Assisted Living Services Policy, 2023

An updated services program offered in supportive housing and community settings.[1]

July 13, 2023

[1] This is a Ministry of Health Supportive Housing Program.

Assisted Living Services Policy, 2023

Table of Contents

Assisted Living Services Policy, 2023

1. Background

Assisted Living Services (ALS) have been supporting people living in Supportive Housing in Ontario since their introduction via the *Long-Term Care Supportive Housing Policy* (LTCSH Policy, 1994). Further refinements were made to the program in the *Assisted Living Services for High-Risk Seniors Policy (*ALS-HRS Policy, 2011*).*

ALS were included in the 2021 Auditor General's Annual Report released on December 1, 2021. The Auditor General acknowledged the value of work of ALS Health Service Providers (ALS HSPs) by recognizing that ALS "can significantly improve the quality of life for seniors and people with certain health conditions". At the same time, the Auditor General found opportunities for improvement.

The Assisted Living Services Policy, 2023 (this policy) recognizes a need to combine the strengths of the two previously noted policies, as well as begin to address the recommendations set out in the Auditor General's report. It sets a path forward for continued quality improvement and the ability for ALS to adapt to changing client and health system needs.

This policy sets out provisions relating to:

a) Services available
b) Eligibility criteria
c) Requirements set out in legislation and regulations
d) Service locations
e) Roles and responsibilities
f) Mandatory reporting requirements

In the spirit of respect and Truth and Reconciliation, this policy supports the Indigenous health systems that provide culturally safe care. Any conflict between that goal and this policy should be brought to the attention of the Ministry of Health.

1.1. Definitions

Adult with an ABI:
An individual 16 years of age or older with a diagnosis of an Acquired Brain Injury (ABI), which is damage to the brain after birth that is not due to a congenital disorder, developmental disability or a progressive disease process.

Adult with HIV/AIDS:
An individual 16 years or older with Acquired Immunodeficiency Syndrome (AIDS) which is a chronic, potentially life-threatening condition caused by the Human Immunodeficiency Virus (HIV).

Adult with a Physical Disability:
An individual 16 years or older with an impairment in the person's body structure or function, examples of impairments include but are not limited to loss/paralysis of a limb(s), birth defect, chronic progressive disease, spinal cord injury or other physical disability.

Assisted Living Services (ALS):
ALS are the home and community care services set out section 3.0, as those services are defined in the Home and Community Care Services Regulation *(O. Reg. 187/22) of the Connecting Care Act, 2019 ("HCC Services Regulation").*

Assisted Living Services for High-Risk Seniors Policy (ALS-HRS Policy, 2011):
The Ministry's 2011 policy which outlined specific changes to the delivery of ALS for high-risk seniors.

ALS Health Service Provider (HSP):
A health service provider (HSP) funded to provide one or more home and community care services that constitute ALS to one more eligible population(s) identified in this policy.

ALS Program:
The provision of ALS by an ALS HSP.

Caregiver:
An individual providing unpaid care or support to a person who is living with frailty, illness, disability, injury, functional impairment, or a life-limiting diagnosis.

Circle of Care:
The health information custodians who have the authority to assume an individual's implied consent to share the individual's personal health information for the purpose of providing health care to the individual in accordance with s. 20 of the *Personal Health Information Protection Act, 2004*.

Client:
An individual who is eligible for and receiving Assisted Living Services.

Cognitive Impairment:
The presence of a cognitive disorder that would result in an individual requiring assistance or supervision to perform routine activities of daily living safely or independently.

***Connecting Care Act, 2019* or CCA:**
The *Connecting Care Act, 2019*, S.O. 2019, c. 5, Schedule 1 as amended from time to time.

Designated Geographic Service Area:
A geographic area in which ALS are provided that is designated in accordance with section 5.0 of this policy.

Frail Elderly:
A legacy term from the 1994 LTCSH Policy referring to someone who is 65 years and over who is frail and/or cognitively impaired and requires assistance or supervision to perform routine activities of daily living safely or independently.

Health Service Provider:
A health service provider as defined in s.1(2) of the *Connecting Care Act, 2019*.

High-Risk Senior:
An individual who meets the characteristics in profile 1, 2 or 3 of the Characteristics of a High-Risk Senior Table set out below as determined by the organization responsible for assessing need and determining eligibility for ALS:

a. using the InterRAI common assessment instrument as a guide for the objective assessment of need; and
b. including the preferences of the individual or their Substitute Decision-Maker, if any.

Characteristics of a High-Risk Senior Table 1[2]

Profile #1

a) The Prospective Client or Client:
- has a Caregiver, who may or may not be living with the Prospective Client or Client,
- and the Caregiver is able to provide the required support to the Prospective Client or Client (e.g. provide direction to staff, manage challenging behaviours and potential hazards in the home).

AND

b) The Prospective Client or Client has a MAPLe Score of 4 or 5. A Prospective Client or Client fitting this profile would typically have a combination of some or all of the following:
- Needs assistance with dressing, toileting, transfer, locomotion, hygiene
- Is verbally or physically abusive, wanders, is socially inappropriate, resists care
- Has difficulty with memory, decision-making and/or making oneself understood
- Has a history of falls
- Has difficulty managing medications
- Has difficulty with meal preparation
- Has pressure/stasis ulcers
- Has difficulty swallowing
- Is not functioning safely in the current environment

OR

[2] Norma M. Jutan. *Integrating supportive housing into the continuum of care in Ontario.* A thesis presented to the University of Waterloo in fulfillment of the thesis requirement for the degree of Doctor of Philosophy in Health Studies and Gerontology - Aging, Health and Well-Being Waterloo, Ontario, Canada, 2010. © Dr. Jutan http://uwspace.uwaterloo.ca/bitstream/10012/5450/1/Jutan_Norma.pdf

Profile #2

a) The Prospective Client or Client:
   - does not have an informal Caregiver, or
   - has an informal Caregiver, who may or may not be living with the Prospective Client or Client, but the informal Caregiver is unable to provide the required support.

AND

b) The Prospective Client or Client has a CPS or CPS2 score of 0 or 1. A Prospective Client or Client fitting this profile would typically have a combination of some or all of the following:
   - Cognitively intact or borderline intact
   - No or limited difficulty with short term memory
   - No or limited difficulty with cognitive skills for daily decisions making
   - No or limited difficulty making oneself understood
   - Difficulty eating.

AND

c) The Prospective Client or Client has an IADL Capacity Scale of 5 or 6. A Prospective Client or Client fitting this profile would typically have a combination of some or all of the following:
   - May need assistance with meals preparation
   - May need assistance with ordinary housework
   - May need assistance with using the phone.

OR

Profile #3

a) The Prospective Client or Client:
   - Does not have an informal Caregiver, or
   - Has an informal Caregiver, who may or may not be living with the Prospective Client or Client, but the informal Caregiver is unable to provide the required support.

AND

b) The Prospective Client or Client has a CPS or CPS of 2+. A Prospective Client or Client fitting this profile would typically have a combination of some or all of the following:

- Mild to moderate cognitive impairment
- Mild to moderate difficulty with short term memory
- Mild to moderate difficulty with cognitive skills for daily decisions making
- Mild to moderate difficulty making oneself understood
- Mild to moderate difficulty eating.

AND

c) The Prospective Client or Client is assessed as being no more than "occasionally incontinent" as that term is as defined by the RAI instrument.

Home and Community Care (HCC) Services:
Home and community care (HCC) services as defined in and provided in accordance with the HCC Services Regulation.

Home and Community Care Services Regulation:
Ontario Regulation 187/22 (Home and Community Care Services) under the *Connecting Care Act, 2019* as amended from time to time.

Home and Community Care Support Services:
A local health integration network within the meaning of the *Local Health System Integration Act, 2006* operating as Home and Community Care Support Services or any successor organization accountable for the provision of home care services, including care co-ordination, professional services, personal support services and homemaking services as outlined in the HCC Services Regulation.

Integrated Assessment Record (IAR):
A central repository for clinical assessment data collected from multiple community care sectors. It allows authorized Health Service Providers within the Circle of Care to upload and view a Client's assessment information in a secure and timely manner.

Long-Term Care (LTC) Home:
A long-term care home within the meaning of the *Fixing Long-Term Care Act, 2021*.

Long-Term Care Supportive Housing Policy (LTCSH Policy, 1994):
This policy identified four population groups that would be eligible for ALS: clients with physical disabilities, clients with an Acquired Brain Injury (ABI), clients with HIV/AIDS, and the frail elderly. It set the foundation for the delivery of ALS

throughout the province and is sometimes referred to as the Assisted Living Services in Supportive Housing Policy.

Ontario Health (also referred to as OH):
The Crown agency continued under and governed by the *Connecting Care Act, 2019*.

Ontario Health Region:
One of six regional teams (North East, North West, East, Central, Toronto & West) that are part of Ontario Health.

Prospective Client:
An individual applying for ALS.

Substitute Decision-Maker:
The person who is lawfully authorized to make a decision concerning a home and community care service, including ALS, on behalf of the Client and/or Prospective Client.

Supportive Housing:
A combination of housing assistance and services to enable people to live as independently as possible in the community.

2. Statement of Policy

This policy shall come into effect on July 13, 2023 and replaces the LTCSH Policy, 1994 and the ALS-HRS Policy, 2011.

The objectives of this policy are to:

- Ensure Prospective Clients and Clients have access to high-quality, timely, and equitable ALS throughout Ontario.
- Ensure services and supports are Client-driven and foster independence, respect, dignity and inclusion.
- Enable local communities to fully address the needs of the Clients they serve so that they can remain safe in their community and transition to a new care setting, if required.
- Enable the equitable delivery of quality care that addresses the unique needs of Prospective Clients and Clients throughout the province

- Expand cost-effective and accessible options for community care
- Reduce unnecessary and/ or avoidable hospital utilization, emergency department (ED) visits, and early admission to LTC Homes.
- Provide Ontario Health with the flexibility to adapt the delivery of ALS in local communities, while also maintaining equitable access and a standard of quality care throughout the province
- Clarify the pathway for complaints/concerns about the services being provided, and the pathway(s) for resolution. Outline and clarify the roles of the various organizations involved in ALS, both directly and indirectly
- Ensure Clients are able to access care within an integrated health and social services system, including programs beyond the scope of ALS.
- Promote provincial consistency in ALS data collection methods and access to data

2.1. Performance Measures

Ontario Health (OH) will seek to ensure that ALS Programs contribute to:

1. Reducing unnecessary and/ or avoidable ED visits, hospital admissions, and LTC Home admissions.
2. Increasing the length of time Clients remain safely at home.
3. Achieving or improving equity of access to care for all equity-deserving populations.
4. Increasing Clients perceived satisfaction of care and quality of life.
5. Ensuring Clients are appropriately supported to meet their needs.
6. Creating a robust, provincially shared data set for ALS planning and evaluation.
7. Reducing service duplication and enhancing integration across various organizations, allowing for better equity and access to care.

3. Assisted Living Services

Below are the Home and Community Care (HCC) services that are included in ALS and each type of ALS has the same definition as that service has in HCC Services Regulation.

Every ALS HSP is required to comply with the *Connecting Care Act, 2019* (CCA) and the HCC Services Regulation in the provision of these services. If anything in this policy conflicts with the CCA or its regulations, the CCA and its regulations prevail.

Where a Client requires services in addition to ALS, such as a Client who requires professional services, the ALS HSP is expected to work with Home and Community Care Support Services and/or relevant HSPs funded to provide professional services to support continuity of care and progress towards the Client's evolving care goals. When a client requires such services, the priority should be on stability of care and service provision with the Client and, if relevant, their chosen Caregiver at the centre.

Where a Client's care needs exceed what can safely be provided through ALS in their home, alternative supports may need to be explored with Home and Community Care Support Services.

Personal support services

Personal support services are personal support services as defined in s. 2(1) of the HCC Services Regulation. They are services directed to personal hygiene activities and routine personal activities of living, and include carrying out those activities, assisting a Client to carry out those activities, and training a Client to carry out or assist with those activities.

Personal support services shall be available at all times (24 hours a day/7 days a week) both on a scheduled and unscheduled basis. Where it is not possible for ALS HSP staff to directly provide personal support services on a 24/7 basis to a Client, the ALS HSP shall notify Ontario Health and work with Ontario Health to ensure the Client has the necessary supports to remain at home safely. The ALS HSP may only deviate from the requirement to make services available at all times with the approval of Ontario Health and such approval may only be granted for a limited time until the ALS HSP can rectify the issue and provide the services.

Homemaking services

Homemaking services are homemaking services as defined in s. 2(1) of the HCC Services Regulation and include assisting a Client with any of these activities and training a Client to carry out or assist with any of these activities.

Homemaking services shall be available at all times (24/7) both on a scheduled and unscheduled basis. Where it is not possible for ALS HSP staff to directly provide homemaking services on a 24/7 basis to a Client, the ALS HSP shall notify Ontario Health and work with Ontario Health to ensure the Client has the necessary supports to remain at home safely. The ALS HSP may only deviate from the requirement to make services available at all times with the approval of Ontario

Health and such approval may only be granted for a limited time until the ALS HSP can rectify the issue and provide the services.

Security Checks or Reassurance Services

Security checks or reassurance services is a type of community support service defined in s. 2(1) of the HCC Services Regulation. They include visits, conducted via phone, virtually, or face-to-face, to assure a Client's health or safety.

Security checks or reassurance services shall be available at all times (24/7) both on a scheduled and unscheduled basis. Where it is not possible for ALS HSP staff to directly provide security checks or reassurance services on a 24/7 basis to a Client, the ALS HSP shall notify Ontario Health and work with Ontario Health to ensure the Client has the necessary supports to remain at home safely. The ALS HSP may only deviate from the requirement to make services available at all times with the approval of Ontario Health and such approval may only be granted for a limited time until the ALS HSP can rectify the issue and provide the services.

Care Co-ordination Services

Care co-ordination services means care co-ordination services as defined in s. 2(1) of the HCC Services Regulation. These are the services required to facilitate access to and the co-ordination of home and community care services to clients, including, but not limited to:

1. assessing and reassessing client requirements.
2. making determinations of eligibility.
3. developing, evaluating, and revising care plans.
4. making referrals to other providers
5. terminating the provision of a service.

With the consent of the Client or the Client's Substitute Decision-Maker, Care Co-ordination Services shall include regular and ongoing communication by the ALS HSP with other HSPs, including Home and Community Care Support Services, serving the Client.

Beyond communication, care co-ordination shall also include developing effective working relationships with other providers of health and social services in the Designated Geographic Service Area and supporting Client and Caregiver social networks, including to plan (with the Client) for a Client's anticipated future health

care requirements and establishing linkages to other services to help ensure continuity of care.

3.1. Principles of Assisted Living Services

The following are goals of ALS:

1. Integration with other health and social services
2. Creation of community alternatives to institutional care settings
3. Improved access to quality services that are reflective of a Client's level of independence.
4. Optimal Client participation and direction of services.
5. Access to supports that are inclusive of the Client's linguistic, cultural, and religious needs.

ALS HSPs shall make reasonable efforts to ensure that their provision of ALS reflect the following principles:

Individualization

To serve people with varying needs, it is imperative that ALS have the capability to respond to specific Client requirements while helping them to maintain the best possible quality of life. This principle supports the development of ALS that meet the needs of the Client and requires providers to take an equitable approach to care delivery. It is inherent in this principle that the dignity and uniqueness of each Client is recognized and respected, with additional care given to Clients who are at greater risk of marginalisation. The regulations governing the provision of ALS affirm this principle of individualized needs-based care.

Health Equity

Health Equity means providing Clients with the unique mix of ALS they require in a way that is accessible and appropriate to them. This requires ALS HSPs to be cognisant of the ways in which marginalized groups may be prevented from actively participating in the health system and to work to mitigate any barriers experienced by their Clients.

Connectedness

Connectedness means maintaining the maximum level of integration with the community at large. The design of ALS should enable Clients to feel part of their community and to interact with others, including those with and without similar needs.

Integration

A primary focus of the design of ALS should be to enable Clients to feel a part of their community and to provide an environment that supports their ability to interact with others, including those with and without similar needs.

Independence

Independence means that Clients are able to live in the community with as much freedom, self-determination, choice and responsibility as is feasible given their support needs and the networks they rely upon.

Stability

Stability refers to continuity of a Client's preferred place of residence, provision of ALS, and social relationships.

Safety

The principle of safety is the core of ALS. It is the component that allows Clients to feel secure at all times regardless of their needs and includes physical safety, psychological safety, and cultural safety. The level of safety required or requested may vary from Client to Client, but in all cases, it is the measure of a sensitive and responsive ALS Program. The balance between this principle and independence allows Clients to have the "dignity of risk".

Self-Help

It is important that a service system enhance and not interrupt or replace self-help or peer, family, or any other network of supports desired by the Client. This principle strengthens the idea that people have and want the self-reliance that ALS offers.

4. Eligibility Criteria[3]

An ALS HSP and/or a Home and Community Care Support Services organization must provide and explain the eligibility criteria for ALS to the Prospective Client or to a Client (referred to as "individual" in this section) if requested. An ALS HSP shall not provide ALS to an individual unless the individual meets all of the following

[3] The Ministry recognizes the need to review the eligibility criteria for ALS. While some updates are included below, the Ministry is committed to continuing to work on broader changes to the eligibility criteria for ALS.

eligibility criteria:

- The individual shall meet the definition of resident under the *Health Insurance Act*.
- The individual shall be an Adult with an ABI, an Adult with a Physical Disability, an Adult with HIV/AIDS, or a High-Risk Senior.
- The individual shall require personal support and homemaking services on a 24-hour basis and have care requirements that cannot be met solely on a scheduled visitation basis. The individual shall require services be available in a frequent, urgent, and intense manner described as follows:
    i. Frequent meaning that the individual has needs where intermittent visits through the day may be necessary;
    ii. Urgent meaning that the individual has concerns that warrant a prompt response that cannot wait to be scheduled; and
    iii. Intense meaning that the individual's condition or predicament demands direct individual attention from staff to address needs.
- The individual shall reside in a Designated Geographic Service Area and shall not reside in a retirement home within the meaning of the *Retirement Homes Act, 2010* or in a Long-Term Care Home.
- The individual shall be able to remain safely in their community between visits.
- The risk that staff who provide ALS to the individual will suffer serious harm while providing the services must not be significant or, if it is significant, the ALS HSP must be able to take reasonable steps to reduce the risk so that it is no longer significant.
- The individual may, but does not have to be, on a waiting list for one or more LTC Homes.

5. Service Locations, Designated Geographic Service Areas

Each Ontario Health Region shall be responsible for determining and designating the geographic service areas within their region in which at least one ALS HSP is funded to provide ALS to Clients who reside in that area.

Clients may reside in a variety of settings within a Designated Geographic Service Area. These settings include private or non-profit housing such as stand-alone homes, townhouses, apartments, condominiums, housing co-operatives or traditional subsidized housing such as social housing or supportive housing buildings/apartments.

In order to designate a particular geographic service area, OH shall consider Client and community needs in ensuring the area meets the following criteria:

1. Responsive: The geographic service area shall have one or more ALS HSPs with sufficient resources to respond to unscheduled calls from Clients who require the immediate provision of personal support, homemaking and security checks or reassurance services. OH, in collaboration with ALS HSPs shall determine the allowable safe response time that shall be met by the ALS HSPs in the area in order to minimize any harm to Clients.
2. Quality: The geographic service area shall have one or more ALS HSPs that are able to attract and retain appropriate staff in order to achieve a predictable and reliable staffing arrangement for ALS continuity and quality Client care.
3. Integrated: The geographic service area shall have one or more ALS HSPs that are prepared to support a Client to establish linkages with existing services for that Client.
4. Efficient: The geographic service area shall have a sufficient number of Clients to provide for operational efficiencies relative to other available service delivery options (e.g. congregate and facility care).

Where OH was funding an ALS HSP immediately before this policy came into effect and to which the LTCSH Policy, 1994 and the ALS-HRS Policy, 2011 applied, OH shall take all reasonable steps towards ensuring that the areas where their funded ALS HSPs are providing services comply with the designation criteria listed above. At its discretion, the Ministry may ask for and OH shall provide, progress reports or explanations where the designation criteria cannot be met.

OH shall be responsible for deciding which HSPs to fund to provide ALS within each Designated Geographic Service Area.

Portability of Services

In the event that a Client moves within or outside of a Designated Geographic Service Area, all HSPs involved in the client’s care shall aim to ensure that the Client continues to receive the care they need.

6. Roles, Responsibilities, and Scope for Service Delivery

Ontario Health (OH)

- OH is responsible for the planning, priority-setting, funding, and evaluating of ALS within each of its regions.
- OH will review proposals for new and existing ALS HSPs and make funding decisions as required. OH will aim to ensure that local needs are addressed, that appropriate policies and procedures are followed, that planning is updated to meet changing Client needs, and that data collection support program oversight.

Home and Community Care Support Services

- Where the ALS is provided as part of a supportive housing program and there is an arrangement whereby an Home and Community Care Support Services organization manages the admission of clients to the program, the Home and Community Care Support Services organization may be responsible for assessing Prospective Client needs, including inquiring if there are other government services that the Client receives in order to get a comprehensive picture of the full spectrum of services that the Client is receiving to avoid duplication of services.
- Home and Community Care Support Services may also be responsible for determining eligibility.
- If a Client receiving ALS requires professional or other HCC services outside of the ALS program, the ALS HSP is responsible for referring the Client to Home and Community Care Support Services to determine eligibility for, and coordinate those services and/ or provide the Client with applicable community resources.
- Home and Community Care Support Services is responsible for making aggregated, de-identified information available to OH and other system partners to enable ALS planning.

ALS HSPs

- ALS HSPs shall provide ALS in accordance with this policy.
- ALS HSPs may be responsible for providing all of the care co-ordination services applicable to the provision of ALS, including confirming if there are other government services that the Client receives or is waiting to receive in order to get a comprehensive picture of the full spectrum of services that the client is receiving and to avoid duplication of services.

- ALS HSPs are responsible for providing data to Home and Community Care Support Services and aggregated, de-identified data to OH, as required to facilitate the integrated planning, delivery, and evaluation of health services.
- ALS HSPs shall connect clients with other programs beyond the scope of ALS where it is identified that a client could benefit from these services (e.g., Community Paramedicine) and ensure the services are coordinated efficiently.

6.1. Models of Service Delivery

ALS are HCC Services, as defined in the HCC Services Regulation, and ALS HSPs must comply with the requirements of the CCA and that Regulation.

The two service delivery models described below shall be used to implement this policy (Models A and B). Alternate integrated care service delivery models may be used with agreement from Ontario Health.

- In Model A, an ALS HSP is responsible for determining eligibility and assessing care needs, managing the waitlist and development of the Client's care plan.
- In Model B, Home and Community Care Support Services determines eligibility, assesses the Client's care needs, develops the care plan, and may or may not manage the waitlist while an ALS HSP provides the ALS. Respective responsibilities are set out below in the Model Tables.

The choice of the delivery model rests with OH, which shall consult with Home and Community Care Support Services, ALS HSPs, as well as other appropriate community HSPs and stakeholders when determining which model(s) to implement in a Designated Geographic Services Area.

Model A – The ALS HSP Model

In this model, an ALS HSP shall be responsible for all the functions involved in the provision of ALS to one or more of the eligible ALS population groups.

Table 2

Key Functions	**Responsibilities**
Assessment of care needs	ALS HSP
Determination of eligibility	ALS HSP
Waitlist management	ALS HSP

Key Functions	Responsibilities
In consultation with the Client/Caregiver, develop a care plan that meets the requirements in the HCC Services Regulation	ALS HSP
Scheduling and other co-ordination of service delivery	ALS HSP
Review requirements and revise care plan	ALS HSP
Provide ALS	ALS HSP
Transition and/or discharge planning	ALS HSP

Model B – The Mixed Home and Community Care Support Services and ALS HSP Model

In this model, both Home and Community Care Support Services and an ALS HSP shall have roles and responsibilities for the delivery of ALS to one or more of the eligible population groups.

Table 3

Key Functions	Responsibilities
Assessment of care needs	Home and Community Care Support Services
Determination of eligibility	Home and Community Care Support Services
Waitlist management	Home and Community Care Support Services
In consultation with the Client/Caregiver, develop a care plan that meets the requirements in the HCC Services Regulation	Home and Community Care Support Services
Scheduling and other co-ordination of service delivery	ALS HSP
Review requirements and revise care plan	ALS HSP
Provide ALS	ALS HSP
Transition and/or discharge planning	ALS HSP

7. Expectations for Key Service Delivery Functions

There is a need to ensure awareness amongst the general public about the availability of ALS. ALS HSPs are encouraged to work with sector partners (e.g., Home and Community Care Support Services, hospitals, rehabilitation centres, and primary care) to make them aware of the availability of ALS and the eligibility requirements of the ALS Program.

7.1. Clients Involvement and Preferences

ALS HSPs shall provide the Client, their Substitute Decision Maker, if any, and any individuals designated by them an opportunity to participate fully in the development, evaluation, and revision of a care plan. If a Client is incapable, decisions relating to the provision of ALS may be made on their behalf by their Substitute Decision-Maker. ALS HSPs shall take note of all the requirements applicable to assessments, reassessments and care planning with which they must comply in the HCC Services Regulation.

ALS HSPs shall also take into account a Client's preferences based on ethnic, spiritual, linguistic, familial and cultural factors when developing, evaluating and revising the Clients care plan.

7.2. Referral and Intake

Referrals to ALS may be made directly through self-referral or with expressed consent from the Client, Prospective Client, or their Substitute Decision Maker, from hospitals, Home and Community Care Support Services, primary care, HSPs, other health professionals, family members, neighbours, friends, and/or community support staff/ volunteers. The assessment and intake process shall be transparent for the Prospective Client and their Substitute Decision-Maker, if any.

7.3. Assessment of Requirement

ALS HSPs shall use the most appropriate assessment instrument according to the situation/setting, assessor, Prospective Client, Client and their family. With the consent of the Prospective Client or Client, this assessment will be uploaded to the IAR, if compatible, and shared with the other HSPs within the Client's Circle of Care.

7.4. Eligibility

Subject to the Proposed Client's availability, Home and Community Care Support Services or the ALS HSP shall contact the Proposed Client to begin the assessment and eligibility determination process within a reasonable time of receiving the referral.

7.5. Availability of Assisted Living Services and Waitlists

The goal is to have ALS available to Clients who have been determined eligible for these services, as soon as possible. However, if one or more ALS is not immediately available, the ALS HSP shall ensure the individual is placed on a waiting list, as required under the HCC Services Regulation. The ALS HSP shall advise the individual when the service becomes available.

7.6. Development of a Client's Care Plan

1. The ALS HSP shall comply with all the requirements for care planning set out in s. 18 of the HCC Services Regulation, as applicable.
2. When the ALS HSP is required to develop a care plan, it shall do so based on the results of an assessment of the Client's care needs, in collaboration with the Client, their Substitute Decision-Maker, if any, and any other individual designated by either of them, such as the Caregiver.
3. The care plan shall include at a minimum:
    i. the type and amount of ALS required, including the duration of the services that the Client shall receive, whether the service is to be provided in person or virtually and the care goals of the Client, including targeted outcomes for the Client,
    ii. other community health and social services the Client is receiving,
    iii. the Client's linguistic, cultural, and religious needs,
    iv. the security checks or reassurance services; and
    v. discharge considerations.
4. The ALS HSP will coordinate linkages with other HSPs providing services to the Client, including support for the Client's Caregiver(s).
5. The ALS HSP will establish a contingency plan together with the client and with every organization involved in the provision of ALS to the Client to ensure continuation of ALS for the Client in a safe manner.

7.7. Review of Care Requirements

ALS HSPs shall review the care needs of Client's receiving ALS on a regular basis and when appropriate depending on changes to the Client's condition and circumstances to determine whether the existing care plan is appropriate and/ or whether adjustments are required when the Client's care needs change. ALS HSPs shall conduct a formal reassessment of care requirements at least annually. In all cases, the care plan shall be reviewed and/or revised when the client's needs change.

7.8. Transition and Discharge Strategy

While the intent of ALS is to support the principle of stability, there may be instances that will require the Client to be transitioned to another care setting or to be discharged from an ALS program. This may occur when a Client's needs change and continuous medical or professional services are required or when the Client no longer meets the eligibility criteria of ALS. Every ALS HSP shall only make decisions relating to transition and discharge after conducting a formal review of the Client's care needs.

Should alternative accommodation and/or service arrangements be required, the Client's safety and required level of service shall be considered before any action is taken. Prior to discharging a Client, an ALS HSP shall ensure that they meet all the requirements in s. 26 of the HCC Services Regulation including ensuring that:

1. With the participation of the Client, their Substitute Decision-Maker, if any, and any other individual designated by either of those persons, a written transition plan is developed that:
    i. considers the Client's goal and preferences;
    ii. identifies the information required to be safely discharged where the Client will no longer be receiving services; and
    iii. supports a seamless transition to the next care provider, if any.
2. The ALS HSP shall ensure that the portions of the transition plan within its control are implemented.
3. The ALS HSP shall ensure that a copy and explanation of the transition plan is offered to the Client, their Substitute Decision-Maker, if any, and any other individual designated by the Client or the Substitute Decision-Maker, such as the Caregiver or the next care provider.
4. The ALS HSP shall involve the Client and their Substitute Decision-Maker, if any, when making transition and discharge decisions.

8. ALS HSP Qualifications

Under the CCA, an organization must be not-for-profit to receive funding from OH to provide HCC Services.

OH shall review requests for ALS funding from interested organizations and determine whether they meet the criteria for funding under OH's home and community care funding approval processes. This includes confirmation by the interested organization that they are aware of and prepared to comply with all applicable requirements governing the provision of ALS set out in the Connecting Care Act, 2019 and the HCC Services Regulation (O. Reg. 187/22), this policy, and all other relevant policies.

Prior to providing funding to a new ALS HSP to provide ALS, Ontario Health shall be satisfied that the ALS HSP meets the criteria below. In addition, OH will work with existing ALS HSPs to ensure they meet the criteria within a reasonable timeframe. All ALS HSPS shall have a plan that:

1. Demonstrates they will at program launch have the staff, expertise, and capacity to deliver the required nature and level of services associated with this policy.
2. Demonstrates they will, at program launch, be able to provide ALS on the expected day of service initiation.
3. Demonstrates the HSP's ability to collect and report data on Clients and provide documentation of all services delivered.
4. Ensures appropriate training for staff, including training on processes when there are changes in Client needs, emergency situation processes, and health and safety process including Infection, Prevention, and Control (IPAC) processes.
5. Reflects a commitment to equity, diversity, and inclusion training for staff, including organizational policies on cultural safety and anti-racism
6. Sets out a performance improvement system and a reporting mechanism to its Board of Directors.
7. Demonstrates linkages with community partners, including primary care professionals, to meet the ongoing care needs of the Client or have a plan to achieve same.
8. Sets out the policies in place to escalate and refer Clients experiencing a mental health crisis.

9. Client and Staff Protections and Safeguards

In alignment with standards of service excellence, the experience of Clients, Caregivers, HSPs and the health workforce is a priority in all health system planning and delivery. The following sections safeguard Clients, Caregivers, HSPs, and the health workforce and mitigate against workforce turnover resulting in safer, more consistent care delivery.

9.1. Staff to Clients Ratios

ALS HSPs will work with Ontario Health Regions to agree on appropriate staff to client ratios that meet the needs of the population they serve, satisfy any local by-laws and maintain the efficiency of the system.

9.2. Complaints and Appeals Process

- ALS HSPs shall ensure that a notice containing all of the following is given to each of their Clients, to the Client's Substitute Decision-Maker, if any, and to anybody designated by the Client or their Substitute Decision-Maker per the HCC Services Regulation:
    i. The rights listed in the Patient Bill of Rights and that the ALS HSP is obliged to ensure those rights are fully respected and promoted;
    ii. The procedures for making complaints or suggestions relating to the provision of ALS;
    iii. That a request for access to a record of personal health information, including assessment information and the care plan, may be made by a person entitled to the access under the *Personal Health Information Protection Act, 2004*, and the contact information of the person to whom the request must be made;
    iv. That a person making a request for access to a record or personal health information may request a clear and accessible explanation of the assessment information and the care plan; and
    v. How to access linguistic supports, if available and relevant.

- Every ALS HSP shall ensure that a Client is provided with all of the following:
    i. Clear and accessible information about the ALS provided to the Client; and
    ii. How to appeal decisions made by the ALS HSP that give rise to a right of appeal to the Health Services Appeal and Review Board.

- If a Prospective Client or Client indicates a preference to receive ALS in French, the ALS HSP shall provide the ALS in French or refer the Prospective Client or Client to another HSP that offers ALS in French. This obligation does not in any way alter an obligation that otherwise exists in law on an ALS HSP or Home and Community Care Support Services to provide care co-ordination services or ALS in French.

- If a person entitled to access a record of personal health information about a Client requests an explanation of the assessment information or the care plan, the ALS HSP shall ensure that the person is provided with a clear and accessible explanation of the assessment information or the care plan, as the case may be.

- Every ALS HSP shall report to OH the number of complaints received about the ALS and how they were resolved, at a frequency to be determined by OH. The reports shall not contain personal health information. OH shall provide this information to the Ministry through the Annual Business Plan and quarterly reports.

- A Client may make a complaint to the Patient Ombudsman about an unresolved issue about the provision of personal support services or homemaking services that is not otherwise subject to a right of appeal. Issues related to the tenant-landlord relationship, if applicable, would be addressed by the Landlord and Tenant Board as they are outside of the health system.

9.3. De-linked Services

To satisfy the service principles of ALS, OH shall favour as much as possible proposed ALS HSP initiatives where the ALS HSP is not also the provider of the accommodation. In situations where the ALS HSP is also the owner of the building in which the Client lives, it is the responsibility of the ALS HSP to ensure that the Client understands that issues or complaints related to their health care services will not impact on their housing security and, likewise, issues or complaints about their landlord will not impact on the care they receive, subject to lawful action that may be taken by the landlord.

10. Funding and Reporting

10.1. Funding of Assisted Living Services

The source of funding for ALS shall come from OH's annual ALS allocation, either one-time or base. OH may also, with approval of the Ministry of Health if required, allocate funding from other allocations. The ALS Program funding level should be sufficient to deliver the hours of service consistent with the service delivery targets set by each OH Region. ALS HSPs shall adhere to the Community Financial Policy.

10.2. Additional Charges

ALS HSPs are given funding and are expected to manage that funding, in compliance with the Community Funding Policy, to cover all costs of the services and should not be charging or accepting payment for any ALS services set out in the Client's care plan. With respect to any co-payments, ALS HSPs must comply with the CCA, 2021.

HCC Services that are community support services provided outside the ALS program (e.g., meal delivery services) may be subject to a fee (or co-payment), where permitted by law.

If an ALS HSP charges an ALS client for additional scheduled services and/or non-essential services other than the ALS set out in the Client's care plan, the HSP is required to clearly itemize their charges on an invoice provided to the Client that demonstrates the charges are not for eligible ALS.

10.3. Reporting Standards

Below are the key reporting requirements related to Clients served under the ALS Policy for the fiscal year 2023/24. ALS HSPs should refer to the Ontario Healthcare Reporting Standards (OHRS) for detailed requirements.

1. Primary functional centre (FC) codes to report ALS:
   FC 72 5 82 45 CSS IH COM – Assisted Living Services (for services provided to clients excluding ABI clients)

   FC 72 5 83 45 CSS ABI Assisted Living (for services provide to all ABI clients)
2. Specific reporting requirements under the individual ALS codes are included in the tables below.

Table 4: FC 72 5 82 45 COM IH & CS – Assisted Living Services

Code No.	Account Name	Requirement
403 ** *0	Inpatient/Resident Days	Mandatory
455 ** *0	Individuals Served by FC	Mandatory
955 80 10	CSS - Individuals Served – Physical Disability	Mandatory
955 80 15	CSS - Individuals Served – Cognitive Impairment	Mandatory
955 80 20	CSS - Individuals Served – Frail and/or Elderly	Mandatory
955 80 22	CSS - Individuals Served – High Risk Senior	Mandatory
955 80 25	CSS - Individuals Served – Living with effects of HIV/AIDS	Mandatory
453 ** *0	Hours of Care / Hours of Service – Contracted-Out	Mandatory[4]
454 ** *0	Hours of Care / Hours of Service – In House	Mandatory[5]

* indicates that various numbers can be used to represent different information, such as age categories.

Note: Clients grand-parented from the previous ALS policies can continue to be reported under FC 72 5 82 45 CSS IH COM – Assisted Living Services along with the appropriate secondary statistical codes on Client types set out in Table A.

Table 5: FC 72 5 83 45 CSS ABI – Assisted Living Services

Code No.	Account Name	Requirement
403 ** *0	Inpatient/Resident Days	Mandatory
455 ** *0	Individuals Served by FC	Mandatory
453 ** *0	Hours of Care / Hours of Service – Contracted-Out	Mandatory[6]
454 ** *0	Hours of Care / Hours of Service – In House	Mandatory[7]

* indicates that various numbers can be used to represent different information, such as age categories.

Up to date OHRS reporting standards are posted on the Ministry's Health Data Branch website (https://hsim.health.gov.on.ca/hdbportal/) under the Ontario Healthcare Reporting Standards section by fiscal year.

[4] This is a new requirement and therefore an implementation period of one year will be accommodated.
[5] This is a new requirement and therefore an implementation period of one year will be accommodated.
[6] This is a new requirement and therefore an implementation period of one year will be accommodated.
[7] This is a new requirement and therefore an implementation period of one year will be accommodated.

10.4. Reallocation of Funds

OH shall comply with the Ministry – Ontario Health Accountability Agreement when reallocating ALS funding to and from other ALS HSPs and to and from other sectors. The Ministry expects OH to work with ALS HSPs to address budgetary pressures and patterns of underspending, in compliance with the Community Funding Policy. The Ministry will continue to monitor the allocations and expenditures by OH, by sector.

11. Accountability and Performance Measurement

11.1. Accountability

1. Every ALS HSP is accountable to the Clients they serve and the Clients' Substitute Decision-Makers, where applicable, and to their funder, OH.
2. OH shall set out performance requirements in relation to the funding provided to ALS HSPs to provide services under this policy in its service accountability agreements with ALS HSPs.
3. OH shall report to the Ministry through an established process.

11.2. Performance Measurement

1. OH shall work collaboratively with ALS HSPs to develop a performance measurement framework relating to ALS, subject to Ministry approval. OH shall report on service inputs and outputs/deliverables. Both OH and ALS HSPs shall report on outcomes (the level of performance or achievement).
2. ALS HSPs shall ensure that service delivery is effective, efficient and client centred. The Ministry and OH have joint responsibility to develop, in consultation with ALS HSPs, operational definitions and technical specifications for each indicator.

12. Implementation Plan

OH shall ensure every ALS HSP funded by OH has a copy of this policy. OH may identify a transition period for an ALS HSP to meet compliance with component/s of the policy where OH is confident that this transition period will not compromise the safety of Clients or care providers.

13. Policy Review Process

This policy will be reviewed annually for the first three (3) years after its initial effective date. Afterwards, reviews will be conducted every five (5) years. An earlier review may be triggered in the following circumstances:

- Legislative or regulatory changes are made that directly affect this policy.
- Stakeholders identify challenges and barriers to the implementation of this policy.
- A decision by the Ministry or a request by a majority of the OH regions to revise the policy to address challenges, barriers or opportunities for improvement.