North East **LHIN**
RLISS du Nord-Est

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ASSISTED LIVING SUPPORTIVE HOUSING

POLICY WORKSHOP

March 25, 2011

Summary Report

of:

North East Local Health Integration Network (NE LHIN)
Réseau local d'intégration des services de santé du Nord-Est (RLISS)

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Acknowledgements

The NE LHIN would like to thank the North East Community Care Access Centre (NE CCAC) for their important role in making this workshop happen. The NE CCAC is a valued partner of the NE LHIN and is an integral part of assisted living programs in Northeastern Ontario given its role of providing home care support and ensuring people get the care they need in communities across NE Ontario.

The NE LHIN also thanks the team of Finlandia Village for their support in this important stakeholder engagement workshop.

The NE LHIN thanks Gisèle Guénard of visionarease for facilitating the workshop and preparing this report.

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positive change leadership & consulting

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Web http://visionarease.com

Executive Summary

The January 2011, the Ministry of Health and Long-Term Care (MOHLTC), distributed the **Assisted Living Services for High Risk Seniors Policy** replaces the Assisted Living Services in Supportive Housing Policy of 1994 (ALSSH). This new policy outlines a number of key directives in order to build on current successes with client services for high-risk seniors.

One of the policy elements is the NE CCAC's enhanced role. This role will include *destination determination*, which means:

- conducting assessments
- managing the waiting lists
- managing placement for Assisted Living

This report is a summary of the presentations, knowledge and ideas-exchange amongst multi-sector participants of the North East LHIN Assisted Living Supportive Policy Workshop, held March 25, 2011.

On March 25, thirty six presenters and participants worked through a busy agenda and had the opportunity to share concerns about the policy, as well as ideas for solutions to its challenges. Evaluations from the workshop showed a high level of satisfaction with this 'first of its kind' stakeholder engagement event. Several comments indicated an interest in more engagement of this nature. 'Less satisfactory' comments reflected time limitations and a desire to continue this collaborative work.[1]

Ideas shared by participants will be useful in planning for further development of the Supportive Housing - Assisted Living sector and services.

[1]Evaluations were received anonymously by the NE LHIN RLISS NE.

Introduction: Workshop Objectives

1. To provide service providers with an interactive opportunity to learn and move forward on the implementation of the Assisted Living Services for High Risk Seniors Policy.

2. To enable service providers and leaders from the NE LHIN and the NE CCAC to exchange perceptions on challenges and ideas for solutions on the policy amongst colleagues.

Keynote Address

Followed by an opening exercise, Louise Paquette, NE LHIN CEO, addressed participants by acknowledging the 17 assisted-living organizations, as well as the planning and presentation teams of each participating organization. Highlighting the **Home First** philosophy, Ms. Paquette acknowledged that all partners are critical to allowing people the option of receiving the care they need in their homes and the importance of collaborating on this key initiative. She addressed the need for all stakeholders to look at how services could be coordinated to ensure an increased focus on the patient/client. Special acknowledgment was given to the District Social Services Administration Board (DSSAB for making community-based services a priority. Ms. Paquette emphasized that the NE LHIN was open and receptive to new ideas for shaping community-based care.

Panel Discussion

An interactive panel discussion was held with four North East leaders from the acute care sector, community care and the assisted living/supportive housing sector. Panelists were asked to share information from their unique perspectives, which would inform and generate discussion. The following are highlighted points, from each Panel guest's 10 minute presentation.

- David McNeil, VP, Hôpital régional de Sudbury Regional Hospital (HRSRH)
  Access to beds challenges, ongoing / ER department overcrowding: unnecessary given the current resources / cost and usage of chronic care beds remains an issue / discharge delay is costing $3.2 million a year / money could be better spent elsewhere / restrictions such as admission criteria need to be changed to create a more patient centered system.

- **Robert Barnett, Director, Strategic Planning and Integration, NE CCAC**
  Supporting Assisted Living Red Cross housing in Timmins: 15 units. / NE CCAC screens client / ICAN 12 units / NE CCAC assessed and screened clients. A slide presentation was used, with participants requesting access to this excellent resource. It has been included in *Appendix B: NE CCAC Supporting Assisted Living,* along with the panelist's contact information on the last slide

- **Heather Cranney, Manager Red Cross – Timmins**
  15 units in Timmins / 7 units in Iroquois falls / started in 2009 / supportive housing is a big part of the solution / assessments usually done right away in Timmins / limited supportive housing units / limited PSWs. Also see: *Appendix B:NE CCAC Supporting Assisted Living.*

- **Brian Marks, Director, Housing Services Cochrane District, DSSAB**
  DSSAB is housing people who are independent / many are 70 plus / will eventually need services / funding is municipal / How do we move forward? By keeping people in units they are in + delivering services cost efficiently / need 10 year plan / non-healthcare partners > very important for housing solutions. Also see: *Appendix B:NE CCAC Supporting Assisted Living.*

Note: Sudbury MPP and Minister of Community Safety and Correctional Services, Rick Bartolucci, joined the group over the two days. He commended the NE LHIN and participants for their important work to improve access to care for the region's senior and frail elderly population.



Policy Overview & Implementation Discussion

With a focus on the main policy objectives, presenters worked through the policy elements with participation from attendees. The presenters were:

- Don Langlois, Director, NE CCAC
- Phil Kilbertus, Senior Consultant, NE LHIN
- Robert Barnett, Director, Strategic Planning and Integration, NE CCAC
- Terry Tilleczek, Senior Director, NE LHIN
- Valerie Scarfone, Consultant, NE LHIN

In addition, a presentation by Brenda Loubert, Administrator of Cassellholme in North Bay, was included within the solution-finding group activity. Participants learned about the importance of current statistical information which cannot be overestimated in planning for successful outcomes with seniors. As an example, bladder incontinence has been shown to be highly predictive of challenges with the discharge planning process once a person is in hospital. One solution brought forward by a participant was that "maybe community staff can go into the hospital with admitted clients and assist with feeding, toileting etc., so the client does not deteriorate."

Questions Asked:

Q. Who will coordinate all this?
A. The *NE* CCAC is mandated to take on an enhanced role. This role will include *destination determination*, which means:

- conducting assessments
- managing the waiting lists
- managing placement for Assisted Living

Q. What changes are expected for the non-senior population currently in supportive housing?
A. The policy brings no changes for this population group.

Q. What about the person on a wait list for long-term care?
A. The policy reads that a person who is waiting for long-term care is not eligible for assisted living. The policy statement is an end statement: *when the system is correctly aligned an individual would be on the waiting list for the most appropriate*

service and therefore a person waiting for assisted living would not be waiting for other services such as long-term care. This will be an implementation issue and does not reflect current practices as in many instances an individual would be waiting for both.

Q. Who pays for a safe home - example, retrofitting?
A. No change to existing and various funding available to individuals.

Q. Re. assessments in client's home… it is happening now?
A. Yes: if patient is in the hospital, the case manager works with the discharge planner.

From Policy to Practice

Presentations included:

- Policy Overview & Implementation Discussion in table format, developed from the participants' discussion

- Continuum of Care included graphic depictions created by the group in order to trigger ideas for common understanding, alignment and integration.

Note: the Policy Overview & Implementation Discussion (Table) highlights challenges brought forward by participants, with respect to specific elements of the Policy (full Policy – see Appendix C: Assisted Living Services for High Risk Seniors Policy, 2011) and ideas for solutions which emerged from the day's group work. They are presented along with the Policy element which triggered the question or discussion.



Policy Overview & Implementation Discussion

Implementation discussions generated the following diagrams, created by four participant working groups.

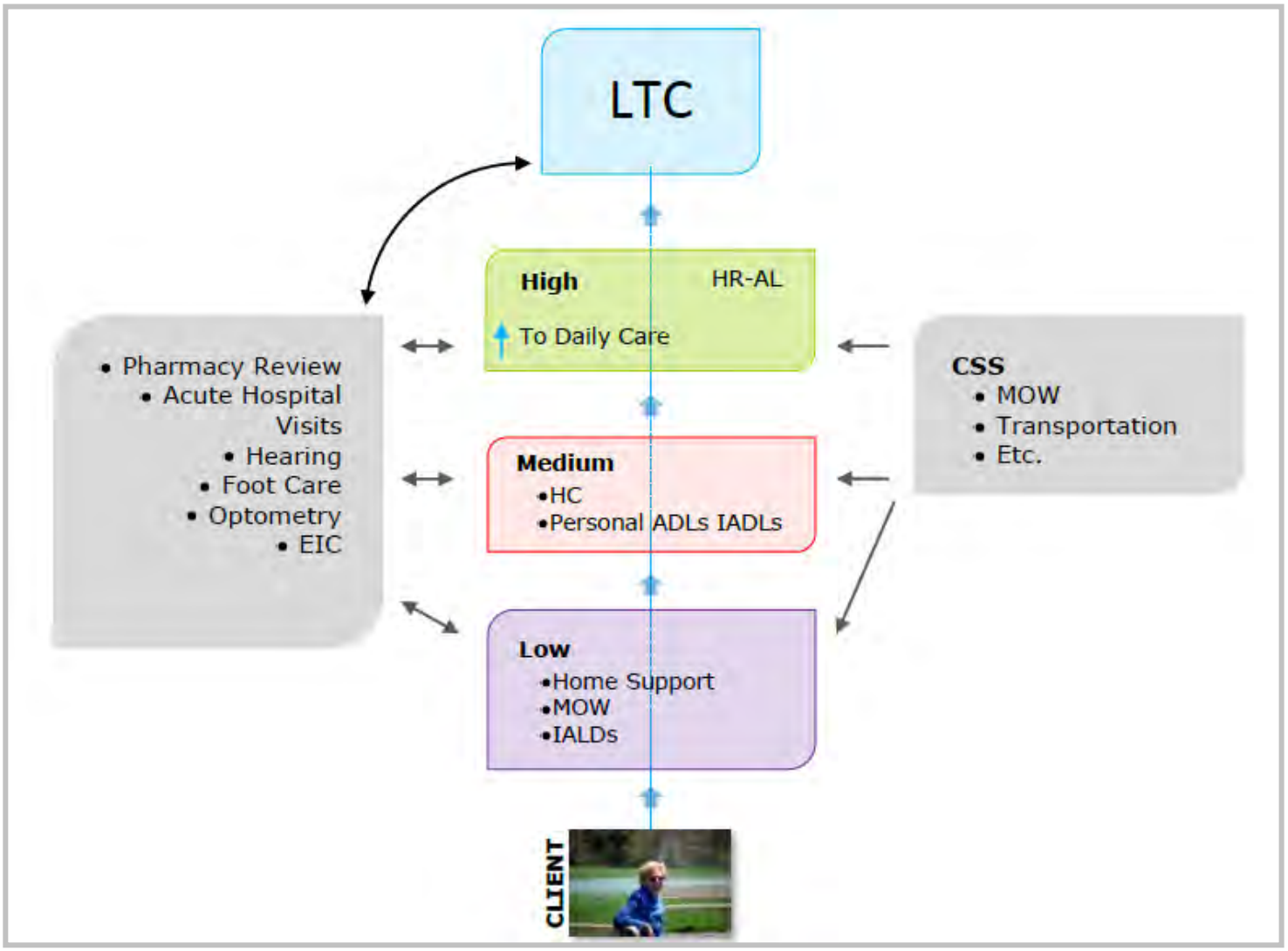
Policy Element	Challenge	Suggested Solutions
2.0 Objectives/Measure This policy will be evaluated on the extent to which it contributes to: • Reducing unnecessary and/ or avoidable ER visits by high risk seniors Reducing unnecessary and/ or avoidable LTCH admissions by high risk seniors • Increasing the number of high risk seniors who are discharged from hospital without an Alternate Level of Care (ALC) designation • Reducing the length of stay for high risk seniors in hospital after ALC designation • Reducing wait-time to discharge destination for high risk seniors who live in the community • Increasing the length of time high risk seniors remain safely at home after hospital discharge	• Tools for gathering data: not accessible now • Or/also perceived as: • Tool exists, tracking is an issue	Establish centralized analysis capacity group: producing for broader sector
5.0.2 Assisted Living Services Homemaking services including shopping, housecleaning, and meal preparation that are necessary to maintain people in their own residences but that they are unable to perform safely for themselves. These services shall be available at all times (24/7) both on a scheduled and unscheduled basis.	• 24 hour implementation: safety, night time, safety of geographical service areas • Cannot recoup hours	Hand held devices On-call coordinator Taxis for staff, within a service area. Two people visits Egg timer Collaborate with existing services
7.0 Service Maximums Persons receiving assisted living services shall not receive more than a combined maximum of 180 hours of personal support, homemaking and professional services per month. To ensure that the client's level of care is within the assisted living service maximum, the approved agency must keep a record of all professional hours provided by a CCAC (if any).	• Tracking hours • I.e., lab results, sharing info, case managing	Share information with CCAC and assisted-living provider
8.0 Service Locations: Designated Geographic Service Areas Subject to the exception for care homes noted below, eligible high risk seniors shall only access assisted living services in their homes if they reside within a designated geographic service area (also known as a "hub"). Clients may reside in the hub in a variety of settings. These settings include private sector or non-profit housing such as individual single family homes, townhouses, condominiums, housing co-operatives or traditional social housing buildings/ apartments. However, high risk seniors who reside in care homes within the meaning of the *Residential Tenancies Act, 2006* shall not be eligible to receive assisted living services. Each LHIN shall be responsible for determining and approving the hub(s) within their specific geographic area. To be designated as a hub, the LHIN shall determine that the geographic service area meets the following criteria:	• Retaining PSWs • Currency policy only identifies "PSW" • not enough funding for rural areas	Explore others categories of providers: e.g. attendant care workers More funding for full time for retention of PSWs Address wage disparity between hospital and other providers

Policy Element	Challenge	Suggested Solutions
• **Safe:** The geographic service area shall have approved agencies 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. LHINs shall determine the allowable safe response time that shall be met by the approved agencies in order to minimize any harm to clients. • **Quality:** The geographic service area shall have approved agencies that are able to attract and retain PSWs in order to achieve a predictable and reliable staffing arrangement for service continuity and quality client care. • **Integrated**: The geographic service area shall have approved agencies that are prepared to establish linkages with existing primary care service providers. • **Efficient:** The geographic service area shall have a sufficient number of high risk seniors to provide for operational efficiencies relative to other available service delivery options (e.g. congregate and facility care).		
9.0 Roles and Responsibilities for Service Delivery This section is currently under development. Further MOHTLC policy direction will follow.	• Roles and responsibilities confusion: e.g.: servicing First Nation communities	Solution in progress Explore existing success model CCIM involved
10.2 Referral & Intake Referrals to assisted living services may be made directly through self-referral, hospitals, CCACs, primary care providers, other health professionals, informal caregivers such as family members, neighbours or friends, or community support staff/ volunteers. The intake process shall be transparent and publicized within LHIN communities. If consent is provided by a patient or his/her authorized substitute decision-maker, if any, hospitals shall (wherever possible in collaboration with CCACs): • Complete an initial scan of admitted patients to determine whether any patients may be high risk seniors; • Notify the organization(s) responsible for the provision of assisted living services in their LHIN to alert them of potential clients; and, • Forward discharge summaries to the organization(s) responsible for assisted living services and the primary care provider for each client as soon as possible after discharge.	• Need more alignment	some communities have discharge planners from hospital working with groups from community
10.4 Eligibility Subject to the client's availability, the approved agency shall begin to assess a client for eligibility within 24 hours of receiving notification from the hospital or other referral source of a potential assisted living client.	• Assess within 24 hours	Begin assessment within 24 hours Dataflow between organization Assess currency of data
10.5 Availability of Assisted Living Services and Waitlists The goal is to have assisted living services available on the day of discharge for hospital in-patients who have been determined eligible for these services. However, a waitlist shall be developed and managed in the event that the demand for the services is higher than the immediate availability of services. Approved agencies shall rank clients on the waiting list in accordance with the following priorities: 1. ALC seniors waiting for discharge home from hospital shall be ranked first;	• Waiting list itself • Confidentiality	All Information to CCAC as intake organization Information and referral is in place Case conferencing Integrate with MOHLTC CCAC HHR project

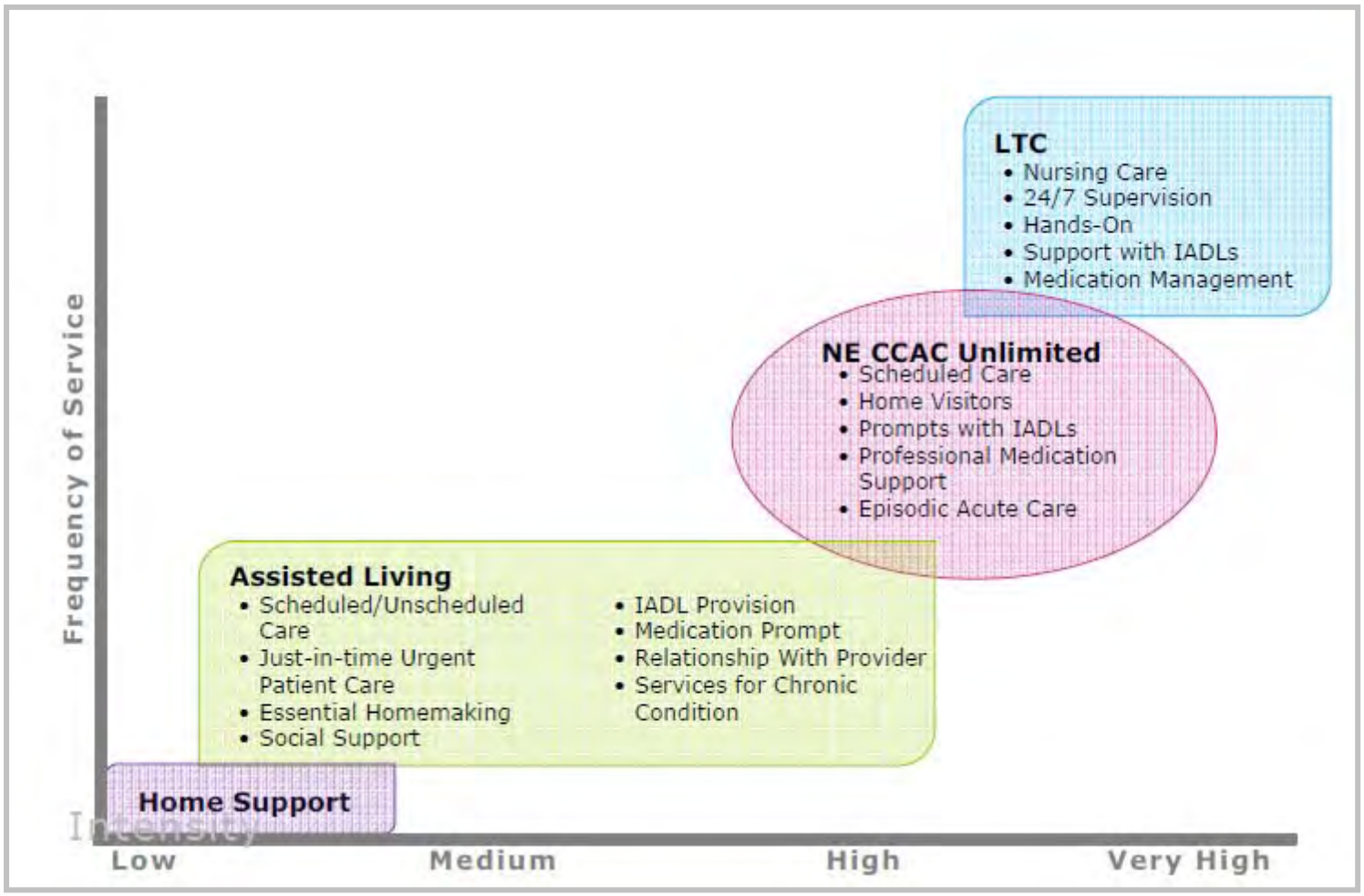
Policy Element	Challenge	Suggested Solutions
2. Seniors in the community who may be in imminent need of a higher level of care than can be provided by CCAC regular services and who would otherwise be at high risk of hospitalization or admission to a LTCH shall be ranked second; and 3. Seniors who are frequent users of emergency room and hospital services shall be ranked third.		
10.6 Development of a Client Plan of Service A plan of service shall be developed for assisted living clients in collaboration with the client, his/her substitute decision-maker, if any, and any other person designated by either of them based on the results of the assessment of requirements. It shall set out the type and amount of assisted living services required, including the frequency and duration of the services that the person shall receive. The plan of service shall also refer to other community health and social services and health care providers with which linkages will be coordinated for the client, including support for their caregiver(s). Linguistic/ cultural needs, the security checks or reassurance services, and discharge considerations shall also be included in the plan of service. Persons receiving assisted living services shall receive no more than a combined maximum of 180 hours of personal support, homemaking and professional services per month.	• 180 hours • Who reports to who	Team meetings Conflict resolution process Breakdown of hours used see 10.7
10.7 Coordination of Services The approved agency shall create an integrated plan of service if the client's assessed needs include services other than personal support, homemaking, and security checks or reassurance services. The integrated plan of service shall specify the services to be provided by the various agencies and/ or health care providers (e.g. pharmacists, primary care services, community support services, CCACs, specialty diabetic clinics, seniors' respite services) involved in the client's care.	• Break down? • Descriptive, not Dx - patient specific • The plan and reality may be different • Forecasting is a challenge • There is a difference in how it is being done	Establish common performance indicators/template Clarify accountability for who contributes Match provincial indicators, consistency Analyze current state & MIS
10.9 Discharge Strategy Approved agencies shall only make decisions relating to discharge after conducting a formal review of care requirements. Approved agencies shall discharge clients who no longer meet the eligibility criteria. Prior to discharge, approved agencies shall ensure that alternative services are available through the CCAC or other approved agencies for clients in the following situations: • Clients whose condition improves such that they no longer qualify as a high risk senior and require a lower level of care than that provided under this policy • Clients who become too ill to remain at home and require admission to a LTCH or a more complex care environment. Persons waitlisted for a LTCH may be eligible for CCAC personal support and homemaking services at a level that exceeds the standard CCAC service maximums for these services. In addition, these persons may be given urgent priority status. • Approved agencies shall involve the client and his/her substitute decision-maker, if any, when making discharge decisions.	• Discharge criteria • Lack of consistency of leave policy • Perception that assisted-living program moving from a lot of care to less services	Should be standardized

Policy Element	Challenge	Suggested Solutions
12.0 Client Protections and Safeguards – Complaints and Appeals Process Approved agencies shall inform their clients about all of the following: • The services they are providing to them • The client's Bill of Rights19 • The procedures for making complaints or suggestions relating to the approved agency or its service providers • How to request access to a record of personal health information • How to appeal decisions made by approved agencies • Approved agencies shall report to the LHINs the number of assisted living client complaints received and how they were resolved at a frequency to be determined by the LHINs. The LHINs shall provide this information to the MOHLTC through the Integrated Health Services Plan and quarterly reports.	• Funding: currently may be waste	Important priority: providers know what the outcome of funding is, eliminating waste
Miscellaneous	• Senior is not defined, no age limit	Further discussion re intentional nature of not defining, scope of policy is in federal jurisdiction Increase understanding of "Different population group = different parameters"

Continuum of Care # 1

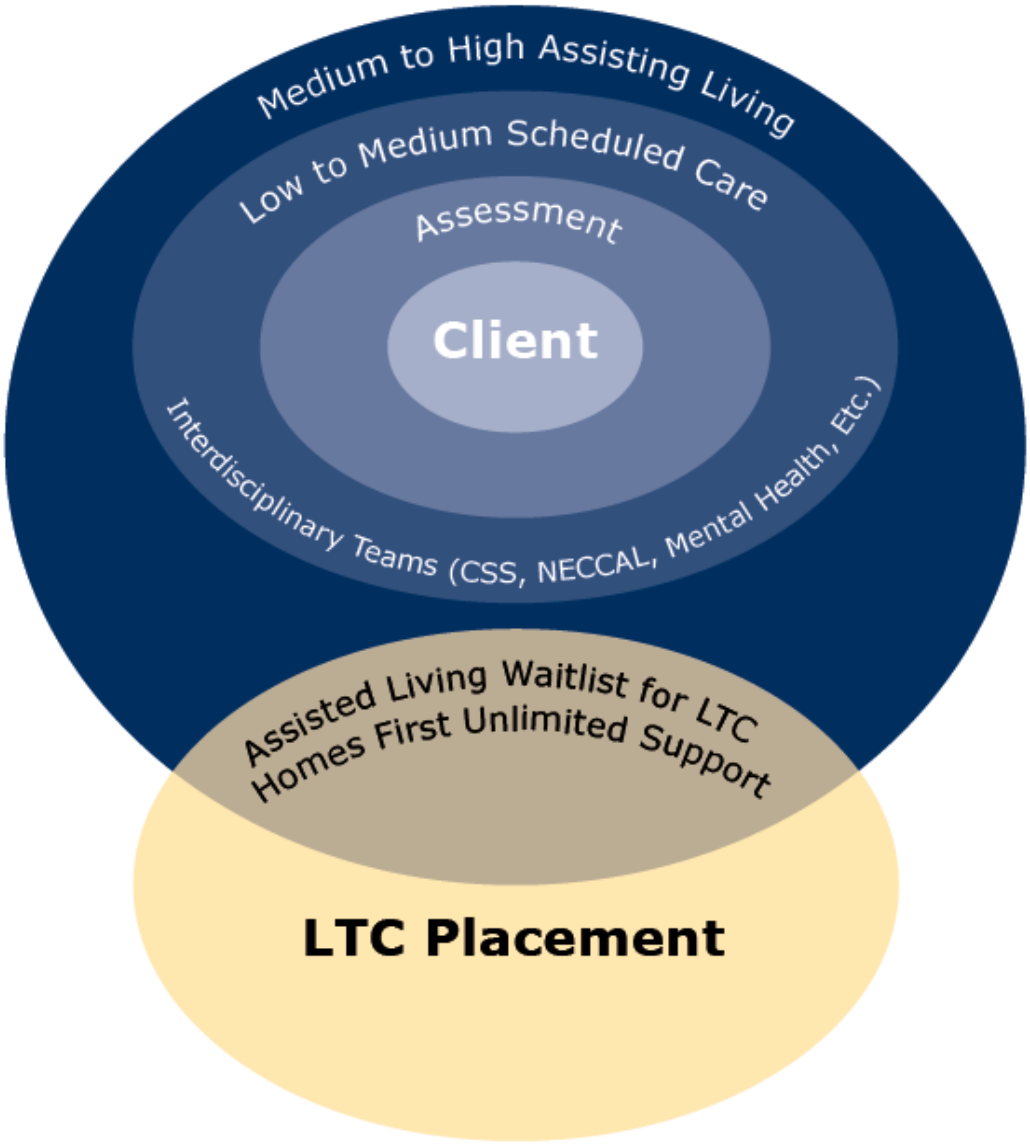


Continuum of Care # 2



Continuum of Care # 3

Continuum of Care # 4



Conclusion

As one participant stated, “we have enough long-term care beds, if we can further implement at-home services.”

The MOHLTC has outlined that the new and clarified provisions made to the ALSSH policy are intended to increase the value of assisted-living services. Service providers and the positive changes they are now bringing to assisted living and supportive housing services will work to enhance alignment with the NE LHIN’s Integration Health Service Plan (IHSP), 2010 – 2013. [2] The IHSP is essentially a three-year strategic plan of each individual LHIN. It identifies priorities and areas of focus over a three year period. All of the NE LHIN’s IHSP priorities directly or indirectly are related to helping to better meet the need of Northeastern Ontario’s growing elderly population.

The collaboration that was further generated by this workshop will greatly contribute to the success of the implementation of the policy in the NE LHIN region and the health and wellness of high-risk seniors throughout Northeastern Ontario.



[2] http://www.nelhin.on.ca/page_ihsp.aspx?id=4020&ekmensel=e2f22c9a_72_204_btnlink&langtype=4105

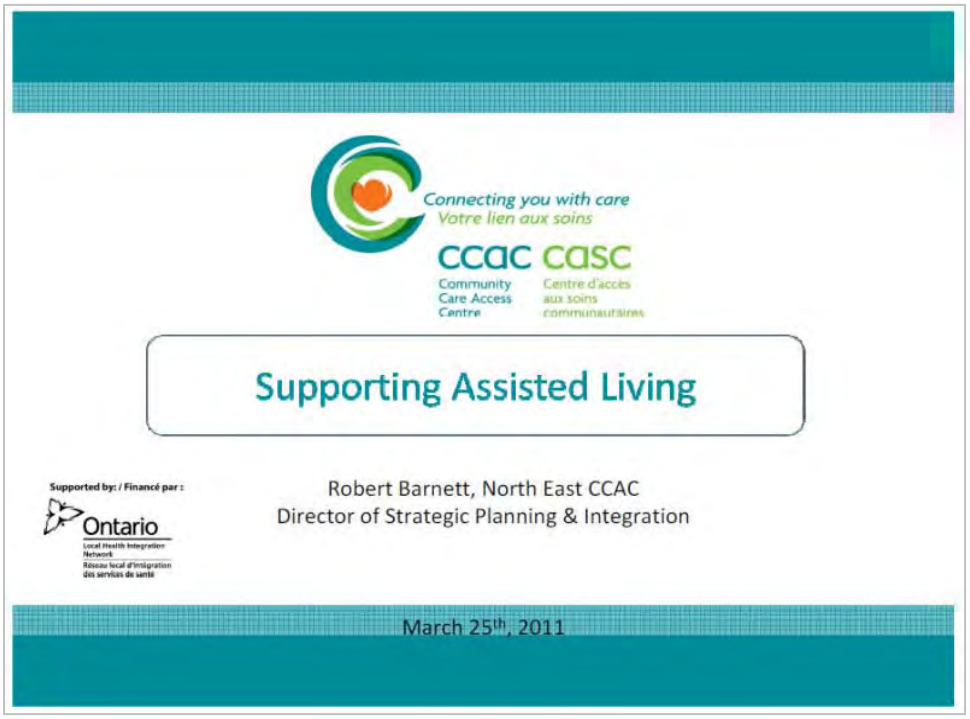
Appendix A
Workshop Participants

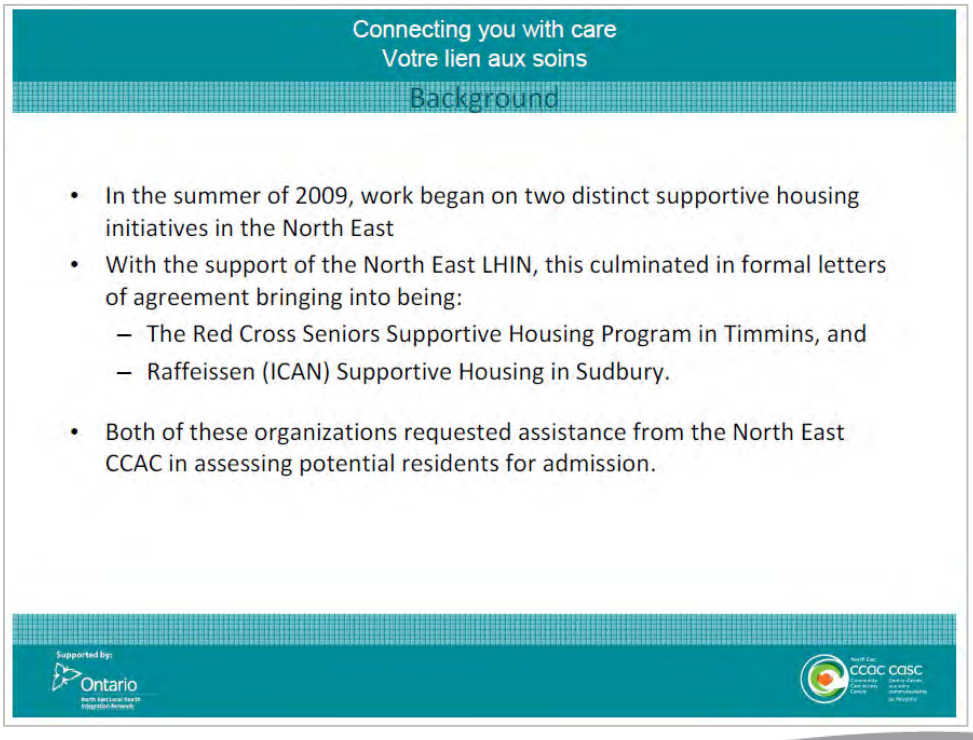
Name	Organization
Alice Radley	Physically Handicapped Adults Rehabilitation Association (PHARA)
Angèle A. Lemieux	Aide Aux Seniors Sudbury Est
Bernard Levesque	Au Chateau Sturgeon Falls
Brenda Loubert	Cassellholme North Bay
Carole Timm	Red Cross
Carolyn Hendry	Red Cross
Deanna Chisolm-Tuillio	Ontario March of Dimes
Debbie Chartier	Physically Handicapped Adults Rehabilitation A (PHARA)
Debbie Mills	Algoma District Services Admin. Board
Don Langlois	North East Community Care Access Centre (NE CCAC)
Jean-Guy Levesque	Von Canada Greater Sudbury
Judy Sullivan	VON Canada Greater Sudbury
Kim Stretch-Poser	City of Sault Ste. Marie
Lise Comtois	Independence Centre and Network (ICAN)
Louise Paquette	North East LHIN
Lyn Lebean	VON Canada
Marliese Gause	The Friends
Marie Leon	Independence Centre and Network (ICAN)
Pierre Guenette	DNSSAB
Pujo Tartala	Finlandia Village
Rhonda McCauley	Manitoulin-Sudbury District Services Board
Sharon Swain	Red Cross
Shirley Childs	Ukrainian Seniors Centre
Sue Clark	Weeneebayko Area Health Authority
Sylvianne Cardinal Pitre	Aide Aux Seniors Sudbury Est
Tammy Legge	VON Canada Greater Sudbury

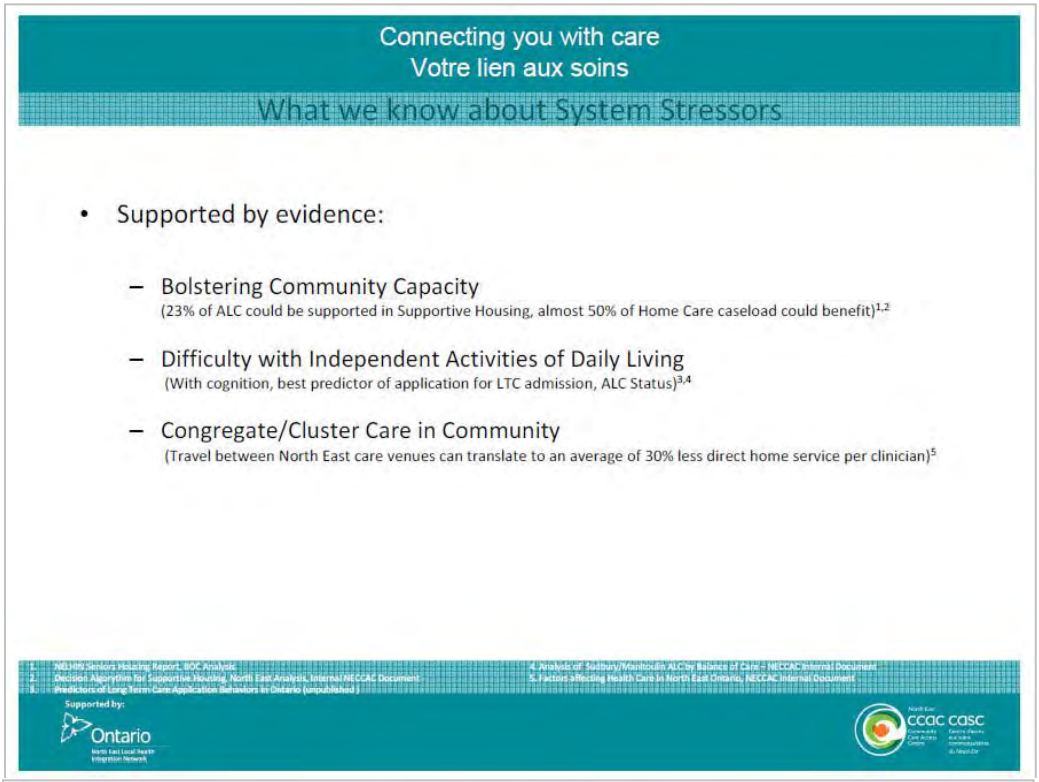
Planning & Presentation Team

Ann Matte, Senior Director, Strategic Planning and Integration, NE CCAC
Brian Marks, Director, Housing Services Cochrane District, DSSAB
David McNeil, VP, HRSRH
Don Langlois, Director, NE CCAC
Gisele Guénard, Facilitator, VisionarEase
Heather Cranney, Manager Red Cross - Timmins
Phil Kilbertus, Senior Consultant, NE LHIN
Robert Barnett, Director, Strategic Planning and Integration NE CCAC
Terry Tilleczek, NE LHIN Senior Director
Valerie Scarfone, Consultant, NE LHIN

Appendix B
NE CCAC: Supporting Assisted Living






Connecting you with care
Votre lien aux soins
What we know about System Stressors
• Supported by evidence:
– Bolstering Community Capacity
(23% of ALC could be supported in Supportive Housing, almost 50% of Home Care caseload could benefit)[1,2]
– Difficulty with Independent Activities of Daily Living
(With cognition, best predictor of application for LTC admission, ALC Status)[3,4]
– Congregate/Cluster Care in Community
(Travel between North East care venues can translate to an average of 30% less direct home service per clinician)[5]
1. NELHIN Seniors Housing Report, BOC Analysis
2. Decision Algorithm for Supportive Housing, North East Analysis, Internal NECCAC Document
3. Predictors of Long Term Care Application Initiators in Ontario (unpublished)
4. Analysis of Sudbury/Manitoulin ALC by Balance of Care – NECCAC Internal Document
5. Factors affecting Health Care in North East Ontario, NECCAC Internal Document
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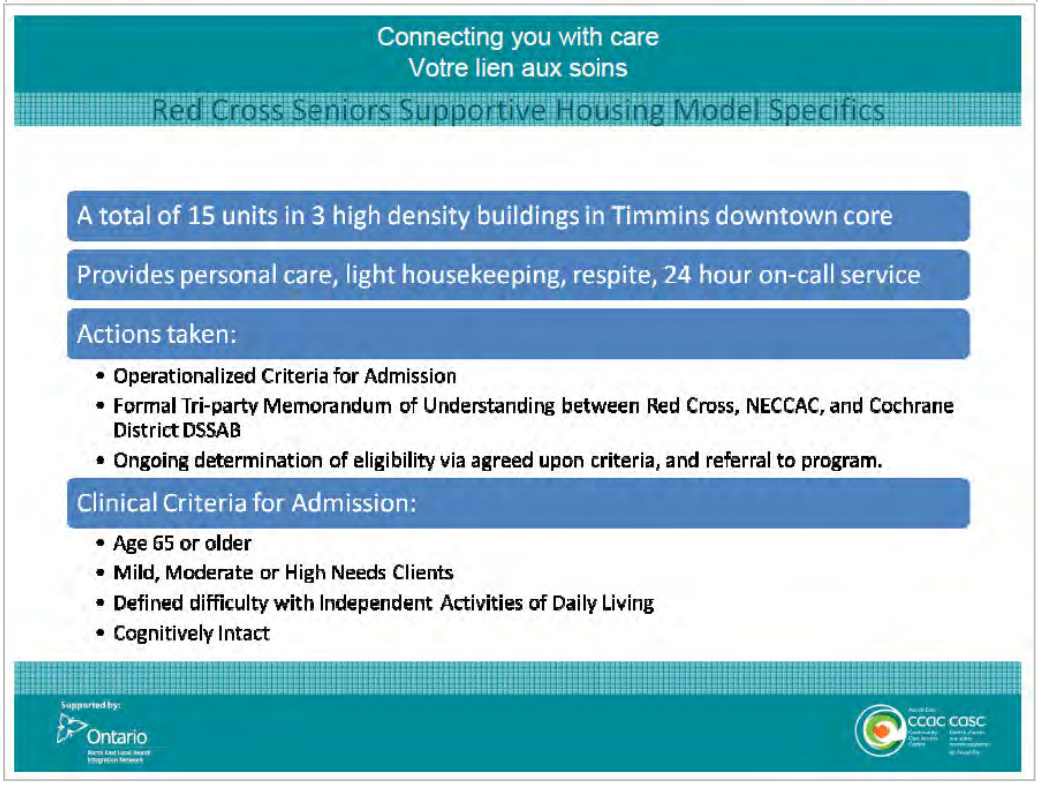
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Red Cross Seniors Supportive Housing Model Specifics
A total of 15 units in 3 high density buildings in Timmins downtown core
Provides personal care, light housekeeping, respite, 24 hour on-call service
Actions taken:
• Operationalized Criteria for Admission
• Formal Tri-party Memorandum of Understanding between Red Cross, NECCAC, and Cochrane District DSSAB
• Ongoing determination of eligibility via agreed upon criteria, and referral to program.
Clinical Criteria for Admission:
• Age 65 or older
• Mild, Moderate or High Needs Clients
• Defined difficulty with Independent Activities of Daily Living
• Cognitively Intact
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Raffeissen (ICAN) Model Specifics

12 specific units in 80+ unit building in Sudbury Downtown

Agency mandate of supporting those with physical disabilities

Provides personal care, light housekeeping, respite, 24 hour on-call service

Actions taken:

- Operationalized Criteria for Admission
- ICAN staff obtained consent for assessment from those waiting with no CCAC exposure
- NECCAC case managers performed assessments
- Raffeissen/ICAN made final determination on offering admission.
- No ongoing NECCAC involvement, though adhoc referral option is available

Criteria for Admission:

- Moderate or High Needs clients
- Capable of directing their own care
- Low medical complexity
- Ranked for admission by overall need

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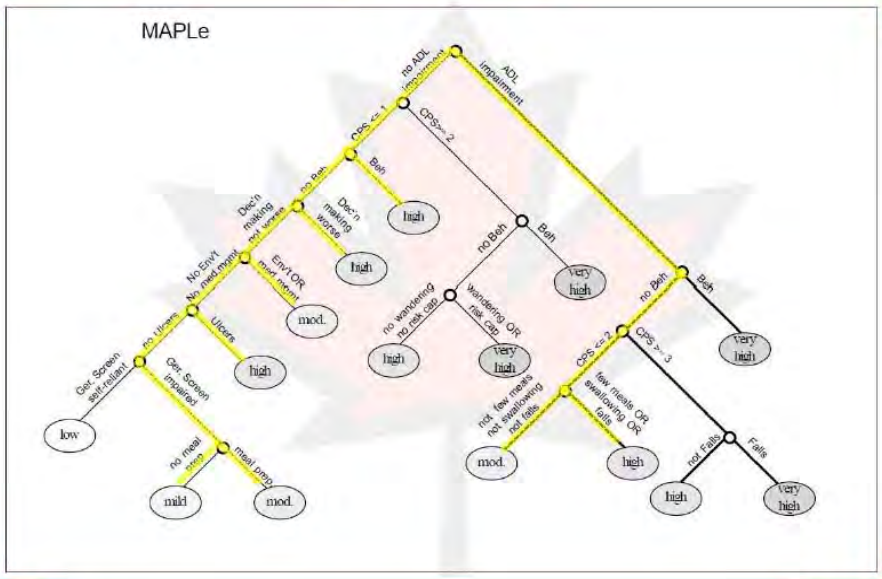
MAPLe



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Commonalities

1) Operationalize admission criteria using RAI-HC Measures

Red Cross (Timmins)			Raffeissen (Sudbury)	
Criteria	Range	**RAI Measure**	Range	Criteria
Mild to High Needs	2-4	MAPLe Score	3-4	Moderate to High Needs
Cognitively Intact	0-1	Cognitive Performance Scale	0-1	Able to Direct Own Care
Difficulty with IADL	2-6	IADL Capacity Score	-	-
-	-	CHESS Score	0-1	Low Medical Complexity
Senior	65+	Age	-	-
-	-	RAI Score	Ranked (Descending)	Ranked by Need

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Commonalities

2) Open option to request NECCAC identify additional clients appropriate for supportive housing venue, via:

- CCAC Case Managers and Management
- Automated client identification algorithm (beta)

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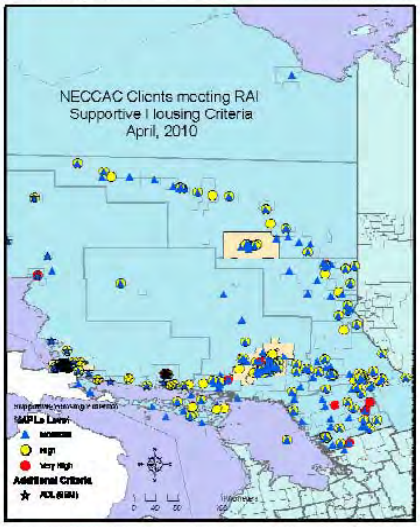
Client Identification Algorithm

- Automated database query, run on demand.
- Results available within minutes.
- Analyses RAI data for all active NECCAC clients (30,000+)
- Allows for diversion from LTC waitlist and/or Home Care to more appropriate venue.



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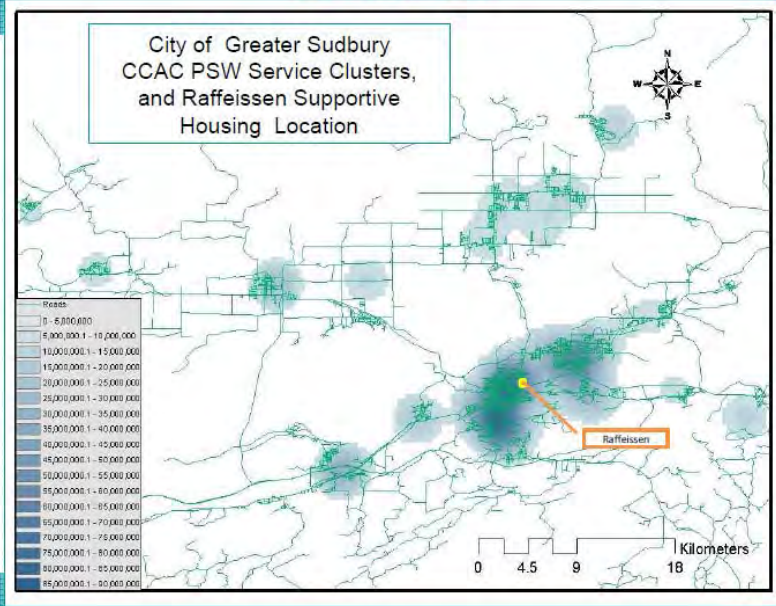

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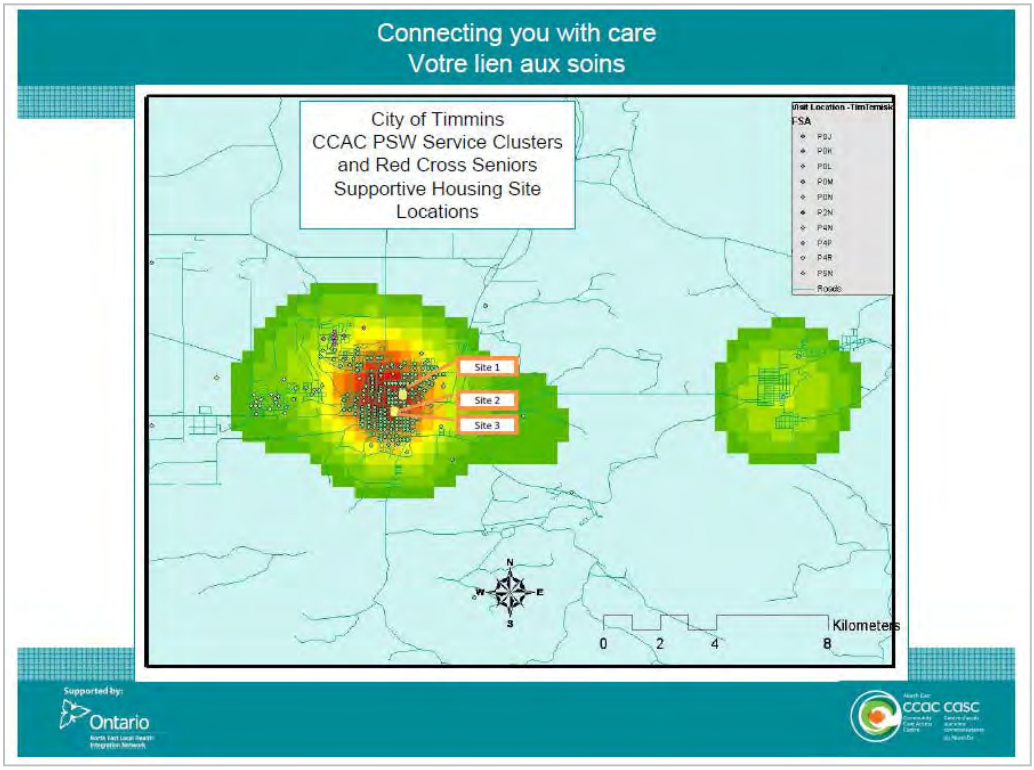
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City of Timmins
CCAC PSW Service Clusters
and Red Cross Seniors
Supportive Housing Site
Locations
Visit Location - TimTemiskFSA
P0J
P0K
P0L
P0M
P0N
P2N
P4N
P4P
P4R
P5N
Roads
Site 1
Site 2
Site 3
N
W
E
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Kilometers
0
2
4
8
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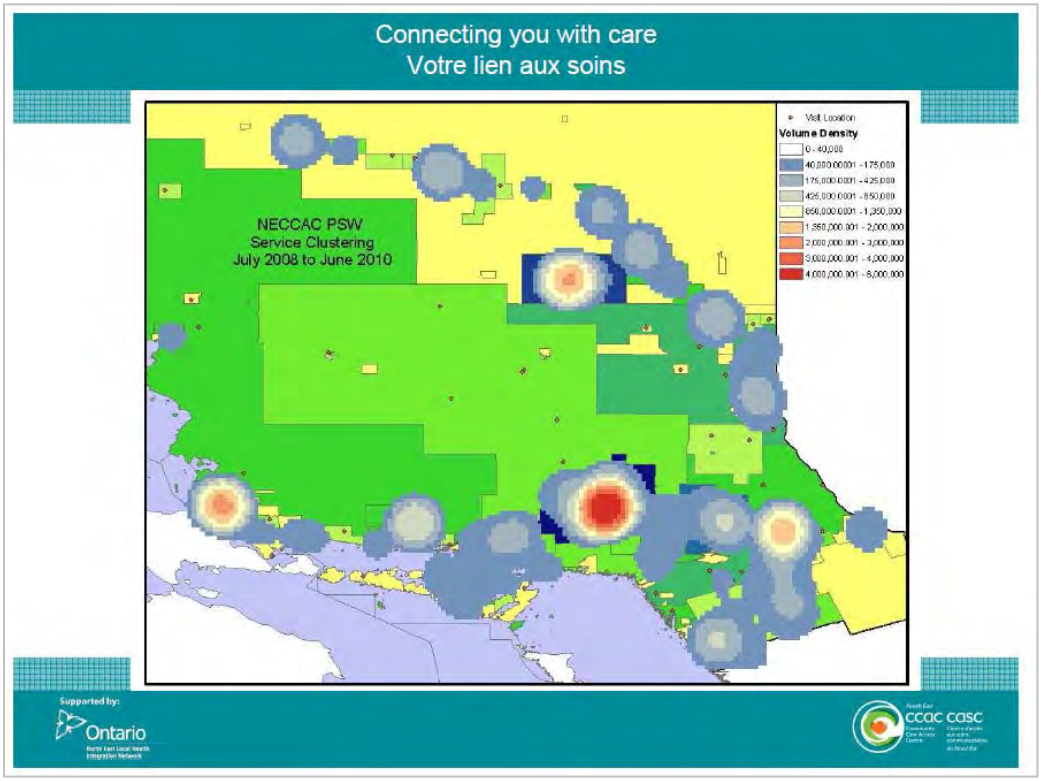
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NECCAC PSW
Service Clustering
July 2008 to June 2010
Visit Location
Volume Density
0 - 40,000
40,000.0001 - 175,000
175,000.0001 - 425,000
425,000.0001 - 850,000
850,000.0001 - 1,350,000
1,350,000.001 - 2,000,000
2,000,000.001 - 3,000,000
3,000,000.001 - 4,000,000
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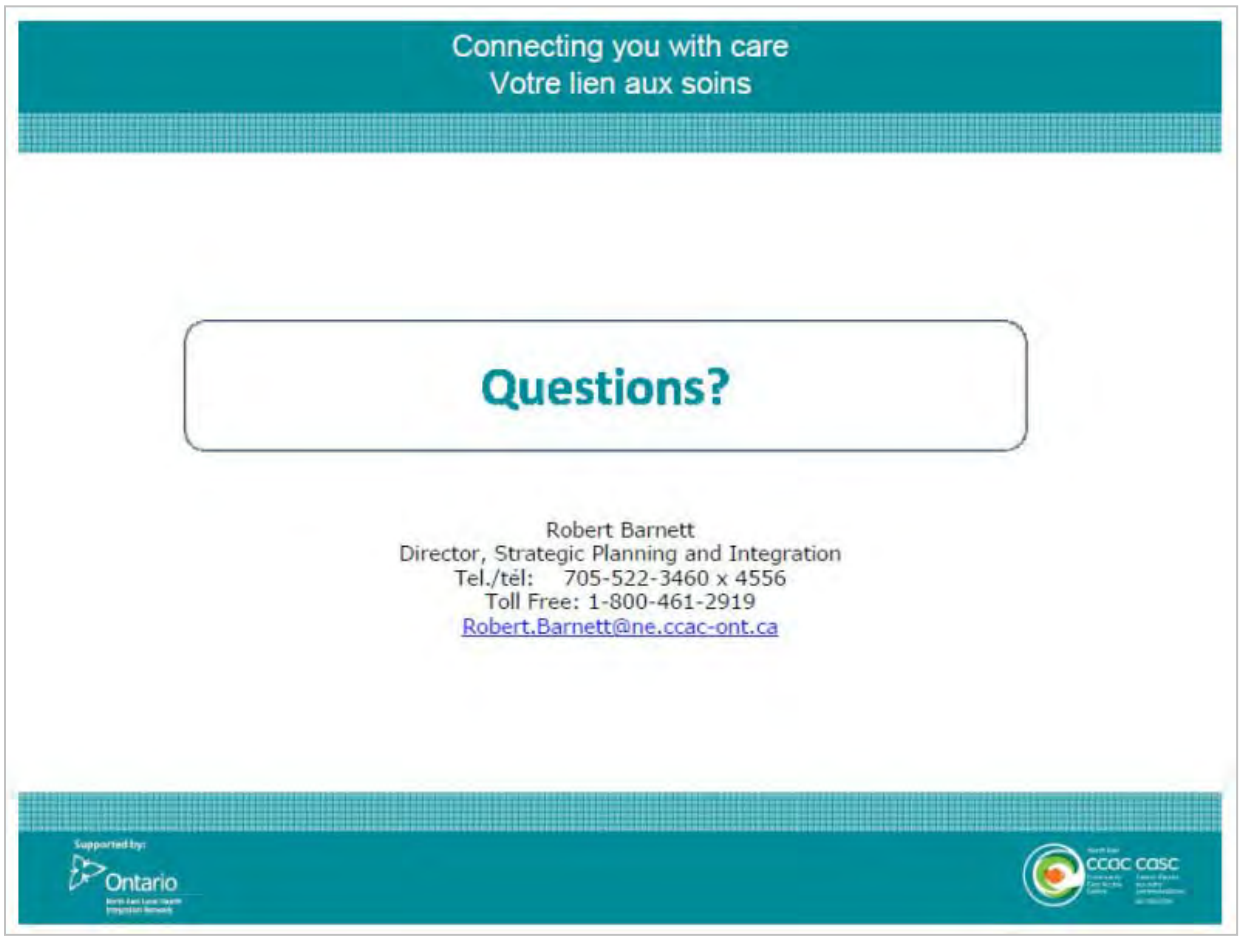
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Appendix C
Assisted Living Services for High Risk Seniors Policy, 2011

Assisted Living Services for High Risk Seniors Policy, 2011

An updated supportive housing program for frail or cognitively impaired seniors

January 2011

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Table of Contents

1.0 Statement of Policy

The *Assisted Living Services for High Risk Seniors Policy, 2011* (the "policy") has been developed to address the needs of high risk seniors who can reside at home and require the availability of personal support and homemaking services on a 24-hour basis. The policy is effective as of January 1, 2011.

This policy updates and replaces the provisions of the *Assisted Living Services in Supportive Housing Policy, 1994* (ALSSH) that relate to seniors who are frail or cognitively impaired and will apply only to new applicants effective January 1, 2011. The ALSSH, 1994 will continue to apply to those frail or cognitively impaired seniors who are receiving services under that policy on December 31, 2010 and who do not meet the eligibility criteria for high risk seniors under this policy. This policy does not affect the provisions of the ALSSH, 1994 policy relating to persons with physical disabilities, acquired brain injuries or Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

This policy targets high risk seniors whose needs cannot be met in a cost-effective manner through home and community care services provided solely on a scheduled visitation basis, but who do not require admission to a long-term care home (LTCH).

The intent of the policy is to:

- Enable local communities to address more fully the needs of high risk seniors so that they are able to remain safely at home
- Expand cost-effective and accessible options for community care
- Reduce unnecessary and/ or avoidable hospital utilization and wait-times of acute care services, emergency room (ER) use, and admission to LTCHs
- Provide Local Health Integration Networks (LHINs) with the flexibility to adapt to clients' changing care requirements
- Strengthen assisted living services to achieve a more functional continuum of care for Ontario's high risk seniors within each LHIN

The services to be provided under this policy are personal support, homemaking, care co-ordination and security checks or reassurance services (the "assisted living services"). An applicant shall meet the eligibility criteria set out in this policy in order to receive these services. Persons receiving assisted living services may also be eligible for CCAC professional services.

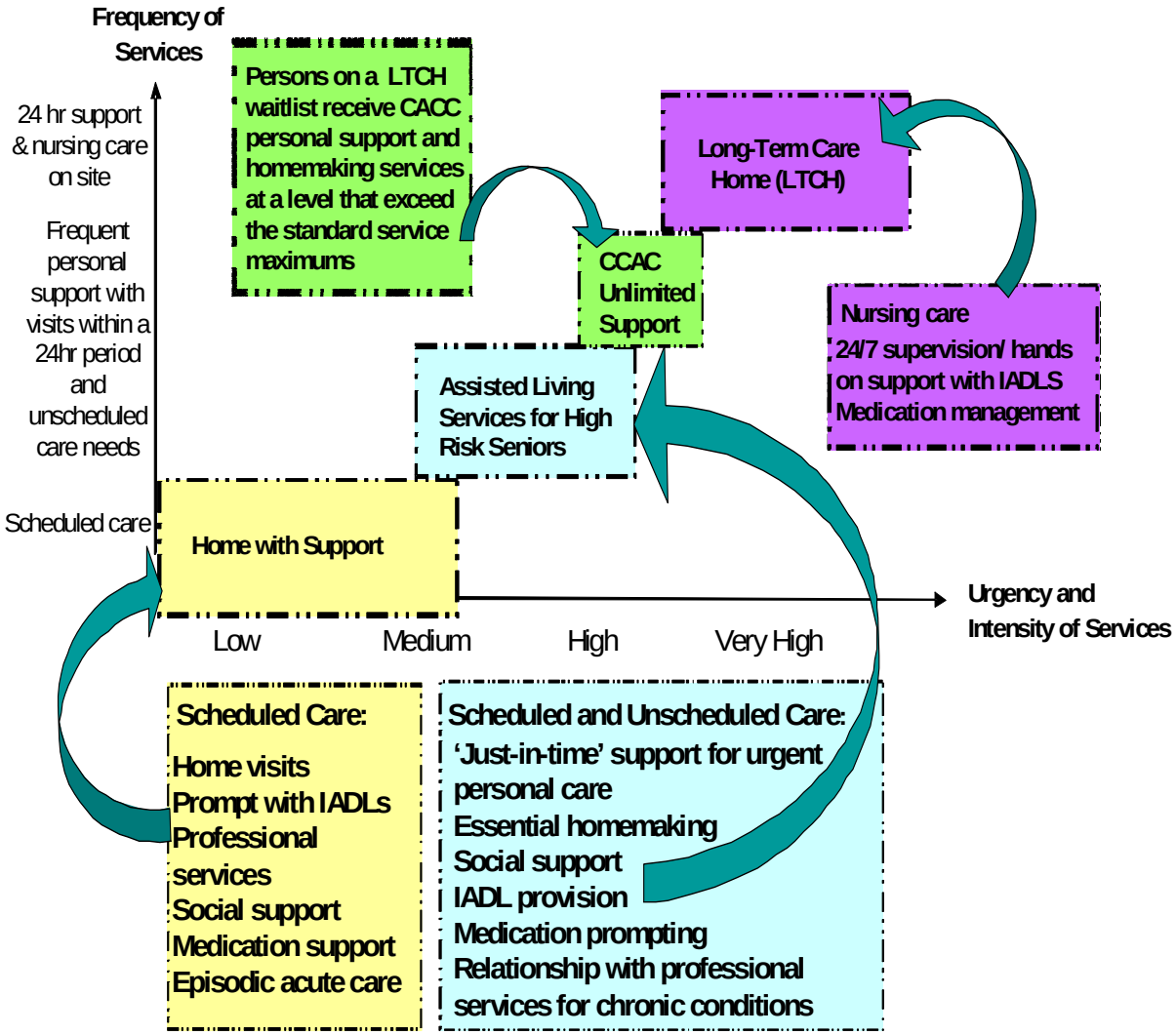
Persons receiving assisted living services shall not receive more than a combined maximum of 180 hours of personal support, homemaking and professional services per month (see Appendix 1 for definitions of these services). Persons whose care requirements exceed the Assisted Living service maximum may require placement in a LTCH or a more complex care environment. Persons waitlisted for a LTCH may be

eligible for CCAC personal support and homemaking services at a level that exceeds the standard CCAC service maximums for these services.

Assisted living services shall be provided by agencies that are approved to provide these services under the *Home Care and Community Services Act, 1994 (*HCCSA – formerly the *Long-Term Care Act, 1994).* The approved agencies shall comply with the HCCSA and the regulations there under as well as all relevant Ministry policies when providing these services. Approved agencies are funded by LHINs as health service providers under the *Local Health System Implementation Act, 2006 (*LHSIA*).*

Assisted living services are part of the continuum of care as shown in Figure 1.

Figure 1:



2.0 Objectives/ Measures

This policy will be evaluated on the extent to which it contributes to:

- Reducing unnecessary and/ or avoidable ER visits by high risk seniors
- Reducing unnecessary and/ or avoidable LTCH admissions by high risk seniors
- Increasing the number of high risk seniors who are discharged from hospital without an Alternate Level of Care (ALC) designation
- Reducing the length of stay for high risk seniors in hospital after ALC designation
- Reducing wait-time to discharge destination for high risk seniors who live in the community
- Increasing the length of time high risk seniors remain safely at home after hospital discharge

Refer to section 14.0 (Performance Management) for details on how these objectives/ measures are to be evaluated.

3.0 Alignment with the ALSSH, 1994 Policy

This policy updates and replaces the provisions of the *Assisted Living Services in Supportive Housing Policy, 1994* that relate to seniors who are frail or cognitively impaired and will apply only to new applicants effective January 1, 2011. The ALSSH, 1994 policy will continue to apply to those frail or cognitively impaired seniors who are receiving services under the ALSSH, 1994 policy on December 31, 2010 and who do not meet the eligibility criteria for high risk seniors under this policy. This policy does not affect the provisions of the ALSSH, 1994 policy relating to persons with physical disabilities, acquired brain injuries or Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

This policy sets out new or updated provisions relating to:

- Eligibility criteria for frail or cognitively impaired seniors (now referred to as “high risk seniors”)
- Service locations
- Roles and responsibilities for care co-ordination
- Protocols and expectations relating to security checks or reassurance services
- Requirements for approved agencies
- Responsibilities for key service delivery functions
- Legislative and regulatory requirements

This policy continues the provisions relating to:

- Personal support and homemaking services as the core assisted living services
- Ministerial approval for premises in buildings designated for assisted living services

4.0 Relevant Legislation

Approved agencies delivering assisted living services under this policy shall comply with all relevant legislation and the regulations there under, including:

- Home Care and Community Services Act, 1994, S.O. 1994, c.26
- Community Care Access Corporations Act, 2001, S.O. 2001, c.33
- Local Health System Integration Act, 2006, S.O. 2006, c.4
- Health Care Consent Act, 1996, S.O. 1996, c.2, Sched. A
- Substitute Decisions Act, 1992, S.O. 1992, c.30
- Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Sched. A
- Ministry of Health and Long-Term Care Appeal and Review Boards Act, 1998[1], S.O. 1998, c.18, Sched. H

5.0 Assisted Living Services

The following are the assisted living services available to eligible high risk seniors:

1. Personal Support Services[2] including dressing, personal hygiene, assisting with mobility, assisting and monitoring medication use and other routine activities of living. These services shall be available at all times (24/7) both on a scheduled and unscheduled basis.

2. Homemaking services including shopping, housecleaning, and meal preparation that are necessary to maintain people in their own residences but that they are unable to perform safely for themselves. These services shall be available at all times (24/7) both on a scheduled and unscheduled basis.

3. Security checks or reassurance services including visits to assure client health or safety. These services shall be provided to address the individual needs of clients based on their clinical condition or environment. These services shall be available at all times (24/7) both on a scheduled and unscheduled basis.

4. Care Co-ordination including co-ordinating all elements of client care. The care co-ordination role shall include the assessment of applicants' needs, determination of eligibility based on the eligibility criteria set out in this policy, and the development, review, evaluation and revision of a plan of service relating to the provision of assisted living services (section 10).

   Care co-ordination shall include regular and ongoing communication with community care access centres, community support service agencies, community social and recreational services, community primary health care professionals (e.g. GPs, family

[1] To access Ontario legislation go to: e-laws Ontario
[2] *See* Appendix 1 for the full list of personal support and homemaking services, or refer to the subsections 2(5) and 2(6) of the HCCSA.

health teams, geriatric and psychogeriatric services, mental health services, and palliative care services), and with agencies providing disability aids, assistive devices and home help equipment.

Care co-ordination shall also include developing effective working relationships with other health/ social service agencies located in the designated geographic service area (see section 8.0) and supporting client and caregiver social networks. This may involve planning for anticipated future health care requirements in cooperation with the client and establishing linkages to other services to help ensure continuity of care.

6.0 Eligibility Criteria

An approved agency shall not provide assisted living services to a person unless the person meets all of the following eligibility criteria:

1. The person shall be an insured person under the Health Insurance Act;
2. The person 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 person shall require services to be delivered in a frequent, urgent, and intense manner described as follows:

    - Frequent meaning that the individual has needs where intermittent visits through the day may be necessary
    - Urgent meaning that the individual has concerns that warrant a prompt response that cannot wait to be scheduled
    - Intense meaning that the individual's condition or predicament demands direct personal attention from staff to address needs;
3. The person shall meet the characteristics of a high risk senior as set out in Table 1 of this policy (section 6.1);
4. The person shall not be on a waiting list for a LTCH;
5. The person shall reside in a LHIN approved designated geographic service area (section 8.0) but shall not reside in a care home within the meaning of the Residential Tenancies Act, 2006 within that area[3];
6. The person shall be able to remain safely at home between visits;
7. The person shall not require immediate or 24-hour availability of nursing care or other professional services;
8. The person's home shall have the physical features necessary to enable the services to be provided; and
9. The risk that a service provider who provides the services to the person will suffer serious physical harm while providing the services must not be significant or, if it is significant, the service provider must be able to take reasonable steps to reduce the risk so that it is no longer significant.

[3] This criterion does not apply to persons residing in supportive housing buildings that are designated as care homes within the meaning of the *Residential Tenancies Act, 2006*, for example, Legion Village Inc. Branch 133 (Coburg) and Alpha House (Windsor).

6.1 Characteristics of a High Risk Senior

Approved agencies shall use the InterRAI common assessment tool to determine whether an applicant for assisted living services meets the following characteristics of a high risk senior as set out in Table 1.

Table 1

Characteristics of a High Risk Senior	Impairment/ Intensity range
Person shall possess *all* of the following characteristics within the designated impairment/ intensity range	
Instrumental Activities of Daily Living (IADL) difficulties	High to very high
Activities of Daily Living (ADL) difficulties	Mild to moderate
Social network decline or unmanageable caregiver burden	High to very high
AND: Person shall possess *two or more* of the following characteristics within the designated impairment/ intensity range	
Multiple chronic conditions that oscillate (e.g. hypertension, arthritis, diabetes, chronic pain, congestive heart failure, speech pathology and aphasia issues, mental illness and substance abuse disorders)	2 or more conditions that demonstrate frailty or cognitive impairment
Falls	Occasional to frequent
Complicated medication management	3 or more medications
Person's self-reported health condition	Poor to very poor
Use of health care resources	High to very high
AND IF the person experiences any of the following, his/her functional capacity(ies) shall fall into the corresponding impairment/ intensity range	
Incontinence	Mild to moderate (manageable)
Behavioural or mood problems	Mild to moderate (manageable)
Cognitive impairment	Mild to moderate (manageable)

7.0 Service Maximums

Persons receiving assisted living services shall not receive more than a combined maximum of 180 hours of personal support, homemaking and professional services[4] per month.

To ensure that the client's level of care is within the assisted living service maximum, the approved agency must keep a record of all professional hours provided by a CCAC (if any).

8.0 Service Locations: Designated Geographic Service Areas

Subject to the exception for care homes noted below, eligible high risk seniors shall only access assisted living services in their homes if they reside within a designated geographic service area (also known as a "hub"). Clients may reside in the hub in a variety of settings. These settings include private sector or non-profit housing such as individual single family homes, townhouses, condominiums, housing co-operatives or traditional social housing buildings/ apartments. However, high risk seniors who reside in care homes within the meaning of the *Residential Tenancies Act, 2006* shall not be eligible to receive assisted living services.[5]

Each LHIN shall be responsible for determining and approving the hub(s) within their specific geographic area. To be designated as a hub, the LHIN shall determine that the geographic service area meets the following criteria:

- Safe: The geographic service area shall have approved agencies 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. LHINs shall determine the allowable safe response time that shall be met by the approved agencies in order to minimize any harm to clients.
- Quality: The geographic service area shall have approved agencies that are able to attract and retain PSWs in order to achieve a predictable and reliable staffing arrangement for service continuity and quality client care.
- Integrated: The geographic service area shall have approved agencies that are prepared to establish linkages with existing primary care service providers.
- Efficient: The geographic service area shall have a sufficient number of high risk seniors to provide for operational efficiencies relative to other available service delivery options (e.g. congregate and facility care).

[4] Only CCACs are approved to provide professional services.
[5] This criterion does not apply to persons residing in supportive housing buildings that are designated as care homes within the meaning of the *Residential Tenancies Act, 2006*, for example, Legion Village Inc. Branch 133 (Coburg) and Alpha House (Windsor).

9.0 Roles and Responsibilities for Service Delivery

This section is currently under development.

Further MOHLTC policy direction will follow.

10.0 Expectations for Key Service Delivery Functions

10.1 Client Involvement, Preferences and Consent

Approved agencies shall provide clients, their substitute decision-makers, if any, and any persons designated by them the right to participate fully in the development, evaluation and revision of a plan of service.[6] If a client is mentally incapable, decisions relating to the provision of assisted living services can be made on his/her behalf by his/her authorized substitute decision-maker.

Approved agencies shall also take into account client preferences based on ethnic, spiritual, linguistic, familial and cultural factors when developing, evaluating and revising the client's plan of service.[7]

Nothing in the HCCSA authorizes an approved agency to assess a person's requirements, determine a persons' eligibility or provide a community service to a person without the person's consent, or the consent of their substitute decision-maker, if any.[8]

10.2 Referral and Intake

Referrals to assisted living services may be made directly through self-referral, hospitals, CCACs, primary care providers, other health professionals, informal caregivers such as family members, neighbours or friends, or community support staff/ volunteers. The intake process shall be transparent and publicized within LHIN communities.

If consent is provided by a patient or his/her authorized substitute decision-maker, if any, hospitals shall (wherever possible in collaboration with CCACs):

- Complete an initial scan of admitted patients to determine whether any patients may be high risk seniors;
- Notify the organization(s) responsible for the provision of assisted living services in their LHIN to alert them of potential clients; and,

[6] subsection 22(4) of the HCCSA
[7] subsection 22(6) of the HCCSA
[8] subsection 22(7) of the HCCSA

- Forward discharge summaries to the organization(s) responsible for assisted living services and the primary care provider for each client as soon as possible after discharge.

10.3 Assessment of Requirements[9]

While the standardized assessment tool will provide an objective assessment of need and assist in the determination of eligibility, the results of the assessment shall include the wishes and preferences of the client or his/her substitute decision-maker, if any, and incorporate the expert opinion of the person conducting the assessment.

As appropriate, the assessment shall be conducted in the client's home. Approved agencies shall use the InterRAI common assessment tool.

10.4 Eligibility[10]

Subject to the client's availability, the approved agency shall begin to assess a client for eligibility within 24 hours of receiving notification from the hospital or other referral source of a potential assisted living client.

10.5 Availability of Assisted Living Services and Waitlists[11]

The goal is to have assisted living services available on the day of discharge for hospital in-patients who have been determined eligible for these services.

However, a waitlist shall be developed and managed in the event that the demand for the services is higher than the immediate availability of services. Approved agencies shall rank clients on the waiting list in accordance with the following priorities:

1. ALC seniors waiting for discharge home from hospital shall be ranked first;
2. Seniors in the community who may be in imminent need of a higher level of care than can be provided by CCAC regular services and who would otherwise be at high risk of hospitalization or admission to a LTCH shall be ranked second; and
3. Seniors who are frequent users of emergency room and hospital services shall be ranked third.

10.6 Development of a Client Plan of Service[12]

A plan of service shall be developed for assisted living clients in collaboration with the client, his/her substitute decision-maker, if any, and any other person designated by either of them based on the results of the assessment of requirements (section 10.3). It

[9] subsection 22 (1) of the HCCSA and Reg. 386/99 thereunder
[10] subsection 22 (1) of the HCCSA and Reg. 386/99 thereunder
[11] subsection 23 (2) of the HCCSA
[12] subsection 22 (1) of the HCCSA and Reg. 386/99 thereunder

shall set out the type and amount of assisted living services required, including the frequency and duration of the services that the person shall receive.

The plan of service shall also refer to other community health and social services and health care providers with which linkages will be coordinated for the client, including support for their caregiver(s) (section 10.7). Linguistic/ cultural needs, the security checks or reassurance services, and discharge considerations (section 10.9) shall also be included in the plan of service**.**

Persons receiving assisted living services shall receive no more than a combined maximum of 180 hours of personal support, homemaking and professional services per month.

10.7 Co-ordination of Services[13]

The approved agency shall create an integrated plan of service if the client's assessed needs include services other than personal support, homemaking, and security checks or reassurance services. The integrated plan of service shall specify the services to be provided by the various agencies and/ or health care providers (e.g. pharmacists, primary care services, community support services, CCACs, speciality diabetic clinics, seniors respite services) involved in the client's care.

10.8 Review of Care Requirements[14]

Approved agencies shall informally review the care needs of assisted living clients on an ongoing basis to determine whether the existing plan of service is appropriate and/ or whether adjustments are required. Approved agencies shall conduct a formal reassessment of care requirements on a quarterly basis. The plan of service shall only be revised when the person's requirements change.[15]

10.9 Discharge Strategy[16]

Approved agencies shall only make decisions relating to discharge after conducting a formal review of care requirements (section 10.8). Approved agencies shall discharge clients who no longer meet the eligibility criteria (section 6.0).

Prior to discharge, approved agencies shall ensure that alternative services are available through the CCAC or other approved agencies for clients in the following situations:

[13] subsection 22 (3) of the HCCSA
[14] subsection 22 (2) of the HCCSA
[15] subsection 22(2) of the HCCSA
[16] subsection 22 (1) of the HCCSA and Reg. 386/99 thereunder

- Clients whose condition improves such that they no longer qualify as a high risk senior and require a lower level of care than that provided under this policy
- Clients who become too ill to remain at home and require admission to a LTCH or a more complex care environment. Persons waitlisted for a LTCH may be eligible for CCAC personal support and homemaking services at a level that exceeds the standard CCAC service maximums for these services. In addition, these persons may be given urgent priority status.

Approved agencies shall involve the client and his/her substitute decision-maker, if any, when making discharge decisions.

11.0 Qualifications of Approved Agencies

Agencies shall only be approved to provide services under the HCCSA if they meet the eligibility criteria set out in the HCCSA.[17] LHINs shall review the agencies that are being proposed to provide assisted living services and make a recommendation to the Minister of Health and Long-Term Care as to whether these agencies meet the eligibility criteria.

The following are the eligibility criteria and how they shall be met:

1. The agency, with financial assistance under the HCCSA, 1994 will be financially capable of providing the service. The agency:
   - Shall demonstrate that it is in good financial standing
   - Shall provide all planning, funding and accountability documents to the LHIN in a timely fashion.

2. The agency is or will be operated in compliance with the Bill of Rights set out in section 3 of the HCCSA, 1994 and will act with competence, honesty, integrity, and concern for the health, safety, and well being of the persons receiving the service. The agency:
   - Shall demonstrate that it has the staff, expertise and capacity to deliver the required nature and level of services associated with this policy as set out in the client/ caregiver plan of service section of this policy (section 10.6)
   - Shall demonstrate that it is able to provide assisted living services on the day of discharge for clients coming home from hospital
   - Shall have explicit complaints, appeals and abuse prevention policies
   - Shall demonstrate the ability to collect and report data on clients and provide documentation of all services delivered
   - Shall have a performance improvement system and a reporting mechanism to its Board of Directors
   - Should have linkages with other community partners, including primary care professionals, to ensure necessary partnerships are in place to meet the ongoing care needs of the client or have a plan to achieve same.

[17] section 5 of the HCCSA

Upon receiving the recommendation from the LHINS, the Minister of Health and Long-Term Care may approve an agency to provide assisted living services. LHINS shall review the status of approved agencies as an integral part of the renewal of service accountability agreements every two years.

12.0 Client Protections and Safeguards

12.1 Complaints and Appeals Process[18]

Approved agencies shall inform their clients about all of the following:

- The services they are providing to them
- The client's Bill of Rights[19]
- The procedures for making complaints or suggestions relating to the approved agency or its service providers
- How to request access to a record of personal health information
- How to appeal decisions made by approved agencies

Approved agencies shall report to the LHINs the number of assisted living client complaints received and how they were resolved at a frequency to be determined by the LHINs. The LHINs shall provide this information to the MOHLTC through the Integrated Health Services Plan and quarterly reports.

12.2 Client Tenancy Issues and De-linked Services

Clients receiving assisted living services in designated buildings may be subject to eviction proceedings. Notwithstanding any such proceedings, approved agencies shall maintain the provision of assisted living services to these clients until these matters are resolved.

The Ministry continues to encourage de-linked service arrangements where services are delivered to clients who live in social housing.[20]

13.0 Funding

13.1 Funding of Assisted Living Services

The source of funding for assisted living services shall come from the LHIN's negotiated annual allocation, either one-time or base. The funding level should be sufficient to deliver the hours of service consistent with the service delivery targets set by each LHIN.

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[18] subsection 25 (2) of the HCCSA and sections 39 through 48 of the HCCSA

[19] section 3 of the HCCSA

[20] De-linking services means that the health services provider is **not** the provider of housing. De-linking can be demonstrated by an independent Board governing health services provision where a housing provider wishes to offer health services.

Paymaster (flow-through) arrangements should be avoided. They are only acceptable when the third party does not have a service accountability agreement signed with the LHIN or the MOHLTC (e.g. provincial programs).

13.2. Reporting Standards

A unique MIS code shall be used to report assisted living services activity by resident days. This MIS code shall only be used for clients served under this policy. The code is as follows:

- **Primary code FC 72 5 82 45 CSS IH COM – Assisted Living Services**
- **Secondary Code 955 80 22 CSS – Individuals Served – High Risk Senior.**

The 955 80 22 CSS code is defined as *"the number of individuals receiving assistance or supervision to perform routine activities of daily living safely or independently, and meet the characteristics and ranges for a high risk senior as defined in the Assisted Living Services for High Risk Seniors Policy, 2011".*

For those clients grandfathered from the ALSSH, 1994 policy, they can continue to be reported under the same primary functional centre code of FC 72 5 82 45 CSS IH COM – Assisted Living Services along with the appropriate secondary statistical codes on client types below OR report the activity under the codes for the relevant program, such as Acquired Brain Injury or homemaking.

Table 2

Secondary Statistical Accounts (these are reported under a primary functional centre account)		
955 80 10	CSS - Individuals Served – Physically Disability	The number of individuals who require assistance to perform routine activities of daily living as a result of a physical disability, including a sensory impairment.
955 80 15	CSS - Individuals Served – Cognitive Impairment	The number of individuals who require assistance or supervision to perform routine activities of daily living safely or independently as a result of cognitive disorder, such as Alzheimer Disease, or a related dementia.
955 80 20	CSS - Individuals Served – Frail and/or Elderly	The number of individuals who require assistance or supervision to perform routine activities of daily living as a result of impairment or loss of functional abilities due to aging.
955 80 25	CSS - Individuals Served – Living with affects of HIV/AIDS	The number of individuals who require assistance or supervision to perform routine activities of daily living a result of impairment or loss of functional abilities as a result of HIV or AIDS.

13.3 Realignment of Funds

LHINs shall retain the discretion to re-allocate all funds, with the exception of dedicated funding specified in Ministry-LHIN accountability agreements. Accordingly, there shall be no restriction on LHINs with respect to re-allocation of all assisted living funding to/ from approved agencies. LHINs shall ensure that appropriate documentation is in place, prior to requesting re-allocations in the Allocation Payment Tracking System. The Ministry will continue to monitor the allocations and expenditures by LHINs, by sector.

14.0 Performance Management

14.1 Accountability

Accountability for the funding provided to approved agencies to provide services under this policy shall be included in the service accountability agreements between approved agencies and their LHIN. LHINs shall report back to the Ministry through the quarterly LHIN Liaison Branch review process and through joint MOHLTC/LHIN evaluations.

14.2 Performance Measurement

Each LHIN shall develop a performance measurement framework relating to assisted living services in conjunction with their approved agency. LHINs shall report on service *inputs* and *outputs/ deliverables.* Both LHINs and approved agencies shall report on *outcomes* (the level of performance or achievement). Approved agencies shall ensure that service delivery is *effective, efficient* and *client-centred*. The Ministry and the LHINs have joint responsibility to develop operational definitions and technical specifications for each indicator.

14.3 Timeline for LHIN Performance Management

In order to monitor performance improvement within each LHIN and to inform policy evaluation, the LHINs shall comply with the following timeline for the first three years of the policy:

- By the end of Year 1, LHINs shall determine performance baselines for assisted living services
- By the end of Year 2, LHINs shall report on their business improvement practices and the number of assisted living services clients served
- By the end of Year 3, LHINs shall report on their performance improvement relative to the Year 1 baseline targets

15.0 Policy Review Process

This policy will be reviewed by the MOHLTC no later than thirty-six (36) months after its effective date. An earlier review may be triggered in the following circumstances:

- Legislative or regulatory changes are made that directly affect this policy
- LHINs and their stakeholders identify challenges and barriers to the implementation of this policy
- A decision by the MOHLTC or a request by a majority of the LHINs to revise the policy

Appendix 1: List of Homemaking, Personal Support and Professional Services

For the purposes of this policy, the following are homemaking, personal support and professional services (as set out in the HCCSA):

Homemaking services

1. Housecleaning.
2. Doing laundry.
3. Ironing.
4. Mending.
5. Shopping.
6. Banking.
7. Paying bills.
8. Planning menus.
9. Preparing meals.
10. Caring for children.
11. Assisting a person with any of the activities referred to in paragraphs 1 to 10.
12. Training a person to carry out or assist with any of the activities referred to in paragraphs 1 to 10.

Personal support services

1. Personal hygiene activities.
2. Routine personal activities of living.
3. Assisting a person with any of the activities referred to in paragraphs 1 and 2.
4. Training a person to carry out or assist with any of the activities referred to in paragraphs 1 and 2.

Professional services

1. Nursing services.
2. Occupational therapy services.
3. Physiotherapy services.
4. Social work services.
5. Speech-language pathology services.
6. Dietetics services.
7. Training a person to provide any of the services referred to in paragraphs 1 to 6
8. Diagnostic and laboratory services.
9. Medical supplies, dressings and treatment equipment necessary to the provision of nursing services, occupational therapy services, physiotherapy services, speech-language pathology services or dietetics services.
10. Pharmacy services.
11. Respiratory therapy services.
12. Social work services.

Appendix 2: Acronyms

Activities of Daily Life (ADLs)
Alternate Level of Care (ALC)
Assisted Living Services for High Risk Seniors (ALS-HRS, 2011)
Assisted Living Services in Supportive Housing Policy (ALSSH, 1994)
Community Care Access Centre (CCAC)
Community Care Access Corporations Act, 2001 (CCAC Act, 2001)
Community Support Service (CSS)
Emergency Room (ER)
Health Care Consent Act, 1996 (HCCA)
Health service provider (HSP)
Home Care and Community Services Act, 1994 (HCCSA)
Instrumental Activities of Daily Life (IADLs)
Local Health Integration Networks (LHINs)
Local Health System Integration Act, 2006 (LHSIA)
Long-term care (LTC)
Long-term care home (LTCH)
Ministry of Health and Long-Term Care (MOHLTC)
Ministry of Health Appeal and Review Boards Act, 1998 (MHARBA, 1998)
Ontario Health Insurance Plan (OHIP)
Personal Health Information Protection Act, 2004 (PHIPA)
Personal Support Worker (PSW)
Residential Tenancies Act, 2006 (RTA)
Substitute Decisions Act, 1992 (SDA)