Court File No. CV-23-00698007-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY

Applicants

-and-

HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO, THE MINISTER OF HEALTH, and THE MINISTER OF LONG-TERM CARE

Respondents

AFFIDAVIT OF SANDRA IAFRATE

I, SANDRA IAFRATE, of the City of Toronto, in the Province of Ontario, MAKE OATH AND SAY:

1. I am Interim Vice President, Patient Services for the Toronto Central and Central branches of Home and Community Care Support Services (HCCSS). HCCSS is a provincial agency that co-ordinates in-home and community-based services to support the health and well-being of Ontarians, provide access and referrals to other community services, and manage Ontario's long-term care home placement process. I have been employed by HCCSS and its legacy organizations for almost twenty years. As a member in good standing of the Ontario College of Social Workers and Social Service Workers, I am a Regulated Health Professional.

2. When Bill 7 received Royal Assent in August of 2022, the Ministry of Long-Term Care required HCCSS to carry out implementation of the changes brought about by the bill.

During this time, and through to February of 2024, I served as the Director for Placement Services for HCCSS Central. My direct service territory includes York Region, South Simcoe County, North York and parts of Etobicoke.

3. I have been asked by the Government of Ontario to address the following questions:

    a) What is the role of a care coordinator in hospital once a patient has been designated alternate level of care (ALC)?
    b) What information do care coordinators provide to patients as part of the counselling process and when discussing long-term care options?

A) The Role of Care Coordinators

4. When a physician designates a hospital patient as ALC and the patient is medically stable, the hospital sends a referral to HCCSS. This usually comes from a discharge planner or social worker at the hospital and comes to HCCSS through the electronic Resource Matching and eReferral system. HCCSS has teams of care coordinators working in each hospital in the province. One of these care coordinators will pick up the referral and begin the process of assessing and counselling the patient. The care coordinator engages with the patient or caregiver/substitute decision maker (SDM) to obtain consent, assess the care needs of the patient, and develop a care plan considering the patient's wishes and the availability of family and other caregivers to provide care for the patient. This process is an iterative one, which may take several days and include multiple meetings with the patient, their family, and the care team.

5. HCCSS has a home-first philosophy. Our goal is to get patients home where they want to be and to consider and exhaust all options and community resources before considering long-term care (LTC) as the most appropriate discharge destination. Where LTC is found to be the

most appropriate option for a patient, the goal is to place a patient as quickly as possible, recognizing that patients may deteriorate rapidly as a result of an extended stay in hospital.

6. To fulfill a LTC home application and admission process – including for hospital patients designated ALC – HCCSS care coordinators adhere to provincial legislation and regulations, as well as to the Ministry of Long-Term Care's guidance document entitled "Admissions to Long-Term Care Homes for Alternate Level of Care Patients from Public Hospitals: Field Guidance to HCCSS Placement Co-ordinators" (April 2023). A copy of this guidance document is attached hereto as Exhibit "A".

7. The role of the placement coordinator is to counsel patients and families regarding LTC to support a safe, timely discharge from hospital. This includes reviewing care options in the community, determining eligibility for LTC admission, evaluating patient capacity (where appropriate), counselling patients and families on LTC home choices, supporting the LTC application process (e.g., completing application forms, etc.), ongoing patient/SDM support and counselling, and offering a bed and authorizing admission to LTC when an appropriate LTC bed becomes available.

8. To break this down further, after the care coordinator completes a comprehensive assessment of the patient, they recommend all LTC choices that can meet the patient's care needs, and are within the patients preferred location(s), including homes with shorter waitlists for the patient to consider. The care coordinator will reassess the patient on an ongoing basis and review LTC choices with the goal of expediting the patient's admission to LTC. Patients and their families are encouraged to tour homes, virtually or in person. Care coordinators also provide information about wait times to assist patients and families in making informed choices. ALC patients awaiting placement in LTC homes are designated as having the highest

level of priority for placement: crisis level. Patients in the crisis category may apply to as many LTC homes as they would like.

9. The changes made under Bill 7, which came into effect in September of 2022, enable certain actions to be taken without the patient or SDM's consent to support patients who are designated ALC to LTC to be discharged to a safe, alternate care setting. The *Fixing Long-Term Care Act, 2021* (FLTCA), requires the placement coordinator arrange for the completion of the following assessments and provide them to the LTCHs the patient applies to:

    (a) An assessment of the applicant's physical and mental health, and the applicant's requirements for medical treatment and health care.

    (b) An assessment of the applicant's:

        i. functional capacity,

        ii. requirements for personal care,

        iii. current behaviour, and

        iv. behaviour during the year preceding the assessment.

    In the event that the patient/SDM does not consent to an assessment for LTC admission, these assessments would require information from hospital records and other care providers.

10. If a patient/SDM refuses to add LTC home(s) with reasonable wait times, the HCCSS care coordinator provides counselling and reviews the benefits of waiting in an alternate location for the patient's first choice or preferred home. As part of this counselling, the "Transitioning

from Hospital to Home" patient fact sheet is provided to the patient/SDM. A copy of this fact sheet is attached hereto as Exhibit "B".

11. Where a patient continues to refuse to add a LTC option with a reasonable wait time to their list, pursuant to changes made by Bill 7, the care coordinator may select choices on behalf of the applicant that will meet their care needs, expedite admission and enable the applicant to wait for their preferred choice outside of the hospital. Care coordinators may select choices on behalf of the applicant taking into consideration their ethnocultural preferences and the travel distance of caregivers. They may share the patient's application and health information with LTC homes for the purposes of accepting or declining their application. That said, hospital care coordinators make every reasonable effort to obtain the patient's consent for LTC applications multiple times throughout the placement process.

12. Once the patient has chosen the LTC homes where they would like to apply, information about the patient is sent to the LTC homes so they can determine whether they can offer the patient a suitable placement. The personal health information provided to LTC homes is the same regardless of whether the home is chosen by the patient or applied to by the care coordinator without the patient's consent. Section 51(7) of FLTCA provides that the LTCH is required to approve the person's application unless:

    (a) the home lacks the physical facilities necessary to meet the applicant's care requirements;

    (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

13. The assessment information provided to LTC homes must be current within three months of the initial application and current within three months of bed match. Once an application has been made to a LTC home, the home has five days to accept or decline the patient, although in some cases they may advise the care coordinator that they require more information in order to make this determination. In that case, the care coordinator will work to obtain the information sought by the LTC home.

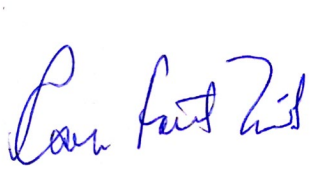
B) <u>Information Provided to Patients about LTC Options</u>

14. A major part of the care coordinators' role is to communicate with the patient and their family. In my view, the changes brought about by Bill 7 have increased the importance of clear communication and enhanced the quality of counselling that patients are offered about their LTC options.

15. HCCSS care coordinators provide information about alternative options to LTC, including retirement homes and other support services. They share information about LTC homes that can support a patient's care needs, including services available at the LTC home, type of beds available, accommodation costs, and any unique or specialized facilities or services (e.g., bariatric beds, hemodialysis chairs, behavioural support services, etc.). Care coordinators provide information about the LTC application process, admission process, what occurs if a bed has been declined and what to expect when an applicant has been accepted to the waitlist. In addition, they provide documentation required to complete the application. Care

coordinators also provide information about options for a patient who is ineligible for LTC, including information about how to appeal to the Health Services Appeal and Review Board.

SWORN BEFORE ME in the City of Toronto by Sandra Iafrate in the City of Toronto before me on February 23, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.



……
Commissioner for the Taking of Affidavits

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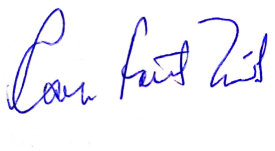
SANDRA IAFRATE

This is **Exhibit "A"** referred to in the Affidavit

of **Sandra Iafrate,** sworn this 23rd day of

February, 2024, in accordance with O. Reg 431/20,

Administering Oath or Declaration Remotely



A Commissioner for taking Affidavits etc. (or as may be)

(pursuant to O. Reg. 431/20)

Admissions to Long-Term Care Homes for Alternate Level of Care Patients from Public Hospitals

Field Guidance to Home and Community Care Support Services Placement Co-ordinators

Revised: April 11, 2023

Ontario

Table of Contents

Definitions

In this document:

- "**alternate level of care (ALC) patient**" refers to someone who occupies a bed in a hospital under the *Public Hospitals Act* and has been designated by an attending clinician in the hospital as requiring alternate level of care. This means, in the clinician's opinion, the person does not require the intensity of resources or services provided in the hospital care setting (FLTCA s. 60.1).
  - For the purposes of this document, "ALC patient":
    - also refers to their substitute decision maker, if any, when referring to consent and decision making, and
    - does not include patients who are currently in a transitional care unit based in the community and not designated as hospital premises under the *Public Hospitals Act*.

- "**first-choice home**" refers to the top ranked LTC home on the ALC applicant's LTC home choice list.

- "**long-term care home**" "**LTC home"** refers to a place that is licensed as a long-term care home under the *Fixing Long-Term Care Act, 2021* (FLTCA), and includes a municipal home, joint home or First Nations home approved under Part IX of the FLTCA, unless otherwise specified.

- "**placement co-ordinator selected home**" refers to an LTC home that the placement co-ordinator has chosen for the ALC patient, but the ALC patient has not consented to be on the waitlist at the time of LTC home selection.

- "**patient-selected home**" refers to one of the homes that the ALC patient chooses to be on the waiting list for at the time of LTC home selection.

- "**placement co-ordinators**" refer to placement co-ordinator as defined in subsection 51 (2) of the FLTCA.

Summary of Revisions

Revision Date	Description of Changes	Page(s)
April 11, 2023	Revised section 6.0 Preferred Accommodation Top-Up to provide greater clarity on requirements regarding the admission of Alternate Level of Care (ALC) patients to preferred accommodation (where the resident pays the basic rate). Changes align requirements with amendments to Ontario Regulation 246/22 that came into force as of April 11, 2023.	15 - 17

1.0 Introduction

This document sets out guidance for Home and Community Care Support Services (HCCSS) placement co-ordinators to support the flow of eligible alternate level of care (ALC) patients from public hospitals to long-term care (LTC) homes, where LTC is under consideration as the most appropriate care setting. As managed in current practice however, Home First should be the preferred discharge destination before LTC is considered.

The intent of this guidance document is to be a resource for placement co-ordinators to implement recent changes to the placement of ALC patients based on the provisions set out in the *Fixing Long-Term Care Act, 2021* (FLTCA) and Ontario Regulation 246/22 (Regulation).

This document should be read in conjunction with the FLTCA and the Regulation and, in the case of any conflict or inconsistency between this document and the FLTCA and the Regulation, the provisions of the FLTCA and the Regulation prevail. This document does not constitute legal advice or interpretation. This document does not apply to admissions to settings other than LTC homes. Additionally, this document and the recent amendments to the FLTCA and Regulation do not apply to individuals seeking admission to Direct Access Beds, High Acuity Priority Access Beds, or beds in LTC homes set out in the Table to section 368 of the Regulation (the four First Nations LTC homes).

1.1 Consent

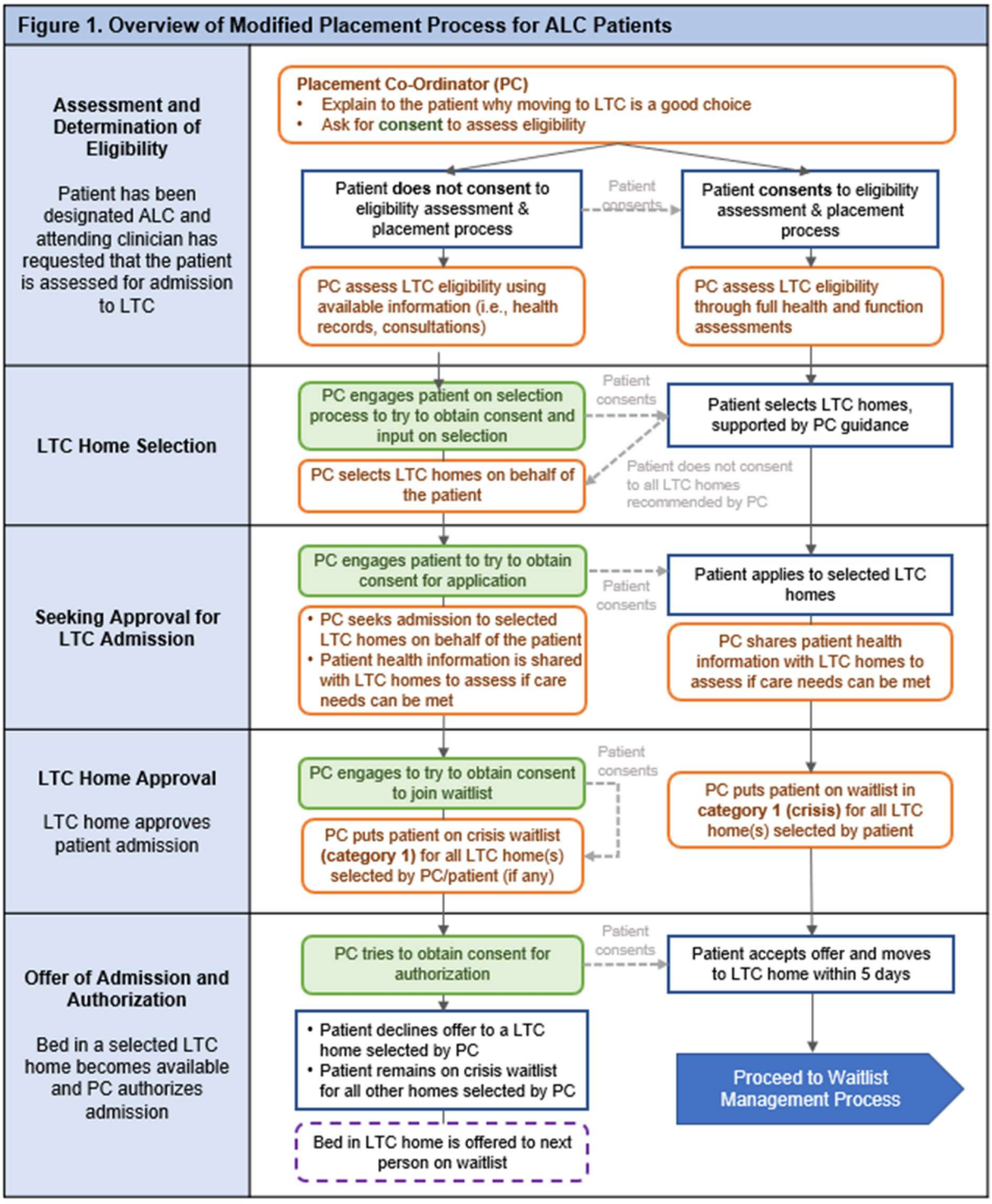
The LTC admissions process for ALC patients will continue to be grounded in an ongoing dialogue with ALC patients, their families, and caregiver(s) about a safe transition to LTC, striving to understand preferences and promote as much choice as possible throughout the entire process.

Where an ALC patient requiring LTC declines to participate in the admission process, these changes will allow that process and conversation to continue. Placement co-ordinators must continue to strive to engage the ALC patient to participate in the process and obtain consent whenever possible.

Legislative and regulatory changes have been made to enable the collection, use and disclosure of personal health information by and to placement co-ordinators for the purposes of determining LTC eligibility of ALC patients and determining admission of an ALC patient to a LTC home in circumstances where consent may not be provided. Details of the changes can be found in para. 5 of s. 60.1(3) of the FLTCA and ss.240.1(9) and (10) of the Regulation.

Please see figure 1 for an overview of the modified placement process and how it may vary, depending on consent from the ALC patient.

Figure 1. Overview of Modified Placement Process for ALC Patients



2.0 Initial Discussions with Hospital ALC Patient

Once it has been determined that a patient no longer needs treatment in a hospital setting, the determination of the most appropriate discharge destination should be an interdisciplinary and collaborative process amongst hospital staff including the discharge co-ordinator, the patient's health care providers and support services, such as HCCSS, and including the ALC patient, family and/or caregiver(s).

Following comprehensive assessments, the attending clinician or care team may request for the ALC patient's LTC eligibility to be determined. However, Home First should be explored as the preferred discharge destination before LTC is considered.

Placement co-ordinators must meet with ALC patients and facilitate initial discussions about exploring LTC. These discussions may take place virtually, over the phone, or in person and should include family and/or caregiver(s). If family and/or caregiver(s) cannot attend in-person, efforts should be made still to include them or ensure their involvement. These discussions should be a collaborative effort supported by both the placement co-ordinator and the hospital discharge team.

It should be explained to the patient why LTC might be a more suitable environment to meet their personal and medical care needs than the hospital. Rationale that could support this conversation may include:

- All LTC homes are required to meet the same standards of care, regardless of home type, ownership model, location, size, etc.
- LTC homes provide a home-like environment and can offer more recreational services and social supports.
- Some LTC homes are better able to provide culturally appropriate, religious and linguistic services, tailoring meals, daily practices and activities to meet these needs.

Ensure the patient's understanding of why the hospital is no longer an option to wait for further services, including the need to provide care for more acute and emergent patients.

If a transitional care unit, in the community and not designated as hospital premises, is under consideration for the ALC patient and they move to that transitional care unit, the ALC patient would not be eligible for the modified admissions process described in this guidance document.

It is important at this step that the hospital discharge team provides sufficient information regarding the implications of remaining in hospital after being discharged if it has not been provided earlier in their hospital stay. This information should continue to be readily available and understood throughout this process.

Every effort must be made to obtain consent from the ALC patient to explore moving to an LTC home, beginning with the assessment for LTC eligibility. If the ALC patient does not initially consent to starting the process to assess LTC eligibility, the placement co-ordinator must explain the next steps that will still be taken to perform the assessment (see s.240.1(5) of the Regulation and also section 3 for further details on determining eligibility) and to select LTC homes if the patient is determined to be eligible.

Throughout this process, the patient should be reminded:

- that they can provide consent at any time without having to start from the beginning, and
- of the implications of consenting or declining to consent during the process.

Placement co-ordinators must provide the patient with all necessary information about the LTC application and placement process, as per sections 49 to 54 and 60.1 of the FLTCA. The initial conversations with the ALC patient should also address choices available regarding accommodation types, payment responsibility, and available financial supports (for example, preferred accommodation top-up, basic accommodation rate reduction).

3.0 Determining Eligibility

3.1 Eligibility Criteria for LTC

The existing eligibility requirements, as set out in s.172 of the Regulation continue to apply for ALC patients.

In accordance with the existing Regulation, it is important to consider the availability of publicly-funded community-based services (including services that may be available on-reserve, for First Nations individuals) and other caregiving, support or companionship arrangements that could be made.

If these are sufficient to meet the individual's care needs, in any combination, the individual would not be determined eligible for LTC admission, as there is a more appropriate care setting or services outside of LTC that could support the patient in the community.

It is important that this LTC eligibility criteria is thoroughly considered by placement co-ordinators based on their knowledge of all available services and care settings, and their ability to utilize their network with the home and community care support services sector to ensure that the patient is directed to the most appropriate care.

If it is determined that the ALC patient is already or should be on the waitlist for other services that would be able to meet their care needs, they would not be eligible for LTC

placement, regardless of the date of availability of the services. The hospital discharge team may have already conducted an assessment for appropriate services. Placement co-ordinators are encouraged to confirm the appropriateness or completeness of these assessments and follow up if necessary.

- Examples of services to consider include adult day programs, community support services, and community-based developmental supports and services through Developmental Services Ontario.
    - ALC patients with developmental disabilities who may already be on a waitlist or should be on a waitlist for community-based services would likely not be eligible for LTC placement. The applicable Developmental Services Ontario office should be consulted to confirm if a request for community-based services has been made, to understand the status of any developmental services assessments and/or the need to conduct a reassessment, if required.
    - If the ALC patient has or may have a developmental disability but has not yet been connected to appropriate supports by the hospital discharge team, placement co-ordinators should raise this as a consideration for discharge and can connect directly with Developmental Services Ontario if necessary.
    - The joint Ministry of Long-Term Care and Ministry of Children, Community and Social Services' *Guidelines For Supporting Adults With A Developmental Disability When Applying To, Moving Into And Residing In A Long-Term Care Home* can provide supplemental information to guide decision-making.

3.2 Assessing Eligibility

In circumstances where the ALC patient does not consent to the assessments required to determine eligibility, placement co-ordinators must attempt to determine eligibility based on as much information as is available in the circumstances.

If the ALC patient does not consent to a health or functional assessment as defined under the FLTCA s.50(4), placement co-ordinators are able to assess eligibility through review of available hospital records and health records from the patient's primary care provider, home and community care provider, an application entity or a service agency defined under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act*, *2008* (SIPDDA).

- As per para. 5 s. 60.1(3) of the FLTCA and s. 240.1 (10) of the Regulation, regulatory changes have enabled the collection, use and disclosure of patient health information to placement co-ordinators.

To support a records-based assessment, consultations with the ALC patient's attending clinician, primary care provider, home and community care provider(s), and/or Developmental Services Ontario and service agency(ies), if available and applicable, are also strongly recommended.

- It will be important to ensure completion of the Health Assessment form by the attending clinician for a patient that is not consenting to an LTC assessment/application; a copy of this assessment should be included to support the LTC application.

If after conducting consultations and reviewing available patient records, there is still insufficient information to make an accurate determination of eligibility, the placement co-ordinator is encouraged to continue discussions with the ALC patient to consider the transition to LTC and obtain consent for the required assessments.

3.3 Determination of Ineligibility

If it is determined that the patient is not eligible for LTC, this should be communicated back to the hospital discharge team so the appropriate next steps can be taken. This process of determining the ALC patient's most appropriate discharge destination should be a collaborative effort supported appropriately by the patient's clinician(s), hospital discharge team and the HCCSS placement co-ordinator.

4.0 Homes Selected by the Placement Co-ordinator

4.1 Identifying LTC Homes for Selection

If an ALC patient is determined to be eligible for LTC without their consent, it is important to re-engage the ALC patient to communicate this decision and inform them of the next steps.

As it would occur with a regular LTC applicant, once the individual is determined to be eligible for LTC, the placement co-ordinator is to provide the ALC patient with information regarding relevant LTC waitlists and vacancies of the potential LTC homes under consideration, and how to obtain additional information about LTC homes.

If the ALC patient withholds consent to apply for LTC or to apply to additional LTC homes or to LTC homes to which admission would likely happen within a relatively short period of time (for example, they are currently on the waitlist for only 1-2 LTC homes with long waitlists), the placement co-ordinator should identify as many additional LTC homes that they feel would be appropriate matches for that individual based on their conditions and circumstances, class of accommodation and the proximity of the LTC home to the patient's homes, family/caregiver(s) or current hospital.

4.1.1 Required Considerations

The patient's conditions and circumstances

The LTC home(s) selected by the placement co-ordinator must be able to adequately meet the individual's care needs. This includes determining if the ALC patient has specialized care needs and whether there are resources/supports in place or that could be arranged to meet their needs upon admission to that LTC home (for example, additional resources for specialized care).

Specialized Care or Supports Required

- If specialized care or supports are required to enable placement of an ALC patient or a community applicant to an LTC home, or it is known that an LTC home under consideration does not have appropriate supports in place to meet the applicant's needs, the placement co-ordinator can help facilitate a discussion with the LTC home and Ontario Health to determine the availability of services and resources that could enable placement.
- Possible supports include the Local Priorities Fund for investments in specialized equipment (such as bariatric equipment) and services to support placements in particular local contexts, the Virtual Behavioural Medicine program for virtual inpatient neurobehavioural services, services from Behavioural Supports Ontario and the LTC High Intensity Needs Fund (HINF).
- For patients who are eligible for LTC but also have a developmental disability (as defined by eligibility criteria under the SIPDDA), consider the wraparound supports and services that may be required and how these will be provided within an LTC home setting. Placement co-ordinators will need to work with Developmental Services Ontario and the appropriate service agencies in such cases to understand supports and services that would be appropriate and required, and to ensure these wraparound supports are available to support the patient following admission to the LTC home.

Geographic proximity

The LTC home(s) selected by the placement co-ordinator must be within 70 kilometres (km) of a location of the patient's choosing, if input is provided, and more than one location can be used. Possible locations could include the first-choice LTC home, if available, the location of a caregiver or family member, or the current hospital. If the ALC patient does not provide a preferred location(s) from which to search, the patient's preferred location will be the patient's primary residence; or if the patient's primary residence is unknown, then the patient's preferred location will be the hospital in which they are located.

If the patient's preferred location(s) are in the North East or North West HCCSS, the LTC home(s) selected by the placement co-ordinator must be within a 150 km radius of the preferred location(s).

However, if in these regions there is no suitable LTC home in the applicable radius, or if there are extremely limited vacancies in the available homes within the geographic boundary, the next closest home or homes to the patient's preferred location(s) can be selected.

Within the 70 km or 150 km boundary, as applicable, efforts should be made to place the ALC patient as close as possible to their preferred location(s), subject to considerations regarding care needs and accommodation type.

Accommodation type

If a patient is open to admission to preferred accommodation, in addition to basic accommodation, suitable LTC homes with greater availability of preferred accommodations should be prioritized.

If a patient prefers admission to basic accommodation, suitable LTC homes with basic accommodation availability should be prioritized in conjunction with other considerations outlined above. However, as noted under section 240.3(6) of the Regulation, placement co-ordinators are authorized to place these patients in preferred accommodation. See Section 6: Preferred Accommodation Top-Up for further details.

If the patient does not select a class of accommodation, the default accommodation type selected by the placement co-ordinator must be basic.

4.1.2. Additional Considerations

Religious/ethnic/linguistic circumstances

Circumstances that may be unique to the patient, including religious, ethnic and linguistic factors, should be considered when selecting LTC homes in a balanced way, in conjunction with the other requirements set out in the Regulation (that is, care needs, geographic proximity, and accommodation type). Where these factors inform the selection of LTC homes, it is important for the placement co-ordinator to provide updated waitlist information to support realistic wait time expectations.

When considering LTC homes that are designated to serve specific religious, ethnic or linguistic populations, placement co-ordinators should avoid as much as possible matching ALC patients who do not match these designations or those who do not request these designations.

If an ALC patient would like to be placed in an LTC home of a specific religious, ethnic or linguistic origin, it may be advantageous to also consider homes that have a substantial population of residents who also identify such preferences, even though they may not be designated.

- For example, if an ALC patient is only able to communicate in French, according to their linguistic needs, placement co-ordinators should attempt to place them in a home that provides services in French. If the applicant also has religious beliefs but the home is not primarily engaged in serving the interests of persons of that religion, placement co-ordinators would need to work with the applicant to determine how these factors should be prioritized to support selection of homes.

Consideration should be given on best practices for working with ALC patients who identify as First Nations, Inuit or Métis on their options, especially if they have language barriers and/or are far from their support networks.

- Translators/Indigenous language speakers should be used where appropriate.
- Placement co-ordinators should also recognize the importance of prioritizing geographic proximity for Indigenous patients, given the history of relocation and potential traumatization associated with moving an individual far from their home community.
- Ensuring placements within LTC homes where Indigenous language supports are available may be necessary for some Indigenous patients.
- Consideration should be given to LTC homes that are able to provide access to Indigenous staff, Indigenous programming and/or where staff have undergone Indigenous cultural competency.
- Placement co-ordinators should be encouraged to request information regarding Indigenous programming from prospective LTC homes.

Ranking of choices

Placement co-ordinators can consider ranking the LTC homes that they have selected based on proximity to their preferred location. However, the ALC patient should be engaged to determine how homes should be ranked and how other circumstances, such as cultural or religious, should be prioritized.

- These discussions should also set realistic expectations regarding wait times for prioritized LTC homes. This is especially relevant for LTC homes that are primarily engaged in serving the interests of residents of a particular religion, ethnic origin or linguistic origin, which may also be in high demand.

Other

Placement co-ordinators are encouraged to select homes with idle beds or short waitlisted homes within their region and the appropriate geographic parameter,

wherever possible, which will likely have beds available in the immediate term to support patient flow.

There is no minimum or maximum number of LTC homes that a placement co-ordinator can select for an ALC patient. Acknowledging the variation in factors important in meeting the patient's needs, such as geographic limits or cultural circumstances, the number of appropriate LTC homes will also vary.

Placement co-ordinators are encouraged to review the selected LTC homes if there is a significant change in the patient's care needs or they have identified specific circumstances that would require a change (such as their preferred location).

Placement co-ordinators should continue to engage and inform the ALC patient throughout the selection process, while encouraging their participation and consent.

4.2 Seeking Admission Approval to an LTC Home Selected by a Placement Co-ordinator

Placement co-ordinators may share information with a long-term care home licensee to review and determine their approval or non-approval of the admission of the patient to an LTC home selected by the placement co-ordinator . Placement co-ordinators may share patient personal health information with LTC homes as early as possible in the process to support homes in determining if they have the facilities and expertise to be able to meet the care needs of the patient.

If an LTC home withholds the approval of an application, the placement co-ordinator should engage with the LTC home to explore reasons for the rejection and determine if there are opportunities to address barriers to admission. For example, if the reason for rejection was the lack of larger doorways to accommodate oversized beds, specialized supports through the Local Priority Fund could be considered (see section 4.1).

5.0 Waitlist Management

For all ALC patients, the placement co-ordinator will place the patient in category 1 (Crisis Category) of every LTC waiting list on which they are placed, until they can be admitted to a home selected by the patient (unless the patient would otherwise be placed in a higher-ranking category).

5.1 Reunification Priority Access Beds (RPABs)

If an ALC patient meets the criteria for a RPAB, their place on the applicable waitlist for a RPAB would be maintained even if the ALC patient is admitted to a home chosen by

the placement co-ordinator or the ALC patient consents to admission to a home chosen by the placement co-ordinator. The existing placement mechanisms and waitlist categorization continue to apply to support LTC applicants seeking reunification with spouses and partners.

In instances where two spouses are both in hospital waiting for an LTC placement, the placement coordinator must look for opportunities to place them in the same home. The placement coordinator must not authorize admission for either spouse unless there are available placements for both spouses in the same home, or the spouses have consented to separate admissions.

5.2 Strategies for Waitlist Management

Current waitlist management requirements which prioritize individuals within an LTC waitlist category in consideration of their care needs and need for admission continues to apply.

As per existing provisions in s. 200 of the Regulation, individuals with the highest need of admission should be given priority within the crisis waitlist category regardless of current location. Changes to an individual's condition or circumstances should also be considered when determining their level of priority within the waitlist category.

Placement co-ordinators are to take into consideration the urgency for ALC patients to be placed into an LTC home, while balancing the risk of hospitalization for community applicants if they are not placed in LTC imminently.

Where possible, consideration should be given to patients who have been waiting in the hospital as ALC the longest when prioritizing available beds for ALC patients. A regional approach that reflects local contexts in this prioritization strategy is recommended.

Placement co-ordinators are encouraged to conduct regular interviews with those on waitlists to ensure any changes in care needs (through updated assessments), preferences and readiness to be placed into LTC are captured accurately to allow for appropriate prioritization of individuals within waitlists.

6.0 Preferred Accommodation Top-Up

Placement co-ordinators may authorize the admission of alternate level of care (ALC) patients into preferred accommodation in cases where only basic accommodation has been requested by the ALC patient or their substitute decision-maker (or selected by the placement co-ordinator) and, in such a case, the licensee must make the accommodation available as basic accommodation.

The maximum cost difference between preferred and basic accommodation will be reimbursed to the licensee by the Ministry of Long-Term Care (Ministry).

This reimbursement is known as the **Preferred Accommodation Top-Up**.

Eligibility for the Preferred Accommodation Top-Up applies when only basic accommodation has been requested by the ALC patient or their substitute decision-maker (i.e. no request for preferred accommodation has been made). For example, it does not apply when:

- An ALC patient requests both basic and preferred accommodation and is placed in preferred accommodation (semi-private or private), or
- Where an ALC patient selects 'semi-private' accommodation as their only desired class of accommodation and is placed in 'private' accommodation.

Placement co-ordinators can direct the licensee to refer to the *Temporary Measures Funding Policy* (formerly named *COVID-19 Emergency Measures Funding Policy)*, the *Informational Bulletin for Long-Term Care Home Licensees: Preferred Accommodation Top-Up* and any related communications materials from the Ministry for information about the reimbursement process for the preferred accommodation top-up and the reporting requirements.

Placement co-ordinators may share the *Informational Bulletin for (Prospective) Long-Term Care Residents: Preferred Accommodation Top-Up* with ALC patients before authorizing their admission to ensure their understanding about the change in their accommodation, how accommodation charges will work, and the conditions under which the Preferred Accommodation Top-up would stop applying to them. Details provided should include, but are not limited to, the following:

- The maximum cost difference between preferred and basic accommodation, as stipulated by the *Bulletin to Residents of Long-Term Care Homes: Important News Regarding Long-Term Care Home Accommodations Charges*, will be reimbursed to the licensee by the Ministry.
- Once the ALC patient moves into the LTC home (now an LTC resident), the licensee will place them on the internal transfer list for basic accommodation based on the date of their admission, even if they do not explicitly request the transfer.
- During the period that the resident is eligible for the preferred accommodation top-up or once they are transferred to basic accommodation, if the resident is unable to afford the basic accommodation rate, they may be eligible to apply for the Long-Term Care Rate Reduction Program. Please refer to the Co-Pay Bulletin for the applicable rate.

- The Ministry will continue to pay the cost difference until the resident:
    a) transfers to basic accommodation; or
    b) refuses an offer to transfer to basic accommodation (internally or to another LTC home); or
    c) chooses that the resident stay in preferred accommodation

- In scenarios b and c above, the resident may be charged the applicable accommodation rate only if the resident signs an accommodation agreement.
- Additional details can be found in the *Informational Bulletin for (Prospective) Long-Term Care Residents: Preferred Accommodation Top-Up* and the *Temporary Measures Funding Policy* on the terms and conditions that apply to preferred accommodation top-up funding.

7.0 Offer of Admission to an LTC Home Selected by a Placement Co-ordinator

If admission has been authorized to an LTC home selected by the placement co-ordinator, it is important to notify the hospital that an LTC placement has been facilitated and if consent has or has not been provided by the patient or substitute decision-maker.

7.1 Continuing Conversation to Support Getting Consent

If an ALC patient refuses a bed offer in an LTC home that was selected by the placement co-ordinator, placement co-ordinators are encouraged to continue to engage the patient in conversation to explore their concerns or needs and how these can be addressed to get consent.

If a bed offer is refused, placement co-ordinators are encouraged to continue to work with the ALC patient to select other LTC homes where the patient may accept a bed. See section 7.2 for suggested rationale and strategies to support why a transition to LTC would be beneficial.

7.2 Following Refusal of Admission to LTC

If an ALC patient refuses a bed offer to a home selected by the placement co-ordinator, they will remain on all other LTC home waitlists that were selected by both the patient and the placement co-ordinator.

If an ALC patient refuses a bed offer, the discharge team for the hospital should be consulted for more specific information about actions they may take if an ALC patient

who no longer requires treatment in the hospital and is eligible for LTC refuses a bed offer to an LTC home.

If the placement co-ordinator is made aware that the ALC patient refuses to move into the LTC home prior to the five days, they are able to offer the bed to the next person on the waitlist.

ALC patients are not precluded from seeking alternative care options after they are discharged from the hospital. Alternative care options may include seeking private care at home.

Please note that nothing in the *Fixing Long-Term Care Act, 2021* or its regulation allows for the physical transfer from a hospital to a long-term care home without the patient's consent.

7.3 Timeline for Moving into the LTC Home After Accepting an Offer

Once an offer for LTC is accepted, the ALC patient has five days to move into the LTC home.

If the ALC patient does not move into the home before noon of the fifth day following the day on which they are informed of the offer, the placement co-ordinator may offer the bed to the next applicant on the waiting list, unless arrangements were made with the licensee for the patient to move at a later time on the fifth day.

7.4 Transportation to the LTC Home

ALC patients who are discharged from the hospital for admission to an LTC home are responsible for arranging and paying for their own transportation to the LTC home. Hospitals are not required to arrange, provide, or pay for transportation services for people who have been discharged from hospital.

In some cases, hospitals may be able to provide background and contact information to patients and their families about transportation options such as private patient transportation services, wheelchair transportation and stretcher transportation services for patients who must travel in a fully reclined position.

Where the ALC patient has no means to arrange or pay for transportation, the placement co-ordinator should consult with the hospital discharge team and Ontario Health about options and next steps.

8.0 Steps Following Initial Admission

8.1 Following Admission to a Placement Co-ordinator Selected Home

If an ALC patient consented to admission to an LTC home selected by the placement co-ordinator, following admission to the home, the placement co-ordinator must limit the number of remaining waitlists to five and should engage with the ALC patient (now LTC resident) to determine if they still wish transfer to a home from their list of patient-selected homes.

If the resident expresses within the first six months of admission that they wish to apply to another LTC home, the placement co-ordinator will maintain the category 1 (crisis) designation for those five waitlist choices.

At this time, the placement co-ordinator should share with the resident information about the length of the waiting list and approximate time to admission for their preferred home to support the resident in making an informed decision.

See the appendix for a process flow of waitlist management following admission.

8.1.1 If No Additional Home(s) are Selected by the Patient

If an ALC patient is admitted to a home selected by the placement co-ordinator and is not on the waiting list for any other home of their choice, the placement co-ordinator should determine if they wish to select other LTC homes for a future transfer.

The placement co-ordinator should also ensure that the resident understands that they would only qualify for the crisis waitlist category if they selected additional LTC homes within the first six months of admission.

If the resident does not select other homes for transfer within six months of their admission to their current LTC home, the placement co-ordinator may assume the resident's current LTC home has become a patient-selected home.

If the resident selects other LTC homes to apply within six months, the placement co-ordinator should then place them in the crisis category of the waitlist for all of homes they may select (up to five).

If the resident expresses a desire to transfer after the first six months of admission to the LTC home, the placement co-ordinator would then place them based on the normal transfer rules according to the Regulation for the LTC homes they have now selected.

8.2 Following Admission to a Patient-Selected Home

If an ALC patient is placed in an LTC home that was a patient-selected home but it is not their first-choice home, placement co-ordinators should engage with them to determine if they wish transfer to their first-choice home or another home from their list of patient-selected homes.

If the resident wishes to be transferred to another home from their list of patient-selected homes, including their first-choice home, the placement co-ordinator should then place the resident on the waiting list for their patient-selected home(s) in accordance with the waiting list prioritization scheme set out in Regulation. The resident would likely be placed into category 3A/4A "Others" of the waiting list for the home (unless the resident's circumstances warrant placement into a higher category).

At this time, the placement co-ordinator should share with the resident information about the length of the waiting list and approximate time to admission for their preferred home to support the resident in making an informed decision.

8.3 Conditions for Removal from Waiting List

If an ALC patient is admitted as a resident to a placement co-ordinator-selected LTC home, and the resident later refuses an offer of admission to one of the patient-selected

home, the placement co-ordinator is required to remove the resident from all waiting lists.

9.0 Process for Addressing Complaints

9.1 Documentation

To ensure that all components of the ALC-to-LTC transition process are clearly communicated to all relevant parties, including the ALC patient caregiver(s) or family, and other supporting providers, placement co-ordinators should ensure that all actions taken, progress made, and decisions are appropriately and clearly documented. This will support any future need for review, in case of complaints and/or disputes.

9.2 Patient Experience Manager, Client Experience Office and LTC Family Support and Action Line

Placement co-ordinators should communicate to hospital patients and their families the process for communicating their concerns or complaints regarding the service from HCCSS organizations. This may include sharing information about the Patient Experience Manager, Client Experience Office, Long-Term Care Family Support and Action Line (Action Line) and the option of speaking to an Independent Complaints Facilitator (ICF).

If an ALC patient or their family members have any concerns or complaints regarding the service from HCCSS organizations, they can contact the Patient Experience Manager or the Client Experience Office for HCCSS (where these are available) or they can contact the Action Line.

In addition to the Action Line, they also have the option of speaking to an ICF to discuss their concerns. ICFs are located throughout Ontario and are trained to listen to concerns from persons receiving service from LTC Homes and HCCSS organizations.

HCCSS organizations' clients who would like to reach the Action Line can call 1-866-876-7658. To work with an ICF, they would call the same number and then request to work with an ICF.

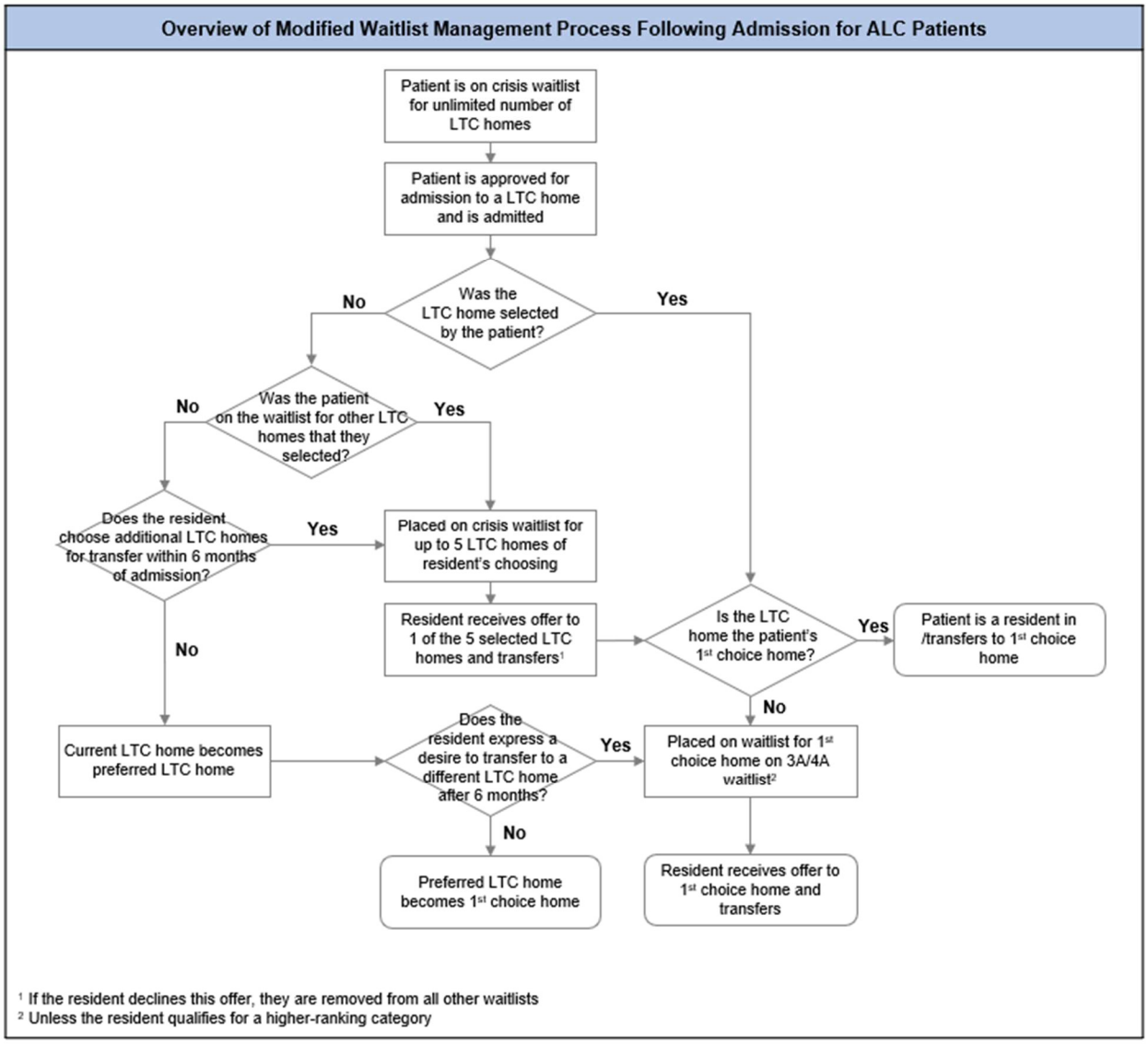
Placement co-ordinators are encouraged to offer to work with patients, applicants and family members to resolve their concerns before they are referred to the Action Line or an ICF.

9.3 Ombudsman Ontario and Patient Ombudsman

Patients and their families may be directed to the Office of The Ombudsman of Ontario in cases of unresolved complaints regarding the Ministry of Long-Term Care.

In cases of unresolved complaints about public hospitals, LTC homes, HCCSS organizations, patients and their families can be directed to the Patient Ombudsman's office.

Appendix

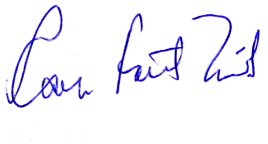

Overview of Modified Waitlist Management Process Following Admission for ALC Patients
Patient is on crisis waitlist for unlimited number of LTC homes
Patient is approved for admission to a LTC home and is admitted
Was the LTC home selected by the patient?
No
Yes
Was the patient on the waitlist for other LTC homes that they selected?
No
Yes
Does the resident choose additional LTC homes for transfer within 6 months of admission?
Yes
Placed on crisis waitlist for up to 5 LTC homes of resident's choosing
No
Resident receives offer to 1 of the 5 selected LTC homes and transfers[1]
Is the LTC home the patient's 1st choice home?
Yes
Patient is a resident in /transfers to 1st choice home
No
Current LTC home becomes preferred LTC home
Does the resident express a desire to transfer to a different LTC home after 6 months?
Yes
Placed on waitlist for 1st choice home on 3A/4A waitlist[2]
No
Preferred LTC home becomes 1st choice home
Resident receives offer to 1st choice home and transfers
[1] If the resident declines this offer, they are removed from all other waitlists
[2] Unless the resident qualifies for a higher-ranking category

This is **Exhibit "B"** referred to in the Affidavit

of **Sandra Iafrate,** sworn this 23rd day of

February, 2024, in accordance with O. Reg 431/20,

Administering Oath or Declaration Remotely



A Commissioner for taking Affidavits etc. (or as may be)

(pursuant to O. Reg. 431/20)

TRANSITIONING FROM HOSPITAL TO LONG-TERM CARE

Leaving the hospital is the next step on your care journey.

Your care provider has informed us that you no longer need acute medical care at a hospital.

In Ontario, you have a range of options to help you get the appropriate care you need. **We have explored these options with you and determined that long-term care may be the most appropriate setting for your care needs.**

If eligible, your admission to a long-term care home is coordinated by placement coordinators at Home and Community Care Support Services. Your placement coordinator will work with you to support your move into a long-term care home that can meet your care needs. The home will be your first choice home or another one that can meet your needs while you continue to wait for your first choice home.

Patients, their families and caregivers are encouraged to visit the long-term care homes discussed. If you are unable to visit the homes, you can view photos, information or virtual tours of Ontario's long-term care homes at ***www.thehealthline.ca***. This will help you get a sense of what the home looks like, where it is located, and meet the people who work and live in the home.

About Long-Term Care Homes

Long-term care homes offer a safe, secure and specialized care environment for people who can no longer live independently because of the high level of care or supervision they require. Long-term care homes are licensed and funded by the Government of Ontario and must meet requirements under the *Fixing Long-Term Care Act, 2021*.

- All long-term care homes are required to meet the same standards of care, regardless of home type, ownership model, location or size.
- Long-term care homes provide a home-like environment and can offer recreational services and social supports.
- Some long-term care homes are better able to provide culturally appropriate, religious and linguistic services; tailoring meals, daily practices and activities to meet these needs.

How is a home selected?

The placement coordinator is here to support you. Our goal is to work with you to find a home that meets your care needs within a 70 km radius of your preferred location(s). Your preferred location(s) can be anywhere in Ontario, and could be the location of your first choice long-term care home, or the location of a caregiver or family member. If your preferred location is in the North East or North West region of the province, the homes selected may be within a 150 km radius of your preferred location or further to ensure we can select a home to meet your needs. Where possible, the care coordinator will consider your religious, linguistic and ethnic preferences when selecting a home.

How long will I have to wait to get into a home that I selected?

Long-term care wait times vary depending on the homes chosen. Please speak with your placement coordinator to discuss wait times for specific long-term care homes.

Why can't I wait in hospital?

A hospital is not a home. Hospitals are not designed to meet an Alternate Level of Care (ALC) patient's restorative, supportive or rehabilitative needs, and while you wait in hospital, you are at risk for hospital-based infections. There are more appropriate settings, such as long-term care, where you can receive the right care in a home-like environment and benefit from social activities like dining, recreation and physical activity. There is evidence that without the social and recreational supports provided in other care settings, you could be at risk for physical and cognitive decline. Your timely admission into a long-term care home will ensure you get the health and personal care required to support your independence, safety and quality of life. As well, other respiratory illnesses may put added pressure on the health system and limit capacity in our hospitals. This impacts all Ontarians, including those who may require hospital care.

What happens if I do not agree to the long-term care admissions process?

If you do not consent to being assessed for admission to long-term care, a placement coordinator will use your hospital and health records, and will consult with your doctor and home and community care providers, to determine your eligibility, where required. If you are eligible for long-term care, the placement coordinator will identify one or more homes within your geographic radius that meet your care needs and share your information with the homes for the purposes of accepting or declining your application. The placement coordinator will continue to keep you informed throughout the process and inform you when a bed becomes available.

What happens to my list of homes if I move into a home that was selected by my placement coordinator?

Patients who move into a long-term care home selected by the placement coordinator will continue to remain on the waitlist in the crisis category for their top five choice homes. Once you have moved into a home, the placement coordinator will contact you to discuss transfer options and work with you to select your preferred homes for a future transfer, if you have not already done so.

I applied for a basic bed and don't have the means to pay for a private/semi-private room that you are offering. Do I have to pay the higher rate for the private/semi-private bed?

The placement coordinator will work with the home directly to make the bed available at the basic accommodation rate. You will only be required to pay for the bed-type that you requested. Once you move into the home, you will be placed on an internal transfer list for basic rate accommodation. When a basic bed becomes available, you will be required to transfer to that basic bed or begin paying the preferred accommodation rate for the current room.

What if I get to the long-term care home and I do not like the home?

If you have concerns about the care in the long-term care home, please speak with the home's Administrator to resolve the issues. You can also contact the ***Long-Term Care Family Support and Action Line*** at 1-866-434-0144 or the ***Patient Ombudsman*** at 1-888-321-0339 to voice your concerns and complaints.

What happens if I do not accept the bed offer?

If you decline a bed offer from a long-term care home, you will continue to remain on the waitlist for the long-term care homes you and the placement coordinator have selected. Regardless of whether the home was selected by you or the placement coordinator, the hospital discharge team will be informed if you decline a bed offer.

Hospitals will charge you a rate of $400 per day if you no longer require acute medical care and have received an offer for a bed in long-term care but choose to remain in hospital while waiting for a setting that best meets your care needs. Patients and substitute decision makers are encouraged to speak with the hospital directly if you have questions or concerns about the fee.

If I am not satisfied with the process, who can I speak to about my concerns?

Please speak with your placement coordinator to discuss any concerns or complaints. The placement coordinator is most familiar with your situation and wants to hear what is going well and what they can do to address your concerns. Your placement coordinator will work with you or your substitute decision maker to address any concerns. If your concern is not addressed to your satisfaction, you can contact your local Home and Community Care Support Services patient experience team. If your concerns are not resolved with Home and Community Care Support Services, you can contact the ***Long-Term Care Family Support and Action Line*** at 1-866-434-0144 or the ***Patient Ombudsman*** at 1-888-321-0339.

For more information:

- 310-2222 (no area code required) | ***www.healthcareathome.ca***
- Long-term care in Ontario: ***www.ontario.ca/page/ministry-long-term-care***
- For virtual tours of Ontario's long-term care homes: ***www.thehealthline.ca***
  Enter your city or postal code in the search field, then search "long-term care homes"
- For long-term care inspection reports: ***http://publicreporting.ltchomes.net/en-ca/default.aspx***

Ontario

ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY (Applicants)	HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO, THE MINISTER OF HEALTH, and THE MINISTER OF LONG-TERM CARE (Respondents)	Court File No.: CV-23-00698007-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

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