

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

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

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

In 2012, the Advocacy Centre for the Elderly (ACE) had over 250 requests for assistance relating to discharge from hospital. In the first six months of 2013, this number skyrocketed to 200 such requests! Patients requiring admission to other care settings or requiring additional care in the home are often told that they must comply with hospital or Community Care Access Centre (CCAC) policies. These policies may “require” the patient or substitute decision-maker (SDM) to select possible LTC homes from a “short list” where a bed is or will soon be available. If they do not comply with the policy, the hospital threatens to charge the uninsured daily rate which ranges anywhere from \$500.00 to \$1,500.00 or more per day. Hospitals may also require the patient/SDM to sign a “contract” indicating that they “agree” with this policy. In fact, no one is required to sign such a contract. More and more frequently, hospitals are blocking LTC home applications and CCAC workers are refusing to take applications from hospital patients, based on their interpretation of hospital policies or Home First/Wait at Home Program requirements.

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

² S.O. 2007, c. 8.

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

ADMISSION INTO LONG-TERM CARE HOMES AND DISCHARGE POLICIES

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

When a hospital patient requires admission to a LTC home, the patient/SDM will complete an application, if it has not already been done in the community. Hopefully, both the hospital and the patient/SDM will agree that this is the best course of action.⁴ While awaiting placement to LTC in hospital, the person will be designated by the physician as “Alternate Level of Care” or “ALC.” This simply means that the person is in hospital awaiting a different type of care somewhere else that is not presently available.⁵

To determine eligibility and the person’s care requirements, an assessment is completed by the hospital CCAC case manager, which includes a “RAI” (Resident Assessment Instrument) application. An evaluation of the person’s capacity to make the placement decision will also be completed in order to determine who makes the decision for placement.⁶ Once the person is assessed by the CCAC as being eligible for admission to a LTC home,⁷ the person will be asked to choose homes to which they wish to apply. A person may choose up to **five** LTC homes.⁸ This is the maximum number, unless the person is put in the crisis category waiting list (which is unlikely if they are in hospital). While an applicant/SDM is not required to apply for the maximum number, we encourage people to do so if at all possible when they are awaiting placement from hospital. Hospitals are not appropriate places to stay for great lengths of time when the patient does not require acute care. The applicant/SDM must also act “reasonably” when applying to LTC from hospital as there are other hospital pressures in play.

Hospitals often have policies requiring applicants to make one of the following so-called “choices”: accept the first available bed in any LTC home; return home to wait for their home of choice; go to a retirement home to await their home of choice;

⁴ Where the patient or SDM refuses to consent, the process will either be discontinued or one of a number of hearings may be heard pursuant to the *Health Care Consent Act*.

⁵ The Ministry of Health and Long-Term Care’s standard definition for ALC can be found at <https://www.cancercare.on.ca/ocs/alc/>.

⁶ 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 they have been named as the attorney in a power of attorney for personal care.

⁷ If the person is found to be ineligible for long-term care, they may apply to the Health Services Appeal and Review Board for a review of the determination of incapacity: *LTCHA*, s. 43(9).

⁸ O. Reg. 79/10, s. 166(1)(d).

or pay the “daily rate” for the hospital bed (also known as the uninsured rate). However, the legislation is clear that this is not legal. In a recent *Toronto Star* article, Sheamus Murphy, Director of Communications for the Minister of Health and Long-Term Care stated: “The primacy of choice and consent” is entrenched in the *LTCHA* and that the government has no plans to remove applicant choice.⁹

Consent for admission into a LTC home is regulated by both the *LTCHA* and Part III of the *Health Care Consent Act*.¹⁰ It is up to the applicant/SDM to choose the homes where they want to apply. Valid consent, as defined in the *LTCHA*, is required prior to placing the person on the waiting list for a home:

Elements of consent

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

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

Informed consent

- (2) A consent to admission is informed if, before giving it,
- (a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the admission; and
 - (b) the person received responses to his or her requests for additional information about those matters.

Same

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

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

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:

⁹ *Toronto Star*, Long-term health care: A look inside the often baffling system (June 21, 2013), http://www.thestar.com/news/insight/2013/06/21/longterm_health_care_a_look_inside_the_oftenbaffling_system.html.

¹⁰ S.O. 1996, c. 2, Sched. 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.

The requirements on SDMs when making choices are restrictive, meaning that they can **only** make their decision in compliance with these principles. This list is exhaustive: neither the *LTCHA* or the *Health Care Consent Act*, or their regulations, allow for any other matters to be taken into consideration by the SDM. There is no mention of hospital policies, the requirements of the acute care system or any other programs in the decision-making process. As the government has chosen not to include any of these policies or considerations in the recently enacted *LTCHA*, it is further evidence that hospitals cannot "override" the legal decision-making process by creating their own policies.

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

The regulations to the *Public Hospitals Act* require a person to leave the hospital no later than 24 hours after a discharge order has been made. 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 who stay until a LTC home bed or other type of accommodation/facility becomes available.¹¹

Hospitals rely on this section of the legislation to require people to comply with their internal policies about accepting the first available bed, moving to a retirement home or going home with some assistance from the CCAC. However, we do not believe that this is supportable in law.

First and foremost, one must understand that it is the **attending physician, registered nurse in the extended class, midwife, or dentist who is an oral and maxillofacial surgeon** who discharges, not the hospital. In almost all cases, it would be the attending or “most responsible” physician who must discharge. IF they discharge a patient inappropriately because of a “hospital policy”, this could be grounds for a complaint to their College or potential civil litigation.

The regulations to the *Health Insurance Act* 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 person is waiting for placement from hospital; it is the same amount that a resident in basic accommodation at a LTC home can be charged (including any applicable rate reductions).¹² If the regulation was applied equally across the board, it would mean that **everyone** who required LTC or other accommodation/ facility would be discharged within 24 hours of no longer requiring acute care, whether a bed was available or not; this is not the case.

It is also clear in law that both the hospital and the attending physician owe the patient a duty of care, which includes a safe discharge. LTC is part of our health-care system, and as such, the person is entitled to a seamless transition from one level to the next. Keep in mind that it is not the hospital, but the physician, that discharges the patient.

¹¹ R.R.O. Reg. 965, s. 16.

¹² R.R.O. Reg. 552, s. 10. The rate is currently \$56.14 per day. The provincial government adjusts the rate annually on July 1st.

There is often a disagreement about what a “safe discharge” means. If the hospital/doctor say that the person must go to a retirement home and either apply for or await LTC placement, is this safe? Retirement homes are, first and foremost, tenancies.¹³ They are not equivalent to LTC homes and are not part of the health care system.¹⁴ While many people choose retirement home living for a variety of reasons, one cannot be forced into a retirement home as an alternative to a LTC home. Not only are retirement homes less regulated with no required standards, they are entirely private pay and outside of the public health system.

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

Placement into homes which are not of a person’s choosing can be detrimental to both their physical and mental health. Homes may be located far from families and other support systems, leading to deleterious effects on the person’s health, including death. In other cases, there may be available beds because the homes themselves are unsatisfactory in some way.¹⁵ Luckily, both the *LTCHA* and the *Health Care Consent Act* provide that it is up to the applicant/SDM to make the placement decision: nowhere does the law give this role to hospital staff. For this reason, a person cannot be “offered” a bed to which they have not applied, and not taking such a bed can therefore not be deemed a refusal. Beds can only be offered after the applicant/SDM consents to an application being sent to a specified home, the home accepts the application, and the CCAC offers the bed in accordance with the regulations.

Generally, the main issue is whether the choice of LTC homes made by the applicant/SDM is appropriate. Legally, the hospital or CCAC cannot simply disagree and ignore the decision and force the person into a home to which they have not consented. If the patient has been evaluated as being incapable of making the placement decision, the authority to make that decision passes to their SDM. However, this cannot be done merely because the team does not like the decision

¹³ Retirement homes come under the definition of “care homes” which are tenancies under the *Residential Tenancies Act, 2006*, S.O. 2006, c. 7.

¹⁴ The *Retirement Homes Act, 2010*, S.O. 2010, c. 11 has been passed but only certain sections have been enacted. Retirement homes must be licensed and there is a process for reporting of improper treatment, abuse and neglect to the Retirement Home Regulatory Agency. However, their ability to inspect and take action when problems are found is limited.

¹⁵ Applicants/SDMs should always visit the LTC home prior to including it on their waiting list. Inspection reports on homes can be found on the Ministry of Health and Long-Term Care’s website – http://www.health.gov.on.ca/en/public/programs/lc/26_reporting.aspx.

of the person. If it is the decision of the SDM which is determined to be unacceptable, the CCAC (and only the CCAC) may challenge the decision of the SDM by bringing an application to the Consent and Capacity Board alleging that the SDM is not complying with the statutory principles for giving or refusing consent set out in the *Health Care Consent Act*.¹⁶ There is no ability to challenge the decision of the competent person who is not “complying” with “hospital policy” regarding choices.

The only case heard to date on the issue of discharge from hospital to LTC is *Duffy v. OHIP*,¹⁷ arising from an appeal after a denial of OHIP benefits. Mrs. Duffy, a patient at Joseph Brant Memorial Hospital, was awaiting placement into LTC. Although applications for three homes had been submitted, the hospital required that more homes be added.¹⁸ When this was not done, OHIP was advised that the patient had been discharged but remained in hospital. OHIP payments for the bed were discontinued and the hospital began to charge Mrs. Duffy \$120 per day for the bed. An appeal was brought before the Health Services Appeal Board by Mrs. Duffy who argued she was entitled to OHIP coverage for the hospital fees. The Board held that the rate being charged by the hospital appeared completely arbitrary and there was insufficient evidence that the appellant or her family had been advised of the discharge policy. In any event, the Board concluded, it was clear that a discharge did not simply mean “to leave the hospital on the day of discharge” as had been argued by OHIP but in fact meant an appropriate placement into LTC. Therefore, the Board ruled in favour of Mrs. Duffy and ordered coverage of the fees by OHIP.

This case does not mean, for example, that an applicant can simply wait in hospital for a specific LTC home where that home has a three-year long waiting list, unless it can be proven that that home is the only one which can meet the person’s needs.¹⁹ Applicants and their SDMs must act “reasonably” when making their choices. However, there is no clear definition of what “reasonable” means and it will change in each individual situation. In addition, staying in hospital may be often not in the best interests of the person. Hospitals do not provide the same assistance and social programming as LTC homes. The likelihood of the patient deteriorating while waiting for placement, including loss of mobility and incontinence, are high. Finally, staying in hospital for prolonged periods of time increases the chance of contracting hospital borne infections, such as *MRSA*, *VRE*, and *C. difficile*. One must weigh all of these considerations when making a placement decision.

¹⁶ *Health Care Consent Act*, s. 54.

¹⁷ Health Services Appeal Board (February 4, 1999).

¹⁸ At the time, the legislation did not include a maximum number of homes that could be applied to. The hospital was requesting that 10 homes be included in the application.

¹⁹ An example of this would be an applicant who required peritoneal dialysis, which is only offered at a very limited number of homes in Ontario.

In general, patients in hospital are not eligible for a “crisis” designation which would put them in the highest general waiting list category. A person will be placed in the crisis category “by the placement coordinator if the applicant requires immediate admission as a result of a crisis arising from the applicant’s condition or circumstances.”²⁰ Local Health Integration Networks (LHINs) are also now able to designate hospitals as being in “crisis” if the hospital is “experiencing severe capacity pressures.”²¹ Even when a hospital is designated as being in crisis and ALC patients are moved to the top category of the list, they are not required to take any bed simply because it becomes available or is an “idle bed”. The crisis designation means that the person is placed into the crisis category of waiting lists for all the homes that they have chosen. When in the crisis category, applicants/SDMs are no longer limited to five LTC home choices but can choose as many homes as they like.²² Placement from the crisis category is based upon the applicant’s need and not by date they are placed on the wait list as is the rule in other categories. It is up to the placement co-ordinator to determine who will be put into the crisis category and the priority within that list.

It is also important to understand that when on the crisis list, the placement is made as of need, not as of the date on the waiting list. It is therefore quite possible to be “bumped” by someone who was just put onto the list because their needs are greater than your own.

REFUSAL OF ADMISSION TO HOSPITAL DUE TO LONG-TERM CARE CHOICES

Recently, we have been informed that some rehabilitation and complex continuing care hospitals are refusing admission due to the patient’s long-term care application choices. Sometimes, rehabilitation or complex continuing care is expected to be a stepping stone into long-term care. But, these hospitals have refused to accept applications on the basis that the patient has not chosen a certain number of homes or a certain number of short-listed homes.

Again, we believe this is illegal. Hospital admission is based only upon need and relevant clinical criteria, not on perceived issues of discharge. We believe such actions are contrary to the requirements of universality and accessibility, as set out in the *Canada Health Act*²³ and the admission provisions of the *Public Hospitals*

²⁰ O. Reg. 79/10, s. 171(1). Similar wording appears in s. 39 of the *Health Care Consent Act* which states that pertaining to admission, a “crisis means a crisis relating to the condition or circumstances of the person who is to be admitted to the care facility.”

²¹ O. Reg. 79/10, s. 171(4).

²² O. Reg. 79/10, ss. 164(4) and 171.

²³ R.S.C., 1985, c. C-6, s. 7.

*Act.*²⁴ Hospitals cannot try to do on admission what they cannot do on discharge; that is, force patients to make applications that they do not want.

PLACEMENT FROM HOSPITAL: ISSUES WITH THE CCAC

Under the *LTCHA*, CCAC placement coordinators are delegated specific placement duties which cannot be designated to others (such as hospital social workers or discharge planners). The placement coordinator must determine eligibility when requested and then authorize the admission of the person to the LTC home in accordance with the *LTCHA*. The CCAC must comply with specific rules regarding the eligibility and admission process, including the following:

- If an applicant/SDM requests that the placement coordinator determine eligibility for placement into LTC, the placement coordinator **must** take an application and determine eligibility in accordance with the criteria set out in the regulations.²⁵
- The placement coordinator can only authorize admission to LTC homes **which have been selected by the applicant/SDM.**²⁶
- The placement coordinator shall, if requested by the applicant/SDM, assist the person in selecting homes.²⁷
- When assisting the person in choosing a home, the placement coordinator is to consider the following criteria: the applicant's preferences relating to admission based on ethnic, spiritual, linguistic, familial and cultural factors.²⁸
- The placement coordinator can approve eligibility or authorize admission to a specific nursing home only if the applicant/SDM **specifically applies** for such admission.²⁹ Therefore, if the applicant/SDM does not consent for the application to go to 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.

²⁴ R.S.O. 1990, c. P.40, s. 20.

²⁵ *LTCHA*, s. 43(1) and O. Reg. 79/10, s. 155(1).

²⁶ *LTCHA*, s. 44(1).

²⁷ *LTCHA*, s. 44(3).

²⁸ *LTCHA*, s. 44(4).

²⁹ *LTCHA*, s. 43.

- “Matching Programs” operated by CCACs, which use data from applications to identify homes which may meet residents’ needs, are for information purposes only. There is no requirement that the person either applies or be admitted to a home because they have been “matched.”
- If a person has already applied to five homes, their eligibility for admission to another home cannot even be **considered** until the person removes one of their choices from the list.³⁰ Again, a home can only be removed from the choice sheet with the express consent of the applicant/SDM.

Nothing in the legislation makes the application process any different for patients in hospital than it would be for applicants living in the community, with the exception of applications for interim LTC homes.³¹

Refusal by the CCAC to Determine Eligibility/Take an Application

CCAC staff cannot refuse to take an application to determine eligibility for placement. The legislation is clear that the CCAC placement coordinator **must** take an application and determine eligibility upon request.³² For example, the CCAC cannot require a person to return home or comply with hospital policies before an application will be accepted.

It is also the obligation of the placement coordinator to ensure that consents is valid, meaning that they comply with the *LTCHA* and the *Health Care Consent Act*. If LTC “choices” are made based upon misinformation, such as applicants/SDMs being told that they **must** choose from a short list or that they **must** choose a specific home, then the consent is not valid and cannot be accepted by the placement coordinator. The placement coordinator must ensure that the rules have been explained to the applicant/SDM and compliance with the law. In fact, where there is an SDM, the placement coordinator has an obligation to advise them of the decision-making rules contained in section 42 of the *Health Care Consent Act*.³³

Refusal of the CCAC to Accept Choices or Changes

The person/SDM not only has the right to choose the LTC homes to which they want to apply, but they can also amend choices or withdraw consent to this list at any time prior to a bed offer being made. This is important as people may initially

³⁰ O. Reg. 79/10, s. 166(1)(d).

³¹ Interim short-stay beds can only be applied to from hospital. The applicant must be on a wait list for a regular LTC home. The interim bed application is not included as one of their five choices and once the person is admitted, they do not drop in any category on the regular waiting list.

³² *LTCHA*, s. 43(4).

³³ *M.A. v. Benes*, 1999 CanLII 3807 (ON C.A.).

include certain “choices” because they felt they had no other option due to “hospital policy.” If this occurs, the applicant/SDM should immediately contact the placement coordinator to change their choices. Placement coordinators cannot refuse to make such changes on the basis that it will violate “hospital policy.” They cannot agree to accept the change only if other criteria are met, such as the discharge planner “approving” the change or exchanging one “short list” home for another, as this is also contrary to the legal requirements.

The right to withdraw consent or to change choices is absolute. The law does not allow the placement coordinator to restrict the person’s choices to LTC.

Refusal of the CCAC to Take an Application from Hospital Patients

Some CCACs refuse to take applications to determination eligibility for LTC from hospital patients, or they only accept such applications under strict circumstances. Generally, this is associated with the Ministry of Health and Long-Term Care’s “Aging at Home Strategy.” Under this strategy, hospital patients are encouraged to return home with increased levels of care from the CCAC in the hopes that they can either wait at home until a LTC home bed becomes available or a bed is no longer necessary.

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

“Wait at home” and “home first” strategies or programs are not a universal panacea and are not appropriate for all. Participation in these programs is not mandatory and the person must be provided with all the information necessary to decide whether such a program is right for them in their individual circumstances, have their eligibility determined upon request, and apply to LTC homes in accordance with the legislation. The CCAC cannot require persons to enter these programs by threatening to withhold other types of services.

Requirement of Admission into a Retirement Home

Applicants are more frequently being told that they must go to a retirement home pending placement in a LTC home. As previously mentioned, retirement homes are **not** part of the publicly funded system, nor is the care provided in them presently regulated. While the placement coordinator has an obligation to advise the applicant about other options that the person may wish to consider,³⁴ there is no obligation on the person to go to a retirement home when they qualify for publicly funded LTC.

Refusal to take an Application and Determine Ineligibility

It is clear that where requested, the placement coordinator **must** take an application for admission and determine eligibility. Placement coordinators cannot simply refuse to take an application because they have pre-determined that the person might be ineligible. If no application is taken, the person's right to apply to have the finding of ineligibility reviewed by the Health Services Appeal and Review Board is negated.³⁵

MINISTRY OF HEALTH AND LONG-TERM CARE

In response to the many complaints that it has received regarding the admission process for LTC from hospital, the Ministry of Health and Long-Term Care has sent at least three memos to the LHINs regarding the legality of the process.

Early in 2011, the Erie St. Clair LHIN announced that it was instituting a "first available bed" policy requiring persons waiting for LTC homes in hospital to "accept" the first available bed or be charged the uninsured rate. Ruth Hawkins, Assistant Deputy Minister (Acting), wrote a memorandum to the LHIN CEOs dated February 23, 2011 stating that this was not consistent with the *LTCHA* and hospitals/LHINs were prohibited from making such policies. She further confirmed that the maximum amount that hospitals could charge patients awaiting LTC beds was the maximum co-payment allowed under the regulations to the *Health Insurance Act*, known as the "chronic care co-payment." Ms Hawkins confirmed that LHINs/hospitals could not vary the legislative rules for application and placement onto waiting lists and into LTC homes.

On May 23, 2012, a letter from Rachel Kampus, Assistant Deputy Minister (Acting), clarified that the uninsured rate could only be charged to patients if a bed from one

³⁴ O. Reg. 79/10, s. 154(1).

³⁵ *LTCHA*, s. 43(8).

of their legally chosen pre-selected lists of homes was offered and refused. It was necessary to clarify this point as some hospitals had believed that a person could not be charged unless they refused their first choice home. The imposition of the uninsured rate makes sense, as it is expected that a person is only putting homes on their list if they are willing to accept them. Refusing to go to one of these homes when offered would be similar to other patients refusing to return to their home in the community.³⁶

The most recent memo was sent to the LHIN CEOs from Catherine Brown, Assistant Deputy Minister, on January 9, 2013. This memo was in response to complaints the Ministry had received regarding the “Home First Programs” being operated in many of the LHINs. Ms Brown emphasized that these were not “programs” but a “philosophy,” and must comply with the requirements of the *LTCHA* and other legislation. It further stated that patients are able to apply to LTC from hospital, and that such programs were only one of the number of options that a person might have when requiring care upon discharge.

While the Ministry does not directly inspect hospitals, we recommend that complaints regarding hospital policies be sent to the Ministry where they are not in compliance with the law. The Performance Improvement and Compliance Branch of the Ministry does inspect CCACs, however, and complaints can be made through the ACTION Line if CCAC employees are refusing to take applications or not complying with the legislation.³⁷

CONCLUSION

The *Long-Term Care Homes Act* clearly sets out the rights of applicants for long-term care, supporting the model of consent and choice of the individual. Neither hospitals nor CCACs have the right under the legislation to make “choices” for the applicant. It is hoped that by having the correct legal information, the applicant/SDM will have the tools to better advocate for their rights.

³⁶ This only applies where informed consent has been obtained. If the choices were made through misinformation or coercion (e.g., telling the person they “had” to make certain choices), this does not apply.

³⁷ The Ministry of Health and Long-Term Care toll-free ACTION Line is 1-866-434-0144.