Office of the Auditor General of Ontario

Value-for-Money Audit:

Assisted Living Services

December 2021

Ministry of Health and Ontario Health

Assisted Living Services

1.0 Summary

In 2020/21, about 23,100 vulnerable Ontarians—primarily seniors but also people with certain health conditions such as physical disabilities, acquired brain injury and HIV/AIDS—received assisted living services. Assisted living services are publicly funded health-care services that consist of home-based help, which include personal support services such as feeding and toileting; homemaking services such as meal preparation and laundry; and calls or visits to homes to check on the client's health and safety. A prominent feature of this program that makes it stand out from other community-based health services such as home care, is the potential for clients to receive 24/7 unscheduled service visits. About 63% of clients received assisted living services in an assisted living building—usually an apartment building—and about 37% received services in the community.

The Ministry of Health (Ministry) provided funding for assisted living services through Local Health Integration Networks, and effective April 1, 2021, to Ontario Health. Ontario Health is a Crown agency of the government established in June 2019 that provides an integrated, centralized point of governance, accountability and oversight for the health care system. In 2020/21, the Ministry provided around $389 million to 182 not-for-profit organizations, primarily community-based agencies, to deliver these services.

According to the Ministry, which provides policy direction on this program, assisted living services are intended for people who require a greater frequency, urgency and intensity of care than those who receive scheduled home care supports, but do not require the ongoing direct medical supervision provided in long-term care homes. Ministry policy from 2011, which is directed at seniors (the most common group receiving assisted living services), notes that the services are aimed at people who are at risk of emergency room visits or admission to long-term care, making this program an important initiative to keep Ontarians at home for as long as it is safe to do so.

Several government organizations are involved in delivering assisted living services, many of which were in the process of significant transformation during our audit:

- before April 1, 2021, the Ministry, and the Local Health Integration Networks (LHINs) (hereafter usually referred to as health regions); and
- since April 1, 2021, the Ministry, Ontario Health, and Home and Community Care Support Services (HCCSS) organizations;

These changes in delivery agent names are required because the health regions evolved into other entities on April 1, 2021. They continued to operate under a new name (HCCSS) with a narrowed mandate to deliver and arrange patient services, which include liaising with clients to determine their initial eligibility for assisted living services, where applicable. Their health system funding, planning and community engagement functions were transferred to Ontario Health, which is also responsible for managing service accountability agreements with, and overseeing the delivery of services by assisted living agencies. As well, Ontario

Health Teams, a new health care delivery model in Ontario, may also be involved in delivering assisted living services. As of August 2021, Ministry staff indicated that there was no set timeline for when Ontario Health Teams were to be operating at full capacity.

Our audit found that health regions, and Ontario Health since April 1, 2021, had little information to confirm that clients receive the quality of assisted living services sufficient to meet their needs. For example, they did not require agencies to report staff-to-client ratios, the rate that agencies accept client referrals from health regions (since April 1, 2021, HCCSS organizations), and the frequency of missed visits. Moreover, while Ontario Health holds agencies accountable for the number of clients served and the number of days services are provided to clients, only one of the 14 health regions held agencies accountable for the number of service hours provided to clients.

As well, health regions (since April 1, 2021, Ontario Health) did not know whether clients are subject to neglect or abuse by assisted living agency personnel. Health regions did not involve themselves in ensuring complaints about services were resolved satisfactorily. Half of the complaints we reviewed focused on the sufficiency of services and quality of services, such as scheduled care visits that were missed, and decreases in the quality of care.

We also found that the program has the potential to offer a cost-effective means of allowing vulnerable adults to remain in their homes, instead of being hospitalized due to care not provided as soon as it is required—since assisted living services allow for more immediate care compared to home care—or admitted prematurely to a long-term-care home. However, the Ministry has not effectively leveraged assisted living services to improve the performance of the overall health system by reducing costs or identifying opportunities to improve quality of care. For example, those that do not receive timely access to assisted living might be forced to choose long-term care, which in comparison, is a more costly public program to deliver. The Ministry has also not assessed whether there is value in combining home care and assisted living; both of these programs offer similar services to similar client groups. Moreover, the current structure does not support home-based care for vulnerable people that effectively integrates assisted-living services, as well as long-term care, home care and other services, which means clients may not receive the level of care they need when they need it. This is a key issue, because it generally costs less to provide residential assisted living compared to long-term care.

The Ministry has also not demonstrated that assisted living services have improved service recipients' quality of life. For example, only two of the 14 health regions (since April 1, 2021, Ontario Health) require their agencies to report data related to client hospitalization and long-term care admissions, and they do not present this data to the Ministry.

The following are some of our significant findings:

Centralized and Accessible Care

- **Familiarity with assisted living services is low among the public and program stakeholders.** The government has taken little action to inform the public about the assisted living program. In fact, neither the Ministry, many of the health regions, nor Ontario Health had tracked the locations of where assisted living services were provided. Ontario Health had to compile this information for us when we asked for it as part of our audit. Most of our interviews with stakeholders indicated a similar lack of familiarity with the programs offered by assisted living agencies as well as confusion regarding where they are delivered, what they consist of, and who is eligible to receive them. This general lack of information represents a significant barrier to vulnerable people finding the help they need to live safely and comfortably in their homes, and to avoid long-term care, or hospitalization.
- **Dual approach to assessing eligibility of clients is confusing and open to potential agency bias.** Depending on where they live, people who need assisted living are assessed by either a health region care co-ordinator or an assisted living agency. The Ministry has never evaluated whether this dual approach, in place since 2009, is effective

and objective. For example, centralizing this responsibility with only HCCSS care co-ordinators could be beneficial for several reasons. First, it would be less confusing for people looking to access these services, especially since certain eligible individuals may be living with dementia. Second, HCCSS care co-ordinators can also help clients access other government-funded programs, such as mental health services and home care, whereas agencies cannot. Third, when assisted living agencies determine client eligibility, there is a risk that they might apply eligibility criteria inconsistently and contrary to Ministry policy. Neither the Ministry nor Ontario Health has monitored whether agencies have admitted people with less complex care needs than suggested by the 2011 policy in order to reduce their staff's workload.

- **The Ministry and Ontario Health have not used available data to appropriately plan for assisted living services.** The Ministry has not analyzed demographics and other available information, such as wait lists, to help inform current and future investments in assisted living in relation to other health programs. We found that the province has no central wait list for assisted living services and the reporting of wait-list information was incomplete or not transparent. Only 11 of the 14 health regions (since April 1, 2021, Ontario Health) had full wait-list information while the others had allocated this responsibility partially or fully to assisted living agencies and therefore did not have ready access to such information. The wait list data we reviewed did not specify whether people were waiting for service in an assisted living building or in the broader community, and wait times are not publicly available.

Funding and Health Service Planning

- **Other related government programs relevant for many assisted living clients exist, but access to them is not co-ordinated.** Assisted living services are among a suite of services that help support independent living for seniors, and adults with physical disabilities, acquired brain injury or HIV/AIDS. The suite of services is most commonly offered by the Ministry and may also be by service agencies directly, separately through health regions (since April 1, 2021, Ontario Health) or by another ministry. We found that the Ministry has not worked with other ministries to determine whether the services provided are equitably available to all Ontarians according to their needs and don't duplicate services they already receive. As well, it has not examined the potentially significant benefits of centralizing care co-ordination with HCCSS to improve convenience and awareness for people trying to access multiple services, but also to streamline the government's delivery of services.
- **The Ministry has not assessed whether assisted living services are meeting the needs of vulnerable adults.** The Ministry introduced its policy for non-senior groups including adults with physical disabilities, an acquired brain injury or HIV/AIDs in 1994 and has not assessed whether it still meets the needs of these population groups now, 27 years later. Evaluating the performance of these assisted living programs can help drive decisions on the best model of care. For example, the Ministry has not evaluated whether people with HIV/AIDS should continue to qualify for assisted living services given medical advances in the past decades, or clarified whether assisted living services can be provided to adults with physical disabilities, an acquired brain injury or HIV/AIDS outside of designated buildings and in their homes instead. The 1994 policy makes no mention of home-based services—that is, beyond the confines of an assisted living building—and stakeholder groups have mentioned that such services are typically only available in assisted living buildings and not commonly offered in the community.

Agreements and Oversight

- **Ministry data on the number of clients receiving services have not been corroborated by health regions and Ontario Health.** Our audit identified variances, including 18% of total clients served in 2020/21, between what assisted living agencies

reported to the Ministry and other information gathering exercises that were conducted as part of our audit. These discrepancies highlight the need for greater oversight on assisted living agencies going forward to help support more meaningful discussion and analysis of assisted living services.

Complaint Process and Escalation

- **Vulnerable clients have few means of advancing complaints, with minimal protection of rights.** Assisted living agencies are responsible for addressing complaints about their own services, and little third-party oversight is provided to verify that the complaint resolution process is fair. By comparison, the Patient Ombudsman investigates complaints about long-term-care homes, the Retirement Homes Regulatory Authority investigates complaints about retirement homes, and health regions (HCCSS organizations since April 1, 2021) oversee complaints about publicly funded home care services. One stakeholder group told us that assisted living clients may be reluctant to complain directly to their attendant or agency out of fear of reprisals, given that they rely on attendants to support them in their daily living.

Agency-Operated Assisted Living Buildings

- **In many cases, agencies operate as both landlord and care provider to clients, despite the risk of abuse inherent in these arrangements.** Since 1994, it has been the Ministry's policy that service delivery should not include housing management, yet we found that there are no additional procedures to guard against the types of risks—for example charging clients for personal support services, one of the main assisted living services, which is not permitted by the *Home Care and Community Services Act, 1994*—that these arrangements present for clients. There are still more than 140 such buildings, and neither the Ministry nor many health regions (and since April 1, 2021, Ontario Health) had information on their location.

This report contains 24 recommendations, consisting of 53 action items, to address our audit findings.

Overall Conclusion

Our audit found that the Ministry of Health (Ministry), Ontario Health and the 14 Local Health Integration Networks (LHINs) did not have effective processes in place to provide cost-effective assisted living services in an equitable manner across the province. As well, the assisted living services program is not integrated within the provincial continuum of care for home-based care services. Integration would minimize confusion and improve convenience for clients if they could access all the care they are eligible for from a single source. It could also streamline the government's delivery of services, creating cost efficiencies and allowing for better insights into changing demand.

Ontario Health (which took over some of the LHINs' responsibilities on April 1, 2021) did not effectively oversee assisted living agencies to confirm they were providing services to eligible Ontarians according to applicable legislation and policies. For example, it did not collect and analyze comprehensive data—such as time spent on providing care, the rate that agencies accept client referrals from health regions (since April 1, 2021, HCCSS organizations), and the frequency of missed visits—from assisted living agencies to confirm whether they operate efficiently.

Lastly, the Ministry has not fully measured or reported on the quality and effectiveness of these services. For example, the Ministry does not analyze demographic trends of eligible client groups and wait lists to appropriately plan for assisted living services. As well, only two of the 14 health regions (since April 1, 2021, Ontario Health) require their agencies to report data related to hospitalization and long-term care admissions, and none of these health regions share this data with the Ministry.

By allowing these weaknesses to continue, we found that the Ministry is not providing Ontarians with the best value in its assisted living program. However, just as important, it is also neglecting a significant opportunity to improve the overall delivery of health care in the province because it does not fully realize the benefits of helping as many vulnerable people as possible to live safely and comfortably in their homes for as long as possible, and avoid long-term care and hospitalization.

OVERALL MINISTRY RESPONSE

The Ministry of Health (Ministry) thanks the Auditor General for the comprehensive review of Assistive Living Services (ALS). The recommendations included in this report will support improvements to strengthen accountability, improve access to quality person-centred care and contribute to our commitment to modernize home and community care.

ALS support people who require certain services at a greater frequency or intensity than home care clients, but do not require around-the-clock nursing supervision provided in long-term care homes. Governed by legislation and Ministry policies, the ALS program is intended to be responsive to a wide range of client needs in a way that supports equitable outcomes. The Ministry is committed to addressing the recommendations of the audit as part of a broader review of the ALS program to ensure that the policies are appropriately updated and provide effective support for the client populations and the health system. The Ministry will also work with Ontario Health to communicate some key initial actions to ALS providers in a timely manner.

The recommendations from this audit will be addressed in the context of the government's approved plans for health care system transformation. On April 1, 2021, the responsibility for funding and accountability of ALS transferred from the Local Health Integration Networks to Ontario Health. The transformation also includes the implementation of Ontario Health Teams (OHTs), which, at maturity, will provide a full and co-ordinated continuum of care for a defined population, including ALS. As of September 2021, there were 50 approved OHTs in the province and they are already making a difference in their communities. The Auditor General's thoughtful advice will inform the continued evolution of Ontario's connected and patient-centred health system.

OVERALL RESPONSE FROM ONTARIO HEALTH

Ontario Health appreciates the opportunity to participate in the Auditor General's comprehensive audit of Assisted Living Services. The valuable observations, insights, and recommendations presented within this report support our ongoing efforts and commitment to continuously improve Ontario's health system for the individuals and communities we serve. As a result of the introduction of Ontario Health Teams, the recommendations will be considered within the context of the changing roles and responsibilities that are occurring in the health system.

Ontario Health Teams are groups of providers and organizations that, at maturity, will be clinically and fiscally accountable for delivering a full and co-ordinated continuum of care to a defined population, while Ontario Health will be responsible for monitoring and reporting on system performance, quality and accountability.

Within this framework, Ontario Health welcomes the opportunity to work with our health system partners, including the Ministry of Health, Home and Community Care Support Services, Ontario Health Teams, Assisted Living providers, patients and families, to ensure that Assisted Living program participants are receiving the best possible care.

OVERALL RESPONSE FROM HOME AND COMMUNITY CARE SUPPORT SERVICES

Home and Community Care Support Services appreciates the Auditor General's review of the Assisted Living Program. Assisted Living Services are a critical part of the health care continuum and important system partners for Home and Community Care Support Services. As part of the broader health care transformation and home care modernization work that the Ministry of Health (Ministry) is undertaking, Home and Community Care Support Services would support a broad review of the Assisted Living program to ensure better integration of the program with other community services, and that the program continues to meet the needs of Ontarians.

As identified in the Auditor General's report, 11 of the 14 Home and Community Care Support Services are responsible for determining eligibility for Assisted Living services within their geographic areas. With appropriate resources, the role of Home and Community Care Support Services could be expanded across the province to support the integration of home care and assisted living services, and help bring consistency to the management of the assisted living program, including how assessments are conducted, eligibility is determined, and wait list data is collected and administered.

Home and Community Care Support Services looks forward to working with the Ministry, Ontario Health, Ontario Health Teams and Assisted Living providers in addressing the recommendations in the report.

2.0 Background

2.1 Clients of Assisted Living Services

In 2020/21, about 23,100 individuals received assisted living services in their homes; these services were provided by 182 agencies that are primarily community-based, not-for-profit assisted living agencies, but also include some municipalities and hospitals (shown in **Appendix 1**). These services are targeted toward certain vulnerable population groups in accordance with Ministry policies, specifically high-risk seniors (that is, those who are at high risk of hospitalization or admission to long-term care), as well as adults with physical disabilities, Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), or with an acquired brain injury. An acquired brain injury is an injury to the brain that is not related to damage that occurred during the birthing process, a congenital disorder or a degenerative disorder.

As shown in **Figure 1**, in the past five years between 2016/17 and 2020/21, the most common assisted living clients were seniors, at 83% of the total clients served, followed by adults with physical disabilities, at 13%. Adults with HIV/AIDS and adults with an acquired brain injury made up about 2% each of all clients served over that period.

2.2 Key Players Involved in Planning, Funding, Delivering and Overseeing Services

Several organizations are involved in planning, funding and delivering assisted living services. These have evolved from before 2007 to now, as shown in **Appendix 2.** At the time of the completion of the audit, the Ministry of Health (Ministry), Ontario Health and 14 Home and Community Care Support Services (HCCSS) organizations shared responsibility for the assisted living services program, described in more detail in **Figure 2.**

As we were completing the audit, the Ministry had finalized its accountability agreement with Ontario Health in October 2021 and began working toward revising its accountability agreement with HCCSS in November 2021. These agreements define roles and responsibilities going forward under the new health system planning, oversight and delivery

Figure 1: Number of Assisted Living Services Clients Served, by Target Population Groups, 2016/17–2020/21

Source of data: Ministry of Health

Target Population Groups[1]	2016/17	2017/18	2018/19	2019/20	2020/21	% of Total over 5 Years
High-risk seniors (2011 Policy)	5,426	5,131	5,276	5,712	5,286	23
Frail and/or elderly seniors	13,159	13,065	14,335	11,960	12,915	56
Seniors with cognitive impairment	1,158	1,408	1,151	926	766	5
Total Seniors[2]	**19,743**	**19,604**	**20,762**	**18,598**	**18,967**	**83**
Adults with physical disabilities	2,863	3,088	3,369	3,397	3,075	13
Adults with HIV/AIDS	368	331	343	338	711[3]	2
Adults with acquired brain injury	343	366	367	378	363	2
Total	**23,317**	**23,389**	**24,841**	**22,711**	**23,116**	**100**

1. Data reported by assisted living agencies directly to the Ministry of Health. Only high-risk seniors data is linked to a specific Ministry policy (i.e., *Assisted Living Services for High Risk Seniors Policy, 2011*). The other line items of clients do not include a reference to any policy document.
2. The vast majority of the clients reported here are seniors as indicated by the client group name used by the Ministry; in a small number of cases, these totals may include individuals who are under 65 years of age.
3. The majority of the increase was attributable to one agency that received additional funding in 2020/21; that agency served 343 more clients in 2020/21 than the year prior.

framework. The key responsibilities of the Ministry and Ontario Health as outlined in the accountability agreement are described in **Appendix 3.**

Going forward, Ontario Health Teams are expected to be the primary means of delivering most health services,including assisted living. As of August 2021, Ministry staff informed us that there was no set timeline for when Ontario Health Teams were to be operating at full capacity.

2.3 Services Offered by Assisted Living Agencies

Assisted living services support people who require home-based help. Specifically, this includes personal support services (that is, assistance with personal hygiene and activities of daily living, which include essential and routine tasks, including eating, getting dressed, and toileting) and homemaking (that is, vacuuming, meal preparation, laundry) at a greater frequency, urgency and intensity compared to scheduled home care visits, but who do not require ongoing direct medical supervision such as is provided in long-term care homes. Assisted living services also include security checks (where someone visits the home to check on the client), reassurance services (where someone calls to check on the client's health and safety), and 24/7 unscheduled service visits (where someone can respond when the client needs immediate support and cannot wait for a scheduled visit). Because assisted living agencies do not provide professional services such as nursing, Ministry policy directs clients to obtain these services from home care agencies (agencies that health regions, or HCCSS organizations since April 1, 2021, have contracted with to provide care services including professional services) when needed. In contrast, home care services include personal support services, homemaking and professional services. **Appendix 4** contrasts assisted living with home care.

In Ontario, assisted living is part of a continuum of care for individuals who require support in the community to remain more independent, as shown in **Figure 3.** Other provinces offer similar services to their residents. **Appendix 5** shows the comparison of key aspects of assisted living services, such as eligibility and oversight, between Ontario and selected provinces that provide comparable services.

Appendix 6 shows how assisted living services have helped some individuals remain in the community and with family.

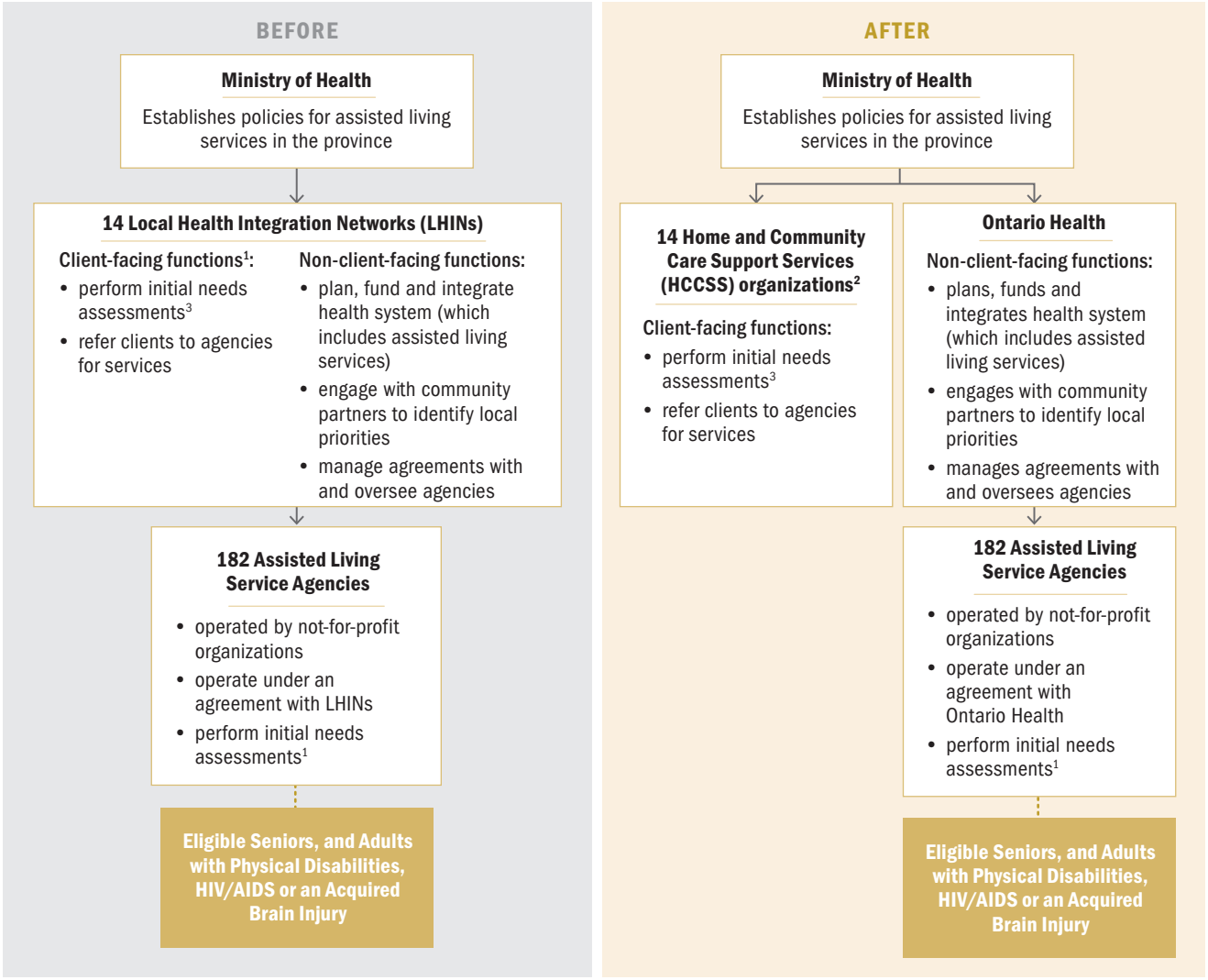
2.3.1 Assisted Living Service Agencies and Programs

A total of 182 assisted living service agencies, each reporting to a board of directors, collectively provide about 500 assisted living programs either in an assisted living building or in the community. Some agencies run a combination of building-based and community-based programs and some only provide services in one or the other, as shown in **Appendix 7.**

As shown in **Figure 4**, in 2020/21, 63% of clients received assisted living services in a standalone assisted living building. Some 37% of clients received services in the community, including the clients' rented or owned place of residence—which might be either within a community near a "hub" (that

Figure 2: Planning, Funding and Delivering Assisted Living Services in Ontario, Before and After April 1, 2021

Prepared by the Office of the Auditor General of Ontario



1. LHINs expanded their role to include client-facing functions in spring 2017 when Community Care Access Centres were transferred to them.
2. New business name for the 14 LHINs.
3. The determination of eligibility for assisted living services may be conducted by HCCSS or an assisted living agency, or both, based on local practices that have remained since 2009. See discussion in **Section 4.1.2.**

Figure 3: Continuum of Care—Home Care, Assisted Living Services and Long-Term Care as Presented in the Most Recent (2011) Ministry of Health Policy on Assisted Living Services

Source of data: Ministry of Health

LOW → VERY HIGH

Home with Support (Home Care)	Assisted Living Services for High-Risk Seniors	Home Care Unlimited Support	Long-Term-Care Home
Scheduled Care: • Home visits • Prompts with instrumental activities of daily living* (IADLs) • Professional services • Social support • Medication support • Episodic acute care	**Scheduled and Unscheduled Care:** • 'Just-in-time' support for urgent personal care • Essential homemaking • Social support • IADL provision • Medication prompting • Relationship with professional services for chronic conditions	Persons on a long-term care wait list receive home care personal support and homemaking services at a level that exceeds the standard service maximums	• Nursing care • 24/7 supervision • Hands-on support with IADLs • Medication management

Note: Low to Very High applies to a) frequency of services and b) urgency and intensity of services.

* Activities of daily living include personal hygiene, toilet use, locomotion and eating.

Figure 4: Assisted Living Services Clients, by Location of Service Delivery, 2020/21

Source of data: Ontario Health

	In Assisted Living Building		In Community		
Target Population Group	#	% of Total	#	% of Total	# Total
High-risk seniors (2011 Policy)[1]	3,150	51	2,992	49	6,142
Frail and/or elderly seniors and seniors with cognitive impairment	1,505	87	224	13	1,729
Seniors (mix of the two categories above)	2,929	67	1,436	33	4,365
Total Seniors	**7,584**	**62**	**4,652**	**38**	**12,236**
Adults with physical disabilities[2]	1,152	68	535	32	1,687
Adults with HIV/AIDS[2]	442	92	37	8	479
Adults with acquired brain injury[2]	234	75	77	25	311
Mix (population group not specified; may contain any of the above)	2,512	60	1,656	40	4,168
Total	**11,924**	**63**	**6,957**	**37**	**18,881[3]**

1. The *Assisted Living Services for High Risk Seniors Policy, 2011* (2011 Policy) specifies eligibility for seniors who are at high risk of hospitalization or long-term care admission (now referred to as high-risk seniors) who fit the profiles as shown in **Figure 6.**
2. The *Long-Term Care Supportive Housing Policy* dated December 1994 (1994 Policy) states that the client must be at least 16 years old, have a specific health condition (i.e., physical disability, brain injury, or Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) and require personal support and homemaking services on an ongoing basis.
3. Data was obtained from the 14 health regions, which were transitioned to five consolidated regions under Ontario Health effective April 1, 2021. Health regions contacted the service agencies on our behalf to obtain this information. This data-gathering exercise resulted in lower numbers than the amount reported by agencies to the Ministry of Health. This is discussed further in **Section 4.4.3.**

is, a central assisted living building) or not. (Ontario Health does not, and before that health regions did not, break down this information.)

Assisted living services are delivered in over 140 assisted living buildings, which are often apartment buildings where the agency owns or operates the assisted living building; the clients not only receive assisted living services from the agency, but may also pay rent to the agency, the clients' landlord. **Appendix 8** shows a list of these buildings.

Each assisted living agency has a service accountability agreement with the health region (since April 1, 2021, Ontario Health) that funds it based on a template agreement set originally by the health regions; regions have the discretion to determine the term of the agreement which is usually three years in duration. The agreement outlines the terms and conditions that third-party agencies must comply with in delivering health services to their clients. The health regions could make changes to services at their discretion; the agreements included schedules that are updated annually to specify annual funding and performance targets, as well as an acceptable range of results for those targets that each agency negotiates with the health region. The agreement also outlines performance indicators, which vary between the health regions, but usually consist of the number of clients served and number of days these clients received services. The targets also vary between the health regions.

These agreements were transferred from each of the 14 LHINs to Ontario Health on April 1, 2021. The agreements' terms are for multiple years; currently, all agreements have been amended to end on March 31, 2022. Ontario Health informed us that it does not expect any new agreements to be created to formalize the reporting relationship between itself and the agencies.

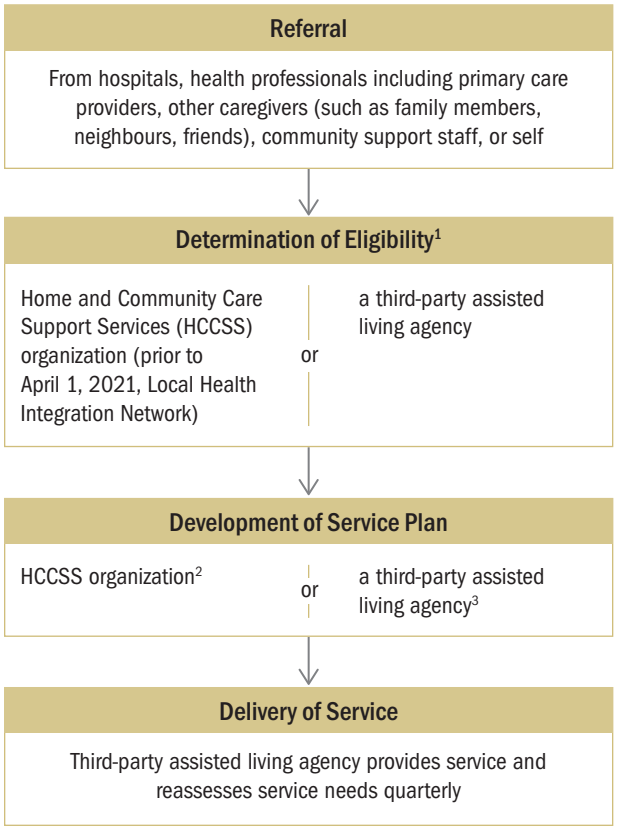
Appendix 9 shows a sample of assisted living agencies and the services they offer.

2.3.2 Access to Services and Service Eligibility

Figure 5 shows the pathway for an individual to obtain assisted living services. Unlike home care services where the initial client intake is always done at the health region (as of April 2021, the HCCSS organization), some health regions have allowed agencies to conduct these initial intake assessments primarily because of local practices that have remained since 2009. For 234 (46%) of the 507 assisted living

Figure 5: Process of How Individuals Obtain Assisted Living Services in Ontario

Prepared by the Office of the Auditor General of Ontario



1. The responsible party differs from one health region to another, and sometimes within same health region, based on local practices that have remained since 2009 and as permitted by the *Home Care and Community Services Act, 1994*.
2. Where HCCSS organizations determine eligibility, some HCCSS organizations provide a high-level service plan, but that does not include hours, times or frequency of service.
3. Where assisted living agency determines eligibility, it develops a service plan that sets out the amount of service the eligible individual is expected to receive.

programs delivered, initial eligibility is determined by care co-ordinators who work out of the 14 HCCSS organizations; care co-ordinators may refer clients to home care, assisted living services or to long-term care. For the remaining 273 (54%) assisted living programs, the service agencies assess eligibility with little or no HCCSS involvement.

Ministry policy states that whichever organization determines eligibility also determines the service plan, which includes the amount of services a client will receive based on their assessed needs.

The Ministry developed two policies that set out the eligibility criteria for services and the expectations of how these services would be delivered to clients, one from 2011 that is aimed at high-risk seniors and the other that dates back to 1994, for adults with physical disabilities, an acquired brain injury or HIV/AIDS; see **Appendix 10** for more information on these two policies. **Appendix 11** outlines key sections of the more recent, 2011 policy.

The HCCSS organizations and assisted living agencies use a common eligibility instrument to help ensure that decisions on who receives what services are consistent and based on key aspects of a person's conditions. The tool used is called the International Resident Assessment Instrument or interRAI. **Figure 6** shows the characteristics and assessment instrument scores an individual must meet to be considered a "high-risk senior" eligible for assisted living services under the 2011 policy.

2.3.3 Complaint Appeals to the Health Services Appeal and Review Board

Clients (or their families) who are not satisfied with how their assisted living agency resolved their complaints, specifically those about determination of their eligibility for services, the exclusion of a service from their service plan, the amount of service in their service plan, or the termination of a service, can

Figure 6: Profiles of High-Risk Seniors per the *Assisted Living Services for High-Risk Seniors Policy, 2011*

Source of data: Ministry of Health

Profile[1]	Description	interRAI Assessment Instrument[2] Outcomes
1.	The applicant has an informal caregiver (i.e., likely a family member) who is able to provide required support and has a combination of needs, such as needing assistance with dressing, hygiene, difficulty with decision-making, has a history of falls and/or difficulty managing medication.	MAPLe[3] Score of 4 or 5
2.	The applicant does not have an informal caregiver or has an informal caregiver who is unable to provide the required support. The applicant is cognitively sound, has little-to-no difficulty with short-term memory, cognitive skills for daily decision-making, or making oneself understood, and/or has difficulty eating. The applicant also may need assistance with preparing meals and ordinary housework.	Cognitive Performance Scale[4] of 0 or 1 and Instrumental Activities of Daily Living Capacity Hierarchy[5] Scale of 5 or 6
3.	The applicant does not have an informal caregiver or has an informal caregiver who is unable to provide the required support. The applicant has mild to moderate cognitive impairment and the applicant is assessed as being occasionally incontinent.	Cognitive Performance Scale of 2+ and not more than "occasionally incontinent"

1. An individual must meet one of the three profile descriptions to qualify for assisted living services.
2. Evaluates the needs, strengths and preferences of persons in home and community care settings; focuses on the person's functioning and quality of life; and facilitates referrals to appropriate health services.
3. MAPLe—Method for Assigning Priority Levels—is a decision-support tool that can be used to prioritize those needing community- or building-based services and to help plan resource allocations. It assigns one of five priority levels to the assessed individual based on information from the interRAI assessment, with higher scores indicating higher probability of requiring residential care.
4. Rates a person's cognitive status on a scale of 0 to 6, with higher scores indicating more severe impairment.
5. Measures a person's capacity to complete tasks (e.g., meal preparation, ordinary housework and managing medications) on a scale of 0 to 6, with higher scores indicating less capacity in performing activities of daily living including personal hygiene, toilet use, locomotion and eating.

appeal to the Health Services Appeal and Review Board as long as the complaint does not centre on the quality of services. The Board is an independent tribunal and is referred to under various legislation that relates to health care, including the *Home Care and Community Services Act, 1994* as well as the *Ambulance Act* and the *Health Protection and Promotion Act*. Clients and their families could also report any concerns about potential abuse or neglect to police.

2.4 Financial and Service Data Reporting

In 2020/21, the Ministry provided almost $389 million ($343 million in 2019/20) to third-party assisted living agencies through the health regions; this was up 24% from $313 million in 2016/17. As shown in **Figure 7**, the annual increase in 2020/21 surpassed the average annual increase in prior years partly because of the impact of the COVID-19 pandemic. On a cost per client basis, assisted living is about double the cost of "long-stay" home care (where clients typically receive services for longer than one year) and about one-fifth of the cost of long-term care, as shown in **Figure 8.**

On average, each agency spent about $17,400 on each assisted living client in 2020/21, as shown in **Figure 8**; this cost ranged from $1,151 to $228,393 as shown in **Appendix 1.** Costs may vary due to different levels of service, client needs, capacity of the agency and the geography where services are provided.

Figure 7: Transfer Payments from Local Health Integration Networks to Assisted Living Services and Other Programs Aimed at Those Who Require Personal Support and Homemaking Services, 2016/17–2020/21 ($ 000)

Source of data: Public Accounts of Ontario

	2016/17	2017/18	2018/19	2019/20	Avg Annual % Change 2016/17–2019/20	2020/21	% Change 2019/20–2020/21[1]
Assisted living services	312,961	323,080	337,644	343,301	3	388,572[2]	13
Home care	2,736,514	2,611,545	2,780,291	2,878,836	2	3,080,825	7
Long-term-care homes	3,687,241	3,781,585	3,929,078	4,023,425	3	5,939,893[3]	48

1. The increases in funding between 2019/20 and 2020/21 are primarily due to expenses related to the COVID-19 pandemic.
2. Includes about $38 million of funding related to the COVID-19 pandemic and increased funding to service agencies, which in turn had more capacity to serve clients.
3. Includes former LHIN funding and Ministry-managed funding.

Figure 8: Average Annual Cost per Individual of Assisted Living Services, Home Care and Long-Term Care, 2016/17–2020/21 ($)

Source of data: Ministry of Health

	2016/17	2017/18	2018/19	2019/20	2020/21[1]
Assisted Living Services	10,499	14,592[2,3]	14,221[2]	15,768[2]	17,400[2]
Home Care (Long-Stay Only)[4]	7,359	7,564	7,743	8,059	8,849
Long-Term Care	73,291	72,673	75,469	76,832	88,028

1. The increases in funding between 2019/20 and 2020/21 are primarily due to expenses related to the COVID-19 pandemic and partly due to increased funding to service agencies, which in turn had more capacity to serve clients.
2. Includes funding and clients provided under the short-term transition care program, as explained in **Appendix 1.**
3. The increase is primarily due to across-the-board funding to all 14 Local Health Integration Networks (LHINs), ranging from 1% to 8% depending on the LHIN, which was used to increase client services.
4. Home care can be categorized into either short-stay or long-stay. Short-stay clients are typically those whose needs are acute or are related to wound, rehab or oncology. Long-stay clients typically receive services for longer than one year.

As shown in **Figure 9**, based on data that agencies reported to the Ministry, across the 14 health regions, the average agency cost per client ranged from $7,987 in Waterloo Wellington to $42,495 in South East, where clients received on average 18 hours and 93 hours of services a month, respectively. As well, average cost per service hour ranged from $35 in North East to $67 in North Simcoe Muskoka.

As required by the service accountability agreements with the health regions (responsibility for agreements has since been transferred to Ontario Health), assisted living agencies report detailed financial and patient care data to the Ministry's Health Data Branch three times a year. Examples of the type of information submitted are the number of clients admitted and waiting for service. Health regions (since April 1, 2021, Ontario Health) can access this data. **Figure 10** shows a sample of the key service data that agencies reported over the last three years. Service demand and level have generally remained constant over the years, while the number of new clients admitted has decreased.

Agencies also report certain measures to health regions (since April 1, 2021, Ontario Health) three times a year, as required in the Ministry policy and their service accountability agreements; these measures vary between health regions. The most common of these are the number of different clients served during a year and the number of "resident days," which is the number of days where the assisted living agencies provided service to a client. If assisted living service agencies do not achieve these minimum performance levels of service, Ontario Health will discuss with the agency staff how to address the deficiencies.

Figure 9: Cost per Client Served and Monthly Service Hours, by Health Region, 2020/21

Source of data: Ministry of Health

Health Region	Total # of Clients Served	Cost[1] per Client ($)			Avg Service Hours per Client per Month	Avg Cost per Service Hour ($)
		Minimum	Maximum	Average		
Central	2,150	7,725	91,354	22,431	47	39
Central East	2,668	4,382	87,355	10,550	24	37
Central West	404	8,367	76,162	12,541	19	54
Champlain	1,180	2,446	70,815	20,895	41	43
Erie St. Clair	370	13,524	53,587	37,210	84	37
Hamilton Niagara Haldimand Brant	2,252	6,109	75,407	25,477	54	39
Mississauga Halton	3,552	4,490	70,467	13,414	27	42
North East	2,202	3,928	59,231	12,996	31	35
North Simcoe Muskoka	456	8,786	40,554	23,586	30	67[2]
North West	1,197	952	38,595	13,966	31	38
South East	247	17,157	206,075	42,495	93	38
South West	849	10,277	173,084	41,153	92	37
Toronto Central	3,967	2,251	103,791	15,842	27	50
Waterloo Wellington	1,622	912	55,975	7,987	18	38
Province	23,116	912	206,075	17,400[3]	36[3]	41

1. Based on costs spent on serving assisted living clients as reported by assisted living agencies, funded by revenue from the Ministry of Health and other sources, such as from fundraising.
2. The health region was unable to explain this anomaly (i.e., highest cost per hour of all health regions) when we completed our audit.
3. We observed ranges of similar magnitude in 2019/20.

Figure 10: Select Service Data Reported by Assisted Living Agencies in 14 Health Regions, 2018/19–2020/21

Source of data: Ministry of Health

Health Region	# of individuals referred to receive assisted living services[1]			# of clients waiting for service initiation[2]			# of clients admitted[3]			# of clients served[4]			# of resident days[5]		
	2018/19	2019/20	2020/21	2018/19	2019/20	2020/21	2018/19	2019/20	2020/21	2018/19	2019/20	2020/21	2018/19	2019/20	2020/21
Central	20	88	43	1,678	1,067	1,055	463	579	260	2,426	2,453	2,150	699,028	689,947	634,790
Central East	320	582	488	1,321	1,423	1,364	757	894	635	3,691	3,051	2,668	619,648	755,694	713,800
Central West	0	0	0	144	49	99	237	140	119	495	363	404	79,350	66,508	77,176
Champlain	104	157	35	528	691	707	453	353	220	1,992	1,413	1,180	301,621	300,799	263,247
Erie St. Clair	0	0	3	204	518	531	84	73	118	324	364	370	88,214	89,228	89,333
Hamilton Niagara Haldimand Brant	17	8	4	387	143	242	1,677[6]	147	69	2,618	2,877	2,252	512,628	520,493	511,193
Mississauga Halton	145	92	102	478	628	505	651	702	399	2,632	2,797	3,552	568,482	545,295	532,076
North East	30	130	127	527	852	426	469	222	234	1,750	1,467	2,202	330,199	321,457	307,013
North Simcoe Muskoka	11	9	3	463	483	449	93	38	31	677	573	456	148,907	134,973	119,606
North West	0	0	0	502	543	611	143	171	102	1,034	1,297	1,197	260,940	259,152	250,751
South East	4	2	1	214	237	237	65	38	36	304	284	247	82,848	81,252	71,657
South West	89	153	124	139	159	116	133	136	136	849	877	849	213,319	224,282	220,893
Toronto Central	415	436	252	809	770	792	6,420[6]	445	284	5,047	3,793	3,967	1,076,309	931,327	1,040,814
Waterloo Wellington	874	866	2	61	34	0	12	15	12	1,002	1,102	1,622	47,903	78,880	74,342
Total	**2,029**	**2,523**	**1,184**	**7,455**	**7,597**	**7,134**	**11,657**	**3,953**	**2,655**	**24,841**	**22,711**	**23,116**	**5,029,396**	**4,999,287**	**4,906,691**

1. Number of adults and seniors who were newly referred to assisted living services during the year.
2. Number of individuals accepted to receive assisted living services and were waiting for service as of March 31 of the year.
3. Number of individuals who have had their assessment for assisted living services completed and received their first service during the year.
4. Number of individuals served by the agency in the year. Individuals are counted only once in the year, regardless of how many different services they have received or the number of times they were admitted and discharged within the year.
5. Number of days where the assisted living agency provided service to a client.
6. The health region was unable to explain this data anomaly and indicated that its data was different from the Ministry's.

2.5 Legal and Governance Framework

Assisted living services are delivered as community services under the *Home Care and Community Services Act, 1994*. The repeal of this Act will come into force upon proclamation of the *Connecting People to Home and Community Care Act, 2020*, which the Ministry expected will occur by the end of 2021/22.

The *Home Care and Community Services Act, 1994*:

- defines the different groups of community services that comprise home and community care and the specific services within each group;
- establishes a patient's bill of rights (see **Appendix 12**) for persons receiving community services, which service providers must fully respect and promote;
- sets out the Minister of Health's authority to approve and fund agencies to provide community services and to set terms and conditions on those approvals and funding;
- sets out care co-ordination requirements, including that the agency approved to provide community services must assess the person's needs, determine their eligibility for service, develop a plan of service provided and co-ordinate planned services, place the person on a wait list if required, and reassess needs and revise the plan of service as the person's circumstances require;
- requires approved agencies to establish a process for reviewing and responding to complaints;
- establishes a patient's right to appeal the approved agency's decisions about the patient's eligibility for a community service, the amount of service, the exclusion of a service from the person's plan of service, or the termination of service; and
- requires approved agencies to develop and implement a quality management system for monitoring, evaluating and improving the services provided.

On April 1, 2021, the government transferred some of the responsibilities, including oversight of assisted living services, from the health regions to Ontario Health, and the LHINs began operating under a new business name of HCCSS with a narrower scope of responsibility (i.e., primarily home care and long-term care home placement services, as well as determining eligibility for some assisted living services). We discussed this in **Section 2.2.**

In February 2019, the Ministry introduced Ontario Health Teams as part of a developing initiative intended to create a "connected health care system in the province." The Teams are to consist of health care organizations such as hospitals, primary care, long-term care homes and home and community care service agencies. As of September 2021, 50 Ontario Health Teams were formed; they were at early stages of development but were not yet operating at full capacity. These included about 70 assisted living agencies that had joined an Ontario Health Team. The Ministry has indicated that once Ontario Health Teams are fully established, they will have shared accountability for health services delivery. The Teams are intended to integrate care and funding; connect patients and families in the community to health-care agencies and services by understanding patients' health-care history; connect patients to the different types of care they need; and help patients navigate the health care system. As of August 1, 2021, Ministry staff indicated there was no set timeline for when Ontario Health Teams were to be operating at full capacity, due partly to the impact of the COVID-19 pandemic.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health (Ministry), and Ontario Health, including the legacy Local Health Integration Networks, have effective processes in place to:

- plan for assisted living services, as a cost-effective component of the continuum of care, in an equitable and integrated manner across the province;
- oversee assisted living services health service agencies in providing such services to eligible Ontarians in accordance with applicable legislation and policies; and
- measure and report on the quality and effectiveness of these services.

In planning for our work, we identified the audit criteria (see **Appendix 13**) we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Ministry and Ontario Health reviewed and agreed with the suitability of our objective and associated criteria.

We conducted our audit between January 2021 and October 2021. We obtained written representation from Ministry and Ontario Health management that, effective November 19, 2021 they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

In conducting our work, we reviewed applicable legislation, agreements, reports, program guidelines and policies. We examined documents, analyzed data, reviewed information technology controls and assessed risks, and collected assisted living service data through two surveys and interviewed staff from the 14 Local Health Integration Networks (responsibilities now divided between Ontario Health and 14 Home and Community Care Support Services [HCCSS] organizations). The surveys have provided us with more specific data on assisted living services across Ontario, including how involved the health regions (since April 1, 2021, Ontario Health) were in providing oversight of the services and where the services were provided, including whether in central congregate living settings or in the broader community. We also obtained and assessed eligibility scoring data, wait-list information and home care service information for assisted living clients in data from Ontario Health's Client Health and Related Information System for the 11 health regions (since April 1, 2021, HCCSS) in the province that are responsible for determining client eligibility.

At seven assisted living agencies, we interviewed senior and care staff to better understand how they provide assisted living services, reviewed a sample of patient records to determine the amount and type of care provided and how this relates to their accountability agreements with the health region, and attended live virtual tours of a sample of their service locations. We selected these agencies from four health regions (Central, Mississauga Halton, North Simcoe Muskoka and Toronto Central) since their combined assisted living expenditures in 2020/21 was about 46% of the overall Ministry expenditures in this area. Within these health regions, we selected agencies to reflect a range of urban and rural settings and service delivery models including agencies that own or operate buildings and agencies that provide services outside such buildings in people's homes, and a range of sizes, from smaller dollar annual funding to larger and multi-location assisted living buildings.

We also reviewed the publicly available information for agency-operated assisted living buildings to identify those that indicated they charged clients for services. As well, we posed as the family of potential clients looking for placement in residential assisted living services, and contacted a sample of five agencies by phone to inquire about their charges and services. We were unable to reach two agencies because they did not answer their phones when we called, and obtained information from the remaining three agencies.

Additional work we did is listed in **Appendix 14**.

We conducted our work and reported on the results of our examination in accordance with the applicable Canadian Standards on Assurance Engagements—Direct Engagements issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies the Canadian Standard on Quality Control and, as a result, maintains a comprehensive quality-control system that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional

competence and due care, confidentiality and professional behaviour.

4.0 Detailed Audit Observations

4.1 Centralized and Accessible Care

4.1.1 Ontarians and Public Sector Partners Are Not Well Informed about Assisted Living Services

Our audit found that the government has not taken enough action to increase public awareness of the assisted living program. In fact, neither the Ministry, many of the health regions, nor Ontario Health tracked the locations of where assisted living services were provided. Even the agreements between the assisted living agencies and the health regions (since April 1, 2021, Ontario Health) did not indicate where services were to be delivered. The health regions and the Ministry had to compile this information for us when we asked for it as part of our audit.

This general lack of information represents a significant barrier to vulnerable people in finding the help they need to live safely and comfortably in their homes, and to avoid long-term care or hospitalization. Another less common but serious potential outcome that can be averted is homelessness—one of the assisted living agencies that we engaged with specialized in providing services to those who were at risk of becoming homeless.

At the time of our audit field work, we found the Ministry had taken little action to communicate pertinent information on its assisted living program to the public or other parts of government since it last updated the program 10 years ago. The two most recent Ministry reports, compiled by experts and aimed at improving home and community care (*Thriving at Home: A Levels of Care Framework to Improve the Quality and Consistency of Home and Community Care for Ontarians* from June 2017 and *Bringing Care Home* from March 2015) did not reference assisted living services.

Most of the stakeholder groups we spoke to showed a similar a lack of familiarity with the programs offered by assisted living agencies as well as confusion regarding where they are delivered, what they consist of, how many spaces are available, wait times, application processes and who is eligible to receive them. Responses to our survey of personal support workers also reflected confusion about the assisted living services program—some confused the program with long-term care. As well, according to data that assisted living agencies reported to the Ministry, the number of new referrals to the program averaged 85 per region in 2020/21 and 180 per region in 2019/20, but in both years, for about half of the health regions, there were fewer than 10 people and in some cases no one referred to receive assisted living services.

Further contributing to confusion about the program, some retirement homes refer to themselves as providing "assisted living" or offering "assisted living services," since the term assisted living is not a protected term; however, the government does not fund the care services that retirement homes offer to their residents. Contributing yet more to this confusion is the number of name changes amongst organizations that deliver the government's home and community care program, which includes assisted living—most notably, Community Care Access Centres were transferred to the LHINs in 2017, and more recently, the LHINs were renamed HCCSS organizations. Such changes in names can make it more difficult for Ontarians to know what organization to turn to when they require care services.

When we began our field work in early 2021, we found that both the health regions and the Ministry had minimal information on the program displayed on their websites. However, with the transition of the health regions to HCCSS organizations on April 1, 2021, this situation improved as we found more information across these organizations about how assisted living services can help those who need other services that the home care program does not provide, such as more frequent care and unscheduled visits. However, we found that the information

published was not always consistent or complete. Specifically,

- Ontario Health and HCCSS organization websites do not specify the locations or areas where assisted living services are delivered, or include links to assisted living agency sites. Also, the information they provide on home care services does not specifically communicate that some home care clients may be eligible for assisted living services as well.
- The Ministry of Health's website has useful information on home care services and mental health services, but still does not have easily locatable information on assisted living, such as a basic program description or links to direct the public to HCCSS organization websites.

Other public sector partners also have little information on assisted living. For example, when we asked for information that Public Health Ontario maintains on assisted living buildings, such as any significant incidents of public health that have occurred there, the agency informed us that although it receives a list of the names and addresses of long-term-care homes in Ontario from the Ministry of Long-Term Care to identify outbreaks in that setting, a similar list is not available to help identify assisted living buildings, further described in **Section 4.6.3.**

RECOMMENDATION 1

To make the availability of assisted living services more transparent to the public and other public sector partners, we recommend that the Ministry of Health publish a basic program description of assisted living services on its website, including who is eligible for this service, and provide links to direct the public to Home and Community Care Support Services organization websites.

MINISTRY RESPONSE

The Ministry accepts this recommendation and is committed to improving information available on its website and will be making the necessary updates to information on assisted living services, including eligibility criteria and links to the Home and Community Care Support Services websites.

The Ministry will also work with Ontario Health to issue a communication to assisted living health service providers to ensure they are informed of the services for which their clients may be eligible.

RECOMMENDATION 2

To build on the progress made during our audit and to further improve the public's and other public sector partners' understanding of the assisted living services program, we recommend that Home and Community Care Support Services organizations:

- maintain and update their listings of where assisted living services are provided; and
- publish information on their websites that shows where assisted living services are offered, and include links to the assisted living agency websites.

HOME AND COMMUNITY CARE SUPPORT SERVICES RESPONSE

Home and Community Care Support Services recognize the importance of accurate up-to-date information being available so that Ontarians are aware of the services that are available to them. To ensure a comprehensive list of assisted living services is publicly accessible, Home and Community Care Support Services commit to maintaining and updating their regional databases of assisted living services. The listings will be publicly accessible through their websites (healthcareathome.ca) and on the provincial health services directory (thehealthline.ca). Each record will provide a description of offered services, and where available include links to the agency's website.

4.1.2 Multiple Parties Involved in Assessing Initial Eligibility for Services, Leading to Inconsistent Care Decisions That Could be Subject to Bias

Care Co-ordinators Can Maintain Objectivity in Assessing Initial Eligibility, but Often are not Involved in these Assessments

The current process for assessing vulnerable individuals' eligibility for assisted living services at home is not well integrated across the continuum of care, that is in conjunction with long-term care, home care or other needed services. This is a key issue, especially because it generally costs less to provide residential assisted living compared to long-term care.

Depending on where they live, people who need assisted living services are assessed by either a health region (since April 1, 2021, HCCSS) care co-ordinator or an assisted living agency. The Ministry has never evaluated the effectiveness of this dual approach, in place since 2009, to determine whether it is effective and objective. This varied pathway to obtaining service can be confusing to the public, and especially for those clients who may be living with dementia. Our research found that better practices were followed in other Canadian jurisdictions where initial eligibility assessments are conducted by a single party other than assisted living agencies, such as ministries or provincial or regional health system agencies.

In 2009, the Ministry gave the then Community Care Access Centres (CCACs) the option of taking on the role of assessing client eligibility for services or allowed this function to remain with the assisted living agencies. The CCACs eventually were integrated with the health regions, and the dual approach to assessing clients persisted. If the CCACs did not take the role of assessing client eligibility, then assisted living agencies continued the requirement to do so. The Ministry explained that it did not merge home care and assisted living services at that time because they have different staffing models—home care is typically scheduled or shift-based whereas assisted living is not. As a result, assisted living agencies continued to perform eligibility assessments.

For 234 (46%) of the 507 assisted living programs, initial eligibility for assisted living services is determined by HCCSS care co-ordinators; care co-ordinators may refer clients to home care, assisted living services or long-term care. For the remaining 273 (54%) assisted living programs, the agencies are responsible for assessing eligibility with little or no HCCSS involvement.

Centralizing eligibility assessments with only HCCSS care co-ordinators could be beneficial for several reasons. First, it would be less confusing to people looking to access assisted living services, especially since certain eligible individuals may be living with dementia. Second, HCCSS care co-ordinators can also help clients access other government-funded programs, such as mental health services and home care, whereas agencies cannot. Third, when assisted living agencies determine client eligibility, there is a risk that they might apply eligibility criteria inconsistently and contrary to Ministry policy.

Our survey of the health regions (since April 1, 2021, Ontario Health) showed that 164 or 59% of the 278 programs that serve seniors admit clients under the less prescriptive 1994 policy, which we confirmed by our work at the agencies we engaged with. For example, one agency explained that it did not have adequate resources to provide services for seniors with more intensive care needs. Of these 164 programs that served seniors under the 1994 policy, assisted living agencies were responsible for determining initial client eligibility for 80 or 50% of the programs.

RECOMMENDATION 3

To improve objectivity and consistency in assessing client eligibility for assisted living services according to Ministry policy, we recommend that the Ministry of Health transfer the responsibility of performing initial eligibility assessments from assisted living agencies to Home and Community Care Support Services organizations only or merge

home care and assisted living services to help provide more integrated care.

MINISTRY RESPONSE

The Ministry acknowledges the importance of ensuring the integration of home and community care services and is committed to exploring the feasibility of this recommendation.

The government has announced its intent to modernize home and community care, including by transferring, in a staged manner, the responsibility for providing home care—including for assessing needs and determining eligibility for home care services—from Home and Community Care Support Services to health service providers and Ontario Health Teams (OHTs) in order to better integrate care. Home and Community Care Support Services organizations will eventually be wound down as part of this process.

The Ministry is working with system partners to support this future transition. The Ministry will assess the feasibility of this recommendation and other options to strengthen the integration of assisted living services with home care delivery in the context of OHTs.

HOME AND COMMUNITY CARE SUPPORT SERVICES RESPONSE

Home and Community Care Support Services support this recommendation. Currently 11 of the 14 Home and Community Care Support Services organizations perform the initial eligibility assessments for assisted living services. With appropriate resources, and subject to the government direction on home care modernization, as well as the broader health system transformation, Home and Community Care Support Services could take on responsibility for determining eligibility across the province.

Assessment Information is Not Centrally Stored

We found that assisted living client assessment information is stored in multiple information systems that do not interface with each other. Further, the Ministry has not required assisted living agencies to enter assessment results into the central repository it had developed in 2009. The lack of centrally stored and complete assessment information prevents health regions (since April 1, 2021, HCCSS organizations) and agencies from easily sharing information, which is needed to promote more appropriate services to clients, for example, by ensuring care providers have a more complete picture of a client's health.

Assessment results including eligibility scores, as discussed in **Section 2.3.2**, are stored in various stand-alone information systems, either:

- at the health regions, most frequently the Client Health and Related Information System, administered by Ontario Health; or
- at the health service agencies, which record assessment results in their own internal systems, but can then upload them to a central database called the Integrated Assessment Record (IAR). The Ministry developed the IAR in 2009 for health service agencies, including assisted living service and home care agencies, to electronically view client assessments that had been conducted by other agencies to help foster continuity of care between services. The Ministry has administered the IAR since its inception, but transferred it to Ontario Health on September 1, 2021.

We obtained the IAR data from the Ministry and compiled results from our survey with the health regions (since April 1, 2021, Ontario Health) and found that less than half of assisted living agencies entered the assessment results of their clients to the IAR. Our 2015 audit of the Community Care Access Centres—Home Care Program recommended that, in order to increase sharing of assessment information and reduce duplication of effort, the Ministry, in conjunction with the LHINs, should require all health service agencies to upload complete assessment information on a common system.

As well, only 11 of the 14 health regions (since April 1, 2021, Ontario Health) use the Client Health and Related Information System for assisted living services eligibility and wait-list management. This system and the other systems used by the remaining three health regions also do not interface with the IAR.

RECOMMENDATION 4

To improve the sharing of client assessment information between Home and Community Care Support Services organizations and assisted living agencies, we recommend that the Ministry of Health, in conjunction with Ontario Health:

- require all assisted living agencies to upload client assessment information into a central repository that includes the entire continuum of care including long-term care services clients receive;
- require all Home and Community Care Support Services organizations to enter assessment results into this central repository;
- monitor that the central repository contains all clients' assessment information and follow up as needed; and
- in the interim, prior to the creation of a central repository, build an interface between all repositories of assessment information, including those used by both assisted living agencies and home care agencies.

MINISTRY RESPONSE

Information-sharing between care providers is critical to delivering effective care and services and improving the client experience.

The Ministry is committed to improving health system data management and improving the analysis of data across sectors within appropriate legal frameworks. The Ministry, in partnership with Ontario Health, is working to support access to provincial digital health assets for Ontario Health Teams (OHTs), which may support a repository of client assessment information for community providers of assisted living services. The Ministry has provided implementation funding to all approved OHTs to support the advancement of key priorities, including digital health. OHTs are required to develop a plan to integrate and co-ordinate digital tools and improve information sharing around organizations within an OHT. At maturity, OHTs will support integration and access to many types of clinical data including client assessment information across the OHT to support integrated care delivery.

The Ministry will work with Ontario Health to support access to a provincial repository for the purposes of maintaining assisted living client assessment information and supporting access for OHTs. In addition, the Ministry, in partnership with Ontario Health, will work in the interim to address information sharing within appropriate legal frameworks.

The Ministry will also work with Ontario Health towards a solution in which health service providers provide the required client information to appropriate parties within the clients circle of care and that service providers who provide services under the *Home Care and Community Services Act, 1994* are aware of their ability and responsibility to rely on a patient's implied consent to share the patient's personal health information with other healthcare service providers within the circle of care unless the patient has expressly withheld or withdrawn the consent.

The Ministry will work with partners in the Ministry of Long-Term Care to examine opportunities to incorporate long-term care data into the provincial repository.

ONTARIO HEALTH RESPONSE

Ontario Health supports this recommendation and will work with the Ministry of Health (Ministry) in considering options for improving the collection and sharing of assessment information.

Currently, long-term care homes, assisted living service providers, Home and Community Care

Support Services, community and hospital mental health and addictions services, and community support services agencies submit assessment information to the Integrated Assessment Record (IAR) through interfaces. However, submission of this data by the providers is not currently mandatory.

Ontario Health will work with the Ministry to research and assess making submission of assessment data mandatory, and if required, to ensure that the appropriate authorities are in place to permit the collection and sharing of assessment information.

HOME AND COMMUNITY CARE SUPPORT SERVICES RESPONSE

Subject to consent by the patient, all Home and Community Care Support Services eligibility assessments are automatically uploaded to the Integrated Assessment Record (IAR) daily through the Client Health and Related Information System (CHRIS) and IAR interface. Home and Community Care Support Services assessments will continue to be uploaded until the development of a centralized repository.

4.1.3 Ministry Has Not Clarified How Clients Receiving Assisted Living Services Can Access Nursing and Other Professional Services

The Ministry recognizes that assisted living clients may also require professional services that can only be provided by other parties such as home care agencies, but it does not clarify in its policies how assisted living services and home care services are to be aligned. While the Ministry's 2011 policy notes that an agency's service plan should refer to other health providers and agencies "with which linkages will be co-ordinated for the client," our work with the seven assisted living agencies we engaged with indicated that these arrangements were not effectively co-ordinated as suggested in the policy. Similarly, the Ministry's 1994 policy that describes the program for clients with physical disabilities, acquired brain injury or HIV/AIDS, is also unclear on how to co-ordinate these two services. The Ministry has still not revised this policy since it was originally released in 1994, around 27 years ago.

Proportion of Assisted Living Clients Also Receiving Professional Services Unknown

The Ministry and the health regions (since April 1, 2021, Ontario Health) have not tracked and assessed the extent to which assisted living clients have received home care since 2009, even though this would help them to better understand the amounts and types of services these individuals receive relative to their health conditions or needs.

The Ministry's policy suggests that assisted living clients would have higher needs than home-care clients, as shown in **Figure 3.** Nonetheless, assisted living does not provide professional services such as nursing (as explained in **Section 2.3**), even though clients are likely to have health conditions that require these services. The primary means of obtaining professional services at home is through home care.

In 2009, when the Ministry last assessed what other services assisted living clients were receiving, it found that 91% of these clients also received professional services, as allowed by Ministry policy. We could not readily determine the current rate because neither HCCSS organizations nor Ontario Health have centralized, client-specific information available for assisted living clients, as they do for home care clients.

Our work at assisted living agencies and our reviews of assessment data indicated it was reasonably common for assisted living clients to also receive professional services. Three of the seven agencies we engaged with have either an on-site or on-call nurse; another agency indicated that it is not allowed to hire professional staff and therefore relies heavily on home care to provide nursing services for its clients.

Assisted Living Agencies and Home Care Agencies Do Not Effectively Exchange Client Health Information

We found that some assisted living agencies were under the impression that, following the initial referral to the agency, they cannot freely exchange

client health information with home care agencies as their service agreements with the health regions (since April 1, 2021, Ontario Health) prohibit them from sharing personal health information with other parties. Four of the six agencies that we engaged with, whose clients also receive home care services, informed us that they cannot easily exchange information with home care agencies regarding patient condition and the timing of services. The health regions mostly supported these agencies' interpretation. One of these agencies has adopted a workaround practice to manage the care of its clients more effectively. It has requested that the home care agency send an email every month with a list of shared clients that will be receiving care (morning or evening), but the home care agency does not provide information on the condition of the clients. As well, staff at another agency informed us that they had wanted to hire a nurse to help provide better and more appropriate care to their clients, but the Ministry did not authorize them to do so. The Ministry informed us that approving the agency to provide nursing services would likely result in a violation of the *Long-Term Cares Homes Act, 2007*. Meanwhile, Ontario Health informed us that, in their view, the sharing of personal health information between home care and assisted living staff would be appropriate, as part of the "circle of care."

This confusion and lack of established process consistent with the patient information-sharing envisaged when the IAR was developed can lead to inefficient care. For example, staff from both agencies might arrive at the client's home at the same time, and home care nurses may or may not share insights on patient conditions that could help assisted living agency staff provide better care to the client. In comparison, similar information exchanges occur at long-term care homes between shifts, where one shift briefs the next on anything that would be needed to facilitate continuity of care.

Better collaboration between agencies is extremely important to provide the best care to clients. Through our work reviewing complaint information at health regions, we found a 2019 case where a client living with multiple health conditions including blindness and multiple sclerosis had a serious wound that the assisted living agency staff missed and had not treated appropriately, and the client was not referred to a home care agency. Despite the client eventually receiving better wound care after the client's family complained to the health region, the client's wound had worsened considerably in the interim and their health had deteriorated significantly until the client had to be admitted to hospital, where they stayed for treatment for over four months.

Ministry Policy Requires Assisted Living Agencies to Have Ongoing Communication with Primary Care, but Only 37% of Assisted Living Agencies Do So

According to the 2011 assisted living policy that applies to seniors, agencies are responsible for ensuring that total care provided to clients is adequate for their needs, including regular and ongoing communication with other agencies and primary care providers. Our survey of health regions indicated that only 37% of the assisted living service programs delivered by agencies help clients arrange medical appointments. In another 27% of the programs, either the client, a family member, or a substitute decision-maker would arrange medical appointments. In the remaining 36% of the programs, the health regions indicated that they were unable to determine who was responsible for arranging medical appointments.

RECOMMENDATION 5

To better serve clients receiving both assisted living services and other health care services, we recommend that Ontario Health:

- amend service agreements to clarify that assisted living agencies and other service agencies can exchange information, such as the timing and the type of services provided to clients and the condition of a client, when it is necessary to help maintain continuity of care; and
- instruct assisted living agencies and monitor that they maintain ongoing communication

with other health service providers, including primary care providers.

ONTARIO HEALTH RESPONSE

Ontario Health recognizes the importance of sharing information between health service providers to improve patient care. However, information sharing must be done within the legal framework in place to protect patient privacy. Ontario Health will commit to reviewing and amending the service accountability agreements with their assisted living agencies, as appropriate, and to clarifying expectations for sharing information to the extent permitted under applicable privacy legislation.

Since Ontario Health is not directly engaged in the delivery of care for assisted living services, it is not able to monitor the internal communications between assisted living agencies and other health service providers. However, as part of the ongoing engagement between Ontario Health and its health service providers, Ontario Health is able to monitor at a system-level and work with the providers to identify barriers and solutions.

Under a mature Ontario Health Team model, the sharing of information across providers may be facilitated, as all providers would be part of a shared governance framework.

RECOMMENDATION 6

To better align the provision of assisted living with other health care services that a client may require, we recommend that the Ministry of Health update the assisted living services policies to clarify that assisted living clients of all population groups can access professional services and outline the pathway to do so.

MINISTRY RESPONSE

The Ministry accepts this recommendation and will update the assisted living policies. In the interim, the Ministry will partner with Ontario Health to communicate this clarification to assisted living service delivery partners.

4.1.4 Ministry and Ontario Health Lack Information on Actual Demand for Assisted Living Services

Neither the Ministry nor Ontario Health (formerly the health regions) has comprehensive information to fully measure the unmet demands of assisted living services across the province. We found that the province has no central wait list for assisted living services and the reporting of wait-list information that was available was incomplete or not transparent.

The Ministry requires that agencies report wait-list information three times a year; Ontario Health also has some wait-list information in the Client Health and Related Information System, but this information is not complete. We analyzed wait-list information from the Ministry and noted the following:

- Between 2019 and 2021, the number of people waiting for assisted living services averaged about 7,400 each year.
- In 2020/21, people waited 69 days on average to be admitted into assisted living services, down from 120 days in 2019/20; some people waited up to over 1,000 days in one North East region agency in 2020/21.
- While waiting for assisted living services, 1,259 people died and 907 people were admitted to long-term care over the five years from 2016/17 to 2020/21. This represents data from only 11 of the 14 health regions, since the Client Health and Related Information System that contains this information was not used by three health regions—Mississauga Halton, Toronto Central and Waterloo Wellington.

With the transfer of health system planning and funding functions from the health regions to Ontario Health on April 1, 2021, the layout of these local wait-list processes did not change significantly since Ontario Health is operating much as the health regions did previously; Ontario Health did not yet

have any plans to restructure wait lists to provide more centralized health region information to feed into a provincial wait list.

We also found weaknesses in the way wait-list information is tracked, including incomplete and insufficiently detailed information to help support planning processes and inform the public of the availability of services. **Appendix 15** explains these weaknesses in further detail.

RECOMMENDATION 7

To help eligible individuals obtain more timely and equitable access to assisted living services and to help plan health services in Ontario, we recommend that Ontario Health, in conjunction with Home and Community Care Support Services:

- collect and review wait lists to confirm their completeness, including whether the person is waiting for a spot in an assisted living building versus the community, as well as the priority of the client as indicated by their needs and length of time on the wait list;
- track people waiting in hospitals for assisted living separately from supervised living;
- publish wait time and wait lists by region; and
- work toward developing a central wait list for the whole province.

ONTARIO HEALTH RESPONSE

Ontario Health supports reporting and monitoring of wait-list information as a means of improving the quality of services provided. However, with eligibility determination for assisted living services split between Home and Community Care Support Services and assisted living providers, there is currently no consolidated, centralized wait list or wait-time information in the province.

Additionally, while Ontario Health funds and has accountability agreements with assisted living providers and does have a role in supporting and reporting on health system performance, including wait-time information, it does not have the authority to collect and review patient-level data.

Under health system transformation, as Ontario Health Teams mature, they will assume responsibility for delivering the full range of health services within a defined area—including assisted living and home care services—and may be in the best position to collect and review wait-list and wait-time information within the continuum of services they will provide.

Ontario Health will work with the Ministry of Health, Home and Community Care Support Services, and Ontario Health Teams to clarify where the authority for collecting and reporting on assisted living services appropriately sits and the process for collecting and reporting on this data.

HOME AND COMMUNITY CARE SUPPORT SERVICES RESPONSE

With eligibility determination for assisted living services split between Home and Community Support Services and assisted living providers, there is currently no consolidated, centralized wait-list and wait-time information in the province.

Consolidation of the eligibility determination function within Home and Community Care Support Services, as per **Recommendation 3**, would centralize the collection and facilitate review of wait-time information.

Home and Community Care Support Services will work with the Ministry of Health and Ontario Health to develop and implement a process for collecting and reporting on this data.

4.2 Equitable Service Provision

4.2.1 Most Health Regions Have Not Held Assisted Living Agencies Accountable for the Amount of Service Hours They Provide to Their Clients

Neither the Ministry nor the health regions (since April 1, 2021, Ontario Health) have assessed or compared the amount of service home care and assisted living services clients actually receive, and the Ministry has not clarified to health regions whether clients in assisted living should expect to receive more personal support and homemaking service hours than home care clients receive. Moreover, the Ministry has not assessed why home care costs per client have been consistently less than assisted living costs per client—a trend that is unexpected given that home care workers include professionals who would generally cost more; this trend is shown in **Figure 8.**

As well, health regions did not have common provincial service prioritization guidelines, and each region had different criteria to prioritize which of individuals waiting for home-based assistance would receive home care or assisted living services; this further impedes equitable service provision. In addition, only one health region (Central East) specified the number of hours agencies should provide to clients in their accountability agreements with agencies. However, even this region did not always require that homemaking and personal support be reported separately and in one case, an agency reported being more than 11,000 hours, or 15% under its target in the 2020/21 fiscal year. The agency's explanation was two-fold: clients requested less service due to concerns regarding the risk of contact with workers due to the COVID-19 pandemic, and insufficient numbers of PSWs due to the Ministry's directive that restricted cross-agency service provision. The region did not have any further information on what this meant for the well-being of the clients of this agency.

All assisted living agencies report the service hours they provided to clients to the Ministry; however, the health regions did not regularly review the information that was available to them for accuracy, and had not analyzed the data to identify variances of service hours across the 14 health regions or used it to make funding decisions. In contrast, all home care agencies are required to report their number of service hours and visits to the health regions (since April 1, 2021, HCCSS) that directly oversee them. Assisted living clients are therefore not assured that they are receiving adequate service hours. Our work at the seven assisted living agencies that we engaged with found that three agencies did not track the number of hours of care they provided to clients. For those that did, we found that on average, clients received between 1.25 and four hours per day. We discuss service hours further in **Section 4.4.2.**

We surveyed all 14 health regions and found that only one health region has observed the Ministry's policy intention that assisted living clients have higher needs than home care clients, as shown in **Figure 3.** Two health regions indicated that their home care clients had greater needs than assisted living clients; seven health regions did not have enough information to determine this; and four health regions noted that neither group necessarily had greater needs than the other, with one health region further observing that "at times, (the health region) may provide supplemental professional services or may serve clients previously supported through (assisted living agencies) as their needs increase or become more unpredictable."

Ontario Health informed us that since 2011, home care clients' health conditions have become more complex, and their urgency and intensity of services required have significantly changed. As such, the continuum of care in the Ministry's policy no longer reflects the current state; there is likely overlap between the home care program and the assisted living program.

We describe other concerns that indicate increased risk that clients will not receive an appropriate amount of service hours in **Appendix 16**.

RECOMMENDATION 8

To improve the consistency and sufficiency of services that assisted living agencies provide to clients, we recommend that the Ministry of Health, in conjunction with Ontario Health:

- collect and validate information on the number of service hours clients receive in the assisted living services program and in the home care program as well as the corresponding assessment scores, and compare them and re-assess whether the service maximum hours for both programs are still reasonable; and
- develop monthly minimum service hour targets for various care levels—for example, based on assessment scores—and update its policies accordingly.

MINISTRY RESPONSE

The Ministry will work with Ontario Health to assess current service volumes in assisted living services (ALS).

The Ministry recognizes the importance of ensuring that care volumes are allocated based on need, equity, and clinical best practices. The Ministry also notes that data for the 2020/21 fiscal year was atypical due to the impact of the COVID-19 pandemic. Costs and volumes were more variable and admissions may have been reduced due to COVID-19 protocols and/or client preference.

The Ministry has also announced its intent to remove service maximums from the regulations governing home and community care services, including in ALS.

The Ministry, in partnership with Ontario Health, will develop monthly minimum service hour guidelines for ALS. Guidelines can improve transparency and equity and can be an important resource for the professionals responsible for assessment and care planning. Other important resources are clinical judgment, the interRAI suite of assessment instruments and other guidance tools.

ONTARIO HEALTH RESPONSE

Ontario Health supports this recommendation and will work with the Ministry of Health in reviewing hours of service.

RECOMMENDATION 9

To improve the consistency and sufficiency of services that assisted living agencies provide to clients, we recommend that Ontario Health:

- update its agreements with assisted living agencies to include monthly minimum service hour targets for various care levels; and
- monitor reported service hours against the revised Ministry standards.

ONTARIO HEALTH RESPONSE

Ontario Health supports this recommendation and will review and amend its service accountability agreements with assisted living agencies, as appropriate, to ensure agreements reflect updated policy and program specifications established by the Ministry of Health. Ontario Health will develop and implement a system to track and monitor the reported data.

4.2.2 Health Regions Have Not Validated that Clients with Similar Assessment Scores Receive Similar Types and Levels of Service

The 2011 Ministry policy on assisted living sets out eligibility requirements as defined by capability assessment scores, but the health regions (since April 1, 2021, Ontario Health) have not assessed whether these scores are matched with appropriate levels of service—that is, whether those who have similar needs are receiving the same type of service and at a similar level of service consistently across the province.

The capability assessment scores, as produced from the common assessment instrument described in

Section 2.3.2, are intended to measure the physical and mental capabilities of individuals and aid in determining if the individual's needs are appropriate for assisted living services as opposed to long-term care (which serves a less capable, higher-needs population) or home care (which serves a more capable, lower-needs population) with the exception of those receiving home care who are also on a long-term care wait list.

As described in **Section 4.1.2**, we obtained the assessment data from the Integrated Assessment Record for assisted living service programs across the health regions, but the system does not discern between individuals who are in service or waiting for service. As a result, we could not determine whether agencies appropriately admitted clients into assisted living based on their assessment scores or whether agencies denied services to some individuals, for instance, because their needs exceeded those that the agency can provide. We also could not compare the assessment scores of home care clients to determine, on a provincial basis, how frequently ministry policy intentions were being realized—that is, that home care clients were to have more capability compared to assisted living clients.

Even if information was available on assessment scores, as discussed in **Section 4.2.1**, because service hours are not validated for accuracy, an analysis of assessment scores against service levels was not possible.

We reviewed a sample of client files at the seven agencies we engaged with during the audit and one agency, for example, informed us that the majority of the clients they admit had less needs (as defined in the capability assessment score) than is required in the Ministry policy. The agency indicated this is because they do not have the resources to care for clients if they all have higher care needs.

RECOMMENDATION 10

To provide equitable access to assisted living services for those who most need it to live independently, we recommend that Ontario Health, in conjunction with the Ministry of Health:

- collect data on client needs and service hours, monitor cases where ineligible clients are admitted to assisted living services and clients who receive services above or below the intended level as established in **Recommendation 8**, and require agencies to provide services only to eligible clients, refer ineligible clients to other services and adjust the nature and amount of services provided as needed; and
- at least annually, collect and analyze data on the assessment scores of assisted living and home care clients to confirm they are commensurate with their health profiles.

ONTARIO HEALTH RESPONSE

Ontario Health recognizes the important role that the collection of data plays in being able to evaluate whether the services being delivered meet the needs of clients, and if the program is meeting its goals. As Ontario Health is not directly engaged in the delivery of care and does not have access to patient-level data, it will work with the Ministry of Health to establish a process for collecting and reviewing data within Ontario Health's legislative authority. This process will include the frequency with which such a review would occur, and how results would be used and communicated to improve service delivery.

In the future, as Ontario Health Teams mature, this function may be more appropriately undertaken by the Ontario Health Teams, which would be responsible for the delivery of services across the continuum of care within a defined geographic area.

MINISTRY RESPONSE

The Ministry of Health supports this recommendation and will work with Ontario Health to establish a process for collecting and reviewing data within appropriate legal frameworks.

4.2.3 Eligibility of Almost 80% of Assisted Living Clients Not Based on Their Capabilities and Needs

As indicated in **Figure 1**, assisted living agencies reported to the Ministry that only 23% of the clients served met the requirements of the Ministry's 2011 policy. That policy is the only eligibility policy that includes specific need-based criteria; the policy applies to high-risk seniors. For the remaining 77% of assisted living clients, services are provided without specific criteria to define their needs and abilities.

The eligibility criteria and other policies for the other three target populations—adults with physical disabilities, an acquired brain injury or HIV/AIDS—are defined only in the original 1994 program policy that is now 27 years old. The policy merely requires that the client be at least 16 years old and that their needs cannot be met merely through scheduled visits. The policy does not include any capability profiles or values reflected in capability assessment scores that apply to seniors under the more current, 2011 policy. Consequently, some people currently receiving assisted living services may be much more capable than, for example, some of those on the wait list who might benefit from them more.

In particular, regarding clients with an acquired brain injury, our analysis of assisted living agency data indicated that the cost per client for these services was almost seven times higher on average compared to other client groups. The Ministry confirmed that the staffing requirements for such clients are often extensive due to the needs of the clients. Our engagement with one such agency indicated that the staff are always on-site assisting clients; for example, in helping them make meals and doing laundry. However, the 1994 policy does not provide any additional guidance regarding such staffing models.

The 1994 policy also applied to frail or cognitively impaired seniors. As explained in **Section 2.3.2**, with the introduction of the 2011 policy for "high-risk" seniors, seniors who were already being provided services under the 1994 policy were allowed to continue receiving services even if they had fewer needs than those set out in the 2011 policy. However, 10 years later, according to what assisted living agencies reported, 72% of seniors served were still receiving assisted living services according to the 1994 policy. The Ministry had not yet investigated whether health regions (since April 1, 2021, Ontario Health) were complying with the 2011 policy and could not explain why they had not reviewed it since 2011, and the extent to which agencies had continued to admit clients based on the less prescriptive, 1994 policy eligibility requirements.

4.2.4 Ministry, Health Regions and Ontario Health Have Not Examined Whether Policy-Driven Exclusion Criteria or Local Practices Have Caused Unintended Consequences Such as Higher Public Costs

The Ministry's 2011 policy prohibits certain Ontarians, such as those who reside in retirement homes and those who are on a long-term care wait list, from being eligible for assisted living services (see **Appendix 17** for details). In the case of retirement homes, the Ministry indicated that its intention was to set a clear distinction between those receiving publicly funded services (assisted living) versus privately-funded services (retirement home); retirement home residents can, however, access home care services via HCCSS organizations. Also, the policy indicates that only those living within particular areas of the province may be considered eligible for assisted living services. However, the Ministry has not examined whether these exclusions make economical sense within the context of the whole health system, and whether they are consistent with the

principle of providing equitable services to people who need these critical services. For example, those that do not receive timely access to assisted living may be required to choose long-term care, which is a more expensive program for the provincial government to maintain, as shown in **Figure 7.**

In addition, while not specifically excluded by the Ministry policy, certain groups, as shown in **Figure 11**, are effectively barred from receiving this service either because of local decisions made by the health regions or by the agencies, even though their needs may exceed or equal those who receive services. Similarly, Ontario Health (and previous to April 1, 2021, the health regions) has not examined the impact of these factors on service provision.

RECOMMENDATION 11

To provide more equitable services to all Ontarians who can benefit from assisted living services according to their need, we recommend that the Ministry of Health, in conjunction with Ontario Health:

- monitor that assisted living agencies do not hereafter admit seniors according to criteria outlined in the 1994 policy;
- evaluate whether the eligibility criteria for adults with physical disabilities, an acquired brain injury or HIV/AIDS should be updated to include evidence-based criteria such as capabilities to live independently, similar to the approach resulting in the updated 2011 policy for seniors; and
- review and revise exclusion criteria (such as those that do not allow services to be provided to people who reside in retirement homes and those on long-term care wait lists) and local exclusion criteria (such as those restricting eligibility to only those who reside within certain areas of the province) that have been used, considering the impact of these criteria on the broader health care system.

MINISTRY RESPONSE

The Ministry accepts this recommendation.

Figure 11: Factors Affecting Access to Assisted Living Services

Prepared by the Office of the Auditor General of Ontario

Factors Affecting Access	Details
Family advocacy	• Staff at one assisted living building in Southern Ontario informed us that, due to practical considerations, they only admit clients with family or friends; these individuals advocated for them and helped them to gain admission. • This barrier to service relates back to the lack of centralized access for assisted living services discussed in **Section 4.1**. • A geriatrician with extensive experience in home-based care for seniors informed us about an instance where a patient of his lived in a supportive housing building that provided an assisted living program in 20 of the 100 units of the building: the assisted living service agency was aware of the patient, but did not offer to admit him into the assisted living program because no one had referred him to the program; the patient did not have any family support. The patient himself lacked the cognitive ability to self-refer because of his dementia. This situation continued for over two years; the senior eventually ended up in the emergency department after living alone with dementia for two to three years.
Age	• Some health regions had introduced a 65-year age minimum for the services. • The 2011 policy does not define an age for a "senior" because the Ministry intended for the services to be provided to those most in need, regardless of age.

The Ministry will partner with Ontario Health to require that assisted living service health service providers sign an attestation to confirm they will not admit seniors according to criteria outlined in the 1994 policy.

The Ministry is committed to supporting the unique care needs of adults with physical disabilities, an acquired brain injury or HIV/AIDS and will evaluate the eligibility criteria for these population groups and update them as required.

The Ministry will review any criteria that may be perceived as exclusionary, consider their impact on the broader health care system and revise as appropriate.

ONTARIO HEALTH RESPONSE

Ontario Health supports a review of the assisted living program to ensure that it is meeting the needs of patients, and the broader health care system.

4.2.5 Homemaking Critical to Assisted Living Services, but Not Offered in Some Regions

We found that, despite both the 1994 and 2011 policies stating that assisted living services should include homemaking services (such as house cleaning, laundry and paying bills), these are not available from all assisted living agencies. Where these services are not available, clients would have to either find and pay for them privately, or forgo them altogether if they cannot afford them or cannot arrange for them because of, for example, cognitive impairment.

As part of a broad review that the Ministry performed prior to releasing the 2011 policy, the Ministry found that personal support and homemaking services were key to reducing alternate-level-of-care pressures in hospitals by finding viable alternatives through safe and cost-effective community supports. The review found that the inability to safely move patients out of these beds and into the community is a key concern since it prevents health care from being provided to acute care patients.

Of the 507 assisted living programs, health regions (since April 1, 2021, Ontario Health) informed us via responding to our survey that 297 or 59% offer homemaking and 60 or 12% do not; the regions did not know if the remaining 150 or 29% offer homemaking or not. Health region staff informed us that agencies often prioritize personal support services over homemaking services.

RECOMMENDATION 12

To help keep assisted living clients from requiring acute care or premature admission to long-term care, we recommend that Ontario Health include in its agreements with assisted living agencies a requirement to provide homemaking services, consistent with the Ministry of Health's policies.

ONTARIO HEALTH RESPONSE

Ontario Health will review the service agreements held with assisted living agencies to ensure that the agreements address the requirement for agencies to meet all of the legislative, regulatory, and policy requirements of the program.

4.3 Funding and Health System Planning

4.3.1 Ministry, Health Regions and Ontario Health Lack Data to Appropriately Plan for Assisted Living Services and Equitably Distribute Funding Among Health Regions and Service Agencies

Ministry Has Not Planned for Future Growth in Demand

The Ministry has not analyzed available information, such as demographics and wait lists, to help inform its current and future investments in assisted living. As well, the Ministry has not assessed whether funding is equitably distributed across the province, as measured by health region funding, based on their relative needs for assisted living; this includes whether some regions have a greater proportion of

people with fewer economic means to pay for retirement home living or have fewer long-term care homes per current and future populations of seniors.

While the Ministry has been making small adjustments to reallocate funding to health regions to account for future populations and marginalized and low-income populations, we found that current funding for assisted living services does not reflect local needs, such as those quantified in wait lists.

Average Funding Per Client Not Analyzed Against Needs to Confirm Reasonableness

Health regions (since April 1, 2021, Ontario Health) do not investigate whether agencies are justified in having varied funding per client. Therefore, they cannot determine whether these variances reflect under-funded service agencies that have clients with higher needs that may not be fully met, or over-funded service agencies that have clients with lower needs requiring fewer services. We found that in 2020/21, agencies on average spent $18,100 per client, but this ranged from $1,151 to $228,393, as shown in **Appendix 1.**

Because the Ministry does not require agencies to enter assessment scores into a central repository, it cannot easily access information about each agency's clients' capabilities and therefore cannot verify if agencies that spend more per client are those that serve more high-needs clients.

The Ministry also stated in the 2011 policy that the policy will be reviewed no later than 36 months after its effective date. While the Ministry updated the policy in 2012 to provide more evidence-based characteristics for eligibility, it has not since reviewed it or requested feedback on it. The Ministry could not provide a reason for why it had not reviewed the policy since 2012.

RECOMMENDATION 13

To best align funding with the future needs of those who will require assistance to live at home and to help ensure more efficient use of funding, we recommend that the Ministry of Health:

- analyze relevant information, such as wait lists and demographics, to understand current and future expected demand for assisted living, home care and long-term care across the province, and adjust funding for assisted living and home care while taking into account local factors such as marginalized or low-income populations;
- request Ontario Health review local information, such as local wait lists and demographics, and reallocate funding across the continuum of care over all regions based on demonstrated need;
- work with Ontario Health to analyze agency funding on a per client or per hour basis periodically and investigate anomalies; and
- review and update all assisted living policies accordingly.

MINISTRY RESPONSE

The Ministry accepts this recommendation.

The Ministry will analyze relevant information to strengthen planning for assisted living services and home care and is committed to working with Ontario Health and Home and Community Care Support Services.

The Ministry will work with the Ministry of Long-Term Care to obtain long-term care data, as appropriate, to inform planning for assisted living services and home care. Funding decisions for long-term care are under the mandate of the Ministry of Long-Term Care.

The Ministry will request that Ontario Health review local information and allocate funding based on demonstrated need for assisted living services.

The Ministry will work with Ontario Health to periodically analyze agency funding per client and per hour and investigate any anomalies.

The Ministry recognizes the opportunity to update the current policies related to assisted living services.

ONTARIO HEALTH RESPONSE

Ontario Health supports a review of the current and future demand for assisted living, home care and long-term care services to ensure an appropriate mix of services to meet the needs of Ontarians.

Based on the findings of the review, and analysis of available data, Ontario Health will work with the Ministry of Health to allocate funding based on identified local and regional needs.

4.3.2 Other Government Programs Relevant for Many Assisted Living Clients Exist, but Access to These Services is Not Co-ordinated

The assisted living services program is one of several provincially funded programs that help support independent living for seniors, and adults with physical disabilities, an acquired brain injury or HIV/AIDS. These other programs—as shown in **Figure 12**—are delivered through various organizations, including assisted living agencies, health regions and sometimes other ministries. We found that the Ministry has not worked with other ministries to determine whether the services it provides are equitably available to all Ontarians according to their needs and not duplicative. Further, it has not examined the benefits of centralizing care co-ordination with the health regions (since April 1, 2021, HCCSS) to deliver these services more efficiently. For example, central co-ordination would allow people to go through one provider to find and readily obtain all the various care services they need, minimizing confusion and missed opportunities for care. It

Figure 12: Select Government Services Supporting Community-based Living Available to Seniors, People with Physical Disability, Acquired Brain Injury or HIV/AIDS

Prepared by the Office of the Auditor General of Ontario

		People with		
	Seniors	Physical Disability	Acquired Brain Injury	HIV/AIDS
Assisted living services (Ministry of Health)	✓	✓	✓	✓
Attendant outreach[1] (Ministry of Health)	×	✓	✓	×
Community paramedicine[2] (Ministry of Health)	✓	×	×	×
Residential services[3] (Ministry of Children, Community and Social Services)	✓	✓	×	×
Home care (Ministry of Health)[4]	✓	✓	✓	✓
Community support services (Ministry of Health)[5]	✓	✓	✓	✓

1. These include personal support and homemaking services and are available to adults with physical disabilities and with an acquired brain injury. The Ministry provided $151 million in 2020/21 to this program. The agencies providing this program determine eligibility.
2. The Ministry piloted this initiative in 2014/15 to help people with chronic health conditions live independently at home, "where they want to be." In 2020/21, the Ministry expanded community paramedicine programs to supplement home and community care where gaps were identified. The paramedics and other workers engaged in the community paramedicine programs work alongside home and community care providers. Nearly 12,000 people received services under the 2020/21 expansion program, based on available data. Funding for this program continued in 2021/22. Clients can be referred to community paramedicine programs through multiple sources, including paramedics, hospital emergency department staff and Home and Community Care Support Services (HCCSS) organizations. Community paramedicine programs can in turn refer clients to other service providers, such as HCCSS organizations, to help clients receive any other home and community care services they may require and to ensure clients receive co-ordinated care. Community paramedicine is a model of care in which paramedics use their training and expertise outside their customary emergency response role, generally with physician oversight, to provide chronic disease management support, health education and assessments. Clients are generally people with chronic conditions who need support to live independently in the community. Community paramedicine is intended to enhance health system capacity and not replace home and community care services, such as assisted living services.
3. These provide developmental services clients, who may concurrently live with physical disabilities, with accommodations and home-based personal supports. According to Statistics Canada, 70% of people aged 15 and over have at least two or more disability types; these include pain-related, flexibility, mobility, mental health, seeing, hearing, dexterity, learning, memory and developmental disabilities. Residential services are funded by the Ministry of Children, Community and Social Services.
4. These are available to all groups that receive assisted living services who require professional services. Adults with an acquired brain injury are one of the primary eligible groups for the family-managed home care program, which was officially launched in May 2018. The program provides funding to eligible clients or their substitute decision makers to purchase home care services identified in a client's plan of care.
5. Examples include adult day programs, meals on wheels and friendly visiting.

would also allow the Ministry to focus its public communications through one source and improve public awareness of its services; have better access to data—such as the extent of referrals from assisted living services to other services or vice versa—to help it make the right decisions about health-care planning; and identify gaps where services are not being offered.

Provincial Geriatrics Leadership Ontario (PGLO) noted the need for holistic co-ordination of services that older adults need. PGLO is an organization that works to improve processes to co-ordinate clinical geriatric services provided by clinicians of a variety of health disciplines such as physicians, nurses and therapists. For example, PGLO noted that patients (or their primary care providers) report there is no single source from which to obtain all the services an older adult with complex health conditions living in the community may need. As well, while in some regions, there may be many services available to older adults, services may be siloed and have individual eligibility criteria and application processes, making it difficult to easily access all available options efficiently. We also found that while the Ministry for Seniors and Accessibility supports seniors and adults with disabilities, it was not involved in co-ordinating these services.

RECOMMENDATION 14

To help provide better co-ordinated care for clients who are eligible for assisted living services and may also receive other similar services such as home care, paramedical services and attendant outreach services, we recommend that the Ministry of Health, in conjunction with other relevant ministries such as the Ministry of Children, Community and Social Services and the Ministry for Seniors and Accessibility:

- identify any duplication of services offered to clients with similar need profiles, and develop a plan to merge or streamline the offering of similar in-home services; and
- improve clients' experiences accessing various services they may be eligible for in their communities, such as through co-ordinating care through Home and Community Care Support Services organizations and providing up-to-date information on service offerings to primary-care providers.

MINISTRY RESPONSE

The Ministry accepts this recommendation.

The Ministry recognizes that many Ontarians live with complexities related to dual diagnoses and looks forward to exploring opportunities to improve access to care for clients with dual diagnoses and is committed to working with partners across government to make the delivery of services more efficient.

The Ministry will work toward improving the care co-ordination and navigation for clients. A range of initiatives is under way to enable this improvement as part of the Ontario government's comprehensive plan for health system transformation. For example, Ontario Health Teams are intended to improve the care experience by improving transitions and strengthening access to navigation services. In addition, the Ministry is taking steps to expand access to digital and virtual care options for Ontarians.

To make it easier and more convenient to access health care services and navigate the health care system, the Ministry is developing a one-stop, digitally-enabled navigation tool with fully bilingual services that will increase access to care and improve equity. With this new tool expected to be ready in early 2022, Ontarians will have a "Digital Front Door" to Ontario's health care system, offering a place where they can have easier access to health information, advice, initial triage, symptom checking, mental health and addictions supports, home and community care, caregiver supports, information on finding a local doctor or nurse practitioner, and virtual

care to become connected to health information and health care services across the province and to receive guidance throughout their health care journey.

4.3.3 Ministry Has Not Leveraged Assisted Living Services to Improve Health System Performance

The Ministry has not assessed whether assisted living services are being used strategically across Ontario to maximize the program's benefits. All seven assisted living agencies we engaged with agreed that assisted living services are effective in helping people delay or avoid long-term care, and allowing them to instead "age in place." Studies have noted similar findings. Enhancing delivery of these services therefore represents a potentially significant opportunity to both improve the quality of life of Ontarians and reduce overall health system costs significantly. For example, the following areas could offer opportunities for enhancing the overall delivery of services:

- unscheduled visits: in which circumstances should they be offered to have the most impact;
- assisted living versus long-term care: what is the maximum amount of assisted living services—as well as the professional services provided under home care—that can be provided and still be less expensive than long-term care;
- combining home care and assisted living services: what value does this offer, considering both programs offer similar services to similar clients in similar settings; and
- gaps in availability across the province: where are services most and least available, and how does that affect demand for other services?

We discuss these and other areas that would help inform better use of assisted living services in **Appendix 18.**

Denmark has a different approach to eldercare than Canada: it makes healthy aging a priority. There are financial penalties imposed on municipalities if seniors are deemed to be institutionalized unnecessarily. As well, general practitioners are responsible for medical follow-up of patients, regardless of whether care is delivered in clinics, in hospitals or at home. The focus of senior care programs in Denmark is helping them maintain or regain their autonomy. The underlying philosophy is to keep seniors as independent as possible.

RECOMMENDATION 15

To strengthen assisted living services' role in helping clients improve their quality of life while living in the community, and lowering the overall costs to the health care system, we recommend that the Ministry of Health, in conjunction with Ontario Health:

- identify what data is relevant to measure the performance of the assisted living program (including the break-even point between assisted living and long-term care, and gaps in availability);
- collect and evaluate this data on an annual basis; and
- use the results to inform how it funds and operates the program going forward.

MINISTRY RESPONSE

The Ministry, in partnership with Ontario Health, will identify what data is relevant to measure program performance, collect the relevant data on an annual basis, and use the relevant data to inform how it funds and manages the program.

ONTARIO HEALTH RESPONSE

Ontario Health supports the identification and measurement of data that will help understand the performance of the assisted living program in improving client outcomes and experience.

4.3.4 Ministry Has Not Assessed Whether Assisted Living Services are Meeting the Needs of Vulnerable Non-senior Adults

The Ministry introduced its policy for non-senior groups including adults with physical disabilities, an acquired brain injury or HIV/AIDs in 1994 and has not assessed whether it still meets the needs of these population groups now, 27 years later. Evaluating the performance of these assisted living programs can help drive decisions on the best model of care.

Since introducing the policy in 1994, the Ministry has not taken any action to investigate the demand for these services or determined whether changes in policies regarding eligibility would be appropriate. We explain these and other areas that the Ministry has not studied in **Appendix 19**.

The Ontario Brain Injury Association informed us that those with an acquired brain injury may become homeless because of limited care options and that care provided in specialized programs or designated assisted living buildings for people with acquired brain injuries would help prevent these individuals from needing to enter long-term care homes or becoming homeless. Similarly, one assisted living agency that provided services to clients with HIV/AIDS informed us that providing assisted living services to clients in their homes would help clients stay connected to their communities, avoid long-term care and also manage their HIV viral load to avoid the more contagious and serious health condition of AIDS. As government moves forward with the Ontario Health Teams model, this is an opportune time to consider such a restructuring of home-based care delivery.

RECOMMENDATION 16

To help ensure adults with physical disabilities, an acquired brain injury or HIV/AIDS receive quality assisted living services, we recommend that the Ministry of Health:

- obtain trend data on the number of people in Ontario living with physical disabilities, an acquired brain injury or HIV/AIDS to inform planning decisions;
- clarify whether assisted living services should be expanded into the community beyond designated assisted living buildings;
- further to **Recommendation 11** on updating the 1994 policy, and with input from relevant experts, identify appropriate outcome targets to help measure the effectiveness of assisted living services; and
- work with Ontario Health to require all assisted living agencies measure and report on outcome data, including reductions of emergency room visits or delayed admissions to long-term care.

MINISTRY RESPONSE

The Ministry accepts this recommendation.

The Ministry looks forward to gathering information that will result in better understanding of the care needs of adults with physical disabilities, an acquired brain injury or HIV/AIDS.

The Ministry will clarify its policy regarding the further expansion of assisted living services outside of supportive housing buildings.

The Ministry will work with Ontario Health to identify appropriate outcome targets and require all assisted living service providers to measure and report on outcome data. The Ministry will identify opportunities to address current barriers to sharing of data across health sectors within appropriate legal frameworks.

ONTARIO HEALTH RESPONSE

Ontario Health supports the recommendation and will work with the Ministry of Health to identify appropriate outcome data for assisted living agencies and amend the service agreements as appropriate.

4.4 Agreements with and Oversight of Assisted Living Agencies

4.4.1 Health Regions and Ontario Health Have Not Evaluated Cost Variations Among Agencies and Cannot Negotiate Service Costs with Agencies

Neither the health regions (since April 1, 2021, Ontario Health) nor the Ministry have analyzed whether cost variations among agencies are reasonable or identified reasons for the variations, even though agencies have provided this data. Such analysis could identify agency performance issues for follow up. The Ministry has also not analyzed whether the cost variations across health regions are reasonable.

We reviewed the cost per client and cost per hour information that assisted living agencies reported to the Ministry, and found a wide range of costs incurred within the region and across the province. For example, as shown in **Figure 9**, while the average annual cost per client in the province was $17,400, it ranged from $7,987 in the Waterloo Wellington health region to $42,495 in the South East health region. The cost per client within each region also varied significantly, for example, from $17,157 to $206,075 in the South East health region. As well, we calculated that the per-hour cost of service ranged from $35 in one health region to $67 in another health region. While the health regions have some information on the reasons for cost variations among agencies—for example, they noted that agencies that serve clients with acquired brain injuries tend to incur higher costs—the health regions have not assessed whether other variances are justified, and to what extent they are explained by factors such as geography or agencies' operational efficiencies.

Assisted Living Services Not Competitively Acquired

The Ministry has also not investigated the potential to competitively procure assisted living services. The health regions (since April 1, 2021, Ontario Health) can do little to improve the cost-effectiveness of the funds paid to assisted living agencies without competitively acquiring services. For example, while they can negotiate with the agencies on some measures of service levels, such as the number of unique clients to whom they are required to provide services over the year, and "resident days" (explained in **Section 2.4**), they cannot do much to negotiate a competitive price since there is no mechanism to facilitate competitive acquisition.

The Ministry informed us that Ontario Health Teams are at the early stages of implementation, but the Teams are built on the model of various health service agencies collectively determining how to best deliver services to a particular community with no assurance that the Teams will be delivering services at a competitive price; in turn, it is not evident how this approach will lead to the best value for clients of assisted living services. Six of the seven assisted living agencies we engaged with during our audit indicated that they were concerned about how this new funding approach would impact them; for example, two agencies voiced concerns regarding how a fair funding model would be established.

RECOMMENDATION 17

To obtain the best value for money for assisted living services, we recommend that the Ministry of Health monitor that Ontario Health Teams provide competitively acquired assisted living services to clients.

MINISTRY RESPONSE

Ontario Health Teams will be subject to government directives or guidelines related to the acquisition of services and the Ministry, in partnership with Ontario Health, will monitor compliance.

4.4.2 Data Reported by Assisted Living Agencies Not Useful to Confirm They Operate Efficiently

13 Health Regions Only Monitor Performance Indicators on Number of Clients Served and Service Days

Despite having access to a wide range of data reported into the Ministry, including detailed financial information and some overall patient care data such as total direct care hours the assisted living agency provides, 13 health regions confine their review of agencies to two measures: number of different clients served during a year and "resident days," which is the number of days where the agency provided service to a client. These two measures alone do not adequately reveal an agency's performance.

For example, although one agency met its performance targets, it was found in a subsequent operational review conducted by a third-party consulting company that the health region engaged, to have serious issues. Specifically, the review found that the agency was "incapable of meeting its obligations to both funders and the community"; the review was only conducted as a result of the agency's Board receiving a petition signed by a group of 46 consumers and supporters outlining a number of concerns, including service reductions, dysfunctional scheduling and treatment of attendants. The review also identified deficiencies in the orientation and training provided to attendants; high turnover of these staff; problems with how complaints were recorded and managed; and "severe disruptions" to vulnerable clients "who had nowhere else to go for the services they needed." This agency is in a health region where the health region only monitors agencies' performance using the two performance measures mentioned above.

The Ministry informed us these measures were chosen as part of the health regions' development of the accountability agreement with agencies including assisted living agencies, which included the identification of these performance measures. Ontario Health did not have information on the reasoning for choosing these measures.

Accountability Agreements Do Not Require Agencies to Report Key Performance Data

We found that the accountability agreements between the health regions (since April 1, 2021, Ontario Health) and the assisted living agencies do not require agencies to report key information that would allow health regions to appropriately oversee that agencies provide quality care to clients or operate efficiently. Specifically, the agreements do not hold agencies accountable to the health regions for the time spent providing care, the rate at which agencies accept clients referred by the health region (since April 1, 2021, HCCSS) or the frequency of missed visits. We explain these further in **Appendix 20**.

4.4.3 Health Regions Rarely Conduct Operational Reviews or Site Visits for Assisted Living Agencies

Health regions have conducted some site visits, and on rare occasions conducted further steps to monitor the performance of assisted living agencies, such as performing or commissioning an operational review. However, the scope of these activities did not include aspects of service delivery such as whether the agency provided service hours to clients according to their service plans and appropriately tracked and resolved client complaints. Deficiencies in the agency's performance in meeting clients' needs can therefore go undetected.

Our review of a sample of clients at the agencies indicated that they all developed service plans for their clients but two did not include the number of hours of service to be provided in the service plans, making it difficult for us to determine what level of care they had assessed for the client. Also, of the agencies that serve seniors, only one had support to show that it reviewed the service plans quarterly, as required by the 2011 Ministry policy.

Based on the service agreements, health regions can perform operational reviews of the agencies (agreements were taken on by Ontario Health on April 1, 2021). The agreements define an operational review as "a financial or operational audit, inspection

or other form of review requested or required by the health region, separate from an annual audit of the health service provider (agency's) financial statements." Since January 2016, only three of the 14 health regions have commissioned an operational review of an assisted living agency in the region. These reviews were conducted between 2018 and 2021; they all addressed the health region's concerns regarding the governance of the agencies, including the incurrence of deficits. Supervisors were appointed in all three cases to take over operations of the agency. For example, in 2018, the North East health region conducted a review at one agency where it identified significant governance and financial issues dating back to 2013/14. The review found that the Board was not focusing enough on strategy but instead on management-level discussions. It also found that communication between the health region and the agency's management regarding strategic direction and service focus was strained and unclear. Further, it noted that the agency restricted clients' services because of the high PSW turnover caused by the large geographic service area, and that the agency did not have sufficient measures of service quality.

Some health regions informed us that they performed site visits at assisted living agencies, but these were aimed at having discussions with agency management regarding the current status of the assisted living services programs, barriers to service delivery, and the current financial status of the agency. Conducting site visits and reviewing selected records at the agency can help the health region identify common concerns raised by clients. We reviewed the complaints log at one agency and noted that several clients reported concerns about missed care. For instance, one client reported that the attendant stayed 10 minutes for a 30-minute visit; another client stated that no one came to an afternoon visit; another client reported that the attendant gave her a slice of bread, but not a full breakfast because the attendant was "running late" and did not have time; and another client missed her medical appointment and had to incur a $130 cancellation fee with that medical professional because an attendant was late for a morning visit.

The *Connecting Care Act, 2019* provides Ontario Health with the authority to appoint investigators to report on the quality of the management or care or treatment provided by an assisted living agency or any other matter relating to an agency if Ontario Health determines it is in the public interest to do so. Ontario Health had not conducted any such activities at the time of our audit.

Health Regions and Ontario Health Did Not Corroborate Service Data with Agencies

Our audit work indicated that agencies were not consistently and accurately reporting data to the Ministry. While we identified minor or no discrepancies for half of the agencies we engaged with, for the other half of the agencies, their 2020/21 records indicated discrepancies of between 17% and 70% compared to what they had reported to the Ministry. Furthermore, for the same year, our work showed a variance of about 4,200 clients or 18% across all agencies when we compared the number of clients served that agencies had reported to the Ministry (**Figure 1**) and the number that we found when conducting our health region survey (**Figure 4**). Variances between clients served reported to the Ministry were also identified by Ontario Health during our audit.

While the Ministry maintains that the values that agencies reported to it are the most reliable, these discrepancies highlight the need for greater oversight on assisted living agencies going forward to help support more meaningful discussion and analysis of assisted living services.

RECOMMENDATION 18

To obtain the highest quality of services for the Ontarians who rely on assisted living services and maximize the value obtained from this funding, we recommend that Ontario Health:

- perform periodic risk-based audits on assisted living agencies to verify whether they complied with assisted living policy requirements such

as developing a service plan for each client and updating it regularly, and providing assisted living services only to clients whose capability assessment scores met eligibility requirements; and

- update the standard accountability agreement with assisted living agencies to use across the province to include the requirement to report data including time spent on providing care, Home and Community Care Support Services referral acceptance rate, and missed visits.

ONTARIO HEALTH RESPONSE

Ontario Health supports the requirement to conduct periodic risk-based audits on organizations delivering assisted living services. To ensure that assisted living service providers are meeting program policies and requirements, Ontario Health will review its current processes to enhance them for administering periodic risk-based audits, and for compliance with program policies.

Ontario Health supports this recommendation and will review and amend its service accountability agreements with assisted living agencies to include reporting requirements that are relevant to the program.

4.4.4 No Standards for Staff-to-Client Ratios for Agencies, which Increases Risk of Inconsistent Quality Care

The Ministry is not involved in setting minimum staff-to-client ratios for assisted living agencies and agreements between the health regions and agencies do not require this either. Our audit work of assisted living agencies indicated that each direct-care staff can be helping anywhere from seven clients during the day to 46 at night for unscheduled visits. Without enough staff, there is a higher risk of poor-quality services being provided to clients.

Furthermore, health regions are not involved in ensuring assisted living staff are properly trained. In contrast, through the *Retirement Homes Act, 2010*, retirement home operators are required to provide their direct-care staff with training related to abuse recognition and prevention, mental health issues, behaviour management and operation of personal assistance service devices. The Retirement Homes Regulatory Authority's inspectors review training records to assess skills and qualifications of staff as part of their inspection process of retirement homes and observe how staff perform their duties to confirm that they comply with the Act.

RECOMMENDATION 19

To improve the quality and consistency of assisted living services provided to clients, we recommend that the Ministry of Health establish standards for staff-to-client ratios (considering the level of client needs) and for direct-care staff qualifications (including minimum initial and ongoing training), and monitor that Ontario Health update the accountability agreements accordingly.

MINISTRY RESPONSE

The Ministry will work with Ontario Health to develop effective practices for staffing and staff training and monitor that Ontario Health update the accountability agreements as appropriate.

ONTARIO HEALTH RESPONSE

Ontario Health will amend its service accountability agreements with assisted living agencies, as appropriate, to reflect program standards as established by the Ministry of Health.

4.5 Complaint Process and Escalation

4.5.1 Vulnerable Clients Have Few Means of Advancing Complaints and Minimal Protection of Rights

Assisted living services, including those offered in buildings and in the community, have some of the

weakest complaint oversight among all services provided to vulnerable adults. Health regions have indicated that assisted living agencies are responsible for addressing complaints made about their services. Little third-party oversight is provided to verify the complaint resolution process is fair, such as from the Patient Ombudsman (which investigates complaints about long-term-care homes) or the health regions (which oversee complaints about home care services).

One stakeholder group we spoke with during the audit indicated that, in some instances, assisted living clients do not want to engage with an attendant who is the subject of their complaint out of a fear of reprisal, given that they rely on attendants to support them with activities of daily living.

We found that the Patient Ombudsman did not have oversight of assisted living services. Moreover, while the Retirement Homes Regulatory Authority oversees and responds to complaints about retirement homes, and the Ministry of Long-Term Care's Long-Term Care Home Quality Inspection Program oversees and investigates complaints about long-term care homes, no such mechanisms exist for assisted living services.

Additionally, a stakeholder group was concerned that the 2020 legislation governing assisted living services, which was not yet proclaimed (as explained in **Section 2.5)**, does not require agencies to have a bill of rights, included in the 1994 legislation that was still in effect during the audit. The current legislation requires approved agencies to fully respect and promote those rights. The Ministry informed us that the Act does not include a bill of rights because the Act covers several other health care sectors, including primary care and mental health and addiction, and so a generic bill of rights to cover all sectors would not be appropriate; however, it plans to include a bill of rights and a requirement that Ontario Health Teams and service agencies fully respect and promote those rights in regulations under the Act governing the provision of all home and community care services, including assisted living.

At the assisted living agency level, the *Home Care and Community Support Services Act, 1994* requires agencies to establish a process for reviewing complaints. However, our review of the logs in the agencies we engaged with indicated that, in some cases, very few complaints were recorded—for example, one in the last year, and in another case, the agency informed us that it shreds all complaints after they are resolved, so we could not assess whether the complaints process was sufficient.

Ontario Health informed us that it is not responsible for providing an escalation process for assisted living agencies, and that if clients contact it or an HCCSS organization for complaints regarding an assisted living agency, they will be re-directed to that agency's own internal complaints process. The Ministry informed us that its understanding is that clients can direct complaints about assisted living services to Ontario Health.

RECOMMENDATION 20

To better inform the public and to confirm that assisted living clients' complaints and concerns are resolved appropriately by the assisted living agencies, we recommend that Ministry of Health establish clear pathways for clients to raise complaints with an entity that has the authority to resolve them, and that is independent of the assisted living agency, such as Ontario Health or the Patient Ombudsman, and monitor accordingly.

MINISTRY RESPONSE

The Ministry accepts this recommendation and agrees with the Auditor General about the importance of ensuring that persons receiving assisted living services have appropriate processes available to make complaints about the quality of their care.

Through the public engagement process related to proposed home and community care regulations under the *Connecting People to Home and Community Care Act, 2020,* the Ministry communicated its intention to enhance complaints

process requirements, including when those services are provided under the assisted living services program.

In this process, the Ministry has also communicated its intention to refine the scope of the Patient Ombudsman's jurisdiction to include personal support services provided by community agencies in programs such as assisted living services.

4.5.2 Ministry Requires Agencies to Report Complaints to Health Regions, but Health Regions Do Not Get Involved in the Process

Recognizing the importance of overseeing complaints by clients who are often vulnerable individuals, the Ministry's 2011 policy stated that assisted living agencies must report the number of complaints they receive to the health regions (since April 1, 2021, Ontario Health), as well as how the complaints were resolved. The health regions must provide this information to the Ministry. However, this has never occurred at either level.

We found that only two health regions (Toronto Central and North Simcoe Muskoka) required assisted living agencies to report serious incidents to them, as outlined in their accountability agreements with the agencies. These health regions, however, did not define what constitutes a serious incident or provide examples of such. For the agencies we engaged with, in 2019/20 and 2020/21, no such incidents were reported to their health regions.

Surveys are one way to obtain feedback from clients on their concerns regarding service; however, such surveys are conducted by the agencies rather than the health regions that are responsible for monitoring the performance of agencies. This arrangement could be problematic if clients do not feel comfortable complaining to the agencies that provide their care, also out of a fear of reprisals.

Health Regions Did Not Maintain Detailed Records of Complaints

To determine the types of complaints that were being made about assisted living agencies and the type of follow-up conducted, we requested complaint logs of assisted living services from all 14 health regions. Four health regions indicated they did not have a log since addressing complaints is the responsibility of the agencies. The other 10 forwarded their logs to us, but noted that they do not have the legal authority to investigate situations where assisted living clients or their families have had concerns with the assisted living services provided.

Our review of these logs from January 2017 to July 2021 showed that each health region had between zero and 30 complaints per year; about half of the complaints were focused on the sufficiency of services and quality of services, such as missed scheduled care visits and a decrease in the quality of care.

We found that depending on the health region, the level of detail recorded varied significantly. For example, Toronto Central region included the nature of the complaint, the agency involved, a description of the issue, any actions taken, a contact at the health region and the outcome, while Mississauga Halton region provided very little and, in some cases, no detail about the complaints. For over 20% of the entries, the logs did not contain sufficient information for us to understand the nature of the complaint and so we could not categorize them.

Health Regions Did Not Confirm that Complaints Were Appropriately Resolved

Our review of a sample of complaints also indicated that health regions do not consider themselves to be responsible for a thorough complaint investigation process. We also found that, in some cases, health region staff could not provide us with enough information to provide a clear understanding of what had occurred and whether the health region's follow-up

was adequate. **Appendix 21** shows a sample of these complaints, which include concerns regarding client safety and the inherent difficulties of complaining to those who provide direct care.

RECOMMENDATION 21

To protect assisted living clients from harm and poor-quality services, we recommend that Ontario Health:

- define serious incidents and include the reporting of them as a requirement in the accountability agreements with assisted living agencies;
- develop a standard format of complaints log, require assisted living agencies to document all information in the log, and track and monitor this information fully; and
- follow up, on a timely basis, with assisted living agencies to confirm each complaint is appropriately resolved or refer the cases to an appropriate third party as noted in **Recommendation 20**.

ONTARIO HEALTH RESPONSE

Ontario Health recognizes the important role that the collection and reporting of serious incident data plays in ensuring and improving the safe delivery of assisted living services. Ontario Health commits to working with health system partners in establishing a process for tracking and monitoring serious incidents, including using a common definition of serious incidents across health sectors, where possible. To support the implementation of this recommendation, Ontario Health will amend its service accountability agreements with assisted living agencies, as appropriate, to reflect the reporting requirements.

As Ontario Health Teams evolve, they will be well positioned to follow up on individual client complaints to ensure that they are appropriately resolved.

4.5.3 Clients Can Appeal Complaint Decisions to the Health Services Appeal and Review Board, but not Those Related to Quality of Care

Most Appeals with the Health Services Appeal and Review Board Relate to Service Levels

The *Home Care and Community Services Act, 1994* allows clients to appeal certain decisions made by assisted living agencies to the Health Services Appeal and Review Board (explained in **Section 2.3.3**). The Board can adjudicate agencies' decisions on the quantity of service, such as reduction or termination of service or a finding of ineligibility, but not on the quality of service.

The Ministry explained that the Board is limited in its jurisdiction and authority and is not in the best position to address the root cause of quality issues, such as poor management of the agency, and that the assisted living agency's funder—Ontario Health—would be in the best position to address the root causes of quality issues.

We reviewed the summary of cases that were brought to the Board between January 2016 and May 2021 and found only 13 cases that related to assisted living services, most of which related to allegations of unreasonable reduction of hours of services provided to clients. For example, a client experienced a reduction in personal support services of 8.25 hours a week because the agency implemented a "workforce transformation" to address the personal support worker shortage in the province. The Board rescinded the decision of the agency and directed it to comply with the service hours set in the client's service plan.

We could not determine if the relatively small number of complaints indicated that clients were largely satisfied with their services, were unaware of the ability to escalate complaints to the Board, or had complaints that related to quality of service and so did not use the Board. We reviewed the complaints received by the assisted living agencies that we engaged with during the audit and found instances where clients or their families had concerns about the quality of care received. At one agency, several clients complained that their attendants were not providing

proper care—for instance, that the attendant was "rough" with a client who was in a lot of pain and could not move much; did not change a soiled soaker pad; did not apply barrier cream properly; did not give medication; or did not give a shower.

Revised Legislation Still Does Not Protect Clients from Receiving Poor Quality of Care

The *Connecting People to Home and Community Care Act, 2020*, similar to the 1994 legislation that it will replace once the repeal is proclaimed, does not contain any independent appeal model for complaints relating to quality of services. One stakeholder group informed us that examples of poor quality of service could include: treating a client roughly when providing services; not respecting how an individual wants their services to be delivered; hygiene or other routines skipped due to "lack of time"; or using scented products when asked not to.

The stakeholder group is also concerned that the 2020 legislation allows for-profit organizations to provide assisted living services under contract to a non-profit organization, which is the current framework. The stakeholder group was concerned that service quality may be sacrificed to obtain cost efficiencies. As noted in our April 2021 *Special Report on Pandemic Readiness and Response in Long-Term Care*, 13 of 15 with the highest number of resident deaths were operated by for-profit entities.

RECOMMENDATION 22

To protect assisted living clients from harm and poor-quality services, we recommend that the Ministry of Health, through regulation under the *Connecting People to Home and Community Care Act, 2020,* develop appropriate processes whereby assisted living services clients can appeal each type of complaint, including those related to quality of care, that they do not believe were appropriately resolved.

MINISTRY RESPONSE

The Ministry agrees with the Auditor General about the importance of ensuring that persons receiving assisted living services have appropriate processes available to make complaints about the quality of their care.

Through the public engagement process related to proposed home and community care regulations under the *Connecting People to Home and Community Care Act, 2020*, the Ministry communicated its intention to enhance complaints process requirements, including when those services are provided under the assisted living program.

In this process, the Ministry has also communicated its intention to refine the scope of the Patient Ombudsman's jurisdiction to include personal support services provided by community agencies in programs such as assisted living services.

4.6 Agency-Operated Assisted Living Buildings

4.6.1 Assisted Living Services Delivered in over 140 Assisted Living Buildings by Agencies that also Act as Clients' Landlord, Despite Ministry Not Fully Supporting this Model of Care

Neither the Ministry nor many health regions (since April 1, 2021, Ontario Health) had information on the location of assisted living buildings where the agency that provides care services to clients is also the clients' landlord. Since 1994, it has been the Ministry's policy that service delivery should not include housing management, yet we found that there are no additional procedures to guard against the types of risks that these arrangements present for clients such as charging clients for assisted living services—which is a violation of the *Home Care and Community Services Act, 1994*. Moreover, when we requested information on agency-operated assisted living buildings from the health regions, four regions (Central East, Erie St. Clair, Hamilton Niagara Haldimand Brant and South West) were not aware of which assisted living services are delivered in agency-operated buildings

and had to obtain this information from their assisted living agencies at our request.

Bill 164, the *Protecting Vulnerable Persons in Supportive Living Accommodation Act, 2020*, a private member's bill, which was referred to the Standing Committee on General Government in November 2020, highlights the risk of abuse inherent in these arrangements. As well, the Ministry's 1994 policy also suggested that, as much as possible, service delivery should not include housing management since it helps in "striking a power balance between consumer and service provider."

While the policy notes that this separation may not always be possible, neither the Ministry, health regions nor Ontario Health have assessed the appropriateness or possible options for these agencies that operate assisted living buildings. For example, the Ministry has not sought to competitively acquire services for the tenants of these buildings from another agency unrelated to the landlord. As noted in **Section 4.4.1**, neither the Ministry nor the health regions have competitively acquired assisted living services.

Assisted living agencies should not be charging clients for personal support services or homemaking services: the charging of personal support services violates the *Home Care and Community Services Act, 1994*; the assisted living agency is funded to provide homemaking services based on assessed needs. But the Ministry did not have any information on whether such charges were occurring. However, we found that two of the seven agencies we engaged with during the audit, both of which also are landlords of assisted living buildings, charge assisted living clients for certain services. We tried to determine how much was charged for care services but could not readily do so because the invoices clients received did not indicate what services were charged for, though tax documentation provided to clients indicated that in one instance, 25% of the $40,000 annual expense was for care costs. The agency explained that its approach to providing services to assisted living building residents was to charge its clients who were more capable of caring for themselves for required services, and to use the assisted living funding to provide services evenly across the remaining 19 or 25% of its assisted living clients. Furthermore, we found that some agencies were charging clients for medication management services even though this service is provincially funded. The Ministry acknowledges that there may be a lack of clarity regarding the prohibition of charging for provincially funded services and informed us that it is committed to examining opportunities to clarify the scope of permitted charges to assisted living agencies.

The Ministry informed us that if a client is receiving assisted living services, then the agency is not allowed to charge the client for services but that the agency can bill others who may live in the building for assisted living services. However, since the identities of assisted living clients are not reported to the Ministry or Ontario Health (health regions prior to April 1, 2021) and invoices provided to residents may not indicate to a resident if the person is considered to be an assisted living client, it could be difficult to determine if a client was being inappropriately charged.

The health regions did not establish any process to prevent such agencies from billing clients for publicly funded services, for example, by requiring agencies to obtain a special purpose auditor opinion that confirms that clients are not billed for care services that have also been paid for through the public purse. The risk of this type of situation occurring is further heightened by the lack of oversight mechanisms, as mentioned in **Section 4.4.**

4.6.2 Some Assisted Living Buildings Exempt from Meeting More Stringent Fire Code Requirements, Putting Residents at Risk of Harm

According to our analysis of information on assisted living buildings that we obtained from our survey of health regions and from care occupancy information provided by the Office of the Fire Marshal, only 59 or 13% of the 449 assisted living buildings are classified as "care occupancies." Assisted living services are

not defined in either the *Fire Protection and Prevention Act, 1997* or in the Fire Code, a regulation under this Act. That said, assisted living buildings that a local fire department determines fall under the "care occupancy" classification are required to adhere to additional fire safety requirements because of the enhanced risk that fire poses to certain vulnerable populations. Long-term-care homes and retirement homes are also subject to similar requirements. One of the key factors that is considered in the definition of care occupancy is whether residents can evacuate without assistance.

Local fire departments are responsible for enforcing Fire Code requirements and those that apply to buildings containing care occupancies are more stringent than those that apply to buildings containing only residential occupancies. For example, under the Fire Code, buildings containing care occupancies are required to have sprinklers installed and to undertake an annual fire drill that is overseen and approved by the local fire department. Fire departments may identify Fire Code violations following a building inspection in a care occupancy.

Six of the seven agencies we engaged with deliver assisted living services in buildings. Following our virtual tours with a sample of the buildings from the six agencies that had assisted living buildings, we found that 11 of the 20 buildings did not have fire sprinklers in client units, while the others did.

RECOMMENDATION 23

To protect vulnerable adults living in assisted living buildings from the risk of financial exploitation and fire, we recommend that the Ministry of Health, in conjunction with Ontario Health:

- update the inventory of assisted living buildings that was compiled for this audit (**Appendix 8**) and include other relevant information, including the characteristics of services provided to clients in those buildings;
- develop mechanisms to segregate the provision of services from landlord responsibilities, such as competitively procuring services from another agency;
- monitor whether assisted living agencies charge for other provincially funded services, including personal support and/or homemaking services, and take corrective actions where non-compliances are noted; and
- identify which assisted living buildings should be considered as care occupancy under the *Fire Protection and Prevention Act, 1997* and share the listing with the Office of the Fire Marshal for enforcement of the Fire Code.

MINISTRY RESPONSE

The Ministry accepts this recommendation.

The Ministry appreciates the effort put forward by the Auditor General in completing this inventory. The Ministry is committed to working with our partners at Ontario Health to examine the type of data that is collected from assisted living health service providers to ensure Ontario Health and the Ministry maintain current and informative information.

The Ministry will research and assess mechanisms to delineate the provision of services from landlord responsibilities.

The Ministry will partner with Ontario Health to review and clarify where charging for provincially funded services is prohibited by policy or legislation, communicate to assisted living services delivery partners the need for compliance and take corrective actions where non-compliance is noted.

The Ministry will share with the Office of the Fire Marshal a list of buildings in which assisted living service is provided. The Ministry will also work with the Office of the Fire Marshal to identify buildings that meet the definition of care occupancy in the *Fire Protection and Prevention Act, 1997* to continue to ensure compliance with these important laws. As well, the Ministry will partner with Ontario Health to communicate this with assisted living service providers.

ONTARIO HEALTH RESPONSE

Ontario Health supports this recommendation and will work with the Ministry of Health to ensure that the appropriate information is being collected to inform the assisted living buildings inventory, and once established, that it is reviewed and kept up to date.

4.6.3 No Inspections and Little Knowledge of COVID-19 Outbreaks in Assisted Living Buildings

Health Region and Ministry Did Not Inspect Assisted Living Buildings

Of the 449 assisted living buildings in Ontario, 24 are funded by the government as supportive housing units. These 24 buildings collectively have 740 units. We found that neither the health regions (since April 1, 2021, Ontario Health) nor the Ministry knows how many of these units are occupied by assisted living clients or the condition of their living situations. The Ministry may visit these assisted living buildings, but it does not formally inspect them to assess the condition of the living spaces that it has financed.

The health regions also do not perform inspections of rooms and congregate settings, such as dining rooms or living areas, to determine whether residents' rights, safety and care meet minimum standards, nor do they oversee whether homes have appropriate processes for medication administration, such as a medication tracking records for each client, even though some assisted living buildings are responsible for ensuring clients take their medication; in particular, we found that the agency that oversaw assisted living services for clients with an acquired brain injury kept the medication of clients in a locked cabinet and oversaw medication administration. In addition, clients with cognitive impairment or dementia would also potentially require more direct supervision of their medication-taking practices. Given that all of the assisted living buildings we engaged with indicated that some of their clients would be eligible for long-term care, such oversight is all the more important. By comparison, the Retirement Homes Regulatory Authority inspects retirement homes and the Ministry of Long-Term Care inspects long-term care homes. We found that most other Canadian provinces oversee assisted living buildings through licensing, inspections and/or investigations.

Additionally, some of these assisted living buildings would not be subject to licensing and inspection oversight by the Retirement Homes Regulatory Authority (Authority) if they, in their entirety or partially, are considered to be a supportive housing program funded under specific legislations. In accordance with the *Retirement Homes Act, 2010*, a retirement home is defined as a residential complex or a part of a residential complex that includes rental units and is occupied primarily by persons aged 65 or older, is occupied by or intended to be occupied by at least six people unrelated to the operator of the home, and where the home operator makes at least two care services available, whether directly or indirectly, to the residents. The Ministry has not shared the list of buildings where assisted living services are provided with the Authority. We confirmed with the Authority that during the course of our audit, it had found one such assisted living building that appeared to meet the definition of a retirement home under the *Retirement Homes Act, 2010* and that the Authority was in the process of working with that building owner to ensure that it was in compliance with that Act. However, the Ministry noted that if there is a portion of such a building in which assisted living clients live, this would not be subject to the Authority's oversight; the building would then be subject to Ontario Health's oversight under the *Home Care and Community Services Act, 1994*. As noted in **Section 4.4**, this oversight was minimal.

We also found that public health units have had little involvement with assisted living buildings, despite some requirements to inspect and ensure safe premises in these buildings. We contacted a sample of public health units; they informed us that they respond to outbreaks but do not perform any proactive infection prevention and control inspections. As noted in **Section 4.5.2**, an agency

allegedly operated a unit that was infested with cockroaches and fungi. We contacted that public health unit and was informed that the health region (Toronto Central) did not refer this case. In the public health unit's view, such a referral should have been made. Similarly, a family member of a resident of one of these assisted living buildings contacted our Office and informed us that the family member was not provided with showers at the frequency agreed upon, resulting in multiple infections, some of which required admission to a hospital. The family member also alleged that the client lived in an unsanitary environment and had several injuries while in their unit at the building. This included a head injury from a fall for which the agency did not provide timely support. In fact, the resident was unable to access the unscheduled care needed because the call button in the unit had been out of order for an extended time. The family member addressed their concerns with the home but informed us the agency did not take effective action to address the concerns. The family member also forwarded some of her concerns to the Ministry of Health and the health region but did not receive assistance from either because both indicated it was not their responsibility to be involved. Neither Ontario Health nor the health region has conducted a site visit at this building to ensure the client had received appropriate care.

COVID-19 Impact on Assisted Living Services Not Known

The Ministry is unable to determine the extent to which assisted living buildings have experienced COVID-19 outbreaks because it lacks information on the locations of all congregate buildings where assisted living services are provided. Likewise, Public Health Ontario was unable to determine the extent to which assisted living buildings have experienced COVID-19 outbreaks because it has not been provided with a list of names and addresses for all congregate buildings where assisted living services are provided so that outbreaks in that setting can be identified in the data. In addition, Public Health Ontario informed us that while public health units collect disease incidence data such as on COVID-19 infections and deaths, the *Health Protection and Promotion Act* does not specify the collection of information on what type of services a client receives outside of a hospital, for example, assisted living services or other services.

The Ministry informed us that the responsibility to vaccinate residents of assisted living buildings resides with local public health units and it therefore does not have information on the extent to which they were prioritized locally—for example, with on-site vaccination clinics. We spoke to a sample of public health units; they informed us that they vaccinate residents of assisted living buildings based on the Ministry's eligibility guidelines and scheduling availability. The set-up of on-site vaccination clinics depended on whether the assisted living building had appropriate physical space. We requested vaccination data from the buildings operated by agencies we engaged with and found resident vaccination rates of 86% to 100% as of September 30, 2021, though one agency informed us that it could not obtain this information due to privacy issues.

In August 2021, the Ministry released a directive that requires, by September 7, 2021, that most health care organizations, including assisted living agencies, have a COVID-19 vaccination policy that requires its employees to provide proof of vaccination or written proof of a medical reason for not being fully vaccinated. If they cannot, they must either undergo regular testing or complete an educational session about the benefits of vaccination, although health care organizations may choose to exclude the option of educational sessions in their policies. Our review of the policies of the seven agencies we engaged with indicated all agencies complied with this directive. However, as of September 30, 2021, staff vaccination rates at these agencies ranged from 54% to 99%.

RECOMMENDATION 24

To provide assisted living clients with protection against infection from COVID-19 and future infectious disease outbreaks, we recommend that the Ministry of Health, in conjunction with Ontario Health:

- identify aspects of assisted living buildings that require oversight, including infection prevention and control, care standards and safety, and work with other partners, such as public health units, to conduct regular, risk-based inspections; and
- work with the Ministry for Seniors and Accessibility to share the listing of assisted living buildings with the Retirement Homes Regulatory Authority such that buildings that meet the conditions in the *Retirement Homes Act, 2010* are regulated as retirement homes.

MINISTRY RESPONSE

The Ministry accepts this recommendation.

The Ministry will identify aspects of assisted living buildings and programs that require oversight regarding infection prevention and control (IPAC), care standards and safety.

The Ministry is working with Ontario Health and other partners on the IPAC Hub initiative, which provides a province-wide network to congregate living settings. This network is a formal and co-ordinated pathway to access IPAC expertise through local IPAC Hubs to encourage readiness, prevention, and management of outbreaks in their settings. This model, although developed in response to the COVID-19 pandemic, is intended to be leveraged in future years.

The Ministry will also further examine with Ontario Health and public health units opportunities to strengthen inspection protocols.

The Ministry will work with the Ministry for Seniors and Accessibility to share a list of buildings in which assisted living service is provided with the Retirement Homes Regulatory Authority.

ONTARIO HEALTH RESPONSE

Ontario Health supports this recommendation and will work with the Ministry of Health to identify aspects of care that require oversight.

Appendix 1: Transfer Payments to Assisted Living Agencies, 2016/17–2020/21

Sources of data: Ministry of Health and Ontario Health

	Agency Name	Health Region	Annual Transfer Payments ($)					# of Clients Served	Avg Payment Per Client ($)
			2016/17	2017/18	2018/19	2019/20	2020/21	2020/21	2020/21
1	Community Care Durham	Central East	1,088,955	1,088,955	1,091,041	1,088,955	1,088,955	482	2,259
2	Haliburton Highlands Health Services	Central East	757,638	757,638	759,385	757,638	757,638	115	6,588
3	Carefirst Seniors and Community Services Association	Central East	1,050,541	1,050,541	1,052,694	1,050,541	1,050,541	293	3,585
4	Scarborough Centre for Healthy Communities	Central East	521,134	536,802	573,552	573,362	573,362	121	4,739
5	Yee Hong Centre – Scarborough McNicoll	Central East	463,851	463,851	464,738	463,851	463,851	156	2,973
6	Participation House Toronto	Central East	507,103	507,103	508,271	507,103	506,604	5	101,321
7	Momiji Health Care Society	Central East	853,845	903,845	905,900	903,845	828,845	221	3,750
8	March of Dimes Canada – Durham	Central East	1,289,048	1,289,048	1,351,258	1,289,048	1,289,048	22	58,593
9	St. John's Retirement Home Inc.	Central East	694,877	694,877	696,181	694,877	769,654	121	6,361
10	Kawartha Participation Projects	Central East	4,193,442	4,193,442	4,219,937	4,209,233	4,110,442	70	58,721
11	St. Paul L'Amoreaux Centre	Central East	1,054,658	–	–	–	–	–	–
12	Branch 133, Legion Village Inc.	Central East	1,178,310	1,166,200	1,216,388	1,216,839	1,289,060	68	18,957
13	Campbellford Memorial Hospital (CSS)	Central East	423,025	419,172	494,776	480,822	396,506	30	13,217
14	Senior Persons Living Connected	Central East	–	1,054,658	1,056,675	1,054,658	1,054,658	112	9,417
15	Community Care, City of Kawartha Lakes	Central East	989,578	989,578	991,477	989,578	989,578	166	5,961
16	Canadian Red Cross – Ontario Zone, Northumberland	Central East	195,092	112,727	–	–	–	–	–
17	Transcare Community Support Services	Central East	707,828	707,828	709,390	707,828	707,828	173	4,091
18	Carefirst Seniors and Community Services Association	Central	1,917,044	1,917,044	1,965,518	1,999,303	2,128,053	230	9,252
19	Etobicoke Service for Seniors	Central	1,275,730	1,192,613	1,214,726	1,202,339	1,202,339	125	9,619
20	Community Home Assistance to Seniors (CHATS)	Central	5,897,464	6,341,853	6,475,531	6,465,897	6,465,897	404	16,005
21	Circle of Home Care Services (Toronto)	Central	2,729,716	3,650,589	4,122,766	4,167,025	3,864,019	350	11,040

	Agency Name	Health Region	Annual Transfer Payments ($)					# of Clients Served	Avg Payment Per Client ($)
			2016/17	2017/18	2018/19	2019/20	2020/21	2020/21	2020/21
22	St. Demetrius Supportive Care Services	Central	740,423	764,525	759,132	758,193	740,193	90	8,224
23	Yee Hong Centre – Markham	Central	240,688	519,251	1,216,228	1,223,688	1,223,688	86	14,229
24	Villa Colombo	Central	1,472,416	1,472,416	1,510,317	1,507,754	1,507,754	158	9,543
25	PACE Independent Living	Central	5,524,307	5,481,859	5,587,582	5,883,955	5,564,730	156	35,671
26	Lumacare Services	Central	1,696,667	1,979,981	2,278,310	2,275,019	2,275,019	469	4,851
27	March of Dimes Canada – York	Central	4,073,205	4,198,205	4,307,363	4,298,962	4,298,962	67	64,164
28	City of Toronto	Central	535,258	530,378	544,949	543,107	545,942	n/a[1]	n/a[1]
29	North Yorkers for Disabled Persons Inc	Central	853,130	883,130	888,130	873,605	873,605	10	87,361
30	Cerebral Palsy Parent Council of Toronto (Participation House)	Central	2,294,895	2,292,530	2,360,313	2,322,142	2,381,809	47	50,677
31	Access Independent Living Services	Central	3,468,858	3,615,921	4,007,119	4,066,307	3,769,647	53	71,125
32	North York Seniors Centre	Central	1,299,108	1,301,950	1,334,311	1,331,742	1,331,742	93	14,320
33	Parkway House	Champlain	730,533	652,033	740,568	603,774	589,463	12	49,122
34	Personal Choice Independent Living/ Choix Personnel Vie Autonome	Champlain	2,930,485	2,928,628	3,126,895	2,232,414	–	–	–
35	North Renfrew Long-Term Care Services Inc.	Champlain	1,037,463	1,031,040	1,066,890	928,673	961,987	14	68,713
36	Montfort Renaissance Inc. (CSS)	Champlain	1,118,730	1,122,358	1,294,689	1,147,546	1,141,105	50	22,822
37	Williamsburg Non-Profit Housing Corporation/ MacIntosh Seniors' Support Centre	Champlain	981,733	960,536	982,086	992,086	992,086	72	13,779
38	Participation House Support Services (Champlain)	Champlain	–	–	–	149,329	456,785	2	228,393
39	Services communautaires de Prescott et Russell	Champlain	62,484	305,727	376,325	457,163	457,163	25	18,287
40	Perley and Rideau Veterans' Health Centre (The)	Champlain	1,815,740	1,822,271	1,872,655	1,971,134	2,051,684	92	22,301
41	Ottawa West Community Support	Champlain	927,675	930,578	1,077,523	1,345,487	1,345,487	65	20,700
42	Hawkesbury and District General Hospital (CSS)	Champlain	198,220	–	–	–	–	–	–
43	Barry's Bay & Area Senior Citizens Home Support Program Inc.	Champlain	477,084	478,535	944	–	–	–	–

	Agency Name	Health Region	Annual Transfer Payments ($)					# of Clients Served	Avg Payment Per Client ($)
			2016/17	2017/18	2018/19	2019/20	2020/21	2020/21	2020/21
44	VHA Health & Home Support	Champlain	3,948,801	4,121,041	4,244,410	6,158,098	7,900,404	199	39,701
45	Carleton Residence Attendant Services Program	Champlain	731,002	771,393	748,886	744,185	677,129	n/a[1]	n/a[1]
46	Algonquins of Pikwàkanagàn	Champlain	231,906	245,027	221,514	221,514	220,196	23	9,574
47	Carefor Health & Community Services – Ottawa-Carleton Branch	Champlain	468,376	1,032,091	3,905,853	3,883,268	4,209,624	185	22,755
48	Renfrew Victoria Hospital/Palliative Care Service	Champlain	427,726	427,607	437,091	436,259	433,659	15	28,911
49	Grove Arnprior & District NH – Arnprior and District Memorial Hospital (CSS)	Champlain	488,381	456,582	608,403	479,634	433,634	18	24,091
50	Mills Community Support Corporation	Champlain	870,071	872,974	902,175	887,472	887,472	40	22,187
51	Canadian Red Cross Society – Cornwall	Champlain	3,278,111	3,045,271	–	–	–	–	–
52	Marianhill Inc.	Champlain	793,537	795,569	811,087	809,408	741,958	65	11,415
53	Bruyère Continuing Care Inc. – Palliative Care Program	Champlain	2,507,139	2,919,622	2,970,441	3,098,825	2,983,641	101	29,541
54	CANES Community Care	Central West	4,763,020	4,819,221	4,894,259	5,194,856	4,950,435	345	14,349
55	Peel Senior Link (Central West)	Central West	663,908	685,828	701,581	723,550	705,512	40	17,638
56	Dufferin County Community Support Services	Central West	577,620	577,494	591,565	627,901	598,358	35	17,096
57	Holland Christian Homes	Central West	743,975	747,695	765,950	812,959	774,709	67	11,563
58	Services and Housing in the Province – CSS	Central West	–	–	–	–	5,231	n/a[1]	n/a[1]
59	Peel Cheshire Homes (Brampton) Inc.	Central West	–	–	–	885,159	845,159	10	84,516
60	Caledon Community Services	Central West	2,115,691	2,167,655	1,998,802	2,309,298	2,101,028	164	12,811
61	Richview Community Care Services Corporation	Central West	1,268,201	1,349,643	1,354,318	1,405,682	1,354,722	128	10,584
62	March of Dimes Canada – Sarnia	Erie St. Clair	3,565,048	3,886,414	3,997,907	3,762,042	3,968,042	213	18,629
	March of Dimes Canada – Sarnia (Short-Term Transition Care Program[2])	Erie St. Clair	–	(273,750)	(250,000)	(300,000)	(100,000)	71	1,408
63	Victorian Order of Nurses	Erie St. Clair	489,444	494,338	495,270	494,338	494,338	34	14,539

	Agency Name	Health Region	Annual Transfer Payments ($)					# of Clients Served	Avg Payment Per Client ($)
			2016/17	2017/18	2018/19	2019/20	2020/21	2020/21	2020/21
64	Canadian Mental Health Association Lambton	Erie St. Clair	–	–	–	–	7,755	n/a[1]	n/a[1]
65	Assisted Living Southwestern Ontario	Erie St. Clair	7,970,052	8,419,425	8,381,563	7,939,763	8,460,763	165	57,924
	Assisted Living Southwestern Ontario (Short-Term Transition Care Program[2])	Erie St Clair	–	(23,412)	(518,000)	(700,000)	(500,000)	259	1,931
66	Canadian Red Cross, Chatham-Kent Branch	Erie St. Clair	279,945	69,993	132	–	–	–	–
67	Chippewas of Kettle and Stony Point Home Support Program	Erie St. Clair	17,948	177,563	177,898	177,563	177,563	n/a[1]	n/a[1]
68	Heidehof Long Term Care Home	Hamilton Niagara Haldimand Brant	919,437	919,437	921,796	919,437	919,437	84	10,946
69	Positive Living Niagara	Hamilton Niagara Haldimand Brant	838,412	838,412	838,412	789,249	789,249	36	21,924
70	Conway Opportunity Homes	Hamilton Niagara Haldimand Brant	635,131	635,131	636,681	635,131	635,131	10	63,513
71	United Mennonite Home	Hamilton Niagara Haldimand Brant	349,928	349,928	349,928	429,928	389,928	52	7,499
72	Regional Municipality of Niagara	Hamilton Niagara Haldimand Brant	980,039	800,039	801,888	800,039	800,039	31	25,808
73	March of Dimes Canada – Hamilton	Hamilton Niagara Haldimand Brant	2,791,240	2,791,240	2,791,240	2,798,879	2,791,240	56	49,844
74	March of Dimes Canada – Niagara	Hamilton Niagara Haldimand Brant	6,142,990	6,142,990	6,157,558	6,400,990	6,628,990	393	16,867
75	CNIB – Hamilton	Hamilton Niagara Haldimand Brant	741,432	741,432	743,260	–	–	–	–
76	Good Shepherd Centre Hamilton (The)	Hamilton Niagara Haldimand Brant	1,590,436	1,590,436	1,538,355	1,587,387	1,639,969	180	9,111
77	Hamilton Jewish Home for the Aged – Shalom Village	Hamilton Niagara Haldimand Brant	386,170	386,170	388,076	386,170	386,170	59	6,545

	Agency Name	Health Region	Annual Transfer Payments ($)					# of Clients Served	Avg Payment Per Client ($)
			2016/17	2017/18	2018/19	2019/20	2020/21	2020/21	2020/21
78	Mennonite Brethren Senior Citizens Home (Tabor Manor)	Hamilton Niagara Haldimand Brant	923,853	923,853	923,853	923,853	793,303	259	3,063
79	Pleasant Manor Retirement Village – Heritage Place	Hamilton Niagara Haldimand Brant	1,276,860	1,276,860	1,276,860	1,294,387	1,311,914	150	8,746
80	Participation House Brantford	Hamilton Niagara Haldimand Brant	2,951,459	3,658,029	3,745,960	3,736,958	3,736,958	97	38,525
81	Ableliving Services Inc.	Hamilton Niagara Haldimand Brant	8,061,941	8,321,467	8,825,620	9,674,406	11,154,576	216	51,642
82	Niagara District Homes Committee for the Physically Disabled (The)	Hamilton Niagara Haldimand Brant	833,316	833,316	833,316	963,316	898,316	15	59,888
83	Capability Support Services Inc.	Hamilton Niagara Haldimand Brant	3,234,369	3,234,369	3,242,730	3,341,426	3,544,955	89	39,831
84	Niagara Ina Grafton Gage Village	Hamilton Niagara Haldimand Brant	1,358,765	1,358,765	1,693,883	1,736,823	1,750,327	191	9,164
85	Six Nations of the Grand River	Hamilton Niagara Haldimand Brant	–	51,024	51,024	61,024	56,024	3	18,675
86	St. Joseph's Home Care	Hamilton Niagara Haldimand Brant	1,968,115	2,268,900	2,846,676	3,500,470	3,500,809	301	11,631
	St. Joseph's Home Care (Short-Term Transition Care Program[2])	Hamilton Niagara Haldimand Brant	–	–	(209,957)	(209,957)	(209,957)	75	2,799
87	Nucleus Housing	Mississauga Halton	9,719,154	10,013,769	10,436,139	10,657,327	10,256,316	427	24,019
	Nucleus Housing (Short-Term Transition Care Program[2])	Mississauga Halton	–	–	–	(926,439)	(926,439)	25	37,058
88	Oakville Senior Citizens Residence	Mississauga Halton	5,958,631	6,026,306	6,061,345	6,003,956	6,226,398	660	9,434
89	Forum Italia Community Services – MICBA	Mississauga Halton	881,848	892,073	865,070	863,580	890,094	95	9,369
90	Yee Hong Centre for Geriatric Care	Mississauga Halton	672,966	672,966	691,004	686,425	686,425	36	19,067
91	Peel Senior Link	Mississauga Halton	6,111,209	6,620,526	6,863,522	6,659,290	6,615,631	335	19,748

	Agency Name	Health Region	Annual Transfer Payments ($)					# of Clients Served	Avg Payment Per Client ($)
			2016/17	2017/18	2018/19	2019/20	2020/21	2020/21	2020/21
92	March of Dimes Canada – Peel	Mississauga Halton	8,664,781	8,664,781	8,957,874	9,125,282	8,838,077	193	45,793
93	Links2Care	Mississauga Halton	205,628	205,628	210,064	209,740	209,740	24	8,739
94	Regional Municipality of Halton – Supportive Housing	Mississauga Halton	3,701,624	3,689,679	3,783,876	3,806,494	3,799,617	241	15,766
95	Ivan Franko Home (Mississauga)	Mississauga Halton	525,092	425,741	384,577	383,820	383,820	15	25,588
96	Victorian Order of Nurses for Canada – Peel Site	Mississauga Halton	2,126,651	2,198,422	2,306,675	2,310,466	2,310,390	153	15,101
97	Independent Living Halton – Joyce Scott Non-Profit Homes Inc.	Mississauga Halton	384,734	384,734	393,027	406,159	427,948	5	85,590
98	Cheshire Homes – Peel Cheshire Homes Inc. (Brampton)	Mississauga Halton	866,630	841,489	897,872	–	–	–	–
99	Cheshire Homes – Peel Cheshire Homes Inc. (Streetsville)	Mississauga Halton	558,483	499,430	510,306	509,419	526,100	10	52,610
100	Halton Healthcare Services Corporation – Supportive Housing Program	Mississauga Halton	451,638	451,638	461,429	460,671	460,671	54	8,531
101	Canadian Deafblind Association Ontario Chapter	Ministry Managed Program	297,007	297,007	297,007	297,007	297,007	n/a[1]	n/a[1]
102	Head Injury Rehabilitation Ontario	Ministry Managed Program	408,000	43,820	-	-	-	-	-
103	Physically Handicapped Adults' Rehabilitation Association	North East	1,921,926	2,044,261	2,085,151	2,085,151	2,085,151	44	47,390
104	Huron Lodge Community Service Board Inc.	North East	2,303,312	2,303,312	2,353,795	2,349,382	2,349,382	66	35,597
105	ICAN–Independence Centre and Network	North East	3,520,187	3,954,379	4,360,429	4,460,429	4,610,429	119	38,743
	ICAN-Independence Centre and Network (Short-Term Transition Care Program[2])	North East	-	(188,000)	(188,000)	(188,000)	(188,000)	16	11,750
106	Services de santé de Chapleau Health Services (CSS)	North East	164,583	164,583	167,873	167,873	167,873	24	6,995
107	North Shore Health Network Community Support Services – CSS	North East	321,508	-	-	-	-	-	-
108	Au Château Home for the Aged – CSS	North East	284,705	284,705	290,790	290,395	290,395	17	17,082
109	Access Better Living Inc.	North East	580,875	580,875	592,495	592,495	592,495	14	42,321

	Agency Name	Health Region	Annual Transfer Payments ($)					# of Clients Served	Avg Payment Per Client ($)
			2016/17	2017/18	2018/19	2019/20	2020/21	2020/21	2020/21
110	Aide aux seniors de Sudbury Est/Sudbury East Seniors Support Inc.	North East	518,142	543,625	555,295	554,495	580,695	66	8,798
111	Ukrainian Seniors' Centre of Sudbury Inc.	North East	203,492	203,492	207,855	207,562	256,892	40	6,422
112	Timiskaming Home Support – Soutien à Domicile	North East	797,916	604,494	917,414	1,498,543	1,415,868	72	19,665
113	Cassellholme – CSS	North East	1,247,589	1,242,589	1,299,765	1,298,039	1,298,039	57	22,773
114	March of Dimes Canada – Sudbury	North East	2,484,133	2,705,467	2,796,035	2,792,217	2,792,217	117	23,865
115	VON – Ontario Branch – Greater Sudbury Site	North East	1,001,325	1,298,810	1,166,818	1,324,790	1,184,790	46	25,756
116	The Friends	North East	1,788,254	1,813,254	1,849,524	1,879,508	1,879,508	89	21,118
117	Ontario Finnish Resthome Association	North East	1,182,766	1,182,766	1,208,204	1,206,426	1,206,426	253	4,768
118	Finlandia Village	North East	1,595,570	1,545,466	1,546,390	1,546,390	1,546,390	253	6,112
119	Canadian Red Cross – Sudbury Branch	North East	4,112,073	4,280,407	4,366,017	4,366,017	4,366,017	64	68,219
120	Helping Hands, Orillia	North Simcoe Muskoka	2,310,357	2,685,042	3,278,658	2,583,526	2,163,154	102	21,207
121	IOOF Seniors Homes Inc.	North Simcoe Muskoka	690,147	725,147	2,381,635	5,247,750	6,257,978	354	17,678
	IOOF Seniors Homes Inc. (Short-Term Transition Care Program[2])	North Simcoe Muskoka	-	-	(1,640,000)	(2,851,800)	(5,110,700)	227	18,450
122	March of Dimes Canada – Barrie	North Simcoe Muskoka	–	299,914	1,013,899	1,012,847	1,012,847	60	16,881
123	(Georgian, Trillium & Sunset Manors) Corporation of the County of Simcoe	North Simcoe Muskoka	363,040	786,040	1,127,506	370,301	422,876	38	11,128
124	Independent Living Services of Simcoe County and Area	North Simcoe Muskoka	4,152,355	4,152,355	4,235,402	4,235,402	4,235,402	91	46,543
125	LOFT Community Services	North Simcoe Muskoka	–	–	–	1,731,460	1,081,460	513	2,108
126	The Canadian Red Cross Society, Simcoe County Branch	North Simcoe Muskoka	1,177,703	670,205	–	–	–	–	–
127	Wendat Community Programs (CSS)	North Simcoe Muskoka	298,376	337,176	344,497	348,420	364,400	27	13,496
128	Northwestern Independent Living Services Inc.	North West	477,796	618,136	–	–	–	–	–

	Agency Name	Health Region	Annual Transfer Payments ($)					# of Clients Served	Avg Payment Per Client ($)
			2016/17	2017/18	2018/19	2019/20	2020/21	2020/21	2020/21
129	Community Services for Independence North West	North West	2,864,384	3,460,044	4,107,025	4,138,822	4,311,968	95	45,389
130	Brain Injury Services of Northern Ontario	North West	2,422,597	2,991,240	3,061,271	3,121,340	3,121,340	121	25,796
131	Pinecrest – CSS	North West	1,275,728	1,275,728	1,337,852	1,395,728	1,395,728	n/a[1]	n/a[1]
132	Nipigon District Memorial Hospital (CSS)	North West	106,000	156,000	156,260	156,000	156,000	19	8,211
133	Corporation of the City of Thunder Bay	North West	988,778	988,778	990,425	988,778	988,778	121	8,172
134	Dilico Ojibway Child and Family Services	North West	–	–	–	60,000	120,000	9	13,333
135	Patricia Region Senior Services Inc.	North West	507,606	557,606	558,534	557,606	557,606	59	9,451
136	St. Joseph's Care Group (CSS)	North West	4,402,920	3,163,877	3,214,443	3,215,877	3,233,877	313	10,332
	St. Joseph's Care Group (CSS) (Short-Term Transition Care Program[2])	North West	–	(30,000)	(85,858)	(40,000)	(40,000)	1	40,000
137	North of Superior Healthcare Group – CSS	North West	108,000	108,000	220,180	190,000	240,000	32	7,500
138	Geraldton District Hospital (CSS)	North West	–	–	–	25,200	60,000	n/a[1]	n/a[1]
139	Sante Manitouwadge Health – CSS	North West	–	–	–	47,900	53,800	34	1,582
140	Riverside Health Care Facilities Inc. (Rainycrest) – CSS	North West	334,711	334,711	395,268	454,711	454,711	48	9,473
141	Wesway	North West	–	–	706,250	697,700	697,700	n/a[1]	n/a[1]
142	March of Dimes Canada – East Region	South East	1,033,298	1,033,298	1,052,900	1,052,900	1,052,900	38	27,708
143	Cheshire Homes (Hastings-Prince Edward) Inc.	South East	715,624	689,599	739,281	722,810	702,681	288	2,440
144	Providence Care Centre	South East	513,800	513,800	523,545	523,545	523,545	n/a[1]	n/a[1]
145	Ingersoll Services for Seniors	South West	381,617	381,617	390,088	461,566	461,566	32	14,424
146	Regional HIV/AIDS Connection (CSS)	South West	439,652	489,527	449,411	448,349	448,349	12	37,362
147	Four Counties Health Services	South West	278,780	278,780	284,968	274,918	284,295	7	40,614
148	Participation House Support Services	South West	5,217,548	6,082,782	6,299,974	7,177,894	6,972,612	41	170,064
149	Corporation of the Town of St. Marys – Home Support Services	South West	161,143	161,143	164,720	164,331	160,537	6	26,757
150	St. Marys & Area Home Support Services	South West	–	–	–	–	22,723	7	3,246

	Agency Name	Health Region	Annual Transfer Payments ($)					# of Clients Served	Avg Payment Per Client ($)
			2016/17	2017/18	2018/19	2019/20	2020/21	2020/21	2020/21
151	Spruce Lodge	South West	371,718	524,987	420,928	564,733	564,733	27	20,916
152	Multi-Service Centre	South West	1,019,214	1,115,583	1,080,525	1,512,372	1,512,372	58	26,075
153	Participation Lodge – Grey Bruce	South West	2,003,687	2,083,687	2,048,165	2,072,482	2,163,679	20	108,184
154	Victorian Order of Nurses – Oxford Branch	South West	–	270,312	499,184	564,145	521,378	21	24,828
155	Victorian Order of Nurses – Perth-Huron Branch	South West	–	98,959	176,193	163,777	175,777	8	21,972
156	Victorian Order of Nurses for Canada – Ontario Branch Grey-Bruce	South West	1,799,676	1,799,676	1,839,625	1,990,858	2,052,478	154	13,328
157	Victorian Order of Nurses for Canada – Ontario Branch Middlesex	South West	2,508,524	2,895,541	3,187,761	3,325,028	3,325,028	139	23,921
158	One Care Home and Community Support Services	South West	793,162	793,162	810,769	953,653	953,653	31	30,763
159	Cheshire Homes of London, Inc.	South West	8,162,008	8,434,263	8,811,939	9,406,516	9,406,516	177	53,144
160	West Elgin Community Health Centre	South West	871,726	871,726	847,577	1,016,571	947,693	37	25,613
161	Canadian Red Cross, Woodstock Branch	South West	1,195,163	535,760	–	–	–	–	–
162	Good Shepherd Ministries	Toronto Central	644,419	644,419	656,174	654,085	689,085	14	49,220
163	Etobicoke Service for Seniors	Toronto Central	70,441	70,441	70,797	70,441	70,441	n/a[1]	n/a[1]
164	Copernicus Lodge	Toronto Central	726,822	726,822	739,102	737,724	737,724	200	3,689
165	Tobias House Attendant Care Inc.	Toronto Central	4,573,188	4,573,188	1,529,355	381,099	–	–	–
166	NABORS	Toronto Central	1,169,458	1,169,458	1,189,301	1,187,000	1,222,000	12	101,833
167	Storefront Humber	Toronto Central	1,899,104	1,899,104	2,473,641	2,427,590	2,427,590	145	16,742
168	New Visions Toronto	Toronto Central	878,253	878,253	891,427	891,427	926,427	96	9,650
169	Warden Woods Community Centre	Toronto Central	338,796	338,796	344,617	343,878	368,878	n/a[1]	n/a[1]
170	West Toronto Support Services	Toronto Central	1,425,438	1,425,438	1,428,941	1,425,438	356,364	n/a[1]	n/a[1]
171	PACE Independent Living	Toronto Central	3,808,854	3,808,854	3,869,484	3,808,854	4,158,854	55	75,616
172	Reconnect Community Health Services (CSS)	Toronto Central	–	3,088,527	3,141,519	3,134,855	4,203,929	451	9,321

	Agency Name	Health Region	Annual Transfer Payments ($)					# of Clients Served	Avg Payment Per Client ($)
			2016/17	2017/18	2018/19	2019/20	2020/21	2020/21	2020/21
173	The Ontario Community Centre for the Deaf (Bob Rumball Centre for the Deaf)	Toronto Central	1,205,795	1,205,795	1,226,054	1,223,882	1,258,882	48	26,227
174	March of Dimes Canada – Toronto	Toronto Central	5,030,074	5,030,074	5,065,083	5,135,218	5,130,074	62	82,743
175	St Christopher House (Soc. Integrat.)	Toronto Central	–	–	–	–	136,311		
176	St. Christopher House	Toronto Central	1,764,540	1,764,540	1,795,033	1,791,008	1,826,008	166	11,000
177	Woodgreen Community Services	Toronto Central	6,175,872	5,675,076	5,771,714	5,760,202	5,760,202	893	6,450
178	Dixon Hall	Toronto Central	593,308	593,308	602,208	602,208	602,208	96	6,273
179	City of Toronto – Long-Term Care Homes & Services – Supportive Housing	Toronto Central	4,064,548	4,064,548	4,134,795	4,125,516	4,225,516	330	12,805
180	Les Centres d'Accueil Heritage – Centre des Pionniers	Toronto Central	490,933	485,985	494,722	493,275	493,275	58	8,505
181	Fife House Foundation	Toronto Central	1,568,761	2,017,816	2,115,141	1,592,292	2,183,601	502	4,350
182	St. Hilda's Towers	Toronto Central	1,102,441	1,552,441	1,120,900	1,118,978	1,153,978	74	15,594
183	St. Clair O'Connor Community Inc	Toronto Central	447,851	447,851	455,393	454,569	479,569	35	13,702
184	St. Matthew's Bracondale House	Toronto Central	388,491	388,491	389,240	388,491	388,491	70	5,550
185	Bellwoods Centres	Toronto Central	4,493,610	5,360,720	7,470,982	7,168,555	8,818,855	105	83,989
	Bellwoods Centres (Short-Term Transition Care Program[2])	Toronto Central	–	(544,434)	(1,407,368)	(2,352,481)	(1,002,300)	33	30,373
186	Hellenic Home for the Aged Inc.	Toronto Central	225,858	225,858	229,246	229,246	229,246	n/a[1]	n/a[1]
187	LOFT Community Services	Toronto Central	4,650,770	4,650,770	4,731,355	4,720,532	4,720,532	431	10,953
188	Family Service Toronto	Toronto Central	367,889	367,889	374,168	373,407	398,407	23	17,322
189	The Neighbourhood Group Community Service	Toronto Central	1,716,575	1,716,575	1,744,622	1,597,131	1,777,324	388	4,581
190	Native Canadian Centre of Toronto	Toronto Central	314,843	280,031	285,228	284,231	299,231	260	1,151
191	Vibrant Healthcare Alliance (CSS)	Toronto Central	–	–	3,125,530	4,260,687	4,641,786	45	103,151
192	The Salvation Army – Meighen Retirement Residence	Toronto Central	356,033	356,033	356,825	356,033	356,033	69	5,160

	Agency Name	Health Region	Annual Transfer Payments ($)					# of Clients Served	Avg Payment Per Client ($)
			2016/17	2017/18	2018/19	2019/20	2020/21	2020/21	2020/21
193	Baycrest Centre for Geriatric Care	Toronto Central	1,780,543	1,780,543	1,783,864	1,780,543	1,780,543	164	10,857
194	Canadian Red Cross – Toronto	Toronto Central	1,800,533	1,425,423	–	–	–	–	–
195	Senior Peoples' Resources in North Toronto, Inc.	Toronto Central	3,265,941	3,165,941	5,346,747	3,213,430	3,213,430	342	9,396
196	St. Clair West Services for Seniors (Toronto Central LHIN)	Toronto Central	3,088,527	–	–	–	–	–	–
197	Traverse Independence Not-For-Profit	Waterloo Wellington	1,708,738	1,708,738	1,708,738	1,708,738	1,708,738	29	58,922
198	Independent Living Centre of Waterloo Region	Waterloo Wellington	2,606,964	2,606,964	2,606,964	2,606,964	2,606,964	73	35,712
199[3]	Guelph Independent Living	Waterloo Wellington	2,155,302	2,155,302	2,155,302	2,155,302	2,155,302	80	26,941
Total Funding (including Short-Term Transition Care Program[2])			**314,860,559**	**324,209,167**	**339,083,261**	**345,944,462**	**349,933,235**		
COVID-19 Related Funding							38,160,138		
Total[4]			**314,860,559**	**324,209,167**	**339,083,261**	**345,944,462**	**388,093,373**	**21,645**	**17,930[1]**

Note: Data on transfer payments from the Ministry of Health. Data on number of clients served from Ontario Health.

1. Ontario Health did not have this data for all agencies. As a result, the provincial average cost per client is different than what is shown in **Figure 8.**
2. The Ministry has provided funding to select assisted living service agencies since 2017/18 under the short-term transition care program. The program provides temporary accommodation and care to patients designated as alternate level of care (ALC) or at risk of being designated as ALC to free up hospital space so they can be transitioned to an appropriate destination. In contrast, funding to other assisted living agencies does not include accommodation costs. In 2020/21, the Ministry provided a total of $8.1 million in funding under this program to serve 1,255 assisted living clients. The portion of funding under this program is shown in parentheses.
3. In 2020/21, 182 assisted living agencies provided services to clients. This list includes 17 agencies that received funding from the Ministry in prior years but not in 2020/21.
4. Transfer payment amounts are slightly different than expenditures reported in the Public Accounts due to accounting adjustments.

Appendix 2: Change in Responsibility for Planning, Funding, Overseeing and Co-ordinating Care for Assisted Living Services, Before April 1, 2007–Current

Prepared by the Office of the Auditor General of Ontario

Responsibility	Before Apr 1, 2007	Apr 1, 2007–Jun 20, 2017	Jun 21, 2017–Mar 31, 2021	Apr 1, 2021–Current
Health system planning	Ministry of Health (Ministry)	Local Health Integration Networks (LHINs)[1]	LHINs	Ontario Health[2]
Funding	Ministry	LHINs[1]	LHINs	Ontario Health[2]
Performance management	Ministry	LHINs[1]	LHINs	Ontario Health[2]
Oversight of service delivery	Ministry	LHINs[1]	LHINs	Ontario Health[2]
Eligibility determination and wait-list management	Assisted living agencies	Community Care Access Centres or assisted living agencies[3]	LHINs or assisted living agencies	Home and Community Care Support Services organizations[4] or assisted living agencies

1. The province's 14 Local Health Integration Networks (LHINs) began assuming their role in managing local health services in April 2007, starting with the hospital sector. By July 2010, the LHINs had fully assumed their role over all other health sectors, including community health and support services such as assisted living.
2. Non-patient care functions from the province's 14 LHINs, such as health system planning, funding and community engagement functions, were transferred to Ontario Health effective April 1, 2021.
3. Prior to 2011, only assisted living agencies were involved in this role. After the Ministry implemented the policy on assisted living in 2011, the role was shared between the province's 14 Community Care Access Centres (CCACs) and the assisted living agencies depending on the service model. The province's 14 CCACs were transferred to the LHINs in May and June 2017.
4. LHINs continued to operate under a new name–Home and Community Care Support Services–with a narrowed mandate to deliver and arrange patient services on April 1, 2021.

Appendix 3: Key Responsibilities of Ministry of Health and Ontario Health as Indicated in the Accountability Agreement Effective October 1, 2021

Source of data: Ministry of Health

Area of Responsibility	Ministry of Health (Ministry)	Ontario Health
General performance obligations	Develop reporting requirements relating to government priorities and notify Ontario Health of the requirements.	• Ensure that service agencies meet any Ontario Health and Ministry reporting requirements as may be outlined in their service accountability agreements. • Respond to Ministry data requests and complete analytic and reporting products, analyses, and performance evaluations as requested by the Ministry.
Health service provider oversight	Support Ontario Health to be the primary contact point with service agencies.	• Hold service agencies accountable through service accountability agreements for the delivery of services funded by Ontario Health and in accordance with provincial standards, directives and guidelines. • Work with the Ministry and service agencies to modernize service accountability agreements, performance management, and funding processes to reflect desired outcomes. • Work with service agencies to achieve identified outcomes and identify and implement measures in support of improved performance. • Inform the Ministry of non-compliance by a service agency with an agreement or legislation that has not been resolved to Ontario Health's satisfaction.
Information management	Communicate applicable policies, processes, standards, requirements, mechanisms, timelines and issues as they relate to priorities and current and applicable strategies to Ontario Health.	• Require service agencies to submit data information as communicated by the Ministry, to the Ministry or a third party. • Require service agencies to make best efforts to meet integrated information management and analytics targets, data quality and submission timelines.

Note: On April 1, 2021, the Local Health Integration Networks (LHINs) continued to operate under a new business name, Home and Community Care Support Services (HCCSS) with a narrowed mandate to deliver and arrange patient services; non-patient functions (such as planning and funding) of the LHINs were transferred to Ontario Health. The service accountability agreements that existed between the LHINs and health service provider organizations, such as assisted living agencies, were transferred to Ontario Health as of that day.

Appendix 4: Comparison of Assisted Living and Home Care According to Legislation and Ministry of Health Policies as of April 1, 2021

Prepared by the Office of the Auditor General of Ontario

	Assisted Living	Home Care
Governing legislation	*Home Care and Community Services Act, 1994*	*Home Care and Community Services Act, 1994*
Funded by	Ministry of Health, through Ontario Health	Ministry of Health
Services provided by	Third-party service agencies that are not-for-profit	Third-party service agencies that are either for-profit or not-for-profit
Associations representing service agencies	Ontario Community Support Association AdvantAge Ontario Ontario Association of Independent Living Service Providers	Home Care Ontario Ontario Community Support Association
Client population	Seniors who meet eligibility criteria under the Ministry's 2011 assisted living policy, individuals with acquired brain injuries, individuals with HIV/AIDS and individuals with physical disabilities	People of all ages who meet the eligibility criteria listed in a regulation under the *Home Care and Community Services Act, 1994*, and require care in their home, school or in the community
Initial needs assessed by	Either third-party service agencies or Home and Community Care Support Services (HCCSS)	HCCSS
Main assessment tool used	Service agencies: interRAI-CHA (community health assessment) HCCSS: interRAI-HC (home care)	interRAI-CA (contact assessment) interRAI-HC interRAI-Palliative
Family-managed home care available (i.e., provincial funding to family to purchase care from a provider of their choice)	No	Clients must meet the eligibility requirements for traditional home care and have a plan of service developed by the HCCSS. They must also meet eligibility requirements for the program and belong to one of the four patient groups: • Children with complex medical needs • Adults with acquired brain injuries • Eligible home-schooled children • Patients in extraordinary circumstances as assessed by a HCCSS care co-ordinator
Available services		
Personal support services (e.g., bathing, dressing, toileting)	Yes	Yes
Homemaking (e.g., laundry, house cleaning)	Yes	Yes

	Assisted Living	Home Care
Professional services (e.g., nursing, speech and language therapy, occupational therapy, social work)	No (not provided by an assisted living agency but can be arranged and provided by HCCSS)	Yes
24/7 unscheduled visits	Yes	No*
Security checks (i.e., where someone calls to check on the client's health and safety)	Yes	No
Reassurance services (i.e., where someone visits the home to check on the client)	Yes	No, but home care clients can access these services through community support services

* Some HCCSS organizations have specialized programs that offer 24/7 unscheduled visits for certain individuals, such as those with complex needs discharged from hospital or at end-of-life.

Appendix 5: Jurisdictional Comparison of Assisted Living Service Programs

Prepared by the Office of the Auditor General of Ontario

Assisted Living Services (Ontario)	**Designated Supportive Living** (Alberta)	**Assisted Living** (British Columbia)	**Supportive Housing** (Manitoba)	**Ressources intermédiaires** (Quebec)	**Adult Residential Facilities** (New Brunswick)
Definition of program					
Supports people with special needs who require services at a greater frequency or intensity than home care but without the medical monitoring or 24/7 nursing supervision provided in long-term care	**Level 3 Program:** Provides 24/7 health and personal care and individuals live independently **Level 4 Program:** Provides a higher level of services onsite for scheduled and unscheduled care needs compared to the Level 3 Program **Level 4D Program:** Provides specialized dementia care to Level 4 residents	Provides 24/7 housing, hospitality services, social and recreational opportunities and personal care services to adults who require a supportive environment due to physical and functional health challenges	For people who require access to 24/7 supervision and some assistance managing activities of daily living with physical limitations, or ongoing health conditions such as dementia	Provides residents a living environment and access to support services for individuals with minor to moderate loss of autonomy	**Generalist Care Homes:** Provides residents with 24/7 access to supervision and personal care services. Residents require increased assistance in activities of daily living but are encouraged to participate in conducting these activities as much as they are able **Community Residences:** Provides residents with 24/7 access to supervision, assistance with activities of daily living and nursing care when required

Assisted Living Services (Ontario)	**Designated Supportive Living** (Alberta)	**Assisted Living** (British Columbia)	**Supportive Housing** (Manitoba)	**Ressources intermédiaires** (Quebec)	**Adult Residential Facilities** (New Brunswick)
Service settings and model					
Operators of assisted living buildings are responsible for providing personal support and homemaking services, some of which is offered in assisted living buildings that may be owned by assisted living agencies and some within private homes within the community.	Designated Supportive Living operators provide or arrange for the delivery of personal care and homemaking services.	Operators of assisted living facilities are responsible for providing housing, supervision, personal care services and hospitality services.	Supportive housing sponsor/landlord provides housing, meals and services.	Residences are owned and managed by operators. Personal care and medical services are delivered by the local health network.	Operators provide housing, 24/7 supervision and personal care services to residents.

Assisted Living Services (Ontario)	**Designated Supportive Living** (Alberta)	**Assisted Living** (British Columbia)	**Supportive Housing** (Manitoba)	**Ressources intermédiaires** (Quebec)	**Adult Residential Facilities** (New Brunswick)
Eligibility requirements					
Clients who require personal support services and/or homemaking in order to remain in the community, and are: • seniors at high risk of hospitalization or admission to long-term care; or • 16 and over with physical disabilities; or • 16 and over with acquired brain injuries; or • 16 and over who are living with HIV or AIDS.	**Level 3 Program:** Individuals who are: • Medically and physically stable but live with physical disability, mental health diagnoses or mild dementia with no known risk of wandering, and are not a risk to self or others; • able to move independently or with the assistance of one other person; and • able to use a call system to get help. **Level 4 and 4D Programs:** • Individuals who have more complex medical needs that are predictable and safely managed with onsite, professional nursing and the direction of the case manager, such as those with moderate to severe dementia; and/or • may require chronic disease management; and/or assistance with daily activities.	Individuals who: • are 19 years of age or older with disabilities, mental disorders and/or substance use issues; • require both hospitality (e.g., housekeeping, laundry, meals) and personal care services; • are able to make their own decisions, or have a spouse living with them who can make decisions on their behalf; and • are at significant risk in their current living environment.	Adults who: • can no longer manage on their own without some form of support; • require assistance with personal care, meals, medication management; and • are minimally dependent on support for ambulation/mobility.	Vulnerable adults experiencing: • a loss of autonomy linked to aging; and/or • an intellectual disability; • a mental health or addiction problem; and/or • a physical disability.	**Generalist Care Home:** Individuals who: • are 19 years of age or older; • have inhibiting health condition or are physically frail (including dementia); • ambulate with some assistance; and • require 24/7 supervision as well as assistance with personal care and activities of daily living. **Community Residences:** Individuals who: • are 19 to 64 years of age; • have physical and/or mental health conditions; • may have additional cognitive and/or behavioural difficulties; • require 24/7 supervision and assistance with personal care; and • may ambulate independently or with some assistance.

Assisted Living Services (Ontario)	**Designated Supportive Living** (Alberta)	**Assisted Living** (British Columbia)	**Supportive Housing** (Manitoba)	**Ressources intermédiaires** (Quebec)	**Adult Residential Facilities** (New Brunswick)
Who pays?					
Publicly funded	Publicly funded for health and personal care services Residents pay for their accommodations, which include housing, utilities, meals and homemaking, with a maximum charge set by the Ministry of Health.	Mixed funding Residents pay a monthly rate based on income for housing, personal care services and hospitality services. If payment of the monthly rate would cause the resident financial hardship, they may apply for a temporary rate reduction.	Publicly funded for health and personal care services Residents pay for housing, meals and light housekeeping.	Publicly funded for health and personal care services Residents pay for housing, meals and homemaking based on an estimate of whether the individual will require more or less than two years in the residence.	The government has set a maximum per diem rate for housing and all services that can be charged by operators. The per diem rate per client is based on a financial assessment conducted by the Ministry of Social Development.
Oversight—licensing and inspections					
Buildings are not subject to licensing or inspections.	The government sets provincial accommodation standards for supportive living and monitors compliance through annual site inspections as required by the *Supportive Living Accommodation Licensing Act*. Non-compliance may result in a refusal to renew a licence, licence cancellation or a stop order.	The *Community Care and Assisted Living Act* requires assisted living operators to register their residences and meet provincial health and safety standards. The Ministry of Health's Assisted Living Registry Branch monitors compliance with legislation of registered facilities, investigates complaints, conducts inspections and publishes this information publicly. Based on inspections and compliance checks, the Branch can cancel or suspend registrations.	Facilities are not subject to licensing or inspections.	The Ministry of Health and Social Services conducts regular quality assessment visits of residences. Results are posted on the Ministry's website, including whether the home is complying with legislation.	Operators must meet all requirements as outlined in the provincial *Standards and Procedures for Adult Residential Facilities* to be licensed to operate. Regional public health inspectors conduct annual inspections that are unannounced and usually take one to two days to complete. If an area of non-compliance is found during a visit or a follow-up, it will be indicated on a publicly available inspection report, published by the Department of Social Development.

Assisted Living Services (Ontario)	**Designated Supportive Living** (Alberta)	**Assisted Living** (British Columbia)	**Supportive Housing** (Manitoba)	**Ressources intermédiaires** (Quebec)	**Adult Residential Facilities** (New Brunswick)
# of individuals or units serviced by program, 2020/21					
23,116 individuals	11,916 spaces, consisting of 1,513 (Level 3), 6,924 (Level 4) and 3,479 (Level 4D)	4,345 units	764 units	16,991 individuals	197 units (Generalist Care Homes) and 670 units (Community Residences)

Appendix 6: Examples of Service Recipient Experiences with Assisted Living Services

Source of data: selected assisted living agencies

Ruth's Family's Story

Ruth's family was first introduced to assisted living services following a two-week hospital stay for their mother. At 93, Ruth and her husband had been doing well living alone in their home, but it became clear that they could use some additional assistance. The assisted living services helped Ruth transition home in December 2017 and continued to support her for more than three years.

Ruth shared a lot of updates with her caregivers and was not shy about sharing her opinions. Ultimately, every caregiver learned how she liked her team and they all became like family. It was Ruth's final wish to be at home when she passed away, something that was made possible through the efforts of the caregivers from the assisted living service provider.

When Ruth's family brought her home from the hospital under palliative care, they did so with the knowledge that the caregivers who had become like family to her would be there around the clock to ensure her comfort during her final days. They were grateful for the caring, compassionate services provided by the caregivers' assisted living service provider.

Emily's Family's Story

Emily has been receiving ongoing and consistent care from her assisted living service agency over the past several years. Her independent living apartment has been wonderful for her confidence and independence. The familiar surroundings make her feel comfortable. While her dementia is progressive, the staff have been attentive to her needs without being intrusive, which allows her to continue to be independent at the age of 92. Of importance, she loves the meals, which is reassuring to her family that she is receiving well-balanced nutritious meals daily.

Overall, Emily's family is happy with the care provided. Emily tells her family often that she is very happy at the assisted living home.

Note: Obtained from a sample of assisted living agencies we engaged with during the audit. The names, locations and identifying details have been changed to protect privacy.

Appendix 7: Location Where Assisted Living Programs are Delivered, May 2021

Source of data: Ontario Health

Where Services are Delivered	Description of Setting	# of Assisted Living Programs	% of Total
Assisted living buildings	A standalone, central "hub"	254	50
Community	Private homes in the community (no central hub)	58	11
Both assisted living buildings and the surrounding community	In a central building and outside in the community near the assisted living building hub	195	39
Total		**507**	**100**

Appendix 8: List of Agencies that Own or Operate an Assisted Living Building, June 2021

Source of data: Ontario Health

	Health Region	Operated by	Address
1	Central	Carefirst	9893 Leslie St., Richmond Hill, ON L4B 3Y3
2	Central	Circle of Care	155 Kendal Avenue, Toronto, ON M5R 3S8
3	Central	Community Head Injury Resource Services of Toronto (CHIRS)	62 Finch Avenue West, Toronto, ON M2N 7G1
4	Central	Community Head Injury Resource Services of Toronto (CHIRS)	2 St Georges Blvd, Etobicoke, ON M9R 1W9
5	Central	North Yorkers for Disabled Persons	2880 Bayview Ave, North York, ON M2N 5K3
6	Central East	Legion Village Inc.	111 Hibernia Street, Cobourg, ON K9A 4Y7
7	Central East	Carefirst Seniors & Community Services Association	300 Silver Star Blvd., Scarborough, ON M1V 0G2
8	Central East	Kawartha Participation Projects	77 Towerhill Road, Peterborough, ON K9H 7N3
9	Central East	Momiji Health Care Society	3555 Kingston Rd, Scarborough, ON M1M 3W4
10	Central East	Participation House – Toronto Parent Association	1 Burnview Crescent, Toronto, ON M1H 1B4
11	Central East	St. John's Retirement Homes Inc.	440 Water Street, Peterborough, ON K9H 7K6
12	Central East	Yee Hong Centre for Geriatric Care	90 Scottfield Drive, Scarborough, M1S 5W4
13	Central West	Dufferin County	200 Mill Street, Shelburne, ON L9V 3R2
14	Central West	Dufferin County	40 Lawrence Avenue, Orangeville, ON L9W 2X1
15	Central West	Holland Christian Homes	7900 McLaughlin Road South, Brampton, ON L6Y 5A7
16	Central West	Peel Cheshire Homes Brampton	156 Murray Street, Brampton, ON L6X 3L7
17	Champlain	Algonquins of Pikwàkanagàn	1669 Mishomis Inamo, Pikwàkanagàn, ON K0J 1X0
18	Champlain	Bruyère Continuing Care	889 Hawatha Park Drive, Orleans, ON K1C 0A9
19	Champlain	Carefor Health and Community Services	700 Mackay St, Pembroke, ON K8A 1G6
20	Champlain	Carefor Health and Community Services	1026 Laurier Street, Rockland, ON K4K 1V6
21	Champlain	J. W. MacIntosh Community Support Services	4324 Villa Drive, Williamsburg, ON K0C 2H0
22	Champlain	Montfort Renaissance Inc.	162 Murray St, Ottawa, ON K1N 5M8
23	Champlain	North Renfrew Long-Term Care Services Inc.	47 Ridge Road, Deep River, ON K0J 1P0
24	Champlain	Parkway House	2475 Regina Street, Ottawa, ON K2B 6X3
25	Champlain	The Perley and Rideau Veterans' Health Centre (Facility 1)	1720 Russell Road, Ottawa, ON K1G 0N1
26	Champlain	The Perley and Rideau Veterans' Health Centre (Facility 2)	1750 Russell Road, Ottawa, ON K1G 0N1
27	Champlain	VHA Health and Home Support	1604 Pullen Avenue, Ottawa, ON K1G 0N7
28	Erie St. Clair	March of Dimes Canada	1212 Michigan Avenue, Sarnia, ON N7S 6M7
29	Hamilton Niagara Haldimand Brant	Ableliving Services Inc.	2080 Trinity Church Rd, Binbrook, ON L0R 1C0
30	Hamilton Niagara Haldimand Brant	Benevolent Society Heidehof For The Care Of The Aged	600 Lake St, St. Catharines, ON L2N 4J4
31	Hamilton Niagara Haldimand Brant	Benevolent Society Heidehof For The Care Of The Aged	565 Lake St, St. Catharines, ON L2N 7R9
32	Hamilton Niagara Haldimand Brant	Capability Support Services Inc.	1401 Ontario Street, Burlington, ON L7S 1G3

	Health Region	Operated by	Address
33	Hamilton Niagara Haldimand Brant	Capability Support Services Inc.	107 Appleblossom Drive, Hamilton, ON L9C 7P1
34	Hamilton Niagara Haldimand Brant	Capability Support Services Inc.	657B Lock Street West, Dunnville, ON N1A 1V9
35	Hamilton Niagara Haldimand Brant	Good Shepherd Centre Hamilton (The)	10 Pearl St., Hamilton, ON L8R 2Y8
36	Hamilton Niagara Haldimand Brant	Hamilton Jewish Home for the Aged – Shalom Village	70 Macklin St N, Hamilton, ON L8S 3S1
37	Hamilton Niagara Haldimand Brant	Mennonite Brethren Senior Citizens Home (Tabor Manor)	1 Tabor Drive, St. Catharines, ON L2N 1V9
38	Hamilton Niagara Haldimand Brant	Niagara District Homes Committee For The Physically Disabled	675 Tanguay Avenue, Welland, ON L3B 6A1
39	Hamilton Niagara Haldimand Brant	Niagara Ina Grafton Gage Home Of The United Church	413 Linwell Rd, St. Catharines, ON L2M 7Y2
40	Hamilton Niagara Haldimand Brant	Ontario March Of Dimes – Hamilton	66 West 28th Street, Hamilton, ON L9C 5A6
41	Hamilton Niagara Haldimand Brant	Participation House Brantford (Facility 1)	10 Bell Lane, Brantford, ON N3T 6A6
42	Hamilton Niagara Haldimand Brant	Participation House Brantford (Facility 2)	10 Bell Lane, Brantford, ON N3T 6A6
43	Hamilton Niagara Haldimand Brant	Participation House Brantford (Facility 3)	10 Bell Lane, Brantford, ON N3T 6A6
44	Hamilton Niagara Haldimand Brant	Pleasant Manor Retirement Village	15 Elden Street, Virgil, ON L0S 1T0
45	Hamilton Niagara Haldimand Brant	Regional Municipality Of Niagara	150 Central Ave, Grimsby, ON L3M 4Z3
46	Hamilton Niagara Haldimand Brant	Six Nations of The Grand River	29 Cao Lane, Ohsweken, ON N0A 1M0
47	Mississauga Halton	Ivan Franko Homes	3058 Winston Churchill Blvd., Mississauga, ON L5L 3J1
48	Mississauga Halton	Joyce Scott Non-Profit Homes Inc.	296 Ontario, Milton, ON L9T 2T9
49	Mississauga Halton	MICBA Forum Italia Community Services	155 Forum Drive, Mississauga, ON L4Z 3M9
50	North East	Ontario Finnish Resthome Association	723 North Street, Sault Ste. Marie, ON P6B 6G8
51	North East	Access Better Living Inc.	506 Lonergran Blvd, Timmins, ON P4P 1B4
52	North East	Physically Handicapped Adults' Rehabilitation Association	122 Massey Drive, North Bay, ON P1A 4L1
53	North East	Board of Management for the Home of the Aged West Nipissing	100 Michaud Street, Sturgeon Falls, ON P2B 2Z4
54	North East	East Nipissing district home for the aged	400 Olive Street West, North Bay, ON P1B 6J4
55	North East	Huron Lodge Community Service Board Inc.	100 Manitoba Road, Elliot Lake, ON P5A 3T1
56	North East	ICAN-Independence Centre And Network	765 Brennan Road, Sudbury, ON P3C 1C4
57	North East	March of Dimes Canada	2915 Bancroft Dr, Sudbury, ON P3B 1T8
58	North East	Physically Handicapped Adults' Rehabilitation Association	200 Oakwood Ave., North Bay, ON P1B 5H9

	Health Region	Operated by	Address
59	North East	Physically Handicapped Adults' Rehabilitation Association	280 Oakwood Ave., North Bay, ON P1B 9G2
60	North East	Services de santé Chapleau Health Services	6 Broomhead Road, Chapleau, ON P0M 1K0
61	North East	Sudbury Finnish Rest Home Society Inc.	233 Fourth Ave, Sudbury, ON P3B 4C3
62	North East	The Friends	27 Forest Street, Parry Sound, ON P2A 2R2
63	North East	Ukrainian Seniors' Centre of Sudbury Inc.	31 Notre Dame Ave., Sudbury, ON P3C 5K2
64	North Simcoe Muskoka	County of Simcoe	988 8th Line, Beeton, ON L0G 1A0
65	North Simcoe Muskoka	IOOF	20 Brooks St, Barrie, ON L4N 7X2
66	North Simcoe Muskoka	Wendat Community Programs	44 Dufferin St, Penetanguishene, ON L9M 1H4
67	North West	St. Joseph's Care Group Corp	330 Lillie St N., Thunder Bay, ON P7C 0B4
68	South East	Pathways To Independence	33 Cloverleaf Drive RR5, Belleville, ON K8N 4Z5
69	South East	Cheshire Homes HPE Inc.	246 John St, Belleville, ON K8N 3G1
70	South East	Pathways To Independence	15 Bachman Terrace, Ottawa, ON K2L 1W2
71	South East	Pathways To Independence	416 Dundas Street W, Napanee, ON K7R 0A4
72	South East	Pathways To Independence	310 Bridge Street W, Napanee, ON K7R 0A4
73	South East	Pathways To Independence	289 Pinnacle Street, Belleville, ON K8N 3B3
74	South West	Cheshire Homes Of London	98 Baseline Rd W, London, ON N6J 1V2
75	South West	Cheshire Homes Of London	559 Topping Lane, London, ON N6J 3M9
76	South West	Participation Lodge	684136 Side Rd 30 RR 1, Holland Centre, ON N0H 1R0
77	South West	Participation House	165 Belgrave Ave, London, ON
78	South West	Participation House	242 Halls Mill Road, London, ON
79	South West	Participation House	6-521 Jeffreybrook Close, London, ON
80	South West	Participation House	141 & 143 Kimberley Ave, London, ON
81	South West	Participation House	134 Millridge Court, London, ON
82	South West	Participation House	608 Southdale Road East, London, ON
83	South West	Participation House	487 Glen Crescent, London, ON
84	South West	Participation House	57 Phair Crescent, London, ON
85	South West	Participation House	319 Vancouver Street, London, ON
86	South West	Participation House	1832 Louise Blvd, London, ON
87	South West	Participation House	586 Creston Avenue, London, ON
88	South West	Participation House	193 Clarke Road, London, ON
89	South West	Regional HIV/AIDS Connection	596 Pall Mall, London, ON N5Y 2Z9
90	South West	Spruce Lodge	639 West Gore Street, Stratford, ON N5A 7N2
91	Toronto Central	Baycrest Centre for Geriatric Care	3560 Bathurst Street, Toronto, ON M6A 2E1
92	Toronto Central	Bellwoods Centre for Community Living Inc.	300 Shaw Street, Toronto, ON M6J 2X2
93	Toronto Central	Bellwoods Centre for Community Living Inc.	1082 Dundas St W, Toronto, ON M6J 1X1
94	Toronto Central	Bob Rumball Centre For The Deaf	2395 Bayview Avenue, Toronto, ON M2L 1A2
95	Toronto Central	City of Toronto, Long-Term Care Homes and Services Division	365 Bloor Street East, 15th Floor, Toronto, ON M4W 3L4
96	Toronto Central	Copernicus Lodge	66 Roncesvalles Avenue, Toronto, ON M6R 3A6

	Health Region	Operated by	Address
97	Toronto Central	Dixon Hall	85 The Esplanade, Toronto, ON M5E 1Y8
98	Toronto Central	Dixon Hall	110 The Esplanade, Toronto, ON M5E 1X9
99	Toronto Central	Dixon Hall	115 The Esplanade, Toronto, ON M5E 1Y7
100	Toronto Central	Family Service Toronto	138 Pears Ave, Toronto, ON M5R 3K4
101	Toronto Central	Family Service Toronto	25 Leonard Ave, Toronto, ON M5T 2R2
102	Toronto Central	Family Service Toronto	128 Sudbury Street, Toronto, ON M6J 3W6
103	Toronto Central	Fife House Foundation Inc.	9 Huntley Street, Toronto ON M4Y 1P2
104	Toronto Central	Fife House Foundation Inc.	490 Sherbourne St. 3rd floor, Toronto, ON M4X 1K9 (Facility 2)
105	Toronto Central	Fife House Foundation Inc.	339 George Street, Toronto, ON M5A 2N2
106	Toronto Central	Fife House Foundation Inc.	70 Denison Ave, Toronto, ON M5T 2MB
107	Toronto Central	Fife House Foundation Inc.	9 Huntley Street, Toronto, ON M4Y 1P2
108	Toronto Central	Good Shepherd Refuge Social Ministries	412 Queen Street East, Toronto, ON M5A 1T3
109	Toronto Central	Hellenic Home for the Aged Inc.	33 Winona Drive, Toronto, ON M6G 3Z7
110	Toronto Central	Les Centres D'Accueil Heritage	33 Hahn Place, Suite 104, Toronto, ON M5A 4G2
111	Toronto Central	Loft Community Services	15 Toronto Street, 9th Floor, Toronto, ON M5C 2E3
112	Toronto Central	March of Dimes Canada	75 Cooperage St, Unit M01, Toronto, ON M5A 0J5
113	Toronto Central	March of Dimes Canada	22 McCaul Street, Unit 201, Toronto, ON M5T 3C2
114	Toronto Central	March of Dimes Canada	30 St. Lawrence Street, Toronto, ON M5A 3N1
115	Toronto Central	March of Dimes Canada	341 Bloor St W, Unit 1008, Toronto, ON M5S 1W8
116	Toronto Central	March of Dimes Canada	4700 Keele St, Toronto, ON M3J 1P3
117	Toronto Central	Meighen Retirement Residence, The Governing Council of the Salvation Army in Canada	84 Davisville Avenue, Toronto, ON M4S 1G1
118	Toronto Central	Native Canadian Centre of Toronto	14 Spadina Road, Toronto, ON M5R 3M4
119	Toronto Central	New Visions Toronto	222 The Esplanade, Lower Level, Unit 10, Toronto, ON M5A 4M8
120	Toronto Central	PACE Independent Living, Broadway Program	12 Broadway Ave, Unit 107, Toronto, ON M4P 3G9
121	Toronto Central	PACE Independent Living, Henry Lane Program	25 Henry Lane Terrace, Unit 442, Toronto, ON M5A 4B6
122	Toronto Central	PACE Independent Living, The Joanne Wilson Program	310-20 Palace St, Toronto, ON M5A 0J4
123	Toronto Central	PACE Independent Living, Edwards Manor (ABI Services)	340 Royal York Rd, Unit 317, Toronto M8Y 2P9
124	Toronto Central	St. Hilda's Towers Inc.	2339 Dufferin Street, Toronto, ON M6E 4Z5
125	Toronto Central	St. Matthew's Bracondale House	707 St. Clair Avenue West, Toronto, ON M6C 4A1
126	Toronto Central	The Neighbourhood Group Community Service	349 Ontario St, Toronto, ON M5A 2V8
127	Toronto Central	Vibrant Healthcare Alliance (Anne Johnston Health Station – Tobias House Attendant Care)	2398 Yonge Street, Toronto, ON M4P 2H4
128	Toronto Central	St. Clair O'Connor Community Inc.	2701 St. Clair Avenue East, Toronto, ON M4B 1M5
129	Toronto Central	Storefront Humber Inc.	2445 Lakeshore Blvd. West, Toronto, ON M8V 1C5
130	Toronto Central	Warden Woods Community Centre	74 Firvalley Court, Toronto, ON M1L 1N9
131	Toronto Central	West Neighbourhood House	20-25 West Lodge Ave, Toronto, ON M6K 2T3
132	Toronto Central	West Neighbourhood House	1447 King St W, Toronto, ON M6K 3K5
133	Toronto Central	Woodgreen Community Services	1070 Queen Street East, Toronto, ON M4M 3M4

	Health Region	Operated by	Address
134	Toronto Central	Woodgreen Community Services	12 Thorncliffe Park Drive, East York, ON M4H 1N8
135	Toronto Central	Woodgreen Community Services	1420 Victoria Park Ave, North York, ON M4A 2P7
136	Toronto Central	Woodgreen Community Services	25 Sunrise Avenue, North York, ON M4A 2S2
137	Toronto Central	Woodgreen Community Services	45 Sunrise Avenue, North York, ON M4A 2S3
138	Toronto Central	Woodgreen Community Services	266 Donlands Avenue, East York, ON M4J 5B1
139	Toronto Central	Woodgreen Community Services	444 Logan Avenue, Toronto, ON M4M 2P1
140	Toronto Central	Woodgreen Community Services	53 Pape Avenue, Toronto, ON M4M 2V5
141	Toronto Central	Woodgreen Community Services	63 Pape Avenue, Toronto, ON M4M 2V5
142	Toronto Central	Woodgreen Community Services	63 Pape Avenue, Toronto, ON M4M 2V5
143	Toronto Central	Woodgreen Community Services	80 Danforth Avenue, Toronto, ON M4K 3Y5
144	Toronto Central	Woodgreen Community Services	9 Haldon Avenue, East York, ON M4C 4P5

Appendix 9: Profiles of a Sample of Assisted Living Agencies in Ontario

Prepared by the Office of the Auditor General of Ontario

	Agency 1	Agency 2		Agency 3
Where services are provided	**Building**	**Community**	**Building**	**Building**
Building Description	Building has six supportive housing sites.	Not applicable: Assisted living services are delivered in the community in a large city neighbouring Toronto.	Two designated buildings in a municipality in the Greater Toronto Area that provides assisted living and supportive housing services for seniors requiring support. The buildings function like a typical apartment complex, i.e., residents pay rent to the landlord.	Three-story residence in a large city that provides assisted living and supportive housing services for seniors requiring additional help with daily activities in a home-like environment. Living accommodations range from an assisted living suite of approximately 400 sq. ft. to two-bedroom apartments of approximately 800 sq. ft.
Ownership	Agency owns two dedicated supportive housing buildings, and holds arrangements with four other housing providers offering supportive housing in the Greater Toronto Area.	Not applicable: Agency delivers services in people's homes in the geographic area around the assisted living building.	Agency does not own the assisted living building.	Agency owns the assisted living building.
Location	Urban	Urban	Urban	Urban

	Agency 1	Agency 2		Agency 3
Type of services provided	**Personal support services:** • care co-ordination • reassurance checks for at-risk seniors • personal grooming and hygiene • assistance with eating • toileting **Homemaking services**	**Personal support services:** • bathing and toileting • mouth and dental care • hair care • routine hand and foot care • preventative skin care • changing non-sterile dressings • dressing/undressing • help with eating • exercises and range-of-motion exercises • transferring positioning/turning • medication assistance (limited scope) **Homemaking services** • preparing meals • cooking • clean-up • changing bedding • light house cleaning • laundry • garbage disposal	**Personal support services:** • bathing and toileting • mouth and dental care • hair care • dressing/undressing • help with eating • exercises and range-of-motion exercises • transferring positioning/turning	**Personal support services:** • assistance with bathing and showering • assistance with personal hygiene • assistance with dressing • health and medication monitoring • 24-hour supervision and emergency response • care co-ordination • reassurance checks • mobility devices service **Homemaking services:** • laundry
Amenities (not publicly funded)	Communal lounge area. Other housing providers may have their own private amenities.	Not applicable.	Recreation room available to rent, operated by building management.	Communal dining rooms. Recreation rooms and workshops including a gym room, a spa room, a solarium, a library, a chapel, a museum of art and an art gallery. Vegetable and flower gardens, orchard, gazebos, a fish pond. Tray services, hairdressing, physiotherapy services, recreational services, laboratory services, on-site chapel.
Monthly rent	Residents are responsible for rent but may be subsidized by rent subsidies.	Residents are responsible for rent but may be subsidized by rent subsidies.	Residents are responsible for rent but may be subsidized by rent subsidies.	Residents have a co-pay. Co-pay ranges from around $1,000 for a bachelor's apartment to $1,260 for a one-bedroom apartment.

Appendix 10: Target Population Groups and Applicable Ministry of Health Policy that Describes Eligibility

Source of data: Ontario Health

Target Population Groups	Year of Policy	Name of Ministry Policy	Description
High-risk seniors	2011	Assisted Living Services for High Risk Seniors Policy	Current Policy: For seniors who are at high risk of emergency room visits or admission to long-term care
Frail and/or elderly seniors and seniors with cognitive impairment	1994	Long-Term Care Supportive Housing Policy	Grandfathered policy: Eligibility criteria are broader than the 2011 policy, but seniors who were already receiving services under the 1994 policy were allowed to continue receiving services even if their needs were less than those set out in the 2011 policy (that is, their eligibility was considered to be "grandfathered")
Adults with: • physical disabilities • an acquired brain injury; or • HIV/AIDS	1994	Long-Term Care Supportive Housing Policy	Only policy developed since 1994 for these groups

Appendix 11: Excerpts from the Assisted Living Services for High Risk Seniors Policy, 2011

Source of data: Ministry of Health

- The *Assisted Living Services for High Risk Seniors Policy, 2011* (2011 Policy) "has been developed to address the needs of high-risk seniors who can reside at home and who require the availability of personal support and homemaking services on a 24-hour basis." The 2011 Policy came into effect on January 1, 2011.
- The 2011 Policy updates and replaces the provisions of the *Long-Term Care Supportive Housing Policy* dated December 1994 (1994 Policy) "that relate to seniors who are frail or cognitively impaired and will apply only to new applicants effective January 1, 2011." The 1994 Policy will continue to apply to those frail or cognitively impaired seniors receiving services under the 1994 Policy on December 31, 2010 and who do not meet the eligibility criteria for high risk seniors under the 2011 Policy. The 2011 Policy does not affect the provisions of the 1994 Policy "relating to persons with physical disabilities, acquired brain injuries or Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)."
- The 2011 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) (these became Ontario Health and Home and Community Care Support Services organizations on April 1, 2021) 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 (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 Community Care Access Centre (CCAC) professional services." (CCACs were transferred to the LHINs in spring 2017 and became Home and Community Care Support Services organizations on April 1, 2021.)
- "An approved agency shall not provide assisted living services to a person unless the person meets all of the following eligibility 10 criteria:
  - the person shall be an insured person under the *Health Insurance Act*;
  - 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 meet the characteristics one of the profiles of a high-risk senior as set out in Table 1 of this policy (described in **Figure 6**);
  - the person shall not be on a waiting list for a long-term care home;

  - the person shall reside in a LHIN approved designated geographic service area but shall not reside in a care home within the meaning of the *Residential Tenancies Act, 2006* within that area;
  - the person shall be able to remain safely at home between visits;
  - the person shall not require immediate or 24-hour availability of nursing care or other professional services (note: nursing care is not a service provided under assisted living; it is provided under the home care program);
  - the person's home shall have the physical features necessary to enable the services to be provided; and
  - 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."

- "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 (of Health) policies when providing these services. Approved agencies are funded by LHINs as health service providers under the *Local Health System Implementation Act, 2006* (LHSIA)."

- The 2011 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"

- "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)."

- "Subject to the exception for retirement 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 cooperatives or traditional social housing buildings/apartments. However, high-risk seniors who reside in retirement homes within the meaning of the *Retirement Homes Act, 2010* shall not be eligible to receive assisted living services." *Note: While the Ministry policy defines "hub" as the designated geographic service area, the health regions we spoke to had interpreted the hub to represent a central location, often an assisted living building, out of which assisted livings services were delivered. We follow this definition throughout the report.*

- "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."

- "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."
- "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."
- "Approved agencies shall discharge clients who no longer meet the eligibility criteria."
- "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."
- "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 Ministry of Health (MOH) through the Integrated Health Services Plan and quarterly reports."
- "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."
- "This policy will be reviewed by the MOH no later than thirty-six (36) months after its effective date."

Appendix 12: Bill of Rights

Source of data: *Home Care and Community Services Act, 1994*

A service provider shall ensure that the following rights of persons receiving community services from the service provider are fully respected and promoted:

1. A person receiving a community service has the right to be dealt with by the service provider in a courteous and respectful manner and to be free from mental, physical and financial abuse by the service provider.
2. A person receiving a community service has the right to be dealt with by the service provider in a manner that respects the person's dignity and privacy and that promotes the person's autonomy.
3. A person receiving a community service has the right to be dealt with by the service provider in a manner that recognizes the person's individuality and that is sensitive to and responds to the person's needs and preferences, including preferences based on ethnic, spiritual, linguistic, familial and cultural factors.
4. A person receiving a community service has the right to information about the community services provided to him or her and to be told who will be providing the community services.
5. A person applying for a community service has the right to participate in the service provider's assessment of his or her requirements and a person who is determined under this Act to be eligible for a community service has the right to participate in the service provider's development of the person's plan of service, the service provider's review of the person's requirements and the service provider's evaluation and revision of the person's plan of service.
6. A person has the right to give or refuse consent to the provision of any community service.
7. A person receiving a community service has the right to raise concerns or recommend changes in connection with the community service provided to him or her and in connection with policies and decisions that affect his or her interests, to the service provider, government officials or any other person, without fear of interference, coercion, discrimination or reprisal.
8. A person receiving a community service has the right to be informed of the laws, rules and policies affecting the operation of the service provider and to be informed in writing of the procedures for initiating complaints about the service provider.
9. A person receiving a community service has the right to have his or her records kept confidential in accordance with the law.

Appendix 13: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Access to assisted living and professional services, when required for assisted living clients, is established to enable eligible Ontarians to have timely and equitable access to assisted living services that meet their needs.
2.	Program planning for assisted living services takes into consideration relevant data including health outcomes of those receiving assisted living services, future demographics, and other related health services, to most cost-effectively meet client needs.
3.	Accurate, timely, complete and validated financial and operational information is regularly collected from health service providers to ensure that they comply with program policies, legislation and contractual agreements, achieve the intended program outcomes and that corrective actions are taken on a timely basis when issues are identified.
4.	Funding provided to service providers is allocated based on established needs of health regions and the relative needs of clients.
5.	Roles and responsibilities are clearly defined and accountability requirements are established to support the delivery of assisted living services in accordance with legislative, contractual and program requirements.
6.	A process to report complaints and incidents about assisted living services is clearly communicated to the public; the process is confidential, impartial and considers the vulnerability of such clients in making complaints about those who may be their landlords and/or direct care providers.
7.	Appropriate and reasonable performance measures and targets are established, monitored and compared against actual results to ensure quality service is provided, intended outcomes are achieved and corrective actions are taken on a timely basis when issues are identified.

Appendix 14: Additional Work Conducted for Our Audit

Prepared by the Office of the Auditor General of Ontario

At the Ministry of Health, we:

- interviewed program staff and obtained program data;
- obtained and analyzed assisted living services data, reported by service agencies, from the Health Data Branch;
- interviewed staff from the Mental Health and Addictions Programs Branch, regarding the government-funded supportive housing in which assisted living services are delivered, and obtained data on such buildings to help us assess whether buildings financed by the Ontario government were appropriately used for the purposes intended;
- interviewed staff and obtained information from the Legal Services Branch, the Financial Management Branch, the Health Capital Investment Branch, the Governance and Accountability Branch, and the Ontario Health Oversight Branch to understand any work performed in the branch related to assisted living services; and
- obtained data from the Health Services Information and Information Technology Cluster, which stores interRAI data (a universal eligibility instrument that establishes degree of need for care services) on clients and patients from across Ontario health programs. Data sought includes that pertaining to clients of assisted living services and home care. Such data is to be used to assess the needs of clients that have access to these services across different Ontario regions and to help inform whether assisted living services are being optimally utilized across the spectrum of out-of-hospital care.

We conducted the following additional work:

- interviewed staff from the Ministry for Seniors and Accessibility to identify any areas where programs may overlap with those provided to the assisted living service client population;
- interviewed staff from the Office of the Fire Marshal and Emergency Management at the Ministry of the Solicitor General to identify any safety concerns facing under-regulated congregate settings where assisted living occurs;
- obtained data from Public Health Ontario on COVID-19 outbreaks and deaths of clients and staff to assess the impacts and risks faced in buildings where assisted living services were delivered;
- contacted six public health units (Halton, Niagara, Peel, Simcoe Muskoka, Thunder Bay and Toronto) and inquired about the nature of work they perform on assisted living buildings;
- interviewed staff from stakeholders that include the Patient Ombudsman, the Ontario Health Coalition, AdvantAge Ontario, the Advocacy Centre for the Elderly, ARCH Disability Law Centre, the HIV & AIDS Legal Clinic Ontario, the Ontario Personal Support Workers Association, the Ontario Community Support Association, the Ontario Brain Injury Association and the Provincial Geriatrics Leadership Ontario to better understand their perspectives of assisted living services;
- requested the Ontario Personal Support Workers Association to survey their members on our behalf to request feedback on the assisted living services program; and
- consulted with a geriatrician and a physician that specializes in emergency and family medicine, both of whom are familiar with the Ontario health care system, including how health care is being provided to seniors, to help provide insights into how assisted living services is used or how such use could be improved.

Appendix 15: Wait List Tracking Weaknesses

Prepared by the Office of the Auditor General of Ontario

Weaknesses	Description
Insufficiently detailed data tracked	Wait lists do not distinguish between people waiting for a service spot in an assisted living building or in the broader community.
Incomplete information at health regions since delegated to agencies	Only 11 of the 14 health regions had full wait-list information while the others had allocated this responsibility partially or fully to assisted living service agencies and therefore did not have ready access to the information. While assisted living agencies generally manage their own wait lists, one of the seven agencies we visited during the audit consolidates the wait list for itself and seven other agencies across their health region, which they all use to fill available spaces more equitably.
Incomplete Information tracked on lengthy wait times	Wait lists do not always reflect the total number of people waiting. For example, assisted living buildings that serve people with an acquired brain injury do not always systemically track the number of people waiting because clients typically live decades in these buildings, and wait times can sometimes span decades and are therefore not meaningful. At the agencies that serve adults with HIV/AIDS or an acquired brain injury that we engaged with during the audit, clients stayed on average from 1.5 years to 12.5 years.
No tracking of unmet demand in certain areas	13 of the 14 health regions informed us that there was unmet demand in certain areas of their region where services were not offered, but none tracked it.
Not publicly available	Wait times are not publicly available, either on the health region websites or the Ministry's website, even though the Ministry receives data on wait lists from assisted living agencies. The Ministry did not require health regions to post wait-time information.
Priority not centrally tracked	While the Ministry expects health regions and agencies to track the priority of the client, agencies do not report this information to the Ministry. Priority is determined by urgency of the client's need for assisted living services and how long the person has waited for service.
Time waited by patients designated as alternate-level-of-care for assisted living not well tracked	Ontario Health tracks the time people designated as alternate-level-of-care (ALC) waited in hospitals before being discharged; however, partly because of the lack of information on the locations of assisted living buildings, it combines assisted living with another type of destination—supervised living, which primarily consists of group homes. Our review of Ontario Health data indicates that ALC patients waited over 116,000 days in hospitals in 2020/21 because there were no spaces in either assisted living or supervised living buildings.

Appendix 16: Weaknesses in Tracking Service Hours and Defining Services Available

Prepared by the Office of the Auditor General of Ontario

Concerns	Details
Assisted living agencies we visited during the audit do not track the number of hours of home care their clients receive.	Agencies explained that they do not receive enough information from Home and Community Care Support Services providers to do so, even though the 2011 policy requires them to track this to ensure service maximums are not exceeded.
Two health regions have established service maximum guidelines that are well below those allowed by the 2011 policy.	For example, one region established a limit of 1.5 hours of personal support and homemaking services a day, whereas the Ministry policy allows for a maximum of 6 hours a day, including professional services. Similarly, the *North East Local Health Integration Network Report on Assisted Living* from 2016 noted 74% of health service agencies indicated that they were not providing the 180 hours of services per month because of a lack of financial or human resources.
The Ministry has still not implemented a recommendation it received from an expert panel in June 2017 to develop a framework to improve home and community care, including assisted living.	This framework was intended to define the needs of each care level depending on a person's functional, clinical, social, cognitive and other needs, and the monthly personal support hours for each care level. In 2018, a decision support tool based on the interRAI-HC assessment to guide care planning and service allocation for personal support hours was implemented. The tool uses the same principles as the framework described in the 2017 expert panel report to support equitable and consistent access to service across the province. In addition, the Ministry informed us that the changes it is planning for home and community care in upcoming years will build on this recommendation.

Appendix 17: Factors Affecting Eligibility for Assisted Living Services under the 2011 Ministry of Health Policy

Prepared by the Office of the Auditor General of Ontario

Factors Affecting Eligibility for Assisted Living Services	Details
Geography	• Only those living within certain areas, usually those within a certain number of kilometres or time in travel distance from a central "hub" from which agency staff provide services, are eligible for assisted living services. The areas are defined by the health regions. • At one health region, an assisted living agency provides assisted living services centrally through a mobile unit so that all residents of the health region, and particularly those patients in hospital designated as alternate-level-of-care waiting for discharge, may access assisted living services. • Neither the Ministry nor Ontario Health has assessed this service delivery model for its wider use, even though the agency received the Minister's Medal Honouring Excellence in Health Quality and Safety in 2013. The Ministry informed us that it has no information on what basis this medal was awarded, and that it was all determined at a health region level.
Community services only to high-risk seniors	• The Ontario Brain Injury Association informed us that many people with a brain injury live in the community, so a community-based service would be very beneficial to them. However, the 2011 policy's expansion of services from a limited number of building "hubs" to the community was limited to only high-risk seniors. • While the previous 1994 Policy did not allow for community-based services, we noted that some agencies had taken the initiative to offer services in the community; others continued to follow the restriction.
Retirement homes	• The Ministry prohibits services from being provided to those living in retirement homes. • The Ministry had not assessed the extent to which long-term-care home admissions or wait lists could have been reduced if retirement home residents had access to 24/7 personal support services offered by assisted living services. • Retirement home residents' conditions may deteriorate over time and force a move to long-term care, resulting in more expense to the health care system since the Ontario government does not fund retirement homes but does fund long-term care. Assisted living services could also help minimize disruption to seniors' lived experiences by delaying or avoiding such a move.
Long-term care wait list	• The Ministry prohibits services from being provided to those who are on a long-term care wait list, though those who are already receiving assisted living may continue to receive those services with additional support from home care services as needed. • The Ministry indicated a person already on a wait list cannot access assisted living services because they can receive home care without being subject to a service limit. • The Ministry has not assessed whether people on the long-term care wait list could also benefit from assisted living services, particularly the 24/7 unscheduled visits program element, to help ensure their safety. • For example, the *North East Local Health Integration Network Report on Assisted Living* from 2016 noted that there continues to be confusion from both service agencies and case managers (then working out of Community Care Access Centres, which later became LHINs) about criteria regarding eligibility of clients who are awaiting long-term care and/or are deemed eligible after already receiving assisted living services.

Appendix 18: Opportunities for Service Enhancement That the Ministry of Health Has Not Evaluated

Prepared by the Office of the Auditor General of Ontario

Potential Opportunities for Service Enhancement	Details
Value in combining home care and assisted living services	• Both programs serve similar clients in similar settings, offer similar services (except for professional services, which are not offered under the assisted living services program), share similar goals, and are governed under the same legislation. • Many clients already receive both services, such as assisted living clients who require professional services. • 37% of assisted living services were provided in the community in 2020/21, similar to home care. • Combining them and offering them centrally has the potential of improving a client's experience.
Specific service mixes within assisted living	• How often assisted living clients receive professional services in addition to personal support care services and homemaking, and how often clients receive other services such as wellness checks.
Unscheduled care	• How much of all assisted living services are provided on an unscheduled basis.
Gaps in availability	• Which parts of Ontario have no access to assisted living services and how that impacts those who are required to rely on other services. • For example, how many people are ideally suited for assisted living, but are forced to choose long-term care because assisted living services are not offered in their community?
Break-even point between assisted living and long-term care	• The average cost to provide long-term care ($88,028 per client per year in 2020/21) is generally considered to be the most expensive option on the continuum of care; this cost consideration is apart from the quality-of-life considerations that make assisted living services a preferred choice for those who do not need the level of care provided in a long-term care home. • A break-even point—the maximum amount that can be paid out for assisted living services and how much service this would pay for, including, if necessary, supplementary professional services that are provided under the home care program and still be less expensive than the cost of long-term care—is critical for service planning.
Reducing hospital use and delay long-term care admission	• The extent to which assisted living services have helped reduce health system costs. • Only two of the 14 health regions require their agencies to report on data related to hospitalizations and long-term care admissions. The results of these reports were mostly reviewed by the health regions, but not presented to the Ministry. • Health Quality Ontario, now part of Ontario Health, noted that in 2019/20 (the last time this data was reported), hospitalization rates per 100,000 people for conditions that can be managed outside hospitals by health regions in Ontario averaged 271, but ranged from 181 in the Mississauga Halton and Central health regions to 479 in the North West health region; higher rates suggest areas where there are less community-based options available.
Service hours provided in relation to health outcomes	• The number of hours of service provided to clients to help determine if a client who receives two hours a day instead of one hour has better outcomes and could continue successfully in assisted living rather than transferring to long-term care.

Potential Opportunities for Service Enhancement	Details
Premature admission to long-term care due to lack of access to assisted living	• The number of seniors who were capable of living in the community with support from assisted living services, but have gone into long-term care either because assisted living wait lists were too long or assisted living was unavailable near their home. The government conducted an analysis in 2018 that showed the wait lists for assisted living services had increased by 60% over six years from 2011/12 to 2016/17. • The Ministry policy on assisted living states that "an approved agency shall not provide assisted living services to a person on a waiting list for a long-term care home." This implies those receiving assisted living must discontinue assisted living and take on home care until they are admitted to long-term care. However, no data exists on the frequency of such occurrences. • Health Quality Ontario (now Ontario Health) found that in 2020/21, the portion of home care patients who entered long-term care but had only low to moderate needs, averaged 14.2% in Ontario, but ranged from 11.1% in the South East health region to 24.1% in the Erie St. Clair health region. • It is not readily determinable how many of these people would have had access to assisted living services or whether the 24/7 service response offered by assisted living, compared to home care, which has only scheduled visits, would have made the difference in allowing such individuals to remain in their homes.

Appendix 19: Areas Not Assessed by the Ministry of Health to Identify Opportunities to Improve Assisted Living Services for Adults with Physical Disability, an Acquired Brain Injury or HIV/AIDS

Prepared by the Office of the Auditor General of Ontario

Areas Not Assessed	Details
Demand growth or change	The Ministry has not examined whether there have been any changes to the number of Ontarians living with these health conditions, which may warrant changes to the funding and services that individuals in these population groups may require. The Ministry informed us that assessing changes to the number of people living with physical disability, an acquired brain injury or HIV/AID is a health region responsibility, now an Ontario Health responsibility.
Policy changes due to medical advances	The Ministry has not assessed whether people with HIV/AIDS should continue to qualify for assisted living services given medical advances in the past decades. Stakeholder groups we spoke to, including those outlined in **Appendix 14**, indicated that clients with HIV/AIDS who receive assisted living services can have significant health issues related to the decades-long impact of the disease, since not all infected individuals have been virtually cured by drug cocktails; however, the overall health outlook for those with HIV/AIDS has improved markedly since the 1990s when this policy was developed.
Higher average costs with acquired brain injury	The Ministry has not looked into why agencies serving people living with an acquired brain injury spent on average $140,112 per client in 2020/21, which is higher than agencies that serve all other assisted living client groups, including seniors at an average of $15,561 per client.
Analyzed outcome data	The Ministry has neither obtained nor analyzed outcome data from all assisted living agencies on the reduction of emergency room visits or delayed admission to long-term care, or used the data some health regions currently collect to determine the effectiveness of assisted living agencies in this.
Considered broader services to community	The Ministry has not clarified whether assisted living services can be provided to adults with physical disabilities, an acquired brain injury or HIV/AIDS outside of designated buildings and in the broader community—that is, in clients' homes—instead. The 1994 policy makes no mention of home-based services–that is, beyond the confines of a building—and stakeholder groups have mentioned that such services are typically only available in buildings and not commonly offered in the community.

Appendix 20: Gaps in Accountability Agreement Between Health Region and Assisted Living Agency

Prepared by the Office of the Auditor General of Ontario

Areas Not Specified in Agreement	Details
Time spent providing services	As discussed in **Section 4.2.1**, most of the accountability agreements between the health regions and the assisted living agencies do not state the number of hours or even a range of hours that agencies should provide to clients or hold agencies accountable for how many hours they provide. This presents a risk that agencies base their evaluation of how many hours of service a client requires purely on their staff's availability rather than the client's assessed needs, especially since the Ministry does not require agencies to provide a minimum number of services hours to clients. Our survey of personal support workers indicated that, in their view, the assisted living services are valuable if they can be provided according to the client's care plan and if there is good continuity among the staff providing the care. As well, one agency we engaged with during this audit also operated a long-term-care home and told us that it does not track service hours for its assisted living clients, but does so for long-term-care home residents because it is a contractual requirement under that program.
Rate agency rejects clients referred to it	Health regions set targets and evaluate performance on referral acceptance rates as part of the service agreements they have with home-care service agencies, but not assisted living agencies. This means that clients that the health region considers to be eligible for assisted living services may be rejected by the agency based on its assessment of the client.
Frequency of missed visits	Health regions set targets and evaluate performance on missed visit rates as part of the service agreements they have with home-care service agencies, which health regions verify and oversee, but do not have a similar measure for assisted living agencies.

Appendix 21: Examples of Complaints Made to Health Regions on Assisted Living Agencies

Prepared by the Office of the Auditor General of Ontario

Nature of Complaint Related to Service Quality	Details
Reducing amount of service	A complaint from a client in one health region (NE) in 2017 identified a client's concerns with changes to the amount of service he was receiving and the "potential for support to be reduced." The client reported friction between himself and management of the assisted living agency, and "accusations of reprisal for asking questions, raising concerns, and advocating for himself and other residents." The health region inquired about the situation with the agency only, which responded that the client's services were suspended as the client had repeatedly violated his service agreement. The health region then deemed the client's concerns unfounded, but did not review any records from the assisted living agency or otherwise investigate further, such as to request details on what the client had done to violate the service agreement.
Health and safety	A complaint from a client's family member in 2019 (Central) related to the personal protective equipment (PPE) and infection prevention and control practices of a specific personal support worker at the onset of the COVID-19 pandemic. The health region directed the complainant to the assisted living agency. The family asserted that the PPE and infection prevention and control practices were not being followed, and agency staff were not wearing appropriate PPE such as masks, gowns, shoe and hair covers even though the client's family provided such equipment. After subsequent follow-up, the health region could not provide any information to indicate whether any actions were taken to address the complainant's concerns.
Allegation of neglect and abuse	One health region (Toronto Central) took very little to no appropriate action to address a complaint concerning allegations of abuse and neglect. The complaint filed in 2020 reported a client's family who witnessed their father's unit infested with cockroaches and fungus. The family made allegations of abuse and neglect against the assisted living agency and requested the health region investigate. The health region contacted the client's family to discuss the concern; however, the health region could not provide us any further information regarding what actions it or the agency had taken to ensure the client's safety. The health region indicated that it had "apologized for the experience and explained decision-making for capable clients, and the ability to choose to live at risk." It was unclear from the documentation available who apologized to whom. The health region could not provide any additional information regarding the outcome of the complaint, for example, whether any actions were taken at the assisted living agency.
Failure to inform client of change in worker	A complaint filed in 2020 (Toronto Central) involved a client who reported that the assisted living agency implemented a new staffing model without notifying residents in advance. As a result, the regular workers were removed from the client's care. The client did not feel comfortable allowing strangers in her home, and requested her regular personal support worker. The health region could not provide any further information regarding the staffing changes at the assisted living agency or how the client's concerns were addressed. The health region instead encouraged the complainant to work with the agency to address her concerns and had not followed up with the client as of the time of our audit.

Office of the Auditor General of Ontario

20 Dundas Street West, Suite 1530
Toronto, Ontario
M5G 2C2

www.auditor.on.ca

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