Policy Brief: *More Beds, Better Care Act*[1]

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Topic:

Transfer of Patients from Hospitals to Long Term Care under *More Beds, Better Care Act*, 2022

Policy Problem:

There are currently a number of patients occupying acute care beds in hospital who are designated Alternate Level of Care (ALC) as they no longer need acute care services. ALC patients that are not able to be in a care environment that aligns with their needs is a sub-optimal use of healthcare resources both for patients that no longer require the intensity of acute care resources and patients requiring access to those acute care services.[3] A substantial subset of ALC patients (about 40%)[4] are waiting for admission to a long-term care home (LTCH). Under prior legislation, patients could select between one to five LTCH's and remain in hospital until a bed in their selected LTCH was available. While waiting for an available bed, patients are charged a daily chronic care co-payment fee ($63.73 per day, effective Oct. 1, 2022) which is equivalent to the accommodation fee they would be charged once in a LTCH. Unfortunately, many LTCH's have lengthy wait lists for admission and patients may wait in hospital months to years before a LTCH bed in one of their chosen facilities becomes available. This has contributed to hospital capacity and patient flow challenges including increasing emergency department and surgical wait times which have been exacerbated by the COVID-19 pandemic. In an effort to help address this health system issue, Ontario recently passed new legislation, the *More Beds, Better Care Act*.

The legislation permits a placement coordinator who is an employee of Home and Community Care Support Services (HCCSS) to determine the patient's eligibility for a LTCH, select all LTCH(s) that meet a patient's needs, share the patient's personal health information with LTCHs, and authorize their admission to the selected home. These steps can be taken without the consent of the patient or their substitute decision-maker (SDM), as long as reasonable efforts are made to obtain informed consent. New regulations and guidance resources provide details to HCCSS placement coordinators on geographic restrictions and consideration of patient psychosocial needs that extend beyond clinical needs (culture, language, religion, etc.).

[1] The More Beds, Better Care Act, 2022 amends the *Fixing Long-Term Care Act, 2021*, Ontario Regulation 246/22, and amends the consent requirements under the *Health Care Consent Act*. More Beds, Better Care Act is also intended to support *Ontario's Plan to Stay Open: Health System Stability and Recovery*.

[2] This resource is intended to be an evergreen document that is updated as required.

[3] CEO and Chief of Staff Letter. Re: The Right Care in the Right Place. Sept. 22, 2022. The letter was signed by 36 CEO's and Chiefs of Staff in the GTA.

[4] Dale A. To solve the hospital capacity crisis, we need better care for seniors. Toronto Star. Sept. 10, 2022.

Unless the patient/SDM refuses physical transfer to the LTCH, the patient will be transferred to the first available bed from among the LTCH choices that were selected either with patient/SDM consent or authorized by the HCCSS placement coordinator without patient/SDM consent. If the patient/SDM objects to physical transfer to the LTCH and no longer requires treatment in the hospital, the law directs specified individuals (e.g., attending physician, registered nurse in extended class) to write a discharge order and the hospital must discharge the patient. Beginning 24 hours after hospital discharge, the hospital must charge the $400 per diem (effective once regulations come into effect in Nov. 20, 2022) for each day thereafter that the patient remains in the hospital. Implementation requires cooperation from a range of interprofessional healthcare providers responsible for supporting the discharge planning process across the healthcare continuum from HCCSS to acute care.

Reasonable people can disagree on the extent to which the objective of alleviating health system gridlock justifies the new legislative approach to waiving LTCH consent requirements, whether it disproportionately burdens patients awaiting LTCH placement, and if the law will achieve its intended objectives. Regardless of the perspectives adopted, implementing the legislation in the most ethically defensible manner requires collaboration between HCCSS, Ontario hospitals, interprofessional healthcare providers, as well as patients, their substitute decision-makers, and families. This collaboration is vital to limit potential disproportionate burdens of this policy, support interprofessional healthcare providers that implement the policy, and facilitate consistent application between and among HCCSS and Ontario hospitals. Finally, ongoing evaluation of the impact of this legislation is required so that course corrections can be made if warranted. Given the authors' primary practice setting is in public hospitals, we focus predominantly on the ethical issues raised by the *More Beds, Better Care Act* for Ontario hospitals.

Policy Question(s):

What ethical principles should guide Ontario hospitals' implementation of the *More Beds, Better Care Act* so that it can achieve its goal in the most just and fair manner?

The ethical principles listed below are not rank-ordered and each ought to be upheld wherever possible, but there may be situations where they conflict with one another. The process by which the principles are balanced when making decisions should adhere to principles of procedural fairness, including transparency and consistency.

Relevant Ethical Principles:

Ethical Principle	*Brief Interpretation in Context of Legislation*
Proportionality	Restrict individual liberty to the least degree possible that is necessary to achieve a legitimate public policy objective (e.g., efficient use of acute care resources), in particular, where there is a risk of harm to self or others. For example, transfer to a LTCH where patient clinical and psychosocial needs are not fully met may harm patients, should be a last resort, and for the least amount of time necessary.

Ethical Principle	*Brief Interpretation in Context of Legislation*
Dignity	Treat persons in a way that honours their inherent value or worth. A LTCH is a person's home and many individuals spend their last months and years living in that home.
Beneficence	Consider to the greatest degree possible, the psychosocial needs of individuals, alongside their clinical needs when LTCH choices are being made.
Non-maleficence	Minimize harm to patients wherever possible by partnering with patients/SDMs to best meet their clinical and psychosocial needs and identify potential harms that may accrue if a patient is transferred to a location that limits the ability of essential care partners, family members and friends to visit.
Respect for autonomy	Actively partner with patients/SDMs to make informed decisions about their care needs and where care is received. Patients should be informed of available alternatives to LTCH, understand what LTCH options exist that meet both their clinical and psychosocial needs, and the implications of LTCH transfer refusal.
Equity	Treat similar cases similarly by focusing on both clinical and psychosocial patient needs and not on arbitrary criteria. Both LTCH selection decisions and assessing the $400 daily fee (where conditions are met) are made through fair and transparent processes.
Stewardship	Use available health care resources and services responsibly to provide the most appropriate care to LTCH residents/patients. Good stewardship reflects a commitment to solidarity across the health system to safely and effectively promote the well-being of all Ontarians.
Solidarity	HCCSS, Ontario hospitals, and LTCHs should collaborate to facilitate the achievement of the intended goals of the law. This includes coordinated implementation of the policy, clear and consistent communication to patients/SDMs, and delineation of respective roles and responsibilities of HCCSS, LTCH's & Hospital staff and physicians. Correspondingly, patients/SDMs should reasonably participate in the process to facilitate efficient use of healthcare resources and promote optimal health system functioning.
Reciprocity	Provide supports to those who are burdened by their transfer to LTCH or face a disproportionate burden. Consider what resources can be provided to those patients who agree to a transfer to a LTCH not of their choosing to acknowledge and address any additional burden they may experience as a result (e.g., transportation assistance, interpretation services, and supports for remote visitation).

General Guidance:

Strategies to Promote the Ethical Implementation of the *More Beds, Better Care Act*	**Relevant Ethical Principle(s):**
1. Communicate clear guidelines that identify a fair and transparent process for identifying and prioritizing patients based on their clinical and psychosocial needs. These guidelines should be consistently applied between and among placement coordinators and hospitals. Other applicable options such as home, and (short and long-stream) rehabilitation must also be explored.	• Autonomy • Equity • Non-maleficence • Beneficence
2. Partner with and empower the patient/SDM to actively participate in the process of selecting a reasonable number of LTCH homes that meet the patient's needs within their preferred geographic area. This should include consideration of the legislative requirements to consider the applicant's preferences (e.g., language, religion).	• Beneficence • Non-maleficence • Respect for autonomy • Dignity
3. Engage all interprofessional healthcare providers that are responsible for implementing the law to facilitate understanding of their associated roles and responsibilities and identify and mitigate any potential barriers that might impair their ability to fulfill their roles and responsibilities in accordance with clinical judgment. For example, where appropriate, physicians or registered nurses in the extended class, have to write a discharge order which initiates the process for hospitals to charge the $400 per diem. Those responsible for writing discharge orders may feel uncomfortable triggering this fee. Acknowledge the role of clinical judgment and importance of consistency between similarly situated patients. Resources should be provided to support associated distress and facilitate a consistent approach.	• Solidarity • Fairness • Stewardship • Equity
4. Constraints on patient/SDM choice should be the least necessary to achieve a legitimate public policy objective. If a patient goes to a LTCH that they did not consent to, potential burdens should be minimized and for the shortest amount of time required (i.e., individuals should be prioritized to move to a home of their choosing).	• Stewardship • Non-maleficence • Proportionality • Reciprocity
5. Empower patients/SDMs to actively participate in the LTCH selection process by using interpretation services and assistive devices, where required, to facilitate communication. Inform patients of implications of non-participation or refusing transfer in clear and non-threatening language. HCCSS and Ontario Hospitals should collaborate to develop shared and consistent messaging and implementation with interprofessional healthcare providers.	• Respect for autonomy • Non-maleficence • Solidarity

Strategies to Promote the Ethical Implementation of the *More Beds, Better Care Act*	**Relevant Ethical Principle(s):**
6. While a formal appeal mechanism does not exist, patients/SDMs can engage local conflict resolution resources including through hospital, HCCSS patient relations, or Ontario ombudsperson (if local processes are exhausted).	• Fairness
7. An evaluation plan should be enacted to measure whether the goal of the legislation is being met and if it is being consistently applied between and among hospitals.	• Non-maleficence • Fairness • Solidarity