# ACE NEWSLETTER

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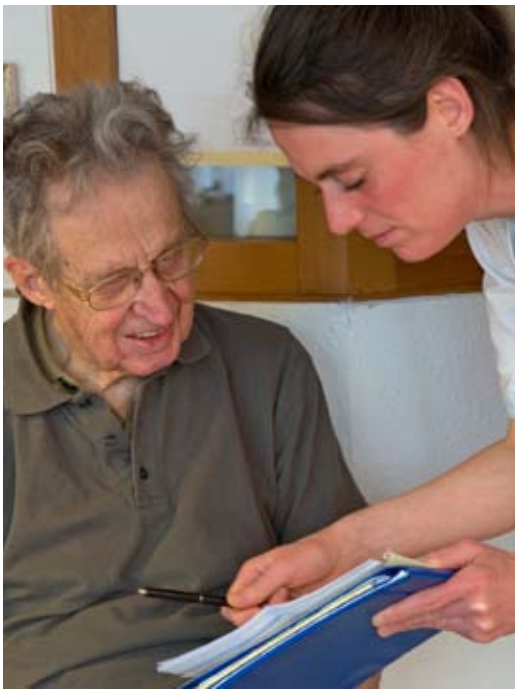
## IN THIS ISSUE



# THE ROLE OF COMMUNITY CARE ACCESS CENTRES IN ADMISSION TO LONG-TERM CARE FROM HOSPITAL

*By Jane E. Meadus, Institutional Advocate & Staff Lawyer*

Being admitted from hospital to a long-term care home can be difficult and traumatic at the best of times. Often, the person has been coping well at home when they become ill and require hospitalization. Due to deteriorating health, they then require long-term care. The person may never have considered this option but is suddenly having to make life-altering decisions under a great deal of pressure.



### HOSPITAL POLICIES

Many hospitals have implemented policies regarding placement into long-term care homes to help the hospital deal with bed shortage issues. These policies generally consist of requirements or restrictions on the choice of long-term care homes. Policies may require that patients "choose" a specific home, or one from a specific "short list", which may not be the homes that the person wants.

We do not believe such policies comply with the current legislation. However, we have a large number of callers requesting assistance when confronted with these hospital policies. In the past, we have advised the caller to deal directly with the Community Care Access Centre (CCAC) to arrange placement. Unfortunately, we have recently been hearing from callers that the CCAC is part of the problem, not the solution.

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# ACE – THE FIRST 25 YEARS

*By Judith Wahl, Executive Director & Staff Lawyer*

It's hard to believe that as of 2009, the Advocacy Centre for the Elderly (ACE) has been in operation for 25 years! ACE opened for service in 1984 with four staff members - two lawyers, an office manager and a community legal worker. Over time, it has grown to its present size of eight staff - five lawyers, two support staff and an office manager. We have been fortunate to have had very little staff turnover with many of the same staff working at ACE throughout a large part of its existence.

A community Board of Directors that ranges in size from 12 to 15 members manages ACE. Many of the members have been on the Board for the maximum term (two terms of three years). In fact, several Board members have returned after a short gap year for yet another term. The ACE staff thanks the Directors for their hard work and dedication.

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# USING RETIREMENT HOMES AS WAY STATIONS BETWEEN HOSPITALS AND LONG-TERM CARE HOMES: WHAT YOU NEED TO KNOW

*By Judith Wahl, Executive Director & Staff Lawyer*

Hospitals across Ontario lack available acute care beds as a portion of these beds are occupied by patients who no longer require acute care services. These patients are referred to as "alternative level of care" or "ALC" patients. ALC patients no longer require acute care but are not able to be discharged home, as they still need another level of health care, such as complex continuing care, rehabilitation or long-term care. Unfortunately, due to a shortage of spaces, these patients have no option but to wait in hospital pending transfer.[1]

Recently, ACE staff have learned about special programs being offered to ALC patients awaiting transfer to a long-term care home (LTCH). Hospitals are entering into agreements with local retirement homes to temporarily house patients, instead of allowing patients to wait in hospital. Additional care and nursing supports for patients staying in the retirement home may also be provided through the local Community Care Access Centre (CCAC).

This article will highlight some of the legal issues that may arise from these arrangements. It is intended to help seniors and their families decide whether or not to agree to a transfer into a retirement home pending admission to a LTCH.

## YOUR CONSENT IS NECESSARY

Even if you are in hospital, no longer require acute care and are eligible for admission to a LTCH, the hospital discharge team cannot make you accept a bed in a retirement home without your express consent. You may consider such a move as one possible option, but no one can require you to accept this option.

## RETIREMENT HOMES ARE NOT REGULATED HEALTH FACILITIES

Unlike hospitals and LTCHs, retirement homes are not regulated health facilities but tenancies regulated by the *Residential Tenancies Act (RTA)*. This legislation regulates all landlord and tenant arrangements. Retirement homes are referred to as "care homes" under the *RTA*. They are described as rental accommodations where you may also purchase a variety of "care services" from the landlord. Examples of care services include nursing care, supervision of medications, an emergency response system and assistance with activities of daily living. However, there is no government regulation or oversight regarding how care and services are provided within retirement homes.

## RENT

When you agree to live in a retirement home, you enter into a tenancy agreement with the landlord in the same way you do in any other apartment (even if you only rent a single room or share a room within the care home). The landlord is required to provide you with a written tenancy agreement which must set out how much you pay for rent. The landlord may charge any amount that he or she chooses, subject to the *RTA* provisions regarding rent increases.

Hospitals, on the other hand, cannot charge ALC patients more than the ALC rate as set out in the regulation to the *Health Insurance Act*. Currently, the rate is $51.88 per day but it will increase to $53.07 on July 1, 2009. This is generally the same rate daily rate as is charged for basic

1. Previous ACE newsletters have contained articles about the legal rights of ALC patients to select long-term care homes of their choice. ACE has also written two papers entitled *Ethical Issues Paper Respecting First Available Beds* and *Discharge to a Long-Term Care Home Home from Hospital* that explains these issues in detail. These documents are available on our website at www.acelaw.ca.

accommodation in a LTCH. The ALC rate in a hospital can similarly be reduced if you cannot afford the full rate. No rate reduction scheme exists under the *RTA* and it is up to individual landlords to decrease rates as they see fit. (It is important to remember that when you are in a LTCH or hospital, the government pays for your nursing care, food and other services but you must pay for everything in a retirement home.)

In order to ease pressure in acute care, some hospitals and other service providers have entered into agreements with retirement homes to provide accommodation and services to those awaiting placement in ALC at a reduced rate (which is usually equivalent to the ALC rate). In some cases, the hospital or service provider may subsidize the fee itself in order to free up beds; in others, the retirement home may agree to provide the same services for a lower amount in order to fill beds.

If you are being admitted to a retirement home to await placement, you need to ask the following questions: (a) is someone else is paying the rent or a portion of the rent on your behalf; (b) is there a fixed amount of time for which such payment is guaranteed; and (c) will payment continue until you are admitted in to a LTCH of your choice. In some cases, you will be considered a "subtenant", as the hospital or service provider will actually be renting the room. It is recommended that you obtain legal advice to determine your rights in your individual situation.

## CARE SERVICES PROVIDED BY RETIREMENT HOMES ARE NOT PAID BY THE PUBLIC HEALTH INSURANCE REGIME

If you decide to move into a retirement home pending admission to a LTCH, make sure you know what care services are available, whether the types of care services you need for your health needs are available and the costs of these care services. The landlord is legally required to provide you with a Care Home Information Package (CHIP) that details all the care services available and the costs, as well as other important information.

The tenant or someone on their behalf pays for care services in a retirement home. The tenancy agreement must set out how much you are paying for any care services as a separate amount from what you pay for rent. You can also purchase services from outside providers of your choice who come into the retirement home. You cannot claim the costs of these services from the Ontario Health Insurance Program (OHIP). However, if you qualify, your local CCAC may provide some services on top of those provided by the retirement home.

During the discharge process from hospital, if you are told that the care services will be paid in the retirement home, you should obtain additional information. For example, find out who is paying for the services. If you will not be held responsible for these fees, you should confirm this fact in writing. You should also verify

whether you will have to pay for extra fees if your care needs increase and additional services are necessary. (You cannot be required to purchase extra services.) You should also get a written agreement that these care services will be provided for the entire time you are in the retirement home until your admission into a LTCH of your choice.

Remember that paying $1000 for a retirement home bed must include not only the bed/room but all food and services. In a LTCH, on the other hand, you are only paying for the bed.

## RETIREMENT HOMES CARE AND SERVICES ARE NOT REGULATED BY THE GOVERNMENT

Unlike LTCHs where the care and services are regulated and subject to inspections by the Ministry of Health and Long-Term Care, retirement homes are not subject to any similar Ministry oversight.

If you have complaints or concerns about your care in a LTCH, you can call the Long-Term Care ACTION Hotline. Your complaint will be forwarded to a compliance advisor who must investigate all complaints about LTCHs. If a complaint is verified, the home is required to resolve the issue in a manner agreed to by the Ministry.

No compliance system exists for retirement homes. However, the industry operates the Retirement Homes Complaints Response and Information Service (CRIS). Although funded by the provincial government, CRIS is operated by the Ontario Retirement Communities Association (ORCA), a voluntary trade association for retirement homes. While Information Officers may assist retirement home tenants with complaints, this service is not arms-length from the industry and they have no authority to require the retirement home landlord to rectify the problem.

## "SECURITY OF TENURE" FOR RETIREMENT HOME TENANTS

As a tenant of a retirement home, you cannot be required to move out unless you choose to do so or the landlord has obtained an eviction order from the Landlord and Tenant Board pursuant to the *RTA*. The ordinary grounds for eviction that apply in any other tenancies apply to tenancies in retirement homes (e.g., eviction for non-payment of rent).

However, there is an additional ground of eviction for care home residents. A retirement home landlord may apply to the Landlord and Tenant Board for an order "transferring a tenant out of a care home and evicting the tenant" if the tenant no longer requires the level of care provided by the landlord or the tenant requires a level of care that the landlord is not able to provide.[2] The Board may only issue such an order if: (a) it is satisfied that appropriate alternate accommodation is available for the tenant; and (b) the level of care that the landlord is able to provide when combined with available community-based services cannot meet the tenant's care needs.

If you agree to live in a retirement home pending admission to a LTCH, and you are either a subtenant or

2. *Residential Tenancies Act*, S.O. 2007, c. 17, s. 148.

your care services are being paid by another party (i.e., the hospital), you should get confirmation that you will not be evicted if your care needs increase and that your changing care needs will continue to be met until you are admitted to one of your chosen LTCHs.

### RENT AND CARE SERVICE INCREASES

A landlord of a retirement home may increase the rent charged on an annual basis by giving 90 days notice to tenants. The increase cannot exceed the rate set by the provincial government unless the landlord gets special permission from the Landlord and Tenant Board.

The landlord may increase the costs charged for care services more frequently than once a year. Unlike rent increases, there is no provincial guideline and no cap on the amount the care services may be increased. Tenants must be given 90 days notice in advance of any increase.

If you are considering moving into a retirement home pending admission to a LTCH, you should find out: whether you are required to purchase any care services; how often the landlord has given notice of increases in the past year; the amount of past increases; the date of the last increase; and the date of the next expected increase.

If you are told that the maximum you will be charged for rent and care services is equivalent to the hospital ALC rate, make sure this is set out in writing. If you would be eligible for a rate reduction for the hospital ALC rate, make sure that you also get that rate reduction while staying in a retirement home.

### TERMINATION OF THE TENANCY NOTICE REQUIREMENTS

The *RTA* specifies that tenants in a retirement home are only required to give 30 days notice to the retirement home landlord if he or she wants to move out.

If you get notice that there is a bed available in one of your chosen LTCHs, you will still be required to give this 30 days notice. You are obligated to pay rent to the retirement home for the entire 30 day notice period unless the landlord either: (a) rents out your space in the retirement home to another tenant; or (b) agrees that you will not have to pay for the full notice period.

You must also give notice that you want your care services and meals discontinued. However, you only need to give 10 days notice to discontinue these services. You do not have to pay for them after the 10 day period, even if they were included in the basic package of services you purchased from the home.

Therefore, it is important that you find out whether the landlord will waive the termination notice period requirements for both the tenancy and services prior to going into a retirement home.

### CONCLUSION

This article highlights a few of the legal issues of which you should be aware if you are considering moving from a hospital into a retirement home to await admission to a LTCH. It is general legal information only and not legal advice. Legal advice pertaining to your situation may only be given if you talk to a lawyer and provide him or her with the details of any proposed arrangement.

If you are thinking of agreeing to such an arrangement, make sure that you understand your rights, your legal relationship with the retirement home and who is paying the bills for rent, care services and meals. Make sure you have a written agreement. Be a good consumer and know your rights before entering into any such arrangement!

Brochures on the rights of tenants living in care homes and tenancy law are available from Community Legal Education Ontario at www.cleo.on.ca, as well as the ACE website.

## THE NEW TORONTO OMBUDSMAN

*By Lisa Romano, Staff Lawyer*

The new Office of the Ombudsman for the City of Toronto opened its doors on April 6, 2009. The mandate of the Ombudsman is to address the concerns of Torontonians about the public services they receive from the city and to investigate complaints of administrative unfairness.

Of particular interest to ACE is the fact that the Ombudsman has the authority to investigate the ten long-term care homes and the long-term care services operated by the City of Toronto. Examples of the long-term care services include: programs in dementia care and other specialized medical needs; community support programs, such as Meal-on-Wheels; supportive housing at select sites; and homemaking services at home.

The Ombudsman is impartial and independent from the City. The services offered by the Ombudsman are both confidential and free of charge. It is an office of "last resort" which means that Torontonians with complaints must first try to work out their issues with the relevant City division before contacting the Ombudsman.

More information about the Toronto Ombudsman can be found at www.ombudstoronto.ca/ or by calling 416-392-7062.

# PERSONAL HEALTH INFORMATION: NAVIGATING THE LAW

*By Graham Webb, Staff Lawyer*

## A MAZE OF RULES

Older adults, and their families and friends, can find *Ontario's Personal Health Information and Protection Act* perplexing and frustrating. The basic rules about the collection, use and disclosure of personal health information are simple enough. The first rule is that a health information custodian (e.g., doctor, nurse, pharmacy, Community Care Access Centre) shall not collect, use or disclose personal health information without the consent of the individual in respect of whom the personal health information is collected or created. The second rule is that the individual has a right to access and correct his or her own personal health information. However, there are exceptions, and exceptions to the exceptions, that sometimes leave us all bewildered. We wish to draw a map through some of the important passages in this maze of rules.

## WHAT IS PERSONAL HEALTH INFORMATION?

Personal health information would include any information regarding your individual health care, including medical records (e.g., hospital, doctor, dentist and long-term care home[1] records) and your OHIP number.

## EXPRESS AND IMPLIED CONSENT

The rules about consent for the collection, use or disclosure of personal health information to a third party are very similar to other aspects of consent, capacity and substitute decision-making law. Where consent is required, it must come from the individual, be knowledgeable, relate to the health information in question, and not be obtained through deception or coercion.

Consent can be express or implied, but express consent is always needed where disclosure is made to a person that is not a health information custodian, or to a health information custodian for a purpose other than providing or assisting in providing health care.

***THIS MEANS*** that if your doctor wants to disclose your personal health information to another doctor for a health care related purpose, your consent to this disclosure can be implied from your having consented to the original health care. (If you do not want information shared with other health professionals, you may have to take special steps to prevent this.) However, if your doctor wants to transmit your personal health information to your spouse, partner or other family members, or to a health practitioner who is not participating in your care, then your express permission is needed.

1. The Office of the Information and Privacy Commissioner has developed a specific fact sheet entitled *Long-Term Care Homes: Consent and Access under the Personal Health Information Protection Act, 2004* which can be obtained online or from their office.

Also, anyone who has the right to give consent also has the right to refuse consent or withdraw consent that was previously given. Giving, refusing or withdrawing consent to the disclosure of personal health information is the personal choice of any individual.

## SUBSTITUTE CONSENT

If an individual is not mentally capable of understanding information and appreciating the reasonably foreseeable consequences of giving, withholding or withdrawing consent, substitute consent can be given or refused by a substitute decision-maker. Mental capacity for this purpose is decided by the health information custodian, whose decision can be reviewed by the Consent and Capacity Board.

If substitute consent is needed, it must be given or refused by the highest ranked person on the list, as specified in the legislation. The hierarchy, from highest to lowest, is as follows: a guardian of the person or of property, an attorney for personal care or for property, a representative appointed by the Consent and Capacity Board, a spouse or partner, a child or parent, a brother or sister, or any other relative related by blood, marriage or adoption. If there is no one else willing or available, the Public Guardian and Trustee may give or withhold consent.

***THIS MEANS*** that if an older adult is mentally capable of making his or her own decision, no one else can give or refuse consent on his or her behalf. On the other hand, if a person lacks mental capacity, there will always be a substitute decision-maker.

## INFORMATION SHARING BETWEEN HEALTH INFORMATION CUSTODIANS

Despite the rule that personal health information may not be disclosed without consent, a health information custodian is allowed to disclose personal health information to another health practitioner if: (i) it is reasonably necessary to provide health care, and (ii) it is not reasonably possible to obtain the individual's consent in a timely manner. An exception to this exception is that this type of disclosure is not allowed if the individual has expressly told the custodian not to make the disclosure.

## DISCLOSURES IF A PERSON IS INJURED OR ILL

The disclosure of personal health information without consent is also allowed for the purpose of contacting a relative, friend or potential substitute decision-maker of the individual, if the individual is injured, incapacitated or ill and unable to give consent personally.

***THIS MEANS*** that if an adult is seriously ill to the point of incapacity, consent is not needed to notify his or her friends and family.

## DISCLOSURES FOR FACILITIES PROVIDING HEALTH CARE

A facility that provides health care may also disclose some limited information about a patient or resident of the facility if, at the first reasonable opportunity after admission, the individual is given the opportunity to object to such disclosures and does not do so. The information that may be disclosed is limited to:

1. The fact that the individual is a patient or a resident in the facility;
2. The individual's general health status described as critical, poor, fair, stable or satisfactory, or in similar terms; and
3. The location of the individual in the facility.

***THIS MEANS*** that a hospital or long-term care home may disclose these basic facts without consent, unless the individual has objected to this type of disclosure.

## DISCLOSURES ABOUT DECEASED INDIVIDUALS

A health information custodian may disclose personal health information about an individual who is deceased in the following situations:

1. To identify the individual;
2. To inform anyone whom it is reasonable of the fact that the individual is deceased, and, where appropriate, the circumstances of death; and
3. To the spouse, partner, sibling or child of the individual who need the information to make decisions about their own health care or their children's health care.

***THIS MEANS*** that the law has some flexibility to disclose critical information about deceased individuals.

## DISCLOSURES ABOUT RISKS OF HARM

Most importantly, a health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

***THIS MEANS*** that if a health practitioner knows that a person is at risk of causing serious bodily harm to him or herself or to others, the health practitioner may disclose health information about that risk with or without consent.

## ACCESSING YOUR OWN INFORMATION

An individual has the right to access his or her own personal health information, except in some limited circumstances.

***THIS MEANS*** that a health practitioner is always free to discuss personal health information about the individual with the individual. An individual may also make a written request to the health information custodian for access to his or her health information. The health information custodian must respond as soon as possible and no later than 30 days after receiving the request. If the request cannot reasonably be met within that time, the health information custodian must give written notice of extension for another 30 days. If the custodian does not respond or refuses a request for access, the individual can make a complaint to the Information and Privacy Commissioner. Frivolous or vexatious requests can be refused.

A reasonable fee for access can be charged if the custodian first gives the individual an estimate of the fee. Due to the discretion given to custodians to charge fees, the amount being charged varies widely across the province. If you think that the charge is too high, you can ask it to be lowered. If the custodian will not do so, you can make a complaint to the Information and Privacy Commissioner.

## CORRECTIONS

An individual may make a request in writing for a health information custodian to correct inaccurate or incomplete personal health information. Similar to access requests, a reply is required within 30-days, or within another 30-day extension. Again, frivolous and vexatious requests can be denied.

***THIS MEANS*** an individual can disagree with the information recorded by a health information custodian about him or herself and ask for it to be changed.

The health information custodian is required to correct a record if the individual demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate and the individual gives the custodian the necessary information to correct the record. A custodian who corrects a record must tell the individual what corrections were made.

However, a custodian may refuse to correct personal health information that he or she did not create, or that is a professional opinion or an observation of a health care provider. If a custodian refuses to correct a record, the custodian must give reasons for the refusal within 30, or if extended, 60 days. The individual may make a complaint about a refusal to the Information and Privacy Commissioner.

## CONCLUSION

There are many other details and nuances to Ontario's personal health information protection law. However, the outline of this information may help older adults and their friends and families, to understand some of the major themes that allow them to exercise control over their own personal health information.

You can obtain more information about this topic by contacting the Information Privacy Commissioner at: 2 Bloor Street East, Suite 1400, Toronto, Ontario, M4W 1A8, 416-326-3333 (Toronto area) or 1-800-387-0073. Their website can be found at http://www.ipc.on.ca/english/Home-Page/.

## ACE – THE FIRST 25 YEARS ... *continued from page 1*

The true indicators of ACE's success as a legal clinic have been the positive remarks from the thousands of clients that have used our services, as well as the many organizations and community groups that ACE has partnered with over the years. The following are but a few comments taken from client and community partners surveys:

*"The information provided helped me prepare to take care of important information, especially with my finances. Thanks to ACE. ACE is the better way."*

*"My questions were answered fully and comprehensively and I recommend others to ACE on a regular basis. Our contact helped improve our services to clients. I have no idea how you can improve. We rely on you heavily."*

*"We used your help with my mom who is 92, both in the hospital and also in the nursing home. You solved the problems we were having. We cannot see any place where you could improve. Thanks so much to a nursing home administrator who gave us your card."*

*"My questions were answered clearly by very professional and knowledgeable staff. I would recommend ACE to others. I followed the advice and instructions I was given. If ACE wasn't available, well heaven forbid! "*

*"Organizations such as ACE provide wonderful resources to seniors and other partners in leading the way on access to justice issues. Without the work of ACE, Canada's seniors would be severely deprived of access to justice. ACE leads the way in providing high value, excellent services as well as providing key law reform and policy information and expertise."*

*"ACE's work volume and work product is astounding. They are able to do so very much in terms of high content, high value work which benefits all Ontarians and by extension, all Canadians. They are the key leaders in the field of law and aging in Canada, and "world class" leaders by any standard. Without the work of ACE, other organizations, strategic partners and systems would cease to work effectively on issues particularly affecting the aging population."*

We thank everyone for their kind remarks!

The challenge now is not only to maintain, but improve, our services. Elder law is a growing area of legal practice and we want to ensure that ACE continues to play a leadership role in order to benefit the seniors' community.

In honour of our 25th anniversary, we are planning a special Annual General Meeting in the fall that we hope everyone will attend. We will also be working with the Canadian Centre for Elder Law and other national groups in the organization of a major international conference on elder law which will take place in Toronto in 2010.

The staff at ACE looks forward to continuing our legal work for older adults in Ontario for the another 25 years!

# MESSAGE FROM THE CHAIR: CONGRATULATIONS TO ACE ON 25 YEARS OF OPERATION

*By Paula Psyllakis, Chair, Board of Directors*

On behalf of the Board of Directors, I would like to congratulate the lawyers and staff of the Advocacy Centre for the Elderly (ACE) on the occasion of the clinic's 25th year of operation!

As Board members, we share ACE's interest in and commitment to the legal issues of older adults. ACE's activities and accomplishments are too lengthy to list in this article but I will highlight the fact that the staff at ACE make a positive contribution to the lives of older adults in Ontario by providing direct legal services, offering ongoing public education, preparing written materials and agitating for law reform.

It is an honour and a pleasure to serve on the Board of Directors and to share in the continuing good work of the clinic. Board members have a variety of skills and come from a myriad of backgrounds including law, health care, social work, community services and business. Older adults are encouraged to participate as Board members – indeed, more that half of the Board's members must be 55 years of age or older. Elections take place every year in the fall at ACE's Annual General Meeting.

If you or someone you know is committed to the legal issues of older adults, I encourage you to explore the opportunity to share in the rewarding experience of Board membership. As a Board member one is able to see firsthand the great work done by the staff and lawyers at ACE and participate in the process of making it the great clinic it is. ACE, well done on your first 25 years!

## ROLE OF THE CCAC IN PLACEMENT

We are hearing more and more that CCACs are refusing to take applications if the applicant (or their substitute decision-maker) refuses to comply with hospital policies. This refusal is in complete violation of the legislation which governs placement into long-term care homes.[2]

Placement coordinators are designated by the Minister of Health and Long-Term Care.[3] At present, they are employees of the CCAC. Individuals may not be admitted to a long-term care home unless the placement coordinator authorizes the admission.[4] The legislation clearly sets out the role of the placement coordinator and how they are to perform the placement function. Please note that there is no legislated role for the hospital social worker, discharge planner or other hospital employee in the placement process. At law, where a statute specifies a class of persons to do a particular task, it must be done by someone in that class unless the law allows for this to be delegated. The legislation here DOES NOT allow for such delegation. Therefore, only the placement coordinator can perform the following roles:

- If a person or their substitute decision-maker (SDM) applies to the placement coordinator for a determination that they are eligible for placement into long-term care, the placement coordinator must find the person eligible if they meet the criteria set out in the regulations.[5]
- The placement coordinator authorizes admission to the nursing home or homes ***as selected by the person/SDM.***[6]
- The placement coordinator ***shall***, if requested by the person/SDM, assist the person in selecting homes.[7] The Act even sets out the criteria that should be used by the placement coordinator when assisting the person choose a home – namely, the person's preferences relating to admission based on ethnic, spiritual, linguistic, familial and cultural factors.[8]
- The placement coordinator can approve eligibility or authorize admission to a specific nursing home only if the person/SDM ***specifically applies*** for such admission. Therefore, if there is no specific consent given authorizing an application for that home, there is no way the person can be considered for that bed. While there may be an "available" bed in a home which meets specific criteria (i.e., a basic room for a female), the placement coordinator cannot determine its appropriateness unless authorized to do so by the person/SDM.
- If a person has already applied for three homes, their eligibility for admission cannot even be ***considered*** until the person removes one of their choices from the list.[9] Again, a home can only be removed from the choice sheet with the express consent of the person/SDM. [emphasis added]

Nothing in the legislation makes application for placement from hospital any different from the community.

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

## THE ISSUES

### 1. Refusal of the CCAC to take the application directly

As set out above, the CCAC is authorized by statute to take applications and authorize eligibility for placement. There is no ability to delegate this role. However, this is exactly what CCACs have been doing. Hospital social workers, discharge planners and others have been acting as if they are placement coordinators. This is problematic for many reasons. For example, they are not as knowledgeable about long-term care. Also, they have different objectives – hospital employees are under pressure from their employer to free hospital beds while the placement coordinator's sole obligation is to place the person in an appropriate long-term care home of their choice.

In practice, however, what has happened is that almost the entire role of the placement coordinator has been taken over by the hospital employee – they commence the application process, take all the information and complete most of the paperwork. At some point, the hospital staff pass this information along to the placement coordinator. The placement coordinator will then visit the person (well into the process) and complete the MDS-RAI assessment tool. The rationale for this process is likely twofold: to lighten the load of overburdened placement coordinators; and to allow the hospital to keep a tight reign over the placement process.

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2. There are three pieces of legislation which are identical in governing this process: the *Charitable Institutions Act*, R.S.O. 1990, c. C.9, the *Homes for the Aged and Rest Homes Act*, R.S.O. 1990, c. H.13 and the *Nursing Homes Act*, R.S.O. 1990, c. N.7 (NHA). For the purposes of this article, we will be referring to the sections of the *Nursing Homes Act*; however, identical sections can be found in each statute.
3. NHA, s. 20.1(2).
4. NHA, s. 20.1(5).
5. NHA s. 20.1(6) and R.R.O. 1990, R.R.O. 832, s. 130.
6. NHA, s. 20.1(6) and R.R.O. 1990, R.R.O. 832, s. 136.
7. NHA, s. 20.1(6).
8. NHA, s. 20.1(7).
9. R.R.O. 832, s. 137.1(1) and (2).

Given that the hospital has no role in this application process, the person/SDM has the right to demand assistance from the placement coordinator, not a hospital employee. Unfortunately, some placement coordinators have been refusing to accept applications or take any other steps unless the application is commenced by the hospital employee as is "usually" done. This has the effect of allowing the hospital employee to try to pressure the patient/SDM into complying with the hospital policy without involvement of the CCAC.

This is not legal. The placement coordinator is legally obliged to complete all paperwork him/herself without relying on hospital personnel.

**2. Refusal of the CCAC to accept the application/choice sheet unless it complies with hospital policy**

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

**3. Refusal of the CCAC to accept choices or changes**

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

If this happens, the person/SDM then has the right to demand that the home be removed from the list and replace it with any other home they choose. In some cases, placement coordinators tell the person/SDM that they cannot make any changes or withdraw a name from a list because it violates hospital policy. Alternatively, placement coordinators may say that they will only make a change if certain criteria are met (e.g., the hospital discharge planner "okays" the change or one "short list" home is exchanged for another).

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

**4. Refusal of the CCAC to make an application from hospital**

ACE is now seeing some CCACs refuse to take applications for long-term care homes from hospital patients or only accepting applications under strict circumstances. Generally, this is associated with the new "Aging at Home Strategy" of the Ministry of Health and Long-Term Care. In this program, increased funding is being made available to seniors to allow them to stay in their home in the community longer. Another purpose of this strategy is to ease pressure on hospitals, enabling seniors to return home with enhanced levels of care rather than go into long-term care.

While this program sounds laudable in theory, we are already seeing problems in practice. Patients are being told that they must return home, even though they believe this would be inappropriate. Take the example of an elderly couple where one spouse is bedridden; even with increased services, the healthier spouse often cannot care for their loved one. As well, the increased services may only be for a set period of time which may create problems when that time is over. We have been advised that placement coordinators have told people that they have to go home into this program and then they can apply for long-term care. As discussed above, this program is available to people but it is not mandatory. If the person/SDM does not feel it would be appropriate, they do not have to accept it. The placement coordinator cannot refuse to take an application just because the person is in hospital or they are not willing to go into this program.

Another variant on this program is the applicant being placed into a retirement home pending placement in a long-term care home. Please see the article in this newsletter, on page 2, entitled *Using Retirement Homes as Way Stations between Hospitals and Long-Term Care Homes: What You Need to Know* by Judith Wahl. Again, a placement coordinator cannot refuse to take and approve your application if you choose not to accept this option.

## LEGAL REMEDIES

If you have difficulties with the actions (or inactions) of a placement coordinator, we recommend that you seek legal advice. Also, as the Ombudsman of Ontario has authority to oversee and investigate the actions of CCACs and their employees, complaints can be made free of charge to the Ombudsman's office.

## CONCLUSION

Placement coordinators are legally obligated to take applications for long-term care, determine eligibility, get valid consents, and authorize admission to long-term care homes in Ontario in accordance with the law. They have no authority to delegate any of those responsibilities to third parties, such as hospital personnel, or to refuse to act in accordance with the law. Instead, placement coordinators should work with their clients to assist in making choices that are best for them.

# THE NATIONAL DO NOT CALL LIST FOR TELEMARKETERS

*By Lisa Romano, Staff Lawyer*

Do you receive unwanted telephone calls from telemarketers at home that interrupt your dinner or favourite television show? Do you want to maintain your personal privacy by not having telemarketers call you at home? If your answer was yes to either of these questions, you may want to register your home phone, mobile or fax number with the National Do Not Call List (List).

The Canadian Radio-television and Telecommunications Commission (CRTC) launched the List in September 2008 to reduce the number of unsolicited telemarketing calls received by Canadians. By registering your phone number on the List, it will reduce most unwanted telemarketing calls. Telemarketers are legally required to subscribe to the List and to ensure that numbers on the List are not called.

Signing up for the List is easy. You can either call 1-866-580-3625 or log onto www.dncl.org and follow a few steps.

Once you sign up, your number will be added to the List within 24 hours. Telemarketers then have 31 days to update their own lists. As a result, you could still receive unsolicited calls from telemarketers within the first 31 days. After putting your name on the List, registration is good for five years.

If you still continue to get calls after being added to the List, you can file a complaint by calling 1-866-580-3625 or going to www.dncl.org. In order to file a complaint, you must provide the following information:

- either the name of the organization that called you OR the number where that organization can be reached;
- the date of the call; and
- your own phone number.

Telemarketers who call numbers on the List can be given penalties of up to $1,500 per violation for individuals and $15,000 for corporations.

Keep in mind that the following types of organizations and groups are exempted from the List and are still permitted to call you even if you are on the List:

- registered charities looking for donations;
- companies conducting polls or surveys;
- political parties;
- newspapers trying to get subscriptions; and
- companies with which you have conducted business in the last 18 months.

However, if you do not want to be contacted by a telemarketer making an exempted call, you can ask to be put on the telemarketer's own internal do not call list. Every Canadian telemarketer is required to keep such a list.

While the List should reduce the number of unwelcome telephone calls to your phone number, it does not prevent fraudulent telemarketer calls. If you receive a call and suspect it is part of a fraud scheme, call the police or PhoneBusters, a national anti-fraud call centre operated by the Ontario Provincial Police and the RCMP at 1-888-495-8501. And remember, you can always hang up when getting one of these unwanted calls!

# IN MEMORIAM – GEORGE MONTICONE

On April 24, 2009, the Board and staff of ACE received the very sad news that our colleague, George Monticone, had passed away. George will be deeply missed by us all, especially by Ann (his wife), George Sr. and Dorothy (his parents), Stephen and Lynn (his brother and brother's wife), the extended Monticone family and his many close friends. George was an outstanding advocate, researcher and lawyer.

To coincide with the 25th Anniversary of ACE this year, the Board of Directors had decided to officially recognize individuals who may not get the respect they deserve for their contributions to elder law. George was going to be the first person to receive this recognition. This decision was made a few months ago and we deeply regret that George will not be here in person to receive this well deserved acknowledgement.

George worked as the research lawyer at ACE for 18 years until he retired in 2005 to spend more time with his wife, family and friends. He had started working at ACE again on contract in the summer of 2008 as editor and lead writer of the elder law practitioners' guide that ACE is planning to publish in 2010 or 2011.

George played many roles at ACE as he: conducted research; edited both the ACE newsletter and our manual entitled *Long-Term Care Facilities in Ontario: The Advocate's Manual*; provided direct client service; gave numerous public legal education sessions for seniors and service providers; and wrote numerous law reform submissions and reports. The list could go on and on. This article will briefly discuss some of his accomplishments.

The position of research lawyer was created when it became clear that there was a need for ACE to commit time to conducting creative research for the purposes of law reform and education. George was the first person hired for this position. He defined the parameters of the job, setting a high standard for subsequent staff to meet.

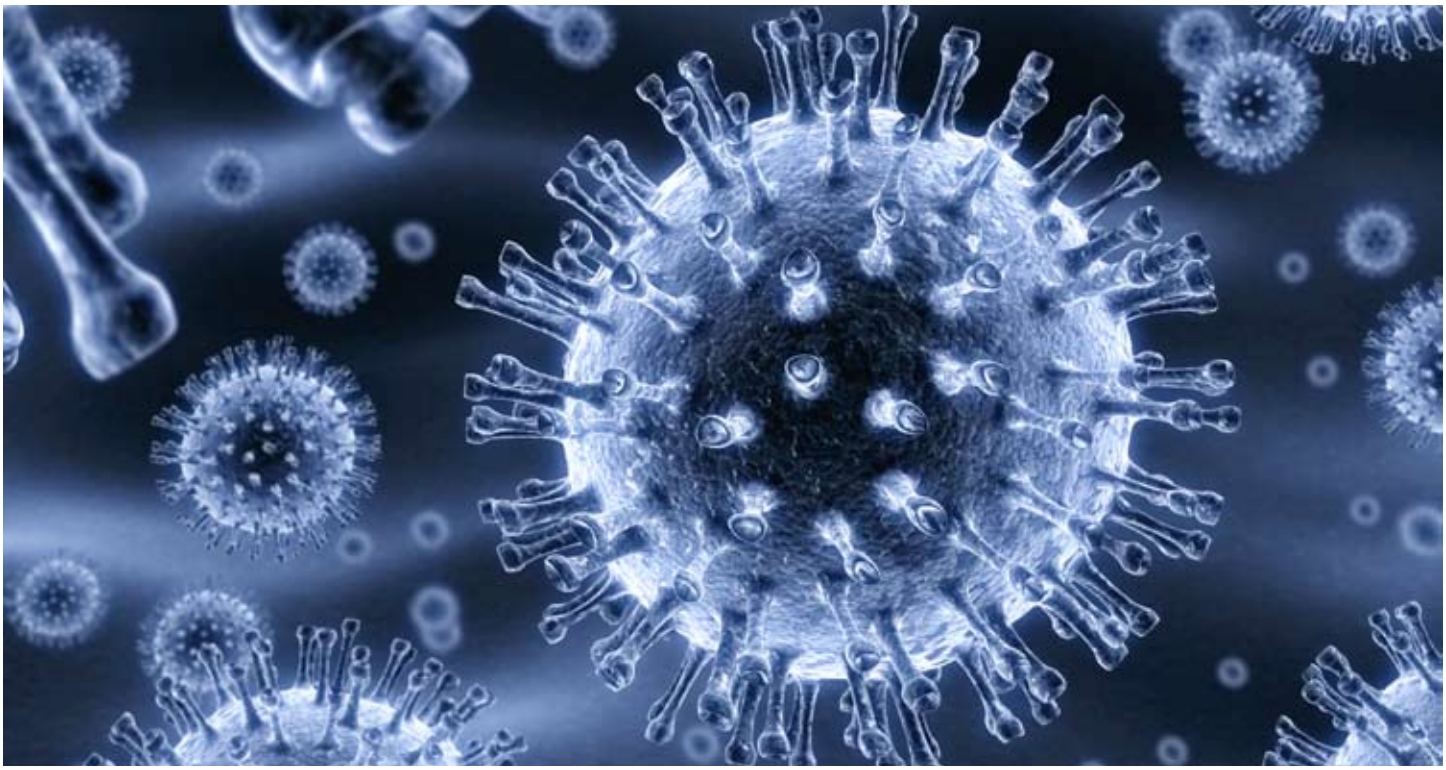
As George believed it was important to work with clients in order to provide the context for conducting research, he provided direct service to clients and was legal counsel on a number of significant cases. One such case determined that retirement homes were subject to rent review and rent control. Up until that time, it had been accepted that retirement homes were exempt from rent control and the tenancy law. George and another ACE lawyer represented 125 tenants of the Grenadier Retirement Home who had received rent increase notices in excess of 30%. The Grenadier case continued for eight years, winding its way through two levels of tribunal hearings and two levels of appeal courts. One of the rent control tribunal hearings alone was heard over 60 days and took over two years to be decided. The final result was that the Grenadier Retirement Home was not exempt from the provisions of the rent control legislation. Due to this and several other cases involving rental accommodation issues where some care services and meals were available, the Ontario government changed the tenancy laws. The new legislation confirmed that retirement homes and other places offering accommodation and care services were to be considered rental accommodations and their tenants enjoyed the same protections and rights as any other tenants, including limitations on rent increases.

George was also the editor of our manual about long-term care. Under George's leadership, this manual developed into a 600-plus page resource on the law of long-term care, retirement homes and community care. George was also the primary author of many of the manual's chapters. The manual went through three editions with George at the helm. It remains the only comprehensive texts on this area of the law in Canada.

On a more personal level, George was much loved by everyone at ACE. He was considerate, supportive and sensitive to all his colleagues. George was an expert on horse racing, in addition to being a gourmand and fine art aficionado, particularly of Inuit sculptures and prints. George loved the outdoors and was an avid hiker and gardener. While working at ACE, he was always the "best dressed" in the office. He was our resident "Doctor" as he had earned a Ph.D. in Philosophy from the University of Calgary before receiving his law degree from the University of Alberta.

The Board and staff at ACE would therefore like to recognize George for all his contributions over the course of his affiliation with ACE. To mark this recognition, the new version of the ACE manual will be dedicated to George.

Please join us in paying tribute to this special person. George will be greatly missed.



# PATIENT SAFETY: NEW INFORMATION AVAILABLE TO THE PUBLIC

*By Lisa Romano, Staff Lawyer*

Have you ever wondered how often health care professionals wash their hands at your local hospital? Or, are you curious about the rates of C. difficile at the hospital where you will be undergoing surgery? This information, and more, can now be found at a new provincial government website - http://www.health.gov.on.ca/patient_safety/. The goal of the website is to keep the public informed about patient safety. It contains information about the following eight topics concerning patient safety at hospitals across Ontario:

1. *The rates of clostridium difficile associated disease (CDAD)* – Clostridium difficile (also known as C. difficile or C. diff) is a common bacterium found in the environment and occurs naturally in some people. When C. difficile damages the bowel and causes diarrhoea, it is called CDAD. C. difficile is the most common cause of infectious diarrhoea in hospitals and/or long-term care homes.
2. *The rates of methicillin resistant staphyloccoccus aureus (MRSA, sometimes pronounced "mersa")* – MRSA is a bacterium that causes infections and can spread in health care settings. MRSA is resistant to antibiotics such as penicillin, methicillin, oxacillin and amoxicillin.
3. *The rates of vancomycin resistant enterococcus (VRE)* – Enteroccocci are a type of bacteria normally present in human intestines and the environment which can sometimes cause infections. Vancomycin is an antibiotic that is often used to treat infections caused by enterococci. When enterococci become resistant to this drug, it is known as VRE.
4. *The hospital standardized mortality ratio at certain hospitals* – This ratio is a measurement tool that provides hospitals with a starting point to assess mortality trends, identify opportunities for improvement and track progress.
5. *The rates of central-line primary (CLI) blood stream infection* – CLI occurs when a central venous catheter, or "line", placed into a patient's vein becomes infected.
6. *The rates of ventilator-associated pneumonia (VAP) in intensive care units* – VAP is a pneumonia that can occur in patients who need assistance breathing with a mechanical ventilator for at least 48 hours.
7. *Public reporting of surgical site infections for hip and knee joint replacement surgeries* – Infections occur when harmful germs enter a patient's body through any cut the surgeon makes in the skin to perform an operation.
8. The *hand hygiene compliance rate* for all health care providers both before initial contact with the patient and after contact with the patient.

# ACE AWARDED RESEARCH GRANT FROM THE LAW COMMISSION OF ONTARIO

*By Lisa Romano, Staff Lawyer*

The Advocacy Centre for the Elderly (ACE) is pleased to be working with the Law Commission of Ontario as it moves forward with its multi-year project to develop a new framework to analyze and understand the impact of law on older persons. Specifically, ACE has been awarded a research grant to research the best ways of enforcing the rights of older adults in institutional settings (e.g., hospitals, long-term care homes and retirement homes).

## ACCESS TO JUSTICE: MYTH OR REALITY?

On paper, there appears to be a multitude of protections available to older adults in institutions, such as:

- Complaints to different professional colleges (e.g., College of Physicians and Surgeons of Ontario, College of Nurses, College of Social Workers);
- Proceedings before the Consent and Capacity Board to challenge findings of incapacity and placement in long-term care homes;
- The ACTION telephone service operated by the Ministry of Health and Long-Term Care to investigate complaints in long-term care homes;
- The statutory Resident's Bill of Rights for residents in long-term care homes;
- Complaints to the Ombudsman of Ontario if residents or their representatives are dissatisfied with the way in which a government institution, such as a Compliance Adviser or the Ministry of Health and Long-Term Care deals with their concerns;
- The Complaints Response and Information Service (CRIS), a telephone service funded by the Government of Ontario but operated by the Ontario Retirement Communities Association; and
- Residents and Family Councils in retirement and long-term care homes.

Access to justice for older persons, however, is a huge obstacle in the administration of both civil and criminal justice. Older adults are confronted with many barriers, such as:

- Ageism;
- The lack of awareness of legal rights;
- Financial and physical barriers in attempting to access the legal system;
- The insufficient number of lawyers practicing elder law; and
- Lengthy court proceedings.

Consequently, many people contend that Ontario has an inadequate legal structure for older adults residing in institutional settings to have their complaints heard and resolved in a timely and satisfactory manner. These residents are particularly vulnerable as they are dependent on those very institutions that have violated their rights, in addition to the fact that they are "out of sight" and public scrutiny is lacking.

In an effort to influence both law reform in Ontario and the best practices of institutions, ACE wishes to examine legal mechanisms available in other jurisdictions respecting the enforcement of rights and remedies for older adults in institutions including, but not limited to, the following:

- Ombudsman models;
- Tribunals/administrative boards;
- Government regulatory bodies;
- Industry regulation;
- Alternative dispute resolutions;
- Advisory groups comprised of older adults;
- Increased education; and
- Independent advocate programs.

These "access to justice models" will be analyzed with the goal of developing an effective, inexpensive model which promotes the autonomy and dignity of older adults residing in institutions.

ACE has been holding meetings and focus groups with a variety of stakeholders in order to obtain their opinions regarding the various methods that might help older adults enforce their rights in institutional settings. Individuals who wish to comment or contribute to the project are encouraged to contact Lisa Romano, Research Lawyer, at ACE.

More information about the LCO's project on older adults can be found at their website: http://www.lco-cdo.org/en/olderadults.html.

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# HOME ADAPTATIONS FOR SENIORS' INDEPENDENCE

*By Rita Chrolavicius, Staff Lawyer*

Approximately four years ago, the Canada Mortgage and Housing Corporation (CMHC) established the Home Application for Seniors' Independence (HASI) program. This program offers financial assistance for minor home adaptations that will help low-income seniors perform activities of daily living in their home.

Eligible seniors and landlords may receive up to $3,500 in the form of a forgivable loan. If you are a homeowner, the loan will be forgiven if you continue to live in the home for six months after the adaptations are completed. A landlord making adaptations to a rental unit cannot increase the rent as a result of the adaptations.

## WHO CAN APPLY?

Homeowners and landlords may qualify for assistance if:

- The occupant is 65 years of age or over and has difficulty with activities of daily living due to age;
- The total household income is at or below the program income limit for that geographical area. For example, the total household income limit is $65,000 for mid-Toronto. Call 1-800-668-2642 to find out the income limits for other areas; and
- The home is a permanent residence.

## ELIGIBLE ADAPTATIONS

The adaptations eligible for this program should be minor and permanently installed or fixed to the dwelling. Examples include:

- Installing handrails, grab bars and vertical poles;
- Adding ramps and handrails;
- Adding lever handles on doors;
- Adding non-slip surfaces in bathtubs and bathrooms;
- Installing lever faucets on kitchen and/or bathroom sinks;
- Replacing the bathtub with a shower stall if the occupant has severe difficulty getting into the bathtub;
- Installing a hand-held shower device;
- Relocating the bedroom, laundry area or toilet to the main floor; and
- Installing easy to reach work and storage areas in the kitchen, laundry area and bedroom.

## INELIGIBLE ADAPTATIONS

Portable aid items (e.g., walkers and household appliances) and therapeutic items (e.g., whirlpools) are not eligible for HASI.

## APPROVAL

In order to be eligible for HASI, work must be approved by CMHC before it is carried out.

## CONTACT

For more information, contact CMHC at 1-800-668-2642 or go to their website at www.cmhc-schl.gc.ca. CMHC will send a HASI application package to individuals who meet the eligibility criteria.

## APPLICATION FOR MEMBERSHIP

Advocacy Centre for the Elderly*
2 Carlton Street, Suite 701, Toronto, Ontario M5B 1J3 • Phone: 416-598-2656 • Fax: 416-598-7924
*Please feel free to photocopy this page and send it to ACE to become a member!*

Name (Individual/Corporate): _____

Corporate Contact (if applicable: _____

Address: _____ Apt.: _____

City: _____ Postal Code: _____

Telephone (Home): _____ Business: _____ Email: _____

MEMBERSHIP FEE (check one) ☐ Individual ($10.00 enclosed) ☐ Corporate ($25.00 enclosed)

In addition to my membership fee, a donation of $ _____ is enclosed.**

**Your membership is important.** If the fee presents financial difficulties, please feel free to join anyway.

Committee Membership: I am interested in seniors' issues and would consider membership on an ACE Committee. ☐ Yes ☐ No

**Membership Expiry Date: Annual General Meeting, Fall 2010.**

By-Law No.1, 14.9 states: No owner or management official of a long term care facility, or employee of any organization representing long term care facilities shall be eligible to be elected to the Board of Directors of the Advocacy Centre for the Elderly.

* ACE is incorporated as a non-profit corporation under the name "Holly Street Advocacy Centre for the Elderly Inc."

** A tax receipt will be issued for donations over $10.00.