Discharge from Hospital to Long-Term Care in the Wake of Bill 7: Important Information You Need to Know

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The Advocacy Centre for the Elderly (ACE) receives hundreds of calls each year with requests for assistance relating to discharge from hospital and admission to long-term care (LTC).

Long-term care homes (LTCHs) in Ontario are publicly funded and governed by the *Fixing Long-Term Care Act (FLTCA),* which was enacted on April 11, 2022[1] and replaced the *Long-Term Care Homes Act* (*LTCHA*), which had been in effect since July 2010.[2] While the *FLTCA* is a new piece of legislation, the bulk of the legislation and regulations remain the same as the *LTCHA.*

However, on September 21, 2022, the *More Beds, Better Care Act*[3] (Bill 7) was enacted and amended the *FLTCA*. The amendments now allow Ontario Health at Home (OHaH)[4] placement co-ordinators to perform certain actions for patients

[1] S.O. 2021, c. 39, Sched. 1.
[2] S.O. 2007, c. 8.
[3] S.O. 2022, c. 16 – Bill 7. For ease of reference the More Beds, Better Care Act, 2022, which was an amendment bill and its regulations will be referred to as "Bill 7" as it is known colloquially, even though the legislation and regulations are now in force.
[4] Previously known as Home and Community Care Support Services (HCCSS) or the Local Health Integration Network (LHIN).

in hospital requiring admission to a LTCH without obtaining consent from the patient/substitute decision-maker (SDM), including: determining eligibility; selecting LTCHs; and, authorizing a patient's admission to a LTCH. Related amendments now require hospitals to charge patients $400 per day when the patient remains in hospital for more than 24 hours following a discharge order.[5]

In this article, we explain the recent changes to the LTCH admission process for patients in hospital. We also address common issues with hospitals and OHaH that patients and SDMs contact our office about.

1. LTC ADMISSION PROCESS

a. Regular Process

Admission to LTC is governed by the *FLTCA*. When a hospital patient is no longer acutely unwell and requires admission to a LTCH, the OHaH placement co-ordinator will be contacted to complete an application in hospital. Contact with OHaH may be initiated by hospital staff, the patient, an SDM or family members. OHaH placement co-ordinators are responsible for determining eligibility and keeping information up-to-date, processing applications to LTCHs, authorizing admissions, and keeping waiting lists.[6]

While awaiting LTC placement in hospital, the person should be designated by the attending clinician[7] as an "Alternate Level of Care" or "ALC" patient. This means that the person is in hospital and the attending clinician is of the opinion that the person no longer requires the intensity of resources or services provided in the hospital care setting.[8]

[5] R.R.O. 1990, Reg. 965, s. 16(3.1).
[6] *FLTCA*, s. 48-50; O. Reg. 246/22 s.182.
[7] In most cases, this will be the attending physician, nurse practitioner O. Reg. 965 s. 16(6).
[8] *FLTCA*, s. 60.1(1).This definition of "ALC" is very problematic with this population as it is subjective and there are often disputes regarding whether the person is truly ALC, and if they are, what the appropriate destination is.

To determine eligibility and the ALC patient's care requirements, the OHaH placement co-ordinator will require that the following assessments be completed for the patient:

i) physical and mental health, and requirements for medical treatment and health care (completed by a doctor or nurse in the required form);

ii) ii) functional capacity, requirements for personal care, current behavior, and behaviour during the previous year; and

iii) any other assessments or information provided for in the regulations.[9]

The OHaH placement co-ordinator will use this information to complete the Resident Assessment Instrument (RAI) assessment. Once completed, a score is generated indicating the level of care required which assists the placement co-coordinator in determining eligibility for admission to LTC. An evaluation of the patient's mental capacity to make placement decisions will also be completed to determine whether the patient is able to make their own decision about placement in a LTCH.[10] If the patient is not mentally capable of their own placement decision, their highest-ranking SDM will make the decision on their behalf.[11]

Once an ALC patient is determined to be eligible for admission to LTC,[12] the patient/SDM will be asked to select LTCHs to which they wish to apply. The placement co-ordinator will provide the patient/SDM with information about the process for being admitted to LTCHs: choices the patient/SDM has and implications of those choices; alternative services; the patient's responsibility to pay LTCH accommodation fees and the maximum amounts that may be charged; rate reductions that are available and application requirements; approximate length of waiting lists; vacancies; and how to obtain information (including inspection

[9] *FLTCA*, s. 50(4).
[10] *Health Care Consent Act, 1996,* S.O. 1996, s. 2, Sched. 2, s. 40(1). Until a person is evaluated and found incapable of making a decision, no one else can make a personal care decision for them, even if the person has named someone as their attorney in a power of attorney for person care.
[11] *HCCA* s. 20.
[12] If the person is found to be ineligible for LTC, they may apply to the Health Services Appeal and Review Board for a review of the determination of ineligibility. *FLTCA,* s. 60.1(8).

reports) from the Ministry of Long-Term Care.[13] Where the patient/SDM wishes, the OHaH placement co-ordinator will assist them in choosing LTCHs.[14] When choosing homes, the placement co-ordinator must consider the patient's preferences relating to admission based on ethnic, religious, spiritual, linguistic, familial and cultural factors.[15] The patient/SDM may choose any LTCH in the province of Ontario and the placement co-ordinator shall work with the OHaH in that area regarding the application.[16]

The OHaH placement co-ordinator will then provide each selected LTCH with a copy of the patient's assessments and information.[17] LTCHs have five business days to review the patient's application and either approve or deny their admission.[18] Where a LTCH requests further information from the placement co-ordinator about the patient, the LTCH has an additional three business days to approve or deny the patient after receiving this information.[19]

Once the patient is approved by the home, the OHaH placement co-ordinator will add the patient to the home's waitlist and will contact the patient/SDM once a bed offer becomes available. Patients/SDMs typically only have 24 hours to accept or refuse a bed offer.[20] Patients can hold a bed for up to five days by paying the accommodation rate before losing the bed. The patient must move in before noon on the fifth day and must pay the applicable accommodation rate even if they do not move in on the fifth day.[21] However, patients would not be penalized if there are reasons beyond their control that prevent them from moving into the home within this timeframe, such as the patient suffering from a health condition, short-term illness or injury, or an emergency or outbreak of disease at the home.[22]

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[13] O. Reg. 246/22, s. 171.
[14] *FLTCA*, s. 51(3).
[15] *FLTCA,* s. 51(4).
[16] *FLTCA,* s. 51(6).
[17] O. Reg. 246/22, s. 178.
[18] O. Reg. 246/22, s. 179(4).
[19] O. Reg. 246/22, s. 179(5).
[20] O. Reg. 246/22, s. 203(e).
[21] O. Reg. 246/22, s. 203(f).
[22] *ALC patients who refuse an offer of admission to a prior-chosen LTC home bed*, Memo of Rachel Kampus, ADM(A), Ministry of Health and Long-Term Care, Health System Strategy and Policy Division, May 12, 2012.

Currently, ALC patients in hospital waiting for admission to LTC are designed as "Category 1 - Crisis"[23] for all LTCH choices, which puts them in one of the highest waiting list categories. Persons in the "crisis category" are not restricted to applying to a maximum of five homes and may apply to mores LTCHs if they wish.

If a patient in hospital has already applied for LTCH admission while in the community, OHaH may be required to update the patient's LTCH application to ensure that the most up-to-date information is available.[24] A new evaluation of capacity may be required if it appears the patient's capacity to make the decision has changed.[25]

b. Bill 7 Amendments

The amendments resulting from Bill 7 modified the admission process for ALC patients requiring admission to a LTCH. OHaH placement co-ordinators are now authorized to take the following actions, with or without the consent of the ALC patient/SDM:

- Commence an application for admission to LTC on behalf of a patient;
- Determine the ALC patient's eligibility for admission to a LTCH;
- Collect and release personal health information from a variety of sources and provide the LTCH with assessments and information, including personal health information;
- Select LTCH(s) for the ALC patient in accordance with the prescribed geographic restriction;
- Authorize the ALC patient's admission to a LTCH; and,
- Transfer responsibility for the placement of the ALC patient to another placement co-ordinator who, for greater certainty, may carry out the actions listed above with respect to the ALC patient.[26]

[23] O. Reg. 246/22, s. 240.3(2).
[24] *FLTCA* s. 51((11).
[25] *HCCA* s. 4(3).
[26] *FLTCA*, s. 60.1(3)2.

The amendments also allow an attending clinician who reasonably believes that a patient in hospital may be eligible for LTCH admission to contact the OHAH placement co-ordinator and request that any or all of the above actions be carried out, with or without the patient/SDMs consent.[27]

The OHAH placement co-ordinator, as well as a physician or registered nurse (who is not employed by OHaH) are now permitted to determine eligibility for LTC dmission for an ALC patient in hospital.[28] While an ALC patient cannot be forced to participate in an assessment to determine eligibility, if they refuse, their eligibility will be determined without their co-operation based on all information available to the placement co-ordinator at the time.[29] Information can be now be collected, used and disclosed to the OHAH placement co-ordinator from a variety of sources, without the patient/SDM's consent, to determine the patient's eligibility for LTC admission or to carry out their admission to a home.[30]

Once the ALC patient is determined to be eligible for admission to a LTCH, the OHaH placement co-ordinator will provide the patient/SDM with information about the approximate length of waiting lists in relevant LTCHs, vacancies in relevant LTCHs, and how to obtain information (including inspection reports) from the Ministry of Long-Term Care.[31] At that point, if the patient/SDM refuses to apply to LTCHs or refuses to add additional homes (particularly homes with idle beds or short-waitlists where admission would occur within six months or less),[32] the OHaH placement co-ordinator will select one or more homes for the patient without consent.[33]

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[27] *FLTCA,* s. 60.1(3)1.
[28] *FLTCA,* s. 60.1(3)3. However, given the overall lack of knowledge by doctors and nurses of the placement process s and eligibility criteria, it is likely that the OHaH placement co-ordinators will continue to determine eligibility in most cases.
[29] O. Reg. 246/22, s. 240.1(8).
[30] Sources include hospitals, primary care providers, home and community care service providers, community mental health and addiction services, and agencies under the *Services and Supports to Promote the Inclusion of Persons with Developmental Disabilities Act, 2008.* O. Reg. 246/22, s. 240.1(8)-(11); s. 240.2(10).
[31] O. Reg. 246/22, s. 240.1(5), 240.2(1)
[32] *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, (*vers. 2); Government of Ontario: April 11, 2023, page 10.
[33] O. Reg. 246/22, s. 240.2(2).There is no set number of homes the OHaH placement co-ordinator must select for the ALC patient.

When selecting LTCHs without consent, the OHaH placement co-ordinator must consider the ALC patient's condition and circumstances, class of accommodation requested (if any), and the proximity of the home.[34] If no class of accommodation has been selected, the placement co-ordinator will select basic accommodation.[35] LTCHs selected by the placement co-ordinator must be within 70 km of the patient's "preferred location", which is the address supplied by the patient/SDM. If no preferred address is provided, then it is either the patient's primary address or, if there is none, the hospital.[36]

If the patient's preferred location is in the North East or North West OHaH region, homes selected by the placement co-ordinator must be within a 150 km radius of their preferred location. However, if there are no homes with vacancies within the 150 km radius, the placement co-ordinator will choose the next closest home or homes to the patient's preferred location.[37] Additionally, OHaH placement co-ordinators have been "encouraged" by the government to select LTCHs with idle beds and short-waitlists.[38]

The OHaH placement co-ordinator will then provide each LTCH with the patient's assessments and information (including personal health information). This includes homes selected by the placement co-ordinator which the ALC patient/SDM did not consent to.[39]

OHaH placement co-ordinators can now authorize a patient's admission to a LTCH selected by the placement co-ordinator.[40] While a person cannot be physically transferred to a LTCH without consent, if the ALC patient/SDM refuses a bed offer to a home that they have selected OR refuses to move to a LTCH selected and authorized by the OHAH placement co-ordinator without their consent AND the patient remains in hospital, a discharge order would likely be signed. If the patient remains in hospital more than 24 hours after the discharge order is signed, the hospital is legally required to begin charging the patient $400 per day for each day

[34] O. Reg. 246/22, s. 240.2(5).
[35] O. Reg. 246/22, s. 240.2(6).
[36] O. Reg. 246/22, s. 240.2(12).
[37] O. Reg. 246/22, s. 240.2(7) & (8).
[38] *Field Guide,* page 13.
[39] O. Reg. 246/22, s. 240.2(10).
[40] *FLTCA,* s. 60.1(3) iv; O. Reg. 246/22, s. 240.3(5).

they remain in hospital.[41] The ALC patient will also be removed from the waitlist for the refused home, but will continue to remain crisis on the waiting list for all remaining homes while in hospital.[42]

It is important to understand that if an ALC patient moves into a LTCH selected by the ALC patient/SDM, the patient would drop in category on the waiting list to transfer to any higher choice homes (i.e. would not maintain their "crisis" status on the waiting list to transfer). In contrast, if an ALC patient/SDM agrees to move into to a LTCH selected and authorized by the OHaH placement co-ordinator, the patient would remain on the crisis category to transfer for up to five preferred homes.[43] OHaH placement co-ordinators can also authorize a patient's admission to preferred accommodation even if only basic accommodation has been requested. The patient would still be charged the basic rate and can apply for any applicable rate reduction.[44] However, the patient would be placed on the LTCH's internal transfer list for basic accommodation.[45] Once basic accommodation becomes available, if the patient refuses to transfer, they will be charged the preferred rate as designated for that room.[46]

The changes resulting from Bill 7 remove the fundamental rights of choice and consent in the placement process for ALC patients in hospital, which we believe to be contrary to the Canadian *Charter of Rights and Freedoms*.[47] However, if the ALC patient/SDM changes their mind and decides to consent at any time during the admission and placement process, the OHaH placement co-ordinator must ensure that all the requirements of the *FLTCA* are now met, including those related to consent.[48]

Section 52 sets out the requirements for consent under the *FLTCA*.

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[41] R.R.O. 1990, Reg. 965, s. 16(3.1).
[42] This is different from applicants in the community. If a person in the community refuses a bed offer in a LTCH applied to they previously applied to, the placement co-ordinator will remove the person from every waiting list they are on. The person must wait at least 12 weeks before they can start a new application, unless there is a deterioration in their condition or circumstances. O. Reg. 246/22, s. 184(1).
[43] O. Reg. 246/22, s. 240.3(11).
[44] O. Reg. 246/22, s. 240.3(6).
[45] O. Reg. 246/22, s. 240.3(7).
[46] O. Reg. 246/22, s. 240.3(8).
[47] See www.acelaw.ca for information about our Charter challenge.
[48] *FLTCA*, s. 60.1(6).

Elements of consent

52 (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 their 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.[49]

Where there is an SDM, the placement co-ordinator has an obligation to advise them of the decision-making rules contained in section 42 of the *Health Care Consent Act (HCCA),*[50] as follows:

Principles for giving or refusing consent

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

[49] *FLTCA*, s. 52.
[50] *M.A. v. Benes*, 1999 CanLII 3807 (ON C.A.).

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.[51]

The placement decision-making requirements for SDMs are restrictive, meaning that they can only make their decision in accordance with these principles. This was not changed by Bill 7. This creates conflict for the SDM when trying to make LTCH choices as they are often being pressured to apply to homes that they do not believe are in the ALC patient's best interests.

Additionally, OHaH placement co-ordinators must make "reasonable efforts" to obtain the consent of the ALC patient/SDM before they can act without consent.[52] "Reasonable efforts" are not defined in the *FLTCA.* However, the OHaH placement co-ordinator must continue to engage the ALC patient/SDM at each stage of the admission process and obtain consent whenever possible. The placement co-ordinator must also explain the consequences of not consenting.[53] However, there is no requirement that they explain the consequences of consenting, which may have a fundamental impact on the placement process as will be discussed in the next section.

2. COMMON ISSUES

a. Hospital discharge "policies"

Hospitals often tell patient/SDMs that LTCH assessments cannot be completed in hospital. Patients may be told that they must return to the community to be assessed and wait for LTCH admission. This is not true. Individuals have the legal right to be assessed for LTC in the hospital OR in the community by OHaH placement co-ordinators. Hospitals cannot interfere in this process. Also, once a patient has been deemed eligible for admission to a LTCH, they can legally stay in the hospital to await LTC placement.

[51] *HCCA, 1996,* S.O. 1996, c. 2, Sched...A, s. 42.
[52] *FLTCA,* s. 60.1(4).
[53] O. Reg. 246/22, s. 240.1(5) (d) & (e).

Regulations to the *Public Hospitals Act* require a person to leave the hospital no later than 24 hours after a discharge order has been made.[54] Looking at this provision, it would appear that once a patient no longer requires treatment, they must be discharged from hospital, with the only exception being a 24-hour grace period. However, the reality is that there are many people in hospital who no longer require treatment but are allowed to stay until their discharge destination, such as a LTC home, becomes available. Hospitals rely on this section of the legislation to require people to comply with their internal "policies". However, we do not believe that these policies are supported in law.

One must understand that it is the attending physician, nurse practitioner, midwife, or dentist who is an oral and maxillofacial surgeon who discharges, not the hospital or discharge planner. In almost all cases, it would be the attending or "most responsible" physician who must discharge. However, the physician owes the patient a duty of care to discharge them to a safe place. LTCHs are part of our healthcare system, and as such, the person is entitled to a seamless transition from one level to the next.

The regulations to the *Health Insurance Act*[55] specifically contemplate that patients will have to wait in hospital until a LTC bed is available. The government has set a maximum daily fee that can be charged while the ALC patient is waiting for placement from hospital into a LTCH (known as the "hospital chronic care co-payment"' or "ALC co-payment"). It is the same maximum amount that a resident in basic accommodation in a LTCH can be charged,[56] subject to any applicable rate reduction.[57] It is therefore clear that those patients waiting for LTCH admission are allowed to remain in hospital until placed, and should not be discharged within 24 hours of no longer requiring acute care.

However, staying in the hospital for any great length of time is also not ideal. The likelihood of a patient deteriorating while waiting for placement, including loss of

[54] R.R.O. 1990, Reg. 965, s. 16.
[55] R.R.O. 1990, Reg. 552.
[56] Effective July 1, 2023, the maximum co-payment amount is $65.32 per day or $1,986.82 per month, subject to any applicable rate reduction.
[57] The rate reduction in hospitals differs from that in LTCHs, see s. 2(e) Issues with Hospital ALC Co-Payment below.

mobility and incontinence, is high. There is also increased risk of contracting hospital-borne infections. Nevertheless, for some patients there is no safe place for them to wait in the community and they have to stay in the hospital to await LTC placement. There is often a dispute with the physician/hospital/OHaH as to what a "safe discharge" is. This will be discussed in section 2(c) below.

It is possible that the attending clinician could sign a discharge order requiring the patient to return to the community. If the patient/SDM disagrees with the discharge plan and refuses to leave the hospital within 24 hours of the discharge order being signed, the hospital would begin charging the patient $400 per day to remain in hospital. If a clinician discharged a patient unsafely to a place that cannot meet their care needs, that could be grounds for a complaint to their professional college or for potential civil litigation.

b. Refusal by OHaH to determine eligibility/take application from hospital patients

OHaH placement co-ordinators are increasingly refusing to take applications for admission to a LTCH from hospital patients.

Patients are being told that they must return to the community before a LTCH application will even be taken. The Ministry of Long-Term Care's *Field Guide* states, "Home First should be explored as the preferred discharge destination before LTC is considered".[58] However, the *Field Guide* only states that "Home First" should be explored: it does not make it mandatory.

Patients are also being told that OHaH policy "requires" a referral from the hospital social worker or other hospital staff worker in order for OHaH to take the application. In many cases, it is the hospital staff who are actively blocking the patient from being assessed.

This is contrary to the legislation, which requires that an application be taken and eligibility determined, upon request.

[58] *Field Guide*, page 7.

The results is that that people who cannot be managed at home, or who have no home to return to, are being told that they must leave the hospital before they are even allowed to apply for admission to LTC. Such rigid "policies" and misinformation are not only against the interest of patients, but they are dangerous to those very individuals that the OHaH has an obligation to assist. These policies only serve to assist hospitals with their bed capacity issues: they are not created for the benefit of patients.

The law is clear that where requested, the placement co-ordinator must complete an application and determine eligibility for admission to LTC, even if the patient is in hospital.

OHaH placement co-ordinators also cannot refuse to take an application because they have pre-determined that the person might be ineligible. If an application for admission to LTC is completed and the person is determined to be ineligible for admission to LTC, then the applicant may have that finding reviewed by an administrative tribunal called the Health Services Appeal and Review Board (HSARB). If an application is not completed, then the person's right to apply to have the finding of ineligibility reviewed by HSARB is negated.[59] Therefore, if the patient/SDM believes that an application is warranted, they must demand that it be completed, so that they can pursue their right to challenge any finding of ineligibility for admission to LTC.

c. Discharge "choices" pending LTC admission

Hospital patients are routinely told that they cannot stay in hospital to await LTCH placement. Patients are often given one of the following so-called "choices": return home or live with family; go to a retirement home; be admitted to a short-term transitional care unit; or go to a residential care facility to wait for admission to LTC. In some cases, patients have even been told they should go to, and in fact have been sent to, homeless shelters to await placement into a LTCH.

[59] *FLTCA*, s. 50(9).

First, the fact that a person has been deemed eligible for LTC admission means that their care needs cannot be met in the community using available publicly funded community-based services and other caregiving, support or companionship arrangements available to the person. While the OHaH placement co-ordinator has an obligation to advise hospital patients about other options that they may wish to consider,[60] a person cannot be forced into one of these "options" outside the healthcare system when they have been deemed eligible for admission to a LTCH.

Under the "Home First/Wait at Home" strategy, hospital patients are encouraged to return home with increased levels of care from OHaH, in the hopes that they can either wait at home until a LTCH bed becomes available, or until a LTCH bed is no longer required. However, what patients are not told is that this increased level of care is generally only provided for a limited amount of time. After a few weeks, services start being pulled back. If the person is not admitted to a LTCH within that period, they would be without the care and services that they require, putting them at serious risk.

Family members are often told that they "must" care for the patient at home. Family members cannot be forced to care for a person. In fact, if a person who had been providing care says they are not able to safely do so any longer, it could be negligent to discharge the patient into that person's care.

Patients are regularly told that they must go to a retirement home pending LTCH placement. Retirement homes not LTCHs. Rather, they are residential tenancies where meals and care services are also purchased.[61] They are not equivalent to LTCHs, and they are not part of the healthcare system.[62] While some people choose retirement home living even when they are eligible for a LTCH, one cannot be forced into a retirement home as an alternative to a LTCH. Not only are retirement homes less stringently regulated with less detailed caregiving standards, they are entirely private-pay and they are entirely outside of the healthcare system.

[60] O. Reg. 246/22, s. 171(1).
[61] Retirement homes come under the definition of "care homes" which are tenancies under the *Residential Tenancies Act, 2006*, S.O. 2006, c. 7.
[62] Retirement homes must be licensed and there is a process for reporting improper treatment, abuse and neglect to the Retirement Home Regulatory Authority. However, their ability to inspect and take action when problems are found is limited.

Patients might also be told that they must go to a "short-term transitional care unit" pending LTC placement.[63] Community-based short-term transitional care units are not a part of the hospital, and they are located in retirement homes or other kind of congregate living setting. The care is typically provided by a private caregiving service. Short-term transitional care units are not regulated, licensed, inspected or overseen by either the Ministry Long-Term Care or any other Ministry, and they are not required to meet the same standards as LTC beds. Those units located in retirement homes are not part of the retirement home and so are not inspected by the Retirement Home Regulatory Authority (RHRA) or required to comply with the *Retirement Homes Act*. In fact, people living in those units report that they are often not allowed to participate in retirement-home programming. Beds in other non-retirement-home facilities are similar in that the accommodation is usually not governed by any legislation regulating care standards. In fact, some of these facilities, whether in retirement homes or other congregate care settings, may be operating illegally contrary to s. 98 of the *Fixing Long-Term Care Act* and/or s. 33 of the *Retirement Homes Act*. Short-term transitional beds may be appropriate temporary accommodation for those who will eventually be discharged to the community, but they are often not appropriate for people who require admission to a LTCH.

Lastly, there is an increased number of patients being referred to residential care facilities, loosely referred to as "retirement homes", but some of these homes are not able to obtain a retirement-home licence[64] and they are in fact operating illegally. Others are operating as unlicensed group homes. The care in these facilities are also not governed by any legislation or standards.

These units and facilities do have to meet other legal criteria, such as public health and fire safety codes, so if there are issues in these areas public health units and fire service agencies can be contacted for assistance.

[63] Determining the status of these facilities can be tricky as some are part of a hospital, and some are not, and there is often not a clear way of determining this as during COVID, hospitals were allowed to designate space in retirement homes and hotels as being part of the hospital. These units are NOT listed on the government website listing public hospital locations and may be staffed by hospital or third party employees. We have also had issues relating to these units as they may try to operate in non-hospital ways in certain situations. If you are unclear, we suggest you seek legal advice on the status of the beds.

[64] Licenses can be checked at: <www.rhra.ca>.

Bottom line, patients deemed eligible for admission to LTC are not required to select any of these "choices" outside the healthcare system when they have been deemed eligible for and require admission to a LTCH. It is something that someone may wish to do if it meets their needs. One must also be aware that if you are admitted to one of these units you are not guaranteed to be a crisis category for admission to your homes of choice. You will need to discuss this with the placement co-ordinator prior to accepting such a bed.

d. Misinformation regarding home choices

Hospitals/OHAH often have "policies" that ALC patients/SDMs are told that they must comply with when selecting LTCHs. For example, patients/SDMs are frequently told that they must select a certain number of LTCHs or must select LTCHs from a short-list, and if they do not, their application will not be "accepted" by the placement co-ordinator. This is not legal.

There is no requirement that an ALC patient/SDM "must" select a certain number of LTCHs or must select LTCHs from a short-list. Many of the LTCHs included on "shortlists" are homes with idle beds and short wait lists because they have difficulty in attracting residents for some reason. For example, the LTCH may be in a bad location, the physical facility may be a problem due to age or poor upkeep, or they may have a poor inspection record.[65]

Despite being told that they "must" comply with these "policies", this is not the case. The consent would not comply with the legal requirements of informed consent, as it would be based on misinformation.[66] Further, if an SDM were to give substitute consent to admission to a LTCH that the ALC patient, while capable, clearly indicated they would not want to be admitted to, or that the SDM did not believe could meet their needs, they would be in violation of section 42 of the *HCCA*, as it would violate the principles for giving or refusing substitute consent. While the OHAH placement co-ordinator can apply to and authorize a patient's

[65] Inspection reports on LTCHs can be found on the Ministry of Long-Term Care's website: <http://publicreporting.ltchomes.net/en-ca/default.aspx>.
[66] *FLTCA* s. 52.

admission to a LTCH selected by the placement co-ordinator without the patient/SDMs consent in some circumstances, the patient/SDM is not "required" to select LTCHs that are not satisfactory and that they do not want to go to.

Also, it also important to understand that any LTCH a patient/SDM includes on their choice sheet (even ones which they are pressured into adding from a "short-list" that they are told will only be temporary) become one of their "preferred homes". If a patient is then admitted to that home, the patient is no longer designated as being on the crisis list for transfer to another LTCH, as it is a home that they "chose". As a result, the patient is unlikely to ever transfer to one of their higher choice homes because individuals in the crisis category will always take precedence. In contrast, in cases where the placement co-ordinator chooses homes without the patient/SDM's consent and the patient is admitted to that home, the patient retains their crisis status for up to five home choices. While people designated as crisis in the hospital and the community awaiting admission to LTCH will still take precedence within the crisis category, these individuals still have a higher likelihood of transferring to one of their true preferred homes than those who were coerced by the placement co-ordinator to "choose" one or more short-listed home, thereby losing their crisis status for transfer.

Next, some patients/SDMs are told that a patient in hospital cannot be designated as crisis in hospital for admission to a LTCH or can only be designated as crisis if the patient selects homes in accordance with a hospital "policy". This is not true, and it is not legal. There is no requirement that a patient must comply with an illegal hospital policy to be designated as crisis for LTCHs in hospital. The law is clear: the OHAH placement co-ordinators must designate all ALC patients in hospital waiting for admission to LTC as crisis for all LTCHs that are on their choice sheet.

Again, it is the obligation of the OHAH placement co-ordinator to ensure that where consent for admission to LTC is given, the consent is valid, meaning it complies with the *FLTCA* and the *HCCA.* If LTCH "choices" are made based upon misinformation, such as ALC patients/SDMs being told that they "must" choose a certain number of homes or they "must" choose homes from a short-list, then the consent is not legally valid and cannot be accepted by the OHAH placement co-ordinator.

Where an OHaH placement co-ordinator does not comply with the law, a complaint should be made to management of the OHaH directly, as well as to the Long-Term Care Family Support and Action Line (Tel: 1-866-434-0144). While the Ministry of Long-Term Care does not directly inspect hospitals, we also recommend that complaints regarding illegal hospital placement policies be sent to both the Ministries of Health and Long-Term Care.

e. Issues with Hospital "ALC Co-payments"

The chronic care co-payment (sometimes referred to as the "Alternate Level of Care" or "ALC" co-payment) is a fee that hospital may charge ALC patients for the cost of meals and accommodation in certain circumstances while in hospital pursuant to section 10 of the regulations to the *Health Insurance Act*.[67] It is the same maximum amount that residents in basic accommodation in LTCHs are charged, subject to any applicable rate reduction. Rate reductions in hospital are calculated differently than in long-term care. Effective July 1, 2024, the maximum co-payment amount is $66.95 per day or $2,036.40 per month.

The ALC designation in itself does not mean the patient can be charged the chronic care co-payment. An ALC patient can only be charged the co-payment if they meet all the requirements set out in the regulation.[68] First, a doctor must designate the patient as either being chronic care, or more or less permanently resident in a hospital or LTCH. Second, the patient must be receiving insured in-patient services in a certain category of hospital as set out in the regulations. Additionally, certain patients cannot be charged the co-payment, such as patients receiving income support from ODSP/OW, patients receiving palliative care,[69] patients admitted to hospital under the *Mental Health Act,*[70] patients in a slow-stream rehabilitation bed, or patients whose ultimate discharge destination is back to the community.[71] It is very common for hospitals to try to charge patients the co-payment when in fact the patient is exempt from such charges.

[67] R.R.O. 1990, Reg. 552, s. 10.
[68] Reg. 552, s. 10(1) & (2)
[69] The patient does not have to be admitted as a palliative care patient for the exemptions to apply.
[70] *Health Insurance Act*, R.S.O. 1990, c. H.6, s.46.
[71] This includes patients waiting for a short-stay convalescent care bed in a LTCH or for home care, supportive housing, retirement home, etc.

Rate reductions are available for low-income patients and patients with dependents. The rate reduction is calculated based on the patient's estimated CURRENT TAXABLE income less a comfort allowance of $149 per month to cover the cost of personal expenses.[72] Some proof of income must be provided, which can be bank statements, an income-tax Notice of Assessment, etc. If using a Notice of Assessment, taxable income is found on line 260. (The following are examples of non-taxable income that cannot be included in the calculation: Guaranteed Income Supplement, Spousal or Survivor Allowance under the Old Age Security (OAS) pension, Ontario GAINS payments, WSIB payments, Universal Child Care Benefits, and payments from a Registered Disability Savings Plan (RDSP).) It is very common for hospitals to overcharge patients as administrators are not properly trained in rate reductions and there is no oversight of their work.

Generally, a rate reduction calculation is based only upon the patient's income. If a patient's spouse has a high income, the spouse's income cannot be included when calculating the patient's rate reduction. However, if there are dependents as defined in the regulations[73] and including them would lower the rate the patient had to pay, this should be done. The rate reduction for qualified dependents (which includes spouses under the age of 65 and children under age 18) of hospital patients is more generous than that available in LTCHs.[74] Where there is a spouse aged 65 or older, if they are entitled to receive either OAS or GIS, they are not classified as dependents; however, if they are very low income they may be able to claim a small rate reduction as well.[75]

Next, hospitals frequently do not tell the ALC patient or their attorney for property that they are going to start charge the co-payment; or, alternatively, they fail to charge the co-payment (often due to disputes over the discharge destination of the patient) and then try to illegally "backdate" it to when they now claim it "should" first have been charged. If this happens, the patient or their attorney for property

[72] This is different from the rate in LTCHs, which is calculated using NET INCOME from the previous year's notice of assessment.
[73] Reg. 552, s. 10(11).
[74] The form to be completed is Form 3264-54 E/F "Hospital Chronic Care Co-payment Form"
[75] The form to be completed is Form 3266-54 "Application for Reduction of Assessed Co-payment fees".

should complain to the hospital and only pay after the date they were notified that a co-payment would apply.

Hospitals also may "require" family members to sign a guarantor agreement consenting to be personally responsible for any outstanding co-payment or other hospital charges. This is not legal. The co-payment is owed by the patient only.[76] Family members, SDMs and attorneys for property are not responsible to pay the chronic care co-payment and should not sign these agreements.

Lastly, where a patient has private insurance to cover the cost for a semi-private or private room in the hospital, they should be aware that, generally, insurance companies will not cover the cost of a semi-private or private room once the patient is designated as "ALC". The patient should immediately contact their insurance company to check their coverage, and if not covered, must notify the hospital that they no longer want a semi-private or private room. Otherwise, they could be personally responsible to cover the cost of a semi-private or a private hospital room, which can run to several hundreds of dollars per day.

CONCLUSION

There is, unfortunately, a great deal of misinformation given to patients and their SDMs concerning the process of applying for admission to a LTCH from hospital. The issue has only been exacerbated by the enactment of Bill 7, which can result in the removal of the fundamental right of choice and consent for hospital patients in the placement process. It is hoped that by having the correct legal information, ALC patients and their SDMs will have the tools to better advocate for the patient's rights during this extremely challenging time.

[76]Reg. 552, s. 10.