EXTERNAL REVIEW OF THE COMMUNITY LIVING BRITISH COLUMBIA (CLBC) HOME SHARE PROGRAM

Final Report

The Review focused on safety in home share arrangements to respond to the concerns identified by the Coroner's Inquest (2025), namely.

- Review of standards that promote quality of life and safety in home-share arrangements
- Review of accountability and service quality oversight measures

Tamar Consultancy Pty Ltd
13 November 2025
Updated 23 December 2025

Covering letter to report

Honorable Sheila Malcolmson
Minister of Social Development and Poverty Reduction
PO Box 9058 Stn Prov Govt
Victoria, BC V8W 9E2

Dear Minister,

We are pleased to present our final report on Home Share in British Columbia. We would like to thank the Minister for the opportunity to undertake this important review and trust that our review will assist the Ministry and Community Living British Columbia in ensuring that Home Share is safe, stable and contributing to enhancing the quality of life of those who reside in them.

We could not have completed this review without the assistance of an enormous number of people. We would particularly like to thank the members of the Advisory Committee, made up of self-advocates, family members, providers, sector organizations and coordinators. Their contribution was invaluable to us in understanding the issues and crafting our final report. Likewise, we would like to thank all of the CLBC staff who shared an enormous amount of information openly and constructively throughout the process.

We also want to acknowledge the community members who contributed to the review in a variety of ways. We hope that they see their many contributions reflected in the final report. Finally, we would like to thank the staff at the Ministry of Social Development and Poverty Reduction who provided both support and input throughout the process.

Lastly, we would like to thank our own review team, Aisling Blackmore and Ramona Sharma, for their many contributions to the work.

Yours sincerely,

Eddie Bartnik (Principal Consultant, Tamar Consultancy)

Dr Tim Stainton (Review Co-Lead)

13 November 2025

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Plain English Summary of the Report

Context: Why the Review happened

This Review was asked for by the Ministry of Social Development and Poverty Reduction (MSDPR) in May 2025.

The Review was done by skilled people who are not part of CLBC or MSDPR. The contract was held by Tamar Consultancy Pty Ltd. The Review Team is:

- Eddie Bartnik (Principal Consultant, Tamar)
- Prof Tim Stainton (Review Co-Lead)
- Aisling Blackmore (Secretariat and Researcher)
- Ramona Sharma (Researcher)

The Review checked:

- Do the safety and quality rules for Home Share keep people safe?
- Do the safety and quality rules for Home Share help people have a good life?
- Do the ways we check if everyone is following the safety and quality rules work?

This report explains what changes will help make Home Share better for everyone. When the report was written, about 4,300 people are living in Home Share with money from CLBC.

The points below helped shape how we understood what people said and what we decided to recommend:

- How to find the right balance between:
    - Respecting the rights of people with disabilities to make their own choices and have privacy, and
    - How services and government keep people safe and make sure supports are good quality.
- Checking if people living in different parts of BC have the same experiences.
- Who is responsible for doing the different activities to keep people safe and have a good life.
- How to make sure **informal safeguards** (family, friends) are part of a person's life, as well as **formal safeguards** (rules, laws, staff).
- Other things happening that change how safe or good Home Share feels for people.

Methodology: How we did the Review

We got information from: an Advisory Committee, by researching other countries, meetings with CLBC, public emails, and key documents.

Our goals for the Review:

- Agree with everyone what the problems are,
- Work together to create the best ideas for change,
- Make sure the final ideas are clear, useful, and can really happen.

The steps we followed to do the Review:

- Setting up and finding information: We asked lots of different people to tell us about Home Share.
- Looking at all the information: We looked at all the information and came up with early ideas about recommendations.
- Checking our ideas: We shared our ideas separately with the Advisory Committee and CLBC staff two times. They helped us decide what is most important.
- Reporting: We wrote a draft report and made changes using the feedback from these groups and the Ministry.

Issues that make it hard for Home Share to work well

Two important things make British Columbia (BC) unique (not like anywhere else):

1. BC closed its **institutions** (places where people with disability lived away from family and the community) a long time ago, and
2. More people live in Home Share than group homes or independent living.

Lots of people who talked to the Review feel that Home Share is the main option to live in the community. People don't feel that they get much choice.

There is less help for people who get help from CLBC to make a plan for their life (**individualized planning**). Responsibility for helping people make a plan is shared by CLBC Facilitators and Home Share Coordinators. It is important that individualized planning happens so that people know they have a number of choices. Plans help make sure people's decisions for their own life are respected.

There are around 1,000 new people who are on a list to live in Home Share. Because there are so many people waiting, it is very important to get Home Share right.

Staff at CLBC and Home Share Agencies are under a lot of pressure to find places for people to live. There are not enough people who want to host Home Share to help everyone live in the community. 19,231 adults with disabilities live mainly with their families, which tells us there are a lot more people who might want to live in a new home in the community with support from CLBC.

The Review learned that organizations worked together to make Home Share better after Florence Girard died. Examples of key organizations that have worked together are:

- CLBC
- Home Sharing Support Society of BC
- BC CEO Network

CLBC wrote a report about the changes they have made so far. The CLBC report is Attachment 2 of this report. CLBC helped the Review by giving the Review Team lots of information and time with CLBC staff. Even though there is a lot of good work happening, the Review Team heard that Home Share and CLBC are under stress and things need to be better.

Two quotes are examples of what people told the Review:

"The policies and checklists in place are fine – don't need more paperwork.... People aren't just asking for more rules – they're asking for better support, stronger relationships, and real accountability. They want a system that sees the whole person, not just a file or a funding category."

Advisory Committee member submission

"However, we remain deeply concerned about the sustainability of Shared Living and the erosion of a strong relational focus being replaced with a transactional one."

BC CEO Network submission

The Review shows that when other government or community supports do not work well, it can make people in Home Share less safe. Changes need to also be made to other supports to make sure Home Share can work well for everyone.

To understand how problems with other services affect Home Share, it is important to know the history of Home Share and disability services in BC. The review found that important things that changed over time are:

- Help to make life plans has gotten weaker. There are not as many people checking if people's plans are working and helping them make changes.
- The people who get help from CLBC has changed.
- CLBC has to help people with more parts of their life, like health, mental health, housing, and if they have trouble with the police or jail. Other government ministries are also responsible for helping people with these parts of their lives.
- CLBC doesn't have enough money to do all the things it is asked to do.

Key findings: What the Review learned

BC has been a world leader in developing and growing the Home Share model. When Home Share works well, people like it and want it to continue. Other provinces and countries are also learning how to help people live in Home Shares. Since 2018, CLBC have worked hard to make Home Share better.

CLBC has two documents that tell everyone the rules for Home Share. These rules are called the **Standards**:

- Standards for Home Sharing, and
- Standards for the Coordination of Home Sharing

The ideas and the rules written in the Standards are good. The Standards use ideas that other people in different parts of the world also think are good for Home Share. But there are not enough staff to do and check everything that is written in the Standards. There should be more information shared with the public about safety and quality of life in Home Share.

Home Share is often the main or only option offered to people who get help from CLBC to live in a new home in the community. There are not many other ways to live to pick from for people seeking support from CLBC. There are lots of people waiting for somewhere to live in the

community. People are waiting a long time for somewhere to live. It might not be possible for Home Share to create a place to live for everyone who wants to live in the community.

Researchers have found there are important steps that that help Home Share work well and last for a long time. The Review learned these steps are not happening for everyone. These steps include:

- Making a good plan with the person for their life. Helping the person to make their plan real. Checking the plan together to make sure it is still the right for the person with disability and that they are getting the support they need.
- Making sure the person hosting the Home Share and the person coming to live in the Home Share will get along. Usually this will mean checking if everyone has similar hopes about Home Share and if there are some things everyone has in common. This is a called a **matching process**.
- Making sure other people who know and care about the person with disability stay part of their life. Sometimes this will be family members, friends, people from community groups, or people from work. We call these **informal supports**. Sometimes if the person does not have informal supports, it will mean making a plan to help them make friends and relationships in their community.

Some things that are not in CLBC's control have changed over time. These changes include:

- More people are eligible for help from CLBC now and their needs are more complicated than the people CLBC was originally helping,
- There are lots of adults with disability living mainly with their families who might choose to live somewhere else if they could get help from CLBC,
- Other supports to help people with disability live in the community are not working well all the time,
- For everyone (not just people with disability), it is more expensive to pay for everyday things like groceries or electricity (**cost-of-living**),
- For everyone, there are more people are looking for a place to live than there are houses or apartments available and rents are high.

Even though there have been lots of changes, the money CLBC is given each year to help people has not changed enough. This means it has been hard for CLBC to keep up and that:

- People with more complicated lives are living in Home Share,
- People who work in CLBC and Home Share Agencies do not stay long enough in their jobs,
- Home Share Providers may decide to stop hosting Home Share.

The Review found that it does not matter how good the rules and people checking the rules are, if there is not enough money to support people with disability, then they will be at more risk.

"Even the best of monitoring and safeguards cannot protect against vulnerabilities created by an underfunded system."
External Review of the Community Living British Columbia Home Share Program, p.23

Recommendations: What to do next

The Review looked at safety and quality rules and how these are checked (**Standards and Monitoring**). It looked at four other things that also will help people safe and live a good life in Home Share. Together these are called the five Key Directions.

Key Directions

1. Standards, Safety and Quality of Life, Monitoring and Oversight
2. Individual Planning, Coordination and Review
3. Key Roles, Qualifications, Training and Supervision
4. Community Living Options
5. Broader Structural Issues

MSDPR told the Review Team that the amount of money paid to Home Share Providers is not part of the Review. But if how much money CLBC pays for something changes if a person is safe or has a good life, the Review can make suggestions about how to make things better.

The Review Team created the Key Directions with the Advisory Committee and CLBC staff. Each Key Direction describes an important area for improvement and has information about:

- Why this is a Key Direction
- Work completed or underway
- The gap

The Key Directions are the five areas that need to be fixed, so that Home Share can:

- Help everyone live a good life,
- Be safe for everyone, and
- Make sure everyone is doing what they say they will do (**accountability**).

Each Key Direction helps the other Key Direction work well. By themselves, the Key Directions all alone can't work as well. It will take years to finish making all the recommendations in this report real. Lots of parts of government, organizations, and the community will need to work together. All the Key Directions must be treated equally.

There are 29 recommendations about what to do next. The report has more information about how important each recommendation is, when it should be done, and who must do it. All the recommendations are written in Attachment 3.

1. Standards, Safety and Quality of Life, Monitoring and Oversight (10 recommendations)
2. Individual Planning, Coordination and Review (8 recommendations)
3. Key Roles, Qualifications, Training and Supervision (5 recommendations)
4. Community Living Options (3 recommendations)
5. Broader Structural Issues (3 recommendations)

Conclusion

This report tells everyone that important changes need to happen fast. The report tells everyone clearly what needs to be in place to make sure Home Share is safe for everyone, helps people have good lives, and works well for a long time.

Executive Summary

Context

This review was commissioned by the Ministry of Social Development and Poverty Reduction (MSDPR) in British Columbia (BC) in May 2025. Tamar Consultancy Pty Ltd was contracted to conduct the review and a deeply experienced external team comprised Eddie Bartnik (Principal Consultant, Tamar) and sub-contractors Prof Tim Stainton (Review Co-Lead), Aisling Blackmore (Secretariat and Researcher) and Ramona Sharma (Researcher).

The purpose of the review was to investigate safety and quality in BC's Home Share arrangements, by completing a review of:

- standards that promote quality of life and safety in home-share arrangements, and
- accountability and service quality oversight measures

The review recommendations identify changes which will further improve the safety and quality of Home Share beyond what has been or is currently being implemented. At the time of writing, approximately 4,300 people are funded to live in Home Share by Community Living British Columbia (CLBC).

The considerations noted below help to inform the interpretation of the information and contributions we received and the final recommendations:

- Balancing the rights of each individual to privacy, autonomy, dignity of risk, and self-determination with the obligations of government and service providers to ensure safety and quality (especially reinforced by the Advisory Committee).
- How consistently practices are implemented in different locations.
- Where obligations appropriately sit across the service system and government departments.
- The role of informal safeguards (family, friends, and unpaid relationships with fellow citizens) alongside formal safeguarding mechanisms and practices.
- The need to carefully consider the wider system within which Home Share operates and the interaction between overall systems pressures and Home Share program safety and quality over a longer period.

Methodology

The review gathered information from a wide range of sources, including:

- an independent Advisory Committee with self-advocate, family, Home Share Provider, and community services representatives,
- briefings from key CLBC staff and senior service delivery leaders,
- review of internal CLBC and external key documents,
- research into policy and practices in other jurisdictions,
- public email submission line,
- targeted interviews.

The aims of the methodology were to achieve shared understanding of the problems, input into the drafting and priority of recommendations and a set of recommendations that are at the right level, well directed, timely and able to be implemented.

The review process was conducted over four key stages.

- Establishment and information gathering: seeking information from a wide range of stakeholders to understand Home Share experiences from a wide range of perspectives.
- Information consolidation and analysis: bringing together all the information and developing Key Directions.
- Testing Key Directions and initial recommendations: two rounds of separate and independent feedback with Advisory Committee members and CLBC staff to consider recommendations and identify priorities.
- Reporting: Draft report submitted and reviewed by stakeholders ahead of finalisation.

Key system pressures impacting on Home Share

Home Share in British Columbia is unique in that institutions have been closed for some time and Home Share is the largest community living option – a situation that doesn't exist in any other jurisdiction. A consistent view is that it has become the default option, rather than an option of first choice and that there are often limited alternatives. It is also clear that individual planning has been weakened over the years as a facilitator of strong individual choice and is split between CLBC and the Home Share Coordinators.

There are substantial numbers of additional people seeking community living /Home Share (some 775 on the Request for Service list as at June 30, 2025, and a further 238 on the Planning Registry) with considerable pressure on the system to find "beds" and significant, deep community concerns with sustainability of the current Home Share program as the primary growth strategy going forward. A further 19,231 adults are living outside of CLBC's funded residential supports and services indicating considerable long-term demand.

The review found that CLBC and key partners in the sector (such as the Home Sharing Support Society of BC and BC CEO Network) have worked extremely hard to make improvements to safety and quality in the period following the death of Florence Girard in 2018. CLBC in October 2025 produced a comprehensive "Progress report: CLBC Home Sharing program and policy improvements from 2019 to 2025" which is at Attachment 2 to this report. A solid body of work is underway and CLBC provided the review with open and comprehensive briefings and information.

Despite this body of work, there was consistent feedback that the Home Share program and CLBC itself continues to be under considerable stress and further urgent improvements are needed. The following quotes are examples:

"The policies and checklists in place are fine – don't need more paperwork…. People aren't just asking for more rules – they're asking for better support, stronger relationships, and real accountability. They want a system that sees the whole person, not just a file or a funding category."

Advisory Committee member submission

"However, we remain deeply concerned about the sustainability of Shared Living and the erosion of a strong relational focus being replaced with a transactional one."

BC CEO Network submission

We considered it essential to place the current system pressures into the overall historical context of delivery of Home Share and disability services in British Columbia through CLBC. Key contextual points outlined in Section 3 include:

- Erosion of robust individual planning, coordination and review
- Changes to the population served by CLBC and covered by the Guide to Support Allocation (GSA)
- Scope creep for CLBC services, including allied services such as health, mental health, housing, corrections
- Sufficiency of CLBC Budget
- Home Share Coordinating Agencies
- Home Share Providers

Key findings

BC has been a world-leader in developing the Home Share model and where Home Share is done well, it is highly valued. Development of robust Home Share systems and options as a quality alternative to institutions and group homes is an ongoing priority project in several comparable jurisdictions. CLBC and key sector partners have worked diligently to make improvements over recent years.

The CLBC *Standards for Home Sharing* and *Standards for the Coordination of Home Sharing* are in line with evidence-based good practice from other jurisdictions. But there needs to be adequate resourcing to ensure these are consistently implemented, monitored and enforced. Greater transparency and public reporting of both safety and quality in Home Share and quality of life outcomes for people supported in Home Share is needed to support accountability and build trust.

Consistent reports are that Home Share has become the default community living option provided through CLBC funding. There are limited alternative options available, and evidence of considerable long-term demand for community living support. It is unlikely Home Share alone can be scaled to accommodate demand.

Key features of the Home Share model have been weakened over time. Namely: individualized planning, coordination and review; matching process between Home Sharers; and the involvement (or development of) of key relationships and informal community supports. The evidence base indicates these features are key to ensuring stable, safe, and successful Home Share arrangements.

Contextual factors have changed over time, including: the population served by CLBC has changed significantly and people with more complex lives are being matched to Home Share; considerable demand and overall sufficiency of the CLBC budget, loss of other allied and community supports; and wider systems pressures such as increasing cost of living and housing scarcity.

Turnover of staff and Home Share providers in all key roles is a major concern, leading to loss of experience and knowledge and increasing risk and vulnerability.

System pressures create vulnerabilities for people in Home Share and need to be stabilized.

As stated in our report:

"Even the best of monitoring and safeguards cannot protect against vulnerabilities created by an underfunded system." p.23

Recommendations

The approach taken has been to have a primary focus on Standards and Monitoring as the core focus of the review, but also to identify the four other key system factors that significantly contribute to risk and the need for improvement in Home Share.

These Key Directions are:

1. Standards, Safety and Quality of Life, Monitoring and Oversight
2. Individual Planning, Coordination and Review
3. Key Roles, Qualifications, Training and Supervision
4. Community Living Options
5. Broader Structural Issues

MSDPR advised that while Home Share provider compensation is outside of the Review scope (e.g. how much should a Home Share provider be paid), funding decisions impacting safety, quality of life, or oversight can be considered in scope (e.g. does Home Share provider compensation support a safe environment with strong quality of life outcomes).

The Key Directions workshop process involved the progressive development and refinement of key content for each Key Direction:

- Why this is a key direction
- Work completed or underway
- The gap

These are the building blocks needed to develop quality of life, safety, and accountability in the Home Share system. These building blocks are mutually reinforcing but cannot be effective in isolation. Implementation will need to take place over a multi-year period, involving a range of agencies and stakeholders, and with equal attention to each key direction.

Underneath the Key Directions are 29 recommendations to guide specific implementation actions, each of which are described in terms of priority, timeline and responsibility:

1. Standards, Safety and Quality of Life, Monitoring and Oversight (10 recommendations)
2. Individual Planning, Coordination and Review (8 recommendations)
3. Key Roles, Qualifications, Training and Supervision (5 recommendations)
4. Community Living Options (3 recommendations)
5. Broader Structural Issues (3 recommendations)

The complete list of recommendations is provided at Attachment 3.

Conclusion

This report presents an urgent call for action and clear roadmap for improvements. The report clarifies the fundamentals needed for a safe, sustainable, good quality Home Share system that supports good lives for everyone involved.

Section 1: Review terms of reference and scope

Extract from the Engagement Letter from the Ministry of Social Development and Poverty Reduction sets out the terms of reference:

Background:

Home sharing is a program funded by Community Living BC (CLBC) where an adult with a developmental disability shares a home with a person, a couple, or family who is contracted by an agency to provide social and homecare-like supports and facilitate appropriate community inclusion opportunities for the person living with them. CLBC monitors the work of the agencies' oversight. About 4,300 people are supported by CLBC in home share living situations. In January 2025 a Coroner's Inquest was held into the death of Florence Girard, a CLBC-eligible person who lived in a home share in Metro Vancouver at the time of her death in 2018. Her home share provider was charged with failing to provide the necessities of life and convicted in 2022.

Approach:

Several changes have been made to home share since Florence Girard's death. A review is needed to evaluate whether CLBC's changes since 2018 have improved safety. The review will identify other changes to further improve the system of oversight for home-share arrangements. The review will be conducted by the Ministry of Social Development and Poverty Reduction ("the Ministry") through an independent contractor ("the contractor"). The Ministry will convene an advisory body made up of service providers, self-advocates, and family members to ensure their voices and perspectives about home sharing are heard. The advisory body will provide additional context to the contractor as required.

Scope:

The scope of the home share review is to be focused on safety in home share arrangements to respond to the concerns identified by the Coroner's Inquest; namely:

- Review of standards that promote quality of life and safety in home-share arrangements
- Review of accountability and service quality oversight measures

Product:

The contractor will provide a final report ("the Report") with findings and recommendations for improvement to the Ministry by September 30, 2025. (later agreed to be October 31st, 2025)

Engagement:

The contractor will be expected to engage with community representatives, including CLBC leadership and staff and members of the advisory body. Further engagement may be required as identified during the term of the contract to fully inform the Report, including with other jurisdictions or public entities.

Within this scope, our approach with the Advisory Committee and their submissions to the review of safeguards in Home Sharing has been focused on two broad questions:

- Are current safeguards as developed by CLBC sufficient to ensure the maximum degree of safety for those living in Home Sharing arrangements while respecting their rights to privacy and autonomy?
- Are these safeguards being effectively implemented on the ground throughout the province?

At the first Advisory Committee meeting held 9 July 2025, it was requested by members and agreed to clarify the two broad questions as follows:

- The focus on formal safeguards such as standards and monitoring needs to be balanced with a focus on informal safeguards, including family, friends and unpaid relationships with fellow citizens. Safeguards should also include working in partnership with other organizations such as Health and Mental Health.
- The review scope includes quality of life as well as safety, so the concept of “dignity of risk” is also important
- Safeguards refers to the policies and processes in place whereas safety refers to the outcome of people being safe.

Section 2: Review team and methodology

Review team

The contractor for the review was Eddie Bartnik from Tamar Consultancy Pty Ltd. Brief details of the Review team members follow:

- Eddie Bartnik from Western Australia is the Director of Tamar Consultancy and is a highly experienced consultant who represents a strong international perspective on best practice from other jurisdictions and has over 45 years' direct experience in disability services, policy and funding and more recently mental health.
- Dr Tim Stainton is a sub-contractor to Tamar Consultancy and the Review and represents deep long-term knowledge of the disability sector in BC and extensive research knowledge of Home Share and other related programs.
- Mr. Bartnik and Dr Stainton recently worked together as the Independent Experts to successfully deliver the 2023 Human Rights Review and Remedy for the Findings of Systemic Discrimination against Nova Scotians with Disabilities. They have a proven track record with the Nova Scotia Review being accepted by all parties and now underway in implementation. Given the importance of Home Share programs in Canada and internationally, they agreed to work together again on this important Review in BC.
- Aisling Blackmore is an independent consultant with extensive experience supporting national and international committees and meetings and has significant experience relevant to this role and knowledge transfer across jurisdictions and has worked closely with Mr. Bartnik on many projects.
- An independent researcher with relevant experience Ramona Sharma was contracted under the guidance of Dr Stainton to undertake the research and jurisdictional scan.

Review stages

The four key stages of the review involved:

Stage 1 Establishment and Information gathering (June/July)

- CLBC Briefings and document review
- Research and jurisdictional scan (national and international)
- Public email line via the Ministry of Social Development and Poverty Reduction
- Advisory Committee establishment and meetings 1 and 2
- Targeted interviews

Stage 2 Pulling together all the streams of information and analysis (August)

- Reviewing all inputs
- Intense team work to integrate key themes and develop Key Directions for recommendations

Stage 3 Testing Key Directions and recommendations (September)

- Advisory Committee meetings 3 and 4; separate workshops with CLBC – to consider options for recommendations and then prioritisation ratings

Stage 4 Reporting (31 September and 31 October)

- Draft Final Report submitted to Advisory Committee and CLBC for review week of 20th October, along with Ministry briefing
- Final Report submission

The Review team worked closely with the Ministry Review contract representative with regular weekly/fortnightly meetings and formal monthly review meetings.

Advisory Committee

The Ministry facilitated the appointment of the Advisory Committee and required matters such as confidentiality agreements, accessibility requirements and honorariums. The Terms of Reference and membership of the Advisory Committee was managed jointly with the consultant and Terms of Reference are at Attachment 1. Specific accommodations were made for plain English papers and briefings for self advocate members as required.

Summary of key themes arising from submissions

- There is more demand than the system can currently accommodate
- Key roles are overburdened, consistent mention of Coordinators and Home Share providers
- Scarcity of Home Share supply
- No real continuum of community living/accommodation supports
- Informal networks are not built into the system in a consistent or reliable way
- Limited scope of implementation resourcing and supports such as respite
- Trust across the system is fractured (people may not report concerns, perceptions of shifting/avoiding responsibility)
- Limited crisis supports and vulnerabilities around children in care transitioning and aging 55+

The Advocate for Service Quality and Chair of the CLBC Indigenous Advisory Council were also interviewed and provided input to the review.

CLBC Briefings and document review

CLBC provided a comprehensive secure document folder including Home Share standards and policies, research, reports and historical documents. These were reviewed at key stages of the briefings process.

CLBC also provided an updated public document outlining the substantial work completed with the sector – "Progress report: CLBC Home Sharing program and policy improvements from 2019-2025" (October 2025). This provides an excellent timeline of events and developments and is included as Attachment 2.

The Progress report provides updates in the following areas:

- Role of the Home Sharing Support Society of BC and the BC CEO Network
- Response to the Office of the Auditor General
- Budget improvements
- Policy updates and guidance
- Indigenous self-determination and cultural safety
- Training improvements

- Standards and monitoring framework for home sharing coordinating agencies and providers.

They also responded to ongoing requests for information and provided a series of 3 head office briefings to:

- Clearly outline the timeline of key events following the death of Florence Girard in 2018 and subsequent internal and external reviews, audits, Coronial Inquiry and CLBC and broad governmental responses and remedial/improvement actions taken, including data and evidence of impact of any changes to safety and quality of life of persons in Home Share;
- Describe in detail the past, current and planned architecture for the delivery of the CLBC Home Share program, including how individual planning and support coordination works, pathways for entry and placement decisions, role and profile of the CLBC Home Share program (including program leadership, accountability and mechanisms for provincial consistency, coordinating organisations and individual organisations/Home Share providers, profile of individuals engaged in Home Share and their demographics, structures for self advocate and family/network involvement and decision making); and
- Outline the assurance framework including CLBC and organisational governance roles, internal and external monitoring roles/mechanisms and service standards, audit processes, data on incidents and quality.

In addition, Regional Operational Directors were provided with 3 additional confidential briefing sessions to outline the ways in which Home Share is implemented and supported in each region, including the key roles and processes for delivery including balancing provincial consistency and implementation of policies and assurance procedures with regional responsiveness. This included a discussion on the realities of regional service provision and key challenges and any concerns with current progress. The operational challenges of implementation identified a broad system under significant stress and a wide range of key issues that were fed into each of the key directions.

Some key themes included increased complexity in people being supported in Home Share, Home Share providers as contractors and accountability, staffing levels and competence/experience/turnover (with loss of expertise and knowledge) across the system, Home Share increasingly seen as a default option, loss of planning infrastructure and focus over time due to scarcity of options and unmet need, complexity of the Home Share Coordinator role.

Public email line

The process involved emails being first handled by MSDPR and first level response, including replying direct (for questions regarding the contractor selection process and ministry management of the review) or refer to Review team. Personal information was removed from submissions before being sent to the review team and were not able to be fact checked.

Examples of key issues:

- Independence of the review, transparency, Advisory Committee membership
- Scope of review
- CLBC funding and use of, culture

- Interactions between CLBC staff and Home Share providers, funding reductions in transition from care to CLBC (including examples of negative consequences when Home Share providers advocate for the needs of the person)
- Funding allocation mechanisms and link to Quality of Life, Guide to Support Allocation (GSA) review processes (including concerns re lack of CLBC Facilitator contact with person involved) and guidelines/practice between CLBC and provincial Health.

Jurisdictional scan

This report presents a jurisdictional scan of Home Share, shared living, and adult foster-care models across Canada, the United States, the United Kingdom, Ireland, Australia, and New Zealand. The analysis applies a consistent framework of variables, including program design, residential arrangements, funding models, target populations, eligibility, governance, host recruitment and vetting, monitoring and safeguarding mechanisms, quality assurance, training, independent planning supports, dignity of risk, psychosocial and cultural supports, quality-of-life outcomes, barriers and facilitators, notable cases, and evaluation evidence.

Attachment 5 includes the complete Jurisdictional Scan report. At a high level, it concludes that across Canada, the United States, the UK and Ireland, Australia and New Zealand, CLBC's model looks broadly aligned with the prevailing architecture: a published provincial standard and coordination framework, structured vetting and home study, scheduled in-home reviews, a policy-defined incident and complaints system that feeds improvement, tenancy-style safeguards in provider-controlled settings, mandated training and competence, formal pathways for any rights limitation and an outcomes-centered lens at monitoring. Where other jurisdictions differ, they tend to be more prescriptive in law about inspection cadence, incident timelines or clinical checkpoints, or they locate oversight in a national statute and regulator rather than in provincial policy and contracts. Those differences are of form more than substance: the underlying safeguards, quality mechanisms and quality-of-life expectations are notably consistent with what CLBC now sets out in its standards and policies

At a high level, however, when compared to international best practice, CLBC also has areas for required improvement including high level program leadership and public reporting on standards and outcomes, as well as some specific elements related to a more differentiated model of monitoring (and staffing) and strengthening the use of external accreditation.

In BC, while CLBC has standards, the *visibility* and *consistency* of monitoring vary, creating vulnerability.

Across all the above review inputs, our approach to the integration of inputs included the following key elements:

- An extremely large volume of information was available through previous reviews, external surveys (e.g. BC CEO Network), jurisdictional scan, related research papers, CLBC briefings and key documents and confidential community inputs (noting that we were not able to fact check some of these).
- Public submissions via the Ministry email line (approximately 20) were received by the Ministry and forwarded on a confidential basis as appropriate to the Review team.
- Responses to the Auditor General's report and Coroner's Inquest report are underway, also there is further substantial CLBC review work on health-related supports and other

internal review areas. Our approach has been to focus on unique high level key levers rather than duplicate other Reviews.

- The detailed jurisdictional scan document was made available to CLBC early in the process as a resource to avoid duplication of other efforts (e.g. around health supports).
- The Final report has both overall and more specific findings for each Key Direction and will incorporate information from the review and anonymize information as appropriate (given the confidential nature of some processes).
- The separate Key Directions Workshop processes enabled all participants to independently question, review and rate each recommendation so that there was a clear line of sight from review inputs to recommendations.
- In order to make the review process accessible to all parties, we made every effort to make the workshop materials high level and accessible as possible so a slide format (with plain English resources as requested) was used to encourage inclusive interaction and feedback.
- Our goals were for the process to achieve shared understanding of the problems, input into recommendations and a set of key recommendations that are right level, well directed, timely and implementable.
- The final recommendations identified a strong sense of shared priority across both the Advisory Committee and CLBC, as well as some specific priority recommendations that reflected the perspective of each group. (See Attachment 4)

Section 3: Context and findings

Unique context of Home Share in British Columbia

The context for Home Share in BC is unique in that institutions have been closed for some time and Home Share has emerged as the largest community living option (some 4300 people supported) – a situation that to our knowledge doesn't exist in any other jurisdiction. A consistent view is that it has become the default option when individuals require residential support, rather than an option of first choice and that there are often limited alternatives. It is also clear that individual planning has been weakened over the years as a facilitator of strong individual choice and is split between CLBC and the Home Share Coordinators.

There are substantial numbers of additional people seeking community living /Home Share (some 775 on the Request for Service list as at June 30, 2025 and a further 238 on the Planning Registry) with considerable pressure on the system to find "beds" and significant, deep community concerns with sustainability of the current Home Share program as the primary growth strategy going forward. A further 19,231 adults are living outside of CLBC funded residential support and services indicating considerable long-term demand as the community norm for most adults is to be living in their own home away from parents. Additionally, this is not a long-term solution as parents age and are no longer able to care. A lack of options inevitably creates a crisis response when no pro-active planning is undertaken.

The following table provided by CLBC shows CLBC caseload distribution as of March 31, 2025:

Caseload breakdown	
Residential	**10,040**
Staffed living	2,998
Shared living (Home Sharing and Live In Support)	4,263
Agency Coordinated	4,263
Direct contracted	-
Independent Living	2,779
Other	**19,231**
Employment (included in Other)	2,530
L.I.F.E. Based (included in Other)	415
Total	**29,271**

Home Share is also in ongoing development in many jurisdictions, including Shared Lives in the UK which supports approximately 10,000 people, Australia as part of the Individual Living Arrangements strategy as alternatives to group homes and Nova Scotia (being scaled as part of the Human Rights Remedy 2023).

The review found that CLBC and key partners in the sector (such as the Home Sharing Support Society of BC and BC CEO Network) have worked very hard to make improvements in recent years and CLBC provided a comprehensive timeline of developments and improvements, related to recent reviews. A solid body of work is underway. CLBC provided us with open and comprehensive briefings and information.

A key initial concern of the Advisory Committee was to ensure there was a balance between safety and quality of life outcomes and that formal regulatory safeguards be balanced by the

important role of family, friends and community members as part of an overall safeguarding strategy.

There was also concern that the level of complexity of people being matched to a Home Share option has increased in recent years and that current program ratios and support/training arrangements have not kept pace with the capabilities required.

While we provide a focus on the standards, monitoring and oversight mechanisms, it was impossible to separate these out from the wider impacts of a system under pressure. We need a balance of both and emphasis on getting things right in the first place as well as monitoring and intervening.

"The policies and checklists in place are fine – don't need more paperwork…. People aren't just asking for more rules – they're asking for better support, stronger relationships, and real accountability. They want a system that sees the whole person, not just a file or a funding category"

Quote from an Advisory Committee submission

"However, we remain deeply concerned about the sustainability of Shared Living and the erosion of a strong relational focus being replaced with a transactional one"

Quote from BC CEO Network submission

Findings of key system pressures impacting on Home Share

System pressures create vulnerabilities for people in Home Share and need to be stabilised.

We considered it essential to place the current system pressures into the overall historical context of delivery of Home Share and disability services in British Columbia through Community Living British Columbia. We also wanted to review key aspects of the Home Share system to help provide context for the recommendations.

Independent planning, coordination and review

Independent, person-centred planning is now considered an essential part of any service and support system across most comparative jurisdictions. Indeed, it is seen as an essential core for truly person centred, rights-based systems which seek to encourage, support and enhance the self determination of people with disability. Independent planning at its best functions outside the service system as a community facing rather than a service led process. Good planning begins with supporting the person to articulate their personal vision for the future, their goals, dreams and needs to effectively pursue that vision, aided by their personal network. Services are seen as a sometimes necessary element of that vision, but good planning should always look first to the community and only after it is clear that certain needs cannot be met by the community should formal services be considered. In this way person centred planning seeks to create inclusion by both connecting the person to community and by developing the community's capacity to meet the needs of all its members, including those with disability. While promoting inclusion, this approach is also efficient in the sense it seeks not to 'over-service' and hence reserves resource use for areas that cannot otherwise be met by more natural, community-based supports.

In the original vision for CLBC as set out in the Transition Steering Committee report *A New Vision For Community Living* (2002), independent planning was a central part of the proposed new system. Originally this was conceived as a quasi-independent arm of CLBC under the leadership of a Planning Commission with regional planning centres available throughout the province and operationally independent of the financial decision-making arm of CLBC. This was ultimately enacted as an arm of CLBC reporting to the CEO rather than under a quasi-independent commission but retained a clear separation from the funding and administrative arm of CLBC to protect the autonomy of the process. Soon after the inception of CLBC this separation was reduced somewhat by bringing the planning function within the general administration structure of CLBC and the independent planning offices were merged with CLBC general offices.

The key role intended to provide this planning function was the *facilitator* role. Caseloads were intended to reflect the intensity of the role. In order to support these lower caseload levels there was not intended to be a formal case management function where facilitators undertook scheduled reviews at fixed periods. They were however intended to be available as required to provide planning and service coordination. This was to be driven by the person and their networks, and a key part of the initial planning role was to ensure people knew how and when they could connect to their facilitator. In addition, if there were concerns about the viability of the person or their network to provide this oversight and request support as needed, the facilitator was to keep a 'light touch' eye on the individual to ensure they were safe, and that they had what they needed to live the life they chose to live and pursue their personal vision.

As demand on CLBC increased, the facilitator's role in detailed independent planning, coordination and monitoring reduced significantly. Most of these roles were shifted to contracted agencies with facilitators focussing largely on initial GSA assessments, service connections and crisis review and response. As one CLBC manager put it 'we really only do crisis planning anymore'. Facilitator caseloads have also risen substantially to a point where there is little time for follow-up, monitoring or review. Data provided by CLBC indicate that caseloads for facilitators now average 177 in 2024/25 up from 156 in 2020/21. By contrast, similar roles now underway in Nova Scotia for a broadly similar disability population have ratios of 25-50, The ratios are mandated as part of the Human Rights Remedy where improved individual planning and coordination is a foundational reform strategy to overcome discrimination. We heard from many families and self advocates about their frustration getting a timely or fulsome response from CLBC and the lack of reviews. Given the caseload this is not surprising nor is it feasible to expect the kind of intensive planning, coordination and review originally envisaged for the role. Not surprisingly, this has taken a toll on staffing with CLBC reporting that 37% of facilitators and 46% of analyst having been in the job for less than 2 years. Some of this is due to new positions being added however, it does point to challenges in maintaining continuity with clients and resource investments to train new hires not to mention the lead time for new hires to learn the system, community resources etc.

CLBC has consciously shifted much of the planning, monitoring and review to community agencies which is not necessarily a bad strategy. However, agencies are not generally contracted specifically for planning but usually for a specific service such as Home Share. We heard from agencies that they do not have the resources to provide comprehensive planning and that planning usually revolves around the Home Share itself though it may include broader planning for community inclusion supports. This creates several structural issues. Firstly, the planning takes place after the decision on Home Share has already been made so there is little

scope to examine broader alternatives or choices the person may wish to consider. Secondly, there is a conflict when the planning support is attached to the service provider rather than a more independent body who can support the person to consider a broader range of options. The coordinating agency also has an interest in retaining the contract for the service. While most agencies act in good faith to honestly respect the person's wishes, they are not well positioned to support them in accessing or coordinating services beyond their own milieux.

This absence of more broadly based independent planning and support coordination has a number of potential impacts. First and foremost is the impact on the person and their ability to make their own life choices and be supported to pursue them. Home Share as what has been termed the 'default option' for residential support is, in many cases, not the individual's preferred mode of support. While most agencies strive to ensure there is a good fit between the provider and the person, the scope of choice available is generally very narrow so that the individual at best receives the 'best available' Home Share rather than a residential support arrangement they genuinely choose. The absence of broader based planning can also mean that more creative options are not pursued and that changing needs are not always responded to in a timely and effective manner even if such change may be towards more independence and potentially less costly alternatives.

Rebuilding an effective independent planning and support coordination system will not be a quick or easy task. Without further resources it will be impossible. That said, there are an array of good models of independent planning and support to draw on from a range of jurisdictions. Independent community-based agencies with an exclusive focus on planning and support coordination is generally considered the ideal approach, supplemented by an array of options for individuals and their network to undertake their own planning and support coordination as is often the case with Microboards and person-centred societies. Peer support options have also been an effective and efficient means of planning and support coordination. CLBC's 2018 changes to its planning approach took some steps towards creating independent planning options, however further work is needed to improve and enhance planning processes. While the specific model of planning and support coordination is beyond the scope of this review, it is a critical component to ensuring Home Share is used appropriately and that the responsibility for all aspects of an individuals support needs does not fall on the Home Share provider. The Nova Scotia Human Rights Remedy (2023) also provides a recent Canadian example of how this function can be remodelled and now demonstrated through evidence based new roles and a strong approach to fidelity of design, implementation and scaling.

Ongoing support coordination and review would generally be encompassed within the remit of whoever has responsibility for planning. Currently this is largely downloaded to coordinating agencies. One option for CLBC would be to reduce the current caseload on facilitators and re-establish or enhance their role in providing ongoing review as required and appropriate based on the person unique needs and situation. This would also provide a somewhat more independent monitoring role beyond the coordinating agency. This would not only add an additional layer of monitoring but also ensure that the current arrangements continue to meet the persons needs and wants and provides an opportunity to seek changes to enhance the person's wellbeing and build on positive growth and change.

Guide to Support Allocation

We heard a lot about the Guide to Support Allocation (GSA) in the context of Home Share, the tool CLBC uses to determine the level of need and subsequent funding an individual requires.

The concerns we heard were generally either about transparency and communication or, about the suitability of the instrument for all of CLBCs current client population. In particular, concerns regarding the GSA not fully identifying all of the potential complexities and challenges faced by some individuals who were being placed in Home Share.

The communication and transparency issues generally revolved around difficulties in having a GSA reviewed or revised as individual's needs changed. Allied with this were a number of comments regarding difficulties in reaching the appropriate CLBC staff and subsequent problems with communication leaving families and individuals frustrated and unsure of what was or was not being done. This is largely a function of the increased demand on CLBC facilitators noted above but adds to the distrust and frustration we heard from some community members regarding CLBC.

The GSA was a tool developed in house at CLBC adapted from a UK tool, the Resource Allocation System (RAS) & Self-Assessment Questionnaire (SAQ), soon after its inception. It provides a ranking between 1-5 with 5 being the highest needs category. In addition, an individual can be assigned 'flags' denoting significant behavioural or medical needs. It does have the advantage of being a relatively straightforward, easy to understand and administer tool and is easy for individuals and families to contribute to. On the other hand, the tool is not psychometrically tested and lacks significant validity and reliability testing, though CLBC does undertake some internal inter-rater reliability testing. A more pressing concern is that the tool was developed for the population served by CLBC at its inception which were generally a more coherent population of individuals with IDD. With the introduction of the Personalized Supports Initiative (PSI) in 2010 as a result of the Fahlman decision CLBC also began offering services to individuals with both significant limitations in adaptive functioning and either a diagnosis of Fetal Alcohol Spectrum Disorder (FASD) or Autism Spectrum Disorder (ASD). This population can present significantly different challenges and needs to the IDD population and can involve significant social and behavioural issues including addiction, drug and street involvement. The GSA was never designed to address the needs of this population and can lead to an under-estimation of support needs.

There are a number of alternatives CLBC could consider. One option would be adding other assessment tools which better fit the unique needs of some of the client population as noted above. Alternatively, CLBC could look at alternatives to the GSA. Many examples exist in other jurisdictions. The Support Intensity Scale Allocation developed by the American Association on Intellectual and Developmental Disabilities (AAIDD) is a widely used option that has been tested for validity and reliability and has both an adult and child version (https://www.aaidd.org/sis). A second option would be the inter-RAI which has a broad set of assessment tools for various populations (https://interrai.org/). Widely used in health and long-term care, they have specific tools for IDD, mental health and other vulnerable populations. This provides the option of using a suite of tools to cover all of a given individuals needs to make a comprehensive assessment. Nova Scotia has recently adopted the inter-RAI and has developed an algorithm to translate scores into funding bands.

There are several advantages to using a more sophisticated assessment tool. Accuracy and comprehensiveness are two obvious advantages but in addition the fact these are independently validated provides a greater degree of transparency to funding decisions that flow from these tools. While there is no perfect assessment tool, CLBC should at minimum expand its range of tools to encompass the whole of its client base and undertake and make public work to assess the reliability and validity of its tools. Applying a more comprehensive set

of assessment tools should help to identify where more support is required for some individuals going into Home Share.

Allied Services - Health and Mental Health

A significant challenge for CLBC Home Share service and more generally is access to essential allied supports. Health and mental health services are increasingly a significant need of CLBC clients due to the aging population and more complex profile of some of the individuals served by CLBC. The direct provision of health services beyond basic physical care and low-level health supports such as assisting with medication was never part of CLBCs mandate nor is it and area where CLBC and its contractors have specialist expertise. Health services for CLBCs clients are, as with all British Columbians, the responsibility of the Ministry of Health and the regional health authorities. Specialist units, Health Services for Community Living (HSCL) are available in all health regions and are intended to provide specialist support to CLBC clients. We heard from numerous sources that HSCL is difficult to access due to their limited capacity. There has been little in the way of growth withing HSCL services despite a significant increase in demand. We also heard that the service, run independently by each health authority, varies significantly across regions and its regional nature creates significant barriers to equity and consistency of services. In the absence of a consistent, easily accessible health service CLBC has had to use their resources to compensate.

Similarly mental health supports are provided regionally through Developmental Disabilities Mental Health Services (DDMHS) who provide individualized assessment, treatment and education for adolescents and adults with developmental disabilities and complex mental health needs. Again, we heard repeatedly about difficulties in access and regional inequity. In addition, DDMHS requires a formal IDD diagnosis including an IQ level below 70. This effectively excludes all of the PSI population who in many cases are more likely to require such services than the general IDD population.

CLBC has been placed in the position of having little choice but to try and fill these service gaps themselves placing significant strain on their resources. CLBC estimates the cost of providing services to fill the gaps in health and mental health services to be approximately 160 million per year. Despite years of effort by CLBC to clarify the roles and responsibilities for these services and help define solutions, significant progress has not been made.

The absence of these services has a number of significant impacts on clients, Home Share providers, agencies and CLBC. Most critically it means that individuals are not getting the supports they need to address their health and mental health needs. For Home Share providers, it often means they are left to cope with health and, mental health issues on their own with little or no training or professional support. This leads to increased stress on providers, breakdown in Home Shares and most critically negative outcomes for individuals.

Health services for people with developmental disabilities has weakened while demand and need have increased. Health Services for Community Living (HSCL) has not had significant staffing increase (i.e. nurses, physiotherapists, occupational therapists, dental hygienists) since early in its 30 plus years of work. Following the deinstitutionalization process when HSCL was established, a medical consultant (Dr. B Plain) was available full-time, and on-call, for Individuals served by HSCL and CLBC. Upon the retirement of Dr. Plain, a program review was conducted and the service evolved to a part-time physician and full-time clinical nurse specialist. These positions provided advice to HSCL staff as well as dealt with macro health

issue related to IDD in the province including data collection and analysis. The positions were cut in 2017 with no replacement service. The Advocate for Service Quality highlighted the increasing need for the position and called for its reinstatement in 2020, a call widely supported by the community including Inclusion BC and the BC CEO Network. This request was turned down by the Government leaving an already tenuous situation to continue to erode.

CLBC did operate the Provincial Assessment Centre since its inception. The PAC was a legacy entity which continued to operate after the closure of Woodlands Institution and offers multidisciplinary mental health services for people with a developmental disability, and a concurrent mental health concern or behaviour issue. The Centre was transferred in 2023 to the BC Mental Health and Substance Use Services in a rare example of CLBC being relieved of services that are better placed within the Ministry of Health.

Calls for regular health checks were part of the Coroner's report as well as subsequent CLBC initiatives. The reality is that the resources to effectively implement this are currently not available. While there are several ways health and mental health services could be improved, it will likely require both a significant investment of resources as well as a restructuring of services to relieve CLBC of those services they are not mandated to provide and changes to both HSCL and DDMHS. The move of the PAC to Mental Health and Addictions services provides a potential blueprint. Consideration should be given to re-establishing the Medical and Health consultant positions as a start. Further, consideration should be given to moving HSCL and DDHHS out of the regional authorities and into the Provincial Health Services Authority under the direction of the Medical Consultant. This would also mean budget transfer as well as a budget increase to bring the service up to a reasonable capacity to meet demand.

Allied Services - Housing

Housing is another area which has required CLBC to operate beyond their core mandate. To cite CLBCs own analysis, 'CLBC's mandate does include home supports for disability related need, including funding for the workers in staffed living (group homes), home sharing and supported independent living. CLBC has a relationship with BC Housing where the Housing Crown acts as a real estate and construction intermediary for CLBC. However, the housing needs of CLBC-eligible individuals far exceed the mandated authority for home support by CLBC. Given the necessity of stable housing for quality of life and the unique needs and vulnerabilities of CLBC-eligible individuals, CLBC expends approximately $40 million on housing costs outside of mandated housing responsibilities.'

The lack of affordable housing creates an additional pressure on Home Share as individuals who may wish to live more independently cannot afford market housing and stock of subsidized housing are extremely limited. .In extreme cases this can lead to CLBC eligible individuals being unhoused altogether. CLBC has developed a number of documents and strategies related to housing but without a supply of affordable stock the possibility of significant progress is limited. While BC Housing and its community partners have worked with CLBC and its community partners over the years, these is no joint strategy or dedicated targets for housing unit development for IDD. We therefore are recommending that a fixed target of new social housing development be dedicated to CLBC eligible individuals sufficient to meet the increasing demand. This would require Housing and CLBC to work together on the development of a strategy. Until more housing stock is available to people supported by CLBC, individuals will be forced to remain in Home Share or families will need to continue to provide housing regardless of whether this is their chosen housing option.

Allied Services - Corrections

People involved with the criminal justice system are another population that was rare at CLBC inception but have increased significantly since then. Some of these individuals present significant involvement with the criminal justice system and in some cases CLBC has been named as the body responsible for risk mitigation and daily community oversight. CLBC's service delivery model never contemplated involvement with corrections-involved individuals and CLBC estimates it invests '$30 million dollars to address risks to community safety and fund enhanced staffing to support individuals involved with general correctional services and discharges from Forensic Psychiatric Hospital outside of disability support needs.' This has sometimes resulted in individuals not well suited to Home Share being placed in it regardless creating significant strain on providers, other individuals who are part of the home share setting and breakdown of placements

The *Corrections Involvement Policy*, effective March 2025, outlines how CLBC and BC Corrections will work together to support individuals who are involved with both organizations. This policy ensures a consistent, transparent, and collaborative approach with updated procedures and a shared understanding between CLBC and BC Corrections, reflecting a real culture shift in how we work. This work has led to a clearer distinction between disability-related support and public safety responsibilities and has strengthened our partnership with BC Corrections. This can provide a useful template for continued work with both Housing and Health.

Indigenous Communities

Indigenous communities both on and off reserve are served by CLBC. Those on reserve fall under federal jurisdiction but as is the norm in most provinces, the province provides the supports and bills the federal government for cost.

Since 2014, through a Memorandum of Understanding with the Ministry of Social Development and Poverty Reduction (SDPR) and Indigenous Services Canada (ISC), CLBC has recovered federal funding to support the delivery of services to individuals living on First Nations. Since 2021, CLBC has been working to establish a funding transfer process that would enable the transition of funding for supports to Indigenous CLBC-eligible individuals to their First Nations or an identified agency, such as an Indigenous Child and Family Services Agency. This approach supports First Nations and their designated bodies, in partnership with CLBC, to deliver services to their own members and, in some cases, to other First Nations people on their unceded territories.

Recognizing that First Nations are in the process of restoring their jurisdiction over matters concerning their people, CLBC acknowledges that this represents an interim but critical first step in its relationship with rights holders. In alignment with the *Declaration on the Rights of Indigenous Peoples Act* (2019), CLBC's goal is to ensure that this funding is restored to First Nations to the extent possible, until such time as they determine how they wish to exercise their authority for services under the *Community Living Authority Act*.

Indigenous communities often have a general distrust of government social services with a long history of abuse, intolerance and cultural suppression. While reconciliation is now the goal, resetting the relationship after decades of colonization, the distrust and suspicion of government services remain an unfinished project.

CLBC has made significant progress in beginning to address relations with indigenous communities in a respectful and culturally safe way but there remain much to be done. CLBC is not well known in many indigenous communities and families struggle to support their loved ones with IDD and other challenges with limited supports. Finding a way to work with Indigenous communities to support them in caring for their members with IDD and other challenges requires an open and honest dialogue as to how they wish to have their families supported.

Home Share is not widely used in Indigenous communities but may offer opportunities to develop a uniquely indigenous version of Home Share, building on traditional ways of supporting their members. For indigenous individuals in Home Share, a clear requirement that cultural connection and safety be part of the planning process and auditing process for Home Share.

CLBC budget sufficiency

Even the best system of monitoring and safeguards cannot protect against vulnerabilities created by an underfunded system. CLBC as a Crown corporation receives a fixed budget negotiated annually and must stay within its budget for each fiscal year. This was a change from when IDD support was within government where budget overruns, a frequent occurrence while within the government, was covered by the province. This provided a safety net for unforeseen expenses and crisis response. While the idea of a fixed annual budget is not unreasonable it has meant that CLBC has less ability to address unforeseen expenses than their predecessor. Overall CLBC's budget on a dollars per client basis has generally tracked inflation according to CLBC annual reports.

While at first look this seems reasonable but a more nuanced analysis of budgetary demand on CLBC suggests that despite the relative stability of the year-on-year budget, CLBC faces major financial challenges brought on by a number of factors. It was early budgetary pressures which led in large part to the rapid growth of Home Share usage as the preferred residential option. At the beginning of CLBC, group homes were the primary form of residential support with Home Share as a relatively small percentage of residential supports. Home Share cost as little as one third of the average group home placement, in large part due to the tax emption for care giving funding under s. 81(1)(h) of the Income Tax Act. The relative cost of Home Share compared to other options has in part led to it becoming the 'default option' and budgetary pressure has led to its potential overuse and a lack of a robust set of other residential options. To put it plainly, our analysis indicates that CLBC in many respects cannot afford to provide a significant range of residential options given its baseline budget is now, rightly or wrongly based on the widespread use of Home Share.

If CLBC had not faced significant budgetary pressure, an inflation neural budget would be reasonable. Unfortunately, the widespread use of Home Share likely undervalues the true cost of the supports CLBC is mandated to supply. Beyond this, CLBC faces a number of key budgetary pressures. CLBC has grown rapidly since its inception and now serves five times the client base it began with in 2005. Several factors have driven this increase beyond just the general increase in population. An aging population, and particularly those who remained at home rather than be institutionalized whose families are no longer able to care due to aging or having passed away and these individuals have entered the system later in life. An increase in lifespan for people with IDD has also added to the aging population in need of support, often of a more complex and costly variety. A second key factor has been the rapid growth in the ASD

population, often with co-occurring IDD. Related to this is the impact of the Fahlman decision in 2007 (Fahlman v. Com. Living (2007), 234 B.C.A.C. 264 (CA); 387 W.A.C. 264) noted above which led to CLBC being required to provide support for those with ASD who did not have co-occurring IDD and those with fetal alcohol syndrome. This population often presents unique and distinct challenges from the population CLBC was designed to serve and in many cases requires a more labour and resource intensive response than the IDD population.

The general increase in CLBC numbers overall likely impacted budget sufficiency as a larger and more complex administrative structure was required though this is likely not a significant factor in the budget pressures faced by CLBC. A more complex regulatory environment has impacted the administrative cost faced by CLBC as has the need to enhance safeguards and monitoring as required by both regulatory changes and various reviews. These factors would not in themselves have created a significant budget crisis for CLBC, but with inflation only increases, they have certainly put financial strain on CLBC.

The larger problem with a basically 'inflation only' increase approach is that the demographic issues noted above - and the introduction of the PSI population - cannot be addressed without additional resources. These populations generally require significantly more supports, and often more costly ones, than the core population CLBC began with. An inflation only increase means essentially that CLBC has been slowly falling further and further behind. They have attempted to address this by cutting administrative cost to channel more resources into direct support, but this has created its own problems with overburdened staff and an inability to provide consistent direct contact with individuals and families. Add to the above the estimated 200 million dollars CLBC invest annually in health, mental health, housing and justice services which are outside their mandate and should be covered by other ministries. Resolving the overall budget situation of CLBC is likely essential to make significant improvements and to avoid further strain on the system.

Home Share Coordinating Agencies

CLBC in the past had a mix of directly contracted Home Shares and agency coordinated Home Shares. They have subsequently shifted to all Home Shares being agency coordinated through contractual arrangements with CLBC. Under the contracts the agencies are responsible for all aspects of recruitment, home study reviews, planning and monitoring. A CLBC analyst monitors and reviews the performance of the agency against the CLBC contract and home sharing policy and standards. The analyst reviews a sampling of files and reviews placements as needed which provides an additional layer of oversight.

Coordinating agencies range from small agencies coordinating a small number of Home Shares to large agencies with multiple coordinators overseeing a large number of Home Shares. The agencies are both for profit and non-profit. The agencies are funded on a pro rata basis for the coordination role at a rate of 1:25 coordinators to Home Shares. Additional funding is provided to cover administration, supervision and overhead. Total funding received amounts to approximately $200,000 per 25 Home Shares. This funding includes coordinator salary, administration, and program costs. Coordinating agencies who are members of the BC CEO Network are well supported to develop collective best practices and access a wide range of training for both coordinators and Home Share providers. The important role and functions of the Home Sharing Support Society of BC and the BC CEO Network are outlined in Attachment 2.

While the 1:25 ratio is standard across the sector, no variation is made to account for the relative workload involved in the Home Shares, though exceptions can be negotiated. If there is a high volume of high needs individuals, this can significantly increase the workload on the coordinator as can a high volume of turnover, home study visits or transitioning individuals. We also heard that many of the coordinators come into the role with insufficient experience or training and that the turnover rate in this role can be very high.

Agencies indicated that they often struggle to cover the full cost of the coordinator role and all the related cost such as supervision, recruitment and training. We were also told there are a multitude of other costs that arise and are not funded (e.g. emergency placement for someone already in a HS, cancellation of a contract with an HSP – means moving the individual immediately but still having to pay the HSP for the balance of the month or months depending on the contract, moving costs and travel costs.

It was also shared with us that given the variation of agencies involved in Home Share coordination, not all of them were equally equipped to deal with individuals with more complex support needs. and the often very complex service delivery model which requires a level sophistication and agency infrastructure/systems that small agencies often do not have. We also heard that in more rural and remote areas, finding suitable agencies to take on the coordinating role can be challenging.

While the use of community agencies is in our view a reasonable way to manage Home Share, we see the need for more differentiation in contracting. Primarily in identifying agencies that have the experience and infrastructure to support Home Share for individuals with more complex support needs and channeling these individuals to the appropriate agencies. This would also require a differentiated funding model with ratios being adapted to reflect the complexity of the work. Further, we note the need for greater clarity in the deliverables for the contract funding beyond simply the coordinator role. This would include supervisory requirements as well as minimum training requirements. Lastly, a standardized planning template across the sector would help to ensure consistent practice.

The contracting in rural and remote areas remains a challenge and will likely require development work on the part of CLBC to address this gap. There may be potential to work with indigenous communities, particularly on reserve to develop their own version of Home Share aligned with their cultural traditions and to take on the Home Share coordination for members. This would align well with CLBC current indigenous focused initiatives.

Home Share Providers

Home Share providers are of course at the heart of the system and critical to the safety, wellbeing and quality of life for the individuals they support. Unlike a staffed residence, the Home Share provider in most cases welcomes the person or persons into their own home and lifestyle. The nature of the relationship between the Home Share provider the individual can vary greatly depending on the wants and needs of the individual and the nature of the home. In some cases the person lives as part of a family fully integrated into the household, while in others they may prefer more of a boarding type arrangement. As one self advocate put it 'I didn't need a new family, I needed a place to live' . This is an important point to understand when planning a Home Share placement, clarity on the nature of the relationships and the 'house rules' is essential to a successful match. Home Shares also vary with regards to the family unit. In some cases, a single individual is the provider whereas others will be couples or families with

children. Each of these factors needs to be accounted for during the planning and home study process particularly with regards to families with children where the impact on the family as a whole must be considered.

It is important to understand that the Home Share providers responsibilities are generally confined to the home and day to day needs and facilitating community connections. They are not responsible for the overall planning and coordination of an individual's support. We heard of providers who frequently go above and beyond this core function, providing transportation, additional supports and introducing individuals to new activities. In early iterations of Home Share, most providers also worked outside the home and the individual would attend work or other day time activities. As the complexity of people in Home Share has increased, we heard of many providers no longer being able to manage full time or any work outside the home due to pressures of supporting the individual. A lack of day supports or being regularly sent home from their day activities due to behavior or other issues creates significant pressures for these providers.

While Home Share provider compensation is outside of the scope of this review, there are some points which speak to the safety and quality of life for individuals. Providers trying to manage additional demands while trying to work to maintain their family's financial viability can potentially create lapses in support due to the number of things a provider is trying to juggle. Further increased demand may engender resentment or a tendency to 'let things go'. To be clear, the vast majority of providers do all they can to meet the individual's needs and many go above and beyond what is required to ensure the safety and quality of life of the individual they support. Additional pressures involved in trying to support individuals with highly complex needs such as addiction issues or mental health concerns without sufficient external supports can create a high risk environment for all involved-the person, the provider and the provider's family residing in the home.

Currently compensation is based on a formulae of GSA score and individual contribution. The underlying assumption is that the GSA, coupled with 'flags' (flag are used to denote exceptional needs related to behaviour or health etc.), takes into account complexity when determining compensation which is true to an extent. However, given the limitations of the GSA tool itself (see above) which does not really take into account factors such as addiction, street entrenchment or significant health factors beyond the 'flags' there is a concern that funding levels may fall short of what is needed to support these more complex situations.

A further concern we heard was the lack of support for provider respite. Respite funding is included in the total funding package based again on GSA and flags. Providers would generally receive $200 per month for respite with additional funding based on flags. While some agencies provide support to find and manage respite workers this is not required or standard across the sector. Without this support, simply finding and providing the administration (payroll, criminal record checks, worksafe, CRA etc.) for respite can add significantly to the provider workload. In many cases we were told that providers just don't bother with respite given the challenges involved and the fact it eats into their total compensation. This potentially creates strain on the provider, the household and the individual if people are not able to decompress and can contribute to tension and potential neglect. A standardized approach to supporting providers to find and manage respite would improve access and uptake to respite.

Lastly, we heard that many providers are not able or willing to undertake training relevant to effective support for the individual due to the time demands and the fact this is not

renumerated beyond their base compensation or incentivized in any way such as paid time to attend training or financial recognition of up graded skills.

The challenges of being a Home Share provider noted above has meant recruitment and retention has become increasingly difficult. Retention particularly is integral to a safe and positive experience for many individuals. Recruitment challenges also may lead to approval of less than ideal providers for a given individual if supply is limited. Further differentiation of providers based on skill set and experience would improve the overall safety and sustainability of the system. This would mean greater recognition of complexity of the role for a given individual and that this should be reflected in both the compensation and in ensuring training was appropriate for the role, that respite planning and support were clearly identified and supported and, systems of monitoring and oversight were appropriate to the complexity of the role for a given individual.

A well supported, reasonably compensated and appropriately skilled network of providers is one of the most important elements of a safe and positive Home Share experience. Better aligning individual's needs with the specifics of the provider will go a long way to ensuring safety and quality of life. It should also be recognized that there are some individuals who are not appropriate for Home Share and care needs to be taken that providers are not asked to take on individual s that are beyond their reasonable capacity.

Section 4: A Key Directions approach

The approach taken has been to have a primary focus on Standards and Monitoring but also to identify the four other key system factors that significantly contribute to risk and the need for improvement in Home Share. These Key Directions are:

- Standards, Safety and Quality of Life, Monitoring and Oversight (primary focus of Review)
- Individual Planning, Coordination and Review
- Key Roles, Qualifications, Training and Supervision
- Community Living Options
- Broader Structural Issues.

MSDPR advised that while Home Share provider compensation is outside of the Review scope (e.g. how much should a Home Share provider be paid), funding decisions impacting safety, quality of life, or oversight can be considered in scope (e.g. does Home Share provider compensation support a safe environment with strong quality of life outcomes).

The Key Directions workshop process involved the progressive development and refinement of key content for each Key Direction

- Why this is a key direction (what we have heard and learnt?)
- What work is already underway?
- What is the gap?
- Options, refinement and ratings for recommendations.

Key Direction 1: Standards and Monitoring

Why this is a key direction

Safeguards only work if they are consistent, visible, and enforced:

- Safeguards and monitoring are the foundation of safe, high-quality home share. Weak or inconsistent oversight has been linked to serious risks, including those identified in the Coroner's Inquest.
- Families and people with disabilities want consistent, visible oversight that ensures hosts are vetted, homes are safe, and problems are caught early.
- International evidence shows strong systems share three features: structured vetting/home studies, scheduled in-home visits tied to plans, and short-clock incident reporting/learning cycles.
- In BC, while CLBC has standards, the *visibility* and *consistency* of monitoring varies, creating vulnerability.
- CLBC has a Safeguarding policy document and multi-level safeguards model, but recent emphasis has been on formal standards rather than on informal safeguards based on a caring connection.
- While the ratio for Home Share Coordinators is 1:25 in terms of Home Share providers and people living in Home Share, the ratios do not vary or account for complexity.
- In terms of CLBC staff positions at each level of the organization, apart from the Provincial Coordinator of Home Share, there are no specific positions such as

Facilitators or Analysts that are specialised Home Share only i.e. staff do a range of functions across other programs as well.

- Independent accreditation of Home Share is not a strong feature as monitoring is done by Home Share Coordinating agencies and CLBC Analysts. While organizations with greater than $500,000 in combined funding from CLBC and/or Ministry of Children and families use external accreditation systems for their organization, agencies with under $500,000 in combined funding are not required by CLBC to have external accreditation.
- Home Share sector representatives expressed concern about some types of arrangements being at the edge of Canada Revenue Agency (CRA) policy and other legal requirements, creating risk and vulnerability and in some cases a hesitation or refusal to provide services.

Work completed or underway

CLBC has built standards, but implementation remains uneven:

- CLBC has Standards for Home Sharing and Standards for the Coordination of Home Sharing (updated 2025), setting expectations for vetting, monitoring, and Quality of Life checks.
- CLBC's Critical Incidents Policy defines categories and reporting pathways.
- Coordination Standards require in-home visits tied to "Quality of Life Support Strategies."
- Following Auditor General and Coroner recommendations, CLBC clarified roles, monitoring expectations, and policy updates in 2025. The Timeline in Attachment 2 provides significant detail of work underway.
- As of June 2025, CLBC has created a specialist Home Share team within the Quality Assurance head office section.

The gap

Policies are there - but without regulation, transparency, or consistent enforcement.

From the jurisdictional scan:

- CLBC Standards are embedded in contracts/policies, not regulation, leading to uneven enforcement across regions.
- Visit frequency, monitoring tools, and performance data are not consistently made public, leading to weaker transparency/accountability.
- Incident management is less prescriptive (for example, no fixed 24 hour/5-day clocks, no independent investigator standards, unlike some other jurisdictions like I Ontario and Australia)).
- No mandated cadence for clinical reviews (in contrast, quarterly Registered Nurse checks in New York).
- CLBC has no province-wide, validated and disaggregatable to individuals Quality of Life outcome tool (contrast: UK *My Shared Life*, US HCBS Quality Measure Set).
- Cultural safety is not defined as an auditable standard; training expectations remain uneven.
- Tenancy-style protections are encouraged but not binding or inspected (contrast: US HCBS Settings Rule, UK Shared Lives inspections).

From the broader review work:

- A new differential model of monitoring has widespread support.
- The ratios of 1:177 for CLBC Facilitators impacts on the level of individual planning capacity, alongside the ratios of 1:25 and workload of Home Share Coordinators.
- CLBC had a system of outcome reporting using the "Include me" scale developed specifically for BC with Prof. Robert Schalock. This was discontinued, in 2023 and there is no external public reporting on outcomes and quality of life in Home Share.
- Investigations are undertaken at various levels by Home Share Coordinators and Agencies as well as CLBC staff, however there is no comprehensive public reporting of this.

Recommendations

A. Establish CLBC senior Home Share leadership position/specialist capacity (underway) and:
   - increase public and sector communication and reporting (underway but stronger public role)
   - explore opportunities to share monitoring tools and findings more transparently, e.g. publish checklists and annual safeguarding reports.

B. Develop a differentiated response model of Home Share monitoring, accounting for complexity and risk.

C. Establish the number of people a Home Share Coordinator has based on complexity (note interdependency with planning role)

D. Review and update CLBC document "Responding to Vulnerability" to reinvigorate community, personal and informal safeguards as complementary to formal safeguards. An associated action plan would focus on tools, resources and enhanced planning/coordination capacity.

E. Require and report on regular health checks for high-risk cases through appropriate provider e.g. HSCL or GP, as defined in the health plan.

F. Mandate and resource the selection/development of a province-wide Quality of Life measurement tool and public outcome reporting (e.g. Include Me)

G. Clearly delineate the core features of Home Share and identify those that do not fit core definition for alternative designation (particularly those that are pushing the boundaries of CRA legislation and present legal risks).

H. Establish an auditable Cultural Safety standard for Home Share.

I. Improve process and reporting on investigations (timeline, required outputs, reporting).

J. Review all current Home Share coordinating agencies to:

- ascertain status of independent accreditations (especially for those under $500,000 funding) and develop options for best form of independent accreditation; and
- review how current external accreditation information is used to support Home Share monitoring and improvement.

Key Direction 2: Individual planning, coordination and review

Why this is a key direction

In addition to the concerns reported in the previous section on systemic issues:

- A new differential model of monitoring has widespread support
- "Seven core factors and practices that contributed to making a "good match." These involved understanding the motivation and reasons for being a home share provider, seeking providers who have an existing "skill set," building on or creating a strong connection, engaging in proactive planning, ensuring appropriate emotional and instrumental supports are in place to sustain the home share, understanding the relational dynamics, and balancing independence and support." (Hole R., Robinson, C., Stainton, T. Lige, S., Crawford C. (2015) Home sharing and people with intellectual disabilities: A Qualitative Exploration. Journal of Policy and Practice in Intellectual Disabilities. Volume 12 Number 4 pp 279–287 (doi: 10.1111/jppi.12138).)
- Importantly, planning and coordination settings to must focus on the process and not simply the written initial plan. This requires an ongoing capacity to engage as required.
- Access to community supports (health, education etc.), informal supports, and other community activities does not happen by default just because someone is living in home share. These require proactive action to build and maintain. These kinds of links are essential to establishing informal and community safeguards around people as well as having a good quality of life.
- Where home sharing is currently working well, a consistent feature is that people have strong links to informal and broader support systems.
- Individualized planning processes are the main opportunity to engage in creative solution finding that helps to drive creation of innovative options/solutions. Effective individualized planning can reduce the risk of a 'bad match' which contributes to home share breakdown and crisis.
- Currently individualized planning is not happening consistently for people in BC. Individual planning has been weakened over the years as a facilitator of strong individual choice and is split between CLBC Facilitators with their very large caseloads and the Home Share Coordinators who have responsibilities for both the Home Share providers as well as the individuals living in Home Share.
- Planning for changing needs and use of the GSA is of significant concern, especially given the broader population of people with disabilities supported by CLBC.

Work completed or underway

- CLBC's "Addressing Personal Vulnerability Through Planning" provides guidance on how to build a range of intentional safeguards into person-centred planning.; however, the activation of family/network and informal community supports need further attention and capacity.
- *Standards for the Coordination of Home Sharing Policy* applies to agencies coordinating the delivery of Home Sharing services and to CLBC staff.
- *Standards for the Coordination of Home Sharing* Standard 30:
  "To further quality of life outcomes, the Coordinating Agency ensures that individuals are supported through a personalized planning process which incorporates:
    - The individual's personal goals (what is important to the person)

    - The individual support needs (what is important for the person)
    - How the design of the service meets identified needs and wants of individuals
    - How the services will be delivered
    - How the outcomes will be evaluated
    - Planning for changing support needs"
- *Standards for Home Sharing Policy* applies to Home Sharing Providers delivering Home Sharing services, agencies coordinating and monitoring the delivery of Home Sharing services and CLBC staff.
- *Standards for Home Sharing* Standard 2: The individual is supported through a personalized planning process to identify goals, support needs, and support strategies that direct service delivery and further quality of life outcomes.
- In response to the Coroner's Inquest, CLBC stated: "CLBC is in the process of updating both the Standards for the Coordination for Home Sharing and Standards for Home Sharing to include clearer definitions for health-care planning and home sharing coordination."
- Training on individual planning is available via Open Future Learning.

The gap

- It's unclear when key evidence-based elements of planning and coordination are occurring in the current system and who is responsible for helping the individual champion their plan.
- Unclear what planning or personal statements are developed by CLBC Facilitators and what information is being shared to Agencies.
- Home Share Coordinators are responsible for personalised planning and coordination of the plan, but do not have enough time to deliver this consistently in the current context.
- The *BC CEO Home Share Coordinator Handbook Template* provides some useful practical guidance on individual planning practices, but this is combined with intake, assessment, and information gathering activities.
- Home Share Providers are responsible for coordinating access to community and building networks, but this expectation is not always clear and/or Providers may not have skills/confidence and time to deliver.
- The broader support system (crisis, health, mental health) is less available.
- It is not clear if the preferences and goals of people with disability are at the centre of plans, how inputs to plans from others (e.g.: family, carers) are balanced with individuals, and if Supported Decision Making is integrated consistently.
- Planning for change is increasingly happening in times of crisis, not in a proactive way.
- The GSA requires review and updating along with a more proactive system for planning for changed needs.

Recommendations

K. Explore options for improved delivery of person-centred planning for both current and new CLBC clientele with particular consideration of timely planning for those transitioning from school and the aging population.

L. Clarify CLBC and agency roles and responsibilities for planning and coordination in relation to complexity/risk, holistic planning versus planning within Home Share, and review processes.

M. Improve the transparency and communication with regards to GSA and reviews with increased person and family involvement in the process.

N. Undertake a thorough review of the GSA with regards to:
- reliability, transparency and scope.
- Consideration of additional tools as required and possible replacement of GSA with alternative tools.
- Improved communication with regards to GSA and reviews with increased person and family involvement in the process.

O. Strengthen the CLBC facilitator role to provide greater capacity to spend time with people for planning, including initial planning, regular check- ins and changed circumstances. Increase focus on developing and supporting personal networks and community connections.

P. For complex circumstances and high-risk factors, consider a stronger service and support coordination capacity.

Q. Examine options for improved quality and sustainability of Home Share coordination in rural and remote areas where there are low volumes. This should include examining how Microboards and/or person-cantered societies can be used as a foundational strategy for supporting Home Share and building family, network and community connections.

R. Establish a standardized core planning template as a required deliverable for all Home Shares. Plan should include:
- Health and Wellbeing plan (including required linkages to GP, HSCL, DDMH as required)
- Monitoring Plan
- Personal network analysis, involvement and development: who they have in their lives now, setting out how the family is going to engage, and what their rights are and aren't.
- Agreement on terms for home share (individual and provider agreement) including roles and responsibilities, household rules etc.
- Financial plan (agreed contributions material)
- Community engagement plan
- Respite plan
- Transition Plan
- Training required by Home Share provider based on individual's needs and provider experience and training
- Cultural safety and recognition

Key Direction 3: Key roles, qualifications, training and supervision

Why this is a key direction

- The Home Share approach is fundamentally based on and reliant on human relationships. The ability to broker connections between people relies on human skills and networks.
- The Home Share Coordinator role has become the lynchpin of the home share system: responsible for quality of activities from Matching through to Monitoring, and for acting as a safeguard for ongoing home share arrangements. This is a highly skilled role requiring experience in social services.
- A consistent view throughout consultations was that high turnover rates in all key Home Share system roles create heightened vulnerability and risk and that for Home Share Coordinators the combination of complexity and holding risk is a major determinant. For CLBC staff, turnover plus the generalist nature of field roles means that precious Home Share knowledge and experience is at increased risk of being lost, thereby diluting quality and increasing risk of inappropriate placements.
- Home Share success factors related to the Provider role include: intrinsic motivation, existing skills in disability support, and their relationship with the person. Factors that contribute to turnover include cost increases, complexity and erosion of allied and community supports and services.
- Other key roles include:
    - CLBC Facilitator and Analyst
    - Natural supports (family, friends, community members)
    - Someone who can support people with disability in self advocacy and capacity building.
- People do not consistently have access to appropriately skilled/resourced people in these key roles.
- The role of self-advocates and lived experience in training staff needs strengthening.
- There is no central registry of Home Share providers so they can move about to avoid accountabilities.

Work complete or underway

- A cluster of recommendations related to the Coordinator role in recent external reports (Coroner's Inquest and BC CEO Network):
    - Increase compensation
    - Reduce caseload/ratio
    - Fund supervision
- A cluster of recommendations related to the Provider role in recent external reports (Coroner's Inquest and BC CEO Network):
    - Increase compensation
    - Increase training requirements
- In response to the Coroner's Inquest, CLBC stated:
    - Rate for home sharing coordinators increased by over 10% in April 2025
    - CLBC will collaborate with the BC CEO Network and sector on compensation, caseloads, and training needs.
    - A commitment to transparent information on rights, responsibilities and complaints processes.

- Training and information resources are available through CLBC, JIBC, BC CEO Network, Open Futures, and Home Sharing Support Society BC.

The gap

- Time and resources to consistently translate the activities outlined in the Standards into reality for each individual, with consideration for the complexity of each individual's personal circumstance and the supports actually available in their context.
- The people accessing Home Share have increasingly complex personal circumstances and needs.
- A safeguarding actor primarily focused on ensuring the person with disability understands and can exercise their rights (i.e. with no competing responsibilities in the system).
- Information about and access to complaints process is reliant on actors who have other roles in the system (funder, intermediary, provider).
- Sustaining or building informal supports are not built into the system in a regular or reliable way.
- Home Share Coordinator skills/training: not clearly defined as minimum qualifications and cannot be required in CLBC contracts.
- Provider skills/training: Standards delegate oversight and definition of disability support related training requirements for Providers to Agencies. 'Core training' is referred to in *Standards for Coordination of Home Sharing* but not defined.
- Unclear if the responsibilities allocated to each role in the system are aligned in a way to support best practice.

Recommendations

S. Continue work to ensure Home Share Provider compensation enables sufficient supply to enable continuity, quality and safety of Home Shares.

T. Establish improved data collection and external reporting (turnover as a quality indicator) for:
   - Turnover rates in Home Share by Region, Coordinating agency, HS provider, CLBC key staff (Facilitators, Analysts)
   - Track individual turnover rates (i.e. how many Home Share has an individual been in and for how long)
   - Establish provincial registry of Home Share providers with service history (to prevent coordinating agency hopping and use of Home Share who have had poor results).

U. Increased role for self-advocate leaders and organisations to provide support and information for people in Home Share and in delivery of training. This to also include their role in the Include Me quality of life surveys under Key Direction 1.

V. Training

- Review current baseline and establish additional training requirements for Home Share coordinators based on existing training options and include more role specific content on monitoring and investigations
- Establish baseline and specialized (as determined in plan) training requirements for Home Share providers
- Compensate/incentivize Home Share providers to attend training

W. CLBC to engage Home Share Coordinating agencies in further analysis and clearer specification of how the current overall construct for Home Share Coordination does or needs to include funding for supervision for Home Share Coordinators.

Key Direction 4: Community Living Options

Why this is a key direction

Home Share has frequently become the default option for those seeking home and residential supports and services rather than one option among many:

- Home Share is consistently reported as having become the default option in BC due to housing shortages and limited alternatives.
- People enter Home Share who may not be well-matched:
    - It was reported to us that there are significant numbers of individuals who could live independently with supports; however the unaffordability of housing in BC, combined with the lack of access to rental units with deep subsidy (i.e. tied to the prevailing PWD shelter rate) has resulted in individuals accessing Home Share as the only viable alternative.
    - individuals with very high support needs.
- The lack of options contributes to mismatches, breakdowns, and crises.
- Families and people with disabilities call for a broader menu of housing and support models to reflect diverse needs and preferences.
- See earlier section on Allied Services – Housing and the impacts of very limited housing affordability and availability

Work complete or underway

Innovation exists, but it is piecemeal:

- CLBC is piloting a hybrid Home Share model combining Home Share with agency support.
- CLBC has a housing working group that has been looking at housing issues.
- Regional innovation (e.g., supported independent living, intentional communities, cluster living) exists but is patchy.
- CLBC has updated standards with more focus on planning and matching to reduce "bad fits."
- Broader system reforms (housing, health, mental health) are underway but fragmented.

The gap

Over-reliance on Home Share masks the lack of real choice:

- Over-reliance on Home Share due to lack of other clear housing pathways.
- Limited innovation and slow development of supported housing options through CLBC.
- Rising housing costs are making it harder to recruit/retain hosts. This in turn is resulting in fewer flexible options.
- There were sector reports of some transitions being poorly supported: youth aging out of care, older adults with changing needs. (also see earlier section on GSA and review processes)
- Pressure on Home Share to take people outside the original model assumptions leading to a higher breakdown risk.
- There is a lack of systematic planning for a full continuum of housing choices.

Recommendations

X. CLBC work with Ministry of Housing, BC Housing and partner agencies to develop a new community living and housing strategy for CLBC that provides a dedicated strategy to build a real continuum of housing and support choices. The strategy to include enhanced individual planning, new funding and training strategies to support the development and delivery of a sufficient range of residential supports and reduce over reliance of Home Share. The strategy should also build on existing contemporary models where possible to ensure timely implementation. Specific elements of the strategy to include:
   - Expand/develop residential support options to decrease pressure on Home Share
   - Identify need for specialized residential supports for individuals with complex support needs
   - Consider development of specialized Home Share with enhanced training and skills as required and increased compensation, including exploring employee-based models for complex situations
   - Work with Ministry of Housing, BC Housing and partner agencies to establish minimum numbers of housing units dedicated to CLBC eligible individuals sufficient to meet the increasing demand.
   - Identify persons in Home Share who are willing and able to move to more independent alternatives and support enhanced planning, funding (including expanded use of Individualized funding), housing affordability and implementation of move
   - Identify persons whose needs are more complex than can be safely met in Home Share and work with them to plan and implement more suitable alternatives. This would also involve working with key system partners (housing, health, mental health and substance use) to develop an improved response for the 5% of most complex individual situations where Home Share is not a good fit. Identify those situations that are not suited to the Home Share model at entry point/first referral.

Y. Improve Home Share opportunities in Indigenous Communities
   - Explore viability of expanded Home Share use with Indigenous people and particularly on reserve and policy alternatives as required
   - Improve general communication with Indigenous peoples particularly on reserve regarding support options

Z. Explore regional crisis management planning with potentially pre-established emergency residential options, including a more proactive approach to individual planning and maximising use of existing infrastructure including family network, community and existing Home Share sector resources.

Key Direction 5: Broad Structural Issues

Why this is a key direction

- Pressure on CLBC and the overall disability services system that has been building for many years is leading to increased risk of vulnerabilities in Home Share and must be addressed at cross ministry whole of government level.
- In the earlier section on Allied Services Health and Mental Health, it was identified that services for people with developmental disabilities has weakened while demand and need have increased.
- Budgetary pressures on CLBC as outlined above.
- Home share has strong inter-dependencies with other social supports. Factors outside the remit of CLBC can impact significantly on the effectiveness of quality and safeguard strategies, with risk of disproportionate impacts on new home shares or people without existing support networks.
- Information sharing across the system is a key friction point, in particular for:
    - Referrals from CLBC to Agencies (quality and accuracy of information)
    - Information to assess Agency/Provider quality
    - Transparency on progress and outcomes of complaints processes
    - Proactive planning for transition for Children in Care (19+) and ageing individuals (55+).

Work completed or underway

- Response to the Coroner's Inquest noted: "CLBC is currently implementing a new information management system designed to improve access to information, reporting, and service coordination. CLBC will explore the feasibility of expanding and standardizing these systems in collaboration with sector partners."
- CLBC piloting a 'hybrid home share' model.
- Both CLBC and the Ministry are working jointly with health regarding responses to the Coroner's Report.

The gap

- Reduced availability of other supports is contributing to increasing pressure on key roles to pick up this support (coordinator and provider in particular), e.g.:
    - Crisis planning and management
    - Health and mental health services
    - Community inclusion/participation support
- High rents, lack of general housing, and limited other accommodation options are driving pressure on home share. People outside the original model assumptions (e.g. those who could live independently and people with higher support needs) are being referred into home share.
- A self-reinforcing crisis cycle is being created by: inconsistent proactive planning; deficit of accommodation options; mismatches in home share pairs; inconsistent health and mental health system support, lack of appropriate monitoring.
- Reports of low trust across all Home Share system actors.
- Service request list has over 800 people waiting for/looking for home share.
- Rapid growth of home share with a different population, with limited alternative options.

Recommendations

AA. Clarify role of CLBC regarding disability related allied health supports and responsibilities and those that belong in health/mental health systems (see Nova Scotia example of Regional Allied Health teams).

BB. Build on current CLBC joint work with the health system on Coroner's findings:

- Engage Ministry of Health in dialogue to improve health and mental health services for people with IDD and CLBC clientele.
- Re-establish the Health Consultant and Nurse consultant for Community Living; consider best approach to leadership position to enable stronger mental health collaboration.
- Explore restructuring HSCL and DDMHS under PHSA under Consultant with dedicated budget and consistent services across the province
- Extend DDMHS services to CLBC clientele under the PSI programme.

CC. MSDPR to conduct a detailed review of CLBC budgetary requirements and work with Treasury Board to increase CLBC funding to a level sufficient to deliver quality services in a safe and timely manner, recognizing changes and increases to the disability population over time as well as the legacy waitlists at the time of establishing CLBC.

Section 5: Classifying recommendations and conclusion

While the specific recommendations have been developed and grouped into each Key Direction area, the review process has also established priority, timelines and responsibility for the overall integrated package by Key Direction, priority and responsibility.

The following tables and graphics provide a comprehensive view of each Key Direction, overall priority level and responsibility.

Overview table

Note on Timeline: As a general guide we consider the following to represent the timeline markers: SHORT 1-18 months; MEDIUM 12-30 months; LONG 18-36 months

KD & No.	RECOMMENDATION	PRIORITY	TIMELINE	RESPONSIBLE PARTIES
KD1	***STANDARDS AND MONITORING***			
A	Establish CLBC senior Home Share leadership position/specialist capacity (underway) and: • increase public and sector communication and reporting (underway but stronger public role): • explore opportunities to share monitoring tools and findings more transparently, e.g., publish checklists and annual safeguarding reports.	HIGH	SHORT	CLBC
B	Develop a differentiated response model of Home Share monitoring, accounting for complexity and risk.	HIGH	SHORT	CLBC
C	Establish the number of people a Home Share Coordinator has based on complexity (note interdependency with planning role)	HIGH	SHORT	CLBC
D	Review and update CLBC document "Responding to Vulnerability" to reinvigorate community, personal and informal safeguards as complementary to formal safeguards. An associated action plan would focus on tools, resources and enhanced planning/coordination capacity.	MEDIUM	MEDIUM	CLBC
E	Require and report on regular health checks for high-risk cases through appropriate provider e.g. HSCL or GP, as defined in the health plan.	HIGH	SHORT	CLBC, M of HEALTH, REGIONAL HAs

KD & No.	RECOMMENDATION	PRIORITY	TIMELINE	RESPONSIBLE PARTIES
F	Mandate and resource the selection/development of a province-wide Quality of Life measurement tool and public outcome reporting (e.g. Include Me)	MEDIUM	LONG	CLBC
G	Clearly delineate the core features of Home Share and identify those that do not fit core definition for alternative designation (particularly those that are pushing the boundaries of CRA legislation and present legal risks).	HIGH	SHORT	CLBC
H	Establish an auditable Cultural Safety standard for Home Share	HIGH	MEDIUM	CLBC WITH INDIGENOUS PARTNERS
I	Improve process and reporting on investigations (timeline, required outputs, reporting).	MEDIUM	MEDIUM	CLBC
J	Review all current Home Share coordinating agencies to: • ascertain status of independent accreditations (especially for those under $500,000 funding) and develop options for best form of independent accreditation; and. • review how current external accreditation information is used to support Home Share monitoring and improvement.	MEDIUM	MEDIUM	CLBC
KD2	***INDIVIDUAL PLANNING, COORDINATION, AND REVIEW***			
K	Explore options for improved delivery of person-centred planning for both current and new CLBC clientele with particular consideration of timely planning for those transitioning from school and the aging population.	HIGH	MEDIUM	CLBC
L	Clarify CLBC and agency roles and responsibilities for planning and coordination in relation to complexity/risk, holistic planning versus planning within Home Share, and review processes.	MEDIUM	MEDIUM	CLBC
M	Improve the transparency and communication with regards to the Guide to Support Allocation (GS)A and reviews with increased person and family involvement in the process.	MEDIUM	MEDIUM	CLBC
N	Undertake a thorough review of the GSA with regards to: • reliability, transparency and scope. • Consideration of additional tools as required and possible replacement of GSA with alternative tools.	HIGH	LONG	CLBC

KD & No.	RECOMMENDATION	PRIORITY	TIMELINE	RESPONSIBLE PARTIES
	• Improved communication with regards to GSA and reviews with increased person and family involvement in the process			
O	Strengthen the CLBC facilitator role to provide greater capacity to spend time with people for planning, including initial planning, regular check- ins and changed circumstances. Increase focus on developing and supporting personal networks and community connections.	MEDIUM	MEDIUM	CLBC
P	For complex circumstances and high-risk factors, consider a stronger service and support coordination capacity.	HIGH	SHORT	CLBC
Q	Examine options for improved quality and sustainability of Home Share coordination in rural and remote areas where there are low volumes. This should include examining how Microboards and/or person-cantered societies can be used as a foundational strategy for supporting Home Share and building family, network and community connections.	MEDIUM	MEDIUM	CLBC
R	Establish a standardized core planning template as a required deliverable for all Home Shares. Plan should include: • Health and Wellbeing plan (including required linkages to GP, HSCL, DDMH as required) • Monitoring Plan • Personal network analysis, involvement and development: who they have in their lives now, setting out how the family is going to engage, and what their rights are and aren't. • Agreement on terms for home share (individual and provider agreement) including roles and responsibilities, household rules etc. • Financial plan (agreed contributions material) • Community engagement plan • Respite plan • Transition Plan	HIGH	SHORT	CLBC

KD & No.	RECOMMENDATION	PRIORITY	TIMELINE	RESPONSIBLE PARTIES
	• Training required by Home Share provider based on individual's needs and provider experience and training • Cultural safety and recognition			
KD3	***KEY ROLES, QUALIFICATIONS, TRAINING & SUPERVISION***			
S	Continue work to ensure Home Share Provider compensation enables sufficient supply to enable continuity, quality and safety of Home Shares.	HIGH	SHORT	PROVINCE, CLBC
T	Establish improved data collection and external reporting (turnover as a quality indicator) for: • Turnover rates in Home Share by Region, Coordinating agency, Home Share provider, CLBC key staff (Facilitators, Analysts) • Track individual turnover rates (i.e. how many Home Shares has an individual been in and for how long) • Establish provincial registry of Home Share providers with service history (to prevent coordinating agency hopping and use of Home Share Providers who have had poor results).	HIGH	SHORT	CLBC
U	Increased role for self-advocate leaders and organisations to provide support and information for people in Home Share and in delivery of training. This to also include their role in the Include Me quality of life surveys under Key Direction 1.	MEDIUM	MEDIUM	CLBC
V	Training • Review current baseline and establish additional training requirements for Home Share coordinators based on existing training options and include more role specific content on monitoring and investigations • Establish baseline and specialized (as determined in plan) training requirements for Home Share providers • Compensate/incentivize Home Share providers to attend training	MEDIUM	MEDIUM	CLBC
W	CLBC to engage Home Share Coordinating agencies in further analysis and clearer specification of how the current overall construct for Home Share Coordination does or needs to include funding for supervision for Home Share Coordinators.	MEDIUM	MEDIUM	CLBC
KD4	***COMMUNITY LIVING OPTIONS***			

KD & No.	RECOMMENDATION	PRIORITY	TIMELINE	RESPONSIBLE PARTIES
X	CLBC Work with Ministry of Housing, BC Housing and partner agencies to develop a new community living and housing strategy for CLBC that provides a dedicated strategy to build a real continuum of housing and support choices. The strategy to include enhanced individual planning, new funding and training strategies to support the development and delivery of a sufficient range of residential supports and reduce over reliance of Home Share. The strategy should also build on existing contemporary models where possible to ensure timely implementation. Specific elements of the strategy to include: • Expand/develop residential support and services options to decrease pressure on Home Share • Identify need for specialized residential supports and services for individuals with complex support needs • Consider development of specialized Home Share with enhanced training and skills as required and increased compensation, including exploring employee-based models for complex situations • Work with Ministry of Housing, BC Housing and partner agencies to establish minimum numbers of housing units dedicated to CLBC eligible individuals sufficient to meet the increasing demand • Identify persons in Home Share who are willing and able to move to more independent alternatives and support enhanced planning, funding (including expanded use of Individualized funding), housing affordability and implementation of move • Identify persons whose needs are more complex than can be safely met in Home Share and work with them to plan and implement more suitable alternatives. This would also involve working with key system partners (housing, health, mental health and substance use) to develop an improved response for the 5% of most complex individual situations where Home Share is not a good fit. Identify those situations that are not suited to the Home Share model at entry point/first referral.	HIGH	MEDIUM	CLBC, M of HOUSING

KD & No.	RECOMMENDATION	PRIORITY	TIMELINE	RESPONSIBLE PARTIES
Y	Improve Home Share opportunities in Indigenous Communities • Explore viability of expanded Home Share use with Indigenous people and particularly on reserve and policy alternatives as required • Improve general communication with Indigenous peoples particularly on reserve regarding support options	MEDIUM	MEDIUM	CLBC AND INDIGENOUS PARTNERS
Z	Explore regional crisis management planning with potentially pre-established emergency residential options, including a more proactive approach to individual planning and maximising use of existing infrastructure including family network, community and existing Home Share sector resources.	MEDIUM	MEDIUM	CLBC
KD5	*BROADER STRUCTURAL ISSUES*			
AA	Clarify role of CLBC regarding disability related allied health supports and responsibilities and those that belong in health/mental health systems (see Nova Scotia example of Regional Allied Health teams).	URGENT	SHORT	MINISTRY of HEALTH, CLBC
BB	Build on current CLBC joint work with the health system on Coroner's findings: • Engage Ministry of Health in dialogue to improve health and mental health services for people with IDD and CLBC clientele. • Re-establish the Health Consultant and Nurse consultant for Community Living; consider best approach to leadership position to enable stronger mental health collaboration. • Explore restructuring HSCL and DDMHS under PHSA under Consultant with dedicated budget and consistent services across the province • Extend DDMHS services to CLBC clientele under the PSI programme	HIGH	MEDIUM	MINISTRY of HEALTH, CLBC
CC	MSDPR to conduct a detailed review of CLBC budgetary requirements and work with Treasury Board to increase CLBC funding to a level sufficient to deliver quality services in a safe and timely manner, recognizing changes and increases to the disability population over time as well as the legacy waitlists at the time of establishing CLBC.	URGENT	MEDIUM	MSDPR, TREASURY BOARD, CLBC

Recommendations by timeline for implementation

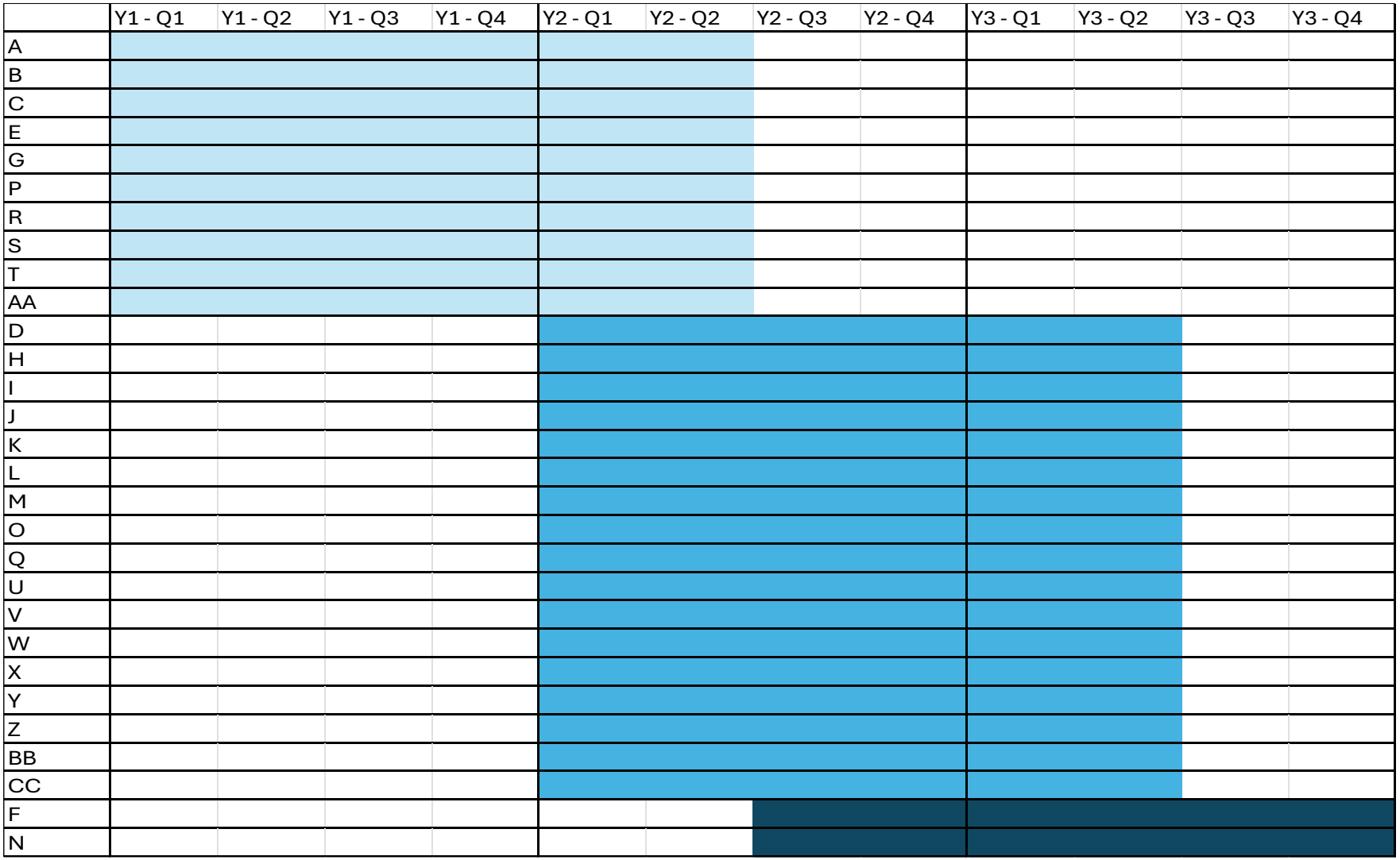

Figure 1: Gantt chart representing recommendation implementation windows

Alignment of recommendations to Key Directions

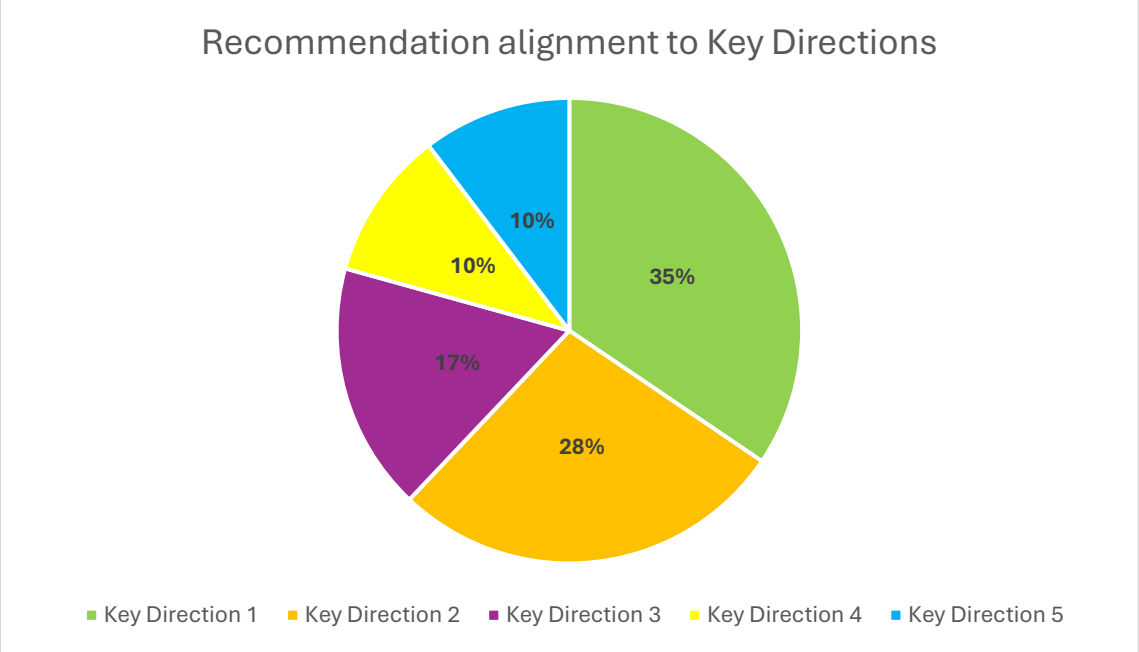

Figure 2: Pie chart of number of recommendations by Key Direction

Alignment of recommendations to priority level

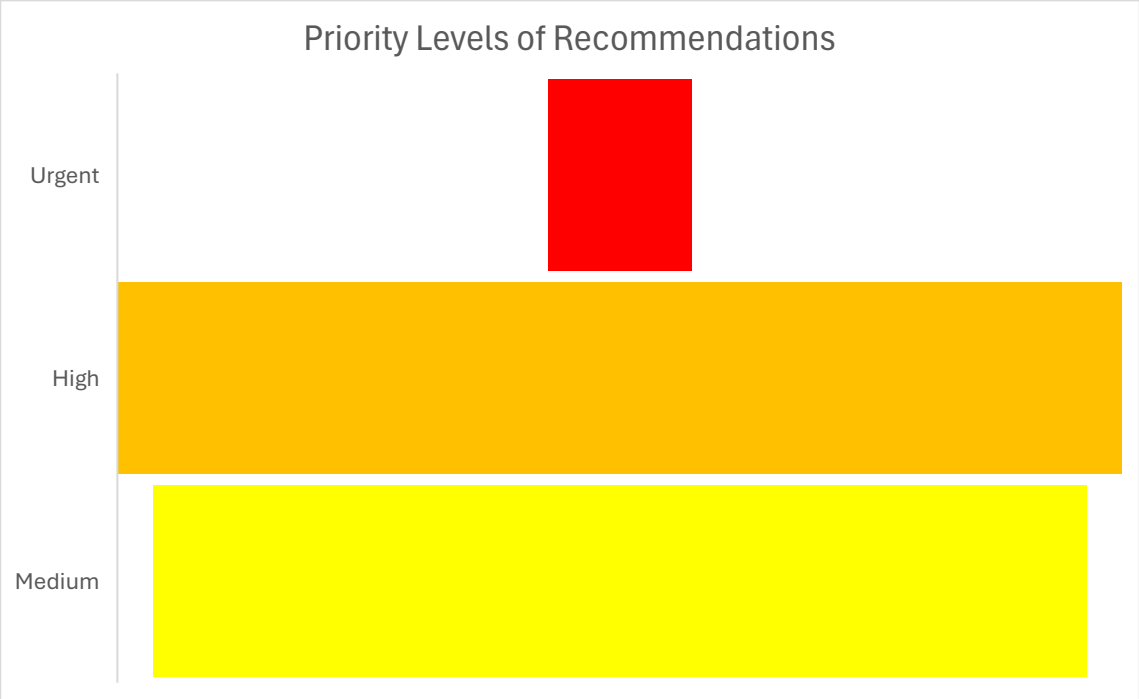

Figure 3: Funnel chart showing number of recommendations by priority level

Recommendations by responsibility

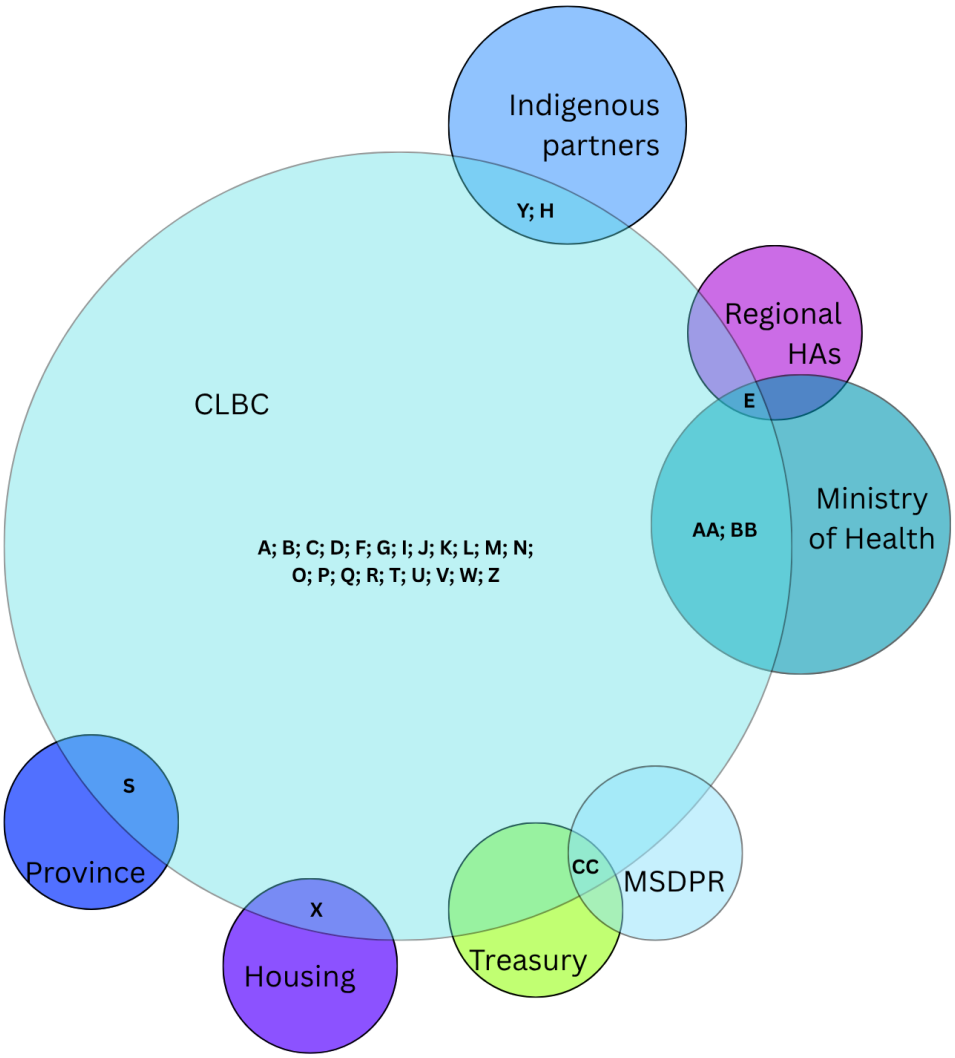

Figure 4: Bubble diagram showing overlapping responsibilities for recommendations

Conclusion

Rankings of recommendations by the Advisory Committee and CLBC can be found in Attachment 3 and indicate that while there was a strong sense of consistency in overall ratings, each group also had some distinctive priorities overall.

In conclusion, the review report is mindful of the large number of recommendations (29) that will need consideration and alignment to the work already underway in response to both the Coroner's Inquest and Auditor General Reports. We have taken a broad whole systems view of the challenges facing Home Share in British Columbia and have allocated priorities and timelines that we believe can enable the urgent improvements that are so critically needed, to be planned, resourced and implemented in a timely and coordinated way.

Given the context in British Columbia, feedback from the sector and the urgent priorities for improvement, we have not recommended any wholesale change of direction regarding oversight and monitoring of Home Share. While the use of community agencies is in our view a generally reasonable way to manage Home Share, we see the need for more differentiation in contracting and monitoring, greater clarity regarding the essential features of Home Share and the population best suited, stronger leadership and public reporting and increased focus on individual planning and the important role of family, networks and informal safeguards

We believe that the whole sector in BC has been working extremely hard to deliver the best Home Share program possible and that substantial improvements have and continue to be made. Further improvements are urgently needed to ensure safety and quality of life, however, this requires that broader systemic issues are tackled and resolved, as these increasingly create growing vulnerabilities and risk.

Attachments

1: Home Share Review Advisory Committee Terms of Reference

Terms of Reference

The Home Share Review is being undertaken by Tamar Consultancy, a contractor hired by the Ministry of Social Development and Poverty Reduction. An Advisory Committee will be appointed to support the contractor and their independent review team.

Purpose:

The Advisory Committee will provide input directly to the contractor, as it pertains to the scope of the Home Share Review (see Appendix), by those who regularly interact with the home sharing system to support a thorough review.

Approach:

The Home Share Advisory Committee will meet as required by the contractor to provide feedback and input. The Committee will be convened at the beginning of the review and will be concluded once the contractor has submitted their report. The Committee will meet virtually, and participation may extend outside of business hours. The frequency and duration of meetings will be negotiated with the Advisory Committee at the first meeting.

The timeframe for the Committee will be from June to October 2025, with meetings once per month for 2-3 hours at a time. Final scheduling will be confirmed by the contractor with the Advisory Committee.

The contractor will be responsible for reaching out to the Advisory Committee and will not be seeking input exclusively from the Advisory Committee. The contractor and review team will consult with the Advisory Committee and workshop key directions; however, the final report will be at the sole discretion of the contractor.

Confidentiality:

Members of the Advisory Committee will be expected to maintain confidentiality regarding discussions occurring at Advisory Committee meetings to support safe, honest, and candid conversations.

Recognition:

In recognition of the participation required to support the work of the Advisory Committee, self-advocates, family members, and home share providers on the Committee will be eligible for an honorarium payable through the Ministry of Social Development and Poverty Reduction.

Membership:

[Added note for final Review Report: public details are only reported here for organisational representatives. A number of other key groups and organisations contributed to the review through individual meetings, including the Advocate for Service Quality and CLBC's Indigenous Advisory Committee. Some members in organisational roles also had a direct family member connection to Home Share.]

Name	Organization
Eddie Bartnik	Lead Contractor
Dr. Tim Stainton	Supporting Contractor
Arlene Zuckernick	Home Share Support Society Board Co-Chair
Alex Magnussen	BC Self Advocate Leadership Network
Michael McLellan	BC Self Advocate Leadership Network
Home Share Provider	
Home Share Provider	
Janice Barr	Community Living Society
Mike Jensen	Community Living Victoria
Family Member	
Advocate	
Advocate	
Karla Verschoor	Inclusion BC
Brenda Gillette	BC CEO Network

Note that while public volunteers on the Home Share Advisory Committee unaffiliated with any specific social sector association or organization are listed here by their respective perspectives, named representatives may also have lived experience as home share recipients, family members of individuals in a home share placement, or have been home share providers.

Appendices:

- Engagement Letter – CLBC Home Share Review

Home Share Review Engagement Letter

Background:

Home sharing is a program funded by Community Living BC (CLBC) where an adult with a developmental disability shares a home with a person, a couple, or family who is contracted by an agency to provide social and homecare-like supports and facilitate appropriate community inclusion opportunities for the person living with them. CLBC monitors the work of the agencies' oversight. About 4,300 people are supported by CLBC in home share living situations.

In January 2025 a Coroner's Inquest was held into the death of Florence Girard, a CLBC-eligible person who lived in a home share in Metro Vancouver at the time of her death in 2018. Her home share provider was charged with failing to provide the necessities of life and convicted in 2022.

Approach:

Several changes have been made to home share since Florence Girard's death. A review is needed to evaluate whether CLBC's changes since 2018 have improved safety. The review will identify other changes to further improve the system of oversight for home-share arrangements.

The review will be conducted by the Ministry of Social Development and Poverty Reduction ("the Ministry") through an independent contractor ("the contractor"). The Ministry will convene an advisory body made up of service providers, self-advocates, and family members to ensure their voices and perspectives about home sharing are heard. The advisory body will provide additional context to the contractor as required.

Scope:

The scope of the home share review is to be focused on safety in home share arrangements to respond to the concerns identified by the Coroner's Inquest; namely:

- Review of standards that promote quality of life and safety in home-share arrangements
- Review of accountability and service quality oversight measures

Product:

The contractor will provide a final report ("the Report") with findings and recommendations for improvement to the Ministry by October 31, 2025.

Engagement:

The contractor will be expected to engage with community representatives, including CLBC leadership and staff and members of the advisory body. Further engagement may be required as identified during the term of the contract to fully inform the Report, including with other jurisdictions or public entities.

Appendix A

Sample Questions for Assessing the Safety, Quality of Life, and Accountability of Home Share Arrangements

The following questions can guide the development of the Report as defined by the contract's Scope. Other questions or avenues of assessment are likely to arise during the Report's development, and this list is not intended to be exhaustive.

Safety and Quality of Life:

- What are the current challenges faced by providers in delivering safe, high-quality home share services?
- How does the Home Share model compare to other home-based options in terms of quality-of-life outcomes and safety?
- How should the needs of individuals be assessed prior to a home share placement (vulnerability assessments, needs assessments, risk assessments)?
- What supports are needed to ensure home share providers prevent burnout and ensure safety?
- Are there certain profiles of individuals who should not be supported in Home Share arrangements?
- Are there sufficient safeguards in place to prevent abuse, neglect, or exploitation?
- How can home share arrangements be better prepared to respond to urgent or unplanned crises while ensuring individual safety?
- What strategies can help prevent placements that are unsuitable or unsafe for individuals?
- What are the financial pressures on providers, and how do they impact service quality?
- How well do Home Share services support individuals in achieving a high quality of life?
- What additional health-related supports are available and needed for home share providers to ensure quality of life expectations are fully realized?

Accountability and Oversight:

- Are there jurisdictional best practices in Home Share funding that CLBC could adopt?
- How effectively are Home Share provider concerns heard and addressed? Is there a fair and transparent process for addressing grievances and safety concerns?
- Are Home Share providers aware of the appropriate agencies or contacts for reporting health and safety concerns, and do they understand the circumstances under which they should escalate issues?
- What is the distinction between oversight and monitoring in Home Share services, and which agencies or entities should be responsible for each function?
- What oversight and accountability measures should be in place to ensure individuals remain safe in home share arrangements?
- How might CLBC proactively assess quality of life before adverse events occur?
- How effectively does CLBC monitor Home Share providers and agencies for compliance with policies, quality standards, and contractual obligations?
- What fail-safe systems exist to reduce risks when service providers do not adhere to policies and processes?
- What structure will provide the most effective and efficient monitoring system? (e.g., separate monitoring agency such as a licensing model, monitoring by CLBC staff, etc.)
- Is the oversight of agencies by CLBC efficient and sufficient?
- Are CLBC's complaints and critical incident systems sufficient, including systems for reporting and responding to "near misses"?
- How can data collection and reporting be improved to enhance transparency and accountability?

2: CLBC Progress Report October 2025

Progress report: CLBC Home Sharing program and policy improvements from 2019 to 2025

October 2025

COMMUNITY LIVING
BRITISH COLUMBIA

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Or visit our website at:

https://www.communitylivingbc.ca

Community Living BC (CLBC) acknowledges with deep respect that our head office sits on the Traditional Territories of the ʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish) and səlilwətaɬ (Tsleil-Waututh) Nations. We recognize and honor the First Nations, Métis and Inuit communities whose histories, cultures and traditions shape the lands on which we live and work across British Columbia.

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Introduction

Home sharing is a cornerstone of Community Living BC's commitment to fostering inclusive communities where individuals with developmental disabilities, autism, and/or fetal alcohol spectrum disorder can live meaningful lives with connection, dignity, and choice.

By enabling individuals to live in welcoming homes supported by caring providers, home sharing reflects CLBC's vision of communities of belonging… where relationships, cultural identity, and personal well-being are nurtured through everyday living. This model offers a personalized approach to support. It also strengthens social inclusion and community participation.

This progress report outlines the significant advancements made in the CLBC Home Sharing Program from 2019 to 2025. It highlights CLBC's response to the Office of the Auditor General's independent audit of home sharing in BC, CLBC-initiated policy and training improvements, as well as the details on updated standards and monitoring frameworks for both the providers of home sharing and their coordinating agencies.

These developments demonstrate CLBC's ongoing commitment to enhancing the quality, safety, and sustainability of home sharing across British Columbia. CLBC is also focused on collaboration with Indigenous partners, service providers, and leadership networks. Together, we can continue to evolve home sharing as a vital pathway to achieving a vision of communities of belonging, lives with connection.

Role of the Home Sharing Support Society of BC and BC CEO Network

In 2019, collaboration between CLBC and BC CEO Network established a three-year work plan on home sharing. Consultations with interest holders and an online survey for the home sharing sector followed in 2020.

The BC CEO Network is a social services leadership network in which many community living agencies are members. The CEO Net has made several significant contributions to the strengthening of home sharing. They developed a home sharing coordinators handbook that supports the home sharing coordinator role and helps define quality service around the province. They previously managed the Open Futures Learning Training Program for home sharing providers and home sharing coordinators. The CEO Net recently finished a hybrid training tour that further develops the skills of coordinators in home sharing agencies.

2022 saw the founding of the Home Sharing Support Society of British Columbia (HSSSBC). CLBC supported the creation of the HSSSBC and contracted the society to enhance and support the sustainability of home sharing in the province.

The HSSSBC's ongoing deliverables include but are not limited to the following:

- Work with key Indigenous partners to strengthen home sharing and gain a stronger understanding of the barriers and gaps that exist for Indigenous partners.
- Collect data, conduct research, deliver workshops, develop resource guides, and document barriers to the recruitment of home sharing providers.
- Increase public awareness about home sharing to attract the interest of potential home sharing providers.
- Increase networking, training, and education opportunities for home sharing providers.
- Find solutions to the challenges of individual and wellness services (formerly referred to as respite services).
- Strengthen peer support connections to help prevent isolation and burnout among home sharing providers.
- Recruit home sharing providers from rural and remote locations and culturally under-represented groups.

The HSSSBC works towards the advancement and promotion of diversity in the home sharing sector. The HSSSBC has Indigenous board representation and is actively recruiting an Indigenous intern to guide the work forward.

In 2023, CLBC awarded the HSSSBC a grant to conduct research into individuals with complex needs in home sharing settings. The objective was to define what skills, knowledge, expertise, training and framework are required to support individuals in a program, if viable.

Response to the Office of the Auditor General

The Auditor General of British Columbia published a report in June 2021 summarizing their independent audit of CLBC's framework for monitoring home sharing agencies and providers. This report closely coordinates with CLBC's on-going efforts to continuously improve home sharing programs to support individuals living in home sharing environments as well as the providers supporting them.

Following the Auditor General's report, CLBC began working on 14 home sharing related projects, some of which were complex and involved partner organizations. CLBC completed the implementation of the projects by 2023. CLBC has made several changes in response to the Office of the Auditor General recommendations including:

- New standards for the coordination of home sharing;
- Updates and education on those standards;
- Improvements to our monitoring framework;
- A review and update of home sharing policies;
- The creation of a new data system for tracking monitoring activities and reporting.

The Auditor General also recommended that CLBC improve monitoring of critical incidents for home sharing and all services. CLBC compiles, tracks, monitors, and analyzes data from critical incident reports. As of September 2025, CLBC also posts summarized data from critical incident reports on its website.

Budget improvements

Since 2019, several budget improvements and special initiatives have taken place to help individuals in home sharing and home sharing providers.

In 2019 the Government of British Columbia increased funding for home sharing by $18.3 million over two years. CLBC used the funding to increase home sharing rates twice over two years beginning in April 2020. CLBC also provided approximately $16 million in emergency funding to support home sharing providers in the first year of COVID-19 pandemic.

Budget 2022 provided CLBC with an increase to base funding of $1.9 million on an annualized ongoing basis to address recommendations from the Office of the Auditor General and enhance the services and sustainability of the home sharing program.

Of this new funding, CLBC dedicated $1.5 million a year to monitoring and tracking oversight systems. CLBC hired 12 full time equivalent staff members (FTEs) to create capacity to put the improvements into place and track their success. CLBC focused on regional operations by hiring eight analyst positions to work directly on oversight and monitoring of home sharing agencies. Another four quality assurance positions help ensure compliance, monitoring, and oversight.

Annual funding from CLBC has also helped to form and maintain the Home Sharing Support Society of BC for the benefit of home sharing providers.

2023: Individual Financial Contribution for Home Support Policy

CLBC has worked with the Ministry of Social Development and Poverty Reduction to support compensation increases where possible. In August 2023 with the increase in Persons with Disability (PWD) support rates, home sharing providers received an additional $125 a month. This funding increase flowed directly to providers.

This increase also complemented the launch of CLBC's Individual Financial Contribution Policy. The policy outlines the financial contribution that an individual makes to a home. It also guides responsibilities between the individual and home sharing provider.

2024: Home Sharing Property Support Program

This program supports home sharing providers when there is damage to a home from the actions or negligence of a CLBC-supported individual. The program includes the Home Share Property Insurance Rider for significant damages and the Home Share Damage Reimbursement program for minor damages. CLBC fully funds this program.

2024: WorkSafe coverage

CLBC increased pay rates to home sharing providers to cover the costs of their WorkSafe BC premiums.

2025: Home sharing coordinator pay increase

Home sharing program and policy improvements from 2019 to 2025

CLBC implemented a 10 percent increase to the pay rates of agency home sharing coordinators in July 2025. Coordinators directly monitor home share providers, conducting quarterly visits and ensuring health plans are in place.

Policy updates and guidance

Effective policy is a cornerstone to providing the best possible service to CLBC-eligible individuals. In 2022 and 2023, the CLBC Policy team completed a comprehensive, accessible, and aligned home sharing policy suite.

The policies are centered on the rights of individuals, and support individuals and families as they consider and use shared living services. The policy framework includes focus areas in human rights as well as an Indigenous- and trauma-informed lens.

Policies and practices are now aligned for the home sharing program. Several policies have undergone updating and enhancement. Those include:

- Standards for Home Sharing Policy – updated in 2023;
- Standards for the Coordination of Home Sharing Policy – new in 2022, updated in 2023;
- Cultural Safety Policy – new in 2022;
- Monitoring Policy – updated in 2023;
- Individual Financial Contribution to Home Supports Policy – updated in 2023;
- Criminal Record Check Policy: Service Delivery – updated in 2022;
- Service Provision by Family Members Policy – updated in 2023;
- Critical Incidents Policy – updated in 2024 along with the Critical Incidents Service Provider Requirements Guide; and
- Behaviour Support and Safety Planning Policy – updated in 2024.

Indigenous self-determination and cultural safety

CLBC is committed to working with Indigenous partners to help eligible Indigenous individuals with developmental disabilities as well as their families in accessing CLBC services. We are doing this by partnering with First Nations as well as Indigenous, Inuit, and Métis organizations. Our objective is to provide supports and resources for home sharing in a culturally safe manner that's responsive to individuals' needs.

As part of this commitment, the BC Association of Friendship Centres (BCAFC) received a grant from CLBC from 2022 to 2025 to focus on the development of Indigenous-led home sharing agencies. The purpose of the work was to better understand the needs of Indigenous peoples seeking home sharing.

The grant helped to pay for a collaboration event between a northern Indigenous community, local CLBC staff, and other community members. This type of event fosters understanding of culture and home sharing.

New work and priorities are expected to be completed in 2025. These initiatives will help to:

- Expand collaboration with Indigenous communities.
- Improve cultural safety and sensitivity among CLBC staff and contracted providers.
- Develop recommendations for home sharing agencies and CLBC's home sharing program on supporting Indigenous individuals with developmental disabilities as well as their families and the communities in which they live.

A collaborative partnership between CLBC and the BCAAFC helped to develop a new resource guide supporting Indigenous shared living in a culturally safe manner.

The guide's purpose is to support the resilience, strengths, and cultural richness of Indigenous peoples and their right to create home environments rooted in their traditions, languages, and ways of knowing and being.

Training improvements

Learning is part of our continuous improvement journey to provide the best support to persons eligible for CLBC services and their families. CLBC has taken many steps to provide more fulsome information to those living in home sharing, home sharing providers, and home sharing coordinating agencies.

In 2021, CLBC produced three detailed informational home sharing manuals. These manuals are specific to individuals, families, and home sharing providers.

In 2022, the Justice Institute of BC's home study training for home sharing coordinators was updated to include information on cultural safety and implicit bias.

2024 saw several changes focusing on Person Centred Societies (PCS, or societies) with home sharing. They are now required to meet consistent standards and policies as outlined in their new framework and contracts.

Some of the changes that are now taking or scheduled to take effect include the following:

- Starting in January 2025, PCS and similarly structured Microboards began incorporating the CLBC service standards into their terms and conditions as they transition to new contracts.
- CLBC is providing support to and collaborating with Vela (an agency supporting Microboards) to provide the societies with training on CLBC's new PCS framework as well as home sharing standards and coordination.
- CLBC's policy governing the societies was updated in 2024 and is now in place.
- CLBC is now offering an updated version of Managing the Money: Person Centred Society Guide.
- A guide for PCS' coordinators is in development for public release in 2025.
- CLBC funding enables societies to access home studies pertinent to their home sharing situations and ensure an agency coordinator is in place. This helps societies to ensure their compliance with the home sharing standards, coordination standards, and monitoring.

Additional training and education will be available to home sharing providers via Open Futures Learning (OFL). This online learning platform provides training modules across a broad array of topics that support home sharing providers and the coordinators in home sharing agencies.

Effective November 30, 2025, the administration of OFL's platform will move from the BC CEO Network to the Home Sharing Support Society BC. CLBC funding is supporting users to learn at their own pace and get practical tools and ideas to help give them the best support.

OFL training services are available at no cost to agency home sharing coordinators, home sharing providers, wellness/supports to shared living (formerly respite) providers, and person-centred societies with home sharing.

Standards and monitoring framework for home sharing coordinating agencies and home sharing providers

Standards are at the heart of home sharing services in guiding consistent, person-centred, and accountable service delivery. CLBC's approach includes monitoring of agencies coordinating home sharing, who in turn monitor home sharing providers. All partners and systems work together to provide a safe and positive experience for individuals living in home sharing environments.

In 2022, CLBC introduced updated standards to:

- Provide a clear framework for home sharing coordinating agencies as well as providers.
- Clarify roles, responsibilities, and expectations for everyone involved.
- Ensure individuals receive high-quality, person-centred support that enhances quality of life.
- Promote a shared understanding between service providers and CLBC staff.
- Support effective monitoring of home sharing providers by agency coordinators, and of the agencies themselves by CLBC's quality service analysts.

Key enhancements in the 2022 standards include the following:

- Integration of quality-of-life principles throughout.
- Inclusion of Gender-Based Analysis Plus (GBA+).
- An emphasis on cultural safety.
- Clarification of safeguards, including medication administration and material well-being.
- A new standard on health care planning to ensure regular access to professionals and adherence to care plans.
- A standard on safety and security to outline a home sharing provider's responsibility for managing identified risks.
- Enhanced accountability for hiring and training wellness/supports to shared living (formerly respite), ensuring alignment with CLBC standards and policies.

These standards are now part of the contractual terms between CLBC and agency service providers and are publicly available on the CLBC website.

In December 2023, an effort to improve quality assurance in home sharing resulted in 180 CLBC-contracted home sharing providers transitioning to agency-coordinated home sharing programs with qualified service providers. Agencies that coordinate home sharing have greater capacity to effectively coordinate, support, and monitor providers.

Monitoring framework:
Monitoring ensures home sharing arrangements remain suitable and responsive to individual needs. This includes CLBC's work to monitor the coordinating agencies, and those agencies' roles in monitoring the home sharing providers that they oversee.

For agencies that coordinate home sharing, CLBC staff conduct in-person monitoring visits with them. These visits are tracked to make sure that there is appropriate follow-up of any matters within established timelines. CLBC has also added Quality Assurance staff to increase oversite of home sharing coordinating agencies and improve compliance with policy requirements.

For home sharing providers, CLBC's monitoring framework requires the coordinating agencies to conduct:

- In-person visits of home share providers within 30 and 90 days of an individual's move-in.
- On-going in-person visits to the home share provider every three months.
- More frequent visits to home share providers as needed based on individual or provider circumstances or emerging risks.

Coordinating agencies are also responsible for ensuring individuals in home sharing have regular access to health care and that care plans are followed, including support for age-related needs.

Oversight and continuous improvement for coordinating agencies:
CLBC monitors home sharing agencies' compliance with the standards of coordination and service delivery for the home sharing providers that they oversee.

In 2025, CLBC strengthened its internal structure by establishing a dedicated home sharing team, led by a Director of Service Quality Improvement. The team also includes a Program Manager, Provincial Lead, and Data Analyst.

Additionally, CLBC launched a pilot program in 2025 in which quality analysts conduct direct visits with home sharing providers. This initiative responds to recommendations from the Coroner's inquest into the death of Florence Girard. CLBC will evaluate the pilot over 12 to 24 months to assess its effectiveness and inform future practices.

Conclusion

CLBC is grateful for the support of staff and a wide range of partners for recent years' progress in policies, procedures, cultural safety, funding, and monitoring for individuals receiving home sharing services, their home sharing providers, and the agencies coordinating home sharing.

Our combined work is centered on the individuals taking part in home sharing. We are working to ensure they live in arrangements that are safe, of high quality, and sustainable.

We will continue to work closely with coordinating agencies and providers in this effort. We will also partner with First Nations as well as Indigenous, Métis, and Inuit organizations to ensure home sharing reflects cultural safety and self determination.

3: Full list of recommendations

A. Establish CLBC senior Home Share leadership position/specialist capacity (underway) and:
   - increase public and sector communication and reporting (underway but stronger public role):
   - explore opportunities to share monitoring tools and findings more transparently, e.g., publish checklists and annual safeguarding reports.

B. Develop a differentiated response model of Home Share monitoring, accounting for complexity and risk.

C. Establish the number of people a Home Share Coordinator has based on complexity (note interdependency with planning role)

D. Review and update CLBC document "Responding to Vulnerability" to reinvigorate community, personal and informal safeguards as complementary to formal safeguards. An associated action plan would focus on tools, resources and enhanced planning/coordination capacity.

E. Require and report on regular health checks for high-risk cases through appropriate provider e.g. HSCL or GP, as defined in the health plan.

F. Mandate and resource the selection/development of a province-wide Quality of Life measurement tool and public outcome reporting (e.g. Include Me)

G. Clearly delineate the core features of Home Share and identify those that do not fit core definition for alternative designation (particularly those that are pushing the boundaries of CRA legislation and present legal risks).

H. Establish an auditable Cultural Safety standard for Home Share

I. Improve process and reporting on investigations (timeline, required outputs, reporting).

J. Review all current Home Share coordinating agencies to:
   - ascertain status of independent accreditations (especially for those under $500,000 funding) and develop options for best form of independent accreditation; and.
   - review how current external accreditation information is used to support Home Share monitoring and improvement.

K. Explore options for improved delivery of person-centred planning for both current and new CLBC clientele with particular consideration of timely planning for those transitioning from school and the aging population.

L. Clarify CLBC and agency roles and responsibilities for planning and coordination in relation to complexity/risk, holistic planning versus planning within Home Share, and review processes.

M. Improve the transparency and communication with regards to the Guide to Support Allocation (GSA) and reviews with increased person and family involvement in the process.

N. Undertake a thorough review of the GSA with regards to:
   - reliability, transparency and scope.
   - Consideration of additional tools as required and possible replacement of GSA with alternative tools.
   - Improved communication with regards to GSA and reviews with increased person and family involvement in the process

O. Strengthen the CLBC facilitator role to provide greater capacity to spend time with people for planning, including initial planning, regular check- ins and changed

circumstances. Increase focus on developing and supporting personal networks and community connections.

P. For complex circumstances and high-risk factors, consider a stronger service and support coordination capacity.
Q. Examine options for improved quality and sustainability of Home Share coordination in rural and remote areas where there are low volumes. This should include examining how Microboards and/or person-cantered societies can be used as a foundational strategy for supporting Home Share and building family, network and community connections.
R. Establish a standardized core planning template as a required deliverable for all Home Shares. Plan should include:
    - Health and Wellbeing plan (including required linkages to GP, HSCL, DDMH as required)
    - Monitoring Plan
    - Personal network analysis, involvement and development: who they have in their lives now, setting out how the family is going to engage, and what their rights are and aren't.
    - Agreement on terms for home share (individual and provider agreement) including roles and responsibilities, household rules etc.
    - Financial plan (agreed contributions material)
    - Community engagement plan
    - Respite plan
    - Transition Plan
    - Training required by Home Share provider based on individual's needs and provider experience and training
    - Cultural safety and recognition
S. Continue work to ensure Home Share Provider compensation enables sufficient supply to enable continuity, quality and safety of Home Shares.
T. Establish improved data collection and external reporting (turnover as a quality indicator) for:
    - Turnover rates in Home Share by Region, Coordinating agency, Home Share provider, CLBC key staff (Facilitators, Analysts)
    - Track individual turnover rates (i.e. how many HS has an individual been in and for how long)
    - Establish provincial registry of Home Share providers with service history (to prevent coordinating agency hopping and use of Home Share Providers who have had poor results).
U. Increased role for self-advocate leaders and organisations to provide support and information for people in Home Share and in delivery of training. This to also include their role in the Include Me quality of life surveys under Key Direction 1.
V. Training
    - Review current baseline and establish additional training requirements for Home Share coordinators based on existing training options and include more role specific content on monitoring and investigations
    - Establish baseline and specialized (as determined in plan) training requirements for Home Share providers
    - Compensate/incentivize Home Share providers to attend training

W. CLBC to engage Home Share Coordinating agencies in further analysis and clearer specification of how the current overall construct for Home Share Coordination does or needs to include funding for supervision for Home Share Coordinators.

X. CLBC Work with Ministry of Housing, BC Housing and partner agencies to develop a new community living and housing strategy for CLBC that provides a dedicated strategy to build a real continuum of housing and support choices. The strategy to include enhanced individual planning, new funding and training strategies to support the development and delivery of a sufficient range of residential supports and reduce over reliance of Home Share. The strategy should also build on existing contemporary models where possible to ensure timely implementation.

   Specific elements of the strategy to include:

   - Expand/develop residential support and service options to decrease pressure on Home Share
   - Identify need for specialized residential supports and services for individuals with complex support needs
   - Consider development of specialized Home Share with enhanced training and skills as required and increased compensation, including exploring employee-based models for complex situations
   - Work with Ministry of Housing, BC Housing and partner agencies to establish minimum numbers of housing units dedicated to CLBC eligible individuals sufficient to meet increasing demand
   - Identify persons in Home Share who are willing and able to move to more independent alternatives and support enhanced planning, funding (including expanded use of Individualized funding), housing affordability and implementation of move
   - Identify persons whose needs are more complex than can be safely met in Home Share and work with them to plan and implement more suitable alternatives. This would also involve working with key system partners (housing, health, mental health and substance use) to develop an improved response for the 5% of most complex individual situations where Home Share is not a good fit. Identify those situations that are not suited to the Home Share model at entry point/first referral.

Y. Improve Home Share opportunities in Indigenous Communities

   - Explore viability of expanded Home Share use with Indigenous people and particularly on reserve and policy alternatives as required
   - Improve general communication with Indigenous peoples particularly on reserve regarding support options

Z. Explore regional crisis management planning with potentially pre-established emergency residential options, including a more proactive approach to individual planning and maximising use of existing infrastructure including family network, community and existing Home Share sector resources.

AA. Clarify role of CLBC regarding disability related allied health supports and responsibilities and those that belong in health/mental health systems (see Nova Scotia example of Regional Allied Health teams).

BB. Build on current CLBC joint work with the health system on Coroner's findings:

   - Engage Ministry of Health in dialogue to improve health and mental health services for people with IDD and CLBC clientele.

- Re-establish the Health Consultant and Nurse consultant for Community Living; consider best approach to leadership position to enable stronger mental health collaboration.
- Explore restructuring HSCL and DDMHS under PHSA under Consultant with dedicated budget and consistent services across the province
- Extend DDMHS services to CLBC clientele under the PSI programme

CC. MSDPR to conduct a detailed review of CLBC budgetary requirements and work with Treasury Board to increase CLBC funding to a level sufficient to deliver quality services in a safe and timely manner, recognizing changes and increases to the disability population over time as well as the legacy waitlists at the time of establishing CLBC.

4: Prioritization ratings by stakeholders

As part of the review process, the Advisory Committee members and CLBC senior leaders were asked to rate the draft of recommendations based on which they thought would make the most positive difference the fastest. The results of this process are below. The wording of recommendations has been updated.

Overall results from Advisory Committee member priority ratings:

- Establish the number of people a Home Share Coordinator has based on complexity
- Clearly delineate the core features of Home Share and identify those that do not fit core definition for alternative designation
- Consider a stronger service and support coordination capacity for complex circumstances.
- Training (baseline for Coordinators, plus specialized, and incentivize for Providers)
- Build on joint work with the health system on Coroner's findings (IDD services, Re-establish Health Consultant, etc.)

Overall results from CLBC senior leader priority ratings:

- Develop a Differentiated response model of Home Share Monitoring accounting for complexity and risk.
- Establish a standardized core planning template as a required deliverable for all home shares
- Establish the number of people a Home Share Coordinator has based on complexity
- Training (baseline for Coordinators, plus specialized, and incentivize for Providers)
- Require regular health checks for high-risk cases through appropriate form as defined in the health plan.

Top three by key direction (Note these are summary examples not full recommendations)

Key Direction 1	
Advisory Committee Members	CLBC
Establish the number of people a Home Share Coordinator has based on complexity	Develop a Differentiated response model of Home Share Monitoring accounting for complexity and risk.
Clearly delineate the core features of Home share and identify those that do not fit core definition for alternative designation	Establish the number of people a Home Share Coordinator has based on complexity
Develop a Differentiated response model of Home Share Monitoring accounting for complexity and risk.	Require regular health checks for high-risk cases through appropriate form as defined in the health plan

Key Direction 2	
Advisory Committee Members	CLBC
Consider a stronger service and support coordination capacity for complex circumstances.	Establish a standardized core planning template as a required deliverable for all home shares
Establish a standardized core planning template as a required deliverable for all home shares	Consider a stronger service and support coordination capacity for complex circumstances.
Explore options for improved delivery of person-centred planning for both current and new CLBC clientele, particularly for transition ages, and clarify roles.	Strengthen the CLBC facilitator role to provide greater capacity to spend time with people for planning etc. and prioritise personal relationships.

Key Direction 3	
Advisory Committee Members	CLBC
Training (baseline for Coordinators, plus specialized, and incentivize for Providers)	Training (baseline for Coordinators, plus specialized, and incentivize for Providers)
Establish improved data collection and external reporting	Establish improved data collection and external reporting
Increased role for Self-Advocacy Leadership Network, or People First.	CLBC and Agencies clarify use of overall Home Share funding

Key Direction 4	
Advisory Committee Members	CLBC
Develop a new community living and housing strategy for CLBC that provides a dedicated strategy to build a real continuum of housing and support choices.	Develop a new community living and housing strategy for CLBC that provides a dedicated strategy to build a real continuum of housing and support choices.
Explore regional crisis management planning with potentially pre-established emergency residential options	Explore regional crisis management planning with potentially pre-established emergency residential options
Improve home share opportunities in Indigenous Communities	Improve home share opportunities in Indigenous Communities

Key Direction 5	
Advisory Committee Members	CLBC
Build on joint work with the health system on Coroner's findings (IDD services, Re-establish Health Consultant, etc.)	Clarify role of CLBC regarding disability related allied health supports and responsibilities and those that belong in health/mental health systems
MSDPR to review and increase CLBC funding	MSDPR to review and increase CLBC funding
Clarify role of CLBC regarding disability related allied health supports and responsibilities and those that belong in health/mental health systems	Build on joint work with the health system on Coroner's findings (IDD services, Re-establish Health Consultant, etc.)

5: Jurisdictional scan

A CROSS JURISDICTIONAL SCAN AND COMPARATIVE ANALYSIS OF HOME SHARE POLICY AND PRACTICE

PREPARED FOR THE EXTERNAL REVIEW OF HOME SHARE ON BEHALF OF THE BRITISH COLUMBIA MINISTRY OF SOCIAL DEVELOPMENT AND POVERTY REDUCTION

BY TAMAR CONSULTING PTY LTD

OCTOBER 12, 2025

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Executive Summary

This report presents a jurisdictional scan of Home Share, shared living, and adult foster-care models across Canada, the United States, the United Kingdom, Ireland, Australia, and New Zealand. The analysis applies a consistent framework of variables, including program design, residential arrangements, funding models, target populations, eligibility, governance, host recruitment and vetting, monitoring and safeguarding mechanisms, quality assurance, training, independent planning supports, dignity of risk, psychosocial and cultural supports, quality-of-life outcomes, barriers and facilitators, notable cases, and evaluation evidence.

In Canada, approaches vary significantly across provinces and territories. Federal frameworks focus on accessibility, funding, and safeguarding principles, while provincial ministries and community agencies carry responsibility for program delivery. Provinces such as British Columbia and Ontario have the most extensive Shared Living/Home Share programs, with structured vetting, monitoring, and safeguarding protocols. Smaller jurisdictions often rely on foster care legislation or agency-driven pilots. In BC, while CLBC has recently updated its Home Share and coordination standards and introduced a Critical Incidents Policy, many requirements remain embedded in policy or contracts requirements rather than regulation and at time uneven enforcement. Monitoring tools and outcomes are not public, incident timelines (reporting, response times , outcomes etc.) are less prescriptive than in Ontario or under Australia's NDIS, and there are no mandated clinical health review cycles or validated quality-of-life tools. Cultural safety and tenancy protections are acknowledged in principle but are not binding or auditable. Internationally, best practice highlights embedding monitoring and incident-reporting requirements in regulation, publishing inspection and safeguarding data, mandating health reviews in higher-risk homes, and adopting standardized outcome tools alongside independent oversight.

The United States anchors host-family and adult foster models in Medicaid Home and Community-Based Services (HCBS) waivers. Federal CMS rules (HCBS Settings Rule) require tenancy protections, autonomy, and community integration, but implementation differs widely across states. Stronger systems, such as those in Pennsylvania and New York, combine robust statutory oversight with regular inspections, while other states rely more heavily on provider self-monitoring.

The United Kingdom has a nationally regulated Shared Lives system, overseen by independent regulators in each country (CQC in England, Care Inspectorates in Scotland and Wales, RQIA in Northern Ireland). Shared Lives Plus serves as a membership network, supporting schemes with outcome tools and practice standards. Shared Lives is consistently rated among the highest-quality forms of adult social care, supported by strong inspection frameworks, person-centred planning, and validated outcome measurement.

Ireland operates Home Share arrangements under HSE guidance, with allowances paid to host families. While national safeguarding policies and panel vetting processes are in place, the absence of dedicated statutory regulation remains a governance gap flagged by experts and review bodies.

Australia incorporates host-family models through the National Disability Insurance Scheme's (NDIS) Individualised Living Options (ILO). These are highly regulated through

the NDIS Quality and Safeguards Commission, which requires worker screening, incident reporting, audits, and monitoring of outcomes, embedding dignity of risk principles into certification.

New Zealand provides flexibility through Choice in Community Living (CiCL), Individualised Funding, and Enabling Good Lives (EGL), offering options such as co-residency, live-in supporters, or family-style homes. Oversight is delivered through Ngu Paerewa national standards, Whaikaha (Ministry of Disabled People) contracting, and the Health & Disability Commissioner's Code of Rights. While the framework is rights-based and flexible, challenges include housing affordability and workforce pressures.

Across all jurisdictions, common facilitators include robust vetting processes, independent planning supports, and national QA frameworks. Barriers often reflect inconsistent implementation, limited host recruitment, and gaps in regulation or data collection. In BC specifically, there is a growing risk that Home Share has become the default rather than a true choice, driven by housing shortages, cost considerations and the lack of alternatives. This has led to mismatches, breakdowns, and crisis placements. While CLBC has begun piloting hybrid arrangements and some regions have explored supported independent living or intentional communities, these initiatives remain fragmented. International exemplars, such as New Zealand's Choice in Community Living, the UK's Shared Lives hubs, and Australia's Individualised Living Options, underscore the importance of diversifying supported housing, formalising transition planning for youth aging out of care and older adults with changing needs, and strengthening cross-sector partnerships with housing, health, and Indigenous organisations.

Overall, family-based models are recognised for enhancing quality of life, autonomy, and community inclusion. Yet they require sustained investment in safeguards, data systems, and workforce development, as well as a deliberate shift toward offering a continuum of community living options rather than over-reliance on Home Share alone.

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Table A1. *High-Level Summary of Home Share, Shared Living, and Adult Foster Models by Jurisdiction*

Jurisdiction	Program / Initiative	Residential Model	Funding Model	Target Population	Governance / Oversight	Safeguarding & QA Highlights	Notable Features	Key Gaps	Best Practice / Recommendations
Canada (Federal & Provinces/Territories)	Shared Living, Home Share, Adult Foster	Host-family care, adult foster placements	Provincial funding; federal frameworks support accessibility	Adults with IDD, autism, mental health	Provincial ministries & community agencies	Vary by province; mix of inspections, case management, agency oversight	Fragmented; BC & ON most developed	Uneven enforcement; standards in policy not regulation; transparency and QoL measurement inconsistent	Adopt validated QoL tools; publish monitoring/incident data
USA (Federal + States)	HCBS Waiver Models	Host Home, Companion Care, Adult Foster	Medicaid HCBS waivers; SSI for room & board	Adults with IDD, mental health, elders	CMS rules; state Medicaid agencies	CMS HCBS Settings Rule + state inspections	Wide variation; strong models in PA, NY, MA	Inconsistent enforcement between states; reliance on providers in weaker systems	Strengthen tenancy protections; replicate PA/NY inspection and reporting standards across states
UK (England, Scotland, Wales, Northern Ireland)	Shared Lives (Adult Placement)	Adults live in carer's home	Local authority contracts; carers self-employed w/ HMRC relief	Adults w/ IDD, autism, MH, older adults	National regulators (CQC, CI, CIW, RQIA)	Strong inspection regimes; outcome tools (My Shared Life)	Among highest-rated care services nationally	No major systemic gaps; strong model overall	Continue investment in Shared Lives Plus; sustain high inspection and outcome frameworks
Republic of Ireland	Home Sharing (Shared Living, Contract Families, Short Breaks)	Adults live with host families	HSE allowances (weekly/monthly, retainers)	Children & adults w/ IDD	HSE guidelines; no statutory regulation	Safeguarding policy (2014); vetting via Garda, panels	Regulatory gap noted; Expert Group calls for legislation	No dedicated statutory regulation	Establish statutory regulation; formalise QA inspection systems
Australia	NDIS Individualised Living	Flexible: host, housemat	NDIA funds (2 stages: design &	NDIS participants	NDIS Commission	Worker screening, incident	National QA system;	Housing affordability/workforce challenges	Maintain strong QA; invest in housing

Jurisdiction	Program / Initiative	Residential Model	Funding Model	Target Population	Governance / Oversight	Safeguarding & QA Highlights	Notable Features	Key Gaps	Best Practice / Recommendations
	Options (ILO)	e, co-residency	implementation)		(registration, audits)	reporting, PBS frameworks	focus on dignity of risk		affordability and workforce supports
New Zealand	CiCL, Individualised Funding, EGL	Flexible: flatting, family, live-in supporters	NASC-assessed packages; supplements	Adults <65 w/ disability	Whaikaha contracts; Ngā Paerewa standards; HDC oversight	Certification audits, advocacy, DAPAR safeguarding	Rights-based, flexible	Housing affordability; workforce pressures	Strengthen housing supply; sustain independent advocacy and EGL principles

Background

Over the past decades, disability policy in many jurisdictions has shifted away from institutional and shift-staffed group home models toward community-based, self-directed living arrangements. One strand of this shift is the family-home model - variously termed Home Share, Shared Living/Lifesharing, Sponsored Residential/Family Care, Adult Foster Care, Family Home Agency, or, in Australia, Individualised Living Options (ILO) with a host or housemate. Despite different labels, these arrangements share a core feature: a person with a disability lives in a private household with a host, family, or co-resident who provides day-to-day support and shares ordinary family life. These models can foster continuity of relationships, flexible routines, and alignment with individual preferences, but are complex to regulate because they straddle private and service domains.

International regulatory frameworks have set expectations for safeguards, rights, and quality. In the United States, Home and Community-Based Services (HCBS) regulations mandate community integration, privacy, and tenancy protections, alongside incident management and person-centered planning. The United Kingdom's regulators inspect Shared Lives schemes against statutory standards for safety, rights, and leadership. Ireland's Health Service Executive (HSE) has issued national Home Sharing guidelines, while New Zealand's Ngā Paerewa standards and Code of Rights provide system-wide safeguards. In Australia, the NDIS Quality and Safeguards Commission enforces national practice standards, worker screening, incident reporting, and behaviour-support rules across ILO and similar supports.

These frameworks aim to balance choice, control, and least-restrictive practice with robust oversight. Risks remain: the privacy and informality of family-home arrangements can make harms less visible, while over-regulation may undermine the ordinary rhythms and autonomy these models seek to preserve. The central challenge is to design mechanisms that protect rights, surface concerns early, and enable dignified risk-taking without turning households into mini institutions.

This review maps how different jurisdictions address that challenge, focusing on operational safeguards and quality measures - such as host vetting and renewal, monitoring frequency and content, incident-reporting protocols, tenancy protections, training requirements, rights-modification processes, and outcome tracking - along with documented barriers and facilitators. The goal is to provide a practical menu of tested mechanisms and identify gaps to inform program design.

Method

Review Purpose and Design

A two-strand pragmatic review was conducted to (a) map academic and grey literature on Home Share, Shared Living, Adult Foster Care, and Host Family models for people with disabilities, with a focus on safeguards, monitoring, quality assurance (QA), quality of life (QoL), and dignity of risk; and (b) complete a jurisdictional/program scan to inventory concrete safeguards and QA mechanisms embedded in policy, regulation, and program guidance. This scope and pragmatic stance followed the internal protocol's directive to examine "what this can tell us about current safeguards… and potential gaps/improvements," rather than provide exhaustive coverage.

The review addressed the following questions:

1. What mechanisms for QA, safeguarding, monitoring, support, QoL, and dignity of risk exist in Home Share-type models across the target jurisdictions?
2. How are these mechanisms specified and operationalised (e.g., frequency of visits, incident reporting timelines, vetting checks, tenancy protections)?
3. What barriers and facilitators to implementing these mechanisms are documented?

Scope and Eligibility

The scope was defined according to the following parameters:

- **Populations**: People of all ages with disabilities, with a primary focus on intellectual and developmental disabilities (IDD), learning disabilities[1], and autism. Broader disability programs were included where they explicitly covered the Home Share/host/adult foster model.
- **Interventions/settings**: Home Share, Shared Living/LifeSharing, Host Family/Sponsored Residential/Family Care, Adult Foster Care/Adult Family Home, Family Home Agency, and Individualised Living Options (host/housemate). All models involved non-shift-staffed family homes or shared households with a live-in supporter/host.
- **Exclusions**: Traditional group homes and generic community supports, unless the document explicitly applied to Home Share/host settings (e.g., statewide incident management rules that covered host homes).
- **Geographies**: Canada; United States (select states from each region); United Kingdom (all nations); Ireland; Australia; and New Zealand.
- **Document types**: Primary statutes, regulations, official policy/manuals/inspection frameworks, regulator guidance, government/commission reports, peer-reviewed empirical and review articles, and credible NGO network materials used operationally by schemes or regulators.
- **Timeframe**: 2009-2025, consistent with the protocol's 15-year review window.
- **Language**: English.

[1] Learning disability is a term widely used in the UK for intellectual and developmental disability

Information Sources and Search Strategy

Academic Databases
Searches were conducted in July-August 2025 using controlled vocabulary and keywords adapted for each database. The following databases were accessed via institutional subscriptions: APA PsycArticles, APA PsycInfo, CINAHL Complete, MEDLINE with Full Text, Social Work Abstracts, SocINDEX with Full Text, Academic Search Complete, ProQuest Central Premium, EconLit, Philosopher's Index, Web of Science (no relevant results for the target combination), ProQuest Dissertations & Theses Global, and selected discipline-specific collections.

A core Boolean search string (EBSCO example) was:

(home N3 shar* OR "home shar*" OR lifeshar* OR "shared living" OR "host famil*"
OR ("adult" N2 "foster care") OR ("adult" N2 "foster home*") OR "life sharing"
OR ("family" N2 "home"))
AND
(intellectual* disab* OR developmental disab* OR IDD OR "learning disab*" OR "autism spectrum" OR ASD)
AND
(safeguard* OR monitor* OR "quality assurance" OR oversight OR ("risk" N2 management)
OR ("abuse" N3 prevent*) OR ("incident" N2 report*) OR "protective factor*")

Grey Literature and Targeted Web Searches
Structured Google and Google Scholar searches, along with site-limited queries (2009-2025; English; filetype:pdf, site:.gov, site:.org, site:.ca), were conducted using variations of model and population keywords paired with terms related to safeguards, monitoring, and quality assurance.

An example search string was:

("home share" OR "home sharing" OR lifesharing OR "shared living" OR "adult foster care" OR "host family program")
AND ("intellectual disability" OR "developmental disability" OR IDD)
AND (safeguard* OR monitoring OR "quality assurance" OR oversight OR "abuse prevention")

Jurisdiction-specific strings were also applied. Examples include:

- **Canada**: "homeshare program" site:gov.bc.ca; "developmental disabilities" AND "home share" Ontario; "PDD" AND "home living" Alberta.
- **USA**: "shared living" AND developmental disability site:.gov; "lifeshare" + state name; "adult foster care" + IDD + state name.
- **UK/Ireland**: "Shared Lives" safeguarding; "HSE Home Sharing" guidelines.
- **Australia**: "NDIS" AND "host arrangement" AND safeguards; "Individualised Living Options" AND host.
- **New Zealand**: "Choice in Community Living" AND safeguards; "family home" intellectual disability NZ.

Stakeholder and Snowballing Sources
Reference lists, regulator/provider resource pages, and networks named in the

protocol (e.g., Shared Lives Plus, HSE Home Sharing, NDIS Commission, Royal Commissions) were used to identify additional sources.

Screening and Selection

A two-stage screening process was applied:

1. **Title/abstract or page-snippet screening** against inclusion criteria.
2. **Full-text review** for documents passing Stage 1.

Screening was conducted by one reviewer with spot-check verification by a second reviewer for borderline cases. Discrepancies were resolved by discussion, and reasons for exclusion were logged (e.g., not a Home Share /host model, incorrect geography, no safeguards/QA content, general residential evidence with no explicit application to Home Share).

Data Extraction

Data were extracted into a standardised inventory table with the following fields:

- Country/Region
- Jurisdiction/Organization
- Program/Initiative Name
- Model/Living Arrangement
- Compensation/Funding
- Target Population
- Resident Eligibility
- Governance Structure
- Host Recruitment & Vetting
- Support, Monitoring, and Communication Mechanisms
- Safeguarding Practices/Frameworks
- Quality Assurance Mechanisms
- Host Education/Training
- Specific Policies/Regulations (name and requirements)
- Independent Planning Supports
- Dignity-of-Risk/Decision-Making Provisions
- Psychosocial/Cultural/Mental Health Supports
- Quality-of-Life Focus/Outcomes
- Barriers and Facilitators
- Notable Cases/Events
- Program Evaluation/Evidence
- Notes/Unique Features

Where possible, plain-language paraphrasing was combined with operational specifics (e.g., visit frequencies, incident reporting timelines, background check components, inspection cadence, tenancy rights clauses).

Source Prioritisation and Verification

Sources were prioritised in the following order:

1. Primary legal/regulatory texts (statutes, regulations, rules).

2. Official program manuals, provider standards, inspection frameworks, and regulator guidance.
3. Government/commission reports.
4. Peer-reviewed literature.
5. Reputable NGO network materials used operationally.

When multiple sources existed, details were harmonised to the most current official source, with version/date recorded. Formal risk-of-bias appraisal was not conducted; instead, source type and recency were recorded, and verifiable operational elements were extracted.

Synthesis

Two main products were generated:

1. **Jurisdiction-by-jurisdiction program tables** specifying concrete mechanisms (e.g., visit schedules, inspection frequency, mandatory trainings, incident management systems, tenancy protections, human rights and abuse reporting pathways, rights-modification safeguards).
2. **Thematic synthesis** of safeguards, QA mechanisms, QoL measures, and dignity-of-risk practices, including barriers and facilitators.

Quality Control and Documentation

A search log (including strings, dates, and platforms), repository of downloaded sources, and citation records were maintained. Jurisdictional content included effective dates, version identifiers, and, where available, inspection or recertification instruments to confirm monitoring requirements. This documentation supports replication and future updates, consistent with the protocol's due diligence requirements for safeguards-focused reviews.

Results

This section presents findings by jurisdiction, beginning with Canada at the federal, provincial, and territorial levels, followed by the USA at the federal level followed by a selection of US states (1-4 from each major region), then the United Kingdom, Australia, and New Zealand.

For each jurisdiction, we examined a consistent set of variables: program or initiative name; residential model or living arrangement; compensation and funding structures; target and eligible populations; resident eligibility criteria; governance structures; host recruitment and vetting practices; support, monitoring, and communication mechanisms; safeguarding practices and frameworks; quality-assurance (QA) mechanisms; host education and training standards; policies specific to safeguarding, QA, or training; independent planning supports; approaches to balancing dignity of risk with safeguards; psychosocial and cultural or equity supports; quality-of-life outcomes; barriers and facilitators to safeguarding and quality assurance; notable cases or events; program evaluation evidence; and other unique program features.

While the subsequent section, *Cross-Jurisdiction Synthesis and Discussion,* provides comparative analysis across countries and regions, the results reported here focus on publicly posted information, government reviews, and organizational materials that outline how host-family, adult foster, or shared-living models are structured and regulated in each setting.

CANADA

Federal Frameworks

At the national level, several resources and frameworks support Home Share, shared-living, and adult foster-care models. These span civil society toolkits, research institutes, statutory bodies, and federal funding programs. Collectively, they establish quality-assurance principles, safeguarding measures, and accessibility standards that provincial and territorial initiatives can align with.

Table 1. *Federal-Level Home Share and Housing Resources*

Governing Body - Document	Scope & Purpose	Details
Inclusion Canada - My Home, My Community tool-suite • Housing-Inclusivity Checklist (2022) • Inclusive Housing Index Primer (2024) Housing-Inclusivity Checklist PDF Inclusive Housing Index Primer PDF	National federation for people with intellectual disability.	**QA / Monitoring** - five-pillar scorecard (Participation, Neighborhood, Support Arrangements, Structure, Dwelling) with yes/5-point items you can insert into intake or annual reviews. **Safeguards** - prompts on safety, tenancy security, "supports move with you". **QoL** - measures autonomy, social belonging and affordability. **Dignity of risk** - items on curfew-free living, unrestricted visitors.
Home Share Canada - Best-Practice Framework & Toolkit (2019) Toolkit PDF	Grass-roots national network connecting provincial host-family programs.	**Host recruitment & vetting** - sample application, interview & reference forms. **Training** - orientation modules and "Home Share Ready" certificate outline. **Monitoring** - template for quarterly host visits and incident log. **Safeguards** - home-safety checklist, medication & money protocols.
IRIS - Institute for Research and Development on Inclusion and Society • From Housing to Home brief (2016) • Person-Centered Planning Framework (2017) From Housing to Home PDF Person-Centered Planning Framework PDF	National research NGO (formerly Canadian Association for Community Living research arm).	**Independent planning supports** - eight-step person-centered planning flowchart and facilitation tips. **Balancing dignity of risk** - tool for mapping "important to" vs. "important for" the person. **QoL outcomes** - aligns to Schalock domains and UN-CRPD Article 19.
Canadian Centre on Disability Studies - Inclusive Housing: Policy Scan & Promising Practices (2018) Policy Scan PDF	University-affiliated think-tank; study funded by CMHC.	**Barriers / Facilitators** - identifies zoning, funding and attitudinal barriers to shared-living; highlights facilitators like portable supports and mixed-ability neighborhoods. **Safeguards** - calls for national tenancy-rights education module for hosts & residents.

Governing Body - Document	Scope & Purpose	Details
Canadian Human Rights Commission - Right to Housing for People with Disabilities (2024) Report PDF	Statutory rights body.	**Safeguards & QA gaps** - documents complaints on abuse/neglect in shared-living; recommends federal guidance on incident reporting and external advocacy access.
Accessibility Standards Canada - Draft Built-Environment Standard (2025) Draft Standard PDF	National standard-setting.	**Safeguards** - forthcoming accessibility requirements (entrance width, visual-fire alarms) will apply to funded Home-Share renovations.
Canada Mortgage and Housing Corporation - National Housing Strategy Co-Investment Fund Applicant Guide	Federal housing funder.	**Funding model** - projects (inc. conversions of single-family homes to host settings) must meet accessibility & energy standards; fund agreements require five-year outcome reporting.
Employment and Social Development Canada - Accessible Canada Act (2019) & Nothing Without Us strategy Accessible Canada Act Nothing Without Us Strategy	Federal legislation & policy.	**Governance / Rights** - embeds duty to consult persons with disabilities; agencies running Home-Share programs receiving federal funds must publish accessibility plans and progress reports.

As shown in Table 1, the federal landscape is characterized by a mix of civil-society leadership, statutory rights bodies, and federal funders. Organizations such as *Inclusion Canada* and *Home Share Canada* provide practical tools for host recruitment, vetting, and monitoring. Research institutes like *IRIS* and *CCDS* contribute evidence-based planning frameworks and policy scans that inform provincial practice. Statutory and policy bodies, including the *Canadian Human Rights Commission* and *Accessibility Standards Canada*, set safeguards and emerging accessibility requirements. Finally, federal funders such as *CMHC* and *ESDC* link program eligibility to accessibility and rights obligations, embedding a quality-assurance layer into housing investments.

Provincial Frameworks

Alberta

Alberta's Persons with Developmental Disabilities (PDD) program does **not** operate a dedicated "home-share/host-family" model comparable to BC's Home Share or Shared Lives UK. Instead, the flagship residential option is Home Living Supports, delivered by accredited agencies in people's own/family homes or shared apartments. Safeguarding and quality assurance (QA) flow through agency licensing, staff screening/training, incident management, and annual reviews: not host-family standards. As shown in Table 2 (below), there is no contracted host role or host stipend in Alberta's model.

Table 2. *Alberta - Overview of Home Living Supports*

Variable	Details
Program / Initiative name	*Home Living Supports* (sometimes called "Family Caregiver" or "Roommate" options). (PDD Manual 2021; PDD Engagement Report 2019)
Residential model / living arrangement	Adults live either: (1) permanently in their own or family home with visiting supports; or (2) in a shared apartment/group of roommates, each with their own lease. (Source: PDD Manual 2021)
Compensation / funding model	PDD pays a monthly support rate to accredited service agencies; agencies remunerate staff who deliver supports. No separate host stipend. (PDD Manual 2021; PDD Engagement Report 2019)
Target / eligible population	Adults assessed as eligible by PDD across the full range of support needs. (PDD Manual 2021)
Resident eligibility criteria	Meet diagnostic/functional-needs criteria under the PDD Act; agree to a Person-Centered Plan specifying goals, support hours, and safety protocols. (PDD Manual 2021)
Governance structure	Ministry of Community & Social Services oversees PDD policy; Regional Community Boards contract/monitor local service agencies. (PDD Manual 2021; PDD Engagement Report 2019)
Host recruitment & vetting practices	Not applicable - no external private hosts are contracted. (PDD Engagement Report 2019)
Support, monitoring & communication mechanisms	Quarterly scheduled visits by agency support workers; incident reporting for critical incidents; annual service-plan reviews with PDD Facilitators. (PDD Manual 2021; PDD Engagement Report 2019)
Resident / tenant safeguarding practices / frameworks	Staff screening (criminal record & vulnerable sector checks); mandatory health & safety training; written Emergency Response and Behaviour-Support Plans where needed. (PDD Manual 2021)
Quality-assurance frameworks / mechanisms	Regional annual reviews of each service agency (support-hour compliance, timeliness of incident-response, participant satisfaction). (PDD Manual 2021; PDD Engagement Report 2019)
Host education / training standards / practices	(Agency staff training) Positive Behaviour Supports, Medication Administration, Person-Centered Planning, Workplace Health & Safety. (PDD Manual 2021)
Specific policies related to	PDD Manual (Aug 2021) - e.g., s. 3.4 (Staff Screening), 5.2 (Incident Management), 7.1(Annual Review). (PDD Manual 2021)

Variable	Details
safeguarding / QA / training	
Independent planning supports / facilitation	PDD Facilitators (separate from service agencies) guide development of Person-Centered Plans. (PDD Manual 2021; PDD Engagement Report 2019)
Balancing dignity of risk with safeguards	Person-Centered Plan includes a Risk Assessment documenting rights/choices and safeguards. (PDD Manual 2021)
Psychosocial supports (mental health, cultural / equity)	Agencies link participants to community mental-health resources and, where relevant, culturally specific supports (e.g., Indigenous Elders, interpreters). (PDD Engagement Report 2019)
Quality of life focus / outcomes measured	Agencies conduct annual participant satisfaction surveys (autonomy, community inclusion, well-being). (PDD Engagement Report 2019)
Barriers to QA / safeguarding / QoL	No discrete host-family model (so no host vetting/stipends); staffing shortages and service caps can limit visit frequency and responsiveness. (PDD Engagement Report 2019)
Facilitators to QA / safeguarding / QoL	Established regional governance with clear procedures; Person-Centered Planning embedded in delivery; annual review cycle supports compliance. (PDD Manual 2021; PDD Engagement Report 2019)
Notable cases / events	2019 PDD Engagement Report recommended clearer role separation between facilitators and direct-service agencies to strengthen independent oversight. (PDD Engagement Report 2019)
Program evaluation / research evidence	2019 PDD Engagement Report reviewed PDD supports (incl. Home Living) and recommended improved transparency, data tracking, and feedback loops. (PDD Engagement Report 2019)
Notes / other unique features	Broad-based approach: funds agencies to deliver supports in any home setting rather than contract individual hosts; QA centers on agency licensing, staff training, and PCP reviews. (PDD Manual 2021; PDD Engagement Report 2019)

British Columbia

Community Living BC (CLBC) operates Home Share and Live-In Support with requirements spread across three documents: (1) Master Terms & Conditions - Shared-Living Services (effective July 1, 2024), which include Schedule A (eight quality-of-life outcomes) and Schedule D (reporting for home visits, incidents, and outcomes); (2) Standards for Home Sharing (Oct 2022), which require at least one announced and one unannounced monitoring visit per year and annual agency audits by CLBC Quality-Service Analysts; and (3) Standards for the Coordination of Home Sharing (Apr 2022), which outline a seven-stage support cycle (Explore → Reflect), risk-based visit frequency tables, and required QA templates/forms.

Safeguarding measures identified in these documents include private, lockable bedrooms, secure storage for medication and money, fire-safety drills, and emergency plans. Host vetting involves criminal-record and vulnerable-sector checks, reference checks, a home-study assessment, and household consent prior to contracting. The standards state a least-restrictive approach and supported decision-making expectations, with cultural-safety and GBA+ considerations.

Training expectations cover orientation and periodic refreshers on abuse prevention, medication administration, positive-behaviour support, risk assessment, privacy, and dispute resolution. For monitoring and QA, agencies submit periodic dashboards (e.g., visit completion rates, incident reporting, training compliance, respite usage). CLBC analysts review incident trends and conduct annual audits of agency tools, templates, and sample files. Agencies are expected to run a local QA cycle (feedback collection, complaints/incidents analysis, an annual QA report) and show evidence of this during audits.

On funding/operations, CLBC contracts pay monthly fees to hosts (room, board, agreed support hours) and provide two paid respite days per month. Approximately 90% of placements are coordinated by agencies and about 10% are direct contracts.

For outcomes, province-wide tracking is aligned to the eight QoL domains in Schedule A; survey/feedback mechanisms (including Include Me! sampling for Home Share participants) feed continuous-improvement activities. Table 3, below, outlines the CLBC Home Share program.

Table 3. *British Columbia - Overview of CLBC Home Share Program*

Variable	Details
Country / Region	British Columbia - Canada *(Standards for Home Sharing (2022))*
Jurisdiction / Organization	Community Living BC (CLBC) *(Terms & Conditions - Shared-Living Services (2024))*
Program / Initiative	Shared Living (Home Share) and Live-In Support *(Standards for Home Sharing (2022); Shared-Living Resource Guide (2018))*
Residential model / living arrangement	Home Share: adult with ID/DD lives long-term in a vetted provider's private home (host). Live-In Support: support worker lives in the person's own home. *(Standards for Home Sharing (2022); Resource Guide (2018))*
Compensation / funding model	Monthly host fee (room, board, agreed support hours) plus two paid respite days/month: ~90%agency-coordinated and ~10% direct contracts. *(Terms & Conditions (2024); Resource Guide (2018))*
Target / eligible population	Adults eligible for CLBC services (intellectual/developmental disabilities) living in community settings. *(Standards (2022))*
Resident eligibility criteria	CLBC eligibility determination and a person-centered plan specifying goals, supports, and safety measures. *(Coordination Standards (2022))*
Governance structure	Province-wide Terms & Conditions and Standards set by CLBC; contracted agencies coordinate most placements; annual

Variable	Details
	audits by CLBC Quality-Service Analysts; direct contracts used in a minority of cases. *(Terms & Conditions (2024); Standards (2022))*
Host recruitment & vetting practices	Criminal-record & vulnerable-sector checks, reference checks, home-study assessment, household consent prior to contracting. *(Standards (2022))*
Support, monitoring & communication mechanisms	Minimum 1 announced + 1 unannounced visit/year (more if risk-flagged) with host written responses (2-4 weeks); annual agency audits; reporting requirements for home visits, incidents, and outcomes (Schedule D). *(Standards (2022); Coordination Standards (2022); Terms & Conditions (2024))*
Resident / tenant safeguarding practices / frameworks	Private, lockable bedrooms; secure storage for medication/finances; fire-safety drills; emergency plans; cultural-safety/GBA+ commitments; behaviour-support plans; near-miss and abuse-allegation reporting with CLBC follow-up on high-risk cases. *(Standards (2022); Coordination Standards (2022))*
Quality-assurance frameworks / mechanisms	Seven-stage support cycle (Explore → Reflect) with risk-based visit frequency and required QA templates; Schedule A QoL outcomes; Schedule D reporting; annual audits of tools/templates/files. *(Coordination Standards (2022); Standards (2022); Terms & Conditions (2024))*
Host education / training standards / practices	Orientation and periodic refreshers covering abuse prevention, medication administration, positive-behaviour support, risk assessment, privacy, dispute resolution. *(Resource Guide (2018); Standards (2022))*
Specific safeguarding / QA policies	Terms & Conditions (2024); Standards for Home Sharing (2022); Standards for the Coordination of Home Sharing (2022) - define visit minimums, reporting, audits, planning cycle, and training expectations. *(T&Cs 2024; Standards 2022; Coordination Standards 2022)*
Independent planning supports	CLBC Facilitators (independent of agencies) lead person-centered planning and annual reviews. *(Coordination Standards (2022); Resource Guide (2018))*
Balancing dignity of risk	Least-restrictive principle; any restrictive/intrusive measure (e.g., door-alarms, CCTV) requires written justification and regular review. *(Standards (2022))*
Psychosocial supports	Expectations for cultural- and gender-safety; respect for language, faith, gender identity, traditions; linkage to inclusion/employment programs. *(Standards (2022); Resource Guide (2018))*
Quality-of-life focus / outcomes measured	Eight QoL domains (Schedule A); reporting on outcomes and incidents (Schedule D); survey/feedback mechanisms used for improvement. *(Terms & Conditions (2024); Coordination Standards (2022))*
Barriers	Host shortages (stipend pressures), coordinator caseloads, uneven training uptake, legacy data-collection gaps prior to 2019. *(Standards (2022); Resource Guide (2018))*
Facilitators	2022 standards refresh; unified Terms & Conditions; Shared-Living Resource Guide; online monitoring; annual audits; built-in respite days. *(Standards (2022); Terms & Conditions (2024); Resource Guide (2018))*

Variable	Details
Notable cases / events	None identified in the posted CLBC standards/tools; agency-level audit findings are tracked but not published as case summaries. *(Standards (2022))*
Program evaluation / research evidence	Use of outcomes (Schedule A), incident analysis, and feedback/surveys (incl. Include Me! sampling) to inform continuous-improvement activities. *(Terms & Conditions (2024); Coordination Standards (2022))*
Notes / other unique features	Mix of agency-coordinated (~90%) and direct (~10%) contracts; two paid respite days/month in host contracts. *(Terms & Conditions (2024); Resource Guide (2018))*

Saskatchewan

Saskatchewan's Approved Private Service Home (APSH) program is administered by Community Living Service Delivery (CLSD) in the Ministry of Social Services. APSHs are licensed under the Residential Services Act, 2019 and its Residential Services Regulations (R-21.3 Reg 1); operators must follow the APSH Proprietor's Reference Manual. Homes provide a family-style living environment for adults with intellectual disabilities who meet CLSD eligibility. The Provincial Auditor's 2021 performance audit found the Ministry had processes to license and monitor APSHs but identified gaps: criminal-record checks were not re-verified periodically after initial licensing; documentation of quarterly case-worker contact with APSH residents was often missing; and follow-up on required improvements was inconsistent. The audit also confirmed expectations for person-centered plans, incident reporting to the Ministry, and routine licensing/re-licensing inspections. Entry to the program involves an application, home-study, police/vulnerable-sector checks, references, and safety inspections before a license is issued. Operators are paid monthly by the Ministry, with rates reflecting each resident's assessed support needs. Table 4, below, outlines the above program.

Table 4. *Saskatchewan: Approved Private Service Home (APSH) Program*

Variable	Details
Country / Region	Canada - Saskatchewan
Jurisdiction / Organization	Ministry of Social Services - Community Living Service Delivery (CLSD)
Program / Initiative	Approved Private-Service Home (APSH) Program
Residential model / living arrangement	1-4 adults with intellectual disabilities live in a family-style home run by a licensed proprietor (host). (Government of Saskatchewan)
Compensation / funding model	Proprietors receive a monthly payment set by the Ministry; rate reflects each resident's support level. (Government of Saskatchewan)
Target / eligible population	Adults (18+) with intellectual disabilities who are eligible for CLSD supports. (211 Saskatchewan)
Resident eligibility criteria	CLSD eligibility assessment plus matching to an APSH vacancy through regional staff. (Government of Saskatchewan)
Governance structure	• APSHs are licensed under the Residential Services Act & Regulations; operators must follow the APSH Proprietor's Manual. (Pubsask Dev) • CLSD regional staff issue licenses and service agreements; Public Health inspectors may be involved for environmental safety.
Host recruitment & vetting practices	Application → full home-study → criminal-record & vulnerable-sector checks for all adult household members → reference checks → safety inspection. (Sask Approved Private Homes)
Support, monitoring & communication mechanisms	• CLSD caseworkers make scheduled monitoring visits (Provincial Auditor found most homes receive at least quarterly contact). (Auditor General of Saskatchewan) • Proprietors keep daily logs and must report critical incidents to CLSD within 24 h. (Pubsask Dev)
Resident / tenant safeguarding practices / frameworks	Proprietor's Manual requires: private bedroom, emergency-evacuation plan, secure medication storage, up-to-date first-aid/CPR for proprietor, and behaviour-support plans where needed. (Pubsask Dev)

Variable	Details
Quality-assurance frameworks / mechanisms	• Initial licensing + periodic relicensing inspections against the APSH standards. • Ministry conducts file reviews and on-site checks; the 2021 Provincial Auditor audit tracks compliance rates and recommends more frequent re-checks of criminal records and follow-up on action items. (Auditor General of Saskatchewan)
Host education / training standards / practices	Mandatory orientation on Ministry policies, abuse prevention and emergency procedures; proprietor must maintain valid first-aid/CPR. (Pubsask Dev)
Specific safeguarding / QA policies	• APSH Proprietor's Reference Manual (Pub #78769) - roles, standards, incident-report templates. (Pubsask Dev) • Residential Services Regulations, R-21.3 Reg 1 - legal requirement to follow the Manual. (Pubsask Dev)
Independent planning supports	Each resident has a CLSD Community Services Worker who leads annual person-centered planning separate from the proprietor. (Auditor General of Saskatchewan)
Balancing dignity of risk	Behaviour-support and risk-management sections in the Manual emphasise least-restrictive strategies and documenting resident consent for higher-risk activities. (Pubsask Dev)
Psychosocial supports	APSH aims at "supportive family-living" with opportunities to build social, recreational and life skills in community settings. (Sask Approved Private Homes)
Quality-of-life focus / outcomes measured	Proprietor's Manual directs proprietors to support personal goals in community participation, relationships and skill development; Auditor report notes CLSD collects but had not fully analyzed quality-of-life information as of 2021. (Auditor General of Saskatchewan)
Barriers	Auditor identified gaps: (i) CLSD not always re-verifying criminal checks after licensing, (ii) inconsistent follow-up on required improvements, (iii) incomplete monitoring documentation. (Auditor General of Saskatchewan)
Facilitators	Statutory licensing, detailed Proprietor's Manual, required incident-reporting and quarterly case-worker contact provide baseline safeguards.
Notable cases / events	2021 Provincial Auditor Performance Audit highlighted monitoring gaps and issued recommendations that the Ministry accepted. (Auditor General of Saskatchewan)
Program evaluation / research evidence	2021 Provincial Auditor audit is the principal external evaluation; tracks 200 APSHs and ~1 600 adults across APSHs and group homes. (Auditor General of Saskatchewan)
Notes / other unique features	Saskatchewan hosts a dedicated non-profit website (saskapprovedprivatehomes.ca) providing public information and proprietor-application steps - useful outreach model. (Sask Approved Private Homes)

Manitoba

Manitoba licenses “Host Family Homes” (Home Share) through the Department of Families’ Residential Care Licensing (RCL). “Host family home” is defined in the Residential Care Facilities Licensing Regulation (Man. Reg. 484/88 R). RCL issues Letters of Approval, and Public Health Inspectors apply environmental and safety checks using minimum standards for approved host family homes.

Community Living disABILITY Services (CLDS) sets Home Share service definitions and funding parameters. Policy documents state homes are licensed for up to four residents by regulation, while CLDS generally considers a maximum of two people in the same Home Share arrangement (exceptions case-by-case). Funding is per diem, with Employment and Income Assistance (EIA) contributing up to a set room-and-board amount; CLDS also publishes a Home Share funding model with rate levels.

Vetting and training requirements are set out in RCL’s Record Check & First Aid policy (CRC with Vulnerable Sector Search, Adult Abuse Registry, and First Aid/CPR; three-year First Aid recertification; requirements also extend to adult household members and certain long-stay visitors). Risk assessment guidance is issued by RCL and identified as best practice for host family homes.

Planning and safeguards are anchored in CLDS person-centered planning policy (annual planning at minimum, aligned to The Adults Living with an Intellectual Disability Act) and service definitions emphasizing least-restrictive support, medication documentation, and financial record practices.

Table 5. *Manitoba - Host Family Homes (Home Share)*

Variable	Details
Country / Region	Canada - Manitoba (Residential Care Licensing overview)
Jurisdiction / Organization	Department of Families - Residential Care Licensing (RCL); Community Living disABILITY Services (CLDS) (RCL; CLDS policies & forms)
Program / Initiative	Host Family Homes (“Home Share”) (Home Share - Regular, Agency Supported PDF; Home Share FAQ)
Residential model / living arrangement	Adult eligible for CLDS shares a home with a licensed support provider (host). Regulation permits up to 4 beds; CLDS generally considers max 2 individuals per arrangement, with exceptions case-by-case (Service Definition)
Compensation / funding model	Per-diem funding 365 days/year; for people on EIA, up to a specified monthly room-and-board amount applies; agency support/administration rates published; CLDS also publishes a funding model with level-based per diems (Service Definition; Home Share Funding Model 2024 PDF)
Target / eligible population	Adults (18+) eligible for CLDS services (definition and eligibility criteria published by CLDS) (Are you eligible?; Assessment & Eligibility PDF)
Resident eligibility criteria	CLDS eligibility assessment; person-centered plan required and reviewed at least annually under CLDS planning policy (Assessment & Eligibility PDF; My Support Plan / Person-Centered Planning Policy PDF)
Governance structure	RCL licenses homes under Residential Care Facilities Licensing Regulation (Man. Reg. 484/88 R); Public Health Inspectors apply minimum health/safety standards; CLDS Facilitators manage planning

Variable	Details
	separate from operators (Regulation (CanLII); PHI Minimum Standards PDF)
Host recruitment & vetting practices	Expression of Interest portal; mandatory CRC with Vulnerable Sector Search, Adult Abuse Registry checks, and valid First Aid/CPR for operators/respite; adult household members and long-stay visitors require checks (RCL Expression of Interest; Record Check & First Aid Policy PDF)
Support, monitoring & communication mechanisms	Licensing inspections/renewals by RCL; operator annual declarations on record-check status; agency oversight and communication among individual/family/provider/CLDS; medication documentation and finance records kept and reviewed (Record Check & First Aid Policy PDF; Service Definition; Personal Funds Policy PDF)
Resident / tenant safeguarding practices / frameworks	Environmental & safety standards (egress, fire, sanitation) via PHI standards; secure medication storage/documentation; emergency planning in service definitions (PHI Minimum Standards PDF; Service Definition)
Quality-assurance frameworks / mechanisms	Statutory licensing/LOA; PHI inspections; RCL review of personnel/visitor checks; annual planning under CLDS policy; financial record reviews in RCL annual reviews (Record Check & First Aid Policy PDF; My Support Plan Policy PDF; Personal Funds Policy PDF)
Host education / training standards / practices	Valid First Aid/CPR (3-year recert); agency provides/coordinates orientation and additional training as required to support the individual (Record Check & First Aid Policy PDF; Service Definition)
Specific safeguarding / QA policies	Residential Care Facilities Licensing Regulation; Record Check & First Aid policy (Host Family Homes); Risk Assessment Policy (applies to host family homes as best practice); PHI Minimum Standards (Regulation (CanLII); Record Check & First Aid PDF; Risk Assessment Policy notice; PHI Standards PDF)
Independent planning supports	CLDS Facilitators (separate from operators/hosts) lead and document person-centered planning and reviews (My Support Plan Policy PDF)
Balancing dignity of risk	Service definitions require least-restrictive, least-intrusive supports; RCL Risk Assessment Policy guides risk-benefit analysis and mitigation (best practice for host family homes) (Service Definition; Risk Assessment Policy notice)
Psychosocial supports	Service definitions reference holistic supports (emotional/psychosocial, community participation, relationships, health) and access to community resources (Service Definition)
Quality-of-life focus / outcomes measured	Annual person-centered planning updates; documentation on medication, health appointments; RCL reviews of personal-funds records during annual reviews (My Support Plan Policy PDF; Service Definition; Personal Funds Policy PDF)
Barriers	Administrative compliance requirements (licensing/renewals, record checks, First Aid recertification) can be ongoing; occupancy beyond two typically requires case-by-case approval (Record Check & First Aid PDF; Service Definition)
Facilitators	Statutory licensing and PHI standards; explicit record-check and First Aid rules; published service definitions and funding model support

Variable	Details
	consistent implementation (PHI Standards PDF; Record Check & First Aid PDF; Home Share Funding Model 2024 PDF)
Notable cases / events	Publication of CLDS Home Share Funding Model (2024); updated RCL Record Check & First Aid policy clarifying visitor thresholds and 3-year First Aid recertification (Home Share Funding Model 2024 PDF; Record Check & First Aid PDF)
Program evaluation / research evidence	Administrative data holdings exist for CLDS (living arrangements, funding sources) in Manitoba's research repository; recent jurisdictional scans discuss Home Share features and implications (MCHP CLDS data description; CIIC Jurisdictional Scan 2025 PDF)
Notes / other unique features	Public "Expression of Interest" portal for prospective hosts; service definitions distinguish agency-supported vs. private 24-hour Home Share; EIA room-and-board contribution rules referenced in service definitions (RCL Expression of Interest; Home Share - 24hr Private PDF)

Ontario

Ontario delivers the Host Family Home (LifeShare) program through Ministry of Children, Community and Social Services (MCCSS)-funded developmental services (DS) agencies under a set of ministry instruments: Policy Directives for Service Agencies regarding the Host Family Program (issued April 2016, updated March 2022), Operational Guidelines for the Host Family Program (2022), and the Quality Assurance Measures (QAM) regulation (O. Reg. 299/10) with an MCCSS DS Compliance Inspection Indicator List used by ministry inspectors. Together, these documents define minimum screening, monitoring, incident-reporting and documentation requirements for LifeShare placements.

In terms of the residential model, an adult with a developmental disability lives long-term in a screened host family's private home and "shares daily life as a family member." The Operational Guidelines state no more than two placements per home unless the ministry approves an exception. Intake to developmental services begins with Developmental Services Ontario (DSO); applicants who meet statutory criteria may be referred to a LifeShare agency for matching. Hosts are paid a per-diem set by the contracted DS agency (funded by MCCSS). The LifeShare booklet notes the individual may also receive ODSP income that can be used toward living costs (e.g., room and board); any additional reimbursements are specified in the service agreement.

Before approval, agencies must complete police and vulnerable-sector checks, reference checks, and a home-safety assessment, and consider lifestyle/cultural fit and capacity to meet support needs. These requirements are set out in the Policy Directives and elaborated in the Operational Guidelines and the ministry's inspection Indicator List. Agencies conduct in-person monitoring visits (including unannounced visits as outlined in the guidelines) and maintain service agreements that spell out expectations, oversight, respite arrangements, and communication. Serious Occurrence Reports (SORs) for defined events (e.g., abuse, injury, police contact) must be filed to the ministry, and MCCSS Program Advisors verify visit frequency, SORs and follow-up actions during QAM compliance inspections using the standardized Indicator List.

Regarding planning, rights and safeguards, individuals keep a person-directed plan that is reviewed at least annually; agencies must ensure privacy (own bedroom), safety plans (e.g., fire/medication/finances), and support for rights and complaint processes, as required under the Policy Directives and QAM. The 2016 issuance of Host Family Policy Directives followed sector reviews and has since been updated in 2022; MCCSS also publishes current service objective pages (e.g., DS Host Family settings) that restate expectations and definitions for funded agencies. Peer-reviewed commentary has described the 2016 changes and their intent to tighten screening and monitoring.

Table 6. *Ontario - Host Family Home/LifeShare Program*

Variable	Details
Country / Region	Canada - Province of Ontario
Jurisdiction / Organization	Ministry of Children, Community and Social Services (MCCSS) - Developmental Services branch
Program / Initiative name	Host Family Home Program (branded LifeShare for families and the public) mcss.gov.on.ca
Residential model / living arrangement	An adult with a developmental disability lives long-term in a screened host family's private home and "shares daily life as a family member." Up to two placements per home unless MCCSS approves an exception. qamtraining.net
Compensation / funding model	• Host receives a per-diem rate set by the contracted DS agency and funded by MCCSS. • The person may keep ODSP income for room & board; extra

Variable	Details
	reimbursements are detailed in each service agreement. mcss.gov.on.ca
Target / eligible population	Adults (18+) who meet Ontario's Developmental Disability Services Act criteria. All applicants start with Developmental Services Ontario (DSO) intake. Ontario
Resident eligibility criteria	Completion of DSO application → referral to a Host-Family agency → matching process that considers lifestyle, culture and support needs. Ontario
Governance structure	• MCCSS issues Policy Directives and Operational Guidelines under s.10 of the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act. • MCCSS Quality Assurance Measures (QAM) inspectors conduct compliance inspections; DS agencies oversee day-to-day monitoring of hosts. Ontario, mcss.gov.on.ca
Host recruitment & vetting practices	Agencies must, before approval: • Review a police + vulnerable-sector check completed in last 6 months. • Conduct reference checks & home-safety inspection. • Assess motivation, lifestyle compatibility and ability to meet support needs. These steps are mandated in Policy Directive 1.0 and detailed in the Operational Guidelines. qamtraining.net, Ontario
Support, monitoring & communication mechanisms	• Agencies must visit each host home at least twice a year in person (one announced, one unannounced recommended). • Hosts keep daily logs; Serious Occurrence Reports for abuse, injury, police contact must be filed to MCCSS within 24 h. • Compliance inspectors verify visit records, incident reports and follow-up actions using the QAM Indicator List. mcss.gov.on.ca
Resident / tenant safeguarding practices	• Directive 1.3 requires up-to-date police/vulnerable-sector checks on all adults in the household. • Directive 1.6 mandates written Safety Plans (fire, medication, finances). • Hosts must respect personal privacy (own bedroom) and rights, and support access to complaint procedures. Ontario
Quality-assurance frameworks / mechanisms	• QAM Compliance Inspections use a standard indicator list that covers host screening, visit frequency, incident-reporting, Safety Plans, outcome reviews. mcss.gov.on.ca
Host education / training standards / practices	Agencies must provide orientation covering abuse prevention, individual support needs, emergency procedures; they document training dates and topics in the host record (Directive 1.4). qamtraining.net
Specific policies related to safeguarding / QA / training	• Policy Directives for Service Agencies Regarding the Host Family Program (2016; rev. 2022) - seven numbered directives. • Operational Guidelines for the Host Family Program - step-by-step screening, monitoring and support requirements. Ontarioqamtraining.net
Independent planning supports / facilitation	Each person keeps a DSO service navigator and an agency support worker not living in the home; annual person-directed support plans are mandatory. Ontario

Variable	Details
Balancing dignity of risk with safeguards	LifeShare booklet stresses that hosts "encourage independence and choice" while providing a safe family environment; plans must document any restrictions and review them regularly. mcss.gov.on.ca
Psychosocial supports / equity considerations	Matching process looks at culture, language, religion, lifestyle; hosts integrate the person into family, neighborhood and cultural activities. qamtraining.net
Quality-of-life focus / outcomes measured	Operational Guidelines require agencies to evaluate progress toward the individual's personal goals at least annually; QAM inspectors check that outcome reviews occurred. mcss.gov.on.ca
Barriers	2016 directives followed a coroner's inquest into a sentinel death, highlighting prior gaps in screening and monitoring; agencies note ongoing host-recruitment shortages. Directory of Open Access Journals
Facilitators	Province-wide directives and indicator list give a unified QA framework; serious-occurrence system ensures incidents reach MCCSS quickly; LifeShare branding aids recruitment.
Notable cases / events	2012 sentinel event (death in Ancaster) → 2015 inquest → April 2016 Policy Directives strengthening screening, monitoring and incident-reporting. Directory of Open Access Journals
Program evaluation / research evidence	2017 journal article "New Policy Directives for the Host Family Program in Ontario" analyzes impact of the 2016 directives; MCCSS publishes annual compliance-inspection summaries. ResearchGate
Notes / other unique features	Ontario's framework is highly prescriptive - seven policy directives, an operational manual, plus QAM inspections - providing a detailed template for host screening, training, visit frequency and incident management.

Quebec

Québec delivers host-family and shared-living through Ressources de type familial (RTF) and Ressources intermédiaires (RI). Provincial rules are set by the Ministère de la Santé et des Services sociaux (MSSS) in the *Cadre de référence - Les RI-RTF* (2016, rev. 2022). Day-to-day oversight is carried out by each CISSS / CIUSSS, which signs a standard service contract with every RI/RTF and is legally responsible for quality and safety. Remuneration is determined centrally using the G26 provincial pay grid (*Rétribution des RI-RTF*) with daily rates by support-need class.

Typical RTF placements involve 1-2 persons (exceptionally up to 4) living in the caregiver's own home and sharing daily life "as family." RI settings with 3+ residents may be an adapted house or apartment where the caregiver also resides. Adults (and some youth) admitted under DI-TSA, DP or SAPA program criteria are matched to an available RI/RTF following interdisciplinary assessment by the local establishment. Each person has an assigned *intervenant-pivot* (case manager) employed by the CISSS/CIUSSS, independent of the host, who leads annual service-plan reviews and advocacy.

Before approval, the establishment verifies police and vulnerable-sector checks for all adult household members, reference checks, and a home-safety inspection (e.g., fire egress; secure storage of medication and money). The framework requires private bedrooms, emergency plans, behaviour-support plans where indicated, and an explicit obligation to identify potential mistreatment and report incidents; allegations or serious events must be reported to the establishment within 24 hours.

Establishments conduct risk-based monitoring visits (*visites de vigie*) with at least one formal evaluation per year. The Cadre mandates each establishment to operate a program of quality, evaluation, surveillance and inspection, including analysis of trends in incidents, complaints and user satisfaction across its RI-RTF network.

Hosts receive orientation on the Cadre, emergency procedures, abuse reporting and infection prevention; first-aid/CPR is required, and refreshers are documented. During the pandemic, MSSS issued Directive DGAPA-013 (2020) with infection-control and clinical-follow-up rules (e.g., limits on visits/outings, staffing substitution procedures).Hosts are remunerated per the G26 grid via contracts with the CISSS/CIUSSS. Québec's RI-RTF network is unionized/collectively bargained, so remuneration details, respite, training hours and grievance procedures are also governed by provincial collective agreements alongside the Cadre.

Public directives from 2020-2023 note workforce shortages and pandemic-related visitation limits as constraints on relational quality and social inclusion; MSSS commits to periodic framework updates to maintain service quality.

Table 7. *Québec - Ressources de type familial (RTF) & Ressources intermédiaires (RI)*

Variable	Details
Country / Region	Canada - Province of Québec
Jurisdiction / Organization	Ministère de la Santé et des Services sociaux (MSSS); day-to-day oversight by each CISSS / CIUSSS (public health & social-services establishments)
Program / Initiative name	Ressources de type familial (RTF) and Ressources intermédiaires (RI) - the province-wide host-family / shared-living model for adults (and some youth) with intellectual disability, autism, physical disability, mental-health needs or age-related loss of autonomy. (publications.msss.gouv.qc.ca)
Residential model / living arrangement	1 - 2 (exceptionally 4) service users live in the caregiver's own home and share daily life "as family"; larger RIs (≥ 3 residents) may be an adapted house or apartment where the caregiver also resides. (publications.msss.gouv.qc.ca)

Variable	Details
Compensation / funding model	Hosts are remunerated according to the G26 provincial pay grid ("Rétribution des RI-RTF") that sets daily rates by support-need class; the CISSS / CIUSSS pays the host under a standard service contract. (grid referenced on the MSSS G26 portal). (g26.pub.msss.rtss.qc.ca)
Target / eligible population	Adults (18+) and some youth who cannot safely remain in their natural home and meet program-service criteria (DI-TSA, DP, SAPA).
Resident eligibility criteria	Admission decided by the local establishment after an interdisciplinary assessment and matching process with an available RI/RTF. (publications.msss.gouv.qc.ca)
Governance structure	*Cadre de référence - Les RI-RTF* (MSSS, 2016 rev. 2022) sets province-wide rules; each CISSS / CIUSSS signs an individual service contract with every RI/RTF and is legally responsible for monitoring quality and safety. (publications.msss.gouv.qc.ca)
Host recruitment & vetting practices	The Cadre requires: (i) police & vulnerable-sector checks for all adult household members, (ii) reference checks, (iii) home-safety inspection (fire egress, medication lock-up), (iv) an interview to evaluate caregiver motivation and capacity. (publications.msss.gouv.qc.ca)
Support, monitoring & communication mechanisms	• Establishment staff carry out *visites de vigie* (monitoring visits) and other planned inspections; frequency is risk-based but at least one formal evaluation each year.• Hosts keep daily logs; all incidents or allegations of abuse are reported to the establishment within 24 h.
Resident / tenant safeguarding practices	Requirements spelled out in the Cadre and the Règlement sur la classification: private bedroom, emergency-evacuation plan, secure storage of medication & money, behaviour-support plans where indicated, obligation to "repérer les situations potentielles de maltraitance." (CREGÉS)
Quality-assurance frameworks / mechanisms	• The Cadre de référence mandates that every establishment run a program de qualité, d'évaluation, de surveillance et d'inspection for its RI-RTF network, and that it analyzes trends in incidents, complaints and user satisfaction. (publications.msss.gouv.qc.ca)
Host education / training standards / practices	CISSS / CIUSSS must give hosts orientation on the Cadre, emergency procedures, infection prevention, abuse reporting; first-aid/CPR is required, and refresher training is documented in the contract file.
Specific safeguarding / QA policies	• Cadre de référence RI-RTF (2016, rev. 2022).• Règlement sur la classification des services offerts par une RI-RTF (legal regulation).• Directive ministérielle DGAPA-013 (2020) - COVID-19 infection-control & clinical-follow-up rules, including limits on visits/outings and staffing substitution procedures.
Independent planning supports	Each user retains an assigned *intervenant-pivot* (case-manager) employed by the CISSS / CIUSSS who is independent of the host and responsible for annual service-plan reviews and advocacy.
Balancing dignity of risk	The Cadre's guiding principles place the user at the center and instruct establishments to promote autonomy and participation while applying the *least-restrictive* measures; any restrictive practice must be justified in the service plan. (publications.msss.gouv.qc.ca)

Variable	Details
Psychosocial supports / equity	Hosts are expected to foster community participation and respect cultural identity; COVID directive DGAPA-013 emphasizes tailored measures for users with communication or comprehension difficulties.
Quality-of-life focus / outcomes measured	The Cadre lists user-centered goals (integration, autonomy, well-being) and instructs establishments to collect user-satisfaction data during annual evaluations, though aggregated QoL results are not yet published provincially. (publications.msss.gouv.qc.ca)
Barriers noted in public documents	2020-2023 directives flag workforce shortages and pandemic-driven visitation limits as challenges to maintaining relational quality and social inclusion.
Facilitators	Statutory framework (Cadre + Regulation) ensures baseline standards; province-wide pay grid (G26) provides predictable funding; dedicated MSSS mailbox (*guichet RI-RTF*) offers technical support to hosts and establishments.
Notable cases / events	Major 2014-2016 revision of the Cadre following new labor-relations legislation; 2020 DGAPA pandemic directives that introduced structured infection-control monitoring in RI-RTF settings.
Program evaluation / evidence	No recent external evaluation: compliance and incident-trend data are internal to each CISSS / CIUSSS. The Cadre commits MSSS to periodic updates “afin d’assurer la qualité des services rendus aux usagers confiés aux RI-RTF.” (publications.msss.gouv.qc.ca)
Notes / unique features	Québec’s RI-RTF system is unionised and collectively bargained, so remuneration, respite, training hours and grievance procedures are spelled out in provincial collective agreements that sit beside the Cadre de référence.

Newfoundland and Labrador

Newfoundland & Labrador delivers host-family/shared-living through the Alternate Family Care (AFC) Home Program, administered by the Department of Health & Community Services (HCS). Operational requirements are set out in the AFC Operational Standards Manual (effective October 1, 2007). Licensing and day-to-day monitoring have historically been performed by the regional health authorities; since April 2023 these functions operate within the single provincial authority NL Health Services (NLHS).

AFC places one to two adults with an intellectual disability in an approved caregiver's private residence to share daily life in a family setting; exceptions above two require health-authority approval. Public materials from HCS/RHAs describe AFC alongside other community residential options. Caregivers are paid a per-diem (room, board, agreed supports) through the health authority under a standard service agreement; rates vary with assessed support needs. Before approval, applicants complete the Application to Provide AFC (Manual Appendix), pass criminal record and vulnerable-sector checks, provide references, and undergo a home-safety inspection by health-authority staff. The Manual assigns regular (at least quarterly) visits by a Community Support Social Worker, with increased frequency when risk indicators are present. Serious occurrences (e.g., allegations of abuse, significant injury, police involvement) must be reported to the health authority within 24 hours using the program's reporting form.

Standards require private bedroom, an Emergency Response Plan, monthly fire-drill log, secure storage for medication and money, and behaviour-support plans when indicated. Each person has an Individual Support Plan developed and reviewed by a health-authority social worker independent of the caregiver.

Health authorities conduct annual operational reviews (file checks for training currency, incident follow-up, safety logs) and renew or revoke approval accordingly. A 2023 external review (Deloitte) recommended building a central data system to track AFC quality indicators and noted variation in monitoring rigor and data availability across regions; government materials list AFC under HCS-funded disability programs. The external review highlights caregiver recruitment challenges in rural areas, limited outcome data, and the need for stronger consistency in oversight. The province has accepted recommendations aimed at improving data systems and quality-assurance practices within the AFC network.

Table 8. *Newfoundland & Labrador - Alternate Family Care (AFC) Home Program*

Variable	Details
Country / Region	Canada - Newfoundland & Labrador
Jurisdiction / Organization	Department of Health & Community Services (HCS); day-to-day licensing and monitoring by the four Regional Health Authorities (RHAs)
Program / Initiative name	Alternate Family Care (AFC) Home Program
Residential model / living arrangement	1 - 2 adults with an intellectual disability live long-term in an approved caregiver's private residence and "share daily life as family." Up to two placements per home; any exception needs RHA approval. Government of Newfoundland and Labrador
Compensation / funding model	RHAs pay caregivers a per-diem rate (room, board, supports) set in the service contract; rate varies with each person's assessed support level. Government of Newfoundland and Labrador
Target / eligible population	Adults (18+) who meet HCS Community Support Program eligibility for intellectual disability and require supervised housing. Government of Newfoundland and Labrador

Variable	Details
Resident eligibility criteria	Referral and assessment by an RHA Community Support Social Worker; placement matched to caregiver based on compatibility, support needs and available vacancies. Government of Newfoundland and Labrador
Governance structure	• Provincial AFC Operational Standards Manual sets province-wide rules. Government of Newfoundland and Labrador • Each RHA signs a standard AFC Service Agreement with the caregiver and performs licensing, monitoring and contract management.
Host recruitment & vetting practices	Before approval, caregivers must: 1) complete an Application to Provide AFC (Manual - Appendix B), 2) pass Criminal Record & Vulnerable-Sector checks, 3) submit personal references, 4) pass a home-safety inspection by RHA staff. Government of Newfoundland and Labrador
Support, monitoring & communication mechanisms	• Monitoring visits: RHA Community Support Social Worker visits each AFC home at least quarterly; frequency increases if risk flags arise. • Incident reporting: caregivers must notify the RHA of any critical incident (abuse allegation, injury, police involvement) within 24 hours using the Serious-Occurrence form in the Manual. Government of Newfoundland and Labrador
Resident / tenant safeguarding practices	Manual requires: private bedroom; Emergency Response Plan; monthly fire-drill log; secure medication and money storage; Behaviour-Support Plan for individuals with high-risk behaviors. Government of Newfoundland and Labrador
Quality-assurance frameworks / mechanisms	• Annual Operational Review: RHA reviews caregiver files (training, incidents, safety logs) and re-approves or revokes the home license. • Province commissioned an external system review (Deloitte Review 2023) which recommends a central data system to track AFC quality indicators. Government of Newfoundland and Labrador
Host education / training standards	Caregivers must finish RHA orientation (abuse prevention, emergency procedures, medication admin) before first placement and hold current first-aid/CPR; refreshers recorded in the annual review. Government of Newfoundland and Labrador
Specific policies related to QA / safeguarding / training	• AFC Operational Standards Manual (Oct 2007, still in force). • Each RHA's *Serious Occurrence Reporting Policy* (referenced in Manual).
Independent planning supports	Every resident has an RHA Community Support Social Worker who develops and reviews an Individual Support Plan separate from the caregiver's role. Government of Newfoundland and Labrador
Balancing dignity of risk	The Manual instructs caregivers and Social Workers to document risk-benefit decisions in the Individual Support Plan, emphasizing community integration and choice while maintaining safety. Government of Newfoundland and Labrador
Psychosocial supports / equity considerations	Caregivers encouraged to integrate residents into family, cultural and community activities; RHAs arrange specialized mental-health or behavioral services as needed.

Variable	Details
Quality-of-life focus / outcomes measured	Annual Individual Support Plan review tracks goals in community participation, relationships and daily-living skills; Deloitte Review notes the absence of a province-wide QoL survey and recommends its development. Government of Newfoundland and Labrador
Barriers	External review highlights: limited data on outcomes, variable monitoring rigor among RHAs, caregiver recruitment challenges in rural areas. Government of Newfoundland and Labrador
Facilitators	Provincial standards create a uniform baseline; mandatory quarterly RHA visits and incident-reporting provide ongoing oversight; 2023 Deloitte recommendations aim to strengthen data and QA consistency.
Notable cases / events	2023 Deloitte Review of Residential Supports - first comprehensive system review in 15 years, prompting QA and data-collection reforms. Government of Newfoundland and Labrador
Program evaluation / evidence	2023 Deloitte Review; RHAs compile internal compliance statistics (not publicly released).
Notes / unique features	AFC homes fall under health-authority governance rather than standalone disability agencies, embedding host-family oversight within the broader healthcare quality framework.

New Brunswick

New Brunswick delivers host-family/shared-living through the "Home" class of Community-Placement Residential Facilities (≤2 residents in a private dwelling). "Home," "Residence" (3-9 beds) and "Residential Centre" (≥10) are defined in the provincial Standards & Procedures for Adult Residential Facilities, which Social Development uses alongside the Community Placement Residential Facilities Regulation (NB Reg 83-77) for licensing and oversight. Operators must maintain incident reporting to the case manager and ARF Coordinator, with Form 76-5168 submitted within 24 hours for specified events (e.g., abuse allegation, injury, medication error).

The manual requires Social Development and Criminal Record Checks (with re-verification at least every five years), and assigns each person a case manager; an Individualized Service Plan is developed and reviewed at least annually. Facilities undergo annual, unannounced inspections by the department, with additional visits as needed. May 2022 updates to the standards expanded resident-rights/complaints procedures and added a Seniors' Advocate requirement (posting contact info and facilitating access).

Table 9. *New Brunswick - "Home" class under Community-Placement Residential Facilities*

Variable	Details
Country / Region	Canada - New Brunswick
Jurisdiction / Organization	Department of Social Development (DSD)
Program / Initiative	Community-Placement Residential Facility - "Home" class (≤ 2 residents in a private dwelling)
Residential model / living arrangement	An adult (or two) with a disability lives permanently in an approved caregiver's home; caregiver provides room, board and daily supports. "Home" class distinguished from "Residence" (3-9 beds) and "Residential Centre" (≥ 10).
Compensation / funding model	Caregivers receive a special-care assistance per-diem (financial assistance) paid by DSD; exact rate set by case manager based on assessed needs.
Target / eligible population	Adults who meet Family Services Act criteria and require long-term support; placement decided through DSD assessment.
Resident eligibility criteria	Admission procedures in s. 5.2; requires DSD Case-Manager referral and completion of an Individualized Service Plan within 30 days.
Governance structure	Homes licensed under Regulation 83-77 - Community Placement Residential Facilities; DSD Adult Residential Facility Coordinators issue/renew Certificates of Approval and conduct inspections.
Host recruitment & vetting	Application package must include: police & Social-Development record checks, references, home-safety inspection reports; checks re-verified at least every 5 years.
Support, monitoring & communication	• Case-manager monitoring visits (quarterly) to review care, finances, records.• Operators must maintain daily logs and incident files for inspection.
Resident / tenant safeguarding	Section 2.11 mandates incident reporting (suspected abuse, injury, medication error, missing resident, etc.) to case manager & coordinator within 24 h using Form 76-5168.
Quality-assurance mechanisms	• Licensing renewal every 12 months (application & fee). • Sections 2.20-2.22 require operators to maintain a *Quality of Services* policy

Variable	Details
	and address resident concerns; senior's advocate standard added 2022.
Host education / training	All caregivers must hold valid First-Aid/CPR and complete orientation covering emergency procedures, abuse prevention and medication administration.
Specific QA / safeguarding policies	• Standards & Procedures for Adult Residential Facilities (93-page manual, rev. 2022).• Incident-report form & Serious-Occurrence protocol (Appendix A).
Independent planning supports	Each resident has a DSD Case Manager (definition section) responsible for developing and annually reviewing the Individualized Service Plan independent of the operator.
Balancing dignity of risk	Section 5.5 *Behaviour Management* & section 5.6 *Use of Restraining Device* require least-restrictive interventions and resident consent when possible; ISP must document any restrictive practice.
Psychosocial supports & equity	Programming standards (5.4) instruct operators to promote community inclusion, decision-making and culturally relevant activities.
Quality-of-life focus / outcomes	Operators must develop annual Individualized Service Plans that set goals in autonomy, social/recreational participation and daily-living skills; files audited by coordinators.
Barriers (noted internally)	Manual recognizes staffing, rural recruitment and documentation burden; 2022 update added Senior's Advocate to strengthen complaint resolution.
Facilitators	Statutory licensing; mandatory incident-reporting; quarterly monitoring; comprehensive standards manual with forms and checklists.
Notable events	May 2022 revision broadened resident-rights section and aligned discharge rules with long-term-care policy.
Evaluation / evidence	No public external evaluations; compliance data held by DSD.

Nova Scotia

Nova Scotia delivers host-family/shared-living through the Alternative Family Support (AFS) program within the Disability Support Program, now under the Department of Community Services and Seniors (DCSS). Current AFS policy (2017 manual) permits up to two adults to live permanently in an approved family home; providers are vetted (police/vulnerable-sector checks, references, home-safety inspection), sign a tripartite service agreement, and receive a monthly allowance tied to Level-of-Support (I-V) for room/board, support/supervision, and respite. Eligibility requires DSP approval and confirmation that needs fit an AFS setting (e.g., no awake-overnight staffing). A Care Coordinator provides early transition contact, then at least annual reviews; serious occurrences are reported to DCSS within 24 hours; each person has an Individual Support Plan reviewed after 3 months and annually. The Human-Rights Remedy (2023) proposes scaling AFS into a province-wide Home Share stream-creating regional hubs and local coordinators, individualized funding (AFS per-diem as a base with add-ons), raised minimum monitoring and QoL reviews, incident dashboards, and enriched host training/respite. For this report, AFS is treated as the current baseline, with Remedy elements noted as in implementation planning rather than in force.

Table 10. *Nova Scotia - Alternative Family Support (AFS) Program*

Variable	Details
Country / Region	Canada - Nova Scotia
Jurisdiction / Organization	Department of Community Services / Seniors (DCSS) - Disability Support Program (DSP)
Program / Initiative	Alternative Family Support (AFS) Program - host-family option within DSP
Residential model / living arrangement	Up to two adults live permanently in an *approved private family home* and "share daily life as family." Government of Nova Scotia
Compensation / funding model	• DCSS pays the AFS provider a monthly allowance for *room & board, support & supervision, respite*; rate depends on the resident's support-level (Levels I-V). Government of Nova Scotia
Target / eligible population	Adults (18+) who meet DSP eligibility and whose support needs *can be met* in an AFS setting. Government of Nova Scotia
Resident eligibility criteria	• Must be DSP-eligible. • Assessment confirms needs fit AFS (no 24-h awake night support). • Resident (or SDM) agrees to the placement. Government of Nova Scotia
Governance structure	• AFS Policy Manual (Chapter 10 of DSP policy) gives provincial rules. • Each resident & provider sign a tripartite AFS Service Agreement with DCSS. Government of Nova Scotia
Host recruitment & vetting	Application must include: police + vulnerable-sector check (≤ 6 mo old); references; home-safety inspection; DCSS interview. ✓ Sections 6 & 10. Government of Nova Scotia
Support, monitoring & communication	• Care Coordinator contact: frequent in first 3 months, then at least annual reviews plus interim phone / home visits. Government of Nova Scotia • Incident reporting: any abuse, injury, police involvement → DCSS within 24 h (Policy §9). Government of Nova Scotia

Variable	Details
Resident / tenant safeguarding	• Written Emergency Response Plan, monthly fire-drill log. • Secure medication & money storage. • Behaviour Support Plan where risk requires. Government of Nova Scotia
Quality-assurance mechanisms	• Individual Support Plan (ISP) review after 3 months and annually - Care Coordinator updates goals, support level & funding. Government of Nova Scotia • DSP division "ensures an effective ongoing review and periodic evaluation" of AFS (Monitoring clause 6.2). Government of Nova Scotia
Host education / training	• Mandatory orientation to AFS policy, abuse prevention, emergency procedures (Policy §7). • Providers must hold current First-Aid/CPR. Government of Nova Scotia
Specific QA / safeguarding policies	• AFS Policy Manual (42 pp, rev. 2017). • ISP template & Level-of-Support Assessment Tool (appendices).
Independent planning supports	Care Coordinator (DSP employee) develops & reviews ISP, separate from provider, using a collaborative approach. Government of Nova Scotia
Balancing dignity of risk	ISP must record the resident's risk-tolerance; least-restrictive supports; restrictions need approvals per Support-Level table (§5.3.4). Government of Nova Scotia
Psychosocial supports / equity	ISP includes community participation, vocational/leisure goals, family-network involvement; Care Coordinator links to mental-health & cultural resources. Government of Nova Scotia
Quality-of-life outcomes measured	ISP goals cover autonomy, community participation, ADLs; progress reviewed at each 3-month and annual visit. Government of Nova Scotia
Barriers noted	Policy flags wait-lists & funding caps (§5.1.5) and cases needing > Night-awake support as outside program. Government of Nova Scotia
Facilitators	Tripartite Service Agreement clarifies roles; Level-of-Support tool aligns funding to needs; early-transition frequent visits.
Notable cases / events	2017 DSP policy consolidation integrated AFS Chapter 10; 2023 Human-Rights Remedy report (Key Direction 3) calls for AFS expansion into province-wide Home-Share.
Program evaluation / evidence	No external evaluation yet; DCSS committed to periodic program evaluation (Monitoring clause 6.2).

The below table contrasts the current AFS policy (the operating baseline) with the Human-Rights Remedy's Key Direction 3 proposals and a "practical link-up" column showing how AFS would be adapted. Headline shifts include: centralized regional hubs and stronger province-level monitoring, individualized funding layered on top of the AFS per-diem, higher minimum monitoring/QoL reviews with incident dashboards, and expanded recruitment/training supports for hosts. The Remedy elements are in planning/implementation; until enacted, AFS (2017) remains the governing policy.

Table 11. *Nova Scotia - AFS (2017) vs. Human-Rights Remedy (2023)*

Aspect	Current AFS Policy (2017 manual)	Human-Rights Remedy - Key Direction 3 (Expert Report, 2023)	Practical link-up
Program name	*Alternative Family Support (AFS)*	Proposes a province-wide "Home Share" stream	Remedy essentially re-brands and scales AFS; the Expert Panel notes AFS is the only existing host-family option and should be the foundation for expansion.
Governance & geography	Managed centrally by DSP; oversight from regional Care Coordinators.	Creates 4 Regional Hubs and Local-Area Coordinators to lead recruitment, matching & QA; establishes an independent provincial monitoring body.	The hubs absorb current DSP regional teams; AFS files and contracts roll into the new Hub structure, giving them dedicated leadership and data capacity.
Eligibility / access	Admission depends on vacancy, provider match and support-level cap (no night-awake staffing).	Introduces a "no-denial" principle: if a person wants Home Share and supports can be wrapped in, the system must offer it.	Removes service-level cap that currently excludes higher-support individuals; AFS eligibility rules will be rewritten.
Funding model	Fixed per-diem to the provider based on Level-of-Support table.	Shifts to individualized funding so participants can blend Home Share payment with additional clinical or respite supports.	Existing AFS per-diems become the "base" Home Share stipend; add-ons (e.g., overnight staffing) funded through individual budgets.
Recruitment & vetting	DSP advertises ad-hoc; orientation + record checks + home inspection.	Regional capacity-development workers lead systematic, culturally matched recruitment; same record-check & inspection core, but with mentoring supports.	Builds on AFS checklist but supplies dedicated HR capacity and mentorship for hosts.
Monitoring frequency	Care Coordinator visit at 3 months, then at least annually (policy allows more).	Annual Quality-of-Life review for every Home Share placement plus real-time incident dashboard; Local-Area Coordinators on call.	Raises minimum visit frequency and adds outcome-based reviews - augmenting AFS's current annual ISP check.
Safeguards / incident response	Serious Occurrence reporting to DSP within 24 h.	Adds emergency-response teams and "no new admissions to institutions" rule; dashboards flag patterns across regions.	AFS incident form remains but data now feed the provincial dashboard for proactive risk detection.
Training & supports for hosts	Orientation; mandatory First-Aid/CPR; agency offers behaviour-support training.	Hubs budget for host orientation, respite, cultural competence & trauma-informed modules; respite framed as burnout prevention.	Enriches the existing training menu and ensures respite funding is built into every contract.

Aspect	Current Policy (2017 manual)	AFS Human-Rights Remedy - Key Direction 3 (Expert Report, 2023)	Practical link-up
Dignity of risk	ISP must document restrictive practices and aim for least-restrictive support.	Remedy frames Home Share as the default community option that enables "positive risk"; back-up teams prevent institutional readmission.	Upholds the AFS least-restrictive principle but wraps it in stronger, rights-based language and support capacity.

Prince Edward Island

Prince Edward Island delivers host-family/shared living through the Associate Family Program, funded by AccessAbility Supports (Department of Social Development & Seniors). Public materials describe placements of one to two adults with intellectual disability or autism in an approved family home, with funding levels based on individual support needs and day-program schedules. Administration is outsourced to four regional NGOs (Queens County Residential Services, Community Connections Inc., Community Inclusions, and Inclusions East) that recruit, assess, match, and monitor associate families; SDS coordinators remain involved in planning.

Public information on PEI's Associate Family Program is high-level only. The SDS "Associate Families" page and the AAS handbook describe purpose, eligibility, and that four NGOs run and monitor the program, but they don't publish procedures, checklists, contracts, visit frequency, incident-reporting forms, or training requirements. NGO sites mostly provide brief overviews; the only concrete glimpse is Community Connections' host application form, which shows screening questions but nothing on post-approval monitoring. In short, the detailed QA/safeguard requirements and contractual clauses exist internally between SDS and the four NGOs and aren't available on public websites. The provincial info page was updated Sept 11, 2024.

Table 12. *Prince Edward Island - Associate Family Program*

Variable	Details
Country / Region	Canada - Prince Edward Island
Jurisdiction / Organization	Department of Social Development and Seniors (SDS) - *AccessAbility Supports*
Program / Initiative	Associate Family Program - host-family ("associate family") living option for adults with intellectual disabilities or autism
Residential model / living arrangement	1-2 adults live long-term in an approved family's private home, sharing daily routines and community life. Government of Prince Edward Island
Compensation / funding model	Caregivers are funded through the AccessAbility Supports program; payment level is "based on the unique support needs and day-program schedule of the client(s)." Government of Prince Edward Island
Target / eligible population	Adults with varying degrees of intellectual disability or autism who require support with daily living and decision-making. Government of Prince Edward Island
Resident eligibility criteria	Clients must be enrolled in *AccessAbility Supports* and be matched by one of four regional NGOs that manage the program. Government of Prince Edward Island
Governance structure	SDS contracts four NGOs to recruit, assess, match and monitor Associate Families: • Queens County Residential Services • Community Connections Inc. • Community Inclusions • Inclusions East. Government of Prince Edward Island
Host recruitment & vetting practices	NGOs "recruit families, assess the home and family, identify clients, connect families and clients," and perform safety assessments before approval. Government of Prince Edward Island

Variable	Details
Support, monitoring & communication mechanisms	NGOs "monitor placements, as well as offer support and guidance." Regular home visits and check-ins are carried out by NGO workers; SDS AccessAbility Support Coordinators stay involved in planning. Government of Prince Edward Island
Resident / tenant safeguarding practices / frameworks	The public page notes creation of "a supportive and safe home," but specific safeguards (e.g., record checks, emergency plans) are handled by the NGOs' assessment processes; details are not published online. Government of Prince Edward Island
Quality-assurance frameworks / mechanisms	Program monitoring rests with the regional NGOs, which report to SDS; no separate public QA manual is posted.
Host education / training standards / practices	Not specified online; NGOs "offer support and guidance" to caregivers, implying orientation/training is provided through each NGO. Government of Prince Edward Island
Specific policies related to safeguarding / QA / training	No standalone public policy manual available; Associate Family page references general AccessAbility Supports legislation and NGO protocols.
Independent planning supports	*AccessAbility Support Coordinators* work "with clients, the Associate Family and day-programming providers to develop a plan of support" that meets everyone's needs. Government of Prince Edward Island
Balancing dignity of risk	Program goal is to "encourage independent living skills and help enhance community involvement and inclusion," pointing to a balanced autonomy-plus-support approach. Government of Prince Edward Island
Psychosocial supports / equity	Emphasis on community involvement and inclusion; placement matching handled by NGOs familiar with local cultural contexts.
Quality-of-life outcomes measured	No public QoL survey; outcomes are embedded in individual support plans developed with SDS coordinators.
Barriers / facilitators mentioned publicly	Page highlights benefits for families and clients but does not list systemic barriers; NGO involvement is a facilitator for ongoing monitoring and match quality.
Notable cases / events	Program page published/updated 11 Sep 2024, signaling a refresh and possible recruitment drive.
Program evaluation / research evidence	No external evaluations published online; SDS and NGOs presumably maintain internal placement and outcome data.
Notes / unique features	PEI is one of the few provinces that outsources host-family recruitment and monitoring entirely to regional non-governmental organizations, rather than a government agency or licensed service provider.

Territorial Frameworks

Northwest Territories

The Northwest Territories delivers Supported Living Services through a mix of agency-run small homes and some family-home/host-style placements (≤5 beds). The 2022 *Supported Living Review* and the GNWT response provide the most concrete public reference point: they document existing contract-monitoring gaps while outlining a territorial workplan that includes the introduction of supported-living standards, partial alignment with Accreditation Canada benchmarks, centralized incident tracking, and outcome/quality-of-life dashboards. These documents offer useful benchmarks for oversight frequency, accreditation goals, and the development of incident-reporting and accountability dashboards (hss.gov.nt.ca).

Table 13. *Northwest Territories - Supported Living (small-home & host-style placements)*

Variable	Details
Program	Supported Living Services (Department of Health & Social Services)
Model	Mix of agency-run small homes and family homes (≤ 5 beds) providing 24-h or intermittent support to adults with cognitive or physical disabilities.
Key documents	• Supported Living Review - Final Report (2022). hss.gov.nt.ca • HSS Response to Review Recommendations (2022). hss.gov.nt.ca
QA / Monitoring	Review notes homes are run under service contracts; Accreditation Canada standards adopted for some sites; recommends territorial Supported Living Standards and central incident-tracking.
Safeguards	Service contracts require criminal-record checks, staff training and monthly reporting; review found gaps in consistent oversight of medication and fire-safety drills.
Outcomes	Report calls for territory-wide QoL and incident dashboards; none yet implemented.
Dignity of risk	Review recommends person-centered plans balancing autonomy with health/safety, especially for Indigenous clients returning to small communities.

Nunavut

Nunavut does not have a public framework for an adult host-family (home-share) model. Adult supports are described primarily through continuing-care centers and staffed group homes, most often operated under Department of Family Services contracts in Iqaluit or out-of-territory facilities when local services are unavailable. Reports and audits note that while children and young adults have sometimes been placed out-of-territory, no public standards for host-family or adult family-care placements exist (Legislative Assembly of Nunavut, oag-bvg.gc.ca). Government documents reference continuing-care homes, income-assistance supplements, and the use of group-home standards under the *Continuing Care Act*, but there is no indication of family-care policy. Strategic planning documents, including the 2022 Continuing-Care roadmap, identify the “future development of community-based residential options” as a priority, yet no public draft standards for host-family care have been released.

Yukon

Yukon does not appear to operate an adult host-family (home-share) program. Publicly available information from Yukon Health and Social Services lists supports such as home-care nursing, respite, and licensed continuing-care facilities, but no “Family Care Home” or

equivalent host-family option for adults with disabilities is included in the service directory (Yukon). Key service pages, such as *Find services if you have a disability* and the *Home Care Program* page, describe in-home health supports rather than family-based residential placements. At present, there is no posted policy, standards manual, or guidance document for an adult foster or home-share model (Yukon).

USA

Federal Frameworks

In the U.S., shared-living/host-home models operate under Medicaid HCBS rules set by CMS and implemented by states. The HCBS Settings Rule (42 CFR 441.301(c)(4)) requires community integration, autonomy, privacy (e.g., lockable doors), and-where the provider controls the home-tenancy protections via a lease or comparable agreement; CMS also supplies Exploratory Questions that states use for site validation.

Person-centered planning is mandatory and independent of the residential provider: plans must reflect what's important to and for the person, document alternatives considered, and record any time-limited modifications of rights. States must meet waiver assurances on health & welfare, qualified providers, and incident management (1915(c) Appendix G), including reporting, investigation, trend analysis, and remediation. CMS's HCBS Quality Measure Set(2022) and the 2024 Ensuring Access rule add a national outcomes framework and require biennial state reporting. Civil-rights enforcement (ADA/Olmstead) further anchors community integration in policy and oversight.

Table 14. *United States (Federal) - HCBS framework relevant to Home Share/host-home*

Variable	Federal Framework	Details
Country/Region	United States (federal)	-
Jurisdiction / Organization Name	Centers for Medicare & Medicaid Services (CMS)	CMS sets the binding Medicaid rules for HCBS (waivers & state-plan options) that every state model (host home, adult foster, shared living) must meet. (Medicaid)
Program / Initiative Name	HCBS Settings Rule (42 CFR 441.301(c)(4) + related sections)	Requires community integration, autonomy, privacy, choice of services & roommates; and tenancy/eviction protections(lease or residency agreement with rights comparable to landlord-tenant law) in provider-owned/controlled homes. CMS also issued Exploratory Questions tools states use for on-site validation. Private homes are generally presumed compliant, but person-centered planning protections still apply. (eCFR, Medicaid)
Residential Model Type / Living Arrangement Description	Any Medicaid HCBS residential setting (includes host home / adult foster / family-home models)	Settings must be integrated, support access to the greater community, protect privacy (lockable doors; control of schedule/visitors), and - if provider-owned/controlled - have a lease/residency agreement with eviction appeal rights. These apply across Home Share-style models when the provider controls the setting. (Medicaid, eCFR)
Compensation / Funding Model	Federal Medicaid authorities (1915(c), 1915(i), 1915(k), managed care)	Federal regs set allowable authorities and guardrails; states define rates. (Settings Rule & person-centered planning requirements must be met to claim federal match.) (Medicaid, eCFR)

Variable	Federal Framework	Details
Target / Eligible Population	Medicaid HCBS beneficiaries (IDD, ABI, seniors, etc.)	-
Resident Eligibility Criteria	Determined in each state's approved HCBS authority but must align with federal person-centered planning and level-of-care rules. (eCFR)	
Governance Structure	CMS approval & oversight of waivers/state plan; state operation	CMS requires states to demonstrate compliance with waiver assurances and health & welfare protections and submits states to ongoing monitoring. (wms-mmdl.cms.gov)
Host Recruitment & Vetting Practices	Waiver assurance: Qualified Providers (state must set and enforce standards)	CMS doesn't prescribe the exact vetting steps but requires states to have and monitor provider qualification standards(e.g., background checks, training). You'll find the specifics at the state level, anchored by this federal assurance. (wms-mmdl.cms.gov)
Support, Monitoring & Communication Mechanisms	Appendix G - Participant Safeguards (1915(c) Technical Guide) + Incident Management	States must run a robust critical-incident system (file, track, investigate, trend, and remediate incidents; ensure protections after incidents), address restraints/restrictive interventions, and medication management - all documented in Appendix G of each waiver. CMS publishes national guidance on incident-management best practices. (Tennessee Health Care Association, Medicaid)
Resident / Tenant Safeguarding Practices / Frameworks	HCBS Settings Rule rights + Person-Centered Plan requirements	Rights include privacy, dignity, freedom from coercion/restraint, control over daily life; any modification (e.g., locking up meds) must follow documented, time-limited, individually-based processes in the person-centered plan. (Medicaid)
Quality Assurance Frameworks / Mechanisms	Waiver Assurances (health & welfare, qualified providers, plan of care, etc.) + HCBS Quality Measure Set (QMS)	CMS requires states to monitor and report on waiver assurances (including health & welfare). The HCBS QMS(national measure set; updated 2024) standardizes reporting on outcomes like community inclusion, person-centered planning, employment, care experience, critical incidents, and equity; states must begin biennial reporting under the 2024 Access Rule. (wms-mmdl.cms.gov, Medicaid)
Host Education / Training Standards / Practices	Federal Qualified Provider assurance; PCP requirements	CMS requires states to define and enforce provider competencies tied to the person's needs; PCP rules require that staff implement supports consistent

Variable	Federal Framework	Details
		with individual goals/preferences (not one-size-fits-all). Details live in state policy, but the federal mandate is the hook. (wms-mmdl.cms.gov, eCFR)
Specific Policies Related to Safeguarding / QA / Training	Key federal pieces you'll cite in files: 42 CFR 441.301(c) (settings qualities & tenancy), Exploratory Questionstool (site validation), 1915(c) Technical Guide & Appendix G(incident mgmt, restraints, meds), HCBS QMS (2022 SMDL; 2024 update & Access Rule link).	These are the national "must-haves" that should show up in state manuals/provider audits and in your internal QA checklists for Home Share. (eCFR, Medicaid, wms-mmdl.cms.gov, Tennessee Health Care Association)
Independent Planning Supports / Facilitation	Person-Centered Planning (PCP)regs (42 CFR 441.725 for 1915(i); 441.540 for 1915(k); incorporated by reference in 1915(c) guidance)	PCP must be led by the individual, include people they choose, reflect what's important to and for the person, record alternative settings considered, and detail risk discussions. This anchors independence from the residential provider (states implement via independent case management/service coordination). (eCFR)
Balancing Dignity of Risk with Safeguards	PCP + modification requirements in the Settings Rule	Any restriction of rights (locks, monitoring, curfews) must be justified by assessed need, document less-restrictive alternatives tried, include informed consent, and be time-limited and reviewed - codifying "dignity of risk" with safeguards. (Medicaid)
Psychosocial Supports (Mental Health, Cultural/Equity)	HCBS Settings qualities + HHS Civil Rights/Olmstead	Federal civil-rights enforcement (ADA/Olmstead) pushes states to support people in integrated community settings with access to relationships, work, and typical life. HHS OCR and DOJ enforce integration and non-discrimination (useful leverage for community-based shared living). (HHS.gov, ADA Archive)
Quality of Life Focus / Outcomes Measured	HCBS QMS (national measures)	The QMS (2022 initial; 2024 update) includes measures on person-centered planning, community participation, employment, care experience, critical incidents/health & welfare, and equity; CMS has posted measure summaries and is phasing in state reporting. (Medicaid)
Barriers / Facilitators (federal view)	Facilitators: Exploratory Questions/toolkit, national QMS, clear PCP/modification rules, tenancy protections;	These are exactly what you'll see states wrestling with in their shared-living/host-home guidance and audits (and what you can mirror internally). (Medicaid)

Variable	Federal Framework	Details
	Barriers: state capacity to do on-site validation, build incident data systems, and align provider leases with tenancy protections.	
Notable Cases/Events	Olmstead (1999); ongoing DOJ integration enforcement; 2024-2025HHS OCR actions reinforcing community living	Use Olmstead/DOJ/OCR when you need a rights-based rationale for Home Share over institutional options or when pushing for integration/QOL. (ADA Archive, HHS.gov)
Program Evaluation / Research Evidence	Federal HCBS QMS + CMS training/briefs on incident management	Not research per se, but the federal measure set and CMS incident-management guidance define what good looks like and how to monitor it. (Medicaid)
Notes / Other Unique Features	Fair Housing Act overlays: reasonable accommodations/modifications and anti-discrimination apply to Home Share/host-home residences (esp. when provider-owned/controlled).	When you see tenancy issues in provider homes, pair the HCBS tenancy rule with FHA reasonable accommodation/modification guidance. (HUD, Medicaid)

Key federal levers that shape state Home Share models therefore include: HCBS Settings Rule (integration, autonomy, privacy, tenancy); person-centered planning regs; 1915 authorities with Appendix G safeguards (incident management, restraints, meds); HCBS Quality Measure Set with Access-rule reporting; and CMS Exploratory Questions for on-site validation in provider-owned/controlled settings.

State-Level Frameworks

Below, we outline states offering Home Share-type services (labels vary: Shared Living, Host Home, Lifesharing, Adult Foster/Family Home, Sponsored Residential). Highlighted/underlined rows in Table 15 below mark the jurisdictions examined in depth in this report; organization is by region and primary administering agency. See state sections for policy specifics and sources.

Table 15. *U.S. states with Home Share/host-home/shared-living options - coverage overview*

Region	State	Common program label	Administering agency (primary)
Northeast	**Vermont**	*Shared Living Program*	VT Dept. of Disabilities, Aging & Independent Living
	Massachusetts	*Shared Living* (DDS) & *Adult Foster Care* (MassHealth)	MA Dept. of Developmental Services + MassHealth
	New York	*Family Care / Shared Living*	NY Office for People With Developmental Disabilities (OPWDD)
	Pennsylvania	*Lifesharing*	PA Office of Developmental Programs
	New Hampshire	*Shared Living*	NH Bureau of Developmental Services
Mid-Atlantic / South-East	**Maryland**	*Shared Living*	MD Developmental Disabilities Administration
	Virginia	*Sponsored Residential Services*	VA Dept. of Behavioral Health & Developmental Services
	Georgia	*Host Home / Companion Care*	GA Dept. of Behavioral Health & Developmental Disabilities
	North Carolina	*Alternative Family Living (AFL)*	NC Dept. of Health & Human Services (NC Innovations Waiver)
Mid-West	**Minnesota**	*Host Family Services* (a subset of Individual Home Supports)	MN Dept. of Human Services
	Ohio	*Adult Foster Care (AFC) / Shared Living*	OH Dept. of Developmental Disabilities
	Kansas	*Shared Living*	KS Dept. for Aging & Disability Services
	Nebraska	*Shared Living*	NE Dept. of Health & Human Services
	Iowa	*Host Home*	IA Dept. of Health & Human Services
Central / South-Central	**Texas**	*Host Home / Companion Care*(HH/CC) / StarPLUS	TX Health & Human Services Commission
	Louisiana	*Shared Living* (ROW waiver)	LA Dept. of Health - Office for Citizens with Developmental Disabilities
Mountain / West	**Colorado**	*Host Home* (within IRSS waiver service)	CO Dept. of Health Care Policy & Financing

Region	State	Common program label	Administering agency (primary)
	Oregon	*Host Home* (IDD Services) + *Shared Living* via Brokerages	OR Dept. of Human Services - Office of Developmental Disabilities Services
	Washington	*Adult Family Home - Developmental Disability Specialty*	WA Dept. of Social & Health Services
	California	*Adult Family Home Agency (AFHA)*model	CA Dept. of Developmental Services
Pacific	**Hawaii**	*Shared Living / Adult Foster Home*(DD waiver)	HI Dept. of Health - Developmental Disabilities Division
Territories	**Guam**	*Family Home Service* (HCBS waiver)	Guam Dept. of Integrated Services for Individuals with Disabilities

Vermont

Vermont delivers Shared Living, also called the Developmental Home program, through a network of Designated and Specialized Service Agencies overseen by the Department of Disabilities, Aging & Independent Living. Adults with IDD live with Shared Living Providers (independent contractors) in family homes, supported by Medicaid HCBS waivers. Agencies recruit and vet providers, conduct safety inspections, and provide ongoing training, while DDSD regulations mandate monthly monitoring, critical incident reporting, and tenancy rights. Vermont is notable for its housing inspection database, strong emphasis on conflict-free case management, and detailed agency toolkits for safeguarding and quality monitoring.

Table 16. *Vermont - Shared Living (Developmental Home) program*

Variable	Details
Country/Region	USA - Vermont.
Jurisdiction / Organization Name	DAIL (Department of Disabilities, Aging & Independent Living) → Developmental Disabilities Services Division (DDSD). Services delivered by a network of Designated Agencies (DAs) and Specialized Service Agencies (SSAs). (vtlawhelp.org)
Program / Initiative Name	Shared Living (also called Developmental Home; providers often called Shared Living Providers - SLPs or "home providers"). (Green Mountain Self-Advocates, Vermont Family Network)
Residential Model Type / Living Arrangement	One or two adults with IDD live in the provider's family home; the provider offers individualized home supports under contract with an authorized agency. Vermont statute defines "shared living provider" accordingly. (Justia Law)
Compensation / Funding Model	Providers are independent contractors paid a stipend/room & board set in the agency contract; funding flows through Vermont's HCBS under the Global Commitment 1115 waiver and the DDSD System of Care Plan. (Example posting shows "tax-free stipend" and monthly room/board figures; amounts vary by person/agency.) (Medicaid, Howard Center)

Variable	Details
Target / Eligible Population	Adults with intellectual and/or developmental disabilities who meet DDSD eligibility and funding priorities. (Howard Center, vsea.org)
Resident Eligibility Criteria	Medicaid financial eligibility plus clinical eligibility for developmental disability; services authorized in an Individual Support Agreement (ISA) per the System of Care Plan. (vsea.org, Howard Center)
Governance Structure	DDSD sets rules via Developmental Disabilities Services Regulations (implementing the Developmental Disabilities Act). DAs/SSAs contract with home providers and are responsible for monitoring quality and safety. (Justia, Howard Center)
Host Recruitment & Vetting Practices	Agency processes include application, criminal & registry checks (e.g., criminal/DMV/abuse registries), home safety inspection, references, and a structured matching process. (GMSS publicly posts background-check forms and safety materials; CSAC flyer lists checks and home-safety inspection.) (Green Mountain Support Services, csac-vt.org)
Support, Monitoring & Communication Mechanisms	Each person has a Service Coordinator who provides training/support to the SLP and conducts regular home visits; one agency specifies at minimum monthly visits + team meetings. State reports note a housing inspection database used to monitor safety and accessibility across home-provider settings. (csac-vt.org, Medicaid)
Resident / Tenant Safeguarding Practices / Frameworks	Statewide Critical Incident Reporting (CIR) requirements; agencies provide CIR forms and FAQs, plus medication incident and seizure reporting templates. DDSD rules require HCBS-compliant choice, privacy, autonomy, tenancy rights and emphasize health/safety. Independent BDAP monitoring visits (pilot) include people living with shared living providers. (Howard Center, Green Mountain Support Services, vtlawhelp.org, Legal Information Institute)
Quality Assurance Frameworks / Mechanisms	DDSD System of Care Plan sets service codes/definitions and calls out CIR definition/clarity work; DAs must maintain local plans & oversight. The housing inspection database (AHS 1115 quarterly report) supports statewide QA on home safety/inspection compliance. (Howard Center, Legal Information Institute, Medicaid)
Host Education / Training Standards / Practices	Agencies deliver pre-service orientation and ongoing training (e.g., posted training registration, Relias modules). Public SLP resources include MAR checklist, medication incident reporting, emergency on-call info, and rights-restriction guidance. (Green Mountain Support Services)
Specific Policies Related to Safeguarding / QA / Training	• DDS Regulations (Developmental Disabilities Services) - define program governance and HCBS rights expectations. • CIR and medication forms (agency-level) for incident management. • Housing inspection database process referenced in AHS 1115 reports. • Agency handbooks/flyers specify background checks, safety inspections, and monthly monitoring. (Legal Information Institute, Green Mountain Support Services, Medicaid, csac-vt.org)

Variable	Details
Independent Planning Supports / Facilitation	Service Coordinators (at DAs/SSAs) lead person-centered planning and budgeting in the ISA; Vermont is implementing conflict-free case management (COI) reforms to separate case management from provider interests. (vtlawhelp.org, vermonthcbs.org)
Balancing Dignity of Risk with Safeguards	DDSD rules require home supports to comply with HCBS principles - choice, control, privacy, autonomy, tenancy rights, independence, inclusion - while maintaining health/safety and using technology/modifications to reduce restrictive staffing. (Legal Information Institute)
Psychosocial Supports (Mental Health, Linguistic, Cultural/Equity)	Agencies highlight matching based on interests, lifestyle, and community; SLP model is relationship-based (family life, belonging). (csac-vt.org, Howard Center)
Quality of Life Focus / Outcomes Measured	No single statewide outcomes tool is published; QA focuses on ISA goals, monitoring visits, incident data, and inspection findings. (Some agencies publish program outcome summaries; statewide SOC plan outlines assessment domains.) (Howard Center)
Barriers to QA/Safeguarding/QOL Measures	Historic observations include limited provider choice, reliance on contracted homes, and perceived power imbalances; ongoing carer recruitment needs. (Older national site-visit report noting VT context.) (rtc.umn.edu)
Facilitators to QA/Safeguarding/QOL Measures	Monthly contact/visits, structured incident & medication reporting, state inspection database, and system moves toward conflict-free case management. (csac-vt.org, Howard Center, Medicaid, vermonthcbs.org)
Notable Cases/Events	2019: launch of statewide housing inspection database for home-provider settings (safety/accessibility monitoring). 2023-2025: HCBS Conflict-of-Interest redesign (RFI issued 2024). (Medicaid, vermonthcbs.org)
Program Evaluation / Research Evidence	Descriptive assessments of Vermont's DS HCBS note that "most residential services" are contracted developmental homes/shared living, with qualitative strengths and challenges documented. (rtc.umn.edu)
Notes / Other Unique Features	SLPs are contracted (not employees); settings are unlicensed private homes overseen by agencies; responsibilities and monitoring are detailed in agency toolkits (CIR, MAR, seizure logs, background checks). (Green Mountain Support Services)

Massachusetts

Massachusetts operates Shared Living under its Department of Developmental Services (DDS) alongside MassHealth's Adult Foster Care (AFC) model. Adults with developmental disabilities or autism live with caregivers in family homes, with agencies providing monthly monitoring, training, and ISP-driven supports. Governance is detailed under DDS regulations, covering background checks, incident reporting, human rights committees, and licensure surveys. Recent updates expanded stipends, standardized assessment tools, and reintroduced in-person training requirements. Massachusetts' layered safeguards, quarterly satisfaction checks, and dedicated Office of Quality Enhancement make it one of the more formalized host-home models.

Table 17. *Massachusetts - Shared Living (DDS) and Adult Foster Care (MassHealth)*

Variable	Details
Country/Region	USA - Massachusetts.
Jurisdiction / Organization Name	Department of Developmental Services (DDS) (state agency) purchases and oversees Shared Living; delivered by contracted provider agencies. Related Medicaid model: MassHealth Adult Foster Care (AFC) (separate program/regulation). (Mass.gov)
Program / Initiative Name	Shared Living (DDS; sometimes "Shared Living - 24-Hour Supports") and Adult Foster Care (MassHealth). (Mass.gov)
Residential Model Type / Living Arrangement	An adult lives in a caregiver's family home. Caregiver (aka "home care provider") is recruited/contracted by a DDS provider agency; the agency supports and monitors the home. AFC similarly places a member with a live-in caregiver under clinical oversight. (Mass.gov, Legal Information Institute)
Compensation / Funding Model	DDS pays providers under 101 CMR 411.00 (Rates for … Shared Living Services). FY25 adjustments increased caregiver stipend levels (removing the four lowest tiers, raising caps, and increasing stipends ~18%), with DDS expecting 100% of increases to flow to caregivers. (AFC has separate payment rules under 130 CMR 408.000.) (Mass.gov)
Target / Eligible Population	Adults eligible for DDS (IDD/Autism, etc.) via 115 CMR 6.00 eligibility process; AFC serves MassHealth members who meet AFC clinical criteria. (Mass.gov, Legal Information Institute)
Resident Eligibility Criteria	DDS: individual must be DDS-eligible and have Shared Living authorized in the Individual Support Plan (ISP) under 115 CMR 6.00. AFC: PCP order and interdisciplinary oversight, with caregiver living in the residence, per 130 CMR 408.415. (Legal Information Institute)
Governance Structure	DDS provider agencies are governed by 115 CMR (notably 7.00 Standards, 8.00 Licensure & Certification, 9.00 Investigations, 12.00 National Criminal Background Checks, 13.00 Incident Reporting). DDS Office of Quality Enhancement (Licensing & Certification) surveys providers. AFC is governed by 130 CMR 408.000. (Mass.gov, Legal Information Institute)
Host Recruitment & Vetting Practices	DDS providers recruit, assess, and approve home care providers; fingerprint-based national criminal background checks and other checks are required under 115 CMR 12.00; agencies must maintain fit/competent caregivers per

Variable	Details
	licensure/certification standards. (AFC caregivers must meet 130 CMR qualifications.) (Legal Information Institute, Mass.gov)
Support, Monitoring & Communication Mechanisms	DDS requires at least monthly provider visits to each Shared Living home to review environment, health/safety, meds, finances, ISP progress, and home maintenance; agencies must annually assess caregiver skills. Providers must also quarterly contact the individual/family for a written satisfaction evaluation of the arrangement. (Mass.gov)
Resident / Tenant Safeguarding Practices / Frameworks	Multiple layers: incident reporting requirements (115 CMR 13.00); investigations & protective services process (115 CMR 9.00) and the state DPPC abuse reporting hotline for adults with disabilities (24/7). Providers must notify individual/guardian of specified incidents within 24 hours; provider Human Rights Committees review restraints/restrictive practices. (Legal Information Institute, dppcmass.gov)
Quality Assurance Frameworks / Mechanisms	DDS Licensure & Certification surveys (OQE) using manuals/tools; 2023 Interpretation guidance clarifies how surveyors evaluate Shared Living (diet, health protections, training, documentation in family homes). DDS also issues contract/rate guidance (e.g., FY25 rate implementation; contract review of nursing/clinical hours). (Mass.gov)
Host Education / Training Standards / Practices	Agencies must ensure ongoing supervision and staff development and verify caregiver competency (health protections, meds, emergency procedures). DDS training memo (May 2025) re-established in-person requirements for First Aid/CPR, MAP (hybrid with face-to-face component), and Crisis Prevention/Response; staff must complete all mandated and individualized trainings before working alone. (Mass.gov)
Specific Policies Related to Safeguarding / QA / Training	• 115 CMR 8.00 (Licensure & Certification) & survey tools (OQE). • 115 CMR 13.00(Incident Reporting) & 9.00 (Investigations). • 115 CMR 12.00 (National Criminal Background Checks). • DDS Human Rights system (HRCs, notifications, consent/review for restrictive practices). • DDS Guidance: Representative Payee in Shared Living (2024), Use of monitoring/tracking tech (2022), Locks (2022), Residential Agreements (2023). • 101 CMR 411.00 (Rates). (Mass.gov, Legal Information Institute)
Independent Planning Supports / Facilitation	ISP process (115 CMR 6.00) centers the person's goals and services; DDS Office of Human Rights provides rights advocacy resources; Human Rights Committees and Service Coordinators are additional safeguards/recourse. (Legal Information Institute, Mass.gov)
Balancing Dignity of Risk with Safeguards	DDS Human Rights materials emphasize the right to "typical developmental experiences, even though such experiences may entail an element of risk," with requirements for least-restrictive approaches, informed consent, and formal review/approval for any restrictions.

Variable	Details
Psychosocial Supports (Mental Health, Linguistic, Cultural / Equity)	Survey guidance expects community inclusion, interest-based matching, and tracking of community participation through monthly home-visit notes; rights resources stress communication supports and inclusion. (Mass.gov)
Quality of Life Focus / Outcomes Measured	Providers gather satisfaction feedback quarterly; surveyors assess diet/health, participation, autonomy/choice in daily routines (e.g., meals), and ISP goal progress within family-home context. DDS news also notes rollout of SIS-A® (2nd ed.) as part of assessment modernization. (Mass.gov)
Barriers to QA/Safeguarding/QOL Measures	Historic challenges include caregiver recruitment and ensuring consistent evidence in family-home settings (less formal documentation than 24/7 staffed homes), which OQE addresses through targeted survey guidance and monthly-visit expectations. (Mass.gov)
Facilitators to QA/Safeguarding/QOL Measures	Monthly home visits, annual caregiver skill assessments, quarterly written evaluations, robust incident & investigations regulations, Human Rights Committee oversight, and updated rate structure (FY25) to strengthen infrastructure and recruitment. (Mass.gov, Legal Information Institute)
Notable Cases/Events	Mar 2025: DDS launched a standardized Shared Living Assessment + Guidebook (required for all new SL assessments and significant changes). Nov 2024-Jul 2024 rates: major rate/stipend update effective July 1, 2024. (Mass.gov)
Program Evaluation / Research Evidence	FY21 Report on Shared Living (DDS legislative/reporting page) notes agency roles: provider screens & trains caregiver; DDS provides service coordination & ensures licensure/certification, i.e., split accountability model; ongoing survey reports available via OQE portal. (Mass.gov)
Notes / Other Unique Features	DDS central Licensure & Certification page houses live tools (manuals, survey worksheets, guidance), plus provider licensing reports by agency; contract review notices show active alignment of staffing/clinical supports with current rate models. (Mass.gov)

New York

New York's OPWDD Family Care program certifies family homes through sponsoring agencies, combining independent-contractor caregivers with intensive regulatory oversight. Adults with developmental disabilities live in certified homes, with compensation tied to Difficulty of Care levels and SSI-funded room and board. Safeguards include monthly liaison visits, quarterly nursing reviews, and at least two OPWDD inspections annually (one unannounced). Mandatory training, detailed incident reporting to the Justice Center, and statewide certification/recertification processes embed strong accountability. Unique features include a standardized set of forms (236/238/239) and nurse-every-90-days rule.

Table 18. *New York - OPWDD Family Care (Shared-living / host-family)*

Variable	Details
Country/Region	USA - New York.
Jurisdiction / Organization Name	Office for People With Developmental Disabilities (OPWDD); Family Care is delivered through sponsoring agencies (state- or agency-sponsored) and is certified/inspected by OPWDD. (Justia Regulations)
Program / Initiative Name	Family Care Homes for People with Developmental Disabilities ("Family Care"). (Justia Regulations)
Residential Model Type / Living Arrangement	One or more adults with developmental disabilities live in the approved provider's family home; the provider is an independent contractor; the home is OPWDD-certified and operates under the Family Care Manual & Part 687.
Compensation / Funding Model	Providers are paid a monthly Difficulty of Care (DOC) payment for Residential Habilitation (pro-rated if <22 service days in a month - "22-Day Rule"), plus room & board funded from the person's SSI/wages/benefits. Individuals are expected to maintain Medicaid and HCBS waiver enrollment.
Target / Eligible Population	People who meet OPWDD developmental disability eligibility and have residential habilitation authorized in their Life Plan. (Justia Regulations)
Resident Eligibility Criteria	OPWDD eligibility and service authorization; Family Care homes must hold an operating certificate; admission and residence are governed by Part 687 and the Manual. (Legal Information Institute, Justia Regulations)
Governance Structure	Family Care is governed by 14 NYCRR Part 687 (program), Part 633 (protection of individuals, medical decision-making & medication), and Parts 624/625 (incident management & events). OPWDD issues Administrative Directives (ADMs) and the Family Care Manual; sponsoring agencies sign a formal agreement with OPWDD. (Justia Regulations, Legal Information Institute, OPWDD)
Host Recruitment & Vetting Practices	Mandatory background checks for the provider, substitute provider, and all adult household members/regular overnights: SEL (Staff Exclusion List), SCR (child-abuse register), and Criminal History Record Check; fingerprinting as required by the Justice Center process. Home study & safety checks precede certification. (All set out directly in 687.8(p) and the Manual.) (Legal Information Institute)

Variable	Details
Support, Monitoring & Communication Mechanisms	• Monthly visit by the Family Care Home Liaison with a Monthly Checklist & summary note (Form 239). • Nursing visit at least every 90 days with a defined clinical review (MARs, orders, controlled-substance counts, health changes, training updates). • At least two OPWDD inspections/year (one unannounced) using Form 236; plus a separate annual safety inspection by OPWDD Safety & Security. • Extra visits occur around hospitalizations/discharge.
Resident / Tenant Safeguarding Practices / Frameworks	• Incident management: programs must follow Part 624 (reportable incidents & notable occurrences) and Part 625 (events/situations). Mandated reporters must file to the Justice Center VPCR within 24 hours. • Rights & protections under Part 633 (e.g., freedom from abuse, privacy, funds protections). • Manual lists the rights set and embeds abuse/neglect reporting, with agency duty to notify individuals/guardians of specified incidents. (OPWDD, justicecenter.ny.gov)
Quality Assurance Frameworks / Mechanisms	• OPWDD inspections (≥2/year per home) + agency monthly QA (Form 239) + 90-day nursing QA. • Required recertification reviews use OPWDD's Family Care Review instrument & Recertification Checklist; agencies also complete self-assessments using OPWDD's inspection instrument. • OPWDD maintains agreements spelling out reporting, fire-safety, finances, meds, and review obligations.
Host Education / Training Standards / Practices	Pre-service and annual training required by 633.8 and 687.8; agency RNs train/assess medication skills; documentation of training is mandatory. Topics include abuse recognition/reporting, rights, medication administration & records, infection control, emergency procedures, and person-specific supports; RNs may conduct observed medication pours.
Specific Policies Related to Safeguarding / QA / Training	• 14 NYCRR Part 687 (Family Care; certification, inspections, provider duties). • 14 NYCRR Part 624 (Incident Management) & Part 625 (Events & Situations). • 14 NYCRR 633.16(person-centered behavioral intervention/least-restrictive), 633.17 (medication). • ADM 2021-05 and the 2021 Family Care Manual (current operational detail, forms). (Justia Regulations, Westlaw Government, Legal Information Institute, OPWDD)
Independent Planning Supports / Facilitation	Planning is led by Care Coordination Organizations (CCOs/Health Homes); Care Managers coordinate the Life Plan and services; the Manual explains CCO roles and documentation in Family Care (e.g., Staff Action Plans, monthly summaries).
Balancing Dignity of Risk with Safeguards	633.16 requires person-centered, least-restrictive behavioral supports; rights in 633 (e.g., freedom from unnecessary/excessive meds) and consent rules in 633.10-633.11 (health-care decisions) guide risk decisions. Nursing/liaison reviews incorporate risk assessment and follow-up actions. (Legal Information Institute)

Variable	Details
Psychosocial Supports (Mental Health, Linguistic, Cultural / Equity)	Monthly liaison checklists and nursing reviews explicitly monitor community participation, relationships, and individualized safeguards; the Ready-to-Go medical info process supports continuity of care during hospital episodes.
Quality of Life Focus / Outcomes Measured	Monthly summary notes (by the liaison) track Life Plan goals, participation, autonomy, and health; 90-day nursing reviews capture health status and medication outcomes; OPWDD inspections review rights, inclusion, and home environment.
Barriers to QA/Safeguarding/QOL Measures	Documentation burden in private homes and maintaining consistent medication oversight(hence defined MAR reviews, observed pours, and 90-day nursing checks). Recruitment/retention of providers is managed through DOC payments and agency support. (All reflected in the Manual's structured visit & training requirements.)
Facilitators to QA/Safeguarding/QOL Measures	Monthly liaison visits, quarterly nursing, twice-yearly OPWDD inspections (inc. unannounced), mandatory incident reporting to VPCR, standardized forms (236/238/239), and annual recertification with checklists.
Notable Cases/Events	2015 incident-management reform created Part 625 and updated Part 624; 2021 Family Care Manual revision (ADM 2021-05) consolidated current policies and forms. (OPWDD)
Program Evaluation / Research Evidence	OPWDD does not publish a single statewide Family Care outcomes report; quality evidence is visible in inspection/recertification instruments and in incident-management trend review requirements within Part 624. (OPWDD)
Notes / Other Unique Features	Independent-contractor provider model; monthly agency QA in the family home; nurse-every-90-days rule; explicit financial governance for room/board & personal funds; and state-funded assistive technology/environmental mods for Family Care residents (not through HCBS waiver).

Pennsylvania

Pennsylvania's Lifesharing model, licensed under Chapter 6500, enables people with intellectual disabilities or autism to live with host families under provider or independent arrangements. Funded via ID/A Medicaid waivers, the program requires individualized ISPs, criminal history checks, and oversight by Life Sharing Specialists. Quality assurance includes the Independent Monitoring for Quality (IM4Q) program, provider self-assessments, QA&I reviews, and trend analyzes of critical incidents. With 24 hours of annual training required for hosts and a structured system of rights protections, Pennsylvania demonstrates one of the most comprehensive statewide QA frameworks for shared living.

Table 19. *Pennsylvania - Lifesharing (Life Sharing Homes under Chapter 6500)*

Variable	Details
Country/Region	United States (Pennsylvania).
Jurisdiction / Organization Name	Pennsylvania Department of Human Services (DHS) - Office of Developmental Programs (ODP). (Pennsylvania Government)
Program / Initiative Name	Lifesharing (also called "Life Sharing Homes" in regulation). (Pennsylvania Code & Bulletin)
Residential Model Type / Living Arrangement Description	Private home of a host individual or family providing a shared-life arrangement; licensable "Life Sharing Home" when operated under Chapter 6500; limited to no more than two non-related individuals with ID/A living in the home at one time (additional limits when relatives live there). (Pennsylvania Code & Bulletin)
Compensation / Funding Model	Medicaid HCBS waivers administered by ODP (Consolidated, Community Living, P/FDS) reimburse Lifesharing as a provider-managed service; separate room-and-board agreements required under §6100.687; procedure codes and "over/under 30 hours" billing levels referenced in ODP announcements. (Pennsylvania Government, RCPA)
Target / Eligible Population	Adults and children with intellectual disability or autism enrolled in ODP ID/A waivers; Chapter 6500 applies to individuals with ID or autism in Life Sharing Homes. (Pennsylvania Government, Pennsylvania Code & Bulletin)
Resident Eligibility Criteria	Enrollment in an ID/A waiver with an approved Individual Support Plan (ISP) authorizing Lifesharing; homes must meet ODP residential setting criteria; Chapter 6500 certificate of compliance required before an individual lives there. (Pennsylvania Government, Pennsylvania Code & Bulletin)
Governance Structure	Statutory/regulatory oversight by DHS/ODP; Life Sharing Homes licensed/inspected per Chapter 6500; Department inspects new homes and annually samples agency-administered homes; independently operated (non-agency) homes inspected annually. (Pennsylvania Code & Bulletin)
Host Recruitment & Vetting Practices	Mandatory Pennsylvania State Police criminal history checks for every person ≥18 residing in the home (FBI check if non-PA resident); applies at move-in and upon turning 18; copies of results must be kept. (Pennsylvania Code & Bulletin)
Support, Monitoring & Communication Mechanisms	Each person has a Life Sharing Specialist (max 8 homes / 16 people per specialist) responsible for assessments, ISP participation, implementing supports, community integration, and family/friend communication; supervision requirements

Variable	Details
	include an accessible specialist when the individual is in the home; agencies must complete a self-assessment of each licensed home 3-6 months before certificate expiration using the state inspection instrument. (Legal Information Institute, Pennsylvania Code & Bulletin)
Resident / Tenant Safeguarding Practices / Frameworks	24-hour reporting to ODP for specified critical incidents and 72-hour reporting for restraints/med errors; immediate protective actions; certified incident investigator requirements; individual/family notification within 24 hours; trend analysis at least every 3 months; policies on abuse/neglect, funds management, and rights. (Pennsylvania Code & Bulletin)
Quality Assurance / Frameworks / Mechanisms	Independent Monitoring for Quality (IM4Q) statewide program collects QoL and satisfaction data via independent interview teams; QA&I (Quality Assessment & Improvement) provider monitoring cycle with self-assessment and onsite reviews; ODP Quality Management Strategy and required provider QM Plans. (Pennsylvania Government, RCPA, Amazon Web Services, Inc., home.myodp.org)
Host Education / Training Standards / Practices	Mandatory pre-placement orientation covering person-centered practice, rights, abuse prevention/reporting, recognizing/reporting incidents, job skills; annual 24 hours of training that must include person-centered practices, rights, abuse prevention/reporting, incident reporting, behavior supports, and ISP implementation. (Pennsylvania Code & Bulletin)
Specific Policies Related to Safeguarding / QA / Training	Chapter 6500 Life Sharing Homes (rights, training, incidents, behavior supports); Medication Administration Training Program requirements (§6500.139) and related ODP announcements; Room & Board Residency Agreement template tied to §6100.687; ISP Manual sections on Lifesharing and IM4Q. (Pennsylvania Code & Bulletin, Pennsylvania Government)
Independent Planning Supports / Facilitation for Residents	Supports Coordination Organizations (SCOs) are qualified annually by ODP and provide independent service planning and monitoring separate from provider agencies; ISP process is person-centered per the ISP Manual. (Pennsylvania Government)
Balancing Dignity of Risk with Safeguards	Rights include the right to make choices and accept risks; any modification of rights must be documented in the ISP and only to mitigate significant health/safety risks; supervision levels are dictated by the ISP and cannot be reduced for convenience. (Pennsylvania Code & Bulletin)
Psychosocial Supports (Mental Health, Cultural/Equity)	Training mandates include “supporting individuals to develop and maintain relationships,” community integration, communication with family/friends; behavior support components built into the ISP. (Pennsylvania Code & Bulletin)
Quality of Life Focus / Outcomes Measured	IM4Q measures individual satisfaction and quality-of-life outcomes statewide via interviews; DHS/ODP posts annual IM4Q reports and resources; QA&I emphasizes person-centered outcomes. (Pennsylvania Government, home.myodp.org)

Variable	Details
Barriers to QA/Safeguarding/QOL Measures	Systemic factors occasionally noted in QA&I updates (e.g., documentation compliance, claim/service documentation focus) and medication-administration training capacity addressed via ODP announcements; not a critique of the model per se but operational constraints. (RCPA, RCPA)
Facilitators to QA/Safeguarding/QOL Measures	Defined caseload ratios for Life Sharing Specialists; mandatory incident management timelines and trend analyzes; standardized orientation/annual training; independent IM4Q and statewide QA&I cycles; required QM Plans. (Legal Information Institute, Pennsylvania Code & Bulletin, Pennsylvania Government, RCPA)
Notable Cases/Events	2019 comprehensive update of Chapter 6500 strengthened rights, training, incident management, and behavior support provisions. (Pennsylvania Code & Bulletin)
Program Evaluation / Research Evidence	Peer-reviewed analysis of IM4Q as a tool to monitor HCBS outcomes in PA; annual statewide IM4Q reports by ODP/Temple University. (AAIDD_CMS, Temple University Disabilities Institute)
Notes / Other Unique Features	Lifesharing Specialist must be accessible when the individual is in the home; explicit limits on capacity; detailed medication rules including training, records, storage, adverse reactions; required annual self-assessment using the state's inspection tool. (Pennsylvania Code & Bulletin, Legal Information Institute)

Virginia

Virginia's Sponsored Residential Services place individuals with developmental disabilities in the private homes of sponsors contracted through licensed provider agencies. Medicaid's Community Living Waiver funds the service, with rules capping occupancy at two residents per home. Rigorous vetting includes background checks, references, health screenings, and financial capacity reviews. Agencies must provide quarterly inspections (two unannounced yearly) and maintain quality improvement plans. Human rights protections, incident reporting within 24 hours, and independent case management reinforce autonomy and safeguards. Virginia's model emphasizes formalized sponsor agreements and codified DSP competency testing.

Table 20. *Virginia - Sponsored Residential Services (DD Waiver)*

Variable	Details
Country/Region	United States - Virginia.
Jurisdiction / Organization Name	Virginia Department of Medical Assistance Services (DMAS) and Virginia Department of Behavioral Health & Developmental Services (DBHDS). (Virginia Law)
Program / Initiative Name	Sponsored Residential Services (SRS) under the DD Waivers (Community Living Waiver).
Residential Model Type / Living Arrangement Description	Person with ID/DD lives in the private home of a sponsor (host family/individual) who provides supports under the supervision of a DBHDS-licensed provider agency. Max two individuals per sponsored home; max seven total occupants in the dwelling. (Virginia Law)
Compensation / Funding Model	Medicaid HCBS via Virginia's Community Living (CL) Waiver. SRS is a tiered, daily unit service (billable up to 344 days/year); room & board is not reimbursed. Customized rates may be approved for extraordinary needs.
Target / Eligible Population	Individuals meeting criteria for Virginia DD Waivers; SRS is available to CL Waiver enrollees.
Resident Eligibility Criteria	Must meet DD diagnosis and ICF/IID level-of-care via the VIDES assessment; meet Medicaid financial & non-financial criteria; slot assignment via statewide waiting list rules. (Justia Regulations, Virginia Law)
Governance Structure	DBHDS licenses provider agencies and enforces provider regs; DMAS sets waiver service definitions, documentation, payment, and competency requirements. Sponsors operate only via a licensed provider with a written sponsor agreement (defines responsibilities, supervision, compensation, training, reporting). (Virginia Law)
Host Recruitment & Vetting Practices	Provider must evaluate and certify each home before placement and annually: face-to-face interviews; home inspection; verify physical environment standards; assess sponsor ability to meet needs; check financial capacity for 90 days without resident payments; verify DMV record, TB screening, First Aid/CPR, medication administration, behavior intervention training; obtain three job-related references, criminal background checks, and child abuse/neglect registry check for sponsor and staff; have

Variable	Details
	policies to screen all adult household members (and act on barrier crimes). (Virginia Law)
Support, Monitoring & Communication Mechanisms	Provider must have written policies for orientation and ongoing support to sponsors; a training plan tailored to individuals' needs; specify on-call and substitute care arrangements; a policy for managing, monitoring, supervising homes as the network grows; conduct at least quarterly inspections of each home, with at least two unannounced per year; annual compliance review of each home/sponsor; policies for termination and transition planning(meeting with individual/AR, case manager, current sponsor, receiving staff). (Virginia Law)
Resident / Tenant Safeguarding Practices / Frameworks	Virginia Human Rights Regulations guarantee rights to dignity, protection from abuse/neglect/exploitation, participation in decisions/consent, least restrictive conditions, and complaint processes overseen by Local/State Human Rights Committees and advocates. Providers must develop policies, protect rights, and act immediately on abuse/neglect allegations. (Virginia Law)
Quality Assurance Frameworks / Mechanisms	All licensed providers must maintain a Quality Improvement (QI) program with a written plan, measurable goals, use of root-cause analysis, tracking statewide measures (if required), and service user input; must monitor corrective actions' effectiveness. (Virginia Law)
Host Education / Training Standards / Practices	Waiver-wide: Direct Support Professionals (DSPs) and supervisors must complete DMAS-approved orientation and pass a standardized test ≥80% before delivering services; complete competency observation & checklist within 180 days; additional training for individuals with intensive needs. Sponsored settings also require First Aid/CPR, medication administration, and behavior intervention training per sponsor vetting. (Virginia Law, Virginia Commonwealth University)
Specific Policies Related to Safeguarding / QA / Training (name & what they do)	12VAC35-105-1180 (Sponsor qualification & approval - vetting, references, checks, required trainings); 12VAC35-105-1190 (Policies: orientation/support, training plan, on-call/substitute care, supervision policy, quarterly & unannounced inspections, annual compliance, transition rules); 12VAC35-105-1230 (Max residents/occupants); 12VAC35-105-620 (Provider QI plan & RCA); 12VAC35-115 (Human Rights - dignity, consent, restrictions, complaints); 12VAC35-105-160 (Serious incident system: Level II/III report to DBHDS within 24 hours; Level I tracked quarterly; root-cause analysis within 30 days); 12VAC30-122-180 (DSP orientation test/competency requirements); 12VAC30-122-530 (SRS definition/allowable activities/limits). (Virginia Law, Legal Information Institute)
Independent Planning Supports / Facilitation	Case management (Support Coordination) is independent of residential providers; regulations require linkage, monitoring, periodic site/home visits, ISP oversight, advocacy, and transition planning; face-to-face visits must assess risks/needs and ensure services are delivered in the most

Variable	Details
	integrated setting per individual preferences. Choice of case manager is protected. (Virginia Law)
Balancing Dignity of Risk with Safeguards	Human Rights regs require services in least restrictive conditions and support everyday freedoms (movement, visitors, money, communication) consistent with safety, with any restriction carefully justified, time-limited, reviewed, and documented; providers must protect from harm while respecting autonomy. (Virginia Law)
Psychosocial Supports (mental health, cultural/linguistic)	Rules require community participation based on personal interests, and the SRS service definition includes supports for socialization, building friendships/circles of support, and behavior supports using positive strategies. (Virginia Law)
Quality of Life Focus / Outcomes Measured	Person-centered desired outcomes must be in the Plan for Supports; documentation must show progress toward outcomes and inclusion activities; providers' QI plans must include individual feedback/satisfaction and measurable goals. (Virginia Law)
Barriers to QA/Safeguarding/QOL Measures	Not explicitly discussed in one place in regulation; potential barriers implied: provider network growth (necessitating supervision policy as homes increase), incident trend analysis requirements (necessitating data systems), and sponsor financial capacity checks (risk of instability). (Virginia Law)
Facilitators to QA/Safeguarding/QOL Measures	Quarterly (incl. unannounced) home inspections, 24-hour serious incident reporting + root-cause analysis, independent case management, formal DSP competency regime, and codified human rights oversight. (Virginia Law)
Notable Cases/Events	Not identified in these core regulatory/DMAS sources.
Program Evaluation / Research Evidence	Administrative/regulatory framework; no single impact evaluation cited in these documents.
Notes / Other Unique Features	Sponsored homes cannot also operate as group homes or DSS foster homes; provider must notify DBHDS when adding/closing a sponsored home and submit service modification for homes >100 miles away. (Virginia Law)

Georgia

Georgia offers Host Home / Life-Sharing through its COMP/NOW waivers under the Community Residential Alternative service. Host homes (1-2 residents) are vetted through extensive home studies, medical checks, references, and environmental standards. Provider agencies oversee subcontracted hosts with monthly visits, while independent Support Coordinators also conduct monthly monitoring. A structured critical incident system, training in rights and safety, and provider quality reviews form the QA framework. Unique aspects include explicit bans on video monitoring in private spaces, mandated emergency preparedness, and quarterly reporting of subcontractor performance to both agency boards and DBHDD.

Table 21. *Georgia - Host Home / Life-Sharing (COMP/NOW waivers)*

Variable	Details
Country/Region	United States - Georgia.
Jurisdiction / Organization Name	Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD); Georgia Department of Community Health (DCH, Medicaid). (Georgia Medicaid)
Program / Initiative Name	Host Home / Life-Sharing delivered as a Community Residential Alternative (CRA) service under Georgia's DD waivers (COMP; some individuals are on NOW for non-residential supports).
Residential Model Type / Living Arrangement Description	Individual lives in the private home of a host (owner/lessee), receiving life-sharing residential supports. Not related to homeowner/lessee; homeowner/lessee may not be employed by the provider agency; 1-2 adults with DD per host home. (Georgia DBHDD)
Compensation / Funding Model	Medicaid HCBS via COMP/NOW waivers. CRA (host home) is a daily, waiver-funded service; DBHDD requires a host-home budget & payment detail per individual (submitted to the Regional Field Office and updated at least annually/when funding changes). Public comment on the NOW/COMP rate study notes a 344-day billing limit for group/host homes (policy adjustment discussed for provider changes). (Health Management Associates)
Target / Eligible Population	People with intellectual/developmental disabilities (IDD) meeting DD waiver criteria. COMP generally for those needing intensive residential supports; NOW provides less-intensive supports. (northcentralhealthdistrict.org)
Resident Eligibility Criteria	DBHDD Regional Field Offices determine disability eligibility; DFCS determines Medicaid/financial eligibility. DD criteria include ID (onset <18) or related condition (onset <22) with substantial adaptive limitations.
Governance Structure	DBHDD sets/updates Provider Manuals & policies; DCH manages the Medicaid waiver manuals. Provider agencies must hold appropriate licensure (e.g., Community Living Arrangement permit) and contract with DBHDD; host homes operate through a DBHDD-approved CRA provider with site-specific enrollment.
Host Recruitment & Vetting Practices	DBHDD policy 02-704 requires a Host Home Study and specific vetting before approval: general health exams for household members; TB/communicable disease screening; criminal history checks (≥17 yrs); three character references; proof of

Variable	Details
	insurance & lease/deed; firearms storage attestation; detailed assessment of the home's physical standards (smoke/CO detectors, fire extinguishers, medication/chemical lock-up, pool security), neighborhood & access to community resources, household composition & dynamics, work schedules/supervision, cultural acceptance, and prior provider history. Each host home gets site-specific Medicaid (CRA) enrollment before placement. (Georgia Collaborative, starchoices.org)
Support, Monitoring & Communication Mechanisms	• Provider oversight: Agencies must maintain active oversight of subcontracted host homes, including financial oversight, staff competency, ensuring care per ISP, and maintaining/refreshing the Host Home Study as household members change. • Home visits & monitoring: Agencies conduct at least monthly site visits to verify safe delivery of care, room, and watchful oversight; Support Coordinators/Planning List Admin also conduct at least monthly home visits to monitor progress. • Quarterly reports to agency boards on subcontractor performance and semi-annual reports to DBHDD Regional Offices on contracted providers. • Environment & safety: Quarterly/unannounced reviews referenced via general standards; limits on video monitoring in private areas; detailed emergency preparedness requirements (fire drills, evacuation/COOP, Mattie's Call for missing persons). (Georgia DBHDD, starchoices.org)
Resident / Tenant Safeguarding Practices / Frameworks	• DBHDD Human Rights framework (Human Rights Council policy referenced in manuals) and abuse/neglect/exploitation protections embedded across standards. • Critical incident system (Policy 04-106): categorizes incidents (I/II/III), mandates same-day or within-48-hour electronic reporting, safety plans with "C" incidents, provider investigations, and DBHDD Office of Incident Management & Investigations oversight. • Personal funds & belongings protections (Policy 02-702) and day-to-day living expenses agreements for agency-operated host homes.
Quality Assurance Frameworks / Mechanisms	Providers must operate a written Quality Improvement (QI) plan (risk identification, root-cause analysis, measurable goals, annual review); DBHDD and the Georgia Collaborative conduct Quality Enhancement Provider Reviews (QEPR); quarterly/annual compliance reviews of host-home networks are authorized in 02-704; Support Coordination monitors ISP outcomes and health/welfare. (starchoices.org, Georgia DBHDD)
Host Education / Training Standards / Practices	Prior to approval, hosts must complete training (with signed attestations & certificates): person-centered values, human rights & responsibilities, recognizing/reporting critical incidents, ISP basics, confidentiality, fire safety, emergency/disaster procedures, standard precautions, basic cardiac life support, first aid & safety, and medication administration/ supervision policies. Agencies also ensure ongoing competency for staff supporting host homes. (Georgia Collaborative)

Variable	Details
Specific Policies Related to Safeguarding / QA / Training (what they do)	• 02-704 - *Process for Enrolling, Matching, and Monitoring Host Home/Life-Sharing Sites*: enrollment prerequisites; home study contents; training attestations; monthly site-visit oversight; budget/payment documentation; transfer/termination steps. • 04-106 - *Reporting & Investigating Deaths and Critical Incidents*: categories, timelines, safety plans, investigations, corrective actions. • 02-702 - *Supervision & Protection of Personal Funds and Belongings*: controls around residents' money/valuables and day-to-day living expense agreements in host homes. • Provider Manual (FY2026) - service standards covering QI & risk management, environment/safety, emergency preparedness, rights, infection control. (starchoices.org, Georgia DBHDD)
Independent Planning Supports / Facilitation for Residents	Support Coordination (and Intensive Support Coordination when indicated) is independent of residential providers; functions include facilitating ISP development, monitoring health/welfare, evaluating service quality/outcomes, and coordinating non-waiver resources. (Georgia DBHDD)
Balancing Dignity of Risk with Safeguards	Provider standards emphasize person-centered planning, most integrated setting, meaningful choice of living environment/provider, and restrictions on surveillance in private areas; incident system focuses on risk mitigation while maintaining community inclusion and everyday rights (e.g., locks must allow individuals to exit without staff assistance).
Psychosocial Supports (Mental Health, Linguistic, Cultural / Equity)	Standards require community integration, support for friendships and typical life roles, access to behavior support services with positive supports/PBSPs, and coordination with the Georgia Crisis Response System for acute behavioral needs.
Quality of Life Focus / Outcomes Measured	ISPs must document desired outcomes and participation in community life; providers' QI programs include service-user input and measurable goals; Support Coordination explicitly evaluates service quality/outcomes and identifies unmet needs. (Georgia DBHDD)
Barriers to QA/Safeguarding/QOL Measures (noted in state docs)	Operational realities highlighted in forums/manuals: relief staffing limits in single-host homes, administrative load for incident reporting and safety plans, and data/trend analysis capacity for QI. (DBHDD)
Facilitators to QA/Safeguarding/QOL Measures	Monthly host-home site visits (agency) + monthly Support Coordination home visits; mandatory training & documented competencies; critical-incident reporting with safety plans; robust home-study and clearance checks; budget/expense agreements clarifying obligations. (starchoices.org, Georgia DBHDD)
Notable Cases/Events	Federal settlement monitoring referenced Georgia's policy limiting host homes to two individuals - reiterating small, non-institutional scale. (Department of Justice)
Program Evaluation / Research Evidence	Administrative framework and QEPRs (Georgia Collaborative) document compliance and quality trends; formal outcome

Variable	Details
	studies are not compiled in these state manuals. (Georgia Collaborative)
Notes / Other Unique Features	Providers must report subcontractor performance quarterly to their Boards and semi-annually to DBHDD; locks on exterior doors must permit egress without staff; explicit prohibitions on video monitoring in bedrooms/bathrooms; extensive emergency preparedness (COOP, disaster drills) requirements.

Texas

HCS Waiver (Host Home/Companion Care)

Texas' Host Home/Companion Care model under the HCS waiver allows up to three people to live in a host's private home, with strict rules preventing providers from owning or leasing the residence. Providers undergo criminal registry checks and ongoing vetting, while agencies conduct quarterly inspections and annual satisfaction surveys. Safeguards include mandatory abuse/neglect reporting within one hour, rights to tenancy agreements, and restrictions on restraints. Service coordination is independent via LIDDAs, and HHSC enforces compliance through surveys and HCBS Settings assessments. Tenancy protections, advisory committees, and mandated corrective action cycles distinguish this model.

Table 22. *Texas - HCS Waiver Host Home/Companion Care (HH/CC)*

Variable	Details
Country/Region	USA - Texas.
Jurisdiction / Organization Name	Texas Health & Human Services Commission (HHSC); Local Intellectual & Developmental Disability Authorities (LIDDAs) for service coordination. (Texas Health and Human Services, Texas Administrative Code)
Program / Initiative Name	Home and Community-based Services (HCS) waiver - Host Home/Companion Care (HH/CC) service. (Legal Information Institute)
Residential Model Type / Living Arrangement Description	Individual lives in the host provider's own home; the host lives in the residence; no more than three people receiving similar services can live there; program provider cannot hold a property interest in the HH/CC residence. (Legal Information Institute)
Compensation / Funding Model	Medicaid 1915(c) HCS waiver; HH/CC paid per-day with rates by Level of Need (e.g., LON 1-9 daily rates published by HHSC). Room & board is separate, paid by the individual/LAR under a residential agreement (tenancy-style) with limits on charges. (pfd.hhs.texas.gov, Legal Information Institute)
Target / Eligible Population	People with intellectual disability or related condition; HCS covers all ages. (stateofthestates.ku.edu)
Resident Eligibility Criteria	Eligibility/enrollment governed by HCS rules (Chapter 263); person-centered planning required; residential agreement and room/board responsibilities apply if HH/CC is selected. (Legal Information Institute)
Governance Structure	State standards set in Texas Administrative Code (TAC) Title 26, Chapter 565 (HCS Certification Standards) and Chapter 263 (program rules). HHSC surveys/enforcement; LIDDAs deliver service coordination per Chapter 263 Subchapter J. (texas-sos.appianportalsgov.com, Legal Information Institute, Texas Administrative Code)
Host Recruitment & Vetting Practices	Program providers must (before hire/contract and ongoing) run DPS criminal history checks; bar hires with certain convictions and registered sex offenders; check the Employee Misconduct Registry & Nurse Aide Registry at hire and annually; check state/federal excluded provider lists monthly. (Justia Regulations)

Variable	Details
Support, Monitoring & Communication Mechanisms	• Provider must conduct on-site HH/CC home inspections before placement and quarterly thereafter to verify safety/accessibility and ensure corrective actions are completed. • Provider must report deaths to HHSC/LIDDA by next business day and enter critical incident data monthly; must have a consumer/advocate advisory committee that meets at least quarterly; must conduct annual satisfaction assessments and act on issues within 60 days. • LIDDA service coordination provides independent monitoring, with required in-person contacts (HHSC Form 8647 indicates minimum face-to-face at least every 90 days). • HHSC/TMHP conducts on-site HCBS Settings Rule assessments of HH/CC settings using a standardized interview/observation tool; remediation required as needed. (Legal Information Institute, Texas Health and Human Services, Medicaid, TMHP)
Resident / Tenant Safeguarding Practices / Frameworks	• Rights: expansive rights including privacy, visitors, choice of providers, freedom from abuse/neglect, and participation in decisions. • ANE: individuals/LARs are educated at start and annually on how to report abuse/neglect/exploitation; staff/hosts must report to DFPS immediately and no later than 1 hour; provider must secure safety, notify stakeholders within 24 hours, and follow HHSC investigation processes. • Restraints: tightly limited (e.g., no prone/supine, no airway obstruction); mandatory restraint risk assessment within 30 days of service and annually; specific documentation and release criteria. (Legal Information Institute, Texas Health and Human Services)
Quality Assurance Frameworks / Mechanisms	• Quarterly HH/CC home inspections and corrective action tracking. • Annual individual/LAR satisfaction assessment with action within 60 days. • Quarterly consumer/advocate advisory committee reviews provider data and recommends improvements. • HHSC HCBS Settings compliance on-site assessments; HHSC survey/enforcement under Chapter 565. (Legal Information Institute, Texas Health and Human Services, Medicaid, Texas Health Law Section)
Host Education / Training Standards / Practices	• Before assuming duties and at least annually, hosts/staff/volunteers must be trained on what constitutes ANE, signs/symptoms, prevention methods, and how to report within 1 hour. • Program must ensure “trained and qualified” service providers; nursing services follow professional standards and HCS Appendix C. • Restraint-related risk assessment and documentation practices required. (Legal Information Institute, Justia Regulations)
Specific Policies Related to Safeguarding / QA / Training (name, focus)	• 26 TAC §565.25 Programmatic Requirements - quarterly HH/CC inspections; death reporting; incident data entry; annual satisfaction; quarterly advisory committee. • 26 TAC §565.31 ANE - training/education and 1-hour reporting rule; safety/notification steps. • 26 TAC §565.33 Restraints - prohibitions (e.g., prone/supine), assessments, documentation. • 26 TAC §263.503 Residential Agreements - tenancy-style leases for HH/CC, eviction safeguards (60-day notice to cure,

Variable	Details
	service coordinator involvement), refund requirements. (Legal Information Institute)
Independent Planning Supports / Facilitation for Residents	Person-centered planning via LIDDA service coordinator using HHSC Person-Directed Plan (Form 8665); service coordinator convenes team, documents outcomes/risks, and monitors implementation. (Texas Health and Human Services, Texas Administrative Code)
Balancing Dignity of Risk with Safeguards	Rights framework protects autonomy (choice, privacy, visitors, participation), with restrictions only as documented in the person-directed plan; tenancy protections (lease; eviction only for unpaid room/board or service termination; 60-day cure period; SC involvement) help maintain ordinary housing rights. (Legal Information Institute)
Psychosocial Supports (Mental Health, Linguistic, Cultural/Equity)	Service delivery requires supports that promote community inclusion, social interaction, leisure, and habilitation consistent with person-directed outcomes; nursing/behavioral supports and protective-device rules integrate clinical safeguards. (Legal Information Institute)
Quality of Life Focus / Outcomes Measured	Annual satisfaction assessments (provider-led) with required follow-up; person-directed outcomes captured in PDP/IPC; documentation requirements tie services to individualized assessments and outcomes. (Legal Information Institute)
Barriers to QA/Safeguarding/QOL Measures	Risk of tenancy disruption for delinquent room/board (mitigated by 60-day cure and SC involvement); ongoing need to meet HCBS Settings standards - HHSC required on-site assessments and remediation. (Legal Information Institute, TMHP)
Facilitators to QA/Safeguarding/QOL Measures	Clear quarterly inspection schedule; mandated ANE training/reporting; formal rights/tenancy protections; advisory committee and satisfaction loops; external HCBS Settings monitoring by HHSC/TMHP. (Legal Information Institute, Medicaid)
Notable Cases/Events	Major rewrite/adoption of HCS Certification Standards effective June 21, 2023; statewide HCBS Settings Rule on-site assessments of HH/CC settings in 2023 with standardized tools. (Texas Health Law Section, TMHP)
Program Evaluation / Research Evidence	Administrative monitoring evidence (HCBS Settings compliance reports/tools) rather than published program evaluations; HHSC publishes rate tables and provider guidance; surveys/enforcement under Chapter 565. (Medicaid, pfd.hhs.texas.gov, texas-sos.appianportalsgov.com)
Notes / Other Unique Features	• Cap of ≤3 people receiving similar services in an HH/CC home. • Program provider cannot own/lease the HH/CC residence. • Pre-enrollment minor home modifications allowed/regulated. • Finances & Rent rule limits room/board charges and sets money-management safeguards when the provider manages personal funds. (Legal Information Institute, Justia Regulations)

STAR+PLUS Adult Foster Care

Under the STAR+PLUS managed care waiver, Adult Foster Care offers supervised family-style living for adults with disabilities or elders. AFC homes must meet licensure and inspection standards, with MCOs overseeing tenancy protections, reporting, and service coordination. Safeguards include 24-hour reporting requirements, annual health inspections, and eviction protections equivalent to landlord-tenant law. Unique to this model is the integration of AFC into Medicaid managed care networks, with service coordinators leading planning and monitoring while homes remain subject to HCBS Settings compliance.

Table 23. *Texas - STAR+PLUS Adult Foster Care (AFC)*

Variable	Details
Country/Region	USA - Texas.
Jurisdiction / Organization Name	HHSC (Texas Health & Human Services Commission) administers STAR+PLUS (Medicaid managed care). AFC is a STAR+PLUS HCBS waiver service delivered via MCO networks. (Texas Health and Human Services)
Program / Initiative Name	STAR+PLUS Adult Foster Care (AFC) - see STAR+PLUS Handbook §7100; STAR+PLUS Program Support Unit OPR Handbook §4100 (AFC operations). (Texas Health and Human Services)
Residential Model Type / Living Arrangement	24-hour living arrangement in a contracted adult foster home for members who cannot safely live alone; AFC is a community setting under the HCBS Settings Rule. (Texas Health and Human Services)
Compensation / Funding Model	Medicaid STAR+PLUS HCBS service paid by the MCO to contracted AFC providers; room & board is not waiver-funded (paid by the member under a residential agreement). (Medicaid Long Term Care, Superior HealthPlan)
Target / Eligible Population	Adults 21+ with disabilities or 65+ needing LTSS under STAR+PLUS; AFC selected for members who require supervised living. (Texas Health and Human Services)
Resident Eligibility Criteria	Must meet nursing facility level of care (medical necessity) and other STAR+PLUS HCBS criteria (age, residency, Medicaid financial eligibility). (Legal Information Institute, Texas Health and Human Services)
Governance Structure	Program rules in STAR+PLUS Handbook; Minimum Standards for AFC in 26 TAC Ch. 278, Subch. B (provider qualifications, home enrollment/licensure, provider responsibilities). MCOs must also enforce HCBS Settings tenancy protections. (Texas Health and Human Services, Justia Regulations, Texas Secretary of State, Superior HealthPlan)
Host Recruitment & Vetting Practices	26 TAC §278.103 sets provider qualifications (responsible adult, able to meet needs, communication ability, etc.); §278.109/§278.111 require home enrollment & annual health inspections and compliance with local health authority standards. (MCOs certify/contract AFC homes per STAR+PLUS Appendix XXIV.) (Legal Information Institute)
Support, Monitoring & Communication Mechanisms	Provider duties to notify the caseworker: within 24 hours/next workday for significant changes, hospitalizations, when a resident leaves the home, and immediately by phone for

Variable	Details
	death/serious injury/abuse with 48-hour written report - plus report APS investigations within 24 hours. Annual health inspection of each home; MCO Service Coordination manages ongoing plan and contacts. (Justia Regulations, Legal Information Institute, Community First Health Plans)
Resident / Tenant Safeguarding Practices / Frameworks	Termination protection: provider cannot terminate services without prior approval from the caseworker/supervisor (except immediate safety threats). HCBS Settings tenancy: MCOs must ensure a legally enforceable residential agreement giving the same eviction protections as Texas landlord-tenant law (use of HHSC Residential Agreement Checklist). (Justia Regulations, Superior HealthPlan, UHC Provider)
Quality Assurance Frameworks / Mechanisms	AFC Minimum Standards (26 TAC Ch. 278) + annual health inspections; HHSC/MCOoversight; statewide HCBS Settings Rule assessments - Texas reports 41 STAR+PLUS AFC settings assessed via self-assessment and virtual/site review with remediation as needed. (Legal Information Institute, Texas Secretary of State, Medicaid)
Host Education / Training Standards / Practices	Appendix XXIV - Minimum Standards for STAR+PLUS AFC requires provider/home qualifications and compliance steps; MCO provider manuals require providers to notify Service Coordinators promptly of ED visits, deaths, adverse changes, relocations, etc., and coordinate discharges - embedding ongoing practice standards. (Texas Health and Human Services, Community First Health Plans)
Specific Policies Related to Safeguarding / QA / Training (name & focus)	• STAR+PLUS Handbook §7100 (AFC service rules). • STAR+PLUS Handbook Appendix XXIV (AFC Minimum Standards, provider/home expectations, reporting to MCO within 24 hours for investigations). • 26 TAC Ch. 278, Subch. B (AFC Minimum Standards: provider qualifications, substitute providers, home enrollment/licensure, provider responsibilities & reporting, termination limits). • Residential Agreement Checklist: requires lease-like protections and submission to HHSC/MCO. (Texas Health and Human Services, Justia Regulations, UHC Provider)
Independent Planning Supports / Facilitation	MCO Service Coordination (RN or Service Coordinator) conducts assessments, develops the individual service plan, and schedules contacts/visits based on risk/needs; members receive written notice of contact frequency. (Superior HealthPlan)
Balancing Dignity of Risk with Safeguards	HCBS Settings tenancy/eviction protections and community-integration requirements preserve normal housing rights and autonomy while AFC reporting & inspection rules ensure safety (rapid notification, health inspections, termination oversight). (Superior HealthPlan, Legal Information Institute, Justia Regulations)
Psychosocial Supports (Mental Health, Linguistic, Cultural / Equity)	STAR+PLUS provides service coordination and LTSS aimed at community participation and independence; AFC includes 24-hour supervision and support in a family-home environment. (Texas Health and Human Services)

Variable	Details
Quality of Life Focus / Outcomes Measured	Person-centered planning through the MCO, with ongoing service-coordination contacts and required provider change/incident notifications; HCBS Settings validation ensures autonomy, choice, and integration standards in AFC homes. (Community First Health Plans, Medicaid)
Barriers to QA/Safeguarding/QOL Measures	Settings Rule implementation created additional documentation (e.g., residential agreements) and site-specific assessments for AFC providers; homes had to remediate findings to maintain compliance. (Medicaid)
Facilitators to QA/Safeguarding/QOL Measures	Clear reporting timelines (24-hour/next-day), annual health inspections, MCO service coordination, and lease-like protections anchored in state landlord-tenant law. (Justia Regulations, Legal Information Institute, Superior HealthPlan)
Notable Cases/Events	2022-2023: Texas conducted HCBS Settings Rule assessments on STAR+PLUS AFC homes and required tenancy agreements; 2024-2025 MCO alerts reinforced the Residential Agreement Checklist submission to HHSC. (Medicaid, UHC Provider)
Program Evaluation / Research Evidence	Administrative monitoring evidence (HCBS Settings assessment report; MCO/provider manuals). No state-level AFC outcomes report identified for STAR+PLUS. (Medicaid)
Notes / Other Unique Features	AFC termination requires prior caseworker approval (except immediate threat); annual health inspection can be performed by local health authority (or HHSC checklist if unavailable). (Justia Regulations, Legal Information Institute)

Ohio

Ohio's DODD Shared Living service under the IO waiver requires the caregiver to live with the individual, fostering a stable, family-style environment with up to four residents. Governance is detailed under OAC rules covering service standards, HCBS tenancy rights, MUI reporting, and provider certification. Independent county Service & Support Administrators oversee planning and monitoring, while providers maintain substitute coverage protocols and service documentation. QA mechanisms include compliance reviews, MUI trend analyzes, and Human Rights Committee oversight. Ohio's model stands out for explicit tenancy agreements, substitute coverage rules, and strong independence of planning/monitoring.

Table 24. *Ohio - DODD Shared Living (IO Waiver)*

Variable	Fields
Country/Region	USA - Ohio.
Jurisdiction / Organization Name	Ohio Department of Developmental Disabilities (DODD); County Boards of DD for Service & Support Administration (SSA). (dodd.ohio.gov, Ohio Laws)
Program / Initiative Name	Shared Living (HCB waiver service under the Individual Options (IO) waiver).
Residential Model Type / Living Arrangement Description	Adult caregiver lives in the same home as the person and provides day-to-day supports; designed to foster stable, long-term, family-style life with shared routines and community participation; max 4 people with DD in the home; the caregiver's home is the caregiver's primary, legal residence.
Compensation / Funding Model	Medicaid HCBS IO waiver; daily rate by ODDP range with county cost-of-doing-business adjustments and group-size adjustments (100/85/75/65% for 1/2/3/4 people); separate rate structures for agency vs independent providers; room & board not included.
Target / Eligible Population	Adults (18+) enrolled in the IO waiver.
Resident Eligibility Criteria	Authorized when one or more adult caregivers who reside with the person provide ≥20% of personal care/supports; must be in the Individual Service Plan (ISP); Shared Living cannot be authorized concurrently with certain services (e.g., residential respite same day), with specific exceptions.
Governance Structure	Service definition and standards in OAC 5123-9-33; HCBS setting and tenancy/rights protections in OAC 5123-9-02; provider certification in OAC 5123-2-08 (agency) and 5123-2-09 (independent); ongoing compliance reviews under OAC 5123-2-04.
Host Recruitment & Vetting Practices	Providers must be certified (agency or independent) and meet background-check standards per OAC 5123-2-02; checks against Abuser Registry (OAC 5123-17-03) and other registries are part of certification; independent providers must meet baseline qualifications (age, education, English proficiency) and complete required training before certification. (Ohio Laws, dodd.ohio.gov)
Support, Monitoring & Communication Mechanisms	• SSA (county board) is the independent care-planning/monitoring lead under OAC 5123-4-02(assessment of "important to/for," risk, outcomes; required contacts). •

Variable	Fields
	Providers must maintain service documentation aligned to the ISP. • Substitute coverage protocol required (who to notify; how to arrange coverage). • Compliance reviews of certified providers occur at least once per certification term. (Ohio Laws, dodd.ohio.gov)
Resident / Tenant Safeguarding Practices / Frameworks	• MUI/UI system (OAC 5123-17-02) with immediate protective actions, defined reporting timelines (written report to county board by 3 pm next working day), administrative investigations by investigative agents, and annual trend analysis with prevention plans. • Rights protections & tenancy via OAC 5123-9-02 require lease/residency agreements with rights to locks/visitors/schedule/food access and defined eviction/termination notice timelines. (Ohio Laws, registerofohio.state.oh.us)
Quality Assurance Frameworks / Mechanisms	• Provider compliance reviews (routine/targeted) by DODD/county boards (OAC 5123-2-04). • Quality Assurance rule (OAC 5123-2-03) frames statewide QA aims (rights, health/welfare, continuous improvement). • MUI rule mandates annual trend/pattern analysis and reporting. (Ohio Laws, registerofohio.state.oh.us)
Host Education / Training Standards / Practices	Initial & annual training for independent providers per OAC 5123-2-09 Appendix A: First Aid/CPR; person-centered planning; rights (ORC 5123.62); MUI rule & Health-and-Welfare Alerts; universal precautions; ISP implementation; documentation/billing; empathy-based care; plus service-specific training. Agencies must ensure staff meet parallel standards under 5123-2-08. (dodd.ohio.gov, mcbdds.org, Ohio Laws)
Specific Policies Related to Safeguarding / QA / Training	• OAC 5123-9-33 Shared Living (definitions, limits, documentation, payment, substitute coverage protocols). • OAC 5123-9-02 HCBS Settings (integration, autonomy, tenancy rights, residency agreements content). • OAC 5123-17-02 MUI/UI (categories, timelines, admin investigations, annual QA review). • OAC 5123-2-06 Behavior Support (restrictive-measure limits, Human Rights Committee review, statewide data reporting).
Independent Planning Supports / Facilitation	SSA (county board) is the independent planner/facilitator of the ISP; cannot be the provider; must coordinate assessment, risk, outcomes, budgets, and monitor implementation. (Ohio Laws)
Balancing Dignity of Risk with Safeguards	HCBS rules require maximizing autonomy (choice of setting/provider, locks, visitors, schedules) while behavioral restrictions (if any) must go through Human Rights Committee review and be tracked/reevaluated; ISP explicitly weighs what's important to and for the person, including known and likely risks. (Ohio Laws)
Psychosocial Supports (Mental Health, Linguistic, Cultural / Equity)	HCBS rule emphasizes community membership, relationships, and person-chosen routines; Shared Living explicitly supports shared decision-making, community participation, and sustaining natural/family connections. (Ohio Laws)

Variable	Fields
Quality of Life Focus / Outcomes Measured	ISP outcomes (community inclusion, skills, health/safety) drive service; MUI trend analysis and restrictive-measures analytics used to improve health & welfare and reduce restrictions over time. (registerofohio.state.oh.us, Ohio Laws)
Barriers to QA/Safeguarding/QOL Measures	Documentation/reporting load (MUI timelines; ISP/service documentation) and compliance reviews can be resource-intensive for small providers; tenancy protections require formal lease/residency agreements, which some homes must implement and maintain. (registerofohio.state.oh.us, Ohio Laws)
Facilitators to QA/Safeguarding/QOL Measures	Clear statutory timelines & tools (MUI reporting; HRC process; compliance review protocols); independent SSA oversight; explicit HCBS tenancy rights; structured training (Appendix A) including MUI & rights refreshers. (Ohio Laws, dodd.ohio.gov)
Notable Cases/Events	Jan 1, 2024: Ohio clarified that Shared Living can be provided during acute hospital stays when criteria are met (to stabilize and smooth transitions). Jul 1, 2025: updated MUI rule with clarified categories/timelines and CQI focus. (Cloudinary, Ohio Laws)
Program Evaluation / Research Evidence	State administrative QA (MUI data reviews; compliance reviews); no Ohio-specific peer-reviewed evaluation of Shared Living identified in the rules - service outcomes tracked via ISP and statewide QA processes. (Ohio Laws, registerofohio.state.oh.us)
Notes / Other Unique Features	• Group size cap = 4 in any Shared Living home. • Independent or agency model allowed; caregiver must reside in the home. • Room & board excluded from Medicaid payment. • Substitute coverage planning is mandatory.

Oregon

Oregon licenses Adult Foster Homes for individuals with I/DD under ODHS regulations, with up to five residents supported in a family home. Providers must pass extensive background checks, licensing inspections, and meet strict physical standards. County case managers conduct quarterly visits, monitor ISP progress, and enforce rights protections. Safeguards include mandatory abuse reporting, strict prohibition of mechanical/prone restraints, and Positive Behavior Support Plans. Oregon's rules emphasize person-centered planning, cultural and equity protections (including LGBTQIA2S+ rights), and detailed home standards such as single-action locks and complaint hotlines posted in homes.

Table 25. *Oregon - Adult Foster Homes for Individuals with I/DD (AFH-DD)*

Variable	Details
Country/Region	USA - Oregon. (Oregon Secretary of State)
Jurisdiction / Organization Name	Oregon Department of Human Services (ODHS), Office of Developmental Disabilities Services (ODDS). AFH-DD is governed under OAR Chapter 411, Division 360. (Oregon Secretary of State)
Program / Initiative Name	Adult Foster Homes for Individuals with Intellectual or Developmental Disabilities (AFH-DD). (Oregon Secretary of State)
Residential Model Type / Living Arrangement Description	Family-style home where the licensed provider lives in the home and supports up to five adults with I/DD. May use a resident manager/substitute caregivers. Home must meet detailed physical standards (e.g., accessible common areas, private bedrooms, single-action locks, safety/egress, sanitation). (Oregon Secretary of State)
Compensation / Funding Model	Medicaid HCBS funding via ODDS; provider must have Medicaid provider enrollment/contract and Residency Agreement with each person. Payment can be adjusted/suspended/terminated for reasons including license action, failure to deliver services in ISP, or when person is absent beyond rule limits; a "day of service" is strictly defined for billing. Residency Agreement governs charges; provider may not seek payments beyond authorized rates. (Oregon Secretary of State)
Target / Eligible Population	Primarily adults with I/DD eligible for ODDS; co-residence with minors only with prior Department approval. Must meet Oregon residency and Medicaid/Healthier Oregon coverage as applicable. (Oregon Secretary of State)
Resident Eligibility Criteria	Must (a) be Oregon resident; (b) have Medicaid Title XIX or Healthier Oregon package; (c) be determined eligible for DD services by the CDDP under OAR 411-320-0080; (d) meet level of care; (e) not receive other ODHS residential services simultaneously. Entry processes require information exchange and case manager entry meeting. (Oregon Secretary of State)
Governance Structure	State licensure and enforcement by ODHS/ODDS under OAR 411-360; inspections, complaint investigation, abuse investigation/protective services, corrective action, sanctions and civil penalties are prescribed in rule. Case management oversight by County CDDPs/Brokerages under Division 415. (Oregon Secretary of State, OregonLaws)

Variable	Details
Host Recruitment & Vetting Practices	Provider qualifications include minimum age, ability to meet standards, and required background checks (ODHS/OHA BCU criminal history & abuse checks per OAR 407-007). Fitness determinations required prior to working/residing. Licensure also requires compliance with zoning/fire codes and a written daily operations plan (coverage, schedules). (Oregon Secretary of State, Oregon)
Support, Monitoring & Communication Mechanisms	Quarterly site visits to each AFH-DD by the case management entity; case management contact at least every 3 months (monthly if multiple significant risks); at least one face-to-face annually. Monitoring reviews rights compliance, health/safety protocols, ISP progress, financial safeguards, and incident reports. Provider must post complaint/abuse reporting numbers and cooperate with investigations. (OregonLaws, Oregon Secretary of State)
Resident / Tenant Safeguarding Practices / Frameworks	Abuse reporting & investigations governed by OAR 407-045 & Chapter 419-100 (OTIS/CDDP receive reports; protective services and unbiased investigations). Emergency physical restraint only as last resort, never mechanical/prone/supine/pain compliance, and must be reviewed within 2 hours. Behavior supports must be via a Positive Behavior Support Plan by a qualified professional. Mandatory reporter requirements for I/DD providers. (OregonLaws, Oregon Secretary of State, Oregon)
Quality Assurance Frameworks / Mechanisms	Licensing inspections; complaint resolution and appeal rights; corrective action processes; case management monitoring & site visits; ONA (needs assessment) QA (state may observe assessors and require documentation). HCBS compliance audits per Division 4 (settings & person-centered planning). (Oregon Secretary of State, OregonLaws, Oregon)
Host Education / Training Standards / Practices	Initial/ongoing training requirements include person-specific training; behavior intervention training using an ODDS-approved curriculum before any safeguarding interventions; medication administration training/delegation rules (RN delegation where applicable); required postings and emergency procedures. Some rights-related training is called out (e.g., LGBTQIA2S+ and HIV non-discrimination). (Oregon Secretary of State)
Specific Policies Related to Safeguarding / QA / Training	Key rules: 411-360-0160 (Behavior supports & restraints), 411-360-0185 (Incident reporting), 411-360-0210 (Inspections/abuse investigations), 411-360-0220 (Complaints), 411-004-0020(HCBS rights), 411-004-0040 (Individually-Based Limitations), 407-007 (Background Checks), 407-045 & 419-100 (Abuse investigations). (Oregon Secretary of State, Oregon, OregonLaws)
Independent Planning Supports / Facilitation for Residents	Person-centered service planning required; case manager contacts ≥ quarterly to ensure risks addressed, supports adequate, and person satisfied; annual face-to-face and quarterly foster home site visits. Monitoring includes review of rights, ISP outcomes, finances, and incidents. (Oregon, OregonLaws)

Variable	Details
Balancing Dignity of Risk with Safeguards	Individually-Based Limitations (IBLs): any restriction of HCBS rights must be based on an assessed need, documented in the person-centered plan, with informed consent, time-limited, and regularly reviewed. Case managers must evaluate ongoing need for any limitation. (Oregon Secretary of State, Legal Information Institute, OregonLaws)
Psychosocial Supports (Mental Health, Linguistic, Cultural/Equity)	Individual's Bill of Rights includes explicit protections for LGBTQIA2S+ and HIV-positive individuals (non-discrimination, privacy). Health/mental-health documentation and coordination requirements; culturally appropriate meals/preferences considered; access to phone, visitors, and community life per HCBS. (Oregon Secretary of State, Oregon)
Quality of Life Focus / Outcomes Measured	QOL embedded through person-centered goals in the ISP (community inclusion, autonomy, relationships, health). Case management monitoring checks whether services achieve identified action plans and honor rights/preferences; required health reviews and medication oversight support well-being. (OregonLaws, Oregon Secretary of State)
Barriers to QA/Safeguarding/QOL Measures (documented in rules)	Rules note capacity/eligibility constraints (e.g., provider capability to meet nursing needs; required approvals for mixed-age homes); payment stops when away beyond thresholds; psychotropic PRNs prohibited - requires structured planning/review. (These are safeguards but can act as operational constraints.) (Oregon Secretary of State)
Facilitators to QA/Safeguarding/QOL Measures	Multiple overlapping mechanisms: licensure standards, mandatory reporting, case management monitoring and quarterly site visits, posted complaint channels, rights framework, IBL process with consent/review, and inspection/enforcement tools. (OregonLaws, Oregon Secretary of State, Oregon)
Notable Cases/Events	Not identified in rule; state framework provides processes for hearings on involuntary exits/reductions and abuse investigation outcomes. (Oregon Secretary of State)
Program Evaluation / Research Evidence	Administrative rules; no embedded outcome evaluations in rule text. (ODHS publishes separate HCBS transition and compliance materials.) (Medicaid)
Notes / Other Unique Features	AFH-DD standards include unusual specifics like posted emergency/complaint numbers, single-action lockable bedroom doors, no mechanical/prone/supine restraints, and detailed medical marijuana procedures. (Oregon Secretary of State)

California

California's Family Home Agency (FHA) model places up to two adults with developmental disabilities in approved family homes, coordinated by vendorized FHAs under regional centers. Monthly FHA visits, quarterly regional center reviews, and unannounced inspections ensure quality and compliance. Regulations emphasize abuse reporting, strict financial safeguards, and prohibited interventions, while training covers rights, cultural

diversity, emergency preparedness, and person-centered planning. Uniquely, California is moving to expand FHA responsibilities to include Family Teaching Homes. Strong tenancy rights and detailed Program Design requirements anchor the system in Lanterman Act principles and HCBS compliance.

Table 26. *California - "Shared Living" under California's Family Home Agency (FHA) model*

Variable	Details
Country/Region	United States - California.
Jurisdiction / Organization Name	California Department of Developmental Services (DDS) and the 21 Regional Centers; vendorized Family Home Agencies (FHAs). (North Los Angeles County)
Program / Initiative Name	Family Home Agency (FHA). DDS is also proposing to add Family Teaching Homes to FHA responsibilities (rulemaking in progress). (Department of Developmental Services)
Residential Model Type / Living Arrangement Description	Adults with developmental disabilities (up to two per home) live in the private family residence of an approved Family Home Provider, sharing family life and receiving supports arranged by an FHA. (Definition and capacity in Title 17.) A "Family Teaching Home" variant (used by some regional centers) has contiguous/attached independent residences and can serve up to three people. (Legal Information Institute, westsiderc.org)
Compensation / Funding Model	Regional centers contract/vendorize FHAs. Rates and payments are set under the Welfare & Institutions Code §4689.1 (tied to 4681.5 rate structure); the FHA also determines the portion of its reimbursement paid to the family home provider (must be in the FHA's program design). (Findlaw, Legal Information Institute)
Target / Eligible Population	Adults (18+) with developmental disabilities who do not require continuous skilled nursing care. (Legal Information Institute)
Resident Eligibility Criteria	Lanterman Act-eligible adults served by a regional center; FHA is selected in the Individual Program Plan (IPP) when it matches needs/preferences; home capacity and health/safety fit must be demonstrated. (Legal Information Institute)
Governance Structure	DDS oversees the system; regional centers contract with/vend FHAs; FHA approves/certifies individual family homes; regional centers and DDS monitor, including unannounced visits (at least two per year to family home settings). (Legal Information Institute, Justia Law)
Host Recruitment & Vetting Practices	FHA must have written procedures for recruiting, assessing qualifications, approving/renewing family homes, ensuring health & safety and a good match; pre-approval home visit requires interviews of all adult residents, review of regs/Lanterman Act with the family, and verification of safe, clean, accessible environment. Criminal record clearances(DOJ; FBI if out-of-state in last 2 years), DS 5407 declarations, and strict timelines (fingerprint cards and forms due within 4 days). Grounds and process for denial/exemption detailed in regulation. (Legal Information Institute)

Variable	Details
Support, Monitoring & Communication Mechanisms	FHA social services staff must monitor each family home monthly (IPP consistency, health/safety, consumer satisfaction, funds/property). Regional center meets quarterly with the person (at least two meetings in the home; up to two unannounced under WIC 4648.1). FHA must maintain 24/7 emergency response capability and have disaster/contingency plans; corrective action plans and sanctions (move resident, revoke home approval, terminate vendorization) are specified. (Legal Information Institute)
Resident / Tenant Safeguarding Practices / Frameworks	Abuse & Special Incident Reporting: provider must report abuse immediately (≤24h) and in writing within 48h; FHA must notify regional center, APS/law enforcement, representatives per timelines. Prohibited practices: no pain/trauma-based behavior interventions, no corporal punishment or seclusion; protections against humiliation, coercion, withholding care. Funds & Property: strict separation, accounting, interest belongs to the person, bond required if provider is rep payee. Termination protections: the person may leave at any time; 30-day notice rules and coordinated planning if home/FHA/RC initiates termination. (Legal Information Institute)
Quality Assurance Frameworks / Mechanisms	FHA's Program Design must define outcomes and how they're achieved & monitored(respectful family life; preferences honored; community participation; cultural respect; relationship building; consumer satisfaction; qualified/trained staff). Systematic monitoring by FHA (monthly), regional center (quarterly with person; annual FHA review), unannounced visits per WIC 4648.1, and formal corrective actions/sanctions. HCBS Final Rule compliance adds person-centered, rights-based QA expectations. (Legal Information Institute, Justia Law, ggrc.org, redwoodcoastrc.org)
Host Education / Training Standards / Practices	Program design must include initial/ongoing training for FHA staff and family homes covering: health & safety, first aid/CPR, nutrition; positive behavioral supports/crisis intervention; consumer rights; community inclusion; adjustment/cultural diversity; building relationships; Lanterman values; person-centered planning & IPP implementation; abuse identification/reporting; record-keeping; plus frequency, needs assessment, and effectiveness evaluation. New staff trained before providing services. (Legal Information Institute)
Specific Policies Related to Safeguarding / QA / Training	Title 17, CCR Subchapter 4.1 (Articles 4-14 incl. §56084 Program Design; §56085 Criminal History; §56087 Home Visit; §56088 Certificate; §56089 Prohibited Interventions; §56091 Funds/Property; §56093 Abuse & SIR; §56094 Termination; §56095 Monitoring/Sanctions). Proposed 2024 rulemaking adds Family Teaching Homes. (Legal Information Institute, Department of Developmental Services)
Independent Planning Supports / Facilitation	Person-centered IPP process is required; FHA/RC roles must support choices and outcomes specified in the IPP; RC holds quarterly meetings to verify progress and satisfaction. (HCBS

Variable	Details
	Final Rule also requires person-centered planning and choice.) (Legal Information Institute, ggrc.org)
Balancing Dignity of Risk with Safeguards	Not labeled as "dignity of risk" in regulation, but HCBS Final Rule and Program Design requirements emphasize choice, rights, cultural preferences, & community participation alongside safeguards (abuse reporting, prohibited practices, monitoring). (Legal Information Institute, Lanterman Foundation)
Psychosocial Supports (Mental Health, Linguistic, Cultural/Equity)	Program Design requires supports that encourage relationships, community participation, and respect cultural preferences/values; training includes cultural diversity and fostering relationships. (Legal Information Institute)
Quality of Life Focus / Outcomes Measured	Outcomes embedded in Program Design/IPP: respectful family life, preferences honored, community inclusion, relationship building, consumer satisfaction; RC monitoring checks goal attainment and satisfaction quarterly. (Legal Information Institute)
Barriers to QA/Safeguarding/QOL Measures	Not explicitly analyzed in regulation text (regs set requirements; do not discuss implementation barriers).
Facilitators to QA/Safeguarding/QOL Measures	Monthly FHA monitoring, quarterly RC reviews with the person, unannounced visits, mandatory training, abuse/SIR reporting timelines, financial safeguards, and sanction authority. (Legal Information Institute, Justia Law)
Notable Cases/Events	2024 DDS proposed amendments to add Family Teaching Homes into FHA responsibilities (rulemaking underway). (Department of Developmental Services)
Program Evaluation / Research Evidence	Not contained in the regs themselves (program rules do not include evaluation findings).
Notes / Other Unique Features	Capacity: max two adults per standard Family Home; three in Family Teaching Home variants in some RC RFPs. Certification: Family Home gets a 1-year Certificate of Approval specifying limits and consumer count. Health-related services must be provided/arranged as needed/per IPP. (Legal Information Institute, westsiderc.org)

UK

Federal Frameworks

Across the UK, “Shared Lives” (also known as Adult Placement) is a regulated adult social care model where individuals live in carers’ family homes for long-term, short breaks, or day support. Each nation has its own regulator: CQC in England, Care Inspectorate in Scotland, Care Inspectorate Wales, and RQIA in Northern Ireland, with Shared Lives Plus serving as the UK-wide network for practice support and outcomes tools. Statutes like the Care Act 2014, the Social Services and Well-being (Wales) Act 2014, and Scotland’s Adult Support and Protection Act 2007 establish safeguarding duties, while inspection frameworks require carer vetting, person-centered planning, and outcome measurement. Despite variations, the model is consistently rated highly for safety and quality, supported by strong national inspection frameworks and the “My Shared Life” outcomes tool.

Table 27. *United Kingdom - Shared Lives National Framework*

Variable	Details
Country/Region	United Kingdom (England, Scotland, Wales, Northern Ireland)
Jurisdiction / Organization Name	National regulators: CQC (England), Care Inspectorate (Scotland), Care Inspectorate Wales (CIW), RQIA (Northern Ireland). Shared Lives Plus is the UK network supporting schemes and outcome tools. (Care Quality Commission, careinspectorate.com, careinspectorate.wales, rqia.org.uk, Shared Lives Plus)
Program / Initiative Name	“Shared Lives” (aka adult placement) schemes; regulated as adult social care services (England/Wales when providing personal care) or as adult placement services (Scotland/Wales/NI). (trixcms.trixonline.co.uk, Legislation.gov.uk)
Residential Model Type / Living Arrangement Description	Person lives in a host/carer’s family home as part of ordinary family life (short breaks, day support, or long-term). The scheme recruits/approves/supports carers and matches people. (Premises themselves usually aren’t “regulated premises”; the scheme’s activity is regulated.) (trixcms.trixonline.co.uk)
Compensation / Funding Model	Local authorities/HSC Trusts commission Shared Lives; schemes/carers are paid under local contracts. Regulation focuses on quality & safety rather than rates. (Wales defines adult placement as up to 3 adults living with a carer under a carer agreement.) (careinspectorate.wales)
Target / Eligible Population	Adults (often 18+; sometimes 16-17 via adult services) with learning disabilities, autism, mental health conditions, or other support needs - defined in local eligibility but regulated as adult social care. (trixcms.trixonline.co.uk)
Resident Eligibility Criteria	Determined by local assessment/care planning; must be set out in personal plans/IPP/care and support plans and kept under regular review by the scheme/authority per each regulator’s framework. (careinspectorate.com, careinspectorate.wales)
Governance Structure	Registration & inspection by national regulator; providers must meet statutory standards (e.g., CQC Fundamental Standards in England; Scotland’s Health & Social Care Standards + SSI 2011/210; Wales RISCA 2016 + Adult Placement Services Regulations 2019; NI Adult Placement Agencies Regulations 2007). (Care Quality

Variable	Details
	Commission, careinspectorate.com, Legislation.gov.uk, careinspectorate.wales, GOV.WALES)
Host Recruitment & Vetting Practices	Safer recruitment and criminal record/barred-list checks required: DBS(England/Wales) for roles doing "regulated activity with adults"; PVG (Disclosure Scotland) in Scotland; AccessNI in NI. Policies must also cover referrals to barring bodies when required. (GOV.UK, GOV.UK, MyGov Scotland, nidirect)
Support, Monitoring & Communication Mechanisms	Regulator inspection frameworks require: regular reviews of personal plans, carer supervision, complaints handling, medication governance, incident reporting, and - NI specifically - at least annual inspections of adult placement agencies. CQC uses a single assessment framework with quality statements and evidence categories for Shared Lives/homecare. (careinspectorate.wales, Care Quality Commission, rqia.org.uk)
Resident / Tenant Safeguarding Practices / Frameworks	Country statutes drive adult safeguarding: Care Act 2014 (England - s.42 enquiries; Making Safeguarding Personal), SSWBA 2014 (Wales - s.126 duty to enquire), Adult Support and Protection (Scotland) Act 2007, and NI Adult Safeguarding Policy (2015) + Operational Procedures (2023). Schemes must have abuse/neglect policies, reporting to local safeguarding partners. (Legislation.gov.uk, GOV.UK, safeguarding.wales, Scottish Government, Department of Health, online.hscni.net)
Quality Assurance Frameworks / Mechanisms	CQC Fundamental Standards (e.g., Reg 13 Safeguarding; Reg 17 Good Governance) require systematic audits, risk management, learning from incidents; Care Inspectorate quality framework sets graded evaluations; CIW maps inspections to Care and Support / Leadership and Management / Environment / Well-being; RQIA inspects against safe, effective, compassionate, well-led. (Care Quality Commission, careinspectorate.com, careinspectorate.wales, rqia.org.uk)
Host Education / Training Standards / Practices	All regulators expect initial and ongoing training proportionate to role (safeguarding, MCA/AWI, first aid/meds, record-keeping, PBS). CQC's framework and CIW/Care Inspectorate quality frameworks explicitly look for competence evidence and supervision records. (Care Quality Commission, careinspectorate.wales)
Specific Policies Related to Safeguarding / QA / Training	Anchor citations for your policies/files: CQC Reg 13 (safeguarding) & Reg 17(governance); Scotland: Health & Social Care Standards + SSI 2011/210; Wales: APS Regulations 2019 with statutory guidance; NI: Adult Placement Agencies Regs 2007 with RQIA provider guidance on inspection approach. (Care Quality Commission, careinspectorate.com, Legislation.gov.uk, GOV.WALES, rqia.org.uk)
Independent Planning Supports / Facilitation	All four nations require person-centered planning/personal plans led by the individual and reviewed regularly (CQC quality statements link to TLAP "Making it Real" "I-statements"; Scotland standards emphasise choice & control; CIW inspection themes include well-being and voice/choice). (Care Quality Commission, local.gov.uk, careinspectorate.com, careinspectorate.wales)

Variable	Details
Balancing Dignity of Risk with Safeguards	England's Care Act embeds Making Safeguarding Personal (outcomes-focused, consent/choice); Scotland's standards/ASP Code stress proportionate risk management; Wales's SSWBA guidance on duty to enquire is explicitly person-centered. Use MCA 2005 (E&W) and AWI 2000 (Scotland) / MCA (NI) 2016 for supported/legally-authorised decision-making; use DoLS in hospitals/care homes (E&W). (GOV.UK, local.gov.uk, Scottish Government, careinspectorate.com, Department of Health, SCIE)
Psychosocial Supports (Mental Health, Cultural/Equity)	National standards/regulators require culturally competent, relationship-centered support and community inclusion (e.g., Scotland My support, my life standards; CQC quality statements "Effective/Responsive/Caring"). (careinspectorate.com, Care Quality Commission)
Quality of Life Focus / Outcomes Measured	Shared Lives Plus "My Shared Life" outcomes tool (10-item QOL questionnaire tracked over time) used by many schemes; regulators assess people's experiences, community participation, relationships, independence via quality statements/illustrations. (Shared Lives Plus)
Barriers to QA/Safeguarding /QOL Measures	Implementation capacity (data/incident systems, consistency across local areas), variable adoption of outcomes tools (Shared Lives Plus notes minority use and inconsistent coverage). (Shared Lives Plus)
Facilitators to QA/Safeguarding /QOL Measures	Clear inspection frameworks with published quality statements/illustrations, mandatory vetting, regular reviews, incident learning, and national person-centered guidance (Care Act MSP; Scotland Standards). (Care Quality Commission, GOV.UK, careinspectorate.com)
Notable Cases/Events	CQC single assessment framework rolled out (2023-2025) aligning evidence and quality statements; CIW embedding RISCA/APS 2019; RQIA annual adult placement agency inspections. (Care Quality Commission, GOV.WALES, rqia.org.uk)
Program Evaluation / Research Evidence	Shared Lives Plus publishes national snapshots - e.g., very high proportion of schemes rated good/outstanding in England and strong gradings in Scotland; regulators publish inspection reports mapping to outcomes. (Shared Lives Plus)
Notes / Other Unique Features	Capacity & rights law differs by nation: MCA 2005 (E&W) incl. DoLS (care homes/hospitals); AWI 2000 (Scotland) with guardianship/interventions; MCA (NI) 2016 (fusion law) phased commencement incl. DoL in some settings. Build provider policies to reference the correct statute per nation. (SCIE, Scottish Government, Department of Health)

Country-Level Frameworks

England

In England, Shared Lives is delivered by local authority or independent schemes that register with the Care Quality Commission (CQC) if providing regulated personal care. Adults with learning disabilities, autism, mental health needs, or age-related support live in family homes, with carers vetted via enhanced DBS, references, and approval panels. Carers are self-employed and receive an allowance (with HMRC tax relief). Schemes provide quarterly monitoring, annual reviews, and safeguarding oversight under the Care Act 2014 and Mental Capacity Act 2005. CQC applies its single assessment framework and reports that 97% of Shared Lives schemes are rated Good or Outstanding, making this one of the best-performing adult social care services.

Table 28. *England - Shared Lives (Adult Placement) Schemes*

Variable	Details
Country/Region	England (UK).
Jurisdiction / Organization Name	Local authorities (councils) and independent providers run Shared Lives schemes; schemes that provide regulated activity are registered with the CQC (national regulator). (nhs.uk, GOV.UK)
Program / Initiative Name	Shared Lives (formerly "Adult Placement"). (GOV.UK)
Residential Model Type / Living Arrangement	An adult with care/support needs lives in the carer's family home (long-term, short breaks, or day support). The scheme recruits, approves and supports the carer; the carer's home is not a registered location - the scheme is the regulated provider when it delivers personal care. (nhs.uk, trixcms.trixonline.co.uk)
Compensation / Funding Model	Carers are self-employed and paid an allowance/fee set by the local scheme; not hourly. Carers can claim HMRC Qualifying Care Relief (tax relief for Shared Lives/Adult Placement carers). Example NHS explainer + HMRC help sheet. (nhs.uk, GOV.UK)
Target / Eligible Population	Adults (16+) with learning disability, autism, mental health needs, physical/sensory disability, older adults needing support. (Typical scheme eligibility pages; national NHS explainer.) (nhs.uk, hertfordshire.gov.uk)
Resident Eligibility Criteria	Accessed via a Care Act 2014 assessment and care & support plan from the local authority; Shared Lives suitability/matching decided by the scheme. (LAs must involve the person and provide advocacy where needed.) (GOV.UK, Legislation.gov.uk)
Governance Structure	Schemes register with CQC where they provide the regulated activity of *personal care*; they are assessed against the fundamental standards (Regulations 9-20). CQC uses a Provider Information Return (PIR) for Shared Lives and a single assessment framework with quality statements. (Care Quality Commission)
Host Recruitment & Vetting Practices	Schemes recruit, assess, train and approve carers; approvals go to an independent Approval Panel. Vetting typically includes enhanced DBS checks, references (incl. GP/landlord/employer), home safety checks, interviews with all household members, and assessment of values/skills. (See Kent, Hull, SW, Leicester, Lancashire examples; CQC Reg.19sets the recruitment standard.)

Variable	Details
	(sharedlivessw.org.uk, Live Well Hull, Lancashire.gov.uk, leicester.gov.uk, Care Quality Commission)
Support, Monitoring & Communication Mechanisms	Each carer has a named Shared Lives worker. Schemes conduct regular support/monitoring visits (commonly quarterly) plus an annual review of the carer and each arrangement; unannounced visits used as needed. Examples: Hertfordshire (at least every 12 weeks), West Berkshire (at least quarterly), Kent (monitoring visits + annual host review). (hertfordshire.gov.uk, West Berkshire Council, jobs.kent.gov.uk)
Resident/Tenant Safeguarding Practices/Frameworks	Providers must meet CQC Regulation 13 (Safeguarding from abuse and improper treatment) and Regulation 12 (Safe care and treatment), operate incident reporting, manage medicines safely, and follow Mental Capacity Act 2005 principles (best interests, least restriction). Local handbooks spell out incident reporting to the scheme and LA; medication and DoLS/community-deprivation processes are policy topics. (Care Quality Commission, GOV.UK, staff.derbyshire.gov.uk, Live Well Hull)
Quality Assurance Frameworks / Mechanisms	CQC inspections/rating (Safe, Effective, Caring, Responsive, Well-led) and the new single assessment framework with quality statements; PIR - Shared Lives sets out what schemes must evidence. Many schemes use independent approval panels as an internal QA layer; quarterly monitoring; incident/complaints audits; finance/medicines checks. CQC rated 97% of schemes Good/Outstanding (Oct 2023). (Care Quality Commission, sharedlivessw.org.uk, gloucestershire.gov.uk, Shared Lives Plus)
Host Education / Training Standards / Practices	Pre-approval training/orientation, ongoing training (e.g., Care Certificate mapped for Shared Lives), first aid/meds/record-keeping, MCA & safeguarding. Examples in scheme handbooks and Skills for Care guidance for Shared Lives Care Certificate assessment. (Skills for Care)
Specific Policies Related to Safeguarding / QA / Training (name/focus/link)	• CQC Reg. 12 (Safe care & treatment) and Reg. 13 (Safeguarding). • CQC Notifications (serious incidents etc.). • CQC Reg. 19 (Fit & Proper Persons Employed - recruitment checks). • CQC PIR - Shared Lives (2024 question set). • Local scheme policies on medication, DBS, DoLS/MCA, approval panels (see Hull guide; Derbyshire medication; SW Approval Panel). (Care Quality Commission, Live Well Hull, staff.derbyshire.gov.uk, sharedlivessw.org.uk)
Independent Planning Supports / Facilitation	Under the Care Act 2014 sections 67-68 and Independent Advocacy Regulations 2014, LAs must arrange an independent advocate for people who would have "substantial difficulty" being involved in assessment/planning/review and lack an appropriate representative. (Legislation.gov.uk, Local Government Association)
Balancing Dignity of Risk with Safeguards	CQC guidance recognises inherent risk and expects providers to show they have taken reasonable steps to manage risk (Reg.12). Carer handbooks emphasise people's decision-making rights (MCA) and that carers are not "in loco parentis"; risk assessments guide positive risk-taking. Reg.10 (Dignity & respect) also applies. (Care Quality Commission)

Variable	Details
Psychosocial Supports (Mental Health, Linguistic, Cultural/Equity)	Schemes recruit diversely and match culturally (example: Coventry diversity statement). The CQC equality & human rights approach requires attention to protected characteristics; NICE NG93 guides community support for people with learning disability & behaviours that challenge (PBS, family support). (Coventry City Council, Care Quality Commission, NICE)
Quality of Life Focus / Outcomes Measured	The sector uses "My Shared Life" and a 10-item outcomes tool (developed for Shared Lives Plus) measuring safety, belonging, independence, health & wellbeing over time; many schemes embed these in reviews alongside CQC quality statements. (Shared Lives Plus, Kent Academic Repository)
Barriers to QA/Safeguarding/QoL	Commissioning & growth challenges, data consistency, uneven outcome-tool uptake; identified in LGA/ADASS guidance (2025) and Shared Lives Plus reflections on outcomes-tool usage. (Local Government Association, Shared Lives Plus)
Facilitators to QA/Safeguarding/QoL	Independent approval panels, structured quarterly monitoring, clear incident/medication procedures, Care Act advocacy, and CQC external oversight/PIR. (Examples: scheme policies; CQC PIR.) (sharedlivessw.org.uk, gloucestershire.gov.uk, staff.derbyshire.gov.uk, Care Quality Commission)
Notable Cases/Events	CQC ratings trend: Shared Lives schemes consistently among the highest-rated adult social care services (reported 97% Good/Outstanding, Oct 2023). (Shared Lives Plus)
Program Evaluation / Research Evidence	Outcome tool development by University of Kent/PSSRU; 2024 multimethod study on Shared Lives outcomes and tool use. (Kent Academic Repository, Wiley Online Library)
Notes / Other Unique Features	• Quarterly visit norm appears across multiple schemes; annual carer approval review is standard. • Tax relief (QCR) unique enabler for carer retention. • Medication/finance/DoLS policies are adapted for family-home contexts rather than institutional settings. (gloucestershire.gov.uk, West Berkshire Council, GOV.UK)

Scotland

Scotland's Shared Lives schemes are regulated by the Care Inspectorate under the Health and Social Care Standards and SSI 2011/210. Adults live in family homes through local authority-run schemes, with placements accessed via Self-Directed Support assessments. Carers must join the PVG Scheme and are approved by independent panels following training and home checks. Monitoring involves regular visits and annual reviews, and safeguarding is reinforced by the Adult Support and Protection Act 2007. Care Inspectorate inspections apply a dedicated adult placement framework, with most schemes graded Good to Excellent. Scotland's emphasis on rights-based practice, self-directed support, and cultural matching ensures strong person-centered outcomes.

Table 29. *Scotland - Shared Lives (Adult Placement) Schemes*

Variable	Details
Country/Region	Scotland (UK).
Jurisdiction / Organization Name	Local authority Shared Lives schemes (providers) regulated by the Care Inspectorate under Scottish care-service law. (Care Inspectorate)
Program / Initiative Name	Shared Lives (also called Adult Placement). (Care Inspectorate)
Residential Model Type / Living Arrangement	An adult lives in an approved carer's family home (long-term, short breaks or day support). The scheme is the regulated service; individual family homes are not registered locations. (Care Inspectorate, Legislation.gov.uk)
Compensation / Funding Model	Carers are self-employed and paid a fee/allowance set by the local scheme (e.g., Fife), with UK Qualifying Care Relief tax treatment for Shared Lives/Adult Placement carers. Some schemes publish example rates (e.g., East Lothian short-break nightly fees). (Fife Council, Shared Lives Plus, East Lothian Council)
Target / Eligible Population	Adults 16+ with learning disability, autism, mental-health needs, physical/sensory disabilities, or older adults needing support (example: Fife). (Fife Council)
Resident Eligibility Criteria	Access via local authority social-care assessment & support planning, delivered through Self-Directed Support (SDS) options; Shared Lives is commissioned when it best fits the plan. (MyGov Scotland, Self Directed Support Scotland)
Governance Structure	Providers must meet the Health and Social Care Standards (HSCS) and the Requirements for Care Services Regulations 2011 (SSI 2011/210). Care Inspectorate inspects Shared Lives using the Quality framework for fostering, adoption and adult placement services. (Care Inspectorate, Legislation.gov.uk)
Host Recruitment & Vetting Practices	Schemes recruit, assess, train and approve carers through an Approval Panel; carers (and adult household members) must be in the PVG Scheme (enhanced disclosure) and provide references; home safety checks carried out. (Example process and PVG requirement shown by Fife and national guidance.) (Fife Council, MyGov Scotland)
Support, Monitoring & Communication Mechanisms	Each carer has a named Shared Lives worker for regular support/monitoring visits plus annual reviews of the arrangement; schemes maintain file audits and quality-

Variable	Details
	monitoring systems (illustrated in Care Inspectorate reports). (Fife Council, Care Inspectorate)
Resident / Tenant Safeguarding Practices / Frameworks	Providers must protect people from abuse/neglect and ensure safe care under HSCS and SSI 2011/210 (e.g., Reg. 11 fitness of persons on premises; Reg. 4 welfare). Local Adult Support & Protection procedures (e.g., Fife inter-agency guidance) set out incident reporting and risk planning. (Care Inspectorate, Legislation.gov.uk, Fife Council)
Quality Assurance Frameworks / Mechanisms	Care Inspectorate inspections using the adult-placement Quality framework (key questions & quality indicators), annual/provider returns, complaints/incident oversight. Sector data indicate strong performance of Scottish schemes (majority graded Good-Excellent). (Care Inspectorate, Shared Lives Plus)
Host Education / Training Standards / Practices	Pre-approval training & ongoing CPD delivered by schemes (e.g., Fife requires core training; PVG membership; first-aid/meds/record-keeping typically included). (Fife Council)
Specific Policies Related to Safeguarding / QA / Training (name & link)	• Health and Social Care Standards: My support, my life (Scottish Government) - person-led, rights-based expectations. (Scottish Government) • SSI 2011/210 - Requirements for Care Services (legal regs for adult placement services). (Legislation.gov.uk) • Care Inspectorate Quality framework - fostering, adoption & adult placement (inspection criteria). (Care Inspectorate) • PVG Scheme (Disclosure Scotland) - regulated roles & membership. (MyGov Scotland)
Independent Planning Supports / Facilitation for Residents	Under SDS, people are entitled to be fully involved in planning and to choose from the four options (direct payment, directing support, arranged services, or a mix). Advocacy is available where needed. (Self Directed Support Scotland, Scottish Government)
Balancing Dignity of Risk with Safeguards	HSCS embed dignity, respect and least-restrictive principles; SDS promotes autonomy/choice with proportionate risk management within the support plan. (Care Inspectorate, Audit Scotland)
Psychosocial Supports (Mental Health, Linguistic, Cultural / Equity)	Schemes match people with carers and communities; HSCS require attention to equality, culture and communication; local pages emphasise community participation and belonging (e.g., Fife). (Care Inspectorate, Fife Council)
Quality of Life Focus / Outcomes Measured	Schemes evidence outcomes in inspections (e.g., inclusion, relationships, independence) against the Quality framework and often use Shared Lives outcomes tools; sector snapshot shows high grades across Scotland. (Care Inspectorate, Shared Lives Plus)
Barriers to QA/Safeguarding/QoL Measures	Expansion is constrained by carer recruitment and data consistency across partnerships (Care Inspectorate/Shared Lives Scotland reports). (Care Inspectorate Hub)
Facilitators to QA/Safeguarding/QoL Measures	Strong national standards (HSCS), PVG safeguarding, and a bespoke Care Inspectorate framework for adult placement; local schemes add approval panels, audits and annual reviews. (Care Inspectorate)

Variable	Details
Notable Cases/Events	2021 launch of the current Care Inspectorate Quality framework for fostering, adoption & adult placement; 2025-26 inspection approach refresh. (Care Inspectorate)
Program Evaluation / Research Evidence	Shared Lives in Scotland - Annual Report (Care Inspectorate & partners) summarises reach and outcomes; sector outcome studies (UK-wide) complement inspection evidence. (Care Inspectorate Hub)
Notes / Other Unique Features	Scotland runs Shared Lives entirely within its national HSCS & SSI regulations, with PVG as the universal vetting route; local schemes (e.g., Fife, Edinburgh) publish clear eligibility/matching rules and confirm carers are self-employed & fee paid. (Fife Council, The City of Edinburgh Council)

Wales

In Wales, Adult Placement (Shared Lives) schemes are regulated by Care Inspectorate Wales (CIW) under RISCA 2016 and the 2019 Adult Placement Services Regulations. Adults (16+) live in host families, with carers vetted through DBS, references, and a six-stage assessment leading to approval panel endorsement. Carers are self-employed and paid a weekly allowance set by local authorities, with national HMRC tax relief. Safeguarding duties are set out in the Social Services and Well-being (Wales) Act 2014, with personal plans reviewed every three months and Responsible Individuals required to conduct quarterly visits. CIW's inspection framework links directly to national Well-being outcomes, with clear statutory guidance ensuring accountability and safety.

Table 30. *Wales - Shared Lives (Adult Placement) Schemes*

Variable	Details
Country/Region	Wales (UK).
Jurisdiction / Organization Name	Local authority Adult Placement / Shared Lives schemes; regulated by Care Inspectorate Wales (CIW) under the Regulation and Inspection of Social Care (Wales) Act 2016 and service-specific regulations. (Care Inspectorate Wales, Legislation.gov.uk)
Program / Initiative Name	Adult Placement Services (Shared Lives). (GOV.WALES)
Residential Model Type / Living Arrangement Description	Adults live in an approved carer's family home (long-term, short breaks, day support). The scheme is the regulated service; carers' homes are not registered as care homes. (GOV.WALES, Care Inspectorate Wales)
Compensation / Funding Model	Carers are self-employed and paid a weekly allowance/fee by the local authority scheme; examples published by councils (Powys: £283-£463/week; West Wales brochure example "up to £357/week"; Gwynedd bands £322-£515/week). HMRC Qualifying Care Relief applies to Shared Lives/Adult Placement carers. (Powys County Council, Carmarthenshire County Council, Gwynedd, GOV.UK)
Target / Eligible Population	Adults (typically 16+) with learning disability, autism, mental-health needs, physical/sensory disability or older adults requiring support. (Social Care Wales)
Resident Eligibility Criteria	Access is via local authority assessment and care & support plan under the Social Services & Well-being (Wales) Act 2014; the scheme assesses suitability & matching before agreeing a placement (with provisions for emergency placements). (Care Inspectorate Wales)
Governance Structure	Providers must comply with The Adult Placement Services (Service Providers and Responsible Individuals) (Wales) Regulations 2019 and Welsh Government statutory guidance; CIW inspects against a dedicated Inspection Framework for Adult Placement. (Legislation.gov.uk, GOV.WALES, Care Inspectorate Wales)
Host Recruitment & Vetting Practices	The provider must have policies for recruitment & training (Reg. 33) and ensure the fitness of adult placement carers (Reg. 36) - including being of good character, having the skills/competence/experience, and DBS checks (with DBS Update Service options). Local brochures show a six-stage

Variable	Details
	assessment, DBS, home checks, and an independent approval panel. (GOV.WALES, Carmarthenshire County Council)
Support, Monitoring & Communication Mechanisms	Each carer is supported by a named Shared Lives officer and the person has a case manager/social worker; schemes provide regular contact and placement reviews. Personal plans must be reviewed every 3 months (or sooner on change). The Responsible Individual (RI) must make quarterly visits (incl. meeting people/carers, checking records/premises) and use findings in the quality-of-care review. (Carmarthenshire County Council, Care Inspectorate Wales)
Resident / Tenant Safeguarding Practices / Frameworks	Reg. 21-22, 24-25 require arrangements to keep people safe from abuse/neglect, govern the appropriate use of control/restraint (proportionate, recorded within 24 hours and reviewed), and require lawful DoLS/MCA processes for any deprivation of liberty. Scheme policies must include safeguarding & whistleblowing and routes to advocacy/ombudsman. (GOV.WALES)
Quality Assurance / Frameworks / Mechanisms	CIW's Adult Placement Inspection Framework maps regulatory requirements to Well-being outcomes and sets lines of enquiry for personal plans, safeguarding, governance, QA, finance, environment, and carer support. Providers must run ongoing QA, six-monthly quality reviews, annual returns, and notify CIW of specified events; RI quarterly visits are mandatory. (Care Inspectorate Wales, GOV.WALES)
Host Education / Training Standards / Practices	Providers must give carers induction & ongoing training aligned to national guidance - explicit topics include recognising abuse, Positive Behavioural Support, basic first aid, health promotion, medicines/self-medication, and record-keeping; providers must monitor training impact. (GOV.WALES)
Specific Policies Related to Safeguarding / QA / Training (name, focus)	• APS Regulations 2019 (legal requirements incl. safeguarding, personal plans, staffing, carer recruitment/fitness, notifications). • Statutory Guidance for APS (2019) - how to comply, incl. safeguarding, carer supervision, training, incident reporting. • CIW Inspection Framework - Adult Placement (2019) - inspection criteria & "what good looks like". • CIW Code of Practice for Inspection (2025) - inspection approach & frequency. • RI Quarterly Visits Guidance (2023) - what must happen each 3-month visit. (Legislation.gov.uk, GOV.WALES, Care Inspectorate Wales)
Independent Planning Supports / Facilitation	Advocacy duty: LAs must arrange Independent Professional Advocacy where needed so people can take part in assessment, planning and review (Part 10 Code of Practice - Advocacy). The APS guidance also requires providers to ensure access to advocacy. (GOV.WALES)
Balancing Dignity of Risk with Safeguards	Inspection framework expects positive risk-taking and proportionate risk management within personal plans; restraint must be exceptional, proportionate and recorded, with governance oversight. (Care Inspectorate Wales, GOV.WALES)

Variable	Details
Psychosocial Supports (Mental Health, Linguistic, Cultural / Equity)	Framework references Human Rights Act, Equality Act, UNCRPD, and Welsh Language Standards; APS Reg. 19 requires meeting language & communication needs. Matching and community inclusion are core scheme aims. (Care Inspectorate Wales)
Quality of Life Focus / Outcomes Measured	CIW inspects against national Well-being outcomes (e.g., rights & entitlements, safety, relationships, contribution, suitable accommodation). Many schemes also use Shared Lives outcomes tools (sector-wide). (Care Inspectorate Wales, Shared Lives Plus)
Barriers to QA/Safeguarding/QOL Measures	Welsh Government consultation feedback noted smaller services may struggle with compliance burden under new regulations - capacity and workforce implications. (GOV.WALES)
Facilitators to QA/Safeguarding/QOL Measures	Clear national regs + statutory guidance, bespoke CIW inspection framework, mandatory RI quarterly visits, 3-monthly personal-plan reviews, and structured carer induction/ongoing training. (Care Inspectorate Wales, GOV.WALES)
Notable Cases/Events	2019: New APS Regulations & CIW adult placement inspection framework replaced the 2004 regime. 2023: CIW issued detailed RI quarterly visit guidance. (Care Inspectorate Wales)
Program Evaluation / Research Evidence	Sector evidence indicates high quality & safety perceptions in Shared Lives (UK-wide outcomes reports); Wales-specific overviews (e.g., “State of the Nation: Shared Lives in Wales”) summarise scale, cost comparisons and expansion aims. (Shared Lives Plus, Individualised Living)
Notes / Other Unique Features	Welsh materials spell out matching & introductions, approval panels, carer supervision, out-of-hours support, and 24-hour incident reporting for restraint - all within providers’ governance and QA cycles. Local brochures (e.g., West Wales) illustrate operational practice. (GOV.WALES, Carmarthenshire County Council)

Northern Ireland

Northern Ireland operates Shared Lives (Adult Placement) schemes through Health and Social Care Trusts, regulated by the RQIA under the 2007 Adult Placement Agencies Regulations. Adults with learning disabilities and older people live in carers' family homes for long-term care, day support, or short breaks. Carers are vetted through AccessNI, references, medical checks, and panel approval. Monitoring involves Trust social worker visits at least twice per year plus annual reviews, and RQIA inspects all agencies annually. Safeguarding is supported by NI's Adult Safeguarding Policy (2015) and MCA (NI) 2016. Recent expansions include Age NI's regional Shared Lives service, broadening reach to older adults while maintaining high inspection standards.

Table 31. *Northern Ireland - Shared Lives (Adult Placement) Schemes*

Variable	Details
Country/Region	Northern Ireland (UK).
Jurisdiction / Organization Name	Health & Social Care (HSC) Trusts operate Shared Lives/Adult Placement schemes; regulated by RQIA under the Adult Placement Agencies Regulations (NI) 2007. (RQIA, Legislation.gov.uk)
Program / Initiative Name	Shared Lives (a.k.a. Adult Placement / Share the Care). Examples: Northern HSC Trust "Share the Care"; Western Trust Shared Lives; Age NI regional Shared Lives service (for older people). (Northern Trust, Western Trust, Age UK)
Residential Model / Living Arrangement	Adults live in an approved carer's family home for long-term arrangements, short breaks or day support; matching and ongoing support are provided by the scheme. (Western Trust, nhs.uk)
Compensation / Funding Model	Carers are self-employed; paid an allowance/fee set in the provider contract. For Age NI's day support, carers receive an hourly rate; the service is funded by the Department of Health and referrals come via HSC Trusts. (Age UK)
Target / Eligible Population	Adults with learning disabilities and older adults (65+); schemes also offer day support and short breaks. (nidirect)
Resident Eligibility Criteria	Access via HSC Trust referral and scheme matching; written placement agreement is required before any placement and limits on numbers per carer apply. (Legislation.gov.uk)
Governance Structure	Providers must comply with the Adult Placement Agencies Regulations (NI) 2007; RQIAinspects adult placement agencies and issues provider guidance on what evidence is required. (Legislation.gov.uk, RQIA)
Host Recruitment & Vetting Practices	Schemes recruit, assess, train and approve carers through an Approval Panel; checks include AccessNI criminal-record vetting, references (incl. GP/employer/friends), and a home health & safety inspection before approval.
Support, Monitoring & Communication Mechanisms	Age NI leaflet (reflecting regulatory expectations) states: social worker visits 3 months after placement, then at least twice per year (one with the person present), plus an annual placement review. RQIA inspects every adult placement agency at least annually (2022-23 guidance). (RQIA)

Variable	Details
Resident / Tenant Safeguarding Practices / Frameworks	Providers must protect people from abuse/neglect and ensure safe care under the 2007 Regulations; RQIA inspection reports evidence AccessNI checks, safeguarding/MCA-DoLS training for staff and carers, with least-restrictive practice emphasised. (RQIA, Legislation.gov.uk)
Quality Assurance Frameworks / Mechanisms	RQIA Provider Guidance sets inspection approach, lines of enquiry and evidence requirements (governance, recruitment, incident management, outcomes, complaints). Agencies are inspected at least once yearly and must evidence quality monitoring. (RQIA)
Host Education / Training Standards / Practices	Carers receive induction and ongoing training from the scheme; RQIA reports require evidence of safeguarding and capacity/DoLS awareness training; providers organise carer support groups. (RQIA)
Specific Policies Related to Safeguarding / QA / Training	• Adult Placement Agencies Regulations (NI) 2007 - placement agreements, reviews, records, fitness of persons, complaints. • RQIA Provider Guidance for Adult Placement Agencies (2019-20; 2022-23) - how RQIA inspects and what "good" looks like. • AccessNIvetting for regulated roles. (Legislation.gov.uk, RQIA, nidirect)
Independent Planning Supports / Facilitation	Placement is part of an HSC Trust care plan; agencies must maintain a service user's plan and conduct placement reviews (set out in the Regulations). (Legislation.gov.uk)
Balancing Dignity of Risk with Safeguards	RQIA guidance expects autonomy and independence to be promoted while risks are managed proportionately; inspection reports look for least-restrictive practice and consent/capacity training. (RQIA)
Psychosocial Supports (Mental Health, Linguistic, Cultural / Equity)	Scheme aims include reducing loneliness/isolation, community connection and participation; matching considers interests and lifestyle. (Age UK)
Quality of Life Focus / Outcomes Measured	RQIA inspection lens includes people's choice, control, inclusion and wellbeing; sector reports summarise usage patterns (long-term vs short breaks vs day support). (RQIA, Shared Lives Plus)
Barriers to QA/Safeguarding/QoL Measures	Uneven investment/staffing across Trusts (Northern Trust provides over half of placements), implying capacity and equity challenges. Carer recruitment remains a limiting factor. (Shared Lives Plus)
Facilitators to QA/Safeguarding/QoL Measures	Statutory regulation (2007 Regs), annual RQIA inspections, structured approval panels, AccessNI vetting, and Trust-led social-work oversight & reviews. (Legislation.gov.uk, RQIA)
Notable Cases/Events	2021-22 regional procurement to expand Shared Lives across NI; Age NI registered by RQIA (Dec 2022) to deliver a regional older-people Shared Lives service funded by DoH. (Find a Tender, Age UK)
Program Evaluation / Research Evidence	RQIA inspection reports (e.g., Age NI) evidence compliance with recruitment, training, and safeguarding; Shared Lives NI Annual Report summarises scheme scale and distribution across Trusts. (RQIA, Individualised Living)

Variable	Details
Notes / Other Unique Features	NI operates both Trust-run schemes (e.g., Western/Northern Trusts) and a regional charity-run scheme (Age NI) under the same regulatory framework; most provision historically short-break/day support with a smaller long-term segment. (Western Trust, Shared Lives Plus)

Key public sources

• Adult Placement Agencies Regulations (NI) 2007 (legislation.gov.uk). Legislation.gov.uk
• RQIA **Provider Guidance**: Adult Placement Agencies (2019-20; 2022-23). RQIA+1
• NI Direct: *Shared Lives services for Northern Ireland*. nidirect
• HSC Trust scheme pages (Western Trust; Northern Trust/Share the Care). Western TrustNorthern Trust
• Age NI Shared Lives (service page + carer leaflet with visit schedule & vetting/training). Age UKLoughshore Parishes
• Shared Lives Plus (NI snapshot of distribution across Trusts). Shared Lives Plus
• Regional procurement notice (Find a Tender, 2021).

IRELAND (REPUBLIC OF)

In Ireland, Home Sharing (Shared Living, Contract Families, Short Breaks) is overseen by the Health Service Executive (HSE) via national guidelines but lacks a dedicated statutory regulatory framework. Adults with intellectual disabilities live with approved host families, recruited through Garda vetting, medical checks, references, and approval panels. Carers are paid allowances varying by arrangement type. Monitoring includes link social workers, placement reviews, and host family reviews every three years. Safeguarding follows HSE's 2014 Vulnerable Persons policy, while the Assisted Decision-Making (Capacity) Act 2015 provides rights-based decision supports. A 2016 Expert Group highlighted strong community outcomes but also a "regulatory vacuum," recommending statutory regulation to strengthen oversight.

Table 32. *Republic of Ireland - Home Sharing Schemes*

Variable	Details
Country/Region	Ireland (Republic of Ireland).
Jurisdiction / Organization Name	Health Service Executive (HSE) funds Home Sharing via service providers (mostly non-statutory/voluntary bodies). National guidance issued by an HSE Expert Group. (HSE.ie)
Program / Initiative Name	Home Sharing (three strands: Short Breaks, Contract Families, Shared Living). (HSE.ie)
Residential Model Type / Living Arrangement	A person with intellectual disability lives with an approved host family either full-time ("Shared Living"), regularly ("Contract family"), or for short breaks; supports are provided in the family's own home under a placement agreement. (HSE.ie)
Compensation / Funding Model	HSE guidance describes allowances paid to hosts; for Shared Living weekly/monthly allowance (some schemes add a retainer + per-night rate). For Contract Families, a retainer plus sessional payments; Short Breaks use per-night/per-session allowances. (HSE.ie)
Target / Eligible Population	Children and adults with intellectual disability (service is used by both, but your review focuses on adults). National snapshot (2016): 853 people (455 adults, 398 children) in Home Sharing across all CHO areas. (HSE.ie)
Resident Eligibility Criteria	Referral/assessment by the commissioning service; matching process via a Matching Panel; written Placement Agreement before any placement (emergency placements procedure included). (HSE.ie)
Governance Structure	National governance comes from the HSE National Guidelines for Home Sharing (Section 2 of the Expert Group report). The report notes a regulatory gap - Home Sharing is not covered by specific legislation/registration (unlike HIQA-registered "designated centres") and calls for statutory recognition and regulation. HIQA guidance clarifies what counts as a designated centre (most family-home hosts fall outside). (HSE.ie, HIQA)
Host Recruitment & Vetting Practices	Structured assessment by social workers; Garda clearance for the host and all adult household members/regular overnight visitors (re-check typically every 3 years); HSE/TUSLA checks, medical reports (updated every 5 years or post-illness), and three written references (plus phone verification). Home

Variable	Details
	visit/home safety inspection is required; applications go to an independent Approval Panel. (HSE.ie)
Support, Monitoring & Communication Mechanisms	Each placement has a link social worker (first point for safeguarding concerns). The link worker initiates each placement review and provides ongoing monitoring/feedback; Home Sharing family reviews at least every 3 years; placement reviews annually (or ≤2-year intervals). Checklists require host logs (arrivals/departures, visitors, incidents).
Resident / Tenant Safeguarding Practices / Frameworks	Schemes must follow HSE Safeguarding Vulnerable Persons (2014) policy; host duties include prompt reporting of any concern, maintaining visitor/incident records, and cooperating with investigations. Training covers Adult Safeguarding and Children First where relevant. (HSE.ie, HSE.ie)
Quality Assurance Frameworks / Mechanisms	The national guidelines set standards & procedures for: matching/approvals, placement agreements, medication management, reviews, complaints, and KPI/records. The Expert Group recommends: a National Lead to monitor schemes, uniform KPIs, and draft regulations (appendix). (HSE.ie)
Host Education / Training Standards / Practices	Mandatory pre-approval training plus annual refreshers. Training checklist includes: Disability awareness; Manual handling; First aid; Complaints; Adult safeguarding; Children First; Incident reporting; Intimate care; Sexuality/relationships; Epilepsy (as applicable); Behaviour support briefing; Medication administration. (HSE.ie)
Specific Policies Related to Safeguarding / QA / Training	• HSE National Guidelines for Home Sharing (operational standards). (HSE.ie) • HSE Safeguarding Vulnerable Persons at Risk of Abuse (2014) (policy & procedures). (HSE.ie) • Assisted Decision-Making (Capacity) Act 2015 - rights-based decision supports (commenced 2023) with HSE implementation resources. (HSE.ie) • HIQA "What is a designated centre?" (clarifies boundary with HIQA regulation). (HIQA) • Provider handbooks (e.g., Home Share Galway) operationalise the HSE guidance locally. (Squarespace, Ability West)
Independent Planning Supports / Facilitation	Person-centered planning (PCP) is core; key-worker/link-worker supports the person to set goals and review plans; some services use Personal Outcome Measures (POMs) alongside PCP.
Balancing Dignity of Risk with Safeguards	The guidelines emphasise rights, informed consent and least-restrictive practice within PCP and placement reviews; escalation pathways exist for emergency risk (including immediate removal if required). ADM(-C) Act implementation strengthens will and preference considerations.
Psychosocial Supports (Mental Health, Linguistic, Cultural / Equity)	Matching considers interests, lifestyle, family composition and local community; guidance expects inclusion, relationships, and belonging; providers (e.g., Brothers of Charity/Ability West) frame Home Sharing as community inclusion support. (Brothers of Charity)

Variable	Details
Quality of Life Focus / Outcomes Measured	The guidelines list Quality of Life as a standard domain and reference use of PCP and, in some organizations, POMs to track outcomes (well-being, participation, relationships, autonomy).
Barriers to QA/Safeguarding/QOL Measures	Regulatory vacuum (no specific legislation/regulation), very limited staffing for oversight (in 2016: 1 WTE : 55 placements) and geographic inequity in availability. (HSE.ie)
Facilitators to QA/Safeguarding/QOL Measures	National guidelines & toolkits (with forms, checklists, approval panels), standardised vetting/medical/reference requirements, structured reviews, and recommendation for a National Lead and KPI integration. Provider handbooks (e.g., Galway) give practical, reproducible processes. (HSE.ie, Squarespace)
Notable Cases/Events	2016 HSE Expert Group report published comprehensive National Guidelines and appended draft legislation, financial regs, and job descriptions (link worker, coordinator). (HSE.ie)
Program Evaluation / Research Evidence	The HSE report synthesises international evidence and Irish practice; providers (e.g., Ability West) commit to expanding Home Sharing and track outcomes locally; further independent evaluation is encouraged in the report. (HSE.ie, Ability West)
Notes / Other Unique Features	Approval & Matching Panels are a distinctive QA layer; host log-keeping & insurance requirements are explicit; medication and emergency procedures are set out for family-home contexts (including for emergency placements).

AUSTRALIA

Australia incorporates host-style living under the National Disability Insurance Scheme (NDIS) through Individualised Living Options (ILO), regulated by the NDIS Quality and Safeguards Commission. Participants can design flexible living arrangements, including living with a host or co-residency models, with NDIA funding provided in two stages (exploration/design and implementation). Hosts must pass the NDIS Worker Screening Check and be engaged by registered providers, who are subject to audits and incident reporting rules. Safeguards include mandatory incident notifications, positive behaviour support frameworks, and rights-based practice standards. Despite systemic challenges with unregistered providers and restrictive practices, ILO reflects a strong national focus on dignity of risk, participant choice, and outcomes tracking through NDIA's Participant Outcomes Framework.

Table 33. *Australia - Individualised Living Options (ILO) under NDIS*

Variable	Details
Country/Region	Australia (national)
Jurisdiction / Organization Name	NDIS Quality & Safeguards Commission (regulator); National Disability Insurance Agency (NDIA) (funding & policy). (NDIS Quality and Safeguards Commission)
Program / Initiative Name	Individualised Living Options (ILO) - including *host* and *housemate/co-residency* models; Supported Independent Living (SIL) (related, higher-needs). (NDIS, NDIS Quality and Safeguards Commission)
Residential Model Type / Living Arrangement Description	ILO funds supports around your chosen home arrangement; options explicitly include living with a *host* or with *housemates*. Not a housing payment - supports are designed and then implemented in two stages (Exploration & Design; Implementation). (NDIS)
Compensation / Funding Model	NDIA funds ILO in two stages (Stage 1: exploration/design; Stage 2: implementing the supports), with banded funding and price limits governed by the NDIS Pricing Arrangements & Price Limits (updated annually). (NDIS)
Target / Eligible Population	NDIS participants requiring bespoke home-and-living supports; ILO is for people who want flexible, person-designed living (including host arrangements). (NDIS)
Resident Eligibility Criteria	Determined through NDIA planning and "Home and Living" processes; ILO must meet funding criteria; ILO is added to the participant's plan when criteria are met. (NDIS)
Governance Structure	Regulated under the NDIS Act & Rules by the NDIS Commission via the NDIS Practice Standards (Core + Supplementary modules) and provider registration & audits (verification/certification). (NDIS Quality and Safeguards Commission)
Host Recruitment & Vetting Practices	Managed by registered providers under NDIS rules: "risk-assessed roles" require an NDIS Worker Screening Check/clearance; providers must induct workers and ensure ongoing suitability. (In host models, hosts are typically engaged as workers/contractors and therefore must meet worker screening and induction.) (Western Australian Government, NDIS Quality and Safeguards Commission)

Variable	Details
Support, Monitoring & Communication Mechanisms	Mandatory service agreements and support plans under Practice Standards; incident management system; required reportable-incident notifications (24h for most serious categories; 5 business days for unauthorised restrictive practice with no immediate harm, plus 5-day follow-up form). Commission also promotes structured *practice reviews* for continuous improvement. (NDIS Quality and Safeguards Commission)
Resident / Tenant Safeguarding Practices / Frameworks	Core module "Rights & responsibilities" requires person-centered supports; communication in preferred language/mode; privacy/dignity; prevention of violence/abuse/neglect; support to access *independent advocacy*. Complaints can go to the provider or directly to the NDIS Commission. (NDIS Quality and Safeguards Commission)
Quality Assurance Frameworks / Mechanisms	NDIS Practice Standards & Quality Indicators; third-party audits by approved quality auditors (verification/certification), with surveillance and 3-year cycles for certification; Commission compliance/enforcement tools and public banning orders register. (NDIS Quality and Safeguards Commission, BSI)
Host Education / Training Standards / Practices	Worker Orientation Module "Quality, Safety and You" explains obligations under the NDIS Code of Conduct and is expected as part of induction; additional Commission e-learning modules available. (Providers must ensure workers/hosts are competent for their roles.) (NDIS Quality and Safeguards Commission)
Specific Policies Related to Safeguarding / QA / Training	• NDIS Practice Standards (Core + relevant Supplementary). • NDIS Code of Conduct (worker guidance). • Incident Management & Reportable Incidents Rules (timeframes & forms). • Behaviour Support & Restrictive Practices Rules (reduce/eliminate RPs; BSPs; monthly reporting). • PBS Capability Framework (practitioner capability levels). • Worker Screening (NDIS Check). (NDIS Quality and Safeguards Commission, Western Australian Government)
Independent Planning Supports / Facilitation for Residents	ILO "Stage 1" can be delivered by an independent provider; participants can use Support Coordinators, capacity-building orgs and advocates; Practice Standards require support for access to independent advocacy. (NDIS, NDIS Quality and Safeguards Commission)
Balancing Dignity of Risk with Safeguards	Practice Standards explicitly recognise the *dignity of risk* and require providers to support informed choice and risk-benefit discussions; ILO is designed to provide "safety, stability and flexibility" while reflecting the person's choices. (NDIS Quality and Safeguards Commission)
Psychosocial Supports (Mental Health, Linguistic, Cultural / Equity)	Core module requires culturally responsive supports, communication in the person's preferred language/mode, and respect for values/beliefs; rights to intimacy and community connection are affirmed. (NDIS Quality and Safeguards Commission)
Quality of Life Focus / Outcomes Measured	NDIA Participant Outcomes Framework - regular national outcomes surveys for participants and families across domains

Variable	Details
	(choice and control, daily living, relationships, social/community participation, health/wellbeing, home, etc.). (NDIS)
Barriers to QA/Safeguarding/QOL Measures	Systemic challenges noted publicly include high rates of unauthorised restrictive practices (historically) and gaps from large numbers of unregistered providers (outside full audit regime) - areas under active regulatory reform (e.g., moves toward mandatory registration/worker screening). (The Guardian, The Australian)
Facilitators to QA/Safeguarding/QOL Measures	National regulator with uniform Practice Standards; mandatory incident reporting with strict timeframes; behaviour support capability framework; worker screening; audit regime; rights-based standards with advocacy access; separation of housing and supports principle to reduce conflicts of interest. (NDIS Quality and Safeguards Commission, Western Australian Government, Summer Foundation)
Notable Cases/Events	National media scrutiny of restrictive practices has driven compliance and reform activity; Commission continues education/enforcement and PBS improvement initiatives. (The Guardian)
Program Evaluation / Research Evidence	NDIA publishes national Outcomes Reports tracking participant-reported outcomes over time; Commission publishes practice guidance and reviews to guide provider improvement. (NDIS, NDIS Quality and Safeguards Commission)
Notes / Other Unique Features	ILO explicitly includes “host” arrangements (closest analogue to Shared Lives / adult foster care in AU). Authorisation of *regulated* restrictive practices occurs under *state/territory* systems, while the Commission oversees reporting and reduction - so providers in host models must comply with both the national Rules and local authorisation processes. (NDIS, Western Australian Government, Communities and Justice)

NEW ZEALAND

In New Zealand, Whaikaha - Ministry of Disabled People funds flexible supports through Choice in Community Living (CiCL), Individualised Funding, and Enabling Good Lives principles. Adults can live with family, flatmates, or hosts, supported under personal plans rather than institution-based residential care. Oversight rests with Whaikaha contracts, Health NZ audits against Ngā Paerewa Health & Disability Services Standards (NZS 8134:2021), and the Health & Disability Commissioner's Code of Rights. Hosts and workers must pass Police vetting under the Children's Act and Ngā Paerewa requirements. Safeguarding blends rapid incident reporting, independent advocacy, and disabled-led initiatives like DAPAR. Evaluations show CiCL improves autonomy, inclusion, and quality of life, though housing affordability and workforce skills remain barriers.

Table 34. *New Zealand - Choice in Community Living (CiCL) and Related Models*

Variable	Details
Country/Region	New Zealand / Aotearoa.
Jurisdiction / Organization Name	Whaikaha - Ministry of Disabled People (funding & contract oversight for disability supports); Health NZ - Te Whatu Ora (system/regulatory levers incl. certification); Health & Disability Commissioner (HDC) (Code of Rights & complaints, independent Nationwide Advocacy Service). (disabilitysupport.govt.nz, Ministry of Health NZ, hdc.org.nz)
Program / Initiative Name	Choice in Community Living (CiCL); Individualised Funding (IF/EIF); My Home, My Choice (residential transformation program); Enabling Good Lives (EGL) (principles that underpin person-led design). (disabilitysupport.govt.nz, whaikaha.govt.nz)
Residential Model Type / Living Arrangement Description	Person chooses where/who to live with; CiCL is an alternative to traditional residential services and can include flatting, living with a family member/ally, or engaging a live-in supporter (e.g., a family member for night support) under a personal plan; IF/EIF lets people directly engage support workers (including family in some cases). Host-family respite for children is funded in some regions (evidence of a host arrangement in practice). (Ministry of Health NZ, disabilitysupport.govt.nz)
Compensation / Funding Model	NASC assessment → funding package added to plan (CiCL specification); flexible spend rules, provider invoices & "wash-up" on exit; IF/EIF rules set what can be purchased. Social supports can be supplemented by benefits (e.g., Accommodation Supplement) but housing cost is separate from support funding. (disabilitysupport.govt.nz, Multiple Sclerosis Society of NZ)
Target / Eligible Population	Disabled adults (primarily <65 under DSS) with significant support needs who want non-residential living options; IF/EIF broader. (disabilitysupport.govt.nz)
Resident Eligibility Criteria	Needs Assessment & Service Coordination (NASC) determines eligibility and support package; ongoing review if needs change. (Government of New Zealand)
Governance Structure	Providers must meet Ngā Paerewa Health & Disability Services Standard (NZS 8134:2021)(certification audits under the Health and Disability Services (Safety) Act); Whaikaha contract terms set quality reporting expectations. HDC Code of Rights applies to

Variable	Details
	all health/disability services. (Ministry of Health NZ, New Zealand Legislation, New Zealand Legislation, whaikaha.govt.nz)
Host Recruitment & Vetting Practices	No single national "host" statute; providers' HR/contract terms + Ngā Paerewa require safe recruitment (criminal-record/Police vetting) and role-appropriate checks. Children's Act 2014safety checks are mandatory for any roles working with children; Police Vetting Service supports checks for roles with vulnerable people. (Standards New Zealand, Ministry of Health NZ, New Zealand Police)
Support, Monitoring & Communication Mechanisms	Contracted providers must: maintain service agreements & support plans, conduct regular reviews, operate a complaints process, and run an incident management system. Critical incidents must be notified within 24 hours to Whaikaha under DSS contracts. Certification audits against Ngā Paerewa test these systems. (disabilitysupport.govt.nz, Ministry of Health NZ)
Resident / Tenant Safeguarding Practices / Frameworks	National safeguarding approach led by Whaikaha (policy & practice guidance), plus HDC Code of Rights (ten enforceable rights incl. appropriate standard, effective communication, fully informed, to complain). DAPAR (Disability Abuse Prevention and Response) provides a disabled-led, multi-agency response model. (disabilitysupport.govt.nz, hdc.org.nz)
Quality Assurance Frameworks / Mechanisms	Ngā Paerewa NZS 8134:2021 sets outcomes & quality indicators; services undergo third-party certification audits; Ministry guidance details expectations (employment checks, governance, incident/complaints learning). HDC monitors complaints; Whaikaha monitors contracts and can intervene (e.g., targeted actions with providers). (Ministry of Health NZ, whaikaha.govt.nz)
Host Education / Training Standards / Practices	Ngā Paerewa requires workforce to be inducted, trained, culturally safe, and competent for their roles (including communication, safeguarding, and minimising restrictive practices). Providers commonly mandate training and supervision documented for audits. (Ministry of Health NZ)
Specific Policies Related to Safeguarding / QA / Training	• HDC Code of Rights (legal rights & provider duties). • Ngā Paerewa 8134:2021 (includes sections on restraint minimisation/restrictive practices, governance, complaints, open disclosure). • Critical Incident notification rules (24 h). • Children's Act safety checks (if any work involves children). • Whaikaha Quality Framework (contractual expectations). (New Zealand Legislation, Ministry of Health NZ, disabilitysupport.govt.nz, Oranga Tamariki - Ministry for Children, whaikaha.govt.nz)
Independent Planning Supports / Facilitation	NASC facilitates assessment & planning; EGL encourages independent facilitation and self-direction; Nationwide Health & Disability Advocacy Service is an independent support for issues/complaints. (whaikaha.govt.nz, disabilitysupport.govt.nz, hdc.org.nz)
Balancing Dignity of Risk with Safeguards	Whaikaha defines safeguarding as protecting a person's right to make their own decisions(risk-enabling); Ngā Paerewa embeds Te Tiriti-aligned, rights-based practice with proportional risk

Variable	Details
	management and open disclosure. (disabilitysupport.govt.nz, Ministry of Health NZ)
Psychosocial Supports (Mental Health, Linguistic, Cultural / Equity)	Ngā Paerewa emphasises culturally safe, person- and whānau-centered care (Te Tiriti); HQSC promotes multi-agency Safeguarding Adults responses for adults at risk; Whaikaha funds DAPAR (disabled- and Māori-led) for violence/abuse response. (Health Quality & Safety Commission, disabilitysupport.govt.nz)
Quality of Life Focus / Outcomes Measured	EGL principles (self-determination, community inclusion) are the national QOL frame; CiCL evaluation found early outcomes of increased control, freedom, and life participation when supports were well-planned. (disabilitysupport.govt.nz, Ministry of Health NZ)
Barriers to QA/Safeguarding/QOL Measures	CiCL evaluation notes housing affordability/availability, uneven staff skills, and need for better inter-agency coordination (NASC, Work & Income, housing) can impede outcomes. Broader system reviews highlight historic gaps in vetting/safety checks and visibility of abuse. (Ministry of Health NZ, abuseincare.org.nz, tikatangata.org.nz)
Facilitators to QA/Safeguarding/QOL Measures	Flexible funding (CiCL/IF), robust audits (Ngā Paerewa), rapid incident reporting, independent advocacy, disabled-led DAPAR, and EGL person-led planning all support quality and safety. (Ministry of Health NZ, disabilitysupport.govt.nz, hdc.org.nz)
Notable Cases/Events	Ngā Paerewa 2021 came into force Feb 2022 (unified health & disability standard); Whaikaha has taken specific actions with providers where complaint systems were deficient. (New Zealand Legislation, whaikaha.govt.nz)
Program Evaluation / Research Evidence	CiCL implementation evaluation (Ministry of Health, 2015) documents processes & early outcomes; ongoing audits publish certification reports against Ngā Paerewa. (Ministry of Health NZ)
Notes / Other Unique Features	NZ's safeguards are system-wide (HDC Code + Ngā Paerewa + Whaikaha contracts) rather than a single Shared Lives statute. Host-style setups are usually built through CiCL/IF planning, sometimes with live-in supporters/flatmates; host-family respite options exist for children in some regions. (Ministry of Health NZ)

Cross-Jurisdiction Synthesis and Discussion

Common Themes Across Jurisdictions

Below is a concise, thematic view of similarities the review shows across Canada, the United States, the UK, Ireland, Australia, and New Zealand. We highlight common mechanisms first, then ground them with representative program or regulator sources from each region.

Safeguards and monitoring

Pre-admission vetting and matching

Across systems, safety starts before move-in: hosts (and usually all adult household members) are screened, homes are studied, and compatibility is checked so the arrangement is preventive by design. In British Columbia, CLBC requires a documented home study, criminal-record checks and references, and structured matching linked to culture, routines, and preferences; these expectations are now embedded both in the Home Sharing Standards and in the Coordination Standards that govern agencies supervising hosts. (Community Living BC) Ontario's Quality Assurance Measures regulation provides the agency-level backbone - mandating screening, abuse-prevention policy, and serious-occurrence management - which host-family programs administered by DS agencies must implement. (Ontario, CanLII) The UK uses regulated Shared Lives schemes to approve carers and match people; inspection is against a single assessment framework that tests safety and people's experiences in ordinary households. (Care Quality Commission) Ireland's HSE Home Sharing guidance and scheme handbooks require Garda/Tusla vetting and staged contact prior to agreement. (HSE.ie, Squarespace) Australia's NDIS framework requires registered providers to screen workers and induct them under the national Practice Standards; New Zealand's Ngā Paerewa standard and Police-vetting regime set similar expectations for safe recruitment. (NDIS Quality and Safeguards Commission, Ministry of Health NZ, Standards New Zealand) In the US, state rules do the same work; for example, Pennsylvania's Lifesharing chapter specifies household vetting and assigns each person a life-sharing specialist, while New York's Family Care Manual sets out provider and household clearances and the structured "home study" before approval. (Pennsylvania Code & Bulletin, Legal Information Institute, Office of Developmental Disabilities)

Home approval and the physical environment

Home Share can only proceed in an approved, safe dwelling. CLBC requires safety and accessibility checks as part of approval and ongoing coordination, with incident and emergency expectations tied to policy. (Community Living BC) US states specify environmental standards in rule: Oregon's AFH-DD rules cover bedroom privacy, egress and alarms; Texas' STAR+PLUS Adult Foster Care sets minimum bedroom sizes and home standards; both are periodically verified. (secure.sos.state.or.us, Oregon, Texas Health and Human Services)

In-home monitoring and clinical review

Monitoring is rhythmic and documented: agency visits in the home, scheduled reviews with the person, and clinical checks where medications or health risks are present.

CLBC's Coordination Standards require on-site monitoring against quality-of-life strategies, with follow-up and corrective actions where needed. (Community Living BC) Ontario's QAM requires ongoing service monitoring and serious-occurrence follow-up at the agency level. (Ontario) UK schemes evidence regular supervision of Shared Lives carers under the CQC framework. (Care Quality Commission) Ireland's home-sharing materials set out contact schedules and escalation routes. (Squarespace) New York adds a defined clinical cadence: monthly liaison reviews and at least quarterly nursing review of orders and MARs. (Office of Developmental Disabilities)

Incident management and complaints

A short-clock incident system underpins day-to-day support. CLBC's Critical Incidents Policy sets definitions, reporting expectations, and CLBC follow-up; agencies' own systems must align. (Community Living BC) Ontario's serious-occurrence regime in QAM requires immediate protective action, notification, and analysis. (Ontario) Australia's NDIS rules require providers to notify reportable incidents to the national regulator, with rapid timeframes and documented learning. (NDIS Quality and Safeguards Commission) New Zealand's certification regime checks that incident, complaints, and open-disclosure processes actually operate in practice. (Ministry of Health NZ) In the US, the federal HCBS Settings Rule sets the rights context, while states specify incident clocks and analysis: Ohio's MUI rule marries immediate response with a continuous-quality cycle; Pennsylvania's Lifesharing chapter and New York's Family Care rules require timely reporting, documented investigations, and trend review. (eCFR, Medicaid, dodd.ohio.gov, Pennsylvania Code & Bulletin, Office of Developmental Disabilities)

Contingency, relief, and financial safeguards

Programs expect written plans for emergencies, relief/substitute support, and transitions; they also regulate people's money in host settings. New York's Family Care materials include personal-funds controls and required notifications, while Canadian handbooks and contracts link hosts to critical-incident clocks and emergency planning duties set in CLBC policy. (Office of Developmental Disabilities, clementscentre.org)

Quality assurance

Licensing, registration, and program approval

Permission to operate anchors QA. Ontario's O. Reg. 299/10 codifies agency-level obligations for rights, inclusion, abuse prevention, medication safety, training, and serious-occurrence reporting - requirements that host-family programs administered by agencies must meet. (Ontario) British Columbia layers provider-level Home Sharing Standards with CLBC's Coordination Standards and policy; the Auditor General has reviewed CLBC's monitoring framework and reinforced expectations for measurable quality-of-life oversight and compliance follow-up. (Community Living BC, OAG British Columbia) In the UK, Shared Lives schemes register and are inspected under national frameworks with published quality statements. Scotland and Wales publish adult-placement inspection frameworks used both for regulation and self-evaluation. (Care Quality Commission, Care Inspectorate, Care Inspectorate Wales) Ireland's HSE guidance functions as the operational standard for home-sharing schemes, even as statutory inspection focuses on designated centres. (HSE.ie) Australia requires NDIS

provider registration against the national Practice Standards with third-party certification audits; New Zealand requires certification to Ngā Paerewa (NZS 8134:2021), a unified health and disability standard. (NDIS Quality and Safeguards Commission, Ministry of Health NZ, Standards New Zealand) In the US, federal HCBS settings criteria apply system-wide and states license or certify shared-living variants through detailed program rules, such as Pennsylvania's Chapter 6500 (Lifesharing). (eCFR, Pennsylvania Code & Bulletin)

Inspection frameworks and cadence

Quality is verified through scheduled and unannounced checks using published tools that translate rights and safety into what surveyors should see in a family home. The CQC single assessment framework and the Care Inspectorate quality frameworks make explicit what "good" looks like and how evidence is judged; Welsh inspection draws on an adult-placement framework aligned to rights and capacity law. (Care Quality Commission, Care Inspectorate, Care Inspectorate Wales) CLBC and coordinating agencies conduct on-site monitoring, incident follow-up, and evaluation against contract outcomes; the Auditor General's review describes the policy and toolset. (Community Living BC, OAG British Columbia) New York requires at least two state inspections annually for Family Care (with unannounced visits) on top of monthly agency liaison oversight. (Office of Developmental Disabilities)

Provider quality improvement and workforce competence

Everywhere, QA is inseparable from competence. Ontario requires training before independent work and regular refreshers in abuse prevention, policy, and health and safety. (Ontario) CLBC's coordination framework expects provider induction on rights, communication, emergency planning, behaviour support, and medication where relevant, with refreshers set in contract and evidenced at monitoring. (Community Living BC) UK schemes supervise carers and are inspected on whether training translates into safe, person-centered practice. (Care Quality Commission) Australia mandates the NDIS worker-orientation module and worker screening; audits sample training records against the Practice Standards and Quality Indicators. (NDIS Quality and Safeguards Commission) New Zealand's Ngā Paerewa requires competent and culturally safe practice, and certification reports test whether governance and improvement cycles operate as intended. (Ministry of Health NZ)

Data, incidents, and learning; tenancy and settings compliance

Incident systems are part of QA, not just safeguarding. Providers must code incidents reliably, analyze trends, and act. Ohio's MUI rule explicitly builds a continuous-improvement loop into incident response; Pennsylvania and New York require trend analysis through agency and state oversight. (dodd.ohio.gov, Pennsylvania Code & Bulletin, Office of Developmental Disabilities) Where the home is provider-owned or controlled, tenancy-style protections are audited as quality items. The US HCBS Settings Rule is the clearest articulation - requiring lease-like agreements, privacy, control of schedules and visitors, and individually justified rights modifications - while Canada, the UK, Australia, and New Zealand inspect for the same outcomes within their own frameworks. (eCFR)

Quality of life

Person-centered planning and review
Quality of life is embedded in plans and then revisited in the home. CLBC's Coordination Standards require monitoring against "Quality of Life Support Strategies," making everyday goals and routines the lens for visits and follow-up; Ontario agencies must show that services promote inclusion, choice, and rights in practice. (Community Living BC, Ontario) UK inspection centres people's experiences using quality statements, and Shared Lives schemes commonly add "My Shared Life," a short outcomes tool developed with the University of Kent, to track autonomy, relationships, and participation. (Care Quality Commission, Shared Lives Plus) Ireland's guidance requires a personal plan for every home-share arrangement and periodic reviews with the person and family. (HSE.ie)

Community inclusion, relationships, and health
Home Share is judged by whether life looks and feels ordinary. Canadian guidance expects opportunities for relationships, community roles, and chosen routines to be documented and adjusted when barriers appear. (Community Living BC) New York's monthly liaison notes and quarterly nursing reviews explicitly link to Life Plan goals and health oversight, ensuring medication practice and health follow-up support participation rather than replace it. (Office of Developmental Disabilities) Australia's Practice Standards and New Zealand's Ngā Paerewa require person-centered, culturally safe support and effective communication, with auditors sampling people's accounts and plans for evidence. (NDIS Quality and Safeguards Commission, Ministry of Health NZ)

Dignity of risk

Rights frameworks that set the tone
The balance between autonomy and safety is explicit. Ontario's QAM and policy suite require least-restrictive practice, informed consent, and documentation when rights are modified; British Columbia's standards and policy build risk-benefit conversations and review into coordination and monitoring. (Ontario, Community Living BC) UK regulators expect Shared Lives schemes to apply capacity law and "Making Safeguarding Personal," evidencing supported decision-making first and recording best-interests decisions only where capacity is lacking. (Care Quality Commission) Australia's NDIS Code and Practice Standards require supported decision-making across everyday choices; New Zealand's HDC Code of Rights and Ngā Paerewa require informed choice, restraint minimisation, and open disclosure. (NDIS Quality and Safeguards Commission, Ministry of Health NZ)

Formal pathways for limiting rights
Where limits are necessary, they must be specific, justified, time-limited, and reviewed. US states give clear examples: Ohio requires committee oversight and data-led reduction of restrictive measures within its behaviour/incident rules; Oregon bans certain restraint types outright and allows only last-resort emergency restraint with documentation and review; New York ties any protection to regulation and plan review. (dodd.ohio.gov, secure.sos.state.or.us, Office of Developmental Disabilities) Australia requires state/territory authorisation of any regulated restrictive practice plus monthly reporting to the NDIS Commission, with a national aim of reduction; New Zealand's

standard embeds restraint minimisation as an audit expectation. (NDIS Quality and Safeguards Commission, Ministry of Health NZ)

Tenancy, stability, and exit
Tenancy-style protections stabilise the home while teams work through risk. The US HCBS Settings Rule is explicit about lease-like agreements, privacy, visitors, and eviction safeguards in provider-controlled settings; states such as Texas operationalise this in adult-foster or host-home rules and handbooks. (eCFR, Texas Health and Human Services) Canadian contracts and guidance increasingly mirror these protections, and UK inspectors check that people have real control of their space and daily life within Shared Lives agreements. (Care Quality Commission)

Shared Standards Across Jurisdictions

Service-quality frameworks used as the audit scaffold
Every country in scope anchors Home Share/shared-living quality in a published framework that translates rights and safety into auditable criteria for family homes. In Canada, provinces do this through policy and regulation: British Columbia uses CLBC's Standards for Home Sharing alongside the Standards for the Coordination of Home Sharing; Ontario applies the Developmental Services "Quality Assurance Measures" regulation across funded agencies, which in turn covers host-family programs operated by those agencies. In the UK, Shared Lives schemes register and are inspected against national regulator frameworks (CQC's single assessment framework in England; Care Inspectorate frameworks in Scotland and Wales; RQIA in Northern Ireland). Ireland's HSE Home Sharing guidance functions as the operational standard for carer approval, supervision and review. Australia requires NDIS-registered providers to meet the NDIS Practice Standards and Quality Indicators, audited by independent certification bodies. New Zealand certifies disability providers against Ngā Paerewa (NZS 8134:2021), a unified, outcomes-based standard that brings governance, restraint minimisation, open disclosure and cultural safety into one matrix. Different titles, same purpose: a single, published rubric that both inspectors and providers use as the day-to-day checklist.

Settings compliance and tenancy-style protections
A second, near-universal layer concerns what "home" must look like when support is delivered there. The US HCBS Settings Rule provides the clearest articulation - privacy (including locks on bedroom doors), control over schedule, visitors and food, community access, and a legally enforceable lease or residency agreement with eviction protections in provider-controlled homes - checked with a standardised "Exploratory Questions" tool most states now use. The same "look-fors" appear in UK inspection frameworks for Shared Lives (privacy, control, visitors, ordinary rhythms) and in Canada's provincial standards, which increasingly require residential agreements and tenancy-like safeguards in provider-controlled settings. Australia's NDIS Practice Standards and New Zealand's Ngā Paerewa embed the same outcomes and test them in on-site audits.

Incident, complaints and investigations - short-clock systems with common content

Incident management has converged internationally. All systems define critical incidents, set short reporting clocks, require immediate protective action and mandate analysis and learning. Ontario's Serious Occurrence regime is a fully specified template (what to report, within-24-hours submission, content of initial and follow-up reports) and ministry inspection checks the paper trail. CLBC policy prescribes incident categories, notification routes and post-incident learning. In the UK, Shared Lives schemes must evidence safeguarding enquiries, complaints handling and learning as part of inspection. Australia's NDIS Reportable Incidents Rules set national timelines (immediate/24-hour notification and five-day follow-ups; monthly reporting for restrictive practices), and New Zealand contracts require 24-hour notification of critical incidents to Whaikaha with certification audits testing that the system actually works. US states layer their own clocks and investigation standards on top of the federal baseline (for example, Ohio's Major Unusual Incident system and Pennsylvania's certified incident-investigator model), but the structure - rapid reporting, documented investigation, trend analysis and corrective action - is the same.

Person-centered planning and outcomes - shared constructs plus a few named tools

Person-centered planning is a universal requirement and the backbone for monitoring visits. Plans specify what an ordinary, good life looks like in that household - routines, relationships, participation, health - and agencies must show, in the home, that supports are being adjusted to achieve those outcomes. For measurement, two named tools have broad traction. In the UK, "My Shared Life" (developed with the University of Kent and Shared Lives Plus) is a short, standardised questionnaire used across many schemes to track change in autonomy, relationships, community participation and wellbeing. In the US, the HCBS Quality Measure Set provides a national menu of outcome and experience measures (choice and control, community inclusion, health and safety, care experience) that states increasingly apply across residential models, including shared living. Elsewhere, provinces and national standards bodies require structured satisfaction reviews and evidence that ISP goals are being met, even if a single branded tool isn't mandated.

Host approval, safety checks and the home study - common components even when forms differ

Vetting content is strikingly consistent across countries. Hosts complete identity and right-to-work checks; criminal history and abuse-registry checks extend to all adult household members; references are verified; and the dwelling is assessed for safety, privacy and suitability. Programs document a structured "home study" that also examines compatibility, culture, routines and support expectations before trial visits and matching. Examples include CLBC's home-study and monitoring templates, Ontario's agency screening and training duties under QAM, Shared Lives carer approval processes inspected by national regulators, and US state specifications such as New York's Family Care home study and Pennsylvania's Chapter 6500 household clearances. New Zealand's Children's Act 2014 safety-check model is widely mirrored where children or young people share the household, with its seven elements and three-year re-checks providing a clear, repeatable pattern.

Training and competence - initial, role-specific, and refreshed

Every framework treats workforce and host competence as a quality requirement. Ontario requires training in abuse prevention, health and safety and agency policy

before anyone works alone, with periodic refreshers. CLBC's coordination standards and agency contracts expect induction on rights, communication, emergency planning, medication (where relevant) and positive behaviour support, with evidence of refresher cycles. UK schemes supervise carers and are inspected on whether training translates into competent practice in the home. Australia mandates worker screening and the national "Quality, Safety and You" orientation module, with audits sampling role-specific competency evidence. New Zealand's Ngā Paerewa expects competent, culturally safe practice and certifiers look for proof in supervision notes, training matrices and observed practice.

Behaviour support and restrictive practice governance - formal authorisation and reduction

Where restrictions are proposed, jurisdictions require a formal, time-limited pathway with review. US states embed this through behaviour-support rules and human rights committees (for example, Ohio), hard bans on certain restraint types and strict emergency-only conditions (for example, Oregon), and plan-level documentation and review (for example, New York). Australia requires state or territory authorisation of any regulated restrictive practice and monthly reporting to the NDIS Commission, with a system-wide goal of reduction and elimination. New Zealand's Ngā Paerewa requires restraint minimisation and open disclosure, and auditors test whether restrictions are justified, consented to and reviewed. Canada and the UK apply least-restrictive principles and capacity law, documenting supported decision-making first and best-interests decisions only where capacity is lacking.

Complaints, advocacy and independent oversight - visible routes and external eyes

Finally, all systems pair provider complaints processes with visible, independent routes. Ontario's regime and UK inspection frameworks insist that people know how to complain and can access independent safeguarding bodies. New Zealand layers the Health and Disability Commissioner's Code of Rights and a nationwide independent advocacy service across the certification standard. Australia's NDIS Commission acts as an external complaints avenue with enforcement powers. In Canada, provincial funders monitor contracts and investigate serious occurrences; in the US, state protection and advocacy systems, Justice Center hotlines and Medicaid survey agencies create additional external eyes.

Put together, these are the shared standards: a published service-quality framework used as the audit spine; a settings-compliance lens that insists on privacy, autonomy and tenancy-style protections; a short-clock incident and complaints system that learns; person-centered planning with observable, in-home review; a standardised vetting and home-study package; mandated training and competence; a formal pathway for any rights limitation with review and reduction; and accessible routes to independent advocacy and oversight. Different jurisdictions supply different brand names and documents, but the underlying tools are, by now, remarkably consistent.

Some examples of shared/similar standards are listed below, with broader exemplars provided in the next section:

Canada (provincial/national context)

- BC - CLBC Standards for Home Sharing and Coordination Standards (plus 2025 policy updates and CLBC monitoring references). (Community Living BC, Government of British Columbia)
- Ontario - O. Reg. 299/10 Quality Assurance Measures, and ministry compliance indicators/training resources. (Ontario, CanLII, qamtraining.net)

United Kingdom & Ireland

- England - Care Quality Commission single assessment framework (quality statements used for Shared Lives inspections). (Care Quality Commission)
- Scotland/Wales - Care Inspectorate quality framework for adult placement (used for inspection and self-evaluation). (careinspectorate.com, hub.careinspectorate.com)
- Ireland - HSE Home Sharing guidance and related provider materials. (HSE.ie)
- Shared Lives outcomes tool ("My Shared Life") - University of Kent/Shared Lives Plus. (Kent Academic Repository, Shared Lives Plus)

Australia & New Zealand

- Australia - NDIS Practice Standards & Quality Indicators and reportable incidents guidance. (NDIS Quality and Safeguards Commission)
- New Zealand - Ngā Paerewa (national certification standard) and the Health & Disability Commissioner's Code of Rights (independent complaints/rights route); government safety-checking (Children's Act) and Police vetting. (qamtraining.net, hdc.org.nz, shop.hdc.org.nz, Oranga Tamariki - Ministry for Children, New Zealand Police)

United States (federal baseline + state exemplars)

- Federal - HCBS Settings Rule and CMS tools: "Exploratory Questions" and the HCBS Quality Measure Set. (Medicaid)
- New York - OPWDD Family Care Manual (monthly liaison visit checklist; 90-day RN reviews; inspections). (Developmental Disabilities Office)
- Pennsylvania - 55 Pa. Code Chapter 6500 (Lifesharing) and self-assessment instrument. (Pennsylvania Code & Bulletin, Pennsylvania Gov)
- Ohio - Major Unusual Incident (MUI) rule (incident clocks, investigation, trend analysis). (Ohio Laws, dodd.ohio.gov)
- Oregon - OAR 411-360 (adult foster homes for I/DD; privacy, safety, egress, etc.). (Oregon, Oregon Secretary of State)

Exemplars, gaps, and recommendations across jurisdictions

Exemplars and "how it is done" in practice

Safeguards and monitoring often begin with a structured home study, multi-layer vetting, and a formal approval decision, then continue with predictable in-home checks. Community Living BC publishes province-wide standards and a companion "on a page" rubric that specify what is checked before approval and during coordination visits, including safety of the dwelling, emergency preparedness, the match to the person's routines and culture, and evidence that support is delivering quality-of-life outcomes; coordinating agencies use these documents as the content backbone for in-home reviews and follow-up actions. (Community Living BC, Office of the Auditor General B.C. -) Ontario gives host-family arrangements an agency-level spine through the Quality Assurance Measures regulation, which requires abuse-prevention and serious occurrence policies, screening and training of anyone providing support, medication and health safeguards, and documentary evidence that incidents were reported within the clock and led to learning. (Ontario, CanLII, myclkd.ca) The UK operationalizes the same ideas inside the regulator's single assessment framework: Shared Lives schemes recruit and approve carers within a registered scheme, then evidence supervision, safeguarding, and people's experiences against published quality statements that inspectors use on site. (Care Quality Commission) Ireland adds clear vetting and training specifics in Home Sharing handbooks, including Garda and Tusla clearances and mandatory Children First and adult safeguarding modules with three-year refreshers. (HSE.ie, Squarespace)

Several jurisdictions spell out the cadence and tools for monitoring inside the home. New York's Family Care Manual requires a monthly liaison visit that includes a walkthrough and checklist, a monthly summary note that ties observations to the person's plan, and at least a 90-day nursing visit that reviews orders, medication administration records, and health follow-up; state inspections then use Form 238 to verify that nursing reviews occurred on time, MARs are accurate, and respite and substitute care were arranged and checked. (OPWDD) Pennsylvania's Lifesharing regulation requires Department inspections of a sample of homes each year, inspection before first occupancy, and a named "life sharing specialist" with caseload caps, which converts oversight into an auditable staffing and visit model. (Pennsylvania Code & Bulletin, Legal Information Institute) Australia standardizes incident clocks and investigation follow-up for all registered providers, including host and house-mate models under Individualised Living Options; providers must notify the NDIS Commission within 24 hours for priority incidents, submit a five-day follow-up, and report use of regulated restrictive practices with state or territory authorisation pathways. (ndiscommission.gov.au) New Zealand brings incident, complaints, open disclosure, cultural safety, and continuous improvement into a single audited standard, Ngā Paerewa, with Ministry-issued auditing requirements that certification bodies apply on site. (Ministry of Health NZ)

Quality assurance is anchored in a published framework and inspection tools that translate rights into observable practice in ordinary households. The CQC single assessment framework sets five key questions and quality statements that Shared Lives schemes evidence during inspection and self-evaluation. (Care Quality

Commission) Scotland complements that with a quality framework for adult placement services that sets indicators for recruitment and approval, supervision, learning from concerns, and the difference support makes to people's lives. (careinspectorate.com) In British Columbia, the Auditor General's review describes CLBC's monitoring framework in concrete terms, including the policy, templates, on-site visits, and post-visit follow-up the funder expects, which functions as an externalized QA map. (Office of the Auditor General B.C. -) In the United States, program rules sit under the federal HCBS Settings Rule and are implemented with two national tools: CMS's Exploratory Questions, which state teams use as a settings checklist for privacy, locks on bedroom doors, visitors, access to food, community integration, and lease-like agreements, and the HCBS Quality Measure Set, which gives states a common outcome and experience menu that can be applied to shared living. (Medicaid, HHS.gov)

Quality of life is made tractable with short, standard tools and with visit content that forces a link back to the person's plan. Shared Lives schemes in the UK use "My Shared Life," a ten-item questionnaire developed with the University of Kent, to track change in autonomy, relationships, participation, and wellbeing, and to produce comparable dashboards across local schemes. (Kent Academic Repository, Shared Lives Plus) CLBC's coordination standard similarly requires monitoring against "quality of life support strategies," which puts everyday outcomes at the centre of each home visit and gives supervisors a concrete yardstick. (Office of the Auditor General B.C. -) New York ties quality-of-life checks to specific clinical and paperwork look-fors in the monthly and quarterly tools, so there is visible evidence that participation, health, and safety are being supported together rather than traded off. (OPWDD)

Dignity of risk is operationalized through formal pathways for any rights limitation and through settings compliance that protects privacy, tenancy-like rights, and everyday control. CMS's residential Exploratory Questions have become the de facto national checklist in the US for verifying lockable doors, access to personal food and schedules, visitors at any time, and eviction protections in provider-controlled homes. (Medicaid) Australia requires state or territory authorization of any regulated restrictive practice, monthly reporting to the NDIS Commission, and demonstrable reduction over time, while New Zealand's Code of Health and Disability Services Consumers' Rights provides an independent rights and complaints route that services must display and explain. (ndiscommission.gov.au, shop.hdc.org.nz) Ontario's regulation requires least-restrictive practice, informed consent, and documentation for rights modifications, and UK inspection frameworks require supported decision-making first, with recorded best-interests decisions only where capacity is lacking. (Ontario, Care Quality Commission)

What is missing or uneven across systems

Safeguards and monitoring are not always equally transparent. Some jurisdictions publish the visit cadence and the exact home-visit checklist, as in New York's liaison and nursing tools, while others reference monitoring in standards but leave the toolset to contracts or providers, which makes external scrutiny harder and creates variability between regions. (OPWDD) Incident systems are universally present, yet public reporting on investigation quality and on system-level learning is inconsistent, with Ontario's serious occurrence regime and the NDIS reportable incidents model more explicit about timelines and follow-up content than many provincial or state contracts. (myclkd.ca, ndiscommission.gov.au) Vetting renewal cycles, particularly for adult household members and regular overnight visitors, are not uniformly specified in law

or standard; where New Zealand's Children's Act model mandates seven safety-check elements and three-year re-checks when children are involved, disability Home Share rules elsewhere often rely on provider policy. (New Zealand Legislation)

Quality assurance documentation is plentiful, yet outcomes data specific to Home Share are sparse outside the UK. My Shared Life gives Shared Lives schemes a common QoL instrument, but comparable, Home Share-specific tools are not routinely mandated across Canada or the US, where measurement often reverts to general ISP reviews or state-level HCBS measure menus. (Kent Academic Repository, HHS.gov) Inspections are regular, but the proportion of unannounced visits in family homes varies, as do requirements for periodic clinical review when medication is administered by hosts. (OPWDD)
Quality of life processes are embedded in plans and visits, although consistent, person-reported experience data in Home Share remain patchy outside the UK. Where tools do exist, schemes sometimes adopt them unevenly or only for a subset of people, which limits trend analysis and benchmarking. (Shared Lives Plus) Cultural safety expectations are strong in Australia and New Zealand through national standards and in parts of Canada, but explicit training requirements for hosts on cultural safety and communication are not uniformly specified across all jurisdictions. (ndiscommission.gov.au, Ministry of Health NZ)
Dignity of risk frameworks are clear in principle, yet the authorization and review of restrictions can be fragmented where the legal authority sits in different statutes, and tenancy-style protections in provider-controlled Home Share settings are less consistently codified in Canada than in the US federal settings rule. (Medicaid)

Best-practice patterns emergent across jurisdictions
For safeguards and monitoring, the strongest pattern is a three-part rhythm: a documented home study and compatibility process before move-in, scheduled in-home visits with published content that link back to the person's plan, and a short-clock incident system with documented investigation, notification, and trend analysis. British Columbia's standards and coordination framework, Ontario's serious occurrence regime, New York's monthly and 90-day clinical cadence, and the NDIS reporting rules illustrate this rhythm at policy, program, and regulator levels. (Community Living BC, Office of the Auditor General B.C. - , myclkd.ca, OPWDD, ndiscommission.gov.au) It works best where the visit checklist is public, incident clocks are explicit, and the match is reviewed at 30, 60, and 90 days as well as annually, so small issues do not calcify.

For quality assurance, the converging practice is to anchor Home Share in a published, auditable framework and inspection toolkit, then require providers to demonstrate a live quality system: self-assessment, corrective actions, workforce competence records, and incident-to-learning cycles. The CQC quality statements, Scotland's adult placement framework, and the CLBC monitoring framework are clear examples of the audit scaffold; the NDIS Practice Standards and New Zealand's Ngā Paerewa show what third-party certification adds in terms of consistency and cultural safety. (Care Quality Commission, careinspectorate.com, Office of the Auditor General B.C. -, ndiscommission.gov.au, Ministry of Health NZ)

For quality of life, two complementary approaches stand out. The first is to make the person's outcomes the lens for every home visit by requiring coordinators to record

“what is working and what needs to change” against the plan, as CLBC and New York do. The second is to add a short, standardised person-reported outcome tool at set intervals, such as My Shared Life in the UK, and to pair that with the broader HCBS Quality Measure Set where system reporting is required. Taken together, these approaches keep everyday life at the centre while still producing comparable, analysable data. (Office of the Auditor General B.C. -, OPWDD, Kent Academic Repository, HHS.gov)

For dignity of risk, best practice is a documented pathway that starts with supported decision-making, records risk-benefit discussions, and permits rights modifications only when necessary, time-limited, consented where the law allows, and reviewed against evidence. Systems that do this reliably also stabilise the home through tenancy-style agreements so that disagreements about support do not automatically cost a person their housing. The US settings rule and exploratory questions provide the most explicit template for home-level rights and tenancy, while Australia’s authorization and reporting rules for restrictive practices and New Zealand’s Code of Rights and audited standard show how to keep reviews and rights visible. (Medicaid, ndiscommission.gov.au, shop.hdc.org.nz)

Across these strands, the similarities are striking. Every jurisdiction has assembled the same core pieces: a published quality framework and inspection tools, structured home studies and vetting, rhythmic in-home monitoring tied to the plan, short-clock incident systems that learn, person-centered outcomes with at least one common instrument, formal pathways for any restriction with a presumption of reduction, and visible complaints and advocacy routes. The differences lie mainly in where these elements live in law or policy, and in how prescriptively they are implemented, rather than in what “good” looks like when a person shares an ordinary home.

Comparison of other jurisdictions with CLBC: where they align and where they differ

Governance and the "audit spine"

CLBC's home sharing system is anchored by two province-wide, published standards - the *Standards for Home Sharing* and the *Standards for the Coordination of Home Sharing* - now backed by companion policies issued in 2025 that clarify roles for coordinating agencies, monitoring content and expectations for quality-of-life-oriented oversight. That combination gives British Columbia a single, provincial rubric that funders and providers both work to. The Office of the Auditor General's 2021 audit reiterated the need for a clear monitoring framework tied to contract requirements and quality-of-life outcomes, a message CLBC has since built into its three-year improvement plan. (Community Living BC, oag.bc.ca)

Other jurisdictions converge on the same idea of a published "audit spine," though they situate it in different bodies of law. Ontario runs host-family arrangements through agency obligations in the Developmental Services Quality Assurance Measures regulation, which standardizes policies on rights, inclusion, screening, training, medication safety and serious-occurrence reporting; ministry inspections are keyed to those requirements. The UK registers Shared Lives schemes with national regulators and inspects them against the Care Quality Commission's single assessment framework built from five key questions and detailed quality statements about being safe, effective, caring, responsive and well-led. Ireland relies on HSE Home Sharing guidance as the operational standard for carer approval, supervision and review. Australia requires NDIS-registered providers to meet the NDIS Practice Standards and Quality Indicators through third-party certification audits. New Zealand certifies providers to Ngā Paerewa, a unified, outcomes-based health and disability standard, with Ministry-published auditing requirements that specify how certification bodies must test governance, open disclosure and continuous improvement. The shared pattern is a single, published framework that translates rights and safety into auditable criteria for family homes; CLBC's current set-up mirrors that pattern. (Ontario, Care Quality Commission, HSE.ie, NDIS Quality and Safeguards Commission, Ministry of Health NZ)

Host approval, safety checks and the home study

CLBC's standards require a documented home study, criminal record checks and references for hosts and adult household members, and an assessment of the dwelling's safety and suitability, with matching that considers culture, routines and preferences. Those expectations are carried into day-to-day practice by coordinating-agency procedures that follow the CLBC rubric. Ontario's approach is substantively similar but implemented through agency-level compliance with QAM: agencies must demonstrate screening and training of anyone providing support, abuse-prevention policy, health and safety controls and service monitoring. The UK's Shared Lives schemes run a regulated approval process for carers within each registered scheme, inspected against CQC quality statements. In Ireland, HSE materials specify Garda and Tusla vetting and staged contact before agreement, and scheme handbooks detail initial training requirements like Children First and safeguarding adults' modules. Australia's NDIS Practice Standards make worker screening and induction mandatory across registered providers, while New Zealand combines Police vetting and the

sector's Children's Act safety-check model where children or young people are present in a household; both jurisdictions expect a structured home assessment as part of service certification. In the United States, the content is comparable but codified state by state: New York's Family Care Manual prescribes a structured home study, monthly liaison walkthroughs with a checklist, and 90-day nursing visits; Pennsylvania's Chapter 6500 sets household vetting and caseload caps for the "life sharing specialist." The similarities with CLBC are clear - the same vetting components and structured home study; the main difference is that some systems, notably New York and Pennsylvania, embed that specificity directly in regulation, whereas BC uses provincial standards and policy plus contract oversight. (Community Living BC, pathwayskelowna.ca, Ontario, Squarespace, NDIS Quality and Safeguards Commission, Standards New Zealand, Developmental Disabilities Office, Legal Information Institute)

Monitoring in the home and clinical review

CLBC's coordination standards make in-home monitoring routine rather than ad hoc. Coordinators visit, check progress against "Quality of Life Support Strategies," review health and medication practices where relevant, confirm emergency preparedness and follow up on corrective actions. Ontario's QAM requires ongoing service monitoring and documentary evidence that serious occurrences lead to protective actions and learning. UK inspection frameworks expect Shared Lives schemes to supervise carers regularly and to demonstrate that reviews with the person happen and are used to adjust support. Ireland's home-sharing materials set out contact schedules, escalation routes and required refresher training for carers. Australia's NDIS and New Zealand's Ngā Paerewa require providers to show, at audit, that monitoring, incident response and improvement cycles are active in practice. A few US exemplars specify cadence more tightly than CLBC does in its province-wide standards; New York, for example, requires a monthly liaison visit using a checklist and at least a 90-day RN health review, and OPWDD conducts additional annual or unannounced visits using a standard form. The common ground is scheduled, documented visits with a defined content; CLBC's distinctive feature is explicitly linking those visits to quality-of-life strategies in the provincial standard. (Community Living BC, Ontario, Care Quality Commission, HSE.ie, NDIS Quality and Safeguards Commission, Developmental Disabilities Office)

Incident management, complaints and learning

CLBC runs a policy-defined critical-incident system that sets categories, notification routes and expectations for analysis and follow-up, and it has publicly committed to strengthening monitoring and learning in response to the Auditor General's findings. Ontario's Serious Occurrence regime is highly specified and time-bound, requiring within-24-hours submission and defined content, which the ministry inspects against a published indicator list. The UK requires Shared Lives schemes to demonstrate safeguarding, complaints handling and organizational learning under the CQC assessment framework. Australia's NDIS Reportable Incidents Rules require providers to notify the national regulator within 24 hours for the most serious matters and submit a five-day follow-up, while monthly reporting applies to restrictive practice use. New Zealand requires disability providers to notify Whaikaha of critical incidents within 24 hours and has published categories and forms; certification audits test whether those systems operate in practice. In the United States, the federal HCBS Settings Rule

supplies the rights context, and states impose specific clocks and investigation standards: Ohio's Major Unusual Incident rule marries immediate response with defined reporting pathways and trend analysis, while Pennsylvania and New York require documented investigations and agency-level pattern review. Across the board, CLBC's structure is recognisably aligned; the difference is that some jurisdictions hard-code incident timelines and investigator credentials in regulation, whereas BC embeds them in policy and contract oversight. (oag.bc.ca, Community Living BC, Ontario, Care Quality Commission, NDIS Quality and Safeguards Commission, disabilitysupport.govt.nz, whaikaha.govt.nz, Medicaid, Ohio Laws, Pennsylvania Code & Bulletin)

Tenancy-style protections and "what home must look like"

CLBC's standards and policies emphasize dignity, privacy and ordinary home life, and coordinating-agency monitoring looks for those conditions during visits; where the service provider controls the premises, BC practice increasingly mirrors tenancy-style safeguards (residential agreements, notice processes) seen elsewhere in Canada. The US articulates these requirements most explicitly through the federal HCBS Settings Rule and its exploratory-questions checklist, which states use to confirm locks on bedroom doors, access to food and visitors, control of schedules and eviction protections in provider-controlled homes. The UK's CQC framework and Scotland's adult-placement quality framework ask essentially the same "look-for" questions in Shared Lives inspections, and Ireland's guidance and scheme handbooks require written agreements and clear exit and escalation processes. Australia's NDIS Practice Standards and New Zealand's Ngā Paerewa embed privacy, visitors and control over routines directly into national standards and test them at audit. The similarity is high; the difference is simply where these expectations live - in BC, inside provincial standards and contracts, rather than in a national settings regulation. (Medicaid, Care Quality Commission, Oregon Secretary of State, HSE.ie, NDIS Quality and Safeguards Commission)

Training and competence

CLBC expects hosts and coordinators to be inducted on rights, communication, emergency planning, medication where relevant and positive behaviour support, with refreshers at intervals set in contract, and coordinating agencies must be able to evidence training at monitoring. Ontario's QAM requires training in abuse prevention, health and safety and policy before independent work and regular refreshers. UK schemes supervise carers and are inspected on whether training translates into competent, person-centered practice. Australia mandates the national NDIS worker-orientation module and worker screening; audits sample role-specific competency evidence. New Zealand's Ngā Paerewa requires competent, culturally safe practice and certifiers look for proof in supervision notes, training matrices and observed practice. The alignment with CLBC's expectations is direct; the implementation mechanisms differ. (Community Living BC, Ontario, NDIS Quality and Safeguards Commission)

Behaviour support, restrictive practices and dignity of risk

CLBC's standards and coordination policy tie planning to risk-benefit conversations and expect any restriction to be necessary, least restrictive, time-limited and reviewed, with monitoring focused on quality-of-life outcomes. Ontario's regulation and policy

suite requires least-restrictive practice, informed consent and documentation when rights are modified, with serious-occurrence review to prevent restrictions from becoming permanent by default. The UK's inspection frameworks look for supported decision-making first under capacity law and "Making Safeguarding Personal," with any best-interests decisions recorded and reviewed. Australia requires state or territory authorisation of any regulated restrictive practice, monthly reporting to the NDIS Commission and a system-wide aim of reduction and elimination. New Zealand's Ngā Paerewa requires restraint minimisation and open disclosure, and the Health and Disability Commissioner's Code of Rights guarantees informed choice and an independent complaints route. Several US states make the authorisation pathway explicit in rule: Oregon bans certain restraint types outright and allows only last-resort emergency restraint with documentation and review; Ohio uses human-rights or behaviour committees and data-led reduction; New York ties protections to plan review and state oversight. CLBC's stance is aligned on substance; jurisdictions differ mainly in the legal locus and prescriptiveness of authorisation and reporting. (Community Living BC, Care Quality Commission, NDIS Quality and Safeguards Commission, shop.hdc.org.nz, hdc.org.nz, Oregon, Ohio Laws)

Outcomes and lived-experience measures

CLBC's coordination standards deliberately orient monitoring to "Quality of Life Support Strategies," making everyday outcomes the lens for visits and follow-up. In Ontario, agencies must demonstrate that services promote inclusion, choice and rights in practice as part of QAM compliance. UK Shared Lives schemes increasingly use the My Shared Life outcomes tool, co-developed with the University of Kent, to track autonomy, relationships, participation and wellbeing across regions, and those results sit alongside CQC's evidence about people's experiences. Ireland's guidance requires a personal plan for each arrangement and periodic reviews with the person and family. Australia and New Zealand test person-centered and culturally safe outcomes through national standards and certification audits. In the United States, CMS's HCBS Quality Measure Set provides a national menu of person-centered and experience measures that states are increasingly applying across residential models, including shared living. The net effect is convergence on a mix of plan-anchored outcomes and short, standardised experience tools; CLBC's "quality of life" framing is consistent with that direction. (Community Living BC, Ontario, Kent Academic Repository, Shared Lives Plus, Medicaid, HHS.gov)

Conclusion

Across Canada, the United States, the UK and Ireland, Australia and New Zealand, CLBC's model looks broadly aligned with the prevailing architecture: a published provincial standard and coordination framework, structured vetting and home study, scheduled in-home reviews, a policy-defined incident and complaints system that feeds improvement, tenancy-style safeguards in provider-controlled settings, mandated training and competence, formal pathways for any rights limitation and an outcomes-centered lens at monitoring. Where other jurisdictions differ, they tend to be more prescriptive in law about inspection cadence, incident timelines or clinical checkpoints, or they locate oversight in a national statute and regulator rather than in provincial policy and contracts. Those differences are of form more than substance: the underlying safeguards, quality mechanisms and quality-of-life expectations are

notably consistent with what CLBC now sets out in its standards and policies. (Community Living BC)

Note on AI Use

Tables and references in this report were formatted and standardized with the assistance of AI tools (OpenAI's GPT-5). All content was reviewed and verified by the research team.