Supports for Daily Living Standards Manual

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Purpose

The Supports for Daily Living (SDL) Standards Manual sets forth, in a single document, the commonly agreed upon guidelines for the operation of SDL services. These standards have been designed to align with the *Assisted Living Services for High Risk Seniors Policy (Ministry of Health and Long Term Care), 2011*, and as a complement to the Mississauga Halton Local Health Integration Network's *SDL Resource Manual: A New Vision of Assisted Living for Seniors 2011/2012*.

This manual is an effort on the part of the SDL community to standardize material aspects of operation between and across agencies in pursuit of a comprehensive SDL program and service delivery system. Inclusive within the manual are the key principles for program development and implementation, as well as performance deliverables for all SDL approved service providers.

SDL service providers affirm that they have a responsibility to respect and adhere to provisions delineated in this manual in order to:

a) Operate in accordance with the SDL Standards established herein
b) Operate in accordance with applicable laws, regulations and policies
c) Establish and maintain an internal framework that effectively addresses the SDL standards

The SDL Standards Manual includes the scope of services, models of service delivery and partners in SDL service delivery. The focus areas include: eligibility criteria, central registry, referrals, assessments, service plans, care coordinating, transfers discharge, complaints and appeals.

This manual applies specifically to the SDL providers in the Mississauga Halton Local Health Integration Network (MH LHIN), and all SDL standards are reviewed by the SDL Steering Committee, whose membership includes representatives from:

Central Registry

MICBA Forum Italia

Nucleus Independent Living

Oakville Senior Citizens Residence

Ontario March of Dimes

Peel Senior Link

Regional Municipality of Halton

VON Peel

Yee Hong Centre for Geriatric Care

Supports for Daily Living (SDL)

SDL incorporates an innovative regional service delivery model to offer efficient and effective ***non-medical*** community-based assisted living support to eligible seniors in their own homes.

SDL services are intended to provide each eligible client with the support they require to continue living comfortably in their own homes while they are still safely able to do so, decreasing the risk of unnecessary hospitalization or pre-mature transition to a more structured living environment.

The program targets high-risk seniors with complex needs who are able to continue living in their own homes and direct their own care as long as there is access to frequent, urgent and intense personal supports throughout a 24-hour period. SDL services are available 24 hours a day, every day throughout the year, on a scheduled and unscheduled basis.

The SDL model includes multiple daily visits based on individual need (approximately 1.5 hours per day) by trained personal support workers (PSWs) to meet, where possible, the preferred schedule of the client.

SDL providers work collaboratively with their partners throughout the health system to ensure services are client-centered from intake to eventual discharge from the SDL program. Providers work to ensure transitions are equally as seamless and straightforward when health status has improved and the client is transitioning to a lower intensity service, as when the client can no longer safely manage in their own home and must transition to a higher intensity and more appropriate provider for their needs.

SDL is designed with a systems approach to provide clients with the right care, at the right time, in the right place.

Scope of Services

SDL services include non-medical personal support, medication reminders and assistance, safety checks/reassurance services and essential homemaking when needed.

SDL Personal Support services include services used to assist with or supervise the Activities of Daily Living (ADL) such as:

- washing and hair care
- bathing
- dressing/undressing
- application of non-medicated creams or eye drops
- transferring/positioning
- mouth care
- assistance with eating
- toileting
- safety checks/reassurance services – telephone or in-person visits to monitor the safety and well-being of the client and their environment.

- medication reminders and assistance
    - **Medication Reminders** (Cueing) is a verbal reminder to the client at scheduled times to take their medications.
    - **Medication Observation** is the tracking/recording of medication consumption as reminders are given. The purpose is to inform the client's family or Power of Attorney (POA) of medication-related activity so they can be informed and responsible for the activities of the client as related to medication.
    - **Medication Assistance** - provides physical assistance with opening or consumption of pre-dosed medication under the direction of a client or written/verbal instruction by the Power of Attorney (POA) / Substitute Decision Maker (SDM).

SDL homemaking services include services used to assist in Instrumental Activities of Daily Living (IADL) as determined by the assessment. Essential homemaking related to the client personal care may include one or some of the following, depending upon assessment:

- Light meal preparation/clean-up after use
- Tidying up the bathroom/kitchen/bedroom after use
- Garbage disposal
- Changing bedding
- Light housekeeping
- Laundry

Clients should be advised that SDL services are **NON-MEDICAL** in nature and although the PSW staff is formally trained, they cannot diagnose or assess health and medical conditions.

Service Maximum

Persons receiving SDL services will not receive more than a combined program average of 1.5 hours per day of personal support, homemaking.

Models of SDL Service Delivery

The MH LHIN has developed three models of service delivery for the SDL program: Hub, Hub and Spoke and Mobile.

1. **Hub Model (In Building)**

The 'hub' service delivery model places an office on-site in a designated building, which serves as a centre for SDL activity. Personal support workers deliver services on-site to eligible seniors in their individual residential units. SDL services are separate and distinct from housing arrangements.

2. **Hub and Spoke Model**

The SDL service provider has an office on-site in a building (hub) servicing clients in the building, and also provides services to eligible seniors who live in the neighbourhood within close geographical proximity to the building (the spokes). Close proximity is defined as a designated geographic area within a specific radius from the hub (i.e., 1km, 2 km) and may be subject to change.

3. Mobile Model

The SDL mobile service model operates without a designated "hub" area and provides SDL services broadly to eligible clients living across designated communities within the MH LHIN boundaries. The mobile service adapts its service areas according to the needs of the population served at any given point in time and is, therefore, able to ensure that high-risk seniors who are being discharged from the hospital are able to return home safely and quickly.

The mobile program also operates as a transitional service for those clients residing in the geographical hub and spoke areas of other SDL service providers. As a vacancy becomes available within that area, the client is transferred to the hub/hub and spoke providers for that catchment area for ongoing SDL service. The clients who live outside any hub and spoke boundaries remain on service with the mobile provider for the duration of their SDL eligibility.

The MH LHIN is responsible for determining and approving the Hubs, Hub and Spokes, and Mobile provider within its specific geographic area.

SDL Eligibility Criteria

Consistent and objective criteria for SDL eligibility shall be used across all SDL approved agencies.

An approved SDL provider shall provide services only to those who meet the following criteria:

- The person is 65 years of age or older, and insured under the Health Insurance Act (OHIP)
- The person has an assessed Method of Assigning Priority Level (MAPLe) score of 3 or higher
- The person must demonstrate a need for personal support services in the form of assistance with ADLs on a 24-hour basis and has care requirements that cannot be met solely on a scheduled visitation basis
- The person must demonstrate a greater need for personal support services over and above homemaking services and/or IADLs
- There is a need for:
    - ***Frequency*** – individual requires multiple/intermittent visits throughout the day on a 24 hour/7 days a week/365 days per year basis, with an average of 1.5 hours of care required per day
    - ***Urgency*** – individual warrants a prompt response that cannot always be scheduled
    - ***Intensity*** – individual's condition demands direct personal attention (MAPLe 3 or higher)
- The person meets the characteristics of a high risk senior as set out and elaborated in section 6.1 of the ALS4-HRS 2011, policy
- The person is personally (or through a readily available Substitute Decision Maker(SDM)) able to direct his/her own care
- The person is medically stable or able to have his/her medical needs met by professionals in the community (i.e. CCAC, family physician, etc.)
- The person is able to be left alone between visits (i.e. does not need constant supervision)
- The person resides in a Mississauga Halton LHIN approved designated geographic service area
- The person's home has the physical features necessary for SDL services to be safely provided

- The nature of the services and the service environment do not pose a serious risk to the client, staff or organization

SDL Exclusion Criteria

All SDL providers shall comply with the following SDL eligibility exclusion criteria:

- The applicant has an assessed MAPLe score of 2 or lower
- The applicant cannot be left safely alone between SDL visits
- The applicant's need for homemaking services exceeds the need for personal support (or requires only homemaking services)
- The applicant or environment poses serious risk to self and/or others
- The applicant's mental health/behavioral needs are not able to be met through professional services in the community
- The applicant's medical needs are not able to be met through professional services in the community
- The applicant's needs can be more appropriately met through other community support options (i.e. CCAC, LTHC, etc.)

SDL Central Registry

On behalf of all SDL service providers, the purpose of the Central Registry is to facilitate referrals and intake through a single point of access. The benefit is that the Central Registry acts as a single entity knowledgeable about the SDL system and its capacity such as vacancies, waitlist management, SDL data, etc.

The waitlists and transfers between providers are facilitated and coordinated in a seamless and system-oriented approach.

The SDL Central Registry will:

- Work in the best interest of the Mississauga Halton LHIN's health care system, SDL system and all SDL service providers
- Be knowledgeable about each SDL Provider and their respective service availabilities
- Act as a coordinated point for referrals to SDL services
- Track Central Registry Activity and report as needed
- Use SDL eligibility criteria to determine appropriateness for SDL service
- Ensure a standardized assessment tool (InterRAI CHA) is used to provide an objective assessment in determining a client's eligibility
- Keep the SDL service providers informed of SDL system information including but not limited to the number of waitlisted clients (per designated geographic area)
- Manage the SDL waitlist according to the standards
- Provide referrals to SDL providers within 5 business days when a vacancy is reported

SDL service providers agree to provide the SDL Central Registry with:

- Community referral information directly obtained at their agency (using appropriate, accurate and current SDL referral forms)
- Vacancy* reporting to ensure that the Central Registry has current information to facilitate more efficient and timely handling of all placements and improved waitlist management.
- The reporting requirements:
    - Must report within two business days of processed vacancy
    - Site locations
    - Date of service availability

Internal referrals can only be accepted by SDL providers after referral to and approval from Central Registry.

Vacancy *– refers to a specified allotment of time which is no less than 90 minutes spread over multiple time slots in one day.*

Referral Priority

Referrals to the SDL Program are accepted from all sources. Upon receipt, all SDL referrals are screened for basic eligibility (i.e. service recipient is 65 years of age and older, lives within the MH LHIN boundaries, is covered by OHIP etc.).

The Supports for Daily Living Program is targeted to support high risk seniors with a goal of reducing ALC days and LTC admissions, therefore, it has been determined by the funder that incoming referrals are prioritized based on referral source as per the waitlist priority from the *MOH and LTC -Assisted Living Services for High Risk Seniors Policy, 2011* section 10.5

1. **Referrals are prioritized in the following order:** *Referrals waiting/ planned for discharge home from hospital shall be ranked first.* Hospital referrals are further prioritized based on planned discharge date from hospital with a goal of minimizing ALC days.
2. *Referrals from the community who would benefit from the SDL model of care and who would otherwise be at high risk of hospitalization or admission to a LTCH*
3. *Referrals from the community who are frequent users of emergency room and hospital services shall be ranked third*
4. Community referrals are further prioritized based on geographical region and date of referral.

Referral Process

All SDL referrals/applications within the MH LHIN are processed through a centralized intake mechanism called the SDL Central Registry. Applicants and/or referral sources can submit a SDL referral by fax, by phone or via website (online application at www.centralregistry.ca).

Referrals are approved or declined for SDL services based on the information provided in the referral/application form, consultation with the applicant and/or circle of care members and the outcomes of a current RAI assessment (either interRAI-CHA or RAI-HC) conducted or obtained by Central Registry coordinators. In order to avoid over-assessing the service recipient, the Central Registry will accept an assessment conducted by another service provider. An assessment is considered current if it

is less than 6 months old and the care circumstances or health condition of the applicant have not changed (as per reassessment triggers) since the date of assessment.

Once the applicant has been approved for SDL service, the Central Registry transfers the referral either to the mobile SDL service provider until a longer term vacancy is available within the geographically appropriate hub and spoke service provider, or directly to the hub and spoke service provider.

All SDL providers are expected to report vacancies to the Central Registry at least monthly but preferably as they occur. The Central Registry will assist with ensuring a service recipient is transferred from the mobile SDL provider caseload to the hub and spoke provider caseload as available. If the hub and spoke declares a vacancy and there are no service recipients on the mobile provider's caseload residing within that geographical area, the next geographically appropriate referral is obtained from the community waitlist for processing.

Waitlist Management

When there are more referrals than there are vacancies available in the system, referrals are placed on a waitlist. Generally, due to the prioritization of referrals, the waitlist is comprised of community referrals due to the fact that hospital discharges cannot be delayed and an alternate source of support is often sought by hospital discharge planners to support an effective discharge.

Waitlist referrals are processed on a first come, first served basis as vacancies become available. The waitlist is reconfirmed every 3-6 months as the Central Registry places a call to the referral source and/or service recipient or designated family member to ensure they have continued interest and need for the SDL program services. The Central Registry reports monthly to service providers and the MH LHIN the number of referrals waiting in each hub and spoke area.

Assessments

An SDL assessment is conducted by an assessor trained in using the interRAI-CHA tool. This is a common objective tool that includes input from the client and the assessor. The interRAI-CHA produces outcome scales that rate cognitive performance, functional abilities, frailty and areas for support needs. SDL providers will ensure that assessments include the wishes and preferences of the client and/or substitute decision-maker (as specified in Section 10.3 and 10.4 *Assisted Living Services for High risk Seniors Policy, 2011*).

Information Sharing

The Central Registry obtains consent from applicants to share their information either electronically or manually with health service providers (HSPs) via the Integrated Assessment record (IAR) or any other processes.

The Central Registry shares the following information with each of the SDL applicants:

- SDL transitional model and how it would apply to them
- SDL eligibility criteria
- Standardized assessment tools and approved information sharing processes
- Scope of SDL services

Intake, Service Planning & Care Coordination

It is the responsibility of a SDL provider to, within reason, be aware of the overall care needs of the client and ensure that appropriate service planning and care coordination services are provided to the client.

Circle of Care – All parties involved in providing care to the client.

Care Coordination – Community level alignment of services to meet the identified needs of an individual. Care Coordination may include gathering information from various circles of care members to facilitate input into a needs assessment or updating a client's Service and/or Care Plan. It also includes arranging various agencies/programs/services together to ensure the needs of the client are met.

Through the assessments (RAI HC or interRAI CHA), Clinical Assessment Protocol (CAPs) are produced and they guide service planning and care coordination on behalf of the client. Understanding that some CAPs are beyond the scope of the SDL providers' responsibilities, there should be some documentation to address how these CAPs are supported by the SDL program and the broader circle of care.

Intake

Following the determination of eligibility, clients are processed by the HSP for intake into a SDL program.

Prior to processing, clients must be informed of the following:

- What it means to "direct one's own care"
- The eligibility criteria for service
- Service suspension, termination and discharge policies
- Scope of SDL service availability
- Client's Bill of Rights
- How to bring forward a suggestion/concern/complaint
- Details regarding transitions if applicable (in the event that the client will be transitioned from one provider to another)
- Any other HSP specific relevant and applicable responsibilities and restrictions

During the intake process, the SDL provider must ensure three documents are completed:

1. Service agreement - the contract signed by both the client and the agency that outlines the rights and responsibilities of both parties for the services to be provided.

2. Service Plan - is the documented plan of service developed by the SDL provider with client participation that identifies the tasks, amount and schedule of services. Service-specific evaluations may need to be completed in addition to the assessment in order to complete the service plan.

3. Care Plan – a document that outlines the various HSPs involved in providing care to the client. The care plan should include the following:
    - Name of HSPs
    - Contact information for the HSPs

- Program and frequency (i.e. 2 times per week)

The care plan, created in collaboration with the client is specifically identified for the client and adheres to the client's preferences and goals of care as supported by the CAPS and outcome measures of the assessment.

All SDL agencies shall have ***policies and procedures*** in place for ensuring potential clients, clients, their substitute decision-makers (if any), and any persons designated by them have the right to participate in the assessment process, the care planning process and provide input into the service plan.

Reassessments

SDL service providers shall conduct a review and/or re-assessment of the client's needs at regular intervals and as needed to ensure ongoing SDL eligibility.

It is the SDL service provider's responsibility to initiate a reassessment when signs of physical and/or cognitive deterioration are observed that may impact on the client's ongoing eligibility or:

- Changes in the client's service needs.
- Changes in the client's health condition (i.e. signs of physical and/or cognitive deterioration).
- Changes in the client's living situation.
- Changes in the client's informal support network.

The re-assessment will occur in consultation with the client, as client circumstances change (as above) or ***at a minimum every 6 months.***

Service plans and/or service agreements should be updated to reflect any changes

Service Agreements

The SDL service agreement shall include at a minimum, the following provisions:

- Client Bill of Rights (as per Home Care and Community Services Act, 1994)
- Responsibilities of the SDL client/Substitute Decision Maker (SDM) / Power of Attorney (POA)
- Roles and Responsibilities of the SDL Service Provider
- The client and/or SDM assumes responsibility for:
- Decisions made to direct the care given
- Be aware of any potential outcomes from the directions which he/she gives
- Communicate his/her needs to the Personal Support Worker or Home Helper
- SDL eligibility and ineligibility criteria (including discharge/termination and suspension protocols)
- Complaints and appeals protocols
- Information sharing and disclosure protocols

Service Plans

The SDL service plan outlines the type, amount and scheduling of service tasks for the client. Clients should receive copies of all service plans and agreements.

Service plans are developed based on the assessed needs of the client and must consider client preferences and goals of service. However, as service time preferences cannot be guaranteed due to the shared nature of a SDL program, scheduling priority will be given to those with a demonstrated medical need for service at that time of day.

Service plans and/or service agreements are updated to reflect any changes in the client's status.

Service plans must clearly define the extent of HSP involvement with controlled/delegated acts and medications. The SDL provider is to ensure that written policies and protocols are developed for any controlled/delegated acts and medication involvement to ensure accurate documentation to support activity.

At a minimum, medication procedures for all SDL providers will include:

- All medications are pre-measured by a pharmacist (blister pack preferred)
- There is an appropriate checks and balance process in place to alert to medication-related issues
- There is a documented plan of action to address adverse medication related events
- Either the client or a Power of Attorney (POA)/SDM takes responsibility to direct their care related to SDL providers' involvement with medications

All SDL providers will make certain that clients and or family members are aware of and consent to the policies of the agency sharing of information, including the following:

- SDL is a non-medical model and services are provided by unregulated health professionals
- SDL does not provide nursing support but can connect to CCAC for assistance in that regard
- The client or the substitute decision maker (SDM) is responsible for informing the SDL program of all changes to medication-related instructions and ensuring the agency has appropriate information to inform changes to the service plans
- SDL only provides physical assistance/observation and/or reminders in order to assist with medications as activities of daily living and is not responsible for decision-making regarding medications -the associated risks regarding medications reside with the client or SDM.

Transfers between SDL Providers

The SDL network of providers has been designed in such a way as to maximize the efficient flow of clients into the SDL services. As such, one SDL provider (Mobile) operates a transitional model of care to provide short- term SDL services until vacancies arise among other SDL providers in specific geographical areas.

To facilitate the transfer, the SDL providers shall complete and share required documentation including:

a) A current assessment (completed within the last six months or earlier)
b) A client's demographic information
c) A client's contact information
d) A summary of the client's service plan

A transitional plan will be developed amongst the two SDL providers to ensure a coordinated transition for the client. The client's service plan could vary based on the new SDL provider but the client will still be eligible to receive the same scope of services.

For those clients who will transition between SDL providers, the SDL Central Registry, the SDL Mobile Program (Transitional Service) and the receiving SDL provider should all use the same messaging to manage the client's expectations across the SDL programs

Collaborative Partnerships

SDL services are exclusively offered by approved SDL service providers, who are distinguished by the use of an SDL approved logo (provided at the onset of this manual). Approved SDL service providers are funded for SDL under the Ministry of Health and Long-Term Care, Assisted Living Services for High Risk Seniors Policy, 2011(ALS4-HRS 2011) and their status must be approved by the MH LHIN.

However, SDL providers also assist in coordinating professional and community services through various collaborative partners including pharmacies, clinics, hospitals, family physicians, among others. Some partnerships include:

Hospitals - The relationship between hospitals and SDL service providers is an important one. Hospitals recognize the SDL program as a viable discharge option for high-risk seniors with complex needs. This program makes the crucial difference between a patient designated as Alternate Level of Care (ALC) and prematurely discharged to a long-term care institution or returning to the comfort of their own home with supports.

CCAC - Community Care Access Centre (CCAC) is often the link for access to in-home, community-based and long-term care services, as well as information and referral.

CCAC personal support services are delivered based on a visitation model. Clients receive services during larger pre-scheduled blocks of time. SDL personal support services are pre-scheduled over a 24-hour period in smaller increments of time to allow for increased frequency and intensity of services.

By transferring existing CCAC clients who are eligible for SDL services, or referring potential clients from hospital or community settings, the CCAC is able to free up existing personal support resources to focus on the needs of other clients in the community. Given that SDL is a non-medical model, CCAC clients eligible for SDL services may still require CCAC professional services like nursing and rehabilitation care. The SDL program eliminates some of the existing pressures on CCAC for non-medical services.

CSS Providers - SDL providers work in partnership with other CSS providers to create an integrated care plan to meet the needs of high-risk seniors. For example: SDL + Meals on Wheels (MOW) + Adult Day Services.

Complementary programs may include:

- Adult day programs
- Safety checks & Reassurance services
- Home maintenance and repair services
- Friendly visiting services
- Meals on Wheels (MOW)
- Diners Club/Wheels to Meals/Congregate Dining
- Transportation
- Caregiver Support
- Home Help Homemaking
- Public Education (Alzheimer's)
- Psycho Geriatric Consulting
- Foot care
- Emergency Response Systems
- Client Intervention & Assistance
- Social & Recreational services

- Aphasia services

LHIN – The LHINs are mandated by the Government of Ontario to plan, coordinate, integrate and fund health care services at the local level. The LHIN is also accountable for establishing SDL service provider criteria, contract deliverables and for monitoring performance.

The LHIN's role as it pertains to SDL service is to:

- create a vision for this program
- facilitate and engage service providers to implement the key elements that will help realize this vision
- make the necessary investments to allow the initiative to realize its potential
- set up an effective monitoring and performance management system
- support new and innovative ideas for health care improvement

Temporary Suspension of SDL Services

All SDL providers may temporarily suspend services in the following situations:

- Circumstances beyond the control of the SDL service provider, i.e. flood, pandemic outbreak, severe weather conditions, fire that prevents the SDL service provider from providing further services to the client etc.
- Services cannot be safely provided and/or place the employees at risk – for example:
    - The client's home environment poses a significant health and safety risk
    - Client or family member or guest assaults, threatens, sexually harasses a staff member
- Breach of service agreement that cannot be remedied.
- Absence of service for less than 30 days.

Discharge from SDL

A discharge policy is communicated to the client during the SDL intake process and from therein the discharge policy is annually re-communicated to the client.

When an SDL client no longer meets the eligibility criteria for SDL service, discharge processes will begin.

Discharge Criteria

SDL service providers may discharge the client when his/her requirements for care have changed or he/she no longer meets eligibility criteria as per below:

- The client's condition improves such that they no longer qualify as a high risk senior requiring a lower level of care than SDL provides
- The client needs are beyond the scope or available hours of SDL services.

- Client's condition worsens requiring the client to seek out the services of a LTCH or a more complex environment
- Client can no longer remain safely at home between visits
- Client's home does not possess the physical features necessary to enable the services to be provided
- Client requires immediate or 24-hour availability of nursing or other professional services
- Client moves out of MH LHIN provider boundaries
- Client moves from one MH LHIN provider area to another area provider (if SDL provider in new area does not have a vacancy client is not guaranteed services)
- Client and/or family pose risk to self and/or others
- Client and/or family are non-compliant with the service plan
- Client decides they no longer require SDL services
- Client demonstrates any of the SDL eligibility exclusion criteria
- If a client is absent for 30 consecutive days
- Funding is withdrawn

No SDL service provider shall discharge a client from the SDL program and/or services unless they involve the client or his/her substitute decision-maker (SDM) as applicable, when making the discharge decisions.

The client shall be made aware of the complaint and appeals process available to them by each SDL provider in the event that they are unsatisfied with a discharge and/or termination decision.

In the event that a client chooses to use the complaint and appeal process to challenge their discharge, the discharge may or may not be postponed (at the discretion of the agency) pending the complaint and appeal process decision.

Prior to discharge, SDL providers shall ensure that clients are provided information and/or referred to programs that will appropriately meet the identified needs of the client.

Complaints & Appeals Processes

SDL providers shall provide clients and applicants with a complaint and appeal process. SDL agencies shall have policies and procedures in place for receiving, recording and investigating a complaint and appeal.

Complaints are defined as a set of formal written accusations. Clients and applicants unable to provide a written complaint must be provided assistance to complete a written complaint.

Scope of Complaints:

The SDL Complaints process applies to complaints and appeals made about service decisions concerning the following:

1. Eligibility for services
2. Exclusion of a particular service from a plan of service
3. Quantity/frequency of a service
4. Quality of a service

5. Termination/discharge/suspension of service
6. Violation of rights

The complaint and appeals process shall be communicated to the client and/or applicant on an annual basis and should contain information regarding the following:

1. Stages of escalation within the agency and respective timelines for response
2. Position of persons involved at each stage
3. A provision for non-retaliation
4. Internal/external appeals mechanisms
5. Information on appeals process offered through Health Services Appeal and Review Board of Ontario

The SDL provider shall organize a means for appeal review (i.e. Appeal Review Committee) following completion of the internal process. The appeal review should consist of objective members outside the employment of the SDL provider under review (minimum three). The committee will provide a written recommendation to the SDL service provider.

Tracking Complaints to the LHIN

As per MOHLTC policy, SDL providers are required to track complaints and provide information to the LHIN on request. A standard tracking process should include:

- Identifying the number of complaints/appeals in process
- Identifying the number of complaints that were based on the six categories of a complaint
- Identifying the number of complaints/appeals resolved quarterly (and year to date)

Reporting

The LHIN sets forth requirements for reporting monthly and quarterly by SDL providers both to the LHIN and the Ministry. The LHINs shall develop a performance measurement framework related to the SDL program and services in collaboration with the SDL leadership team.

SDL program performance will be evaluated on the extent to which the SDL program contributes to:

- Reducing unnecessary and/ or avoidable Emergency Department (ED) 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

SDL Standards Review Process

The SDL Providers within the MH LHIN agree to comply with the SDL Standards set forth in this manual. The Standards set forth herein will be reviewed by the MH LHIN and the approved SDL providers no later than thirty-six months after its effective date. An earlier review may be triggered by the following:

- Legislative or regulatory changes which affect the ALS4HRS 2011 Policy (and thus the Standards set herein)
- LHIN and SDL stakeholders identify possible challenges to the standard

APPENDIX A

InterRAI-CHA Outcome Scales Definitions:

- CHESS Score – The CHESS score identifies individuals at risk of serious decline and can serve as an outcome where the objective is to minimize problems related to frailty (e.g., declines in function) in the elderly population. Higher CHESS scores are predictive of adverse outcomes like mortality and hospitalization.

- MAPLe Score – The Method of Assigning Priority Levels (MAPLe) is used to categorize clients into 5 levels of risk for adverse outcomes. It is a decision-support tool that may be used to inform choices related to allocation of home care resources and prioritization of clients needing community or facility- based services. SDL eligibility requires a MAPLe score of 3 or higher.

- CPS Score – The Cognitive Performance Scale (CPS) is used to categorize the level of cognitive impairment affecting the client.

- ADL Score – Activities of Daily Living (ADL) are activities that promote personal care. ADL include personal care tasks such as bathing, brushing teeth and shaving, putting on clothing, repositioning and moving around the client, especially when physical conditions add to the difficulty of these tasks.

- IADL Score – Instrumental Activities of Daily Living (IADL) are any additional daily activities or tasks that are performed in the course of normal everyday independent living. It encompasses keeping the home tidy by vacuuming and dusting, doing laundry and providing light meal preparation.

In addition to the outcome measures, the interRAI-CHA also produces Clinical Assessment Protocols (CAPs), which are best practice to guide the care plan related to the areas of difficulty identified by the assessment.