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# Enhanced Assisted Living Expansion in Ontario

July 2026

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# 1.0 Introduction & Background

## 1.1 Context & Case for Change

Ontario is experiencing a period of significant demographic change that is fundamentally reshaping demand for housing, health, and home and community care services. Over the next two decades, the population aged 65 and older is projected to increase significantly, from 3.0 million (18.3%) in 2024, to 4.6 million (22.4%) by 2051.[1] This increase is occurring at a time when Ontario's health system is already under considerable strain. Hospitals continue to manage high occupancy levels, including a growing number of patients designated as Alternate Level of Care (ALC) who await transition to a community care or more appropriate housing setting. At the same time, more than 50,000 people are waiting for long-term care (LTC) beds in the province.[2] With approximately 78,000 available LTC spaces for residents across Ontario, the waitlist represents nearly 64% of existing provincial bed capacity, highlighting the significant imbalance between demand and available supply.[3]As the population ages, rates of frailty, chronic disease, functional decline, cognitive impairment, and social vulnerability will further intensify these pressures.

A key contributor to these pressures is a persistent gap, or "missing middle", in Ontario's housing and care continuum. The current system is largely structured around two core pathways: supporting older adults to remain at home with episodic home and community services or transitioning them to LTC as needs escalate. When individuals can no longer be safely supported at home with the limited government subsidized services available, few accessible alternatives exist between these endpoints.

In response to similar pressures and gaps within the continuum, many jurisdictions have begun to implement Enhanced Assisted Living (EAL) models. These models combine stable and typically affordable housing with reliable on-site supportive care, enabling residents to remain in the community longer and reduce reliance on higher-cost settings. While designs vary, they commonly feature small or clustered living spaces, 24/7 non-regulated staffing, flexible community support arrangements, and communal environments designed to promote independence, safety, improved quality of life and social connection.[4]

In France, the COSIMA model offers small, community-embedded homes supported by multidisciplinary teams that focus on autonomy and social connection.[5] In the Netherlands, clustered neighborhood-based homes, such as the well-known Hogeweyk dementia village, offer

[1] Ontario Ministry of Finance. *Ontario Population Projects, 2023 – 2046.* Government of Ontario. https://www.ontario.ca/page/ontario-population-projections.
[2] Ontario Long Term Care Association. *The Data: Long-Term Care in* Ontario. https://www.oltca.com/about-long-term-care/the-data/
[3] Ontario Long Term Care Association (OLTCA), internal analysis, Spring 2026. https://www.oltca.com/about-long-term-care/the-data/
[4] Canada's Drug Agency – Horizon Scan bulletin. *Dementia Villages: Innovative Residential Care for People with Dementia*. https://www.cda-amc.ca/dementia-villages-innovative-residential-care-people-dementia
[5] COSIMA – Community-Integrated Intermediate Care. https://cosima.eu/.

purpose-built communities where residents live in small households located within an enclosed neighborhood.

Interest in EAL and similar models is also growing in Canada. Provinces like Nova Scotia and British Columbia are expanding housing models that integrate 24/7 supportive care, while Ontario is also seeing an increasing number of initiatives mostly led by non-profit operators.[6] These efforts reflect growing recognition that housing models with integrated supportive care play an important role in enabling older adults while reducing reliance on higher-intensity settings.

EAL has significant potential to strengthen Ontario's housing and care continuum, but its development and expansion are constrained by systemic barriers. EAL is not yet recognized as a distinct part of the housing and care continuum, making it difficult for proponents to secure sustainable capital and operating funding and to integrate health and supportive care services within existing delivery models. To unlock the potential of EAL and support broader implementation across Ontario, the Ministry of Health should take action to recognize EAL's role, enable more sustainable funding mechanisms, and support integration with health and community-based services. Doing so will help relieve growing capacity pressures across hospitals, long-term care, and home and community care – ensuring Ontario's aging population can thrive.

## 1.2 Purpose and Scope

In response to the growing need for integrated housing and care solutions, **this report provides a shared understanding of EAL, its role in Ontario's housing and care systems, and the conditions required to support development and scale.**

Specifically, this paper:

- **Defines EAL** and clarifies the model's position within Ontario's housing and care continuum.
- **Profiles five EAL (5) models currently operating in Ontario**, outlining how they are designed, funded, and operated, and what outcomes they are achieving.
- **Identifies enablers and barriers** in the current policies and funding that affect the ability to develop, operate, and sustain and expand EAL models.
- **Proposes a path forward** to support EAL as a core part of an integrated housing and care continuum, with a focus on the policy and funding conditions required to support sustainable implementation and scale.

# 2.0 Methodology

## 2.1 Data Inputs and Approach

This report draws on multiple sources of information to understand the role and implementation of EAL models in Ontario. Sources include:

[6] Homecare Hub. *Shared Living Homes by Homecare Hub*. Shared Living Homes Near You | Homecare Hub

- **Case Studies:** Five (5) EAL models operating in Ontario – purposively selected for their diversity in operator type, scale, design, population served, and support services provided.
- **Environmental Scan:** A targeted review of provincial policy documents, sector reports, academic literature, and broader situational analyses.
- **Key Informant Interviews:** Interviews with model operators, system leaders, and key model partners at the municipal, provincial, and federal levels.

Insights from all sources were synthesized to identify trends, system-level challenges, and common elements of effective model delivery, ultimately informing recommendations for future action.

## 2.2 Limitations

Various limitations should be considered when interpreting the findings of this report, reflecting both the nature of available evidence and the current state of EAL implementation in Ontario.

- **Variation Across Models and Contexts:** The case study models examined operate within diverse organizational and local contexts. Observed outcomes may therefore reflect a combination of model design and local implementation conditions, rather than distinct EAL model features alone. In addition, not all cases align fully with every defining feature of EAL. Some cases, such as LOFT's Back to Home model, were included to illustrate the flexibility of adjacent approaches and how housing and care can be integrated to meet diverse population needs and system pressures. To mitigate this, the analysis emphasizes shared functions, implementation approaches, and enabling conditions across cases, rather than assessing model-specific effectiveness or causal impact.
- **Limited Northern and Rural Representation:** Relatively few eligible models were identified in northern and rural regions, limiting the ability to draw region-specific insights. While this constrains analysis related to geographic variation, the core functions and implementation considerations identified remain broadly applicable across Ontario.
- **Variation in Outcomes Data:** Consistent outcome data cross models was limited, particularly with respect to resident- and system-level impacts. Where available, data has been incorporated and supplemented with relevant external evidence.

Despite these limitations, the methodology and findings provide a strong foundation for understanding how EAL functions within Ontario's system and the enabling conditions required to support them.

# 3.0 Overview of Enhanced Assisted Living

Across Ontario, a range of EAL models have emerged in response to local needs, organizational innovation, and growing recognition of gaps in the existing housing and care continuum.

## 3.1 Definition of EAL

EAL refers to **community-based residential settings that combine stable housing with 24/7 supports for individuals who require ongoing assistance with daily activities and supervision to live safely in the community** but do not require continuous clinical care oversight.

While there is no single standardized model, EAL approaches share a set of core design and operational features. Core features typically include:

- **Small-scale, non-institutional residential settings**, typically fewer than 30 units, with private living spaces and shared common areas such as kitchens, dining, and living rooms.
- **Purpose-built or adapted physical environments** designed to support safety, accessibility, and aging in place.
- **Stable tenancy** within a residential housing environment.
- **24/7 on-site supportive and personal care**, commonly delivered by non-regulated staff (e.g., PSWs) and/or coordinated service providers.
- **Clients with autonomy and the ability to have independence** without significant physical or cognitive barriers
- **Integrated access to health and support services,** typically facilitated through partnerships with community support agencies, primary care, mental health services, or other providers.
- **Structured recreational and social programming** to foster connection, resident engagement, and a sense of community.

While these features are broadly consistent, EAL models may vary in several respects, including:

- **Affordability mechanisms:** Rent-geared-to-income (RGI) subsidies and other affordability mechanisms are commonly, though not universally, incorporated. These mechanisms tend to align with the populations served as well as requirements often attached to municipal or federal capital funding programs.
- **Target populations served:** While the models highlighted in this report primarily serve older adults, the core design principles of EAL - small-scale residential environments with 24/7 integrated support services - may also be adapted to support other populations who may benefit from predictable daily assistance within community-based settings.

Beyond these features, EAL models vary in response to local context, organizational mandate, and available partnerships. Differences in staffing models, service delivery approaches, and physical configurations reflect adaptation to community needs and available resources rather than divergence in core purpose, underscoring the flexibility of EAL models across diverse settings.

## 3.2 Position within Ontario's Housing and Care Continuum

EAL occupies a distinct and increasingly critical position within Ontario's housing and care continuum (see Table 1). By supporting individuals whose needs fall between traditional home care and LTC, EAL models provide an additional community-based option for individuals who might otherwise transition prematurely to higher-intensity care settings, such as LTC.

*Table 1 Ontario's Continuum of Housing and Care Supports*

| | Adult Lifestyle Communities | Naturally Occurring Retirement Communities (NORCs) | Supportive Housing | Retirement Homes | Enhanced Assisted Living (EAL) | Long-Term Care |
|---|---|---|---|---|---|---|
| **Description** | Age-restricted residential neighborhoods for active, independent older adults that offer social connection and convenient amenities. | Existing residential buildings or neighborhoods with a high concentration of older adults, where services are layered on to housing to support aging in place, rather than delivered through purpose-built environments. | Housing with support provided on-site, with a focus on maintaining housing stability. | Privately operated residences, including for-profit and not-for-profit providers, for older adults who are largely independent. | Small, community-based residential settings offering stable tenancy with integrated daily supports. | Government-regulated homes providing 24/7 nursing care and supervision for people with complex medical and personal care needs. |
| **Target Population** | Older adults (often 55+) who are predominantly independent and do not require regular support services. | Older adults (typically 55+ or 65+) living independently in the community with low to moderate and gradually increasing support needs. | Adults, adults living with physical or cognitive disabilities, mental health issues and substance abuse challenges, or other medical or functional conditions who require supports, case management to maintain stability. | Older adults who are generally independent but may require support services to age safely in place, including some individuals with moderate to higher care needs. | Older adults with moderate, evolving needs who benefit from predictable support with Activities of Daily Living and Instrumental Activities of Daily Living, coordinated services, and a strong sense of community. | Older adults with complex care needs requiring continuous clinical oversight. |
| **Level of Support** | Low | Low | Low to Moderate | Variable | Moderate | High |
| **Typical Service Mix** | No onsite care provided. May include a mix of amenities aimed at fostering a sense of community. | Wellness and health promotion programs, social and recreational activities, outreach supports, light personal care, meals, service navigation, and coordination with home | Personal care and attendant services, case management, homemaking, meals or meal support, emergency response. | Optional care services at-cost such as bathing assistance, medication support, housekeeping, and social activities. | 24/7 on-site assistance with ADLs and iADLs, meals and social programming, medication support, care coordination. | 24/7 on-site nursing and clinical care, active medical director, assistance with most ADLs, meals, therapies, recreational programs, and social work. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | and community care providers. | | | | |
| **Housing & Tenancy** | Private rental or ownership of self-contained units. | Private rental, ownership, or social/community housing units; residents maintain independent tenancy within existing housing. | Residential settings or designated buildings that may be subsidized. | Private or semi-private suites. | Clusters of private units with shared common space that may be subsidized. | Private, semi-private, or shared rooms within licensed facilities. |
| **Regulation & Oversight** | Residential Tenancies Act, 2006 or Condominium Act | Residential Tenancies Act, 2006; services delivered through community support services and local health system partners, with no dedicated housing-specific regulatory framework. | Residential Tenancies Act, 2006; applicable community housing legislation | Retirement Homes Act, 2020 | Residential Tenancies Act, 2006; Connecting Care Act | Fixing Long-Term Care Act, 2021 |

**Increasing Care Complexity**

## 3.3 Outcomes Associated with EAL

EAL models support resident health and wellbeing while generating broader benefits for Ontario's housing and health systems. Although Ontario-specific evaluations are limited, consistent operator reporting and findings from international models suggest these approaches support aging in place while moderating demand for higher-intensity care.

Specifically, EAL contributes to:

- **Supporting Housing Stability for Older Adults with Complex Needs:** EAL enables older adults with moderate to high support needs to remain stably housed in the community by embedding 24/7 on-site supportive care within a residential setting. Early reports from EAL providers suggest reductions in emergency department use, fewer hospital admissions, and delayed pre-mature transitions to LTC among residents. Evidence from adjacent models, including studies of naturally occurring retirement communities, suggests that when services are offered within housing and tailored to resident needs, older adults are more likely to age in place and may delay transitions to nursing home care.[7]
- **Enhancing Resident Experience and Quality of Life:** Smaller, home-like environments, like EAL, promote person-centred care, autonomy, and freedom of choice for residents.[8] These environments are typically associated with improved resident quality of life, satisfaction, and psychosocial wellbeing. These findings align with anecdotal evidence from EAL models which emphasize continuity, familiarity, and a sense of home as core contributors to resident wellbeing.
- **Strengthening Continuity and Care Coordination:** The continuous on-site presence of staff enables timely communication, proactive monitoring, and responsivity to changing care needs. On-site teams also facilitate effective coordination with other health and community providers, providing an integrated approach that reduces fragmentation, supports smoother transitions, and promotes more consistent, person-centred care.
- **System Value and Cost Efficiencies:** While detailed cost data varies across models, operators report a high level of support being delivered at a cost lower than hospital care or LTC. For example, WoodGreen Community Services' Cluster Care model is delivered at an estimated $110/day compared to LTC at approximately $201/day and hospital beds at approximately $730/day.[9]
- **Alleviating Health System Pressures:** Emerging evidence suggests that approximately 5% of individuals currently residing in LTC may have needs that could be met in alternative

[7] Sheth MS, Rochon PA, Altaf A, Boblitz A, Bronskill SE, Brown KA, Hahn-Goldberg S, Huynh T, Lewis-Fung SE, Feng P, Savage RD. *Factors associated with transition to a nursing home in older adults living in naturally occurring retirement communities*. J Am Geriatr Soc. 2025 Jan;73(1):88-100. doi: 10.1111/jgs.19038. Epub 2024 Jun 18. PMID: 38888381; PMCID: PMC11734099.

[8] Canadian Journal of Health Technologies (CADTH) – January 22 Volume 2 Issue 1. *The Small House Model to Support Older Adults in LTC*. https://canjhealthtechnol.ca/index.php/cjht/article/view/es0359

[9] WoodGreen Pre-Budget Submission 2023-2024. https://www.woodgreen.org/blog/cluster-care-woodgreen-better-and-cheaper-way-to-care-for-seniors

housing and care settings.[10] Further, several of the EAL models included in this report were designed to alleviate ALC in hospital. When individuals are appropriately matched to service models, reliance on hospital services may decline and transitions to LTC may be delayed or avoided, helping alleviate pressures across hospitals, LTC, and community care systems.[11]

Together, these benefits demonstrate the important role that EAL can play in strengthening Ontario's continuum of housing and care while helping moderate demand for resource-intensive services.

# 4.0 Case Studies

The following case studies highlight five (5) EAL models currently operating across Ontario. While each reflects local context and population needs, together they illustrate approaches to integrating housing and supports to address growing pressures across Ontario's housing and health systems. A comparative overview of model features is provided in *Appendix A: Model Features.*

The cases include:

- **WoodGreen Community Services – Cluster Care:** Selected for its longevity and scale, demonstrating how EAL can be sustained over time, culturally tailored, and integrated with hospital and community partners to provide older adults with daily supports in a home-like setting.
- **Regional Municipality of Waterloo – Sunnyside Supported Living:** Selected for its municipal-led, campus-based approach, illustrating how supportive housing with daily assistance can function as a cost-effective alternative through strong integration.
- **SPRINT Senior Care – Ewart Angus SPRING Home Model**: Selected for its purpose-built, dementia-specific design, demonstrating how small-scale, non-medical housing models can be positioned to support older adults with cognitive impairment in an alternative setting to LTC through predictable routines and specialized environments.
- **Bruyère Health – Place Besserer:** Selected for its hybrid model and hospital partnership that embeds cluster-style living within a larger older adults' housing development, illustrating how small-scale environments can be integrated within broader health infrastructure as an alternative for older adults with moderate needs.
- **LOFT Community Services – Back-to-Home Model:** Selected for its longstanding and scaled model supporting older adults with complex health, behavioral, and social needs, demonstrating how EAL can be implemented to serve individuals with complex profiles in various areas of the province. Importantly, LOFT operates many buildings within this model which vary considerably in size. Some older buildings also operate under community support services supportive housing legacy funding which is no longer available for operators building EAL models today.

[10] Ontario Long Term Care Association. *The Data: Long-Term Care in* Ontario. https://www.oltca.com/about-long-term-care/the-data/

[11] Canadian Institute for Health Information. *Seniors in Transition – Exploring Pathways Across the Care Continuum. https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf*

## 4.1 WoodGreen Community Services: Cluster Care

WoodGreen Community Services operates one of Ontario's longest standing and most developed EAL models: Cluster Care. Cluster Care was first piloted in the early 2000s to support older adults who could no longer manage safely at home, but who did not require institutional LTC. The model has since expanded across East Toronto through a mix of purpose-built and retrofitted sites, taking a common care framework and adapting it to meet the needs of distinct senior populations as well as the infrastructure available.

Today, WoodGreen operates 61 Cluster Care units across 7 sites, serving predominantly low-income older adults aged 55+ with functional, cognitive, and/or behavioral challenges. Across all sites, Cluster Care brings groups of 8-10 residents together in a home-like setting with access to 24/7 onsite PSWs, enabling residents to remain in the community while receiving assistance with ADLs and iADLs.

### Core Features

- **Structure:** Consist of 8-10 private studio residential units, with bathroom and kitchenette, organized around shared common spaces. Clusters are delivered in a range of building types including retrofitted properties and integrated into multi-story buildings.
- **Services:** Assistance with ADLs and iADLs, including meal provision, bathing, and cultural programming.
- **Staffing:** 24/7 onsite PSWs, along with a site supervisor.
- **Eligibility:** Admission based on defined functional, cognitive, and support needs and eligibility for Rent-Geared to Income housing. Intake is managed by a panel and through call outs for referrals rather than a centralized waitlist.
- **System Cost:** Estimated $110 per resident per day – covering staffing, daily supports, and program delivery. Housing costs are subsidized, with rent paid by residents based on income.

### Key Outcomes

- 83% of residents permanently diverted from LTC, despite initial risk.
- Total of 20,660 resident days annually
- Partnership with Michael Garron Hospital has allowed the hospital to move memory care patients back to community.
- Greater stability, improved routines, fewer behavioral escalations, and reduced crisis-driven care.
- Several clients reaching 100 years old or over while in a Cluster

### Model Strengths

- **Cultural Tailoring:** Clusters can be tailored to the unique needs and backgrounds of residents. WoodGreen operates two (2) culturally specific clusters for Chinese-speaking older adults, where language capacity, programming, and meal preparation are aligned with residents' cultural background.
- **Health System Integration:** Recent partnership with Michael Garron Hospital has enabled the model to expand and support older adults with higher and more specialized behavioral and memory needs through clinical linkages.

### Model Challenges

- **Access Constraints:** Unit turnover is infrequent, resulting in uneven access driven by timing of unit availability rather than a coordinated, system-level intake process.
- **Escalating Care Needs:** When residents' care needs increase, despite coordinating with OHaH for higher level supports while residents await access to more appropriate housing or care environments WoodGreen must temporarily absorb additional costs to keep the resident safe in the community and
- **Fragmented Pathways:** Despite aligned goals, housing, health, and municipal systems lack clear, integrated pathways to support development, admissions, and transitions.

## 4.2 Region of Waterloo: Sunnyside Supported Living

Sunnyside Supported Living is a congregate supported housing model designed for older adults who require daily assistance but not 24/7 clinical oversight. The program consists of 30 RGI apartment units within the Sunnyside Campus of Care located in the Region of Waterloo. Established in 2010, with services funded through the province's Aging at Home initiative and capital funding provided by a combination of municipal, provincial, and federal contributions, the model was designed to allow older adults to access affordable housing with supports, who did not require LTC and were experiencing housing instability.

The model serves a mixed population of high-risk older adults and older adults living with chronic mental health challenges, many of whom have limited or no informal supports. While Sunnyside Supported Living is not a medical model of care, its embedded location within a broader campus provides residents with access to a wide range of formal and informal supports not otherwise available in standalone supportive housing.

### Core Features

- **Structure:** 30 congregate supported living apartment units within a campus of care environment.
- **Services:** Homemaking, meal assistance, medication support, and assistance with ADLs and iADLs, delivered in a non-medical model.
- **Staffing:** Onsite supportive living assistants provide hands-on support, supplemented by partnerships with allied health, pharmacy, mental health, and wellness services available across the campus.
- **Eligibility:** Older adults meeting high-risk criteria and/or older adults living with chronic mental illness who require ongoing daily support but do not require LTC. Older adults must also qualify for rent subsidy or RGI through Waterloo Regional Housing.
- **System Cost:** Estimated $110 per resident per day – covering the operating cost of supported living services.

### Key Outcomes

- Supported individuals to transition from LTC back into supportive housing.
- Greater resident stability and engagement through daily contact, social programming, and relational supports.

### Model Strengths

- **Target Population:** Serving older adults with complex needs, including mental health challenges, allows the model to efficiently align housing and appropriate supports, making effective use of resources while addressing a growing unmet need for affordable, supported housing.
- **Campus Integration:** Location within a campus of care enables access to services such as physiotherapy, fitness, pharmacy support, mental health workers, and overnight physician coverage that would not otherwise be available.
- **Cost Effectiveness:** Delivers intensive daily supports at an estimated per-diem cost significantly lower than LTC.

### Model Challenges

- **Access Constraints:** With an estimated waitlist of ~8-10 years, access is largely opportunity-driven and individuals may no longer be eligible by the time a unit becomes available.
- **Funding Misalignment:** Original funding levels through Aging at Home have not kept pace with resident acuity or system pressures, requiring internal resourcing shifts and philanthropic support to maintain program quality.

## 4.3 SPRINT Senior Care: Ewart Angus SPRINT Home Model

Ewart Angus SPRINT Home is a dementia care model, operated by SPRINT Senior Care. It is a purpose-built, small-scale supportive housing model designed for older adults living with mild to moderate dementia who require daily support but not 24/7 clinical oversight. The model is delivered in a mixed-use residential building developed through a partnership arrangement, with the top 2 floors dedicated to dementia care and the remaining floors operating as standard rental housing. The model reflects a deliberate effort to create a safe, home-like environment that prioritizes predictable routines, relational care, and a familiar setting for those with cognitive impairments.

The Ewart Angus SPRINT Home includes 20 private units organized into 4 pods (5 residents per pod), with architectural and interior design features specifically tailored to people living with dementia. Residents furnish their own rooms to reinforce personal identity and memory cues, consistent with dementia-informed design principles. The model is partially funded via Ontario Health and supplemented though monthly client fees, including rent. It operates as a non-medical, dementia-specific housing model, relying on continuous personal support rather than onsite clinical care.

### Core Features

- **Structure:** Homelike environment with 20 private units, complete with full private washrooms, distributed across 2 dedicated floors, organized into 4 pods of 5 residents. Each pod has a kitchen, den, balcony, and walking space.
- **Services:** 24/7 non-medical personal support focused on daily living, cueing, activation, and dementia-specific engagement.
- **Staffing:** Personal support workers (PSWs) and activationists/recreation therapy staff, supplemented by RPN supervisors, social workers and a manager, and a partnership with a home-based primary care team. Volunteers also support, providing assistance with wellness activities (e.g., outdoor walking).
- **Eligibility:** Older adults living with dementia who require ongoing daily support but do not require 24/7 clinical oversight.
- **System Cost:** Estimated $169.70 per resident per day – covering wages and benefits for staff, staff training, PPE supplies, program supplies, and communications. Residents pay approximately $96.00 per day, broken down to $31.00 covering food, program supplies, and activation and $65.00 for rent.

### Key Outcomes

- Improved resident engagement and potentially slower cognitive decline.
- Enhanced quality of life and continuity of semi-independent living.
- Reduced caregiver strain, indirectly alleviating pressure on the health system.
- Lower cost compared to hospital, LTC, and private retirement homes.

### Model Strengths

- **Purpose-Built Design:** Architectural layout, pod structure, and unit design are specifically tailored to the needs of people living with dementia.
- **Population Specificity:** Dedicated dementia care environment allows supports, staffing, and programming to be targeted to meet this population's specific needs rather than widespread across mixed populations.
- **Adaptive Care Approach:** Ability to layer additional supports, including RPN supervision and primary care, as resident needs increase without shifting to an institutional model.

### Model Challenges

- **Capital Development:** Replication is highly constrained by access to suitable land or buildings, as SPRINT does not own housing stock and must rely on partnerships.
- **Escalating Care Needs:** As resident care needs increase, SPRINT must absorb additional costs while residents await access to appropriate higher-level supports.

## 4.4 Bruyère Health: Besserer Place

Bruyère Health Senior Living operates a multifunctional older adults' housing development that integrates cluster-style supportive living within its larger congregate buildings in Ottawa. The site includes a total of 227 residential units, of which 36 are organized into small, cluster-style living environments designed for older adults with higher functional and support needs. The model was developed to expand community-based housing options for older adults who require daily assistance.

Bruyère Health Senior Living reflects Bruyère's broader approach to integrating housing and healthcare by combining affordable older adults' housing, supportive living, and access to health services within a single site. While the building serves a mixed population of older adults, the cluster-style units provide stable tenancy for older adults receiving either Assisted Living Supports (ALS) or Enhanced Assisted Living Supports (EALS).

### Core Features

- **Structure:** 36 units organized into groups of 9 cluster-style living environments within a 149-unit older adults' housing building (Place Besserer).
- **Services:** Onsite personal support for ADLs and iADLs, delivered in a small group setting.
- **Staffing:** Leverage Developmental Support Workers who provide daily support, activations, and emotional assistance.
    - EAL includes 24/7 RPN coverage, coordination with OT, PT, speech therapy, and clinical assessments.
- **Eligibility:** Older adults that have already been wait listed for LTC, requiring higher levels of daily supports than can be provided through standard independent older adults' housing.
- **System Cost:** Estimated at $92.78 per resident per day – covering rent, food, housekeeping, laundry, and care; not including exemptions transportation, incontinence productions, off-the-shelf medications, cable, phone, or TV.

### Key Outcomes

*Across EALS Programs, the following outcomes are observed:*

- 168 avoided ER visits between April 1st 2020 and January 31st 2026.
- 78% of EALS residents remain in the community until end of life.
- Typical length of stay between 226 – 811 days.

### Model Strengths

- **Hybrid Design:** Combines the benefit of small-scale, cluster-style living with the efficiencies of larger older adults' housing developments.
- **Health System Integration:** Direct affiliation with hospital and other clinical services enables expanded access to clinical supports as resident needs escalate.
- **Continuum of Supports:** Residents can access different levels of housing and support within the same building as their needs change.

### Model Challenges

- **Capital Investment:** Development relied on land provided at low to no cost, which, while advantageous, presents challenges for replication.
- **Funding Alignment:** Service funding must be layered onto housing operations through existing provincial and health-system envelopes.
- **Operational Complexity:** Managing mixed populations within a single building requires careful coordination of staffing and supports.

## 4.5 LOFT Community Services: Back to Home Model

LOFT Community Services operates a "Back to Home" model, a specialized affordable housing approach designed for older adults with complex care needs who have been designated as ALC in hospital, due to a lack of appropriate housing and community supports. The model primarily serves those aged 55+ with intersecting needs related to mental health, addictions, behavioral dementia, and other psychosocial challenges. It integrates housing with wrap-around on-site supports to enable individuals to live safely in the community while receiving tailored, person-centred care.

The model emerged in the 1990s in response to a significant service gap for individuals with complex mental health and physical health needs who often fell between available care systems. By combining assisted living supports with specialized mental health expertise and housing, LOFT's community-based alternative provides stable housing, continuous support, and integrated partnerships with hospital and health providers. LOFT now operates the model across Toronto and in several communities in Central and Northern Ontario, including Orillia and Penetanguishene, with a new purpose-built site opening in Bradford.

### Core Features

- **Structure:** Buildings range from 27 to 113 units. While designs vary, they generally include private units alongside shared spaces (e.g., congregate dining areas and social spaces).
- **Services:** Including individualized care planning through InteRAI Community Health Assessment and behavioral supports, life enrichment services, meals, safety-emergency response, case management, and clinical supports.
- **Staffing:** Primarily PSW-led and supported by a multidisciplinary team that includes intensive care managers, behavioral support specialists, and life enrichment staff. Nurses are deployed in some buildings.
- **Eligibility:** Residents are either referred through hospital ALC pathways, transitional care programs, or homelessness-related referral streams.
- **System Cost:** Estimated at $225 per resident per day.

### Key Outcomes [2024]

**Client Impact**

- Transitions 467 complex clients from hospital in 2023.
- Hospital readmission rates reduced by over 85% for the first 29 clients in the program.
- Client satisfaction rate of 90%.

**Improved Patient Flow**

- Reduced ALC rate for partner hospital from 25% to 16%.

**Cost Effectiveness**

- Reduced costs by an estimated $2,225,453 from housing 26 hospitalized individuals for 12 months.

### Model Strengths

- **Specialized Expertise:** LOFT has developed deep expertise in supporting older adults with complex mental health, substance use, and behavioral needs, allowing this model to effectively serve the target population.
- **Integrated Health Partnerships:** Formal partnerships with hospitals, retirement homes, municipal partners, and other healthcare organizations enable coordinated access to primary care, psychiatry, and infection prevention supports, improving resident outcomes.

### Model Challenges

- **Capital and Infrastructure Constraints:** Expanding the model requires access to appropriate housing stock or purpose-built facilities that meet accessibility and safety requirements.
- **Legacy Funding:** Some programs continue to operate under historic CCS senior supportive housing funding programs, which have not fully kept pace with the current cost and intensity of services required.
- **Housing Supply Limitations:** Programs operate across a mix of owned buildings, leased properties, and partnerships within Toronto Community Housing buildings, which can create operational complexity when securing appropriate sites and aligning housing arrangements with service delivery.

# 5.0 Cross-Case Synthesis and System-Level Analysis

Across the EAL models examined, implementation has been shaped by a consistent set of enabling conditions, alongside structural barriers that constrain broader adoption and scale in Ontario. While individual experiences vary, the case studies highlight that success depends less on specific features and more on effective alignment with health, housing, and community service systems.

## 5.1 Enablers

Taken together, the case studies point to a consistent set of enabling conditions that have supported the development and operation of EAL models within Ontario's current policy and funding landscape. These conditions reflect both strengths in local approaches, and the adaptive strategies organizations have used to advance models in the absence of a clear provincial framework.

### 5.1.1 Local Leadership and Innovation

Across all cases, strong local leadership and organizational initiative were foundational to moving EAL from concept to implementation. Without a clearly defined provincial policy or funding pathway, models emerged where organizations identified unmet local needs, articulated a clear service vision, and invested sustained effort in aligning multiple provincial systems. Operators and developers demonstrated a strong willingness to engage system partners and assume development and operational risk.

This pattern highlights that current implementation is largely a function of local capacity, leadership, and persistence rather than coordinated system design or deliberate provincial planning.

### 5.1.2 Strong and Purposeful Partnerships

All cases embedded strong and purposeful partnerships as central to their operations. These relationships expand organizational capacity, enable access to services not delivered in-house, and provide coordinated care for residents with evolving needs. Importantly, they also create opportunities to leverage existing system funding and resources, rather than relying solely on net-new investments.

Examples of partnerships observed include, but are not limited to:

- Hospital partners providing transitional supports, funding support, and referral pathways
- Community support agencies delivering onsite services (e.g., meals on wheels)
- Municipal collaboration to secure or redevelop suitable housing stock and layer affordability mechanisms.

Across cases, partnerships were central to operational stability, alignment with system priorities, and continuity of care. While they do not eliminate the need for transitions as care needs increase,

they support more coordinated responses and clearer pathways when residents require services beyond the inherent scope of the model.

### 5.1.3 Access to Suitable Housing Stock

The feasibility of EAL depends on the availability of infrastructure that can be configured into small, home-like clusters with appropriate safety and accessibility requirements. Where appropriate stock exists, or where municipal, provincial, or federal partners support development through capital funding or land contributions, models can be established efficiently.

Conversely, limited or unsuitable housing stock extends development timelines, increases capital costs, and constrains opportunities for scale.

## 5.2 Barriers

The cross-case analysis also identifies a common set of system-level constraints that hinder the ability to replicate, sustain, and scale EAL across Ontario. These barriers are systemic, reflecting gaps in governance, policy coordination, and funding alignment.

### 5.2.1 Fragmented Ownership and Accountability

EAL aligns closely with several public-sector objectives, including aging in place, reduced hospital and LTC pressures, and improved housing stability. Despite this alignment, no single ministry, agency, or level of government holds clear ownership for EAL. As a result, the model sits at the intersection of multiple policy domains without a clearly designated system lead to guide planning, development, and long-term integration.

Rather, responsibility for the key components required to enable EAL, including capital development, operating funding, and layered support services is distributed across multiple ministries and agencies, each with distinct mandates and accountability structures. This fragmentation challenges planning, slows implementation, and limits the ability to scale models through replication.

Table 2 illustrates the range of focus areas that intersect with EAL, illustrating the breadth of alignment and the absence of a designated system lead.

*Table 2 System Priorities Related to Enhanced Assisted Living*

| Provincial Government Body | High-Level Focus |
|---|---|
| **Ministry of Municipal Affairs and Housing (MMAH)** | Supporting municipal governance and the provincial housing framework, including policies and tools to increase housing supply, support affordability, and enabling municipalities to plan for a range of housing types and needs.[12] |
| **Ministry of Health (MoH)** | Responsible for overseeing and funding Ontario's health system, including hospitals, primary care, home and community care, as well as providing operating support for supportive housing and assisted living services. Key priorities include providing the right care in the right place, improving access to care, and strengthening integrated, community-based models of care. [13] |
| **Ontario Health (OH)** | Operationalizing Ministry priorities with core delivery priorities across reducing health inequities; transforming care with the person at the centre; health system operational management, coordination, performance measurement, and management and integration; enhancing clinical care and service excellence; maximizing system value by applying evidence; and strengthening OH's ability to lead.[14] |
| **OH atHome** | Advancing home and community care modernization, supporting capacity building across home care delivery, and continuing to develop and implement activities to respond to ongoing system needs (e.g., ALC strategies).[15] |
| **Ministry for Seniors and Accessibility (MSAA)** | Improving the lives of older adults and people with disabilities across Ontario to support them to live active, healthy, safe, and socially connected lives.[16] |
| **Ministry of Children, Community and Social Services (MCCSS)** | Supporting vulnerable populations through community-based services, with emphasis on poverty reduction, housing stability, and social supports.[17] |

[12]Government of Ontario (2025). *Published plans and annual reports 2025-2026: Ministry of Municipal Affairs and Housing.* https://www.ontario.ca/page/published-plans-and-annual-reports-2025-2026-ministry-municipal-affairs-and-housing

[13] Ontario Ministry of Health (2023). *Your Health: A Plan for Connected and Convenient Care.* *https://www.ontario.ca/page/your-health-plan-connected-and-convenient-care*

[14] Ontario Health (2024). *Annual Business Plan 2024/25.* *https://www.ontariohealth.ca/content/dam/ontariohealth/documents/business-plan-2024-25.pdf*

[15] Ontario Health atHome. Champlain Home First fact sheet. https://ontariohealthathome.ca/document/champlain-home-first-fact-sheet-english/

[16] Ontario Ministry for Seniors and Accessibility. *Published plans and annual reports 2024 – 2025.* https://www.ontario.ca/page/published-plans-and-annual-reports-2024-2025-ministry-seniors-and-accessibility

[17] Government of Ontario. *Published plans and annual reports 2024-2025: Ministry of Children, Community, and Social Services.* https://www.ontario.ca/page/published-plans-and-annual-reports-2024-2025-ministry-children-community-and-social-services

| Provincial Government Body | High-Level Focus |
|---|---|
| **Municipalities and Service System Managers** | Responsible for planning, funding, and administering affordable housing and homelessness priorities at the local level, often in partnership with other providers and system actors.[18] |

### 5.2.2 Absence of a Clear Policy Framework

As Ontario's current policy frameworks do not clearly recognize EAL as a distinct model in the housing and care continuum, it faces structural barriers related to planning, funding, and overall system design. More broadly, this reflects a longstanding gap in how supportive housing and assisted living have been positioned within the provincial system. While many supportive housing and assisted living programs were established in the 1980s and 1990s and continue to play a significant role in supporting older adults with moderate care needs, there has been limited policy focus on their long-term growth, modernization, or integration within broader health system planning.

Government planning, funding structures, and performance frameworks remain largely structured around recognized system categories such as hospitals, LTC, and home care. As a result, EAL and similar models often fall outside of formal planning and investment decisions, despite serving populations that might otherwise rely on more resource-intensive settings. While recent supportive housing investments have primarily focused on homelessness and mental health priorities, there has been comparatively limited attention to expanding supportive housing and assisted living capacity for older adults. This lack of a clear policy and funding framework constrains opportunities for intentional scale and limits the ability of EAL models to contribute more fully to provincial objectives related to aging in place, health system sustainability, and reducing pressure on hospitals and LTC.

### 5.2.3 Discrete Funding Mechanisms

Across all cases, fragmented funding emerged as the most significant barrier to the development, expansion, and long-term sustainability of EAL. As with governance, funding is distributed across multiple levels of government, each supporting discrete components rather than the integrated model. While individual funding programs align with specific mandates, collectively they create a misaligned and high-risk development environment for operators.

As outlined in *Appendix B: Funding and Development Pathways*, operators must navigate complex, multi-source funding arrangements across multiple programs, approval processes, and timelines to support both capital development and ongoing service delivery. These arrangements typically include:

- **Federal:** The federal government has primarily supported capital development through Canada Mortgage and Housing Corporation (CMHC)-administered affordable housing programs (e.g., Rapid Housing Initiative). While essential for creating physical housing

[18] Government of Ontario. *Consent authority for service managers.* https://www.ontario.ca/page/consent-authority-service-managers

supply, these programs do not fund onsite support, staffing, or operating costs, leaving a significant gap for embedding support services. Recent federal commitments for supportive housing, including initiatives targeting older adults through Build Canada Homes (BCH), signal growing flexibility in this space, though details remain unknown at this time.[19]

- **Provincial:** Provincial ministries fund health and community support services within their respective mandates but generally do not fund housing capital or core operating costs. Service funding can be time-limited, program-specific, or detached from the housing context in which support services and care is delivered. In practice, there is no clear or dedicated provincial funding stream to support the expansion of EAL models, and access to operating dollars is often contingent on Ontario Health-led processes and project-specific arrangements. In many cases, provincial operating funding is committed only after development is complete, exposing operators and developers to significant risk.

- **Municipal**: Municipalities and Consolidated Municipal Service Managers (CMSMs) administer RGI subsidies, allocate local capital, and manage community housing assets. They may also contribute municipally owned land and support ongoing operating costs related to housing and community services (e.g., non-medical support services related to housing stability and social supports). They do not, however, fund personal care, clinical services, or health-related supports, which fall within provincial responsibilities.

In the absence of a single funding pathway covering capital, development, and operating requirements, proponents must assemble funding through parallel and uncoordinated processes, often with differing timelines, eligibility criteria, and accountabilities. Critically, there is no assurance that these funding streams will align or be sustained over time, even when individual components are approved, limiting confidence in replication and scale.

As a result, participation is effectively limited to a small number of highly capable and motivated organizations, constraining broader development and expansion of EAL models and underscoring the critical need for a more coordinated and sustainable funding pathway.

### 5.2.4 Limited Outcome Measurement

Although operators consistently report positive impacts – including improved resident quality of life, greater continuity of care, and reduced reliance on other system resources – structured outcome measurement remains limited. Where data is collected, it is typically driven by funder-specific reporting requirements, rather than a shared, system-level of understanding of value. As a result, outcomes important to provincial and system decision-makers are not measured consistently or at-scale, including:

- Avoidable emergency department visits
- Hospital admissions and reductions in ALC days
- Impacts on LTC transitions and waitlists
- Cost-benefit or cost-avoidance across both housing and health systems

[19] Government of Canada. *The Government of Canada introduces the Build Canada Homes Act.* https://www.canada.ca/en/housing-infrastructure-communities/news/2026/02/the-government-of-canada-introduces-the-build-canada-homes-act.html

The absence of standardized outcomes and common metrics has several consequences. First, it makes the system-level value of these models largely invisible. Second, it limits the ability to compare different model configurations to understand which design features, staffing models, or partnership approaches deliver the greatest impact. Finally, it constrains evidence-based policy development, as decision-makers lack the data needed to justify dedicated funding streams, long-term operating commitments, or regulatory adaptation. Without a coherent outcomes framework and standardized data, these models are treated as a collection of promising local initiatives rather than a scalable system solution.

Together, these findings highlight that while EAL models have demonstrated strong local performance, broader scale depends on clearer policy direction and coordinated funding pathways.

# 6.0 Path Forward & Future Direction

Ontario's experience with EAL demonstrates the potential of these models to meaningfully support aging in the community, improve resident wellbeing, and strengthen continuity within the housing and care continuum. At the same time, their expansion remains constrained by fragmented policy direction, siloed funding structures, lack of dedicated new operating dollars and uneven integration within local and regional planning processes.

To enable the full potential of these models as a scalable component of Ontario's housing and care continuum, coordinated action is required across government, health system partners, housing providers, and community operators. The Ministry of Health has a key role to play in this coordination.

## 6.1 How the Ministry of Health can Support EAL Expansion

**Opportunity 1: Formally Recognize Enhanced Assisted Living as a Valuable Model Within the Provincial Continuum of Care**

The Ministry of Health should formally recognize EAL as a distinct, provincially supported model within Ontario's continuum of care for older adults, positioning it alongside LTC, retirement homes, assisted living, and other residential models. This recognition could be operationalized by:

- Establishing a provincial definition of EAL and embedding it within relevant policy frameworks, planning guidance, and funding directives.
- Explicitly identifying EAL in assisted living and home and community care policy and legislative instruments, where appropriate, to help clarify its role within the continuum.
- Incorporating EAL into provincial capacity planning and forecasting, including assessments of future demand for community-based residential models that provide 24/7 supportive care.
- Using this formal recognition to guide funding pathways and planning decisions, providing clear direction to OH, MCCSS, municipal service managers, and other system partners.

By clearly positioning EAL within the system, Ontario can move away from case-by-case funding decisions and create the conditions needed to intentionally plan for and scale models that deliver system value and better meet the needs of older adults requiring 24/7 supportive care.

**Opportunity 2: Implement a Joint Federal-Provincial Bundled Funding Model for EAL**

To accelerate the development and expansion of EAL across Ontario, the Ministry of Health should work with federal and provincial partners to implement a bundled funding model that aligns capital and operating funding at the outset of project development. Working in partnership with federal housing initiatives such as Build Canada Homes, which have signaled a commitment to supporting flexible, partnership-based housing delivery models[20], the Ministry of Health can establish a funding approach that commits operating funding alongside capital investment.

To support implementation, the funding approach can initially be introduced as a pilot targeting a key provincial priority area (e.g., reducing ED use), supporting a limited number of projects through a competitive or structured intake process. This would allow the Ministry of Health to test the funding approach within a defined investment envelope before broader expansion. The bundled funding model should remain flexible enough to reflect the range of ways these models are developed and delivered in practice.

By tying capital and operating funding more intentionally, the province can reduce uncertainty and organizational risk for proponents and support EAL seamlessly move from concept to implementation and scale.

**Opportunity 3: Build a Central Repository of EAL Models**

To build a stronger knowledge base of EAL, the Ministry of Health should establish a central provincial repository to catalogue existing and proposed EAL models across Ontario. The repository should capture consistent information on model characteristics including, but not limited to, model design, target population(s), service intensity, funding and operating structures, regulatory considerations, and documented outcomes.

Ontario Health can be directed to maintain and operationalize the repository – building on the agency's existing catalogue of assisted living buildings – with operators and developers responsible for providing timely, standardized information on existing models and pipeline projects.

Establishing a centralized mechanism to identify, track, and monitor EAL models will allow the province to better understand where models are already operating and where there are opportunities to expand models in response to regional and system needs.

## 6.2 How Operators can Support EAL Expansion

**Opportunity 4: Demonstrate Alignment with Provincial Priorities**

[20] Government of Canada. *Build Canada Homes Investment Policy Framework.* https://housing-infrastructure.canada.ca/bch-mc/policy-framework-invest-cadre-strategique-eng.html

To build confidence in EAL as a scalable system solution, operators and developers must continue to demonstrate how their models advance provincial health system priorities (e.g., reducing emergency department use, alleviating pressure on long-term care, supporting system flow). This alignment can be supported through intentional partnerships with key system stakeholders such as hospitals, home care providers, and municipalities. These partnerships not only demonstrate a deeper understanding of local needs but also introduce the opportunity to leverage existing funding where possible.

In addition, strengthening data collection and reporting tied to system-level goals will further demonstrate the value of these models and provide funders and planners with clearer evidence to inform decisions about investment and expansion. Data collection should align with provincial requirements and focus on key system pressures such as reducing emergency department use, alleviating alternate level of care days, or supporting the home care system. However, realizing this will require recognition that community agencies may not currently have access to all relevant system-level data, particularly where information is held by hospital partners or depends on formal data-sharing agreements. Strengthening reporting will therefore require closer collaboration across sectors to ensure community agencies can contribute to performance measurement in a meaningful and feasible way.

By jointly demonstrating measurable outcomes and system integration, operators can help build greater confidence among funders, policymakers, and planners to support informed decisions related to the expansion of these models.

**Opportunity 5: Proactively Engage with Municipal and Regional Planning Processes**

To support successful design and implementation, operators and developers should proactively engage municipalities and service managers to ensure EAL models respond to regional and local needs. This includes aligning models with municipal housing plans, priority populations, local affordability expectations, and the planning and land-use context in which the models will be delivered.

By grounding EAL models in municipal and regional needs, proponents can improve feasibility, reduce implementation barriers, and ensure that models are aligned to the needs of target communities. This alignment further supports effective deployment of models across the province while respecting local variation.

# 7.0 Conclusion

EAL models play an important and distinct role within Ontario's housing and care continuum, addressing a critical gap by providing a flexible, community-based option for individuals who require 24/7 daily living support and monitoring but do not require institutional levels of care.

For residents, these models support aging-in-place by providing stable housing environments combined with continuous on-site supports. Smaller, home-like settings promote autonomy, familiarity, and social connection while enabling individuals to maintain independence and remain connected to their communities as their needs evolve.

Beyond individual benefits, EAL models also offer meaningful value for the broader health system. By supporting individuals whose needs fall between episodic home care and LTC, these models help strengthen continuity across the continuum while moderating reliance on higher-intensity and more costly services.

With appropriate policy recognition, supportive housing infrastructure, stable operating funding, and an evaluation framework in place, EAL has the potential to become a scalable solution to Ontario's growing health system pressures, for older adults and beyond. Achieving this potential, however, will require clear provincial leadership. Given the model's alignment with priorities related to system flow, capacity, and aging in place, the Ministry of Health should now take a more active role in advancing EAL expansion across the province. This includes setting policy direction, coordinating planning and implementation, and aligning funding to support intentional expansion. Without this leadership, development will continue to occur on a fragmented, case-by-case basis, limiting the ability to leverage EAL as a meaningful solution to health system pressures across the province.

# 8.0 Appendices

## 8.1 Appendix A: Model Comparison

| Organization | Model | Location | Cluster Size[21] | Population Served | Staffing Model | Rent Subsidy Available (Yes/No) |
|---|---|---|---|---|---|---|
| **WoodGreen Community Services** | Cluster Care | Toronto, ON *Multiple sites across Toronto's East End* | 8-11 residents per cluster, with multiple clusters located across the organization's 7 sites.<br><br>Total of 60 units. | Older adults with moderate to complex needs who cannot live independently yet do not require LTC-level care | Predominantly non-regulated staff (PSWs, home support workers); enhanced clusters include access to social workers, behavioral supports, and hospital/primary care partnerships | Yes – Units are RGI |
| **Region of Waterloo** | Sunnyside Supported Living | Kitchener, ON *Located within Sunnyside Campus of Care* | 30 congregate apartment units. | High-risk older adults and older adults with chronic conditions, including some with mental health needs; many with limited informal supports | Non-regulated support staff providing daily living assistance; access to campus-based services including pharmacy, wellness, mental health, and paramedicine | Yes – Units are RGI |
| **SPRINT Senior Care** | Ewart Angus SPRINT Home | Toronto, ON | 20 units; 4 pods of 5 residents across 2 floors. | Older adults living with dementia who do not require 24/7 nursing or secure LTC environments | Non-medical model with PSWs and activation/therapeutic recreation staff; RPN supervisory support added; embedded primary care (House Calls) | No |
| **Bruyère Health** | Cluster Housing and Enhanced Assisted Living (EALS) | Ottawa, ON *Located within Place Besserer, Bruyère Village* | 36 cluster units (9 units per floor); 20 EALS units within 149-unit building. | Older adults requiring assisted living or enhanced assisted living supports, including individuals awaiting LTC who do not require secure care | 24/7 RPN coverage for EALS; Developmental Support Workers for daily support; shared campus-based services | Yes – The operator receives limited funding to support a subset of rent subsidized cluster units |

[21] Cluster size reflects typical or primary configuration. For models with multiple sites, there may be variation across locations based on available infrastructure.

| | | | | | | |
|---|---|---|---|---|---|---|
| **LOFT Community Services** | Back to Home | Toronto, ON with additional sites in Central and Northern Ontario, including Orillia, Penetanguishene, and Bradford. | Sites range from approximately 50 – 110 units, with over 500 residents supported across LOFT's 24/7 supportive housing sites. | Primarily adults aged 55+ with complex needs, including mental health and substance use challenges, behavioral dementia, and other psychosocial or social determinant-related needs. | PSW-led multidisciplinary teams, including intensive case managers, behavioral supports, life enrichment staff, operational staff (e.g., dietary, property, administration), and nurses at some sites. | Yes – Many sites operate within RGI or social housing environments (e.g., Toronto Community Housing). |

## 8.2 Appendix B: Funding and Development Pathways

The table below describes each of the funding sources used to support the development, implementation, and operations of each model.

| Organization | Model | Capital Development | Core Services Funding | Additional Supports |
|---|---|---|---|---|
| **WoodGreen Community Services** | Cluster Care | **Federal:** CMHC capital grants and seed funding through Rapid Housing Initiative, and others.<br><br>**Municipal:** Loans and grants leveraged under preliminary pro-forma.<br><br>**Operator:** Funding to support municipal planning (e.g., environmental scanning, soil testing, permits, and approvals). | **Ontario Health:** Provide operating funding for personal support and supervision with resident co-pay. | **Michael Garron Hospital:** Targeted funding and in-kind supports for specific populations, namely memory care. |
| **Region of Waterloo** | Sunnyside Supported Living | **Ministry of Health and Ministry of Long-Term Care:** Provided initial funding through 2010 Aging at Home Initiative. | **Ontario Health:** Provide ongoing service and staffing funding.<br><br>**Municipality:** Provide rental subsidies under RGI. | **Campus of Care Model:** Supports financing of gaps in the model, including the provision of additional resources, as required.<br><br>**Philanthropy:** Support in the ability to offset costs not otherwise covered by capital development and core services funding. |
| **SPRINT Senior Care** | Ewart Angus SPRINT Home | **Philanthropy:** Donor-directed capital from Ewart Angus to support purpose-built development of homes with dementia-design principles. | **Ontario Health:** Provide operating funding for personal support and supervision with resident co-pay. | **Health Partners:** Provide access to home-based primary care and RPN supervision to manage acuity creep. |

| | | | | |
|---|---|---|---|---|
| **Bruyère Health** | Cluster Housing and Enhanced Assisted Living (EALS) | **Hospital-Affiliated Sponsor:** Provided upfront land and development costs at reduced rate.<br><br>**Federal:** CMHC capital grants and financing to support purpose-built development. | **Ministry of Health:** Core services funded through hospital global budgets and LTC/supportive living envelopes administered by Bruyère. | **Bruyère Village:** Provide direct access to onsite regulated nursing, allied health, physicians, and specialized clinical supports. |
| **LOFT Community Services** | Back to Home | **Mixed Approach:** Including owned buildings, leased properties, and partnerships within Toronto Community Housing buildings. Some newer developments include purpose-built supportive housing sites developed through partnerships. | **Ontario Health and Ministry of Health:** Core services funded through Community Support Services (CCS) assisted living programs and Mental Health & Addictions (MHA) supportive housing funding streams for some older buildings.<br><br>Some transitional sites also receive Home and Community Care funding. | **Hospital Partnership:** Formal partnerships with organizations such as CAMH, Trillium Health Partners, and UHN support access to primary care, psychiatry, and clinical services.<br><br>**Charitable Funding:** Also used in some cases to offset service gaps where legacy funding levels do not meet current operating costs. |

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