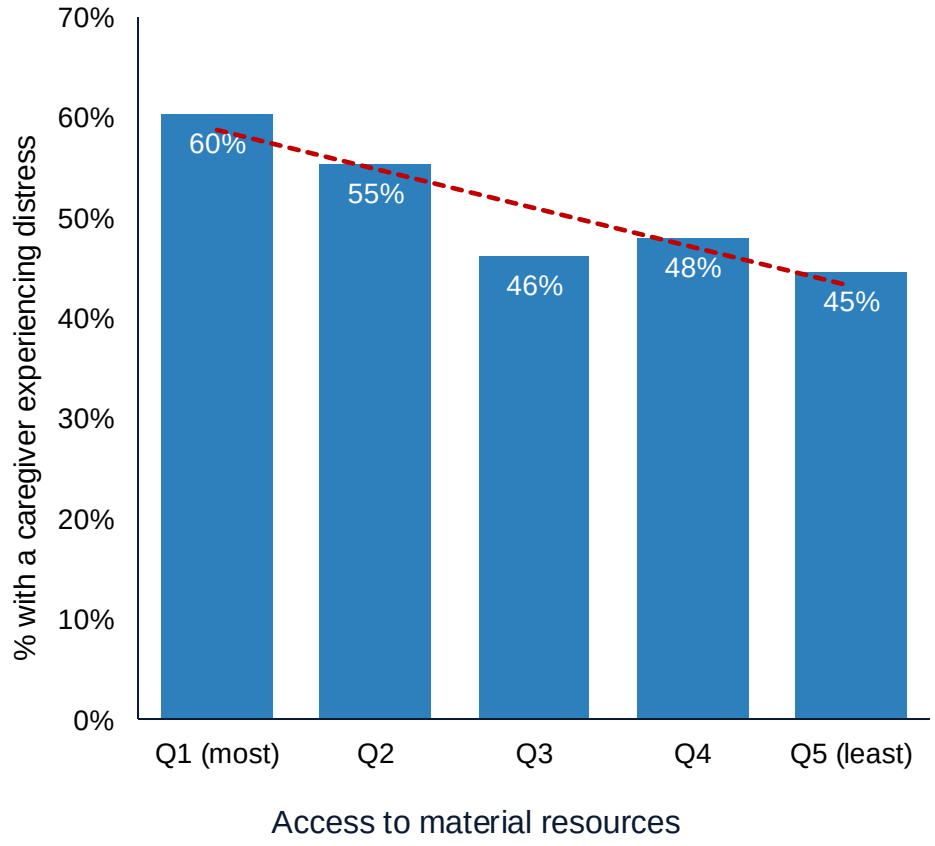


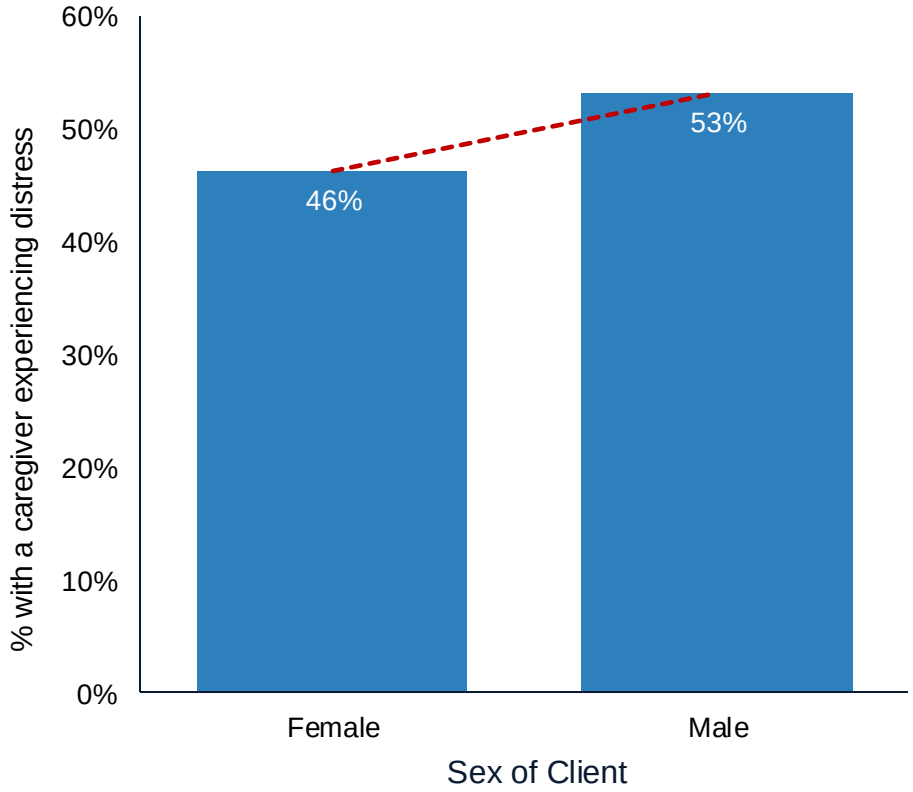
- Distress varies from A Lot (37%) to Far Too High (76%)

The percent of clients who reported that their primary informal caregiver expressed continued feelings of distress, anger, or depression over a six-month period.

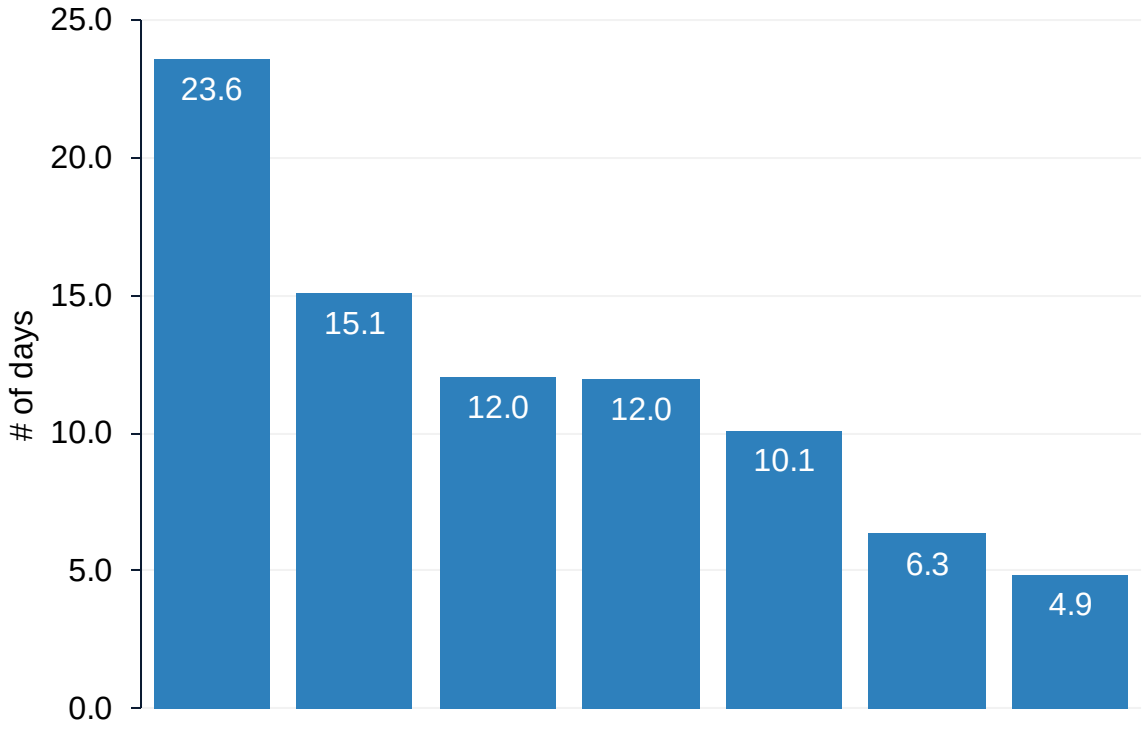
Caregiver distress - by sex and access to material resources

- Here we see some difference by client sex.





Wait time (days) from referral to service



Average number of days between referral and first HC service.

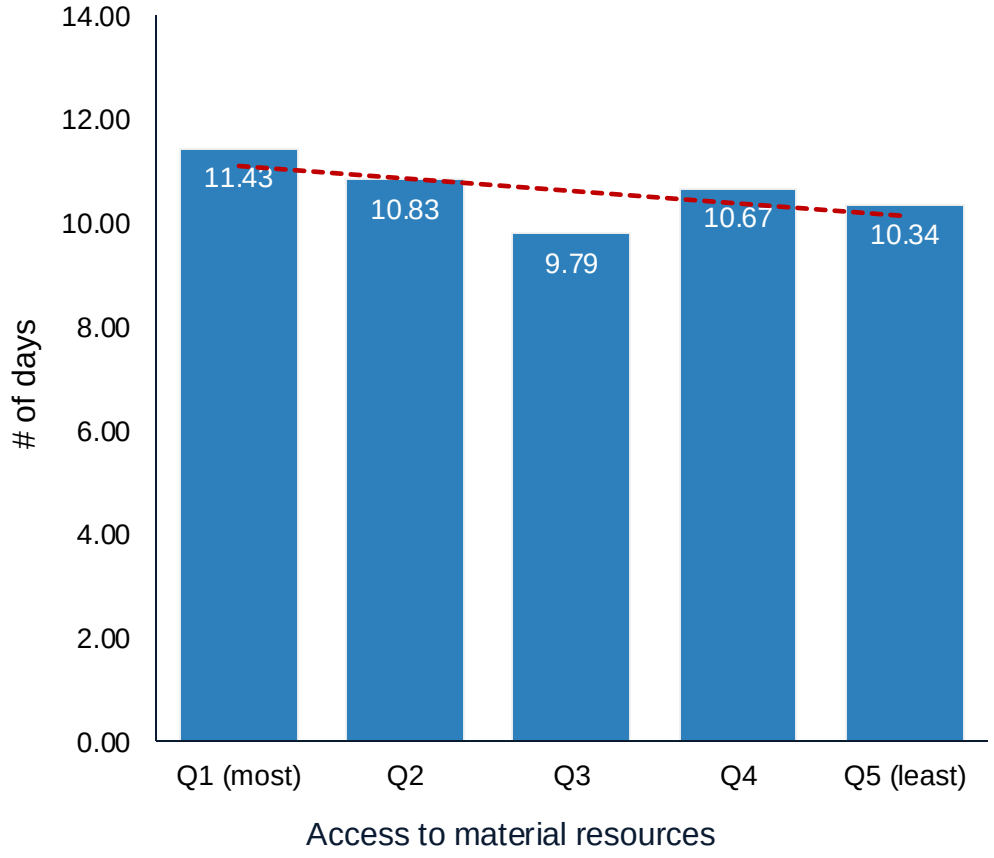
Wait times are an indicator of access/experience with care.

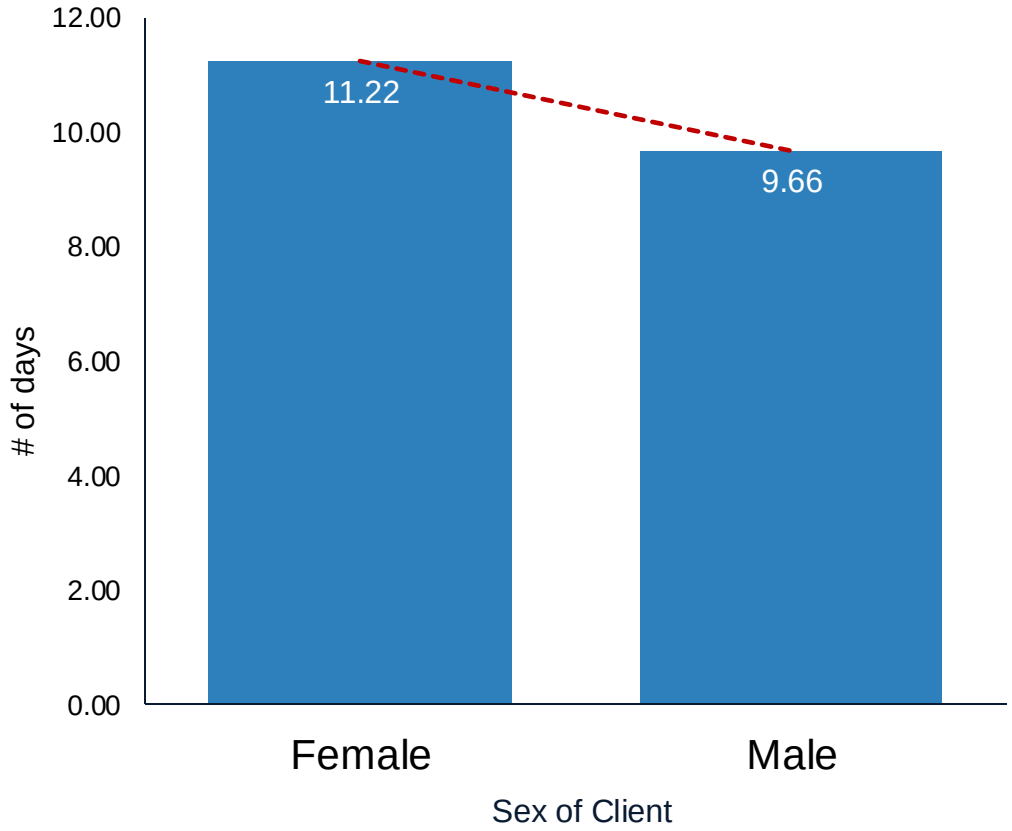
There is a fair bit of variability across programs in the length of time waiting. Most fall in the 10-15 days range.

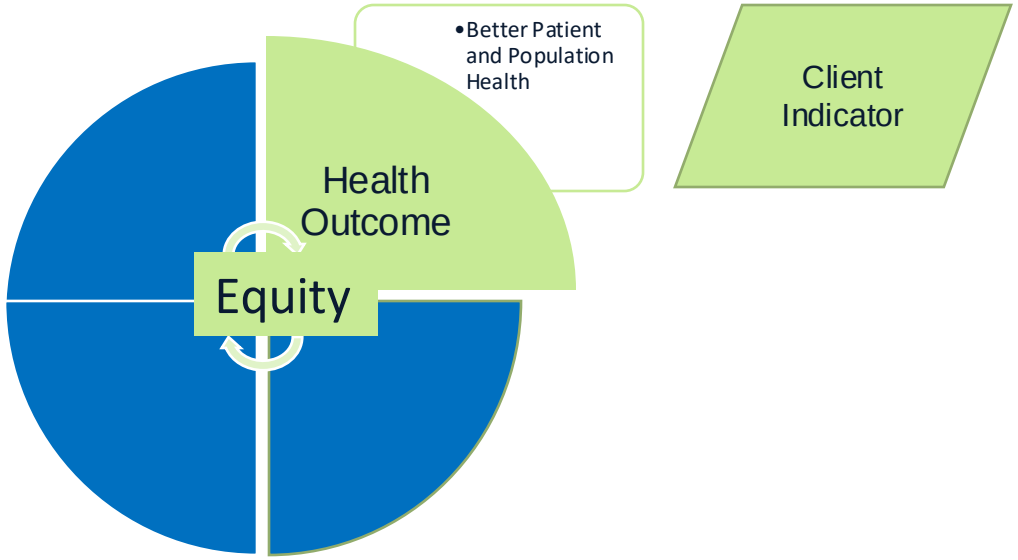
It is hoped that this metric will improve with the Leading Projects.

Equity in wait time (days) from referral to service - by sex and access to material resources

- Here we see some difference by client sex but not by material resources

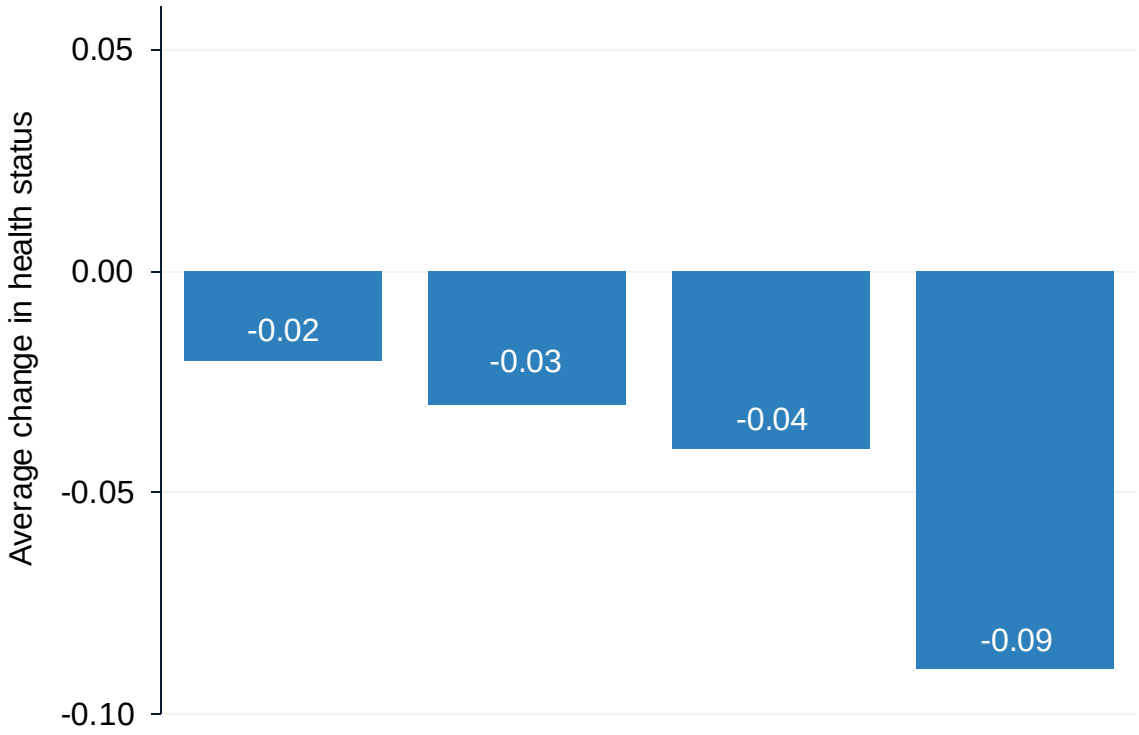






Health Status declines for all long-stay home care clients. The baseline status will help monitor the types of clients enrolled. Changes over time will help measure the extent to which programs are able to slow functional decline.

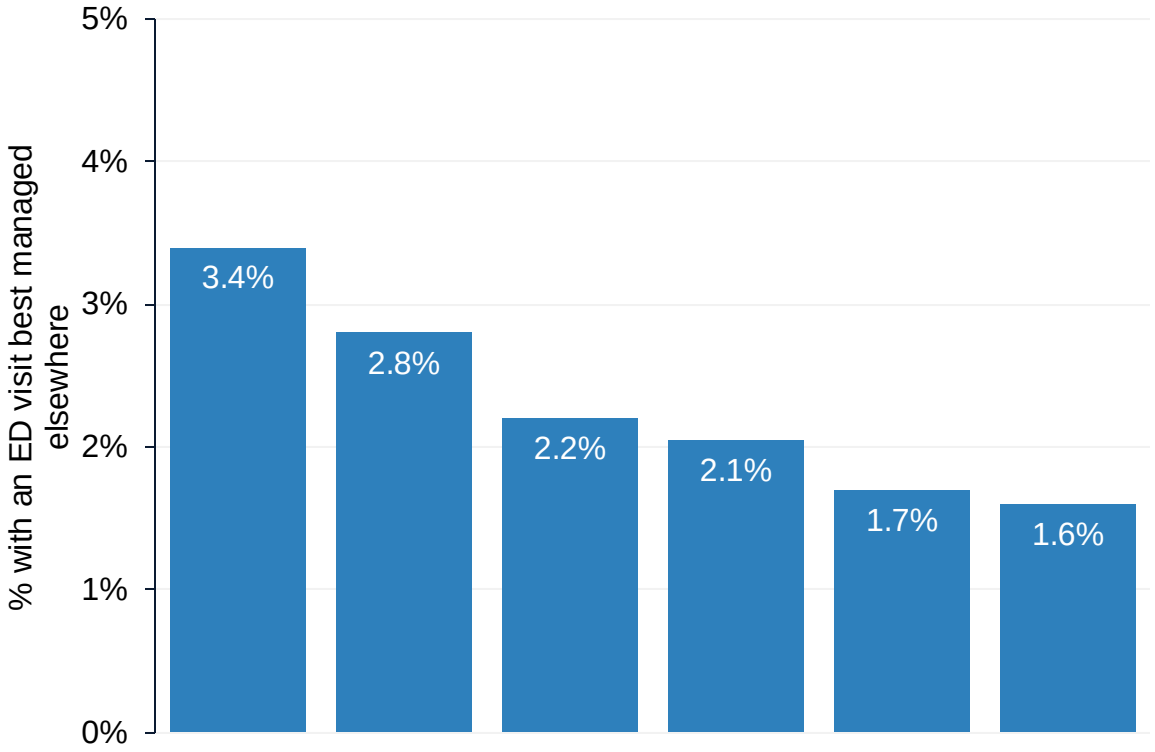
Change in health status



Change in MDSHSI score among home care clients that had two interRAIHC assessments in a 365-day period.

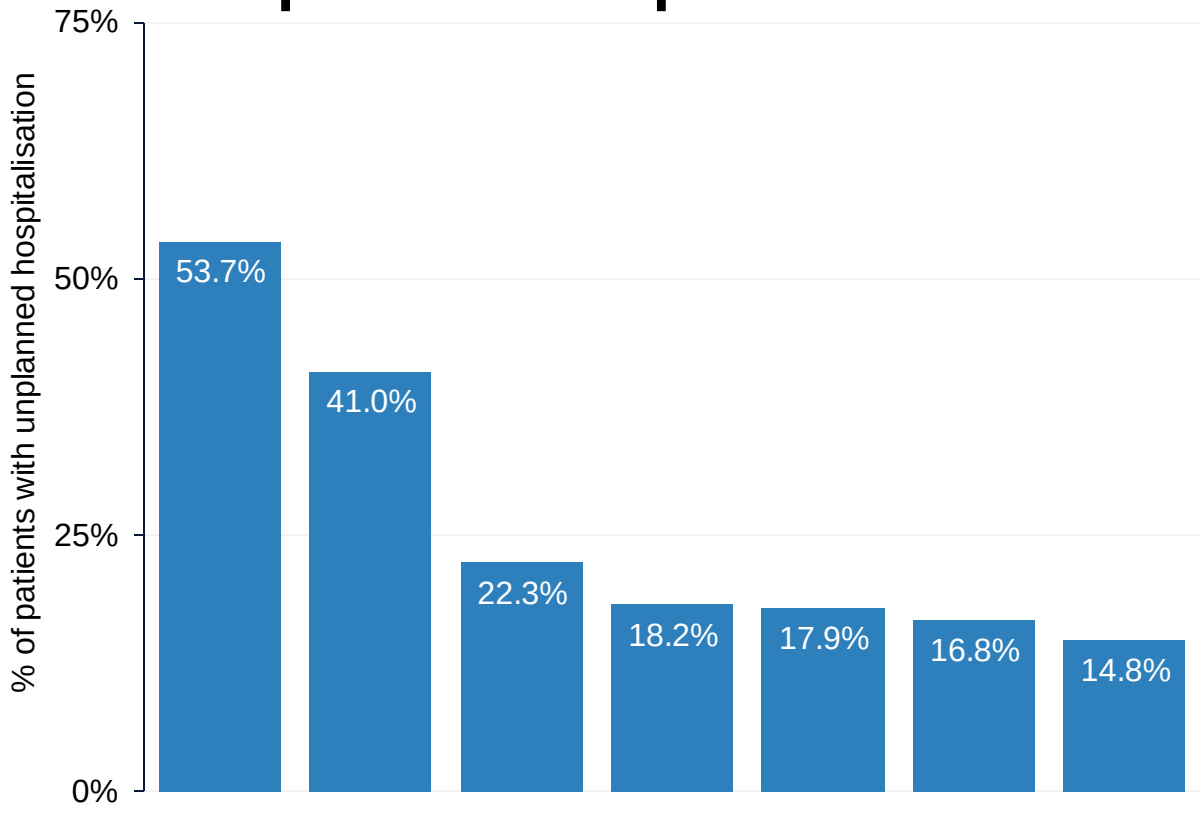
Health Care Utilization & Proxy Measures for Health Status

ED visits for conditions best managed elsewhere



The percent of home care clients who visited the emergency department (ED) for conditions “best managed elsewhere".

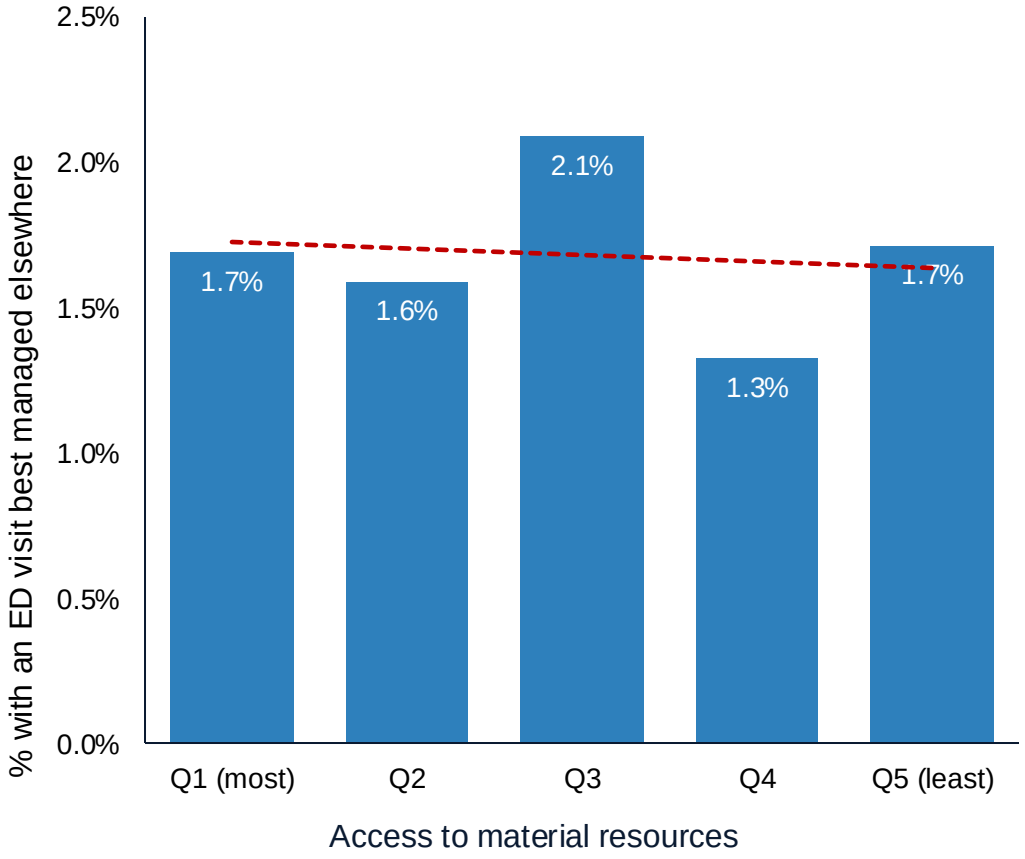
Unplanned hospitalizations

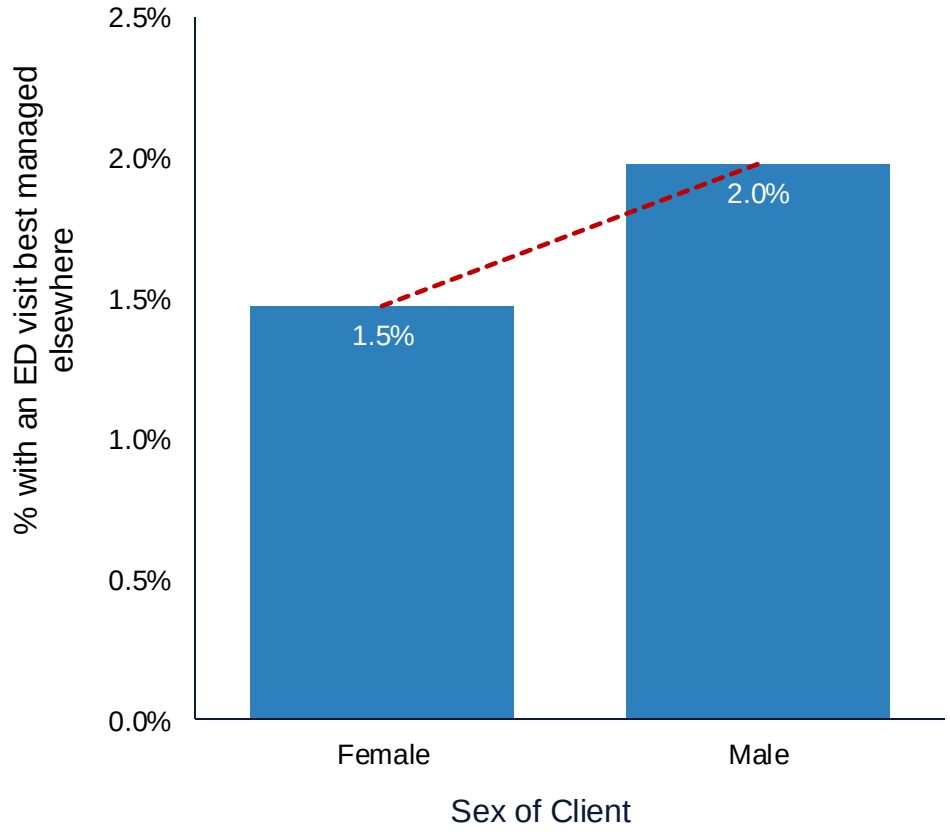


The percent of home care clients who experienced an unplanned admission to hospital for medical reasons.

ED visits for conditions best managed elsewhere - by sex and access to material resources

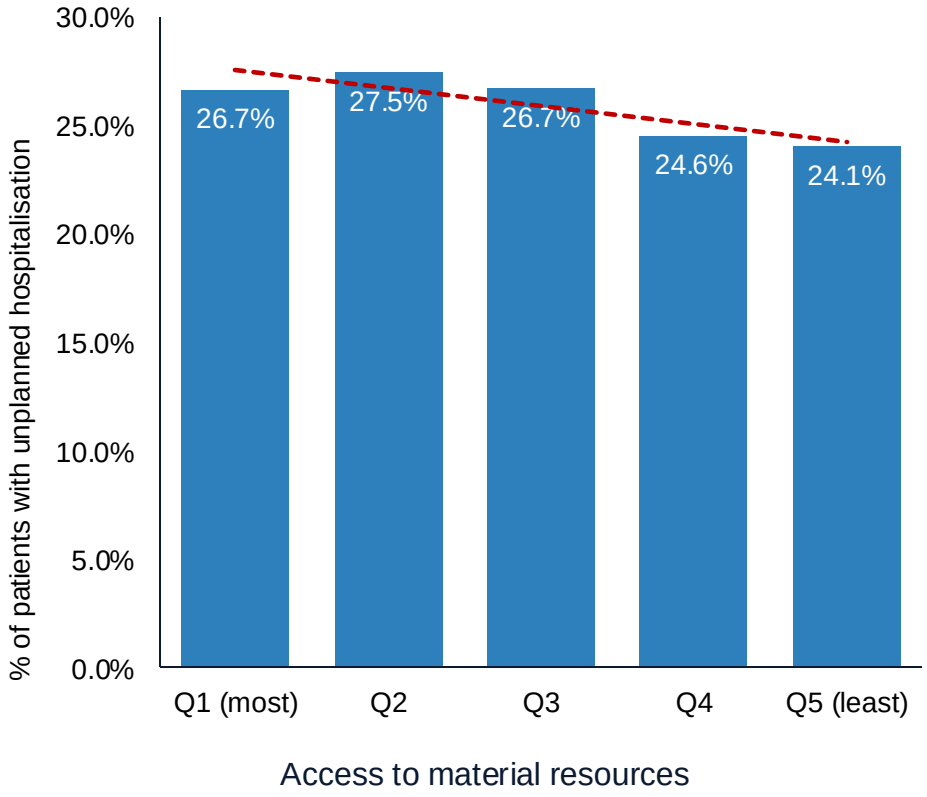
- Here we see some difference by client sex; not by material resources

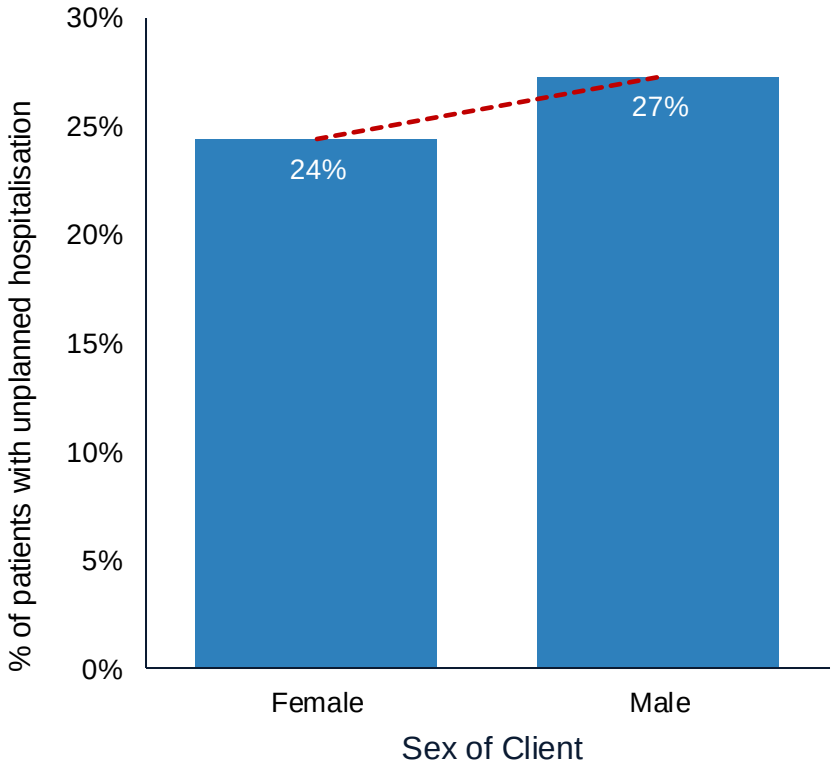




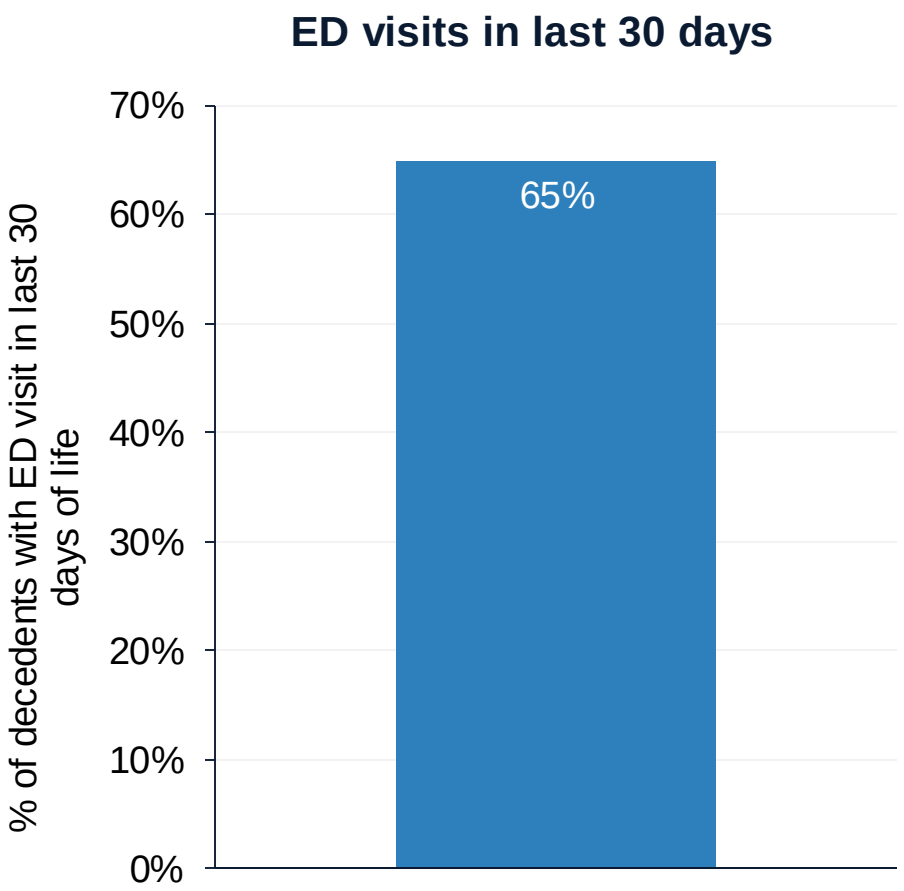
Unplanned hospitalizations - by sex and access to material resources

- Here we see some difference by client sex.

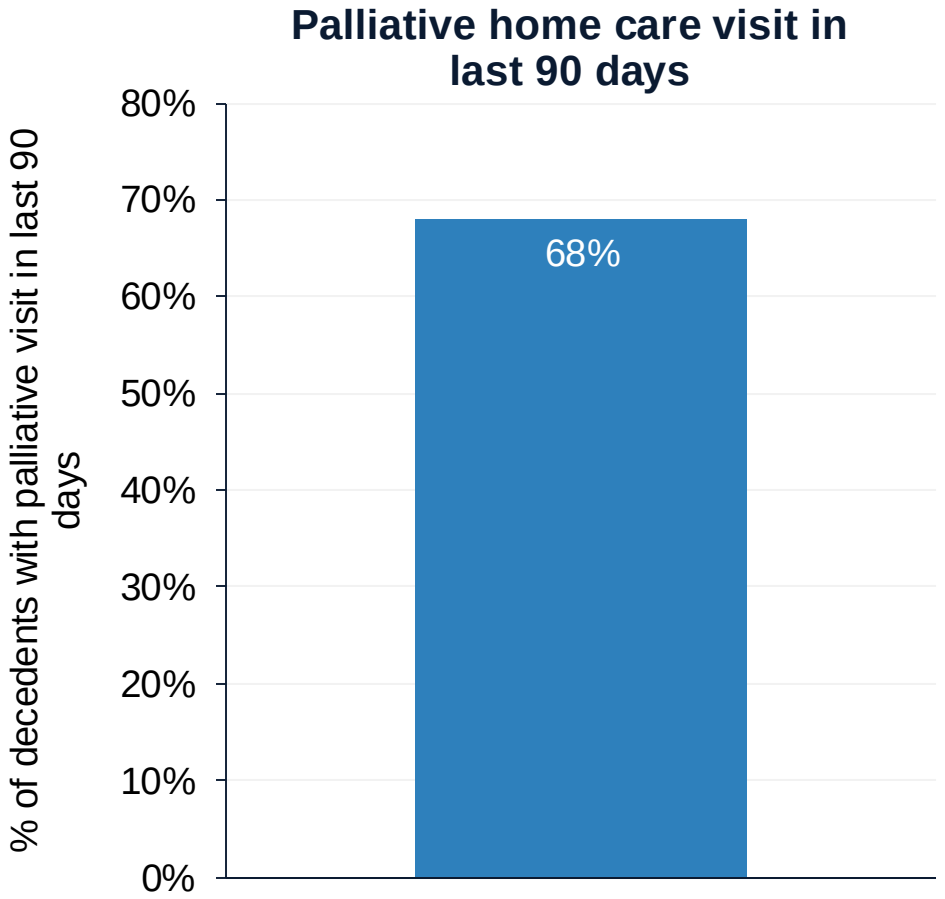




Palliative care indicators

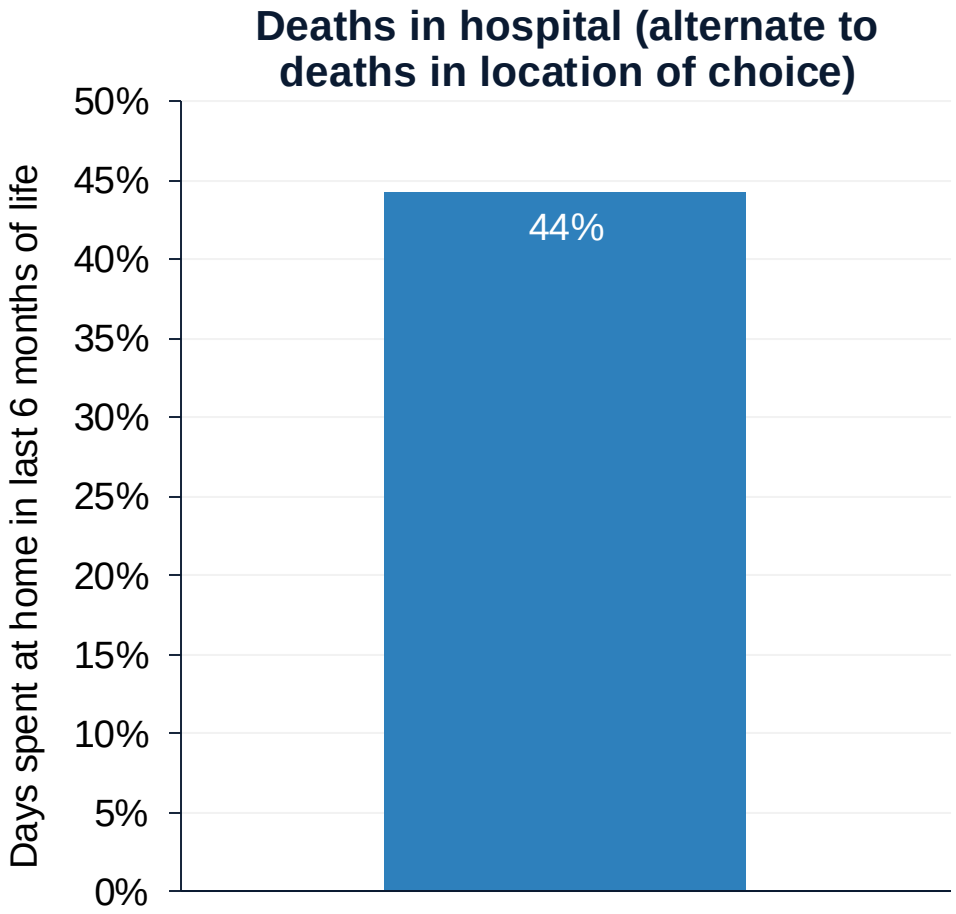


The percent of decedents with 1 or more emergency department visits in the last 30 days of life.

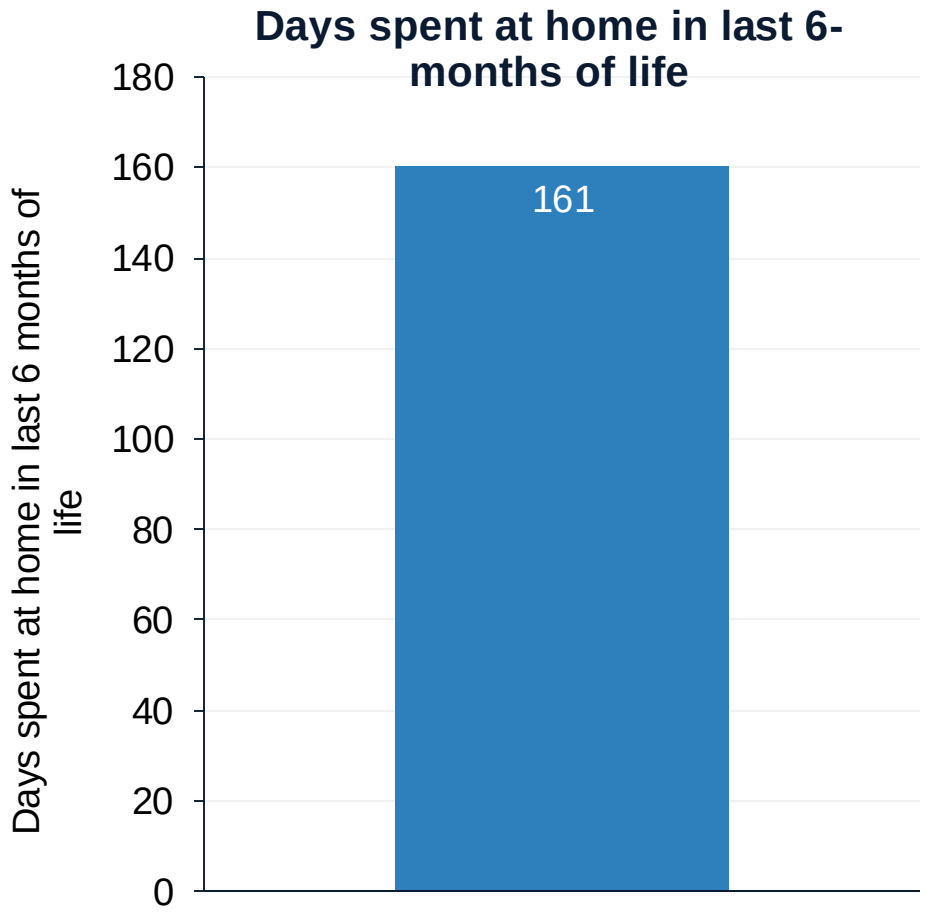


The percent of decedents receiving a palliative home care visit in the last 90 days of life.

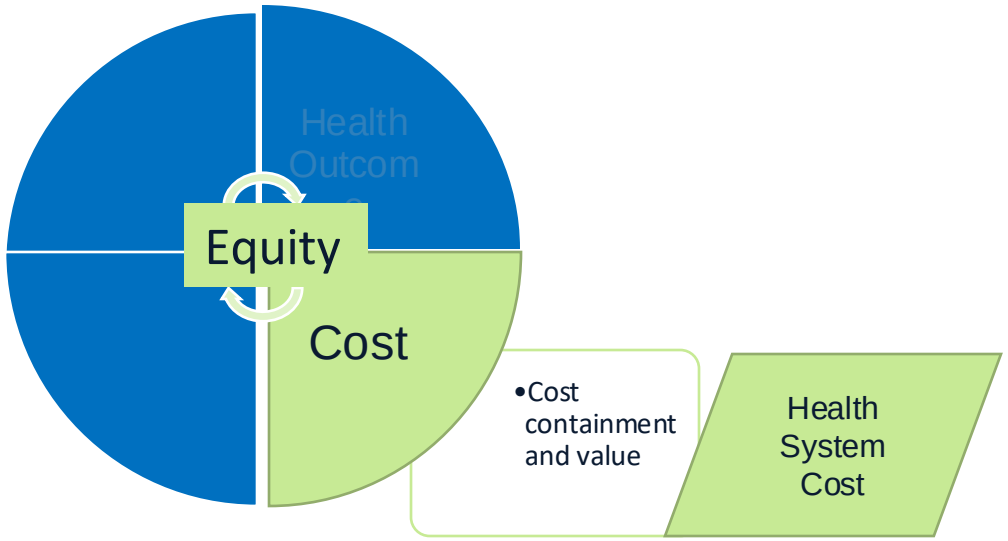
Palliative care indicators



The percent of decedents that died in a hospital setting.



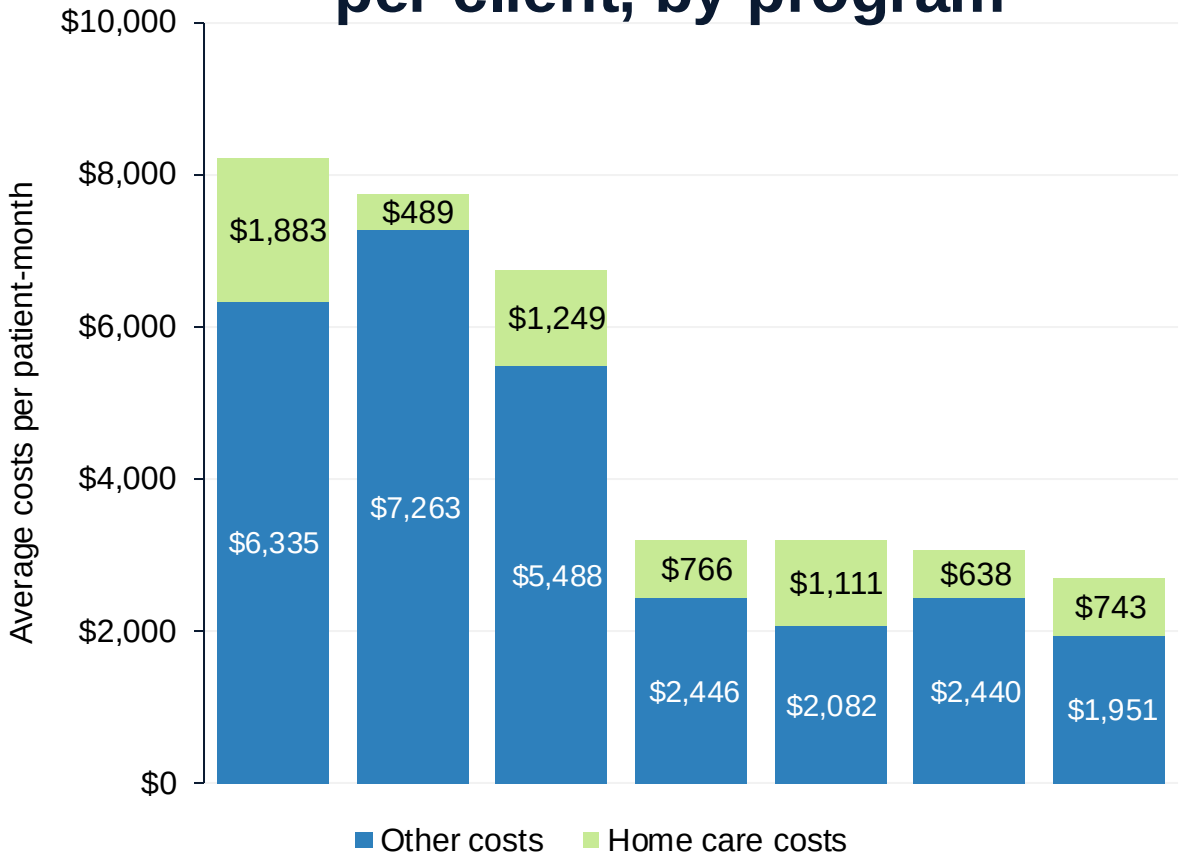
Days spent at home in the last 6 months (180 days) of life.



Total health system cost is an essential element of the Quintuple Aim. We will keep a reporting of this on a lagged-quarterly basis with home care and other health system costs tracked and reported.

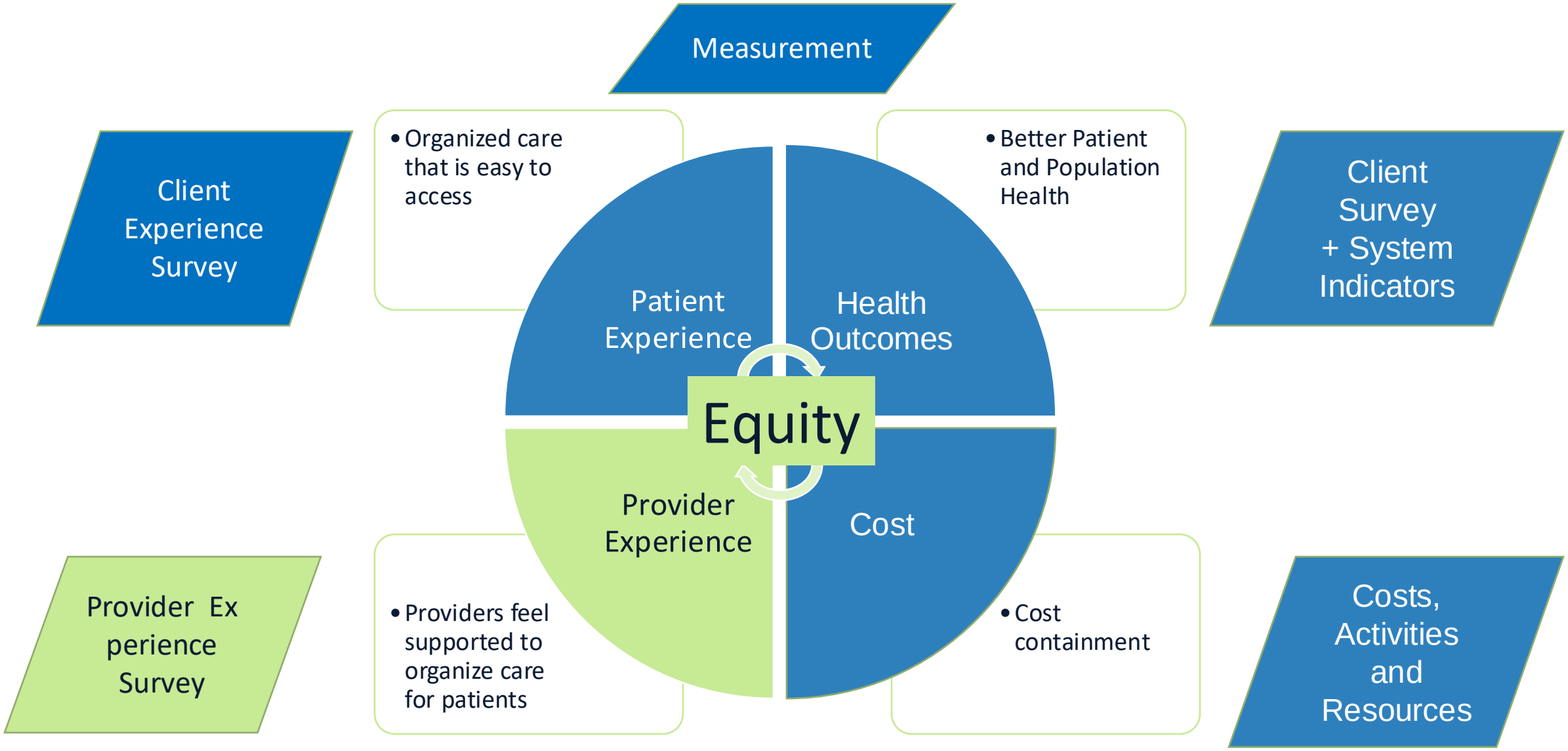
Here health costs are much higher in programs where there are more hospitalizations.

Monthly government spending per client, by program



Average attributable government health care spending per individual, per month alive in FY22-23.

ATTENTION TO PROVIDER EXPERIENCE



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Leading Projects in Homecare Baseline Provider Experience Survey

Interim Results

February 2025

Provider Experience Survey

- HSPN Provider Experience survey was distributed between November 2024 and February 2025
- Distribution lists were provided by Leading Projects
- Overall response rate*: 38%
  - Ranged from 24% to 60% by Leading Project

Survey Domains

- ***Care Coordination**
- Workplace Culture
- Autonomy
- Digital/Virtual Care
- ***Burnout and Satisfaction**
- ***Demographics**

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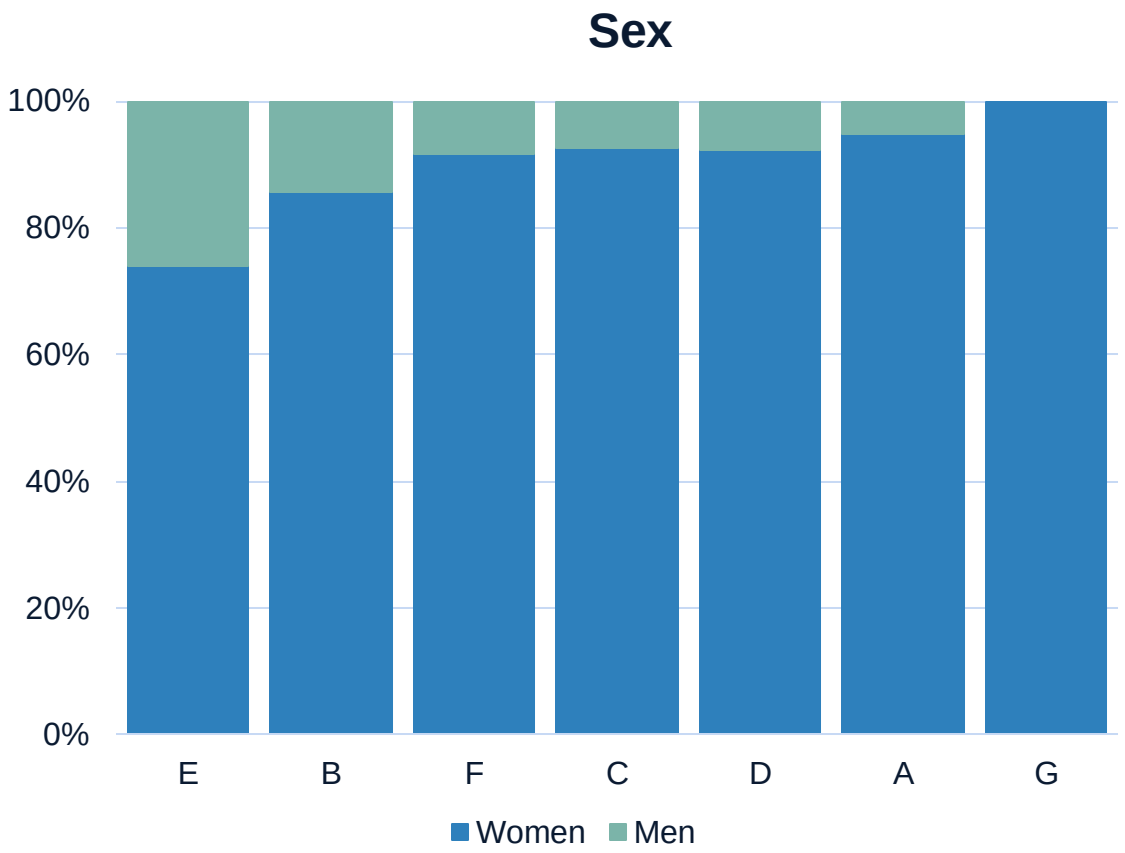
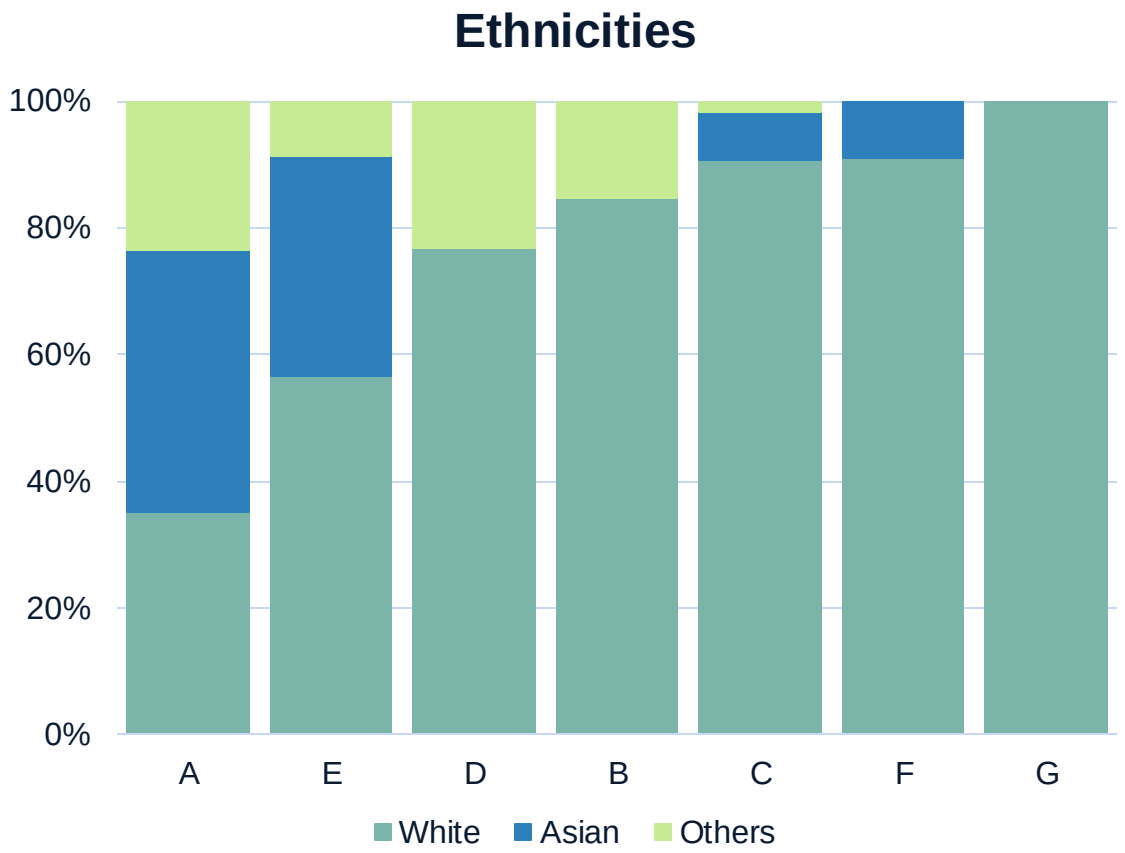
*Completion rate was 33%

Demographics





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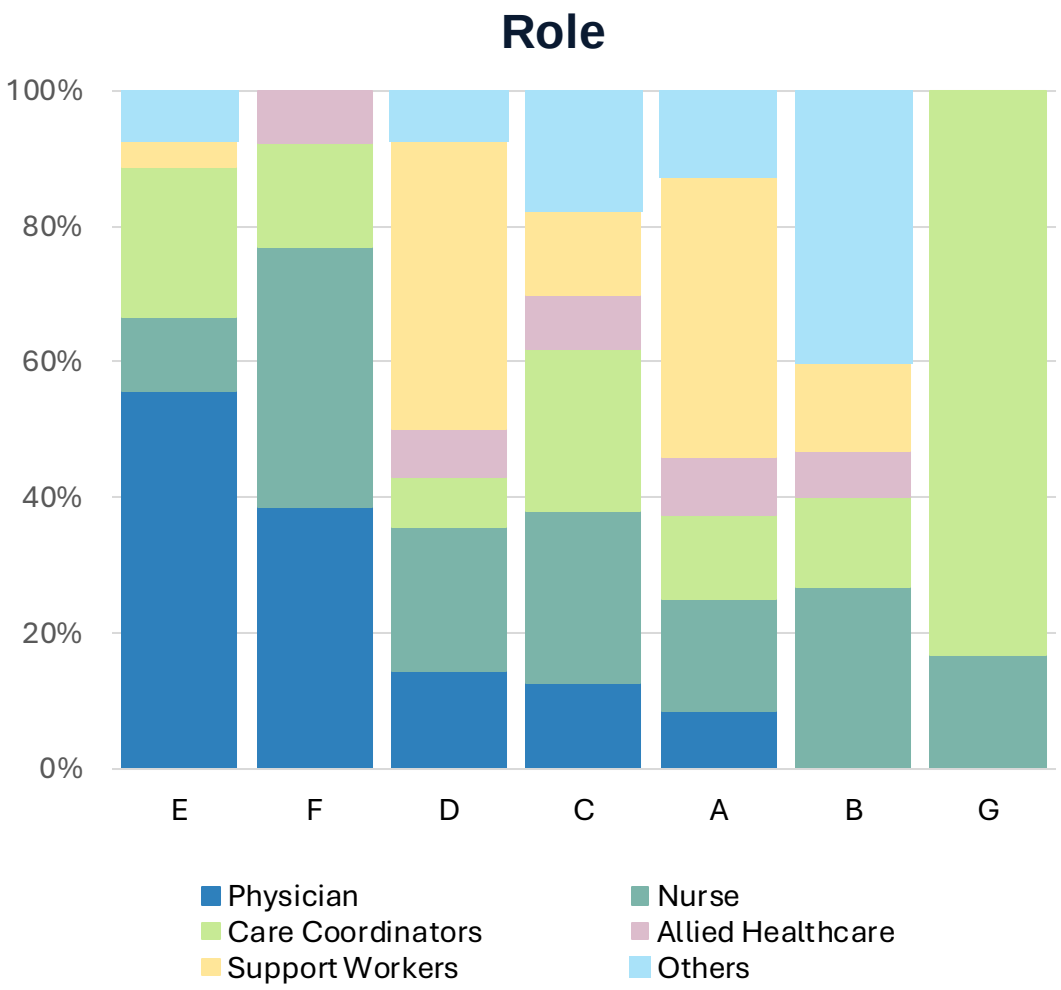
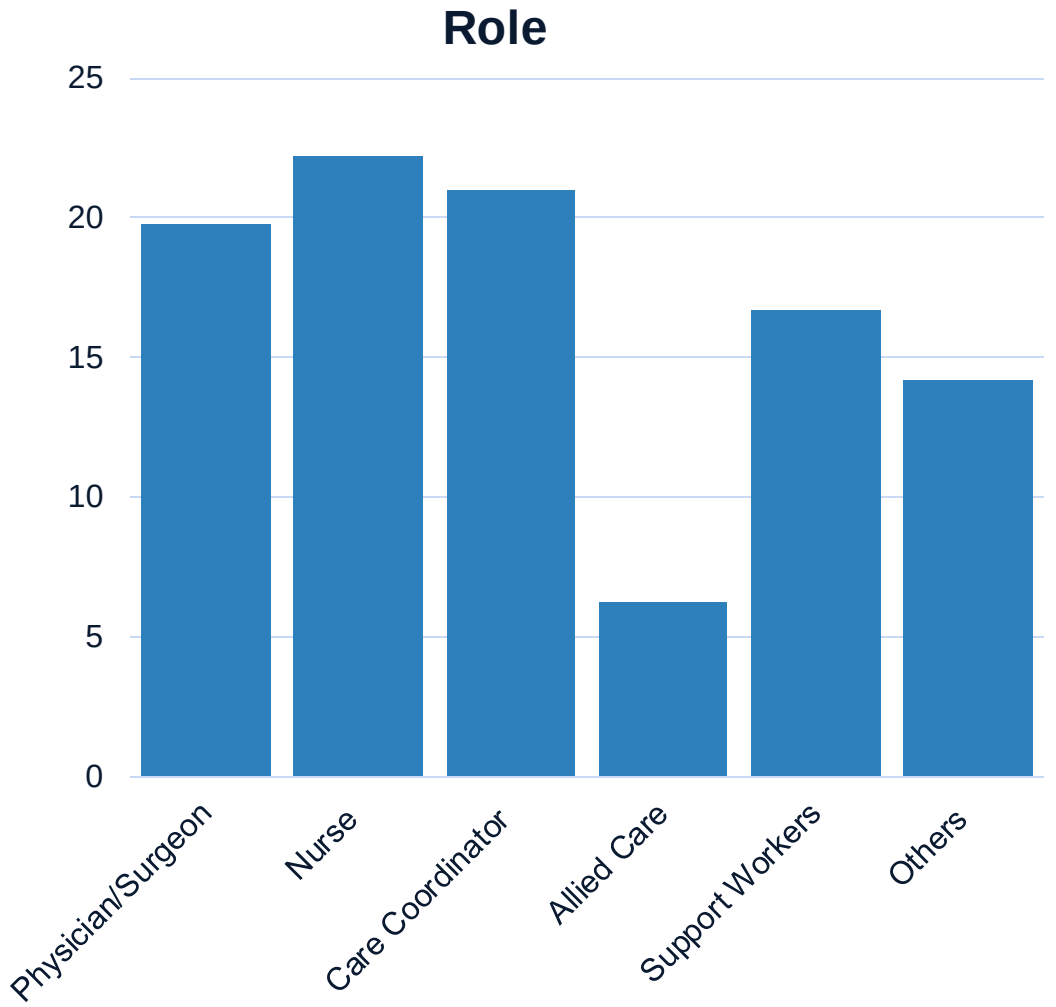
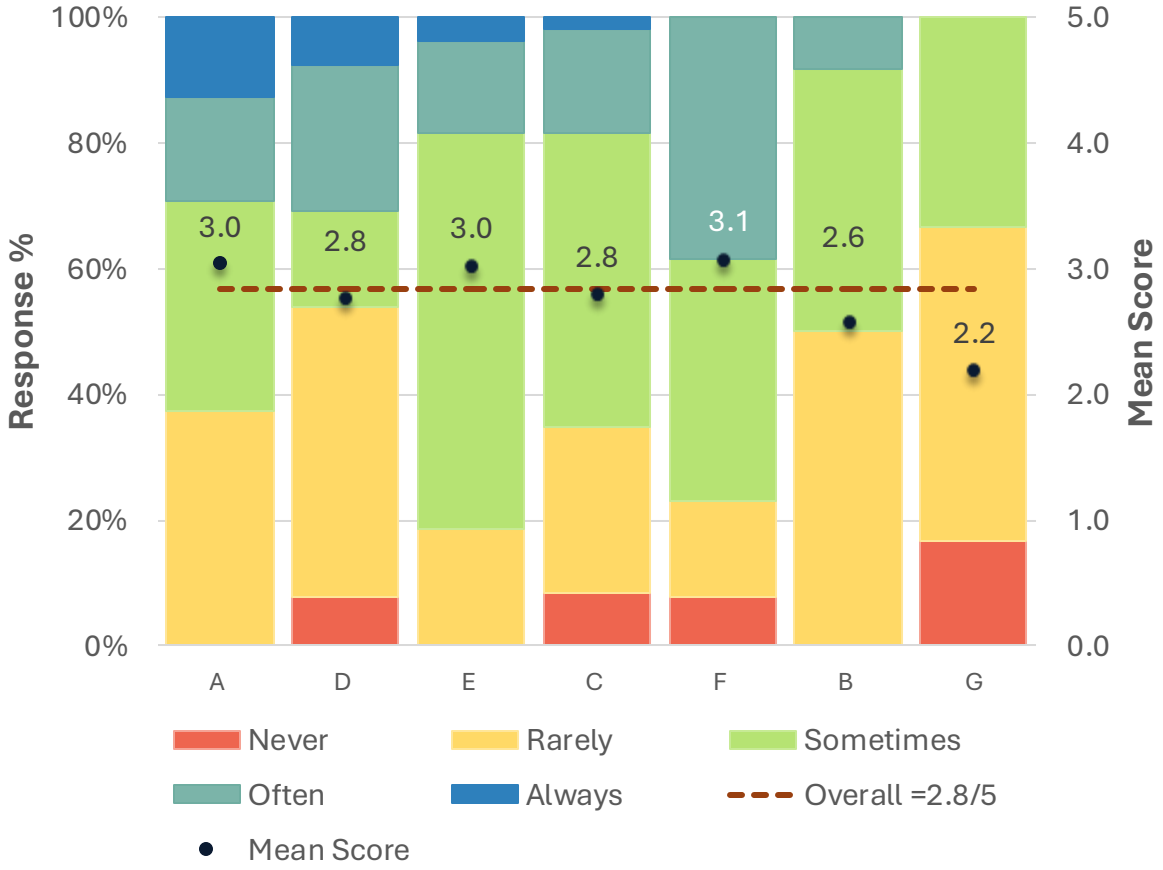
Demographics



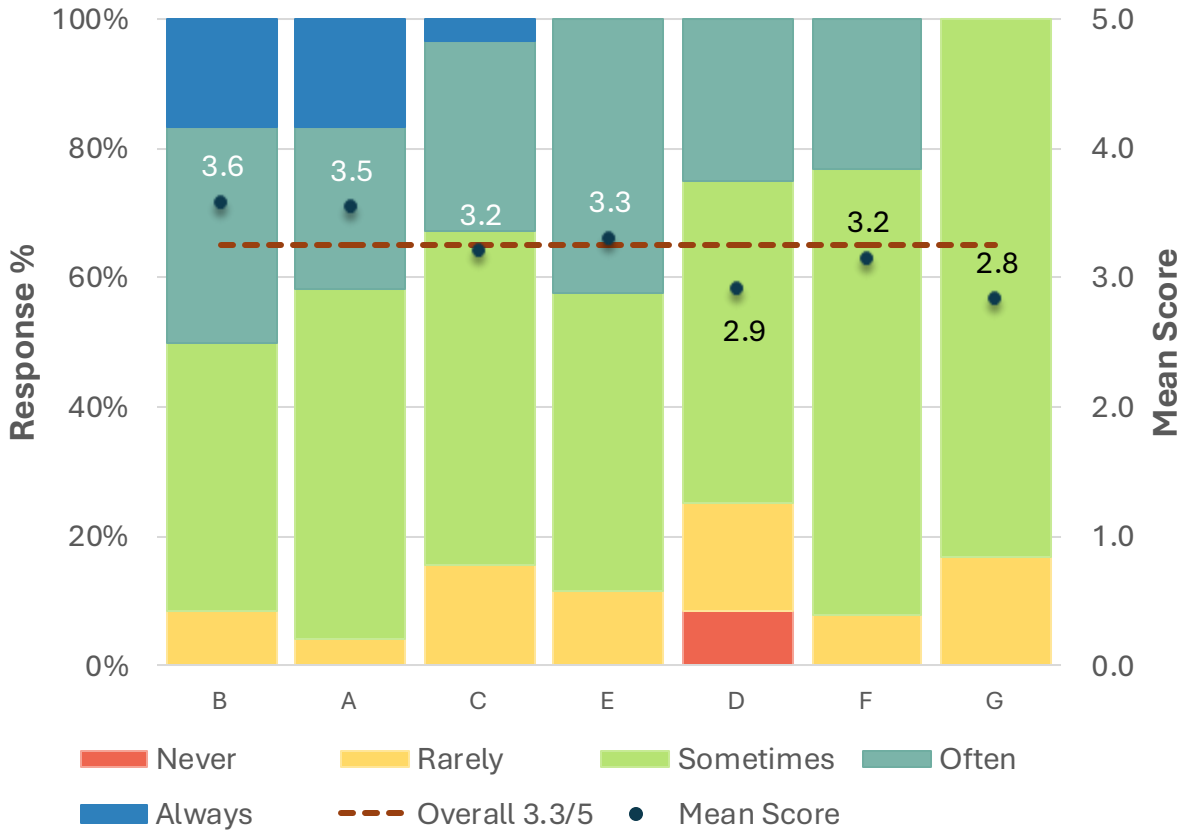


Care Coordination

How often do you know about all the visits that your patients/clients make to other health care providers (including physicians and other care providers? B3



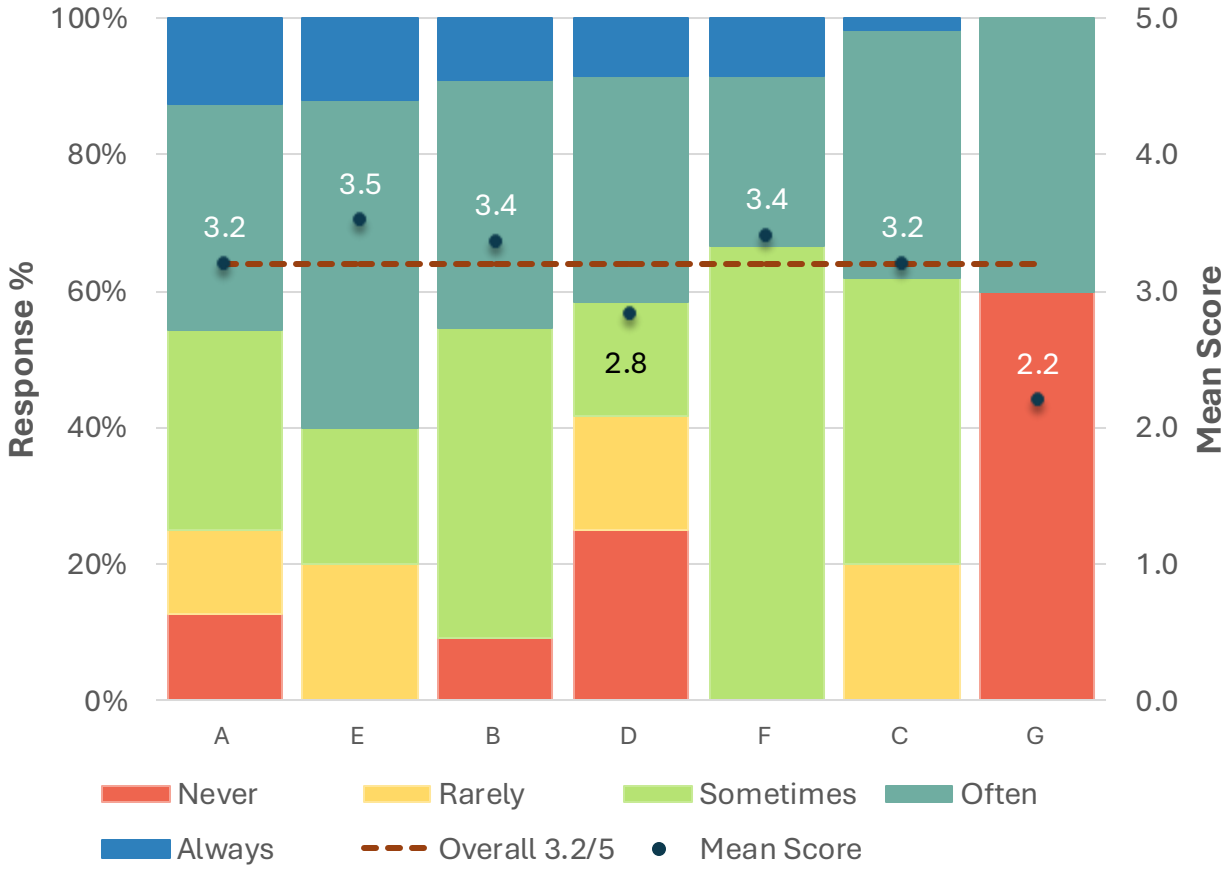
How often do you receive timely AND accurate information that you need to deliver care from other providers? B6



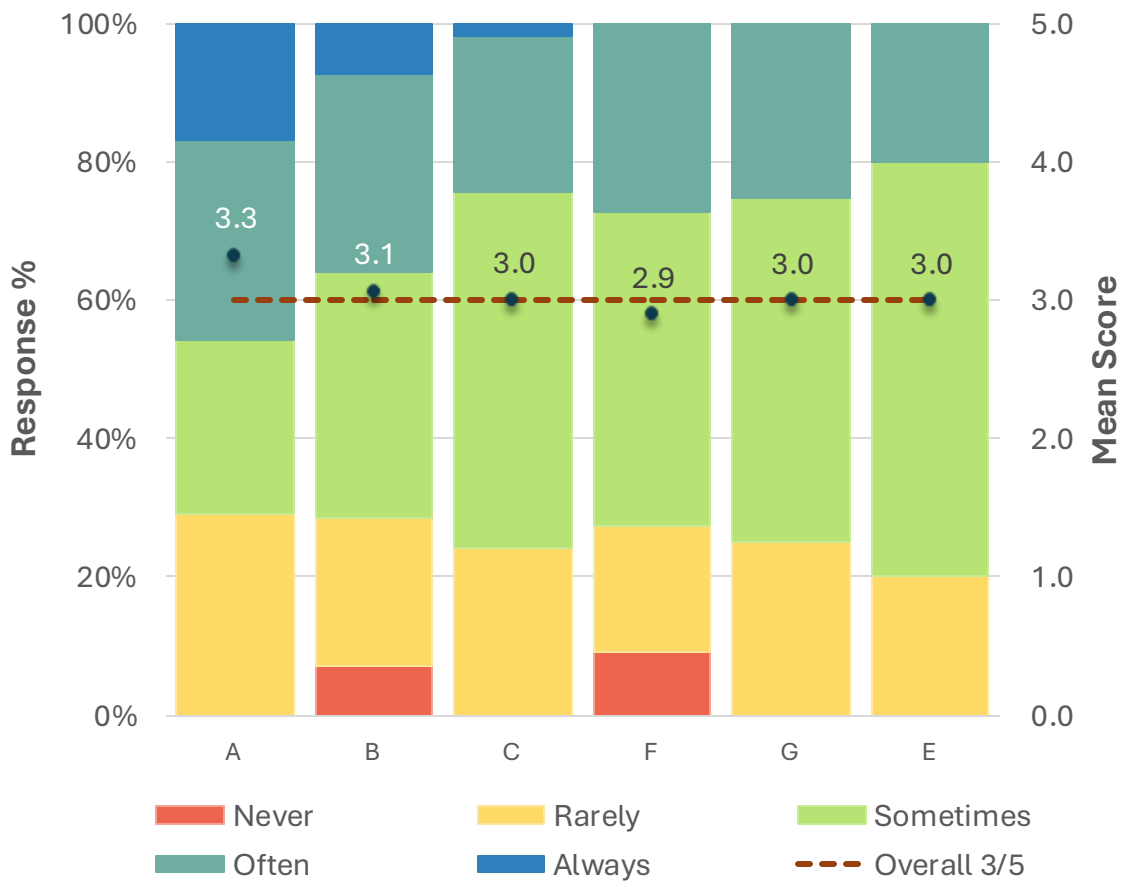
HSPN

Care Coordination

When clinically appropriate, how often is it easy to obtain a ("curbside") consult from peers or other providers in lieu of referring the patient? B7



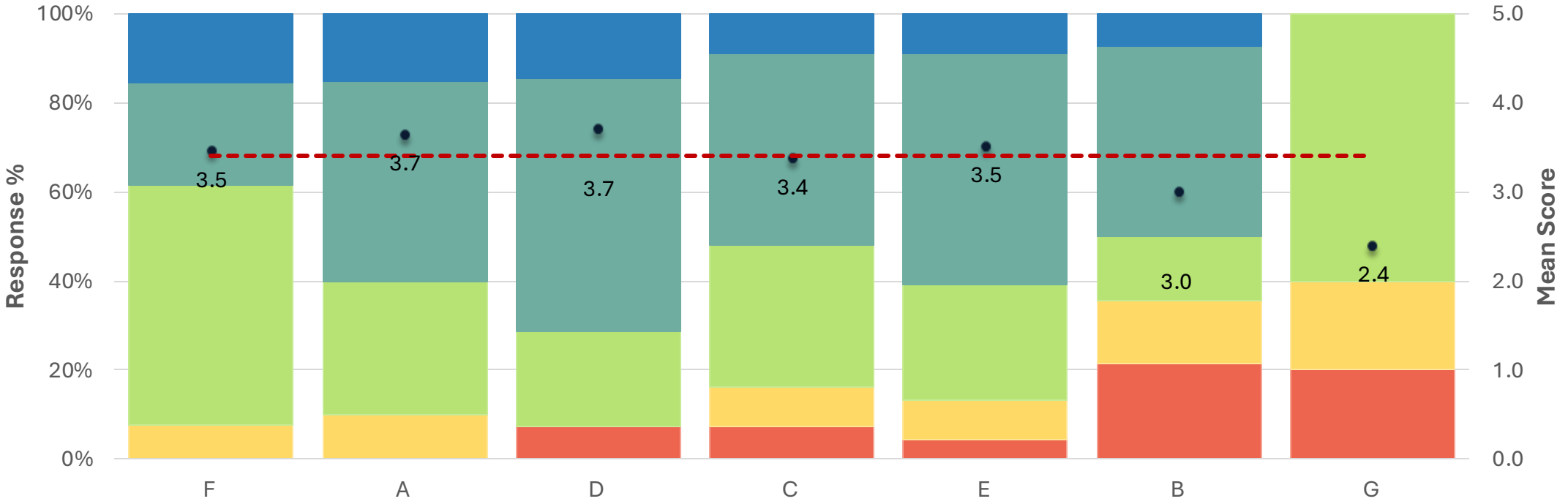
How often is patient care well-coordinated with community resources (e.g., support groups, food banks, shelters)? B9



HSPN

Burnout & Satisfaction

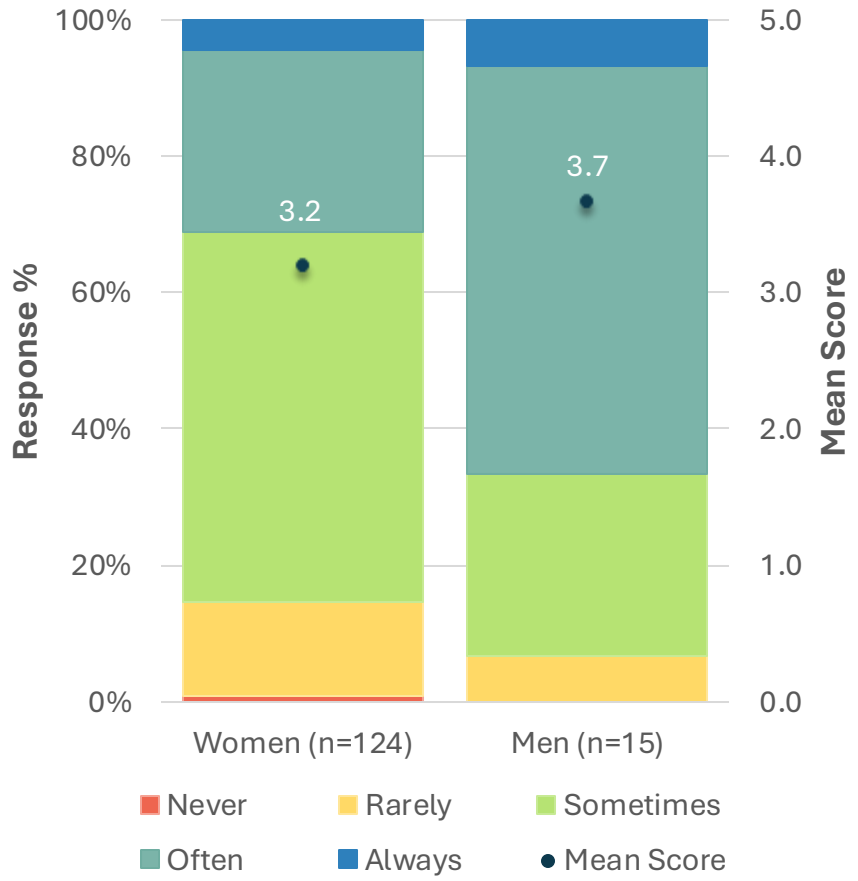
Using your own definition of “burnout”, which statement best describes your situation at work? F1



HSPN

Care Coordination – By Gender

How often do you receive timely AND accurate information that you need to deliver care from other providers? B6



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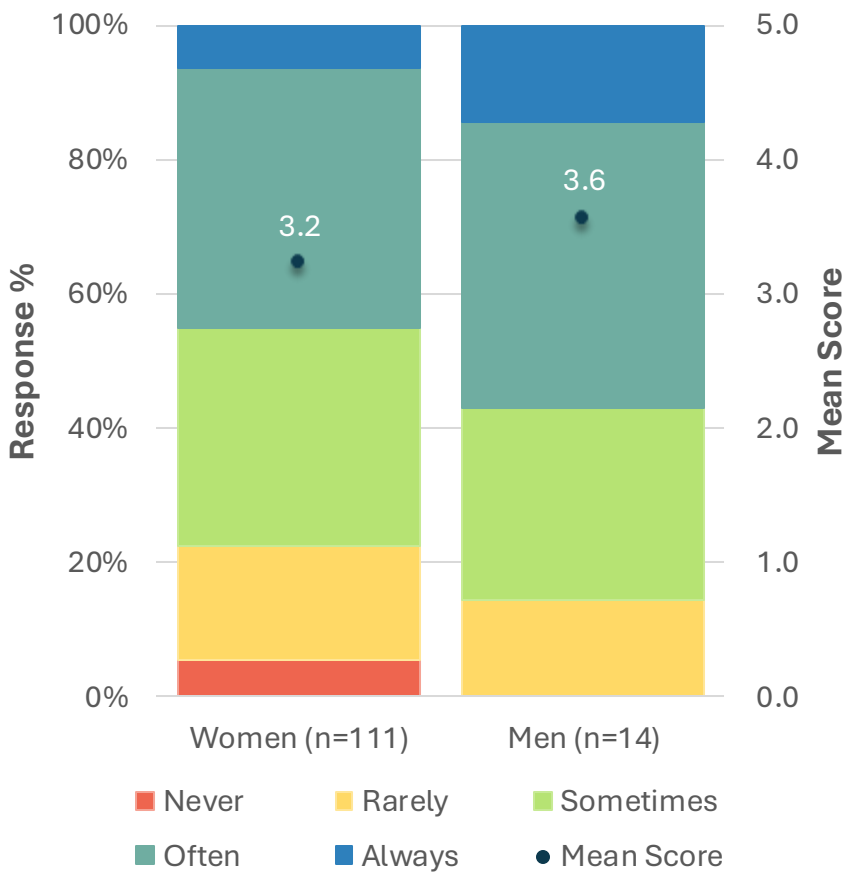
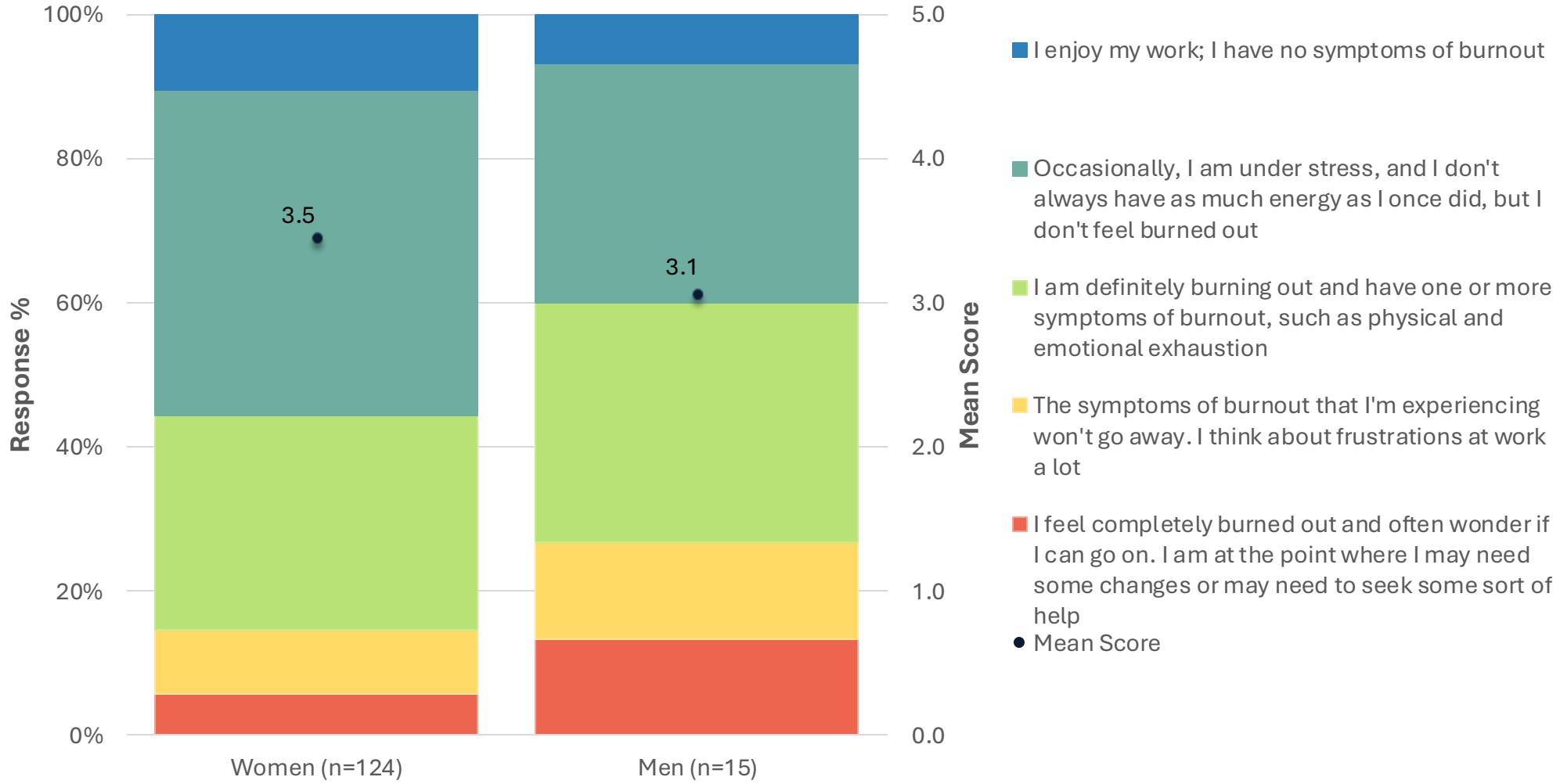


HSPN

Burnout & Satisfaction By Gender

Using your own definition of “burnout”, which statement best describes your situation at work? F1



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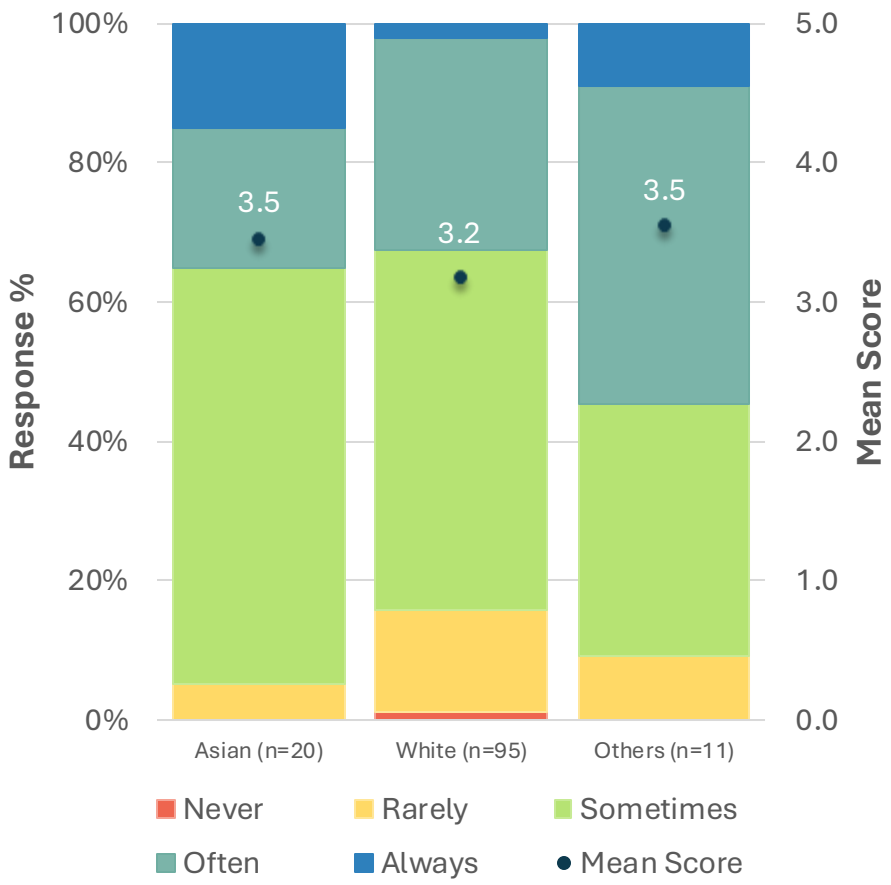
Care Coordination – By Ethnicity

How often do you receive timely AND accurate information that you need to deliver care from other providers? B6



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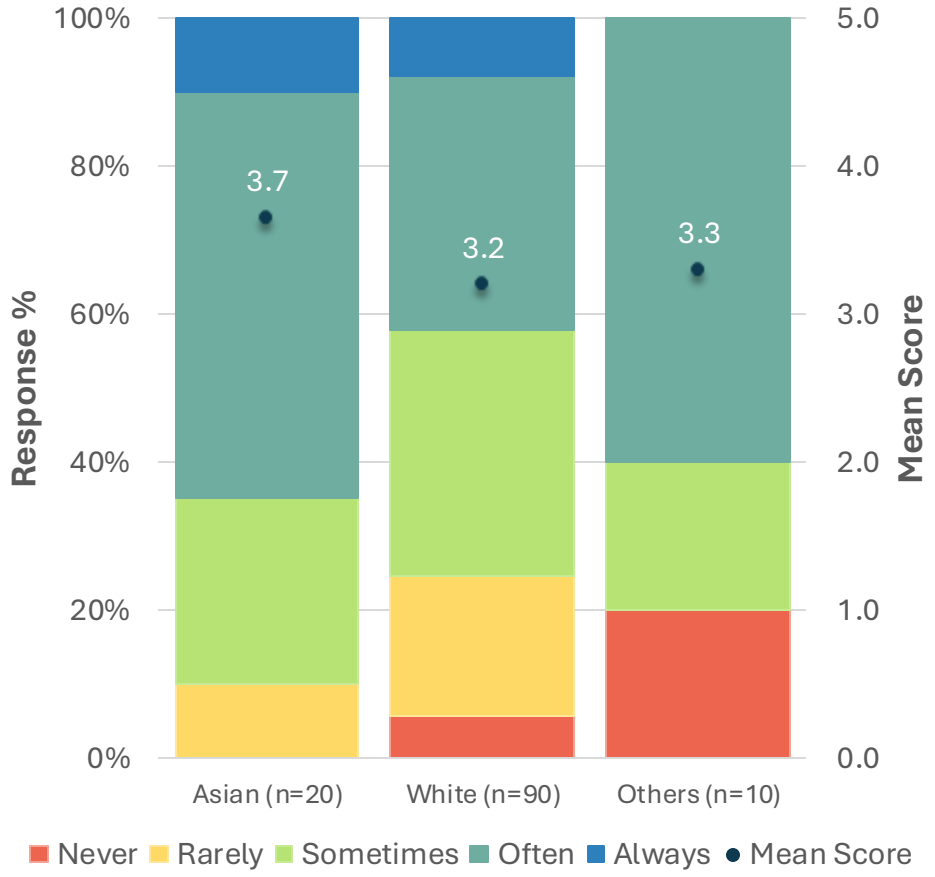
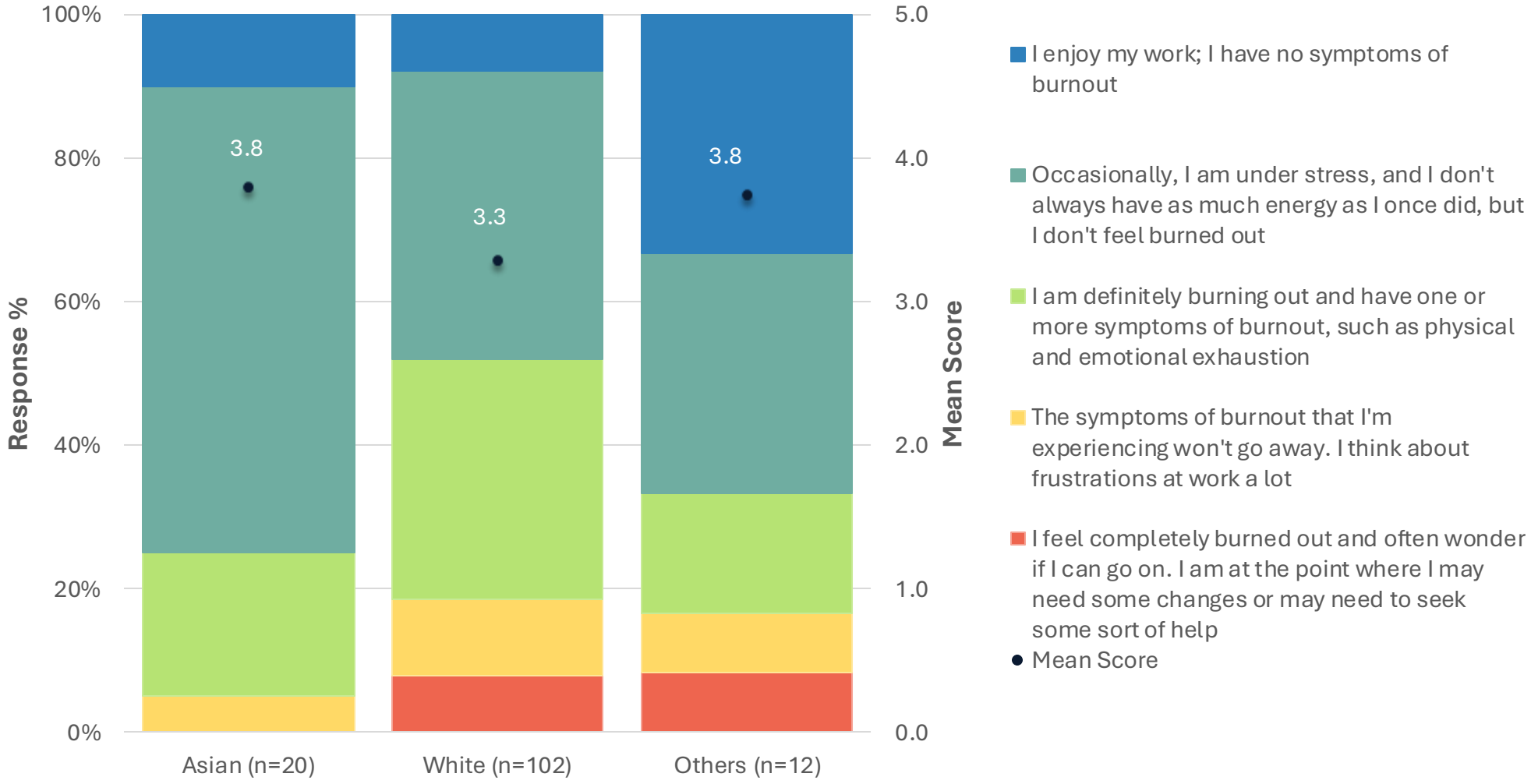


HSPN

Burnout & Satisfaction By Ethnicity

Using your own definition of “burnout”, which statement best describes your situation at work? F1



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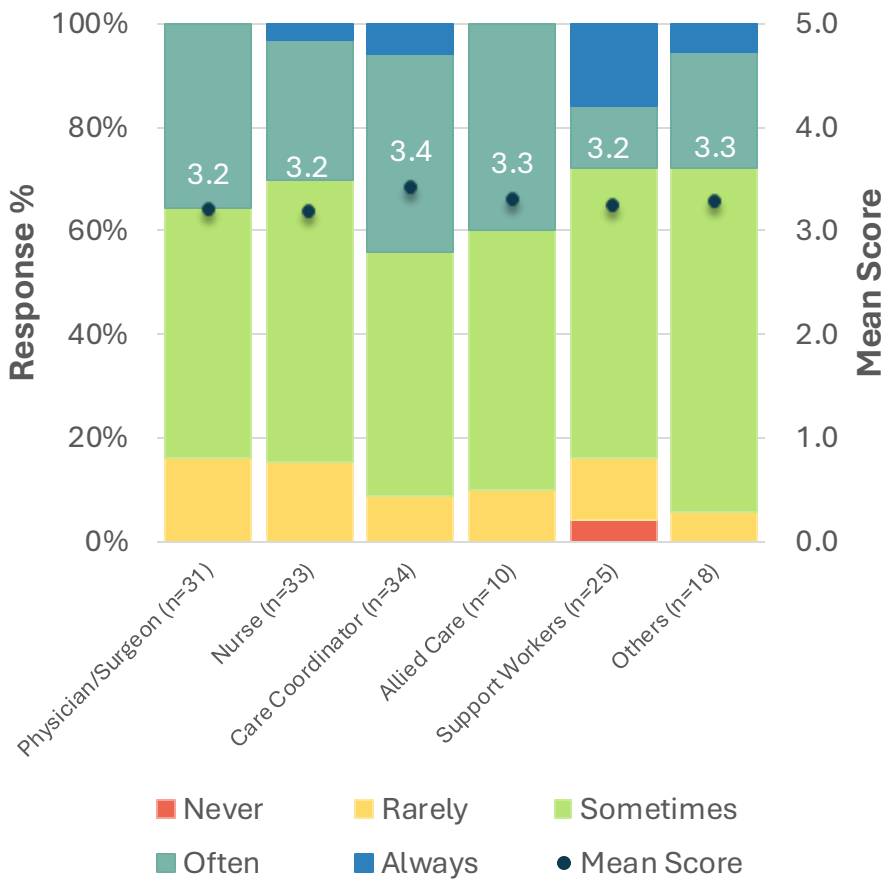
Care Coordination – By Role

How often do you receive timely AND accurate information that you need to deliver care from other providers? B6



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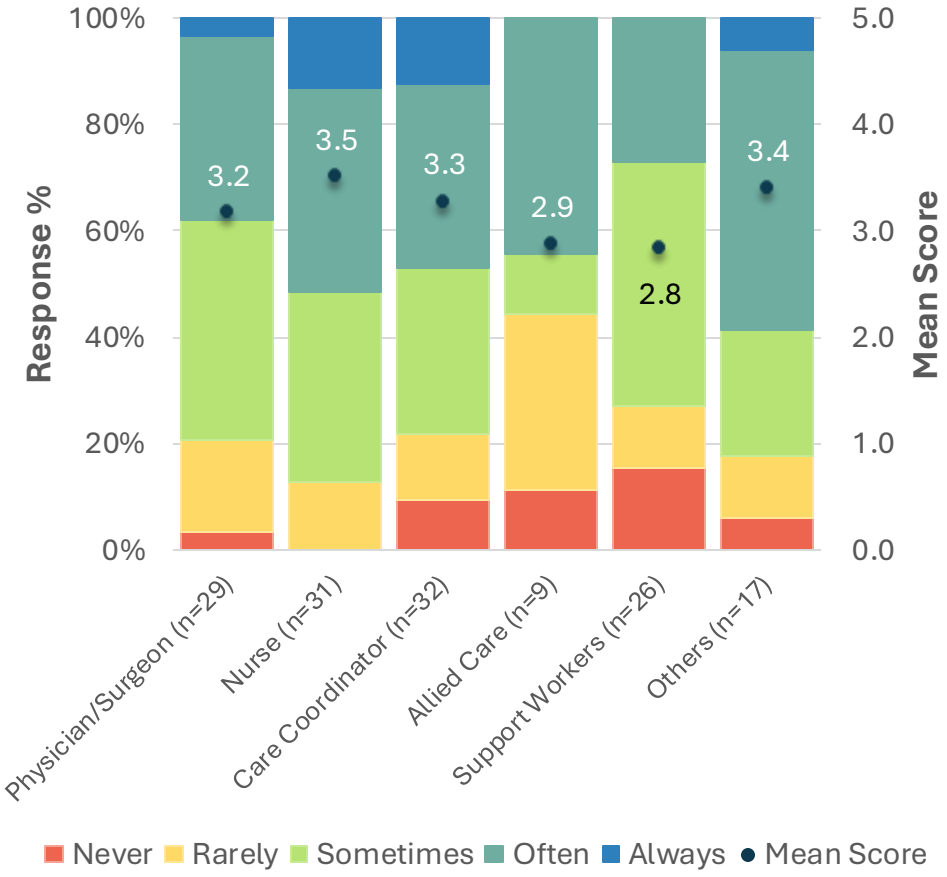

HSPN

Burnout & Satisfaction By Role

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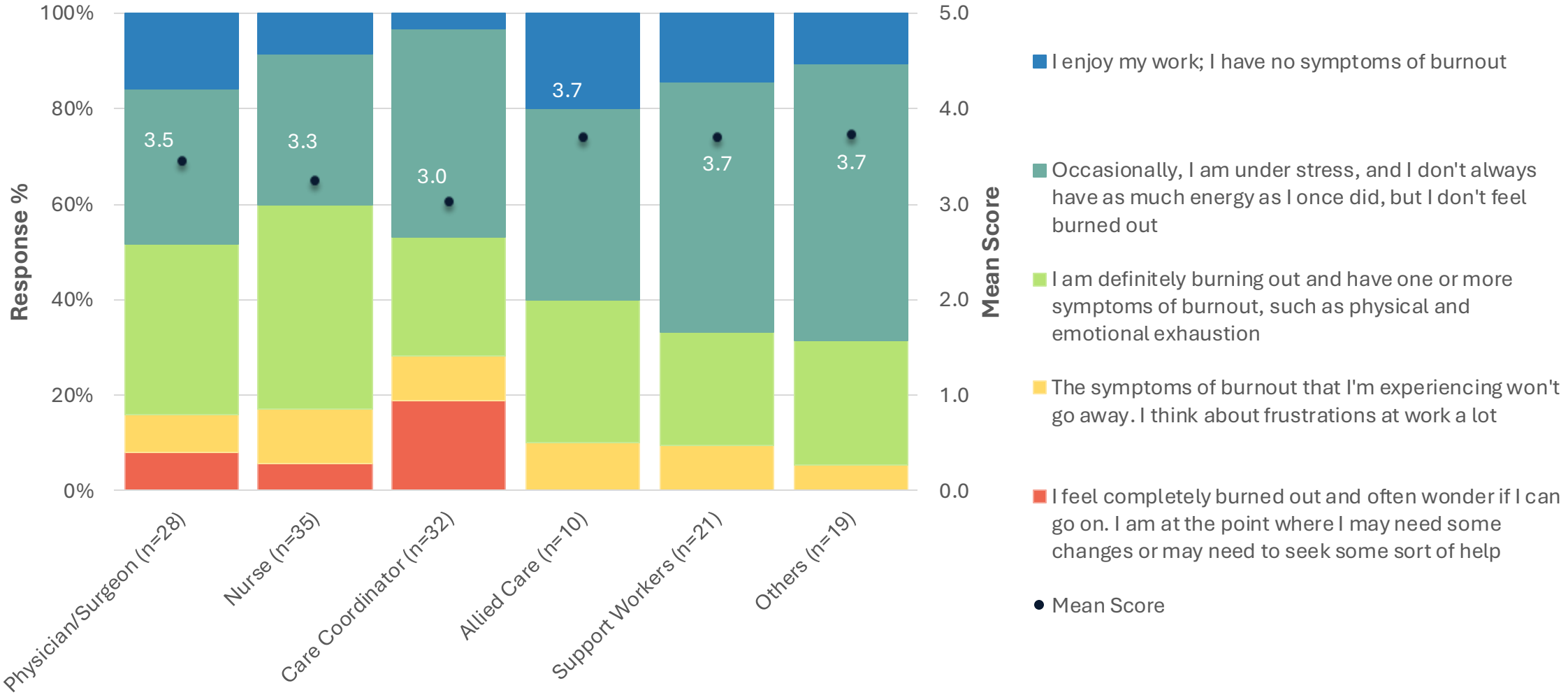

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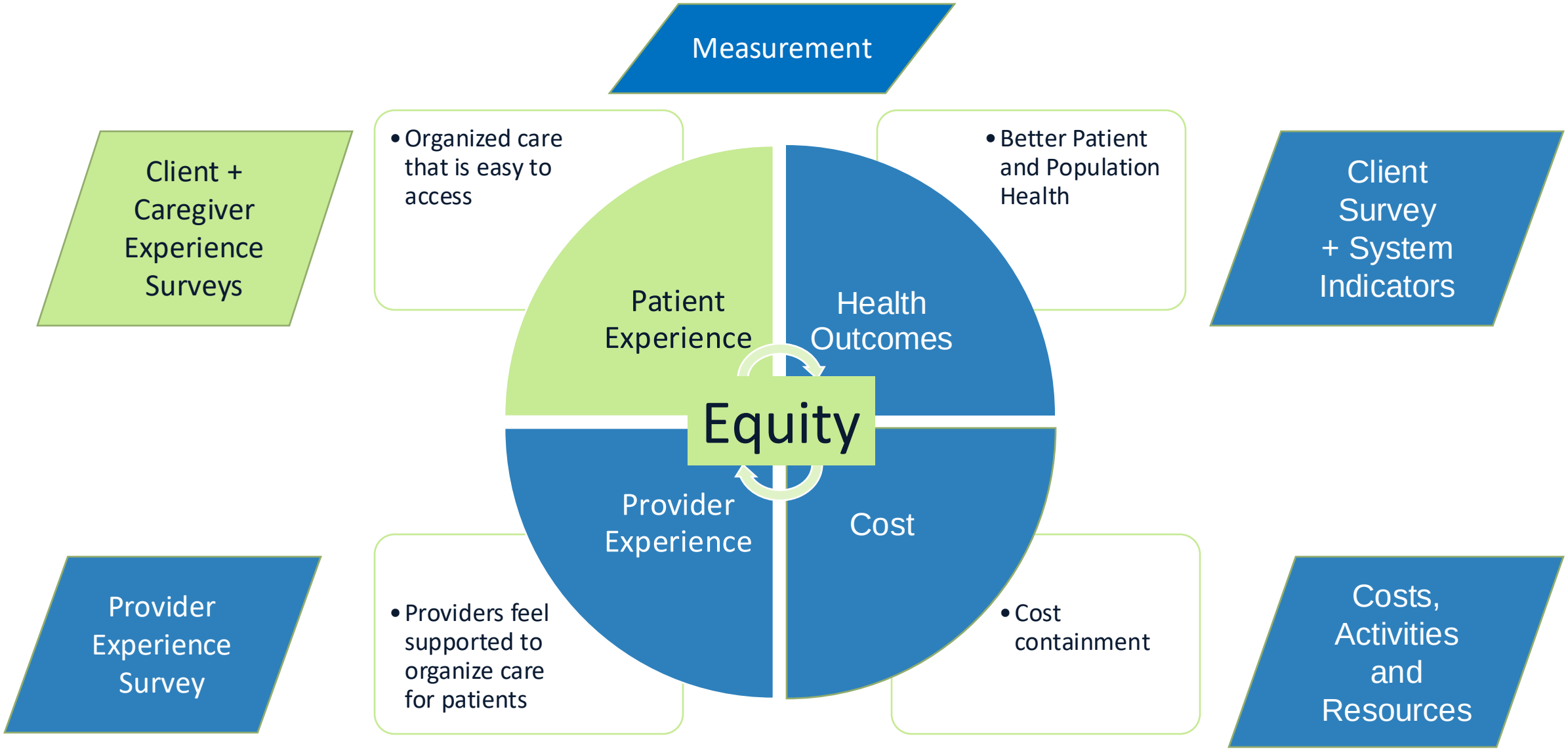
ATTENTION TO CLIENT+CAREGIVER EXPERIENCE



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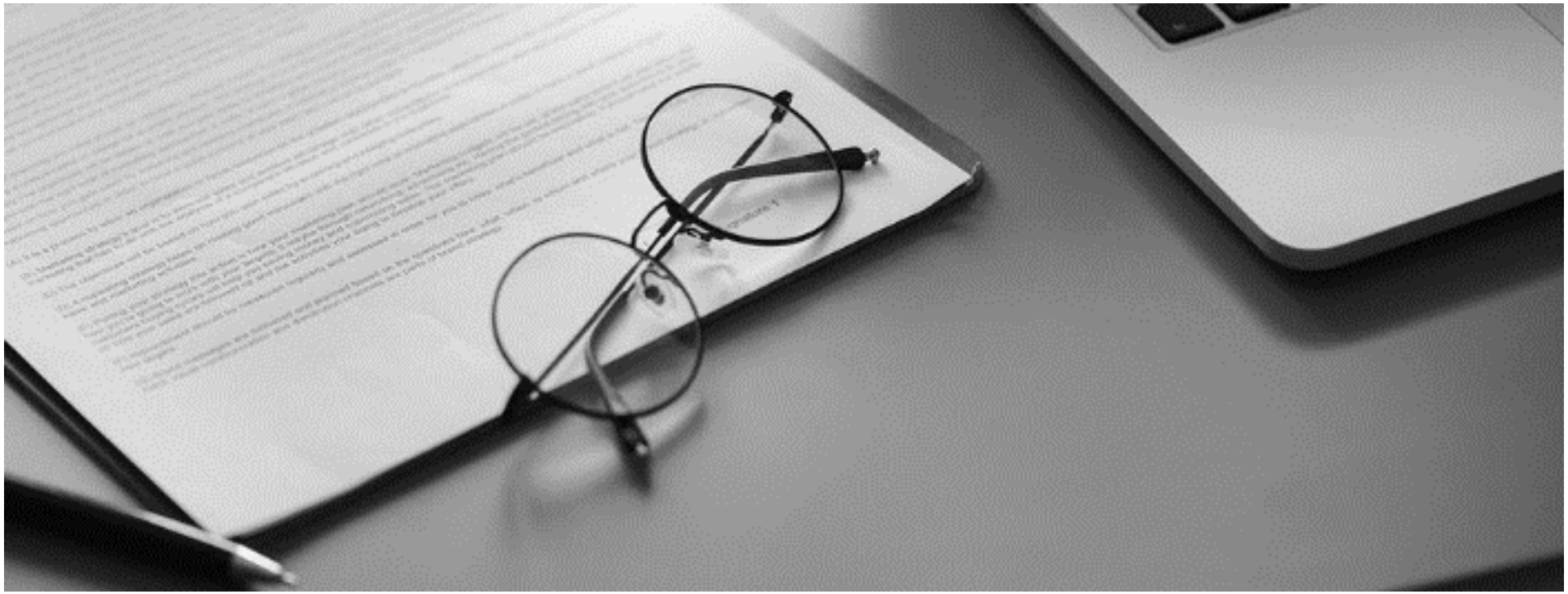
Client and Caregiver Experience

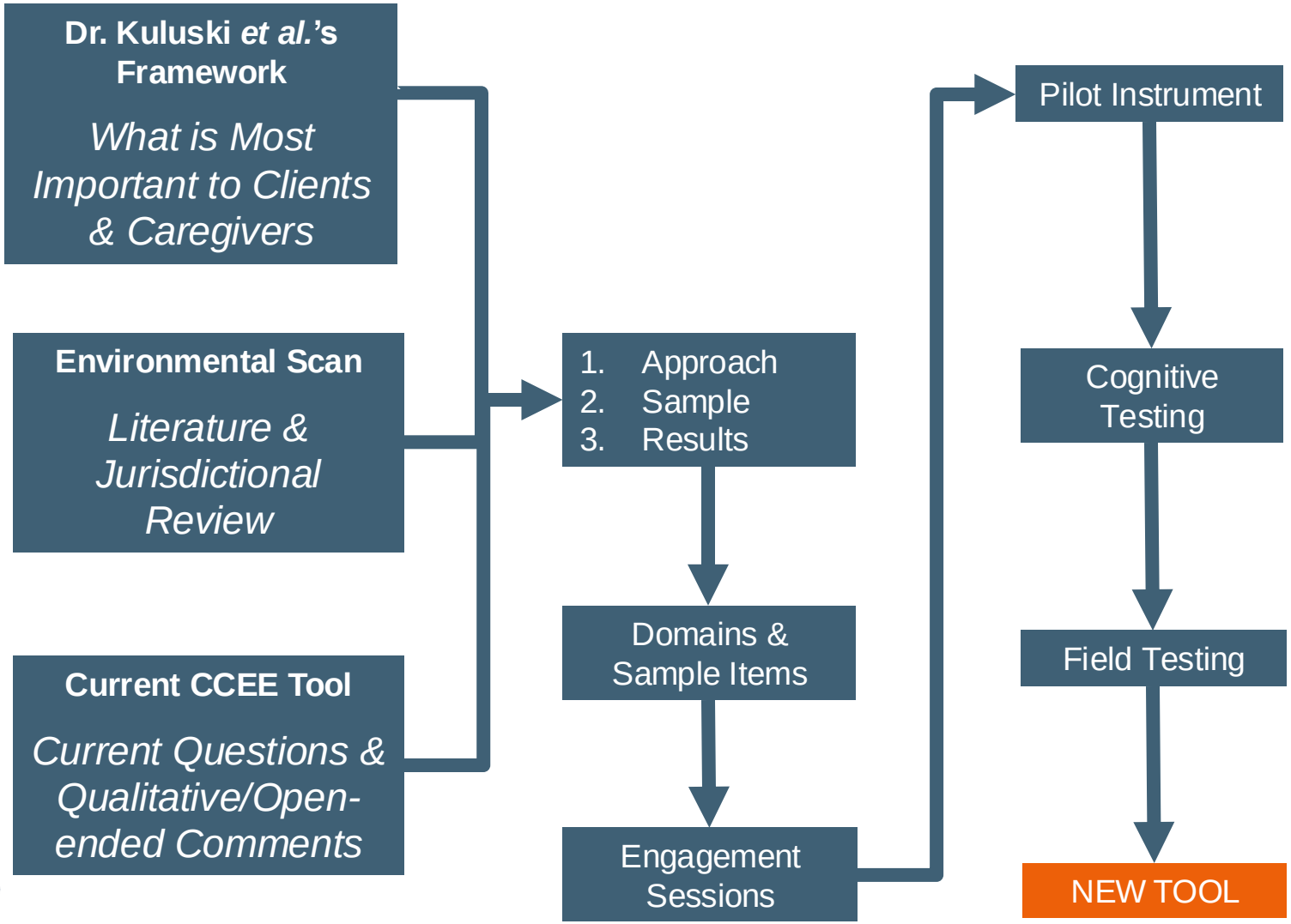
1. Leveraging Existing Surveys
    1. HSPN– OH@Home Client Experience Survey
    2. VOICES Caregiver Survey (palliative)
2. Choosing Priority Measures

HSPRN
health system performance research network

New Ontario Home Care Client & Caregiver Experience Survey



Goal: New Tool



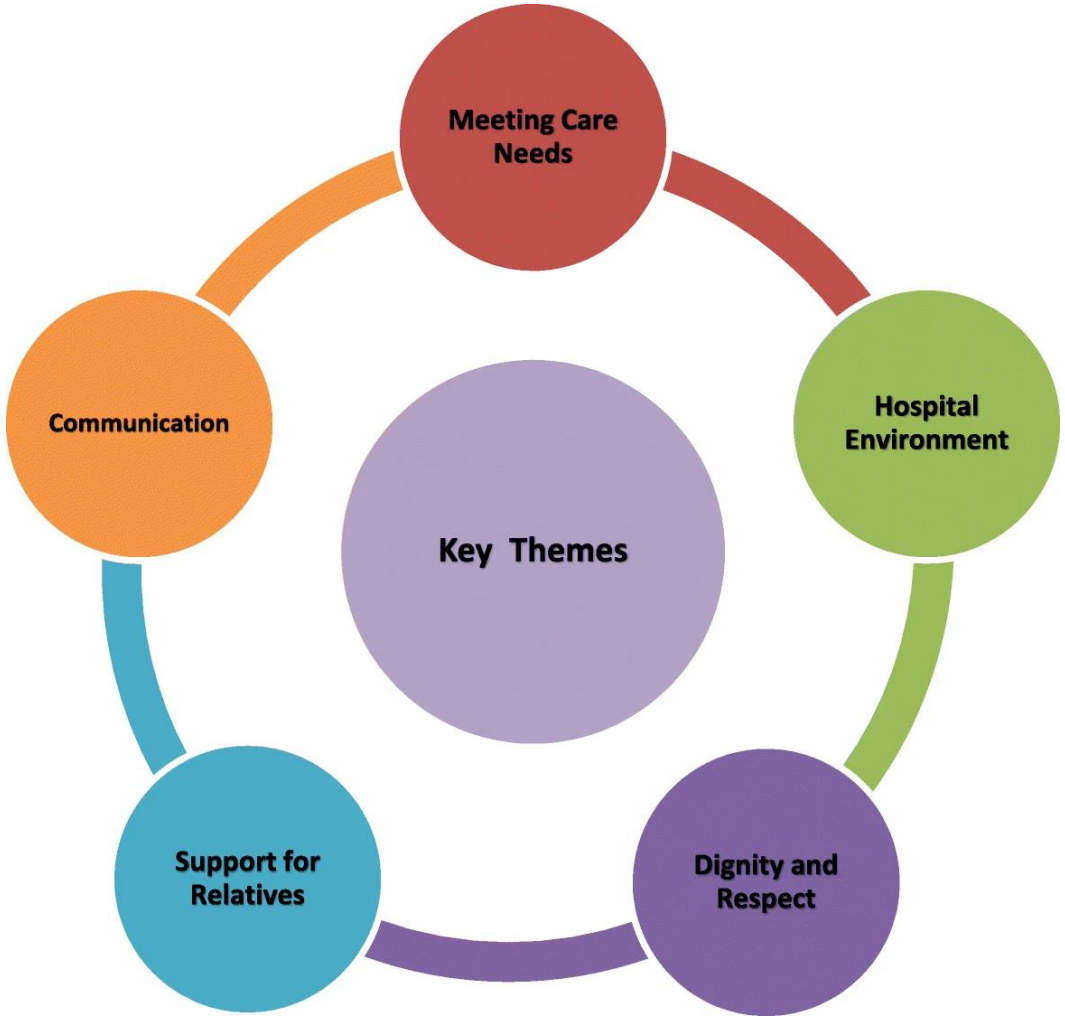
HSPRN
health system performance research network

https://hspn.ca/research/patient-caregiver-experience/redesigning-ontario-client-and-caregiver-experience-surveys/

OH@Home Client Survey Content

Section of Survey (# of questions)	Example items
Planning home care (6)	▪ Were you involved in planning your home care as much as you wanted to be? ▪ Did your home care providers include your family/caregiver in planning your home care?
Accessing home care (9)	▪ Are you receiving the right types of home care services for your needs? ▪ Do you receive enough hours of home care?
Communication (10)	▪ Do home care providers explain things in a way that is easy to understand? ▪ Do you have problems because there are different people providing care? (e.g., with personal support services, or with nursing care)
Home care providers (10)	▪ Do your home care providers treat you with courtesy and respect? ▪ Do your home care providers have the necessary skills to provide you with good home care?
Overall experience (3)	▪ Thinking of the home care services you received in the past 12 months, how helpful are/were they in allowing you to stay at home? ▪ Thinking about the overall quality of care from your home care providers, would you say it was/is…? [vs. Expected]

VOICES Palliative Caregiver Survey

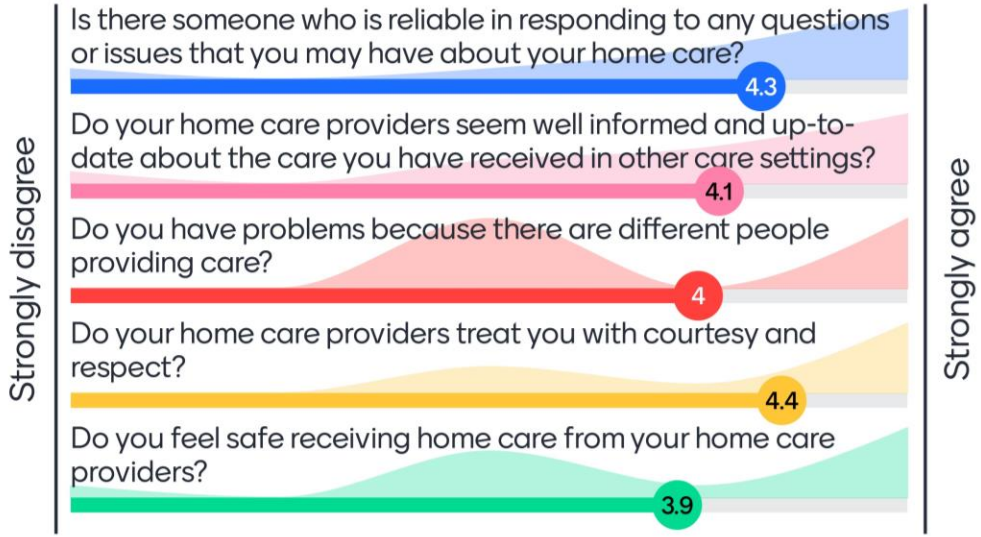


https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-018-0365-6

Choosing Priority Measures for Leading Projects - Collaboration

Mentimeter

Rate how much you agree that this would be a useful question for your Leading Project?



3 14

HSPN Health System Performance Network

OHT Leading Projects

Pre-Implementation Phase

Facilitators & Challenges of Implementation:
The Experience of Home Care Leading Projects

March 25, 2025

Objective

What are the facilitators & challenges experienced by the Home Care Leading Projects, as they planned for implementation?

Methods

Data Collection: April – October, 2024

Document Review

Applications, logic models, etc.

All projects (7)

Meeting Observations

Project specific meetings (monthly)

Cross-OHT planning and evaluation meetings (monthly)

Interviews

3 sets, pre/ post-implementation

~8 participants each;

across range of organizations & roles

Interview/Observ. cases (3)
ETHP, CK, GW

Focus Groups

3X through evaluation period, per LP

FG cases (4)
M, D, FLA, NW

Reflective Check-ins

Ongoing check-ins with project leads

(≈monthly/ quarterly)

All projects (7)

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Implementation facilitators & challenges - Key themes

- Planned levers of change
- Relationship-building
- Leadership
- Building on, testing & managing change
- Flexibility & tailoring of model
- Physician engagement
- Risk & uncertainty
- Commitment & motivation to integration

Relationship-building

- Mature partner relationship correlated with shared vision

"… whenever we [hospital] ask you [HCCSS] to take something [on], you start from yes, and then you figure out how to do it. I think that's a bit unusual, as far as a relationship between hospital and homecare." (Hospital leader)

"… When you come to an in-person Collaborative meeting for [Name] OHT, it's like a party, it really is a unique experience." (HCCSS leader)

- Perception of limits to sharing & collaboration

"…is OH@Home truly a willing and contributory partner to these projects? […] they still hold a lot of power and sway over the outcome of the project. And we see hesitation in terms of how much buy-in we're getting. […] HSPs haven't done this before. I feel like they've asked us, 'Do you accept this set of services that we're offering?' And our response is, 'Yeah, that looks pretty good,' but we don't know what we don't know […] that just feels like an example of OH@Home saying, 'Sure, we'll do this, we'll do exactly what we're asked to do.' […] It would have felt more collaborative for there to actually be a conversation between the HSP and OH@Home to help them understand what's required to run home care." (LP leader)

Building on, testing & managing change

- Building on existing innovations that LPs knew were working well provided a sense of confidence

- Test run of planned innovations allowed gaps to be identified

Solutions developed: Coordinators call physician's office & receptionist triages questions, mentorship provided by experienced navigator (E.g. tandem visits)

"…care coordinator is giving one message, and we're [partner service provider] giving a different message." (Community leader)

"Physicians were being contacted a lot" (LP administrator)

"…change is hard because there's so much ambiguity. But to be uncertain together and to ask the questions in one space and receive that training, I can see the benefits of that." (Hospital administrator)

- Change management sessions:
  - Provided opportunity to introduce project & communicate changes
  - Allowed providers from different organizations to meet, begin team-building, ask questions, voice concerns, & provide input into plans

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Flexibility & tailoring of model

- Lack of flexibility hinders relationship-building & shared vision

"If we're thinking about this as the Thanksgiving dinner table, HCCSS is at the table but limited in their ability to eat the turkey. Constrained by, I think, a culture of risk avoidance, constrained by a directive to standardize provincially, despite there being 58 OHTs and seven leading practices that are, by design, different from each other." (OHT Leader)

- Experienced leader able to creatively negotiate tension between innovation & harmonization

"…across our organization [HCCSS], we're being told [to adopt] a consistent approach so that all seven of our home and community care programs are approaching this in the same way. [… For example] we would do a light touch eligibility and determination of what the patient actually needs, and then send it right over to the leading project. And I'm not sure that works for every population. […] I'm trying to find areas where there's wiggle room, […] find ways to influence things from a home and community care perspective, but still fit within the rules." (HCCSS leader)

Risk, uncertainty and commitment

- Delays put relationships at risk & frustrated momentum

"They [service providers] used to show up faithfully. Like two summers ago, they were at every meeting. We'd get people from their head office there. It's been crickets. We can't even get them to attend locally because they've moved on to other priorities, because this is delay, delay, delay." (HCCSS leader)

- SPO procurement process & engagement timeline contributed to sense of uncertainty

"We have been feverishly working with our [newly announced SPO] partner to figure out privacy, agreements, digital solutions. So we're [only] now getting to, 'What is the transitional lead going to do? What is the care coordinator doing?' But because of the blackout period, we could not advance any of these conversations. We didn't know how well versed our SPO partner was going to be. […] I understand […] RFP and procurement rules – but just the way that the timing fell, it's an unfortunate situation." (LP leader)

- Commitment to LP vision, despite uncertainties

"We're working as though the project's already been funded. And it's not. So you don't do that unless you have significant trust among the partners. If [hospital] doesn't approve it at their board meeting tonight, the leading project partners have said […] we're going to move forward with it. It just means that we may have to adjust it a bit […] that we won't maybe be knee deep in it, we'll be shin deep in it." (HCCSS leader)

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In conclusion: A vision for the future

- Rules (distanced from local context) seen as impairing innovation

"Homecare modernization is removing some of the rules-based thinking that care coordinators are just authorizers of service, that this can't be funded, or this can't be provided because it doesn't fit in our rule-based system. It is one of the things we are unfettered by in [hospital-run homecare program], for the most part. When the team sometimes sheepishly comes to me and says "In order to get this person home, we needed to get them a mattress, so we went and bought a mattress from Sleep Country and had it delivered. Is that okay? I'm like, "Yeah, that's okay, because at least I can say they would have stayed five more days in hospital at $1,000 a day versus the $133 you've spent on a mattress." […] ***the outcome of rules-based thinking is not person-centred care****."*
(Hospital Leader)

- Concern that what really matters to patient isn't being addressed

"… I have workers from the SPO here sitting with my mother, listening to music, doing this and the other thing while I run around, cleaning, doing her laundry, putting in the orders for her supplies, and on and on. And I think, shouldn't I be the one sitting with my mom? Shouldn't somebody else be doing those other things? And they're [PSWs] very, very limited in what they can do. Once I had made the PSW a cup of tea, as it puts you in a better mood for caring for my mother. And as she left she says, 'Oh, I put my cup in the kitchen for you.' Okay. But there are things that they're not allowed to do that I kind of shake my head. […] ***It doesn't cost any more money. It's a better use of the worker's time. But we don't touch that. We're looking at the structure*** *- should it be this agency or that agency who's in charge of homecare?"* (PFAC member)

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Recommendations: OHT stakeholders

- Signal upfront to on-the-ground providers that their patience and buy-in will be required to identify and work through early implementation challenges, so that they are aware that their partnership will be required for eventual seamless patient and provider experience.
- Have open conversations to understand scope for and benefits of both a tailored and standardized approach, in different contexts.
- Unexpected SPO changes will require attention to developing new trusting relationships that was not part of original plans. This may require additional work & time, but is important given evidence that trust is key enabler.

Recommendations: System stakeholders

- Be aware that:
  - Many OHT stakeholders thought that the LPs did not necessarily address key issues pertinent to patients (E.g. PSW roles) and providers (E.g. privacy regulations).
  - Project delays & lack of directional consistency and dependable funding frustrated OHTs' ability to engage stakeholders & hindered understanding of long-term vision.
- Flag expected outcomes in relation to timelines - e.g. what is expected in the short, medium and long-term ⟹ mitigates OHT anxieties, by acknowledging that certain impacts may take time, while providing a realistic roadmap of direction and accountability.

Recommendations: System stakeholders

- The tense relationship between many OHTs & OH@Home needs to be addressed for meaningful collaboration:
  - Is there scope for working on timely responses to requests, given interdependencies?
  - Is there scope for getting all stakeholders on the same page about the legal framework within which OH@Home operates, to mitigate finger-pointing?
  - Is there scope for collaborative guidance provided to LPs/ HSPs to help them understand the intricacies of what is involved in delivering homecare?

Questions?

Up Next

- HSPN webinar series
  - 4th Tuesday of the Month: 12:00 – 1:30 pm
  - April 22nd, 2025

THANK YOU!

@infohspn

hspn@utoronto.ca

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