

DISCHARGE FROM HOSPITAL TO LONG-TERM CARE: ISSUES IN ONTARIO¹

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Hospitals in Ontario are overcrowded. Thousands of people are on waiting lists for long-term care homes (LTCHs). As a result, people requiring long-term care are confronted with a variety of “policies” and “programs” developed to “deal” with these issues despite the legislation governing placement.

In Ontario, LTCHs are publicly funded and governed by the *Long-Term Care Homes Act, 2007 (LTCHA)* which was enacted on July 1, 2010.² This legislation, while having some changes, substantially continued the rights that applicants for placement into LTCHs had under the previous legislation.³

Between January 1 and November 30, 2010, the Advocacy Centre for the Elderly (ACE) had over 145 requests for assistance relating to discharge from hospital. Patients requiring admission to other care settings or requiring additional care in the home are often told that they must comply with hospital or Community Care Access Centre (CCAC) policies. Hospital policies may require the patient or substitute decision-maker (SDM) to select possible LTCHs from a “short list” where a bed is available or where a bed will soon be available. If they do not comply with the policy, the hospital threatens to charge the non-OHIP “daily rate” which ranges anywhere from \$500 to \$1,500 or more per day. Hospitals may also require the patient/SDM to sign a “contract” indicating that they “agree” with this policy. In fact, no one is required to sign such a contract. CCAC policies may prevent patients from applying for LTC from hospital.

ADMISSION INTO LONG-TERM CARE HOMES AND DISCHARGE POLICIES

Placement into a long-term care home in Ontario is regulated by the *LTCHA* and its regulations. The placement coordinator from the CCAC must work with the applicant or their SDM, if the person is incapable, to ensure the needs of the person are met. No role in the placement process is given to hospital workers, such as discharge planners or social workers, in the *LTCHA*.

¹ This article updates and amalgamates two previous articles prepared by ACE called “First Available Bed Policies & Discharge to a Long-Term Care Home from Hospital” and “The Role of Community Care Access Centres in Admission to Long-Term Care from Hospital.”

² S.O. 2007, c. 8.

³ *Charitable Institutions Act, Homes for the Aged and Rest Homes Act and Nursing Homes Act.*

After a determination is made by the care team at the hospital that the person requires admission to a long-term care home, the patient/SDM will be asked to complete an application. In most cases, the patient/SDM will agree to do so.⁴ While awaiting placement in hospital, the person will usually be designated by the physician as “Alternate Level of Care” or “ALC.” This simply means that the person is in hospital awaiting a different type of care somewhere else that is not presently available.

Once the person is assessed by the CCAC as being eligible for admission to a LTCH, the person will be asked to choose homes. The regulations to the *LTCHA* state that a person may choose up to five LTCHs.⁵ This is the maximum number of homes that a person/SDM can choose, unless the person is on a crisis waiting list. While an applicant/SDM does not have to apply for the maximum number, we encourage people to do so if at all possible when they are awaiting placement from hospital. Hospitals are not appropriate places to stay for great lengths of time when the patient does not require acute care. The person/SDM must act “reasonably” when applying to long-term care from hospital as there are other hospital pressures in play.

Hospitals often have policies requiring applicants to make one of the following so-called “choices”: accept the first available bed in any long-term care home; return home to wait for their home of choice; go to a retirement home to await their home of choice; or pay the “daily rate” for the hospital bed.

Consent for admission into a LTCH is regulated by both the *LTCHA* and Part III of the *Health Care Consent Act (HCCA)*.⁶ It is up to the person/SDM to choose the homes where they want to apply. Valid consent, as defined in the *LTCHA*, is required prior to placing the person on the waiting list for a home, as follows:

Elements of consent

46(1) The following are the elements required for consent to admission to a long-term care home:

1. The consent must relate to the admission.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud.

Informed consent

- (2) A consent to admission is informed if, before giving it,
- (a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same

⁴ Where the patient or substitute decision-maker refuses to consent, the process will either be discontinued or one of a number of hearings may be heard pursuant to the *Health Care Consent Act*. These will not be discussed in this article.

⁵ O. Reg. 79/10, s. 166(1)(d).

⁶ S.O. 1996, c. 2, Sched. A.

- circumstances would require in order to make a decision about the admission; and
- (b) the person received responses to his or her requests for additional information about those matters.

Same

- (3) The matters referred to in subsection (2) are:
- 1. What the admission entails.
 - 2. The expected advantages and disadvantages of the admission.
 - 3. Alternatives to the admission.
 - 4. The likely consequences of not being admitted.

Where there is an SDM, they are required to comply with specific rules set out in the *HCCA*:

Principles for giving or refusing consent

42(1) A person who gives or refuses consent on an incapable person's behalf to his or her admission to a care facility shall do so in accordance with the following principles:

- 1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
- 2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

Best interests

- (2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,
- (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
 - (b) any wishes expressed by the incapable person with respect to admission to a care facility that are not required to be followed under paragraph 1 of subsection (1); and
 - (c) the following factors:
 - 1. Whether admission to the care facility is likely to,
 - i. improve the quality of the incapable person's life,
 - ii. prevent the quality of the incapable person's life from deteriorating, or

- iii. reduce the extent to which, or the rate at which, the quality of the incapable person's life is likely to deteriorate.
2. Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility.
3. Whether the benefit the incapable person is expected to obtain from admission to the care facility outweighs the risk of negative consequences to him or her.
4. Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances.

The requirements on SDMs are restrictive: they can **only** make their decision based upon these principles.

This list is exhaustive: nowhere in the *LTCHA*, *HCCA* or their regulations are there any other principles that the SDM is required to take into consideration. There is no mention of hospital policy, the requirements of the acute care system, or any other programs to be considered when making this decision. As the government has chosen not to include this in the recently enacted *LTCHA*, legislation, hospitals cannot "override" by creating their own law or policy.

The question then becomes whether the hospital is required to keep the person while they for their choice of home. Many homes have lengthy waiting lists. Does the hospital have to keep the person until their choice is available?

The regulations to the *Public Hospitals Act* require a person to leave the hospital no later than 24 hours after a discharge order has been made.⁷ Looking at this provision, it would appear that once a patient no longer requires treatment, they must be discharged from hospital, with the only exception being a 24 hour grace period. However, the reality is that there are many people in hospital who no longer require treatment but are allowed to stay until a LTCH bed becomes available.

Hospitals rely on this section of the legislation to require people to comply with their internal policy. However, we do not believe that this is supportable in law. First, the regulations to the *Health Insurance Act* specifically contemplate that patients will have to wait in hospital until a long-term care bed is available. The daily fee that can be charged while the person is waiting for placement from hospital is limited and set by the provincial government: it is the same amount that a resident in basic accommodation at a LTCH is charged (minus any applicable rate reductions).⁸ Second, if this section was applied across the board, it would mean that **everyone** who required long-term care would be discharged within 24 hours of no longer requiring acute care, whether a bed

⁷ R.R.O., Reg. 965, s. 16.

⁸ The rate is currently \$53.23 per day. The provincial government adjusts the rate annually on July 1st.

was available or not, which is not the case. Third, the hospital owes a duty of care to the patient, meaning that a patient cannot be discharged to the community if this is unsafe. This includes requiring patients to go a retirement home to wait for a LTCH placement. Retirement homes are unregulated and not part of the health care system - one cannot be forced into a retirement home as an alternative to a LTCH bed.⁹

There is also often disagreement as to what an “acceptable” bed means. Obviously, not every “available” bed is appropriate for every person awaiting placement from hospital. For example, one person may require a bed on a secure unit while another person does not. This is often the crux of the discharge issue – the hospital believes a bed is suitable while the patient/SDM disagrees.

Placement into homes which are not of a person’s choosing can be detrimental to both their physical and mental health. Homes may be located far from families and other support systems, leading to deleterious effects on the person’s health, including death. In other cases, there may be available beds because the homes themselves are unsatisfactory in some way. Luckily, both the *LTCHA* and the *HCCA* ensure that it is up to the person/SDM to make the placement decision: nowhere does the law give this role to hospital staff.

Hospital policies also frequently misstate the legislation surrounding the “crisis” designation. According to the regulations to the *LTCHA*, a person shall be placed in the “crisis category (1)” by the placement coordinator if the applicant requires immediate admission as a result of a crisis arising from the applicant’s condition or circumstances.”¹⁰ Local Health Integration Networks (LHINs) are also now able to designate hospitals as being in “crisis” if the hospital is “experiencing severe capacity pressures.”¹¹ Even when a hospital is designated as being in crisis and ALC patients are moved to the top of the list, they are not required to take any bed that simply becomes available. The designation means that the person goes to the top of the crisis waiting list for all the homes that they have chosen, and they are no longer limited to only five LTCH choices.¹²

The only case heard to date on the issue of discharge from hospital to long-term care is *Duffy v. OHIP*,¹³ which was an appeal after a denial of OHIP benefits. Mrs. Duffy, a patient at Joseph Brant Memorial Hospital, was awaiting placement in long-term care. Although applications for three homes had been submitted, the hospital required that

⁹ The *Retirement Homes Act, 2010*, S.O. 2010. c. 11, has been passed but only certain sections have been enacted as the regulations are being drafted. This statute will, for the first time, provide some oversight and regulation to the care provided in privately run retirement homes. However, retirement homes will still be part of the private-pay system and no one can be forced into a retirement home if they are eligible for publicly funded long-term care.

¹⁰ O. Reg. 79/10, s. 171(1). Similar wording appears in the *Health Care Consent Act* which states that pertaining to admission, a “crisis means a crisis relating to the condition or circumstances of the person who is to be admitted to the care facility: *HCCA*, s. 39.

¹¹ O. Reg. 79/10, s. 171(4).

¹² O. Reg. 79/10, ss. 164(4) and 171.

¹³ Health Services Appeal Board (February 4, 1999).

more homes be added.¹⁴ When this was not done, OHIP was advised that the patient had been discharged but remained in hospital. OHIP payments for the bed were discontinued and the hospital began to charge Mrs. Duffy \$120 per day for the bed. An appeal was brought before the Health Services Appeal Board by Mrs. Duffy who argued she was entitled to OHIP coverage for the hospital fees. The Board held that the rate being charged by the hospital appeared completely arbitrary and there was insufficient evidence that the appellant or her family had been advised of the discharge policy. In any event, the Board concluded, it was clear that a discharge did not simply mean “to leave the hospital on the day of discharge” as had been argued by OHIP but in fact meant an appropriate placement into long-term care. Therefore, the Board ruled in favour of Mrs. Duffy and ordered coverage of the fees by OHIP.

This case does not mean that an applicant can simply wait in hospital for a specific long-term care home, for example where that home has a three-year long waiting list, unless it can be proven that that home is the only one which can meet the person’s needs. Applicants and their SDMs must act “reasonably” when making their choices. However, there is no clear definition of what reasonable means and it will change in each individual situation. In addition, staying in hospital may be often not in the best interest of the person. Hospitals do not provide the same assistance and social programming as LTCHs. The likelihood of the patient deteriorating while waiting for placement, including loss of mobility and incontinence, are high. Finally, staying in hospital for prolonged periods of time increases the chance of contracting hospital borne infections, such as *MRSA*, *VRE*, and *C. Difficile*. One must weigh all of these considerations when making a placement decision.

Generally, the main issue is whether the facilities choices made by the person or the SDM are appropriate. Legally, the hospital or CCAC cannot simply disagree and ignore the decision. If the patient is evaluated as being incapable of making the placement decision, their authority to make that decision passes to their SDM. However, this cannot be done merely because the team does not like the decision of the person/SDM. If it is the decision of the SDM which is unacceptable, the CCAC (and only the CCAC) may challenge the decision of the SDM by bringing an application to the Consent and Capacity Board (CCB) alleging that the SDM is not complying with the statutory principles for giving or refusing consent set out in the *HCCA*.¹⁵ There is no ability to challenge the decision of the competent person who is not “complying” with “hospital policy” regarding choices.

PLACEMENT FROM HOSPITAL: ISSUES WITH THE CCAC

CCAC placement coordinators are delegated specific placement duties under the *LTCHA*, which cannot be designated to others, such as hospital social workers or discharge planners. The placement coordinator authorizes the admission of the person

¹⁴ At the time, the legislation did not include a maximum number of homes that could be applied to. The hospital in this case was requesting that 10 homes be included in the application.

¹⁵ *HCCA*, s. 54.

to the LTCH. The CCAC must comply with specific rules regarding the eligibility and admission process, including the following:

- If a person/SDM applies to the placement coordinator for a determination of eligibility for placement into long-term care, the placement coordinator **must** find the person eligible if they meet the criteria set out in the regulations.¹⁶
- The placement coordinator authorizes admission only to LTCHs **as selected by the person/SDM**.¹⁷
- The placement coordinator shall, if requested by the person/SDM, assist the person in selecting homes.¹⁸
- The placement coordinator should use the following criteria when assisting the person in choosing a home – namely, the person’s preferences relating to admission based on ethnic, spiritual, linguistic, familial and cultural factors.¹⁹
- The placement coordinator can approve eligibility or authorize admission to a specific nursing home only if the person/SDM **specifically applies** for such admission.²⁰ Therefore, if there is no specific consent given authorizing an application for that home, there is no way the person can be considered for that bed. While there may be an “available” bed in a home which meets specific criteria (i.e., a basic room for a female), the placement coordinator cannot determine its appropriateness unless authorized to do so by the person/SDM.
- If a person has already applied for five homes, their eligibility for admission cannot even be **considered** for another home until the person removes one of their choices from the list.²¹ Again, a home can only be removed from the choice sheet with the express consent of the person/SDM.

Nothing in the legislation makes the application process any different for patients in hospital than it would be for applicants living in the community.

Refusal of the CCAC to Take the Application

CCAC staff cannot refuse to take an application for placement. The legislation is clear that the CCAC placement coordinator **must** take an application and determine eligibility upon request.²² For example, the CCAC cannot require that the person return home or comply with hospital policies before they will accept an application.

¹⁶ LTCHA, s. 43(1) and O. Reg. 79/10, s. 155(1).

¹⁷ LTCHA, s. 44(1).

¹⁸ LTCHA, s. 44(3).

¹⁹ LTCHA, s. 44(4).

²⁰ LTCHA, s. 43.

²¹ O. Reg. 79/10, s. 166(1)(d).

²² LTCHA, s. 43(4).

It is also the obligation of the placement coordinator to ensure that consents are valid, meaning that they comply with the *LTCHA* and the *HCCA*. If LTCH “choices” are made based upon misinformation, such as applicants/SDMs being told that they **must** choose from a short list or that they **must** choose a specific home, then the consent is not valid and cannot be accepted by the placement coordinator. Therefore, it is up to the placement coordinator to ensure that the rules have been explained to the person/SDM and there has been compliance with the rules. In fact, where there is an SDM, the placement coordinator has an obligation to advise them of the decision-making rules contained in the *HCCA*.²³

Refusal of the CCAC to Accept Choices or Changes

The person/SDM not only has the right to choose LTCHs, but can also amend choices or withdraw consent to LTCHs any time prior to a bed offer being made. This is important as people may initially include certain “choices” because they felt they had no other option due to “hospital policy.” If this occurs, the person/SDM should immediately contact the placement coordinator to change their choices. Placement coordinators cannot refuse to make such changes on the basis it will violate “hospital policy.” They cannot agree to accept the change only if other criteria are met, such as the discharge planner “approving” the change or exchanging one “short list” home for another, as this is also contrary to the legal requirements.

The right to withdraw consent or to change choices is absolute. The law does not allow the placement coordinator to restrict the person’s choices in long-term care.

Refusal of the CCAC to Take an Application from Hospital Patients

Some CCACs are now refusing to take applications for LTCHs from hospital patients or are only accepting such applications under strict circumstances. Generally, this is associated with the new “Aging at Home Strategy” of the Ministry of Health and Long-Term Care. Under this strategy, increased funding has been made available to people to facilitate their return to home by providing increased hours of care in the home on a time-limited basis.

While this program is laudable in theory, there have been increasing problems in practice. Patients are being told by the CCAC that they must return home before a LTCH application will even be taken. As discussed above, this is contrary to the legislation which requires that an application must be taken and eligibility determined, upon request. Due to this policy, people who cannot be managed at home or who have no home to return to, are being told that they have to leave hospital before they are allowed to even apply. Such rigid policies only serve to assist hospitals with their bed capacity issues, and are not only against the interest of the patient, but may be dangerous to the person that the CCAC has an obligation to assist.

²³ *M.A. v. Benes*, 1999 CanLII 3807 (ON C.A.).

While “wait at home” and “home first” strategies or programs may be beneficial to many people, they are not a universal panacea and are not appropriate for all. Utilization of these programs is not mandatory and the person must be allowed to apply to LTCHs, have their eligibility determined and to be provided with all the information necessary to decide whether such a program is right for them in their individual circumstances. The CCAC cannot require persons to enter these programs by threatening to withhold other types of services.

Requirement for Admission into a Retirement Home

Some applicants are told that they must go to a retirement home pending placement in a LTCH. As previously mentioned, retirement homes are not part of the publicly funded system, nor is the care in them presently regulated. While the placement coordinator has an obligation to advise the applicant about other options that the person may wish to consider,²⁴ there is no obligation on the person to go to a retirement home when they qualify for publicly funded long-term care.

Refusal to take an Application and Determine Ineligibility

It is clear that where requested, the placement coordinator **must** take an application for admission and determine eligibility. Placement coordinators cannot simply refuse to take an application because they have pre-determined that the person might be ineligible. If no application is taken, the person’s right to apply to have the finding of ineligibility reviewed by the Health Services Appeal and Review Board has been negated.²⁵

CONCLUSION

The new *Long-Term Care Homes Act* clearly sets out the rights of applicants for long-term care, supporting the model of consent and choice of the individual. Neither hospitals nor CCACs have the right under the legislation to make “choices” for the individual who wishes to be placed into long-term care. The system enshrined in legislation is based upon individual choice and, if the person is incapable of making decisions about admission to long-term care, what the SDM determines to be in the person’s best interest. It is hoped that by having the correct legal information, the applicant/SDM will have the tools to better advocate for their rights.

²⁴ O. Reg. 79/10, s. 154(1).

²⁵ *LTCHA*, s. 43(8).