LONG-TERM CARE HOME ACCESS PROTOCOL FOR ADULTS WITH A DEVELOPMENTAL DISABILITY

Ministry of Community and Social Services
and
Ministry of Health and Long-Term Care

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LONG-TERM CARE HOME ACCESS PROTOCOL FOR ADULTS WITH A DEVELOPMENTAL DISABILITY

BACKGROUND

On September 9th 2004, the Ministry of Community and Social Services (MCSS) announced that the government was starting a process to transform the developmental services (DS) system in Ontario so that it is accessible, fair and sustainable in the future.

The transformation is consistent with the philosophy of the *Ontarians with Disabilities Act, 2001* and the *Accessibility for Ontarians with Disabilities Act, 2005* which aim to improve opportunities for persons with disabilities and to provide for their involvement in the identification, removal and prevention of barriers to their full participation in the life of the province.

As an important component of the transformation plan, the government announced that it will be phasing out the three remaining provincially-operated DS facilities for adults who have a developmental disability by March 31, 2009: Huronia Regional Centre in Orillia, Rideau Regional Centre in Smith Falls and Southwestern Regional Centre in Chatham-Kent. The phasing out of the remaining government operated DS facilities completes Ontario's evolution from a facility-based to community-based system that promotes greater inclusion, independence and choice.

For some individuals supported by developmental services agencies in the community or leaving the three DS facilities, a long-term care (LTC) home may be the most suitable setting to meet their health care needs. As part of the planning for these individuals, full assessments and transition plans will be completed to assure the placement to an LTC home is appropriate, and that the transition is safe, secure and comfortable for the individual and for the residents already living in long-term care homes. The planning process will also identify and address an individual's support needs specific to their developmental disability that may not be typically met in a long-term care home and will also determine what additional resources may be required to support their placement.

PURPOSE

The protocol provides expectations by the ministries of Community and Social Services and Health and Long-Term Care to relevant transfer payment agencies and service sectors in support of transitioning adults with a developmental disability in the community and in DS facilities to the long-term care home sector.

The protocol further affirms an established interministerial commitment towards the inclusion and equal rights of adults with a developmental disability in accessing health services and admission into long-term care homes.

The protocol recognizes two distinct planning processes - one for individuals residing in the DS facilities and one for individuals residing in the community who are supported by a developmental services agency residentially and/or non-residentially.

While these planning processes are distinctive in detail, their activities will likely overlap. The DS Facilities Initiative is unique in duration with a prescriptive planning process, and the potential for resource development. The DS Facilities Initiative presents an opportunity for DS service providers to consider the transition of individuals with increasing health care needs that they are currently supporting residentially into an appropriate LTC home setting. This will create DS community-based capacity to accommodate residents moving from the DS facilities.

This protocol is intended to provide guidance to DS placements in LTC homes and is intended to complement, not replace or modify existing statutes or service agreements.

Elements for each planning process include:

- MOHLTC/MCSS linkages and information sharing
- broader systems planning
- service coordination, access and placement process overview
- detailed individual planning and placement process

Transition across sectors from one residential setting to another requires a coordinated approach to planning that is not limited to placement. This protocol supports the coordination of efforts between service providers in both the LTC home and DS sectors in regard to access and the process of maintaining placements to continue meeting the support needs of individuals.

Interministerial linkages will reflect ongoing changes to organizational structures including the implementation of Local Health Integration Networks (LHINs).

PROTOCOL PRINCIPLES

The following acknowledge the guiding principles established for the DS Facilities Initiative (please see Appendix C).

1. A long-term care home setting may be considered appropriate for individuals with a developmental disability when their health care support needs are greater than what can be supported through community based health care.

2. There will be an individualized plan for every individual.

3. Support needs that are specific to an individual's developmental disability and that cannot be met by a long-term care home provider necessitate consideration of additional resourcing through the developmental services sector. Some individuals will not require additional supports/services.
4. The provision of additional resourcing through the developmental services sector to support appropriate LTC home placements is intended to bring equity among all developmentally disabled adults by providing sufficient support and services to accommodate the person's developmental disability(ies) so that the safety and wellbeing to all residents are not affected.

   An individualized plan will identify other supports or services necessary to meet the extraordinary needs specific to an individual's developmental disability and which cannot be met by a LTC home placement. In determining appropriate placement options, the needs and wishes of an individual will be balanced within the available resources of the health and developmental services sectors.
5. The placement processes outlined in the protocol for accessing a long-term care home reflects the legislated requirements of MOHLTC.
6. The placement process outlined in the protocol for facility residents accessing a long-term care home reflects the judicial consent requirements of MCSS.

INDIVIDUAL PLANNING AND ACCESS PROCESS FOR INDIVIDUALS MOVING FROM THE DS FACILITIES

The planning process for individuals moving from the DS facilities to a long-term care home placement is guided by a set of principles and strategies respecting that appropriate supports are in place to meet the needs of the individual.

A LTC home placement represents a support option on the continuum of community-based supports that is comprised of both developmental and health-based services, among others. Referrals and applications for individuals with a developmental disability to a LTC home are no different than that of other persons.

A) MOHLTC and MCSS Linkages and Information Sharing

MOHLTC and MCSS will share on an as needed basis updated information regarding LTC home capacity. This information will be disseminated by local regional offices to inform broader community planning by both sectors.

B) Broader Systems Planning

MOHLTC and MCSS regional offices will work with Community Care Access centres (CCACs) and DS planning and access mechanisms to develop systemic linkages and to improve cross-sectoral cooperation in relation to the transition of DS facilities residents to long-term care home placements.

C) Service Coordination and Access

MOHLTC and MCSS regional offices will facilitate/coordinate discussions with potential LTC home providers to assess their overall capacity to offer residential support to individuals with a developmental disability moving from the DS facilities. These broader discussions will seek to understand the challenges and opportunities presented to LTC home providers and identify options and actions that may be required to move forward with placement planning for specific individuals.

Service coordination and access specific to an individual will occur through the established local access mechanisms of each sector (CCAC and DS Access) and within the applicable statutory framework.

D) Placement Process Overview

CCACs will work with MCSS Regional Placement Facilitators (RPFs) with assistance from the MOHLTC regional office if required, where planning for a facility resident is focused on a LTC home placement given their health care needs.

The planning process for individuals moving from the DS facilities to a LTC home placement is an extension of the established, individualized planning process

integral to the developmental services sector that is focused on the individual and involves a substitute decision maker where the individual is incapable of making decisions respecting his or her admission to a LTC home placement.

CCACs are responsible for the LTC home placement process including assessment eligibility determination and referral. MCSS Regional Placement Facilitators are responsible for placement planning, transition and placement follow-up of individuals moving from the DS facilities.

The planning activities of the RPF are supported by a number of other positions including community-based DS Health Care Consultants (HCCs), Regional Project Managers (RPMs) and facility-based Facility Planning Co-ordinators (FPCs) and their assistants (PCAs).

The CCAC will work with the RPF to gather all the necessary information to conduct the eligibility assessment and to complete the health care assessments required for placement in a LTC home.

1. The CCAC must determine, as the first step of the LTC home placement process, that all community-based resources to meet client needs have been exhausted.
2. LTC home placement planning for an individual will include the identification of necessary supports for successful placement through the development of a Personal Plan. These may include additional supports that are specific to the individual's developmental disability, beyond the basic LTC home service offering, and necessary for successful placement.
3. Where applicable, planning will include but not be limited to a confirmation of the service providers who would be involved in providing direct or indirect support through the developmental services system.

The RPF is responsible for:

- coordinating the necessary steps for the community care access centre (CCAC) to complete the functional and health assessments required for the LTC home application process;
- facilitating visits by family and other parties where appropriate, to potential LTC homes to learn how the home structure, type of placement, accommodation level, environment and staffing model are appropriate to the needs of an individual;
- facilitating visits by LTC home providers to DS facilities where required for planning purposes;
- where applicable, facilitating discussion between the LTC home and the DS supporting agency to identify additional resources required;
- contingency planning for situations in which a client is determined ineligible for placement or cannot, for whatever reason, be placed in a LTC home.

The CCAC is responsible for:

- determining eligibility for admission to LTC homes;
- those persons determined eligible, referring individuals to the LTC homes for acceptance into their waiting lists;
- determining priority for admission and placing all eligible applicants in the appropriate prioritization categories on the waiting lists when beds are not immediately available;
- keeping and managing the waiting lists for admission to LTC homes; and
- authorizing admissions to LTC homes.

The LTC homes are responsible for:

- considering the appropriateness of placement of each individual to LTC homes from DS facilities in relation to the residents currently in the home, the environment and the home's approach to care;
- collaborating in the process of assessing and determining what exceptional supports (e.g., accommodation, education, equipment, staffing) may be required for the successful placement of individuals from the DS facilities. The LTC home may decline to place if these requirements for the DS individual's care cannot be met;
- participating in ongoing knowledge exchange during the individual's application process and information exchange about relevant DS programs and services through DS agencies, CCAC and other service providers;
- identifying their LTC staff training needs for successful placement; DS agencies will be responsible to deliver appropriate training;
- providing reasonable, controlled access to DS agency staff and other care providers into their LTC homes to deliver additional supports identified in the individual's Personal and Support Plans.

E) Detailed Individual Planning and Placement Process for Facility Residents

1. For individuals in the DS facilities, application will be coordinated in conjunction with the individual applying or their Substitute Decision Maker (SDM) (if the client is not capable as per the *Health Care Consent Act, 1996*) by RPFs and/or HCCs. The application will be made through the local Community Care Access Centre (CCAC).
2. In collaboration with the RPF and LTC home the DS supporting agency will develop a Support Plan that will meet the needs of the individual. The RPF will develop an individual Personal Plan. Where the Personal Plan identifies that the future needs of an individual may require supports in addition to the basic care to those typically provided in LTC homes, the RPF will work with the local DS access mechanism and collaborate with the LTC home to identify a DS agency that can assume responsibility for the provision of additional supports to that individual.

3. In situations where an individual or their SDM has indicated preference for a LTC home placement, the RPF will facilitate the family's access to information on the range of LTC home options that may be available to support the individual. CCACs are in charge of providing that information and referral in collaboration with the RPF.
4. Application to a LTC home will be made when a request for admission to a LTC home has been made by the DS facility resident or their SDM. When the individual request is made the facility will refer the individual to their local CCAC for individual assessment and identify to the CCAC, the RPF responsible for planning and their role in the process. Where there are a number of individuals applying for LTC home placement the RPF will discuss with the individuals' SDM/families through the consent process, and with the facility and CCAC, the most appropriate way to streamline the assessment for individuals.
5. The RPF coordinates the development of a draft Personal Plan based on information collected from family, friends, facility staff, health care professionals and relevant assessments. The draft plan is shared with family, friends and DS facility staff for consideration/revision prior to distribution.
6. The CCAC, in collaboration with the RPF, will obtain the required consent for admission to a LTC home and releases of information from the individual or SDM in order to conduct the assessment. The RPF and facility staff will coordinate the meetings required for the CCAC to complete the assessment and will keep the family/SDM apprised of this process.
7. The RPF will remain connected to the family throughout the CCAC referral process. The CCAC will meet with the individual and SDM and an assessment will be completed to determine if the individual meets the eligibility criteria for placement in a LTC home.
8. With the consent and additional release of information from the individual or SDM, the CCAC will forward results of the assessment to the family/SDM, Facility Health Manager and RPF. The CCAC conducting the assessment will also forward the referral and assessment information to the CCAC in the destination community in which the individual wishes to reside.
9. The RPF will work with the individual, family/SDM; local DS community access mechanism, the regional/community HCC and the local CCAC to identify/coordinate appropriate service options to be provided by DS agencies when the individual is to move to a LTC home.
10. If the individual is determined eligible for LTC home placement, the individual or the SDM is able to select up to a maximum of three LTC homes. As part of the development of an individual's Support Plan, the RPF may coordinate with the assistance of the CCAC, visits by the individual and/or family member/SDM to the proposed LTC home(s). Based on particular planning needs visits may also be coordinated to include staff from the DS facilities and staff from DS supporting agencies in the community.

11. As part of the development of the individual's Support Plan the RPF will work with all relevant stakeholders to identify and coordinate access to any additional resources necessary to support an individual within the selected LTC home(s). This may include training LTC home staff and establishment of arrangements for the provision of services by DS service providers.
12. Once the eligible individual has made the selection of one to three LTC home(s), the individual/SDM must apply for authorization of admission. The CCAC, in collaboration with the designated RPF, will assist the individual/SDM to complete the application. The application that will be sent to the selected home(s) along with all the assessment information will indicate the individual/SDM's preferences/choice of accommodation (private, semi-private, or basic). The individual/SDM may select LTC homes based on factors, which include ethnic, spiritual, linguistic, familial and cultural preferences. A copy of the Support Plan for the individual will also be sent with the application.
13. The LTC home is required to provide a written response to both the CCAC and the individual/SDM stating whether or not it is offering the individual a placement in the home within 5 days of receiving the request for application for admission.
14. Should the LTC home not make an offer to the DS applicant, the LTC home must provide a written notice to the Director of the MOHLTC regional office, the CCAC and the individual/SDM with a detailed explanation of the supporting facts.
15. As the LTC home must specify the reasons for the withdrawal of offer related specifically to the condition of the individual, the CCAC in collaboration with the RPF may negotiate a reversal of the LTC home decision not to offer placement based on availability of additional supports as identified in the Support Plan that can be made through the responsible DS supporting agency.
16. After reconsideration, if the LTC home does not offer a placement, the RPF will continue to work with the individual, family/SDM, regional/community HCC and CCAC to select other LTC homes or revisit other community options.

    CCACs will also assist in the planning for alternative delivery options for health-based supports, where a LTC placement is not accessible. These options may include in-home health care supports and training DS providers to provide personal support services which include: assistance with personal hygiene activities, routine activities and procedures of daily living, in order to allow individuals to reside in DS residential settings (please see D) 1.).
17. If an appropriate vacancy exists in one of the LTC homes to which an application has been made, the CCAC will notify the individual/or SDM. The individual, if capable or the SDM will have 24 hours within which to accept or decline the offer. Once an offer has been accepted the individual is expected to move in by the 5th day after the day on which the individual is made the offer of admission. Once the individual/SDM accepts the offer of admission the bed may be held up to 5 days following the date of notification if the individual pays the applicable bed-holding fees.

18. The consent of a capable resident or an incapable resident's substitute decision maker (SDM) is required by MCSS for any placement.
19. Individuals will not move from the DS facilities until the appropriate supports are in place. The Support Plan will become finalized through a written document between the individual, SDM (if applicable), family, DS supporting agency (if applicable) and LTC home provider. This written document will state what supports will be provided, by whom, and the roles and responsibilities of each party in relation to the ongoing assessment/evaluation of the support plan.
20. The RPF will conduct a 3 month post-placement follow-up in conjunction with the LTC home provider, CCAC and DS service provider (if applicable) as appropriate to review the individual's status/progress and the Support Plan in relation to the individual's current situation and circumstances.
21. As in all LTC home placements, where a LTC placement does not occur within a six-month period from assessment, consent must be obtained from the individual, if capable or their SDM for reassessment.
22. In situations where a number of individuals from one facility have been referred to a specified LTC home setting and there is a desire to maintain relationships, the LTC home may consider the development of a specialized area within the home to provide service to individuals with similar needs. In these instances staffing, education, environmental, structural and programming requirements would need to be considered to ensure inclusion, participation and interaction with all residents.

INDIVIDUAL PLANNING AND PLACEMENT PROCESS FOR INDIVIDUALS SUPPORTED BY DS COMMUNITY-BASED AGENCIES

A LTC home placement represents a support option on the continuum of community-based supports that is comprised of both developmental and health-based services, among others. The referral and application process for an individual with a developmental disability to LTC home is no different than processes for other persons residing in the community.

Developmental services community-based agencies may support individuals who are in the community residentially (i.e., a group home) and/or non-residentially (i.e., day supports, respite, case management) and for whom a LTC home placement may be considered. Agencies will work with the individual and their family throughout the planning process for application and transition to a LTC home.

A) MOHLTC/MCSS Linkages and Broader Systems Planning

MOHLTC and MCSS regional offices will work with Community Care Access Centres (CCACs) and DS planning and access mechanisms to develop ongoing systemic linkages and improved cross-sectoral cooperation in relation to the transition of individuals supported by DS community based agencies to long-term care home placements.

B) Service Coordination and Access

MOHLTC and MCSS regional offices will facilitate/coordinate discussions with potential LTC home providers as necessary, to assess their overall capacity to offer residential support to individuals with a developmental disability. These broader discussions will seek to understand the challenges and opportunities presented to LTC home providers and identify options and actions that may be required to move forward with placement planning for specific individuals.

Service coordination and access specific to an individual will occur through the established local access mechanisms of each sector (CCAC and DS Access).

C) Placement Process Overview

The planning process for individuals moving from community placement to a LTC home placement is an extension of the established, individualized planning process integral to the developmental services sector that is focused on the individual and involves a substitute decision maker where the individual is incapable.

The application for LTC home placement made or supported by an agency on behalf of an individual should occur within the larger framework and knowledge of the local DS access mechanism in order to identify and facilitate community support options that may be required to support the LTC home placement.

Not all individuals will require additional supports in order to reside in a LTC home setting. Where an individual's needs exceed the basic care offered by the LTC home, the supporting agency will develop a Support Plan (also known as a transition support plan) to outline how those exceptional needs can be met in the LTC home placement. This plan will be developed in collaboration with the individual, SDM, other family members (if appropriate), DS community access mechanism, CCAC and potential LTC home provider(s) and within the available, existing resources in the developmental services community. Examples of additional supports that may be required through the developmental services sector include one-time or ongoing training and consultation, day activities or accommodation option.

CCACs are responsible for the LTC home placement process. The supporting DS community based agency is responsible for placement planning, transition and placement follow-up.

CCACs will work with DS agencies where planning for an individual's placement into a LTC home is required in response to their increased health care needs.

The CCAC will work with the DS agency, individual and SDM to gather all the necessary information to conduct the eligibility assessment and to complete the health care assessments required for placement in a LTC home.

1. The CCAC must determine, as the first step of the LTC home placement process, that all community-based resources to meet client needs have been exhausted.
2. LTC home placement planning for an individual will include the identification of necessary supports for successful placement through the development of a Personal Plan. These may include additional supports that are specific to the individual's developmental disability, beyond the basic LTC home service offering, and necessary for successful placement.
3. Where applicable, planning will include but not be limited to a confirmation of the service providers who would be involved in providing direct or indirect support through the developmental services system.

The DS agency is responsible for:

- coordinating the necessary steps for the community care access centre (CCAC) to complete the functional and health assessments required for the LTC home application process
- facilitating visits by family and other parties to potential LTC homes which are encouraged to learn how the home structure, environment and staffing model are appropriate to the needs of an individual
- facilitating discussion with the LTC home to identify additional resources required and develop a Support Plan that can meet the needs of the individual
- contingency planning for situations in which an individual is determined ineligible for placement or cannot, for whatever reason, be placed in a LTC home

The CCAC is responsible for:

- determining eligibility for admission to LTC homes;
- for those persons determined eligible, requesting the LTC home's approval for admission to the LTC home;
- determining priority for admission and placing all eligible applicants in the appropriate prioritization categories on the waiting lists when beds are not immediately available;
- keeping and managing the waiting lists for admission to LTC homes; and
- authorizing admissions to LTC homes.

The LTC homes are responsible for:

- considering the appropriateness of placement of each individual to LTC homes from the community in relation to the residents currently in the home, the environment and the home's approach to care, staff and accommodation available;
- assessing and determining what additional supports (e.g., accommodation, education, equipment, staffing) may be required for the successful placement of individuals from the community;
- participating in ongoing knowledge exchange during the individual's application process and information exchange about relevant DS programs and services through DS agencies, CCAC and other service providers;
- identifying their LTC staff training needs to be provided by DS agencies for successful placement;
- providing reasonable, controlled access to DS agency staff and other care providers into their LTC homes to deliver additional supports identified in the individualized plan.

D) Detailed Individual Planning and Placement Process for Individuals Supported by DS Community-based Agencies

1. Application to a LTC home will be made when a request for admission to a LTC home has been made by an individual supported by a DS community-based agency) or their SDM, if the client is not capable as per the *Healthcare Consent Act*. The request for admission will be facilitated by the agency supporting the individual. The request will be made to the local CCAC so that an individual assessment can be made. The agency will coordinate the development of a Support Plan based on information collected from family, friends, agency staff, health care professionals and relevant assessments. The plan is shared with family, friends and agency staff for consideration/revision prior to distribution.
2. The CCAC, in collaboration with the agency, will obtain the required consent for admission to a LTC home and releases of information from the individual or SDM in order to conduct the assessment. The agency staff will coordinate the meetings required for the CCAC to complete the assessment and ensure that the family/SDM is apprised of this process.

3. The DS agency will remain connected to the family throughout the CCAC referral process. The CCAC will meet with the individual and SDM and an assessment will be completed to determine if the individual's placement is appropriate in each selected LTC home.
4. With the consent and additional release of information from the individual or SDM, the CCAC will forward results of the assessment to the family/SDM and to the agency staff person identified as the primary contact. The CCAC conducting the assessment will also forward the referral and assessment information to the CCAC in the community in which the individual will eventually reside (if different).
5. The agency will work with the individual, family/SDM, community-based developmental services system and the local CCAC to identify and coordinate the appropriate service options within the LTC home provided by DS agencies in the community where the individual is to move.
6. If the individual is determined eligible for a LTC home placement, the individual or the SDM is able to select up to a maximum of three LTC homes. As part of the development of an individual's Support Plan, which details the care and services the person will receive in the placement, the agency may coordinate visits, with the assistance of the CCAC, by the individual/SDM to the proposed LTC home(s). Based on particular planning needs, visits may also be coordinated to include staff from the agency and staff from any other DS agencies who may provide service to the individual once they are placed in the LTC home.
7. Once the eligible individual has made the selection of one to three LTC home(s), the individual/SDM must apply for authorization of admission. The CCAC, in collaboration with the agency staff person will assist the individual/SDM to complete the application. The application that will be sent to the selected home(s) along with all the assessment information and the individual/SDM will indicate preferences (choices) for accommodation (private, semi-private, or basic). The individual/SDM may select LTC homes based on factors, which include ethnic, spiritual, linguistic, familial and cultural preferences. A copy of the Support Plan for the individual will also be sent with the application.
8. The LTC home is required to provide a written response to both the CCAC and the individual/SDM whether or not it is offering the individual a placement into the home within 5 days of receiving the request for application for admission.
9. Should the LTC home not accept the application for admission, the LTC home must provide a written notice to the director of the MOHLTC regional office, the CCAC and the individual/SDM with a detailed explanation of the supporting facts.
10. As the LTC home must specify the reasons for not offering placement that are related specifically to the condition of the individual, the CCAC in collaboration with the agency can negotiate a reversal of the LTC home decision based on availability of additional supports as identified in the 'transitional support plan' and made through the responsible DS supporting agency.

11. After reconsideration, if the LTC home does not offer placement, the agency will continue to work with the individual, family/SDM, regional/community HCC and CCAC to select other LTC homes or revisit other community options.

    CCACs will also assist in the planning for alternative delivery options for health-based supports where a LTC home placement is not accessible. These options may include in-home health care supports and/or training DS providers to provide personal support services which include: assistance with personal hygiene activities, routine activities and procedures of daily living, in order to allow individuals to reside in DS residential settings.

12. If an appropriate vacancy exists in one of the LTC homes to which an application has been made, the CCAC will notify the individual or substitute decision maker. The individual, if capable or the SDM will have 24 hours within which to accept or decline the offer. Once an offer has been accepted, the individual is expected to move in by the 5th day after the day on which the individual is made the offer of admission. Once the individual accepts the offer of admission the bed may be held up to 5 days following the date of notification if the individual pays the applicable bed-holding fees.

13. Individuals will not move from their home until the appropriate supports are in place. The Support Plan will become finalized through a written document between the individual, SDM (if applicable), family, supporting agency and LTC home provider. This written document will state what supports will be provided, by whom, and the roles and responsibilities of each party in relation to the ongoing assessment/evaluation of the support plan.

14. The DS supporting agency will conduct a 3 month post-placement follow-up in conjunction with the LTC home provider, as appropriate, to review the individual's status/progress and the support plan in relation to the individual's current situation and circumstances.

15. Where a LTC home placement does not occur within a six-month period consent must be obtained from the individual, if capable or their SDM for reassessment.

APPENDIX A – LTC HOME ELIGIBILITY CRITERIA AND BASIC ACCOMMODATION AND SERVICES

Long-term care home settings are designed for people who require the availability of 24-hour nursing care and supervision within a secure setting

Basic accommodation and services include furnishings (e.g. bed, chair), meals (including special diets), bed linens and laundry, personal hygiene supplies, medical/clinical supplies and devices (e.g. walkers, wheelchairs for occasional use), housekeeping, pastoral services, social and recreational programs, medication administration, assistance with the essential activities of daily living, nursing and personal care on a 24-hour basis, and access to a physician and other health professionals[1] .

Individuals considered eligible***:***[2]

- are at least 18 years old
- are insured persons under the *Health Insurance Act*
- meet at least one of the following conditions:
    1. require that nursing care be available on-site 24 hours a day.
    2. require assistance each day with activities of daily living.
    3. require, at frequent intervals throughout the day, on-site supervision or on-site monitoring to ensure his or her safety or well-being.
    4. are at risk of being financially, emotionally or physically harmed if living in their residence.
    5. are at risk of suffering harm due to environmental conditions that cannot be resolved if they live in their residence.
    6. may harm someone if they live in their residence. *[O. Reg. 373/94, s. 23]*
- meet at least one of the following conditions:
    1. None of the publicly-funded community-based services available to the applicant while the applicant lives in his or her residence and none of the other caregiving, support or companionship arrangements available to the applicant while the applicant lives in his or her residence are sufficient, in any combination, to meet the applicant's requirements.
    2. None of the publicly-funded community-based services available to the applicant in the area to which the applicant plans to move and none of the other caregiving, support or companionship arrangements available to the applicant in the area to which the applicant plans to move are sufficient, in any combination, to meet the applicant's requirements. *[O. Reg. 373/94, s. 23]*

1 **http://www.health.gov.on.ca/english/public/program/ltc/15_facilities.html**

2 Nursing Homes Act, R.R.O. 1990, REGULATION 832

and their care requirements can be met in a nursing home. *[O. Reg. 373/94, s. 23]*

APPENDIX B – GLOSSARY AND DEFINITIONS

CCAC
Community Care Access Centre

DS
Developmental Services

HCC
Health Care Consultant

LHIN
Local Health Integrated Network

LTC
Long-Term Care

MCSS
Ministry of Community & Social Service

MOHLTC
Ministry of Health and Long-Term Care

PERSONAL PLAN
A Personal Plan is developed by a regional placement facilitator based on input from staff, family and significant others to outline the personal history, present situation and future considerations of the individual in relation to their assessed support needs, likes/dislikes and goals.

SDM
Substitute Decision Maker

SUPPORT PLAN
The Support Plan is built on the Personal Plan by the proposed supporting agency to detail how the individual will be supported in a particular placement and when relative to developmental services supports.
DS Facilities Initiative

FPC
Facility Planning Coordinator

PCA
Facility Planning Coordinator Assistant

RPF

Regional Placement Facilitator

RPM
Regional Project Manager

APPENDIX C – DS FACILITIES INITIATIVE GUIDING PRINCIPLES

A careful and thorough planning process will involve the resident, his or her family or advocate, as well as placement facilitators, and the community agency that will be providing services to the resident. The Ministry will engage these participants and work collaboratively to build on the strengths of the existing system and identify models of service delivery to respond to the needs of individuals leaving the facilities. The shift from facilities to community settings will allow for opportunities to reinvest in community supports and build a sustainable future.

We will be guided by the following principles that will define how a person leaving a facility will move to a setting that can support each individual's needs.

Individual Planning

- There will be a comprehensive plan tailored to each individual.

Flexibility and Choice

- Individuals will have the opportunity and support to make informed decisions about their lives.
- An individual's decision in relation to location and type of living arrangements, maintenance of friendship and family ties and other supports and services should be given primary consideration.
- Planning for supports and services for individuals will be flexible and respectful of cultural, language, religious beliefs and lifestyle choices.
- Wherever possible, individuals will have the opportunity to live close to their families or friends.
- Wishes of the individual and those of their families will be balanced with the available resources and community capacity to respond to their needs.

Fairness

- In those situations where an individual does not have family or friends independent of the service system to effectively assist, a neutral third party will be identified to participate in the process.
- Planning for all individuals will involve existing community processes, including access mechanisms, service planning, and service resolution.

Inclusion

- An individual should have the opportunity to live, work and participate with other members of the community.
- Supports for individuals should include existing community services as required.

Health and Independence

- Supports and services will promote the physical and emotional well being of individuals in settings that foster healthy and independent living. Individuals will not leave facilities until arrangements and supports are in place.

Specialized supports and services as required will be provided or developed.