



# Alternate Level of Care (ALC) Capacity Challenges and Long-Term Care Placement

A Roundtable Discussion: Key Messages and Suggested Actions

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## Introduction

The legislative and regulatory environment governing patient care and the transition of patients from hospital to long-term care (LTC) is extraordinarily complex. It involves interpreting numerous pieces of legislation and their corresponding regulations. These complexities, coupled with varying levels of understanding about how each piece of legislation interacts with others, result in different interpretations of the law. A consistent understanding of the legislation, and the roles and responsibilities of hospitals and community care access centres (CCACs) will help to facilitate earlier discharge of patients from hospitals as well as clarify the processes for patients, families and providers.

On May 2, 2012, approximately 50 people gathered in Toronto to participate in an Invitational Roundtable discussion hosted jointly by the Ontario Hospital Association (OHA) and the Ontario Association of Community Care Access Centres (OACCAC). Participants included Chief Executive Officers, strategic leaders and researchers from hospitals, staff from CCACs, Local Health Integration Networks (LHINs) and the Ministry of Health and Long-Term Care (MOHLTC), as well as patient advocates, an ethicist and field experts. (See Appendix A for agenda).

### **Roundtable Objectives:**

- To discuss legislation and issues related to the placement of patients from hospitals into LTC homes
- To achieve a common understanding with respect to obligations under a number of interacting pieces of legislation (i.e., *Long-Term Care Homes Act*, *Public Hospitals Act*, *Health Insurance Act*, *Health Care Consent Act*)
- To identify ways to improve the transition of hospital patients to LTC residents today and in the future

A key focus of the discussion was to identify what can be done to improve LTC placement practices within the existing regulatory environment, and to build on recommendations from recent key reports including, *Caring For Our Aging Population and Addressing Alternate Level of Care* by Dr. David Walker, Former Provincial ALC Lead.

This Roundtable report summarizes the key messages that emerged from the discussions and presents a number of actions that were suggested at length by the day's participants. The report is intended to contribute to future policy and planning discussions about solutions toward the province's ongoing ALC capacity challenges and LTC placement.

## Overview of Key Messages Emerging from the Day

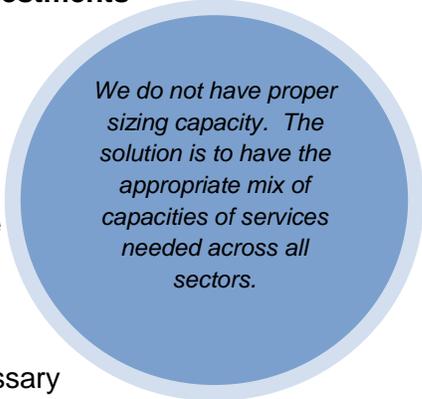
The following key messages support the importance of transitioning patients, whose care needs have already been met in hospitals, successfully and in a timely way to a more appropriate setting for ongoing care and support. There was a clear consensus that we must create viable transition pathways for ALC patients who are waiting in hospital for long-term or community care.

### *Support the Development of a Population-Based Capacity Plan*

1. **Solutions to address the ALC issue must be informed by a comprehensive, system-wide review of capacity across the continuum of care with the MOHLTC, LHINs and health service providers to ensure that evidence-based investments are made in key areas of care.**

There is a mismatch between current levels and types of services and the demographic characteristics and needs of the populations that require services. Capacity assessments must go beyond hospital and LTC beds to include assisted living, group homes, congregate living, neighbourhood/hub models, other flexible settings where care can be provided in the community, home care and community support services (including intensive case management and navigation support for high-risk patients).

Capacity solutions should consider the human resources necessary to help support patients to wait somewhere other than in hospitals for an alternate placement.



*We do not have proper sizing capacity. The solution is to have the appropriate mix of capacities of services needed across all sectors.*

2. **As the population ages and requires more complex care, further discussion with the MOHLTC, LHINs and health service providers is required to determine how best to optimize available capacity and resources – complex/continuing care, community, long-term care, assisted living, etc – to care for our most vulnerable patients.**

Appropriate care options and special programs are needed across the continuum to meet the care requirements of complex, high-need groups. The design of specialized programs should take into account critical mass of residents as well as the resources and skills required to provide safe, high-quality services.



*We need to find a way to quickly upgrade the unused capacity in the LTC sector so that patients are willing, prepared and even desire to access these beds.*

## *Address Issues Related to Legislation and Policy*

- 3. LTC placement is deeply impacted by the complexity of the legislative and regulatory environment.** Some of the biggest challenges arise from different levels of understanding and interpretation of the law and policies (including the *Long-Term Care Homes Act (LTCHA)*, *Public Hospitals Act*, *Health Insurance Act*, and *Health Care Consent Act*).<sup>1</sup>
- 4. Recognizing that LTC is not a transitional destination for most people, patients have a legislative right to choose the place they want to live.** There was little support at the Roundtable for enforcing a “first available bed policy”. However, there was strong consensus that patients need to wait “somewhere other than hospital” for their first choice. It was suggested that hospitals should work closely with CCACs to develop a common framework to facilitate discharge and placement of patients into LTC homes.

### **Suggested Elements of a Framework for Hospital Discharge to LTC Care Placement**

*The framework should be a guide. It should be patient-centred, reflect a patient’s right to choose, and reflect a collaborative approach to assisting patients to move to a more appropriate setting after their acute care needs have been met.*

#### **Principles:**

- Reflect the mission and values of the hospital
- Include open communication with patients and families
- Be consistent with relevant legislation

#### **A LTC Discharge Placement Policy needs to:**

- ✓ Outline the working relationship with hospital discharge planners and CCACs (e.g. establishment of a joint discharge team)
- ✓ Clarify roles of the CCAC and hospital staff as to who is involved in the discharge planning and placement/process
- ✓ Reflect a Home First Philosophy (patient should not be designated ALC for LTC until other available options have been explored)
- ✓ Stipulate that all resources available in the community have been explored, including short-stay and transitional placements
- ✓ Provide scenarios and suggested strategies for addressing potential situations that may arise (e.g., withdrawal of consent)
- ✓ Provide template letters (e.g. information for patients, Substitute Decision Makers [SDMs] and family)
- ✓ Outline the stages or levels of communication with patients/SDMs
- ✓ Explain per diem charges and co-payment charges
- ✓ Include a media communications plan

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<sup>1</sup> To address challenges with interpretation, the Ministry issued a memorandum clarifying expectations with respect to placement in LTC homes on May 23, 2012 (see Appendix B).

On May 25, 2012, the Government announced the appointment of a Lead for the Provincial Seniors’ Strategy. Both announcements will have an impact on ALC capacity and LTC placement.

5. **A clear policy direction is required to address the long-standing confusion about when hospital per diems are allowed and how best to manage difficult situations when a hospital tries to charge a per diem differential rate upon discharge and/or a Chronic Care (Complex Continuing Care) Co-payment Rate.** Per diem and co-payment policies vary in complex continuing care/rehabilitation facilities and LTC facilities. Efforts are needed to standardize co-payment policies, ensure that policies support the philosophy of assess and restore, and clarify roles and practices when a patient (or their SDM) withdraws consent when presented with an appropriate offer of admission.
6. **While hospitals are encouraged to engage in proactive discharge planning with the patients and/or their SDMs, hospitals cannot legally force a patient to leave if they are waiting for their “first choice” and/or choose to apply to only one LTC home.** When a patient rejects an offer of admission from one of their LTC home choices, hospitals are justified in charging the patient a per diem. While patients can withdraw their consent at any time until an offer is made, when they receive an offer of an appropriate bed in the LTC home that they have chosen, the patient is expected to accept the bed. Under certain circumstances, when a patient refuses to accept a LTC bed offer, the hospital is within their parameters to discharge them.<sup>2</sup>

#### *Improve the Transition of ALC Patients Waiting for LTC Placement*

7. **Hospitals and CCACs should work closely together to support a common understanding of their respective roles and responsibilities in communicating with patients and their families on the risks of staying in hospital, planning for discharge, implementing hospital discharge policies, and exploring post-acute care options including LTC placement.** All care providers need to provide consistent messages to patients and families (Hospitals, CCACs, and Primary Care Providers).
8. **Finding the right balance between patient choice and the timely and efficient transition to post-acute destinations (including LTC), is a key challenge that needs to be addressed.** LTC placement is a sensitive issue for many patients and their families. It requires system players to work collaboratively with a shared understanding of the needs of the patient. It also requires a common understanding and awareness of the roles and responsibilities of providers (as set out in legislation and policy)<sup>3</sup>, clear and consistent communications with patients and families about placement options, and consistent processes. This will also help ensure that LTC placement is better understood and fairly represented in the media and/or on political platforms.
9. **There is a need to strengthen the accountabilities that all health care providers in the system have to ensure that ALC patients receive the right care in the right place.** This will require more open discussions about aligning incentives, accountabilities and responsibilities for ALC patients across the continuum.

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<sup>2</sup> This policy was reinforced in the May 23, 2012 Memorandum issued by the MOHLTC (see Appendix B).

<sup>3</sup> For example, the *Long-Term Care Homes Act* assigns the CCAC with the role of managing placement to LTC homes and outlines specific roles and responsibilities of Placement Coordinators.

10. **All hospitals need to embrace, regularly and consistently, a Home First culture (home as the default destination rather than a LTC facility).** This requires the commitment, leadership and support of all players including Senior Management and Physicians/Clinicians within the hospital. Enablers for this change include the expansion of home care, community services and assisted living options (e.g., home first/integrated discharge planning).
11. **Access to short-stay, respite care and wait-at-home options need to improve so patients can wait somewhere other than an acute hospital.** It is in the best interests of the patient to wait somewhere other than a hospital.
12. **Primary care providers have a poor understanding of the LTC sector and/or policies that govern LTC placement.** There is tremendous opportunity for these providers to facilitate advanced care planning and connections to CCACs for discussions about LTC options. Improved education and communication targeted at primary care providers would improve their awareness and understanding of the range of available care options.



*We need to determine whether short-stay should be considered a placement choice or part of a clinical pathway.*

## Suggested Actions

A number of high-value actions were suggested that require further discussion with the MOHLTC and other stakeholders.

### *Capacity Planning*

**ACTION 1: Conduct a comprehensive system-wide capacity review (sizing, costing, resources, evidence-based care pathways, accountability, performance, etc.) to ensure access to appropriate levels of care (i.e. the right care, at the right time, in the right place).** This review should identify any changes required to address capacity and patient flow issues (people and relationships; systems and structures; policies, legislation and regulation; and processes, including access to transitional spaces where patients can wait for placement).

*OACCAC and OHA will continue to communicate with the MOHLTC to reinforce the need for capacity planning to become a priority of government to ensure the availability of the right mix of services across the continuum of care.*

### *The Interpretation of the Legislation*

**ACTION 2: Develop a system-wide education strategy that results in a better understanding of expectations, as well as current legislation and policies that govern patient choice and LTC placement.** Specific education activities should be targeted to:

- **Primary care providers to improve their awareness about options and decisions related to LTC** that will help them inform families/patients earlier in the care trajectory.
- **Hospitals, CCACs and LTC homes to ensure consistent interpretation** of the relevant legislation, regulations and policies, and how best to communicate this information to patients and families (e.g., produce a reference/brochure, similar to the “Circle of Care – Sharing Personal Health Information for Health-Care Purposes” that helped to educate all health care professionals on the application of the consent provisions of the *Personal Health Information Protection Act, 2004*).
- **The broader public about LTC home placement to clarify the roles of various health care providers** and others involved in the transition, to identify transition options, and to encourage people to plan for their care needs.

*To ensure a better understanding of the legislation and regulations guiding the transition of care for stakeholders, providers of care and the broader public:*

- i. OACCAC and OHA will communicate with the Expert Lead for Ontario's Seniors Care Strategy to share key messages and actions outlined, including the need for the development of a multi-faceted educational agenda to ensure that providers and the public have the information required to plan for their care needs.*
- ii. OACCAC and OHA and other stakeholders will develop educational forums and initiatives to help provide clarification and an enhanced understanding of the legislation and regulations guiding the transition of patients.*

### ***The Transition of ALC Patients Waiting for LTC Placement***

**ACTION 3: Re-examine options and solutions to improve accountability and efficiency within the health care continuum, beginning with more open discussions about aligning incentives and accountabilities for ALC patients.** These discussions should address fundamental questions including:

- How should patients and families be involved in discussions about the choices and options needed to support the appropriate transfer of ALC patients?
- How should the LTC sector be engaged in discussions about issues related to unused/undesirable capacity within the sector?
- What is the feasibility of wait time guarantees for a 'place' in LTC that could include a long- or short-stay bed or a space in a day, night or outreach program?

*Recognizing the ALC challenges that exist in hospitals, it is important that MOHLTC together with LHINs and stakeholders (i.e. hospitals, CCACs, LTC, community care providers, patient advocates, etc.), develop a process to ensure the alignment of incentives and appropriate capacities required to care for ALC patients.*

**ACTION 4: Establish a framework for hospital discharge to LTC placement to ensure standard policies and programs govern hospital discharge.** The framework should reflect the Home First philosophy ensuring people are provided with the opportunity to maximize their function, where possible, before making a significant life transition to another living arrangement (e.g., long-term care, assisted living, retirement home, other, etc.). The framework should identify the individual and joint roles and responsibilities of hospitals, CCACs and other community providers to address the needs of patients, outline compliance with the legislation confirming CCACs as the single referral point for LTC placement, and recognize the CCACs' key role in identifying options for placement from ALC beds and diversion from emergency departments.

*OACCAC and OHA, together with other stakeholders, will explore the development of a guidance document with the objective of promoting consistent policies and practices in the management of patients in hospitals requiring LTC/ALC placement.*

## Concluding Remarks & Next Steps

Roundtable participants agreed on the importance and need for the OHA and OACCAC to continue working together, alongside government and others in the care continuum, toward a common understanding of relevant legislation and policies governing the transition of hospital patients to LTC.

There was also recognition of the need to ensure that the right people are at the table working together in the spirit of public interest and trust. Alignment of this work with the Provincial Seniors' Strategy was identified as an opportunity to advance the actions emerging from the Roundtable.

## Roundtable Discussion: Alternate Level of Care (ALC) Capacity Challenges - Long-Term Placement

Wednesday, May 2, 2012  
Toronto, ON



**Roundtable Discussion: Alternate Level of Care (ALC) Capacity Challenges - Long-Term Placement**  
Wednesday, May 2, 2012  
8:30am - 2:00pm

The Sutton Place Hotel  
955 Bay Street, Toronto, ON  
Meeting Room: Royal Sutton Ballroom

The Ontario Association of Community Care Access Centres and the Ontario Hospital Association roundtable discussion on legislation and issues related to long-term care (LTC) placement will specifically focus on the placement of patients into LTC homes from hospitals.

Caring for patients in hospitals who are waiting for an alternate level of care (ALC) is a significant hardship for patients and their families and remains a significant challenge for hospitals as it is a symptom of a larger capacity issue across the continuum of care. Currently, over 50% of ALC patients in hospitals are waiting for LTC placements, creating system-wide concerns and bottlenecks such as increased wait times throughout the hospital, including the emergency departments.

At this invitation-only Roundtable, participants will reflect on the interpretation of the legislation governing this issue. As providers we will discuss our obligations and offer systemic solutions to improve the transitioning of ALC patients waiting for LTC placement, thereby benefiting the patient and improving the flow of patients throughout the continuum of care.

## Agenda

**8:30 am**  
Registration and Continental Breakfast

**9:00 am**  
Introduction  
• Goals and objectives for the roundtable

**Facilitator:**  
Joann Trypuc

**9:10 am**  
Greetings and Opening Remarks  
Co-Host: **Mark Rochon**  
*Interim President & Chief Executive Officer*  
Ontario Hospital Association

### FACES OF THE PATIENTS WAITING FOR LONG-TERM CARE IN HOSPITAL

**9:20 am**  
Perspectives on the Patients Waiting for LTC  
• What do we know about the data that we have?  
• What do we know about the characteristics and needs of patients waiting for LTC?

**Lynn Guerriero**  
*Director, Access to Care*  
Cancer Care Ontario

**Georgina White**  
*Director, Policy and Research*  
Ontario Association of Community Care Access Centres

**Gail Peach**  
*Chief Executive Officer (Interim)*  
Ontario Long-Term Care Association

### PRACTICES AND PERSPECTIVES

**9:45 am**  
First Hand Experience: Placement of ALC Patients into LTC  
• Hospital and CCAC Perspectives

**Rob Devitt**  
*President & Chief Executive Officer*  
Toronto East General Hospital

**Richard Joly**  
*Chief Executive Officer*  
North East Community Care Access Centre

## Agenda

### Facilitated Discussion:

**Joann Trypuc**

- Perspectives on the experiences shared

**10:20 am**

Networking and Refreshment Break

### OVERVIEW OF LONG-TERM CARE PLACEMENT

**10:30 am**

#### Overview of Relevant Legislative Provisions

- An overview of the legislative context relating to the discharge, placement and reimbursement provisions of various legislation:

*Long-Term Care Homes Act*

- Placement provisions

*Health Care Consent Act*

- Jurisdiction of Consent and Capacity Board to deal with issues relating to admission to a care facility/LTC

*Public Hospitals Act*

- Provisions relating to the discharge of a patient

*Health Insurance Act*

- Provisions relating to insured services and patients that are discharged from hospital

#### Legal Perspectives and Interpretations

- Findings from Informant Interviews

**Alissa Raphael**

*Legislative Advisor, Policy, Legislative and Legal Affairs*  
Ontario Hospital Association

**Melissa Prokopy**

*Senior Legislative Advisor, Policy, Legislative and Legal Affairs*  
Ontario Hospital Association

**10:50 am**

Perspectives from the Ministry of Health and Long-Term Care

**Susan Paetkau**

*Director*

Policy Care Standards Branch  
Ministry of Health and Long-Term Care

**Karen Slater**

*Director (Acting)*

Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care

### Facilitated Discussion:

**Joann Trypuc**

- What are the potential consequences of the interpretations offered?
- What does our collective experience teach us?

**11:30 am**

Lunch

### ROUNDTABLE DISCUSSION

**12:15 pm**

An Exchange of Ideas

#### Facilitated Discussion:

**Joann Trypuc**

- Reflecting on our discussion today, what can be done within the current legislative environment and in the future to address this issue?

1. How best can we work together, *within the current legislative environment*, to improve the flow of patients from hospitals to LTC?
2. How best can we work together to move towards an *improved future state*?
3. What else should be considered?

### CLOSING REMARKS

**1:45 pm**

Next Steps

**Co-Host: Margaret Mottershead**

*Chief Executive Officer*

Ontario Association of Community Care Access Centres

**2:00 pm**

Adjournment



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and Long-Term Care**

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MAY 23 2012

**MEMORANDUM TO:** LHIN CEOs

**FROM:** Rachel Kampus  
Acting Assistant Deputy Minister  
Health System Accountability and Performance Division

**SUBJECT:** **ALC patients who refuse an offer of admission to a  
prior-chosen LTC home bed**

In response to requests from hospitals and LHINs, the Ministry wishes to clarify the options available to a hospital if an ALC patient has been determined by the CCAC to be eligible for long-term care (LTC) home admission and has made an informed and voluntary application for admission to an LTC home of their choice, but then refuses a subsequent bed offer from that home.

CCACs are the designated placement co-ordinators for LTC home admissions and have the responsibility for providing assistance, information and counselling about LTC home admission. Persons who have been determined by the CCAC to be eligible for LTC home admission have the right to make voluntary and informed choices in selecting LTC homes to apply to, taking into account their personal circumstances; e.g. they cannot be required to choose from a pre-selected list of homes.

In accordance with s.16 of Regulation 965 made under the *Public Hospitals Act* (PHA), if a patient is no longer in need of treatment in the hospital, the attending physician, nurse practitioner, or other authorized person as described in the Regulation must communicate a discharge order to the patient. The hospital must then discharge the patient, and the patient must leave the hospital on the date set out in the discharge order unless the hospital grants permission for the patient to remain in the hospital for a period of up to twenty-four hours after the date set out in the discharge order.

Treatment of an ALC patient in the hospital may no longer be required if a bed becomes available in an LTC home to which the patient has previously applied. If the patient does not move into the available LTC home bed within 5 days of the offer being made to the patient, the hospital may discharge the patient, unless:

- the patient has a health condition, short-term illness or injury which prevents the patient from moving into the home at that time or which would make moving into the home at that time detrimental to the applicant's health, or

- there is an emergency in the home or an outbreak of disease which prevents the applicant from moving into the home at that time.

Patients who have been discharged but choose to remain in hospital may be charged an unregulated rate by the hospital. Section 10 of Regulation 552 of the *Health Insurance Act*, which sets co-payment amounts that may be charged to chronic care patients, does not apply to patients who have been discharged in accordance with the provisions of the PHA.

Prior to applying for admission to one or more LTC homes, ALC patients must be advised of the consequences of their selection(s). This includes advising them that if they refuse a bed offer for a LTC home they apply to, a determination may be made that they are no longer in need of treatment in the hospital. A discharge order may then be communicated to them, and the hospital may charge them an unregulated daily rate if they choose to remain in hospital.

The Ministry expects hospitals to begin discharge planning as soon as possible, including by making referrals to the CCAC for patients who may require LTC home admission.

This memo does not supersede legislative and regulatory requirements, including requirements related to the LTC home admission process under the LTCHA and Regulation 79/10. Furthermore, LHINs, hospitals and CCACs are encouraged to refer to prior Ministry communications on LTC home placement of hospital patients.

Thank you for your support and cooperation,



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Rachel Kampus  
Assistant Deputy Minister (A)