Ontario Health

Operational Direction
Implementation of the *More Beds, Better Care Act, 2022*: Discharge Planning Policy

ISSUED TO: Hospitals, Home and Community Care Support Services, long-term care homes

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Introduction

The potential for a new wave of COVID-19 and other respiratory illnesses this fall/winter has resulted in a focused effort to ensure patients, residents, clients, and communities continue to receive the care they need from our health system while, at the same time, protecting the capacity of our hospitals.

With this in mind, on August 31, 2022, the Ontario government passed the *More Beds, Better Care Act, 2022* (formerly Bill 7), legislation aimed at facilitating the transfer of eligible alternate level of care (ALC) patients from a hospital into a long-term care home while they wait for placement in their preferred home. They also made changes to regulations under the *Fixing Long-Term Care Act* and the *Public Hospitals Act*.

The hospital discharge process remains grounded in a 'home-first' philosophy, ensuring that, whenever possible, patients arriving in a hospital are supported in returning to their home. However, when it is determined that long-term care can best meet a patient's needs, it is essential that patients are compassionately and respectfully supported in transitioning to long-term care and informed at every stage of the transition process. Communication around transitions remains a challenge; the Patient Ombudsman identified that poor communication is a factor in most complaints related to discharges/patient transfers and transitions in care in their report, *Honouring Voices and Experiences: Reflections from Waves 2 and 3 of the pandemic*.

The recent legislative and regulatory changes represent an opportunity for improvement and standardization of the discharge planning process, with an emphasis on coordinated and integrated communications

between hospital staff, placement coordinators, patients, families, caregivers and substitute decision-makers (SDMs) about hospital discharge and long-term care placement.

Operational direction

1. Hospitals, Home and Community Care Support Services (HCCSS), and long-term care homes will work to improve and standardize the discharge planning process for patients transitioning from hospital to a long-term care home.

   The transition process must be rooted in the following principles and evidence-based guidelines:

   - Early and coordinated communication regarding discharge planning during the admission process
   - Patients, family, caregivers, and/or SDMs are meaningfully engaged as partners within the care team
   - A patient-centred approach to care is taken that considers the unique needs of every patient
   - An equity lens is applied to all discharge planning processes
   - Clear, coordinated, comprehensive, and timely dialogue and communication throughout the care transition process

2. All hospitals must ensure that they have an updated discharge planning policy that includes the following processes:

   i. **Clear articulation of the hospital's discharge policy and process upon admission, including supporting written communication for patients, families, caregivers and/or SDMs.**
      - Discharge planning should ensure a collaborative and coordinated process that begins as early as possible to allow the patient, family, caregiver and/or SDM to ask questions, explore options and understand the quality of care risks to remaining in hospital. This may include early engagement of HCCSS for home care assessment.
      - To support a standardized approach, a patient handout to facilitate early discussions about discharge is provided in Appendix A.

   ii. **An ongoing dialogue about the ALC designation process and what it means for patients, families, caregivers and/or SDMs supported by written communication.**
      - The Alternate Level of Care Leading Practices Guide (Ontario Health, 2021) identifies the need for patients and their designated caregiver or SDM to be included as part of the care team and that they be provided with information, in their preferred format, to let them know what they can expect from the process.

- To support a standardized approach, a letter informing a patient that they have been designated ALC with a destination of long-term care is provided in Appendix B.

iii. **Written material that clearly articulates the new long-term care placement process.**
   - Information must include specific changes to patient consent requirements, including for the collection, use and disclosure of personal health information and use of hospital records to determine eligibility for long-term care.
   - Home and Community Care Support Services placement co-ordinators are working with standardized guidance that reflects the recent changes to the placement of ALC patients with a destination of long-term care.
   - The HCCSS patient information pamphlet given to patients transferring from hospital to long-term care is provided in Appendix C.

iv. **Verbal and written communication on any fees that will be charged to the patient during their stay in hospital.**
   - The Alternate Level of Care Leading Practices Guide (Ontario Health, 2021) outlines the need for the health care team to explain what publicly funded services are available to them and what they will need to pay for. This must include information on copayment charges while an inpatient and daily hospital charges if a patient is discharged from hospital.
   - To support a standardized approach, a letter notifying patients (being discharged to long term care) of the $400 daily fee is provided in Appendix D. (Effective November 20, 2022)

v. **A collaborative process with home and community care support services, the hospital and long-term care homes when planning for patient discharge and transfer.**

Additional resources

- FAQ on the *More Beds, Better Care Act, 2022* (Ontario Hospital Association)
- Field guidance for alternate level of care patients in hospitals moving to long-term care (Ministry of Long-Term Care)
- *Fixing Long-Term Care Act, 2021*, Ontario Regulation 484/22
- *Public Hospitals Act*, Ontario Regulation 485/22 and 486/22

Appendix A: Handout for patients and their families/caregivers upon admission

Preparing for Your Discharge (Leaving the Hospital)

Read this handout to learn about:

- How discharge works at [hospital name]
- Where you may go after you leave the hospital
- What you need to do before leaving the hospital

Planning for your care needs

Planning to leave the hospital begins soon after you are admitted to the hospital from the emergency department. You are considered for discharge when your health care team determines that you no longer need medical care at the hospital.

We know that preparing for discharge, either to your home or to another facility, can feel confusing and overwhelming, especially at the beginning of your care journey. Your care team will work with you, your family and/ caregiver(s) to provide the best plan possible for your safe transition from hospital.

How does discharge work at [hospital name]?

After you are admitted to the hospital, your health care team will work in partnership with you to plan your care goals and plan for the day when you will leave the hospital. This is called your day of discharge.

Conversations about your discharge will take place soon after you are admitted. Knowing when you will leave the hospital can help you, your family and caregiver(s) plan ahead and explore your options. Your health care team can also arrange any follow-up care you may need in time for when you leave the hospital.

Sometimes patients may be transferred to a different unit or another site/hospital during their stay. This depends on your needs and where you can best receive the care you require.

Your health care team will keep you informed of any possible transfers. No matter which site/hospital you are transferred to, they will always help you prepare to leave the hospital.

Where will I go after I'm discharged?

Going home is typically the first choice for patients. This is called the home first approach.

If you need care at home, Home and Community Care Support Services will talk to you about your care needs, while you are in the hospital, about the resources in the community that may be right for you. They may contact you virtually (by phone) or in person, depending on your situation. Ask your health care team for more information.

What do I need to do to prepare for discharge home?

Once you know your day of discharge, you need to arrange your own transportation home. If you need help, ask your health care team for a list of phone numbers for travel options, such as an ambulance, taxi or wheelchair accessible taxi.

Note: [Hospital name] does not pay for your transportation to leave the hospital.

What if my needs can't be met at home?

If your needs cannot be met at home, your health care team will work with you to decide what type of facility can best provide the care you need.

A care site could include:

- Inpatient rehabilitation
- A reactivation care centre
- A transitional care unit
- Complex continuing care
- Convalescent care
- A long-term care home
- A retirement home
- Supportive housing
- Palliative care
- A hospital in your local community

If you are eligible for one or more of these care sites, your health care team will help you apply to and transfer there.

What happens if I need long-term care?

If your needs can best be met in a long-term care home, your care team and a placement co-ordinator from Home and Community Care Support Services will work with you to find a home that meets your care needs. This may include placement in a long-term care home where you will wait until a space becomes available in your preferred home.

Can I wait in hospital for a long-term care home?

Hospitals are not homes and are not designed to meet a person's supportive or rehabilitative needs. There is evidence that while you wait in hospital, without the social and recreational supports provided in settings such as long-term care, you could be at risk for physical and cognitive decline. You may also be at risk for hospital-based infections. Your timely admission into a long-term care home will ensure you get the health and personal care required to support your independence, safety and quality of life.

Who do I contact if I have questions about leaving the hospital?

Speak with any member of your care team. They are here to support you.

Your health care team

Your medical team will help care for you while you are in the hospital. Your medical team will include:

- **Attending Physician:** A doctor who is in charge of your care while you are in hospital. They also supervise the fellows, residents, or medical students who may also be involved in your care.
- **Resident or Fellow:** A doctor or clinician who is completing their training at the hospital.
- **Registered Nurses:** Keep track of your health and well-being, and teach you about your illness or injury. They also supervise nursing students who may also be involved in your care. Each day, you may have 2 to 3 different nurses.

And may include:

- **Consulting Physician:** A specialist doctor who is asked by the Attending Physician to give recommendations about specific aspects of your care. They also supervise the fellows, residents, or medical students who may also be involved with the consultation.

- **Physician Assistant:** A medically educated clinician who works with the doctors. They help assess and manage your health and medical needs while you are in the hospital.
- **Nurse Practitioner:** A nurse who has additional education and specialized training to assess and manage your medical needs and plan your care. They can make diagnoses, order tests, interpret results, and prescribe medications.

Depending on your needs, **other care team members** may also help support you and help you prepare to leave the hospital. This could include:

- **Dietitian:** Helps you choose the right foods for your meal planning.
- **Occupational Therapist:** Helps you plan how to safely do everyday activities such as eating, bathing and getting dressed.
- **Physiotherapist:** Helps you plan how to be more independent by building your strength, balance and coordination.
- **Social Worker:** Helps you manage your feelings, relationships and money needs. They may help you plan for when you go home.
- **Speech-Language Pathologist:** Helps with problems talking or swallowing.
- **Home and Community Care Support Services staff:** Help set you up with care in the community to support your transition home or find you a long-term care home, if needed.

Note: This handout was adapted with permission from a document developed by University Health Network.

Appendix B. Sample letter to patients who have been designated alternate level of care (ALC) and are being assessed for long-term care eligibility

[Insert hospital logo]

Dear [patient/substitute decision maker],

In Ontario, patients who stay in hospital but no longer need the level of care given by the hospital are identified as needing an alternate level of care. At this time, your care team is confident that your acute medical care needs have been addressed, and you are ready to receive care in a more appropriate setting than the hospital.

On [date], your attending clinician, having consulted with your care team, designated you as needing an alternate level of care. In partnership with you, your care team has considered a number of factors, including where your care needs can most safely be met, and has determined that long-term care may be the most appropriate setting for you at this time.

Your placement co-ordinator from Home and Community Care Support Services will work with you and your family/caregiver(s) to confirm your eligibility for long-term care and, where you are eligible, select a list of long-term care homes that meet your needs. This may also include identifying a long-term care home where you will wait until a space becomes available in your preferred home.

If you are assessed as eligible for long-term care, while you are waiting in hospital for placement, you will be charged a daily **chronic care copayment** to help cover the cost of your meals and accommodation. This fee is the same amount you would pay if you were getting care in a long-term care home. The amount you will have to pay depends on your income, and the maximum amount is $63.73 per day. Our finance department is available to answer any questions about this fee.

We are committed to partnering with you and your family/caregiver(s) to identify the best care option for you and to make sure that you have all the information you need. We are here to help if you have any questions or concerns.

[Hospital representative]: _____ **Ext**: _____

Appendix C. Patient information pamphlet – Transitioning from hospital to long-term care

- Patient information pamphlet – Transitioning from Hospital to Long-Term Care (last updated September 23, 2022). Also available in multiple languages here.

Appendix D. Sample letter to notify patients destined for long-term care of the $400 daily fee

[Insert hospital logo]

Dear [patient/substitute decision maker],

Your care team at [Hospital name] has been working with you over a number of [weeks/months] to find a long-term care home that meets your needs. At this time, a long-term care home is the best place to support your care needs, independence, safety and quality of life.

We have been informed by your placement co-ordinator that you were offered admission to an appropriate long-term care home but have declined the offer(s). Your care team and placement co-ordinator have had ongoing discussions with you and have provided written information about the charges that will apply if you decide to stay in hospital and decline an offer of admission.

Under regulations made under the Public Hospitals Act, we are required to discharge you if your attending health care provider determines you are no longer in need of treatment in the hospital. We are also required to charge you a standardized daily fee of $400, effective November 20, 2022, for every day that you remain in hospital, beginning 24 hours after your date of discharge.

Given that you no longer need the specialized care at this hospital, and have been offered admission to an appropriate long term-care home, your attending health care provider will be discharging you from the hospital on **[date]**. Starting on **[date]**, you will be charged $400 for every day that you remain in hospital.

Your placement co-ordinator will continue to work with you to further discuss your options for long-term care placement and revisit your decision to remain in hospital. We know that preparing to move to a new care setting can be stressful for you and your family and caregivers. We remain very committed to working with you to find a long-term care home that meets your needs, and we will support you through the transfer process.

If you have questions or concerns about the $400 daily fee, please speak to **[insert contact info, e.g., for the unit manager and/or patient relations]**.

[Hospital representative]: _____ **Ext**: _____