DISCHARGE FROM HOSPITAL TO LONG-TERM CARE ISSUES IN ONTARIO[1]

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Hospitals in Ontario are overcrowded. There are thousands of people on waiting lists for long-tem care homes. This has resulted in those requiring long-term care to be confronted with a variety of "policies" and "programs" developed to "deal" with these issues, despite what appears to be clear legislation governing placement. This paper will analyze the applicable legislation and discuss the types of policies and why they are illegal in the context of the long-term care system in Ontario.

In Ontario, long-term care homes, often referred to as "nursing homes" are publicly funded and governed by the *Long-Term Care Homes Act, 2007*, which was enacted on July 1, 2010.[2] This legislation substantially continued the rights that applicants for placement into long-term care had under the previous legislation.[3]

In 2006, a case from British Columbia made headlines across Canada when 91 year old Fanny Albo, was shipped from a hospital in Trail, British Colombia, to a long-term care home over 100 kilometers away from Al, her 96 year-old husband of 70 years, who was also in the hospital. She died within 48 hours of the forced transfer: her husband died less than two weeks later. The transfer was blamed on the hospital's "first available bed" policy and lead to questions in the British Columbia Legislature and a review by the Deputy Minister of Health.[4]

After this case hit the headlines, others came forward with similar stories of elderly persons being transferred from hospital to far-away homes because of these policies. People argued that this was a common situation, due to hospital-cutbacks and requirements for beds.

In Ontario, similar issues have been brought up in the Legislature. Shelley Martel pointed to the problem in Sudbury when the Ministry of Health and Long-Term Care applied a crisis designation to the hospital, requiring those who had been made "ALC"[5]

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[1] This paper has been adapted from two previous documents, …
[2] S.O. 2007, c. 8.
[3] *Charitable Institutions Act*, *Homes for the Aged and Rest Homes Act,* and *Nursing Homes Act*.
[4] http://www.cbc.ca/canada/british-columbia/story/2006/03/02/bc_al-albo20060302.html
[5] An "ALC" or "alternate level of care" designation means that the patient is ready to be discharged to a long-term care home in the community but for the fact that there are no such beds available. In most cases, this allows the hospital to charge the patient the "chronic care co-payment", which is the same as the basic accommodation rate in long-term care, pursuant to regulation R.R.O. 1990, Reg 552, to the *Health Insurance Act*.

to accept the first available bed in an area which could include beds in Manitoulin Island, Espanola, or even Parry Sound, due to the lack of beds in Sudbury long-term care homes.[6]

This is not a unique situation. At the Advocacy Centre for the Elderly, from January 1 to December 31, 2010, we had over 160 requests for assistance relating to discharge from hospital and admission to long-term care homes or other setting.[7] Most hospitals in Ontario have discharge policies with which they require patients to comply when moving from hospital into another care setting. The policy may require that the patient or their substitute decision-maker select a certain number of "short list" long-term care homes from a list provided by the hospital or CCAC; or may require the patient to accept a "suitable bed" as determined by the hospital, which may not be in one of the homes chosen by the patient or their substitute decision-maker. Usually, the person is told that if they do not comply with the policy, they will be charged the "daily rate". This is the rate charged for an acute care bed for someone who does not have OHIP[8] or other insurance. Although there is no specific number, this rate may range from $500 to $1,500 or more per day.

ADMISSION INTO LONG-TERM CARE HOMES AND DISHARGE POLICIES

Placement in a long-term came in Ontario is regulated by the *Long-Term Care Homes Act* and its regulations. The process requires that the person or their substitute decision-maker apply for long-term care through the local Community Care Access Centre (CCAC). CCACs have employees working out of the hospital who are in charge of the placement process for patients in hospital. The hospital may also have a social worker or discharge planner who may also discuss placement with them. However, these employees are not neutral, and their job includes enforcing hospital policy. As will be discussed later, the legislation has designated the CCAC placement coordinator as being responsible for the placement process.

Generally, a determination will be made by the patient's care team that the person should be referred for admission to a long-term care home. Depending upon the hospital and the individual situation, this may or may not include the participation of the patient and their family (although ideally, both should be involved in all stages). Once a patient is "designated" by the physician as requiring long-term care, the hospital will attempt to have the person discharged from hospital as quickly as possible. Consent will be sought from the patient or their substitute decision-maker for the application to

[6] Hansard, Legislative Assembly of Ontario (December 6, 2005), Shelley Martel, MPP, Nickel Belt.
[7] Other settings may be complex continuing care (formerly known as chronic care hospitals); palliative care or rehabilitation. They will not be discussed in this paper.
[8] The Ontario Health Insurance Plan which covers hospital fees for residents of Ontario.

long-term care to be initiated, if this has not already occurred. In most cases, the patient or the substitute decision-maker will agree to do so.[9]

The regulations to the *Long-Term Care Homes Act* state that a person may choose up to five long-term care homes,[10] the exception being in a crisis situation where the individual may have more.[11]

The question therefore, is what latitude is allowed for in choosing the homes.

At some point, the patient or their substitute decision-maker will be advised of the hospital policy regarding choices and acceptance of beds in long-term care. The hospital may give a copy of their policy to the patient or their substitute decision-maker, advising them that they must comply with it. In other cases, they may simply be given a list and told they must choose a certain number of homes from that list, be told that the hospital will "choose" a certain number of homes and the patient or their substitute decision-maker can choose a certain number of homes, or that they are required to take a bed that becomes available no matter whether it is one of their "choices" or not. Hospitals may "require" the patient or their substitute decision-maker to sign a "contract" indicating that they "agree" with this policy. Neither patients nor their substitute decision-makers are required to sign such an agreement.

The hospital policy may purport to include other "choices". These may include: accept the first available bed; 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. It is argued here that none of these choices is legal.

Choice is regulated within the *Health Care Consent Act*.[12] Part III of that Act governs the admission of persons into a care facility, which is defined as follows:

> "care facility" means,
>
> (a) a long-term care home as defined in the *Long-Term Care Homes Act, 2007*, or,
> (b) a facility prescribed by the regulations as a care facility.[13]
>
> (Note: As of yet, there are no facilities prescribed in the regulations.)

[9] Where the patient or substitute decision-maker refuse 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 the context of this paper
[10] O. Reg. 79/10, s. 166(1)(d).
[11] O. Reg. 79/10, s. 166(4).
[12] S.O. 1996, C. 2, Sched. A.
[13] *HCCA.* s. 2(1).

The application process requires that the person or their substitute decision-maker apply for the homes of their choice. Valid consent is required prior to placing the person on a waiting list. The *Long Term Care Homes* Act defines the elements of consent as follows:

> **Elements of consent**
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> 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 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.

When choosing a long-term care home, therefore, one has the freedom to choose whatever one believes to be appropriate for them. Where there is a substitute decision-maker, the manner of decision-making is further regulated by specific rules that must be complied with, as set out in the *Health Care Consent Act*:

> 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 for decisions made by the substitute decision-maker as set out above, therefore, are restrictive: the substitute decision-maker can **only** make his or her choice based upon these rules.

Nowhere in the *Long-Term Care Homes Act*, *Health Care Consent Act* or their regulations are there requirements that state that the choice must include anything other than the **person's** own choice, or what is in their **best interest**. Nowhere does hospital policy, the requirements of the acute care system, or any other programs make their way into the equation. Therefore, based upon the legislation, the person is free to choose whatever long-term care homes they like.

In the case of *Gray v. Ontario*, a group of family members of developmentally challenged residents of residential institutions asked the court to determine whether or not the Ministry of Community and Social Services could close those institutions. The Divisional Court held that the Ministry had the authority to do so. A second question was then asked, which was as follows:

> If the Minister acted within her jurisdiction in closing the institutions, is the Minister required to obtain the consent of the resident or his or her next of kin or substitute decision-maker to the community placement selected for the resident? If so, how are disputes to be resolved concerning community placement?[14]

The Applicants submitted to the Court that the consent of the resident or their substitute decision-maker was required regarding any relocation. They went on to argue that in some cases, community placements and the pre-planning were being carried out without regard to the wishes of the residents' next of kin. The Respondents disagreed that consent was required.[15] The Court determined that consent was required. It went on to state:

> Consent to a particular residential placement is required due to the fundamental importance of this issue to the developmentally disabled person…. Due to their vulnerability, inappropriate residential placements have the likelihood of being harmful and may be life threatening to many of these profoundly affected adults. The provision of consent by a substitute decision-maker may be seen in some cases as a circumstantial guarantee of suitable placement. Perhaps more importantly, the refusal of consent by a substitute decision-maker will serve to require further consideration or an adjudication of the issue, so as to operate as a safeguard against erroneous decisions. In any event, the requirement for consent accords respect to the disabled person.
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> . . . .
>
> In summary, I am of the opinion that the consent of a developmentally disabled adult or his or her substitute decision-maker is required to any choice of community residential placement. This is because of the direct

[14] *Gray v. Ontario*, [2006] O.J. No. 226 (Division Court) ¶4.
[15] *Gray v. Ontario*, para. 27.

> and substantial effect this choice will have on the individual's health, safety and personal welfare and is in accordance with the principles of fundamental justice. It is well within the recognized jurisdiction of the Superior Court of Justice in the exercise of its *parens patriae* jurisdiction to declare this right and to see that it is respected.[16]

The Court recognized the importance of placement to the person and the potential for harm to these adults. It is argued here that as with the developmentally challenged, the choice of long-term care home can similarly affect the elderly person's health, and therefore deference to the decision of the person or their substitute decision-maker must be made.

The question then becomes whether the hospital is required to keep the person while they wait for their choice. Many homes have multi-year waiting lists. Does the hospital have to keep the person until their choice arises?[17]

The *Public Hospitals Act* contains a regulation making provision, stating that the Minister may make regulations regarding the "the admission, treatment, care, conduct, control and discharge of patients or any class of patients.[18] The regulations regarding discharge are as follows:

> 16(1) If a patient is no longer in need of treatment in the hospital, one of the following persons shall make an order that the patient be discharged and communicate the order to the patient:
>
> 1. The attending physician or midwife or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.
> 2. A member of the medical, dental or midwifery staff designated by a person referred to in paragraph 1.
>
> (2) Where an order has been made with respect to the discharge of a patient, the hospital shall discharge the patient and the patient shall leave the hospital on the date set out in the discharge order.
>
> (3) Despite subsection (2), the administrator may grant permission for a patient to remain in the hospital for a period of up to twenty-four hours after the date set out in the discharge order.

Based upon this, it would appear that as soon as a patient no longer requires treatment, they must be discharged from hospital, the only exception being a 24 hour grace period.

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[16] *Gray v. Ontario*, paras. 31 & 33.
[17] In fact, there is nothing in the legislation that requires the person to apply to more than one long-term care home: there is only a **maximum** stated.
[18] *Public Hospitals Act*, R.S.O. 1990, c. P.40, s. 32(1).

However, the reality is that persons who are awaiting placement no longer require treatment, yet are regularly allowed to stay in hospital until a bed becomes available. Which then is true?

Hospitals often use the above-noted section as the basis for requiring patients to comply with their discharge policy. The writer's opinion is that this is not supportable in law. First, the hospital's ability to charge alternative level of care (ALC) patients fees pursuant to the regulations to the *Health Insurance Act* would be in contravention of the strict interpretation of this section of the *Public Hospitals Act* regulations. Further, if this section was applied across the board, it would meant that **everyone** who required long-term care would be discharged within 24 hours of no longer requiring acute, whether a bed is available or not. Instead, hospitals are picking and choosing when to rely on this regulation. Rules of natural justice can be used to argue that they cannot do this. Furthermore, the hospital owes a duty of care to the patient, meaning that the patient cannot be forcibly discharged to the community when they are unable to live there safely. This is the same argument that one can make when a hospital attempts to require a patient to go to a retirement home to wait for a long-term care bed: people cannot be forced to "wait" for placement in a retirement home. Retirement homes are not part of the Canadian health care system, and one cannot be forced into one as an alternative to waiting for a bed while in hospital. Retirement homes are not regulated in the same ways as long-term care: the health care provided therein is not part of the health care system, is paid for privately and unregulated, so that safety cannot be assured.[19]

There is also often a 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. Often, hospital policies indicate that it is the physician or "team" who will determine whether these beds are "appropriate" for the person. This is often the crux of the disagreement in these cases: hospitals believe that an available bed is suitable for the person, the applicant or their substitute decision-maker disagree.

Placement into homes which are not of their choosing can be detrimental to the applicant's health. Often these homes are far from families and other support systems: the deleterious effects on person's health can be dramatic, even leading to the death of the person transferred. As well, it can be argued that the reason that some of these homes have available beds is because the homes are themselves unsatisfactory in some way. People should not be required to accept below-standard care, simply because there are no beds in appropriate homes.

[19] Ontario's *Retirement Homes Act, 2010*, S.O. 2010. C. 11, has been passed but not yet enacted, as the regulations are still being drafted. This will, for the first time, provide some oversight and regulation to the care in privately run Retirement Homes. However, it is still part of the private-pay system and no one can be forced to utilize it when they are eligible for publicly funded long-term care.

However, it is clear from the *Long Term Care Homes Act, 2010* and Health *Care Consent Act*, that it is up to the person or their substitute decision-maker to determine what is appropriate: nowhere is there any role for hospital personnel or the treatment team in this type of placement decision. In fact, it is between the person and the CCAC to resolve these issue: the hospital has no voice in this whatsoever.

There is evidence to back up this position. In 2010, with the enactment of the *Long-Term Care Homes* Act, the government could have included first available bed or short list requirements for those applying to long-term care from hospital. This did not occur. Instead, applications from hospital patients are treated the same as those from the community, with a few exceptions, as follows:

1. The crisis category now includes hospital patients where the following criteria are met:

- An applicant shall be placed in category 1 on the waiting list for a long-term care home if the applicant,
    - occupies a bed in a hospital under the *Public Hospitals Act*, requires an alternate level of care and requires an immediate admission to a long-term care home;
    - the hospital is experiencing severe capacity pressures; and
    - the local health integration network for the geographic area in which the hospital is located has, taking into account consultation with the affected hospital and the appropriate placement co-ordinator, verified these pressures to the appropriate placement co-ordinator in writing and set out the time period for which the verification applies.[20]

2. In categories 3 (religious, ethnic or linguistic origin), and category 4(others) on the waiting list, those in hospital awaiting placement are in the higher "A" category rather than the more general "B" category.[21]

3. Patients in hospital can also apply for interim short-stay beds. Interim short-stay beds can only be applied for by patients in hospital beds, who are awaiting placement for regular long-term care beds: you cannot apply from the community. There is, however, no requirement that you apply for these beds if you are in hospital, nor is there any requirement that you must be on "short list" waiting list for regular long-term care beds to apply. The criteria to apply for these special beds are as follows:

[20] O.Reg. 79/10, s. 171(4)
[21] O.Reg. 70/10, s. 173 & 174.

- the person occupies a bed in a hospital under the *Public Hospitals Act* and requires an alternate level of care;
- a physician has determined that the person does not require the acute care services provided by the hospital;
- the person is determined by a placement co-ordinator to be eligible for long-term care home admission as a long-stay resident under section 155;
- the person is on at least one waiting list for admission to a bed in a long-stay program of a long-term care home;
- placing the person on the waiting list will not result in the total number of short-stay waiting lists on which the person is placed exceeding five;
- the person applies in accordance with this Regulation for authorization of his or her admission to an interim bed in the home; and
- the licensee of the home approves the person's admission to an interim bed in the home.[22]

It should also be made clear that the designation of "crisis" does not mean that the person must go to the first available bed in the system. The designation means that the person goes to the top of the list – category 1 for all homes that they have chosen, and they are no longer limited to a maximum of five choices.[23]

Additionally, in 1996, amendments were made to the regulations to the *Health Insurance Act*. This was in response to complaints that people were refusing to apply to or accept long-term care placements from hospital because they did not have to pay for the bed in the hospital. These regulations specified that those in hospital, who, in the opinion of the physician, were more or less permanent residents of a hospital or other institution, could be charged the "chronic care co-payment".[24] This allowed the physician to designate a patient as being "alternative level of care" or "ALC", allowing them to stay in hospital to await admission to a complex continuing care hospital or long-term care home, while charging them the same rate as they would pay in one of those institutions.[25]

Not only does the chronic care co-payment and the designation of "ALC" indicate that those needing long-term care can stay in hospital pending placement, it also places a maximum amount that can be charged to patients. Therefore, the argument that the "daily rate" can be charged is contrary to the *Health Insurance Act*, as the government has already set the rate for ALC patients awaiting placement from hospital.

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[22] O.Reg. 79/10, s. 192.
[23] O. Reg. 79/10 s. 164(4) & s. 171.
[24] R.R.O. 1990, Reg. 552, s. 10.
[25] *Complex Continuing Care Co-payment, 2009*, Ministry of Health and Long-Term Care, available at: http://www.health.gov.on.ca/english/public/pub/chronic/chronic.html.

The only case heard to date on the issue of discharge from hospital to long-term care, is *Duffy v. OHIP,*[26] which was an appeal from a denial of OHIP. In that case, Mrs. Duffy, a patient at Joseph Brant Memorial Hospital, was awaiting placement in long-term care. While applications for three homes had been made, the hospital required that more homes be added.[27] When this was not done, OHIP was advised that the patient was discharged but remained in hospital, OHIP payment for the bed was 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 arguing that there should be OHIP coverage for all the hospital fees. The Board held that the rate being charged by the hospital appeared completely arbitrary, there was not sufficient evidence that the appellant or her family had been advised of the discharge policy and in any event, it was clear that 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 held in favour of the Appellant, ordering coverage of the fees by OHIP.

This does not mean that the person should simply wait in hospital for a specific long-term care home where that home has a three-year waiting list, unless it can be proven that that home is the only one which can meet the person's needs. Applicants and their substitute decision-makers must be reasonable when making their choices, taking into consideration the effect that a lengthy hospitalization would have on the patient. Staying in hospital may not, in fact, be in the best interest of the person. Hospitals do not provide the assistance and social programming required by those needing long-term are. The likelihood of their deteriorating with long-stays in hospital, including loss of mobility and continence are high. Further, given the rise of hospital borne infections, such as MRSA, VRE, and C. Difficile, staying in hospital for prolonged periods of time increases the chance of contracting one of them. One must weigh all of these issues when making a placement decision.

Arguments could also be made with respect to the patient's rights under the *Charter of Rights and Freedoms*. For example, it could be argued that forced placements are contrary to a person's section 7 right to life, liberty and security of the person. Because the long-term care home is the home of the person, as well as part of the health care system, and may be where they live for the rest of their life, any legislative attempt to force placement would contravene these sections.

Finally, within the context of placement in a long-term care home, recourse to the courts has generally not been necessary. The legislation requires that a competent person makes the final decision with respect to where they wish to be admitted pursuant to the

[26] S.5433 Feb 4, 1999.
[27] At the time, the legislation did not include a maximum number of homes that could be applied to: the hospital here was requesting that 10 homes be included in the application.

Long-Term Care Homes Act and *Health Care Consent Act*. With respect to substitute decision-makers, their decisions are governed by section 42 of the *Health Care Consent Act*. The ability to challenge that decision is left not to the hospital, physician or other medical party involved in the person's case, but rather to the CCAC, which has the authority to challenge it to the Consent and Capacity Board.[28] However, this challenge must be based upon the substitute decision-maker's failure to comply with the statutory principles for giving or refusing consent. Nowhere in these principles is there a section which requires them to consider "hospital policy", only to comply with the competent wishes of the incapable person or their best interest. To date, we are unaware of any cases where the substitute decision-maker has been brought to the Consent and Capacity Board because of their long-term care home choices.

Legality of Hospital Policies

It is argued that hospital policies which attempt to control placement choices are not legal. The government has legislated a very specific process and requirements under the *Long-Term Care Homes Act* and its regulations. Nowhere has the legislation given any role to hospitals having policy or other roles in placement choice. It is argued that any policies which claim to do so are, in the opinion of the author, of no force and effect as they are attempting to undermine the requirements already set out in legislation.

ISSUES WITH THE CCAC IN PLACEMENT FROM HOSPITAL

We are hearing more and more that CCACs are refusing to take applications if the applicant (or their substitute decision-maker) refuses to comply with hospital policies. These refusals are in complete violation of the legislation which governs placement into long-term care homes.

Placement coordinators are designated by the Minister of Health and Long-Term Care.[29] At present, they are employees or agents[30] of the CCAC. Individuals may not be admitted to a long-term care home unless the placement coordinator authorizes the admission.[31] The legislation clearly sets out the role of the placement coordinator and how they are to perform the placement function. There is no role for the hospital social worker, discharge planner or other hospital employee. Therefore, only the placement coordinator can perform the following roles:

- If a person or their substitute decision-maker applies to the placement coordinator for a determination that they are eligible for placement into long-

[28] *HCCA*, s. 54.
[29] *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8 ("*LTCHA*"), s. 40.
[30] Hospital employees are not agents: agents would be persons contracted by the CCAC to do assessments in areas where they do not have employees available.
[31] *LTCHA,* ss. 42.

term care, the placement coordinator must find the person eligible if they meet the criteria set out in the regulations.[32]

- The placement coordinator authorizes admission to the nursing home or homes **as selected by the person/substitute decision-maker**.[33]

- The placement coordinator **shall**, if requested by the person/substitute decision-maker, assist the person in selecting homes.[34]

- The *Long-Term Care Homes Act, 2010* even sets out the criteria that should be used by the placement coordinator when assisting the person choose a home – namely, the person's preferences relating to admission based on ethnic, spiritual, linguistic, familial and cultural factors.[35]

- The placement coordinator can approve eligibility or authorize admission to a specific nursing home only if the person/substitute decision-maker **specifically applies** for such admission.[36] 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/substitute decision-maker.

- If a person has already applied for five homes, their eligibility for admission cannot even be **considered** until the person removes one of their choices from the list.[37] Again, a home can only be removed from the choice sheet with the express consent of the person/substitute decision-maker.

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

In the past, we have seen hospitals circumvent the law by trying to get patients to apply to homes that the patient or their family did not feel was appropriate. We are now seeing that the CCACs are supporting these positions in a number of ways, thereby failing to comply with their legislative mandate.

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[32] *LTCHA,* s. 43(1) and O. Reg. 79/10, s. 155(1).
[33] *LTCHA*, s. 44(1).
[34] *LTCHA*, s. 44(3).
[35] *LTCHA*, s. 44(4).
[36] *Long-Term Care Homes Act, 2010*, s. 43.
[37] O. Reg. 79/10, s. 166(1)(d).

Refusal of the CCAC to Take the Application

With the enactment of the *Long-Term Care Homes Act, 2010,* it is clear that the bulk of the application must be completed by the placement coordinator. Certain portions, such as the assessment of the applicant's physical and mental health, must be completed by a physician or nurse,[38] but does not need, and would usually not, be by a member of the CCAC staff. The rest of the application must be completed by an employee or agent of the CCAC.[39] However, the two assessments must be completed by different people.[40] Prior to the enactment of the new legislation, placement coordinators refused to take applications directly, instead insisting that it be commenced by hospital staff.

More recently, CCAC staff will not take an application for hospital patients unless there is a specific referral from hospital staff. Again, this is contrary to the legislation. The legislation is clear that the CCAC **must** take an application and determine eligibility upon request.[41]

It is still common-place, however, for a hospital staff member to complete the home choice sheet portion. While the legislation does not specifically state that the hospital staff cannot help with the completion of the form, there is still a legal obligation on the placement coordinator to ensure that this is done correctly and in accordance with the law. The placement coordinator is required, as follows:

> **Determination of eligibility – information about process**
>
> (7) If the placement co-ordinator determines that the applicant is eligible for long-term care home admission, the placement co-ordinator shall, at the time of making the determination, provide information to the applicant about the process for admitting persons into long-term care homes and explain the process, the choices that the applicant has in the process and the implications of those choices.[42]

It is also the obligation of the placement coordination to ensure that the consent is valid. This includes that the consent complies with all applicable consent legislation, as contained in both the *Long-Term Care Homes* Act, as well as the *Health Care Consent* Act. If the "choices" are made based upon misinformation, such as being told that they **must** choose from a short list, or that they **must** choose a specific bed, then the consent it is not valid and cannot be accepted by the placement coordinator. Therefore it is up to the placement coordinator to ensure that the rules

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[38] *Long-Term Care Homes Act, 2010*, s. 43(4)1 & 43(5)2.
[39] *Long-Term Care Homes Act, 2010*, s. 43(4)2& 43(5)3.
[40] *Long-Term Care Homes Act, 2010*, s. 43(5)4.
[41] *Long-Term Care Homes Act* s. 43(4).
[42] *Long-Term Care Homes Act*, s. 43(7).

have been explained to the person or their substitute, and that they have been complied with in the process.[43] In fact, where there is a substitute decision-maker making the decision, they also have an obligation to advise them of the rules with which they must comply when making their decision. [44]

Given that the hospital has no role in this application process, the person or their substitute decision-maker has the right to demand assistance from the placement coordinator in making their choice, not a hospital employee. Unfortunately, some placement coordinators have been refusing to assist, as this is not the way it is "usually" done. This has the effect of allowing the hospital employee to try to pressure the patient or substitute decision-maker into complying with the hospital policy without involvement of the CCAC.

Refusal of the CCAC to Accept the Application/Choice Sheet Unless it Complies with Hospital Policy

This is a variation on the theme set out above where the placement coordinator refuses to accept the facility choice sheet unless the person has complied with hospital policy. Again, the law states clearly that the placement coordinators must: accept the application; determine eligibility; obtain consent in accordance with the law; authorize admission; and place the person on waiting lists for homes of their choice. There is no place in the process for the consideration of hospital policy, as previously discussed.

Refusal of the CCAC to Accept Choices or Changes

The person or their substitute decision-maker not only has the right to choose the homes to which they wish to apply, they also can change or withdraw consent to those homes at any time prior to a bed offer being made. Often, people initially include choices of homes that the hospital has told them they "must" include, only to find out later that this was not true.

If this happens, the person or their substitute decision-maker then has the right to demand that the home be removed from the list and replace it with any other home they choose. In some cases, placement coordinators tell the person or their substitute decision-maker that they cannot make any changes or withdraw a name

[43] Some CCACs now have policies that evaluations of capacity be done by their own staff as it is their legal obligation to obtain valid consent. However, under the *HCCA*, evaluations can be performed by anyone who is a member of specific colleges. There are presently issues arising around how this policy may be affecting the process, and it remains to be seen whether this will have a positive or negative affect.

[44] *M. A. v. Benes*, 1999 CanLII 3807 (ON C.A.).

from a list because it violates hospital policy. Alternatively, placement coordinators may say that they will only make a change if certain criteria are met (e.g., the hospital discharge planner “okays” the change or one “short list” home is exchanged for another) which would also be 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 of long-term care homes.

Refusal of the CCAC to Take an Application from Hospital Patients

Some CCACs are now refusing to take applications for long-term care homes from hospital patients or only accepting these applications under strict circumstances. Generally, this is associated with the new “Aging at Home Strategy” (often also referred to as Wait at Home Programs) of the Ministry of Health and Long-Term Care. Under this strategy, increased funding has been made available to allow people to stay in their home in the community longer in certain circumstances, by providing time-limited increased hours of care in the home. Another purpose of this strategy is to ease pressure on hospitals, enabling those who would otherwise be going to long-term care to return home with enhanced levels of care rather than go into long-term care.

While this program is laudable in theory, in practice there have been increasing problems. Patients are being told by the CCAC that they must return home before an application for long-term care 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. The result of this policy is that 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 for long-term care. The only purpose of such a policy is to assist hospitals to empty their beds, even though it is not in the interest and, in fact may be dangerous to the person that the CCAC has an obligation to assist.

Take the example of an elderly couple where one spouse is bedridden: even with increased services, the healthier spouse often cannot care for their loved one. As well, the increased services available under this program are only for a maximum of 60 days, and the hours can be decreased at any time during that period. In some cases, the person will not even know how much homecare they may be entitled to until after they return home. It is impossible to make an informed choice when the appropriate information is not being provided.

Finally, there is no requirement to enter into such a program. 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 long-term care, have eligibility determined, and have 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

Another variant on this program is where the applicant is told that they must go to a retirement home pending placement in a long-term care home. 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,[45] 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 Determinations of 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, then the person has no recourse to challenge an application for ineligibility, as would be allowed under the *Long-Term Care Homes Act*.

Further, if a person has been found to be ineligible for long-term care and it is felt that it is inappropriate, an application can be made to the *Health Services Appeal and Review Board* for a review of the finding of ineligibility.[46]

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 to make "choices" for the individual. The system is there to support those individuals in making the choices which are truly in their best interest.

[45] O.Reg 79/10, s. 154(1).
[46] *Long-Term Care Homes Act*, 2. 43(8).