Managing Transitions

A Guidance Document
Third Edition

March 2026

Ontario Hospital Association

Acknowledgements

The content relied on in *Managing Transitions: A Guidance Document – Third Edition* (the Guide) was comprehensively updated and revised by Katharine Byrick, John Hunter, and Heather Webster of Borden Ladner Gervais LLP (BLG).

Katharine Byrick is a Partner at BLG and practices exclusively in health law. Katharine regularly provides strategic and practical legal advice to health care organizations and their staff, in addition to representing them in complex medical malpractice litigation.

Katharine's current practice includes working closely with senior leadership teams and clinical leaders, as well as supporting hospital boards on a range of issues, including risk management, reputational risk, responding to critical and adverse events, complicated discharge planning, consent and capacity, mental health, physician privileges, research misconduct, coroner's investigations and inquests and privacy.

Katharine has been recognized for her expertise in *The Best Lawyers in Canada*® (Health Care Law, Medical Negligence, Personal Injury Litigation); *The Canadian Legal Lexpert*® *Directory* (Medical Negligence); *Lexpert Special Edition: Health Sciences*; and *Lexpert Special Edition: Litigation*.

Katharine is a co-author of the Ontario Hospital Association's (OHA) *A Practical Guide to Mental Health and the Law* and authored the first two editions of *Managing Transitions: A Guidance Documen*t with support from the Health Law team at BLG. Katharine is delighted to partner with John Hunter and Heather Webster on this Third Edition.

John Hunter is a Partner at BLG and has a diverse practice that includes mental health law, medical malpractice, police liability and class actions. John defends hospitals, mental health facilities, and other health care entities in civil lawsuits and inquests and provides strategic advice on complicated and challenging issues facing these organizations.

John's mental health practice includes providing advice on consent and capacity issues, youth mental health, *Mental Health Act* apprehensions, the role of children's aid societies in medical care, difficult discharges, and just about anything else that sounds "messy".

Prior to law school, John was a social worker in a hospital setting and draws upon that clinical experience to offer creative and practical advice that addresses the real-world issues facing organizations and their staff.

Heather Webster is a Senior Associate at BLG where she practices health law. Heather advises health care organizations on a wide range of issues related to physician credentialing, consent and capacity, challenging discharge planning, end of life care, and risk management. Heather represents hospitals and their employees in medical malpractice lawsuits, coroner's inquests, and physician credentialing proceedings. She also has experience defending health providers in regulatory college matters.

Prior to practicing law, Heather obtained her Master of Health Administration degree and worked with legal, risk, and quality teams at health care organizations in Ontario and Nova Scotia.

The Ontario Hospital Association (OHA) thanks Katharine, John, and Heather for their diligent review of this edition of the Guide.

Working in close collaboration with BLG on the development of this edition of the Guide, the OHA acknowledges the following for their significant contributions as authors and editors:

Melissa Prokopy, Vice President, Policy and Advocacy, OHA
Alice Betancourt, Director, Legal, Regulatory and Governance Issues, OHA
Lina Neves-Mera, Manager, Strategic Policy, OHA
Ashley MacDougall, Legal and Policy Advisor, OHA

Finally, the OHA recognizes the dedication and expertise of various stakeholders, including hospitals, Ontario Health, and Ontario Health atHome, for their contribution.

Disclaimer

Managing Transitions: A Guidance Document – Third Edition (the Guide) was prepared as a general guide to assist hospitals and other entities in understanding Ontario legislation and policy related to transitions from hospital to health and community settings.

The information in this resource document is for general use only and may need to be adapted by hospitals and other entities to accommodate their unique circumstances. This document reflects interpretations and recommendations regarded as valid at the time of publication based on available information. It is not intended as, nor should it be construed as, legal or professional advice or opinion. Hospitals and entities concerned about the applicability of the materials are advised to seek legal and/or professional advice. In addition, any resources accompanying the Guide should be reviewed and considered in the unique context of each hospital's existing policies and practices.

The Ontario Hospital Association and Borden Ladner Gervais LLP make no warranty or representation that the information contained in the Guide is fit for any particular purpose and will not be held responsible or liable, jointly or severally, for any harm, damage, or other losses resulting from reliance on, or the use or misuse of, the general information contained in the Guide.

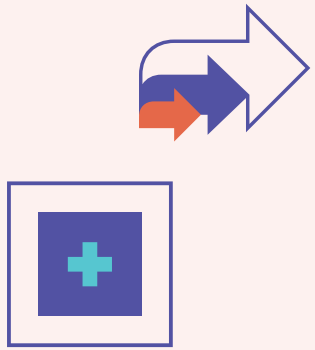


Table of Contents

SECTION 1

Introduction

Appropriately managing patient transitions across the health care system is essential to ensuring individuals receive timely care in the most appropriate setting. While much of the focus is placed on transitioning patients out of the hospital, it is also important to acknowledge how individuals enter the hospital, whether through unplanned emergency visits or planned admissions. As Ontario's population grows and care needs become more complex, hospitals, community providers, and other health system partners face increasing pressures. These challenges are contributing to capacity strains in hospitals, with some patients remaining admitted for longer than necessary while waiting for access to a more appropriate level of care. Many of these individuals have chronic or complex conditions that require a coordinated, cross-sector approach to deliver appropriate, patient-centred care.

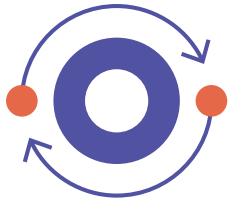
This updated guidance document, which was developed in consultation with Ontario Health, Ontario Heath atHome and hospitals across Ontario, is intended to help standardize policies and programs for hospital discharge when patients no longer require hospital care. The goal of this guidance document is to help manage hospital capacity more effectively while facilitating successful, patient-centred discharges.

Over the past few years, the Province of Ontario implemented significant changes that impact transitions between care settings. These have included legislation that modified the admission process for patients designated as alternative level of care who are ready for discharge to a long-term care home; formalized charges for uninsured services, including when a patient is discharged and remains in hospital; established Ontario Health, tasked with connecting, coordinating, and modernizing Ontario's health care system; and created Ontario Health atHome.

Accurate, clear, and coordinated communication is key to successful discharge planning. This guidance document reviews the legislative framework for discharge planning as well as the different roles and responsibilities of those involved. It also outlines available tools for managing the discharge planning process and addressing some of the potential challenges in navigating this process.

The unique, individual nature of each patient's discharge plan or transition through the health care system cannot be captured in one document. This guidance document is not meant to serve as a template, nor does it set out a prescribed process. It is intended to help identify and clarify provincial legislation and policies on patient transitions between care settings and outline the roles of care team members in facilitating these transitions, especially as new care models emerge. Examples are provided throughout to facilitate understanding and the application of the legislation.

The Ontario Hospital Association recognizes that providing the best care possible during these transitions relies on successful collaboration among health care providers, patients, substitute decision-makers, families, and caregivers. This guidance document was designed to serve as a valuable, supplementary resource for those navigating these transitions.



SECTION 2

Alternate Level of Care

The ALC Designation

Alternate level of care (ALC) is the term used to identify patients who are admitted to a hospital but no longer require the level of care provided at that facility. From a clinical perspective, these patients are ready to leave the hospital, but there may be challenges to an immediate discharge.

Generally, a patient is designated as ALC by their most responsible physician, often in collaboration with members of the patient's interprofessional team. The designation is not a diagnosis, but rather an administrative term to identify patients who are ready to transition to another care setting. For some ALC patients, the discharge destination is known but may not be currently available. For others, specific details of a discharge plan and/or destination may remain to be determined. Typically, patients, their family/caregiver(s), members of the interdisciplinary care team, and others involved in their care work to identify a clinically appropriate discharge plan.

In 2009, all acute and post-acute hospitals in Ontario adopted a standardized definition for the designation of ALC.[1] This definition provides that a patient is designated as ALC when:

- Their care goals have been met
- Their progress has reached a plateau
- They have reached their potential in that program/level of care; or
- Their admission occurs for supportive care because services are not accessible in the community (e.g., social admission)

The exceptions to this standardized definition are set out in the Final Note section reproduced in the table on the next page. The latter exceptions – "waiting in an acute care bed/service for another acute care bed/service" and "waiting in a tertiary acute care hospital bed for transfer to a non-tertiary acute care hospital bed" – confirm that this definition was developed to identify patients who no longer require the level of care they are receiving and whose care needs would be better served elsewhere in the health care system.

Although this standardized definition continues to apply,[2] new legislation has impacted the designation of ALC for patients awaiting care at a long-term care (LTC) home. For clarity, designating a patient as ALC for LTC is not the same as determining they are eligible for LTC.

Find Out More

More information regarding eligibility for LTC is set out in Section 5.

In 2022, and in part prompted by the health care system's experience during the COVID-19 pandemic,[3] the Ontario government introduced Bill 7 – the *More Beds, Better Care Act, 2022*.[4] The Act amended the *Fixing Long-Term Care Act, 2021 (FLTCA)* and *Health Care Consent Act, 1996 (HCCA)* relative to ALC patients who are appropriate for care at a LTC home. Where this is the case, section 60.1 of the *FLTCA* defines an ALC patient as a person who:[5]

- Occupies a bed in a hospital under the *Public Hospitals Act*; and
- Has been designated by an attending clinician in the hospital as requiring an alternate level of care because, in the clinician's opinion, the person does not require the intensity of resources or services provided in the hospital care setting.

It is not necessary for a discharge destination to be identified by the physician/delegate when the patient is designated as ALC. It may be that the clinically appropriate discharge destination has not been identified or there may be more than one clinically appropriate discharge destination.

Definition: When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (acute, complex continuing care, mental health or rehabilitation), the patient must be designated ALC at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

Note 1:

- The patient's care goals have been met,
- Progress has reached a plateau,
- The patient has reached her/his potential in that program/level of care, or
- An admission occurs for supportive care because the services are not accessible in the community (e.g., "social admission").

An ALC designation will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

Note 2:

Discharge/transfer destinations may include, but are not limited to:

- Home (with/without services/programs)
- Rehabilitation (facility/bed, internal or external)
- Complex continuing care (facility/bed, internal or external)
- Transitional care bed (internal or external)
- LTC home
- Group home
- Convalescent care bed
- Palliative care bed
- Retirement home
- Shelter
- Supportive housing

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

Final Note:

The definition does not apply to patients:

- Waiting at home
- Waiting in an acute care bed/service for another acute care bed/service (e.g., surgical bed to a medical bed)
- Waiting in a tertiary acute care hospital bed for transfer to a non-tertiary acute care hospital bed (e.g., repatriation to community hospital)

Definition (for patients awaiting discharge to a LTC home):[6]

An ALC patient is a person who:

- Occupies a bed in a hospital under the *Public Hospitals Act*, and
- Has been designated by an attending clinician in the hospital as requiring an alternate level of care because, in the clinician's opinion, the person does not require the intensity of resources or services provided in the hospital care setting.

Discharge Destinations

There are several discharge and transfer destinations for patients who no longer require the level of care they are receiving in the hospital setting. Most of these destinations are defined in Ontario Health's ALC Reference Manual and are set out on the next page.

Discharge and transfer destinations for patients no longer requiring acute care include:

- **Home** – Private residence, not including group home settings such as LTC or retirement home, where a patient will live in the community upon discharge from hospital. Provision of an array of services that enables clients to live at home, often with the effect of preventing, delaying, or substituting for LTC or acute care alternatives.[7]

> **Find Out More**
>
> The role of Ontario Health atHome, as well as the support and services it provides and arranges, is addressed in more detail in Section 5.

- **Retirement home** – A multi-unit residential facility providing optional services such as meals, housekeeping, recreational activities, and personal support. This discharge destination is a residential facility that offers services that must typically be paid for by the individual. This is a legal 'tenancy,' and services are usually provided under a contract. This is not a private home with LTC services.

> **Find Out More**
>
> More information regarding retirement homes is set out in Section 5.

- **Inpatient rehabilitation** – A designated bed providing care aimed at maximizing patients' overall physical, sensory, intellectual, psychological, and social functions.
- **Complex continuing care** – A designated bed providing specialized care to patients who are medically complex, require hospital stays, regular onsite physician care and assessment, and active management over extended periods of time.[8]
- **Mental health bed** – A designated bed providing therapeutic services to patients with addictions, psychological, behavioural or emotional illnesses.
- **Palliative care bed** – A designated palliative care bed in a hospital or hospice residence setting that provides medical or comfort care to support end-of-life planning to reduce the severity of a disease or slow its progress. The focus is on quality-of-life measures rather than providing a cure.
- **Transitional care bed** – A designated bed located at a facility where other types of care are provided, such as a hospital, reactivation care centre[9] or an alternative health facility. This care setting is meant to be short-term and the focus is on returning individuals to independence in the community.
- **LTC home** – A designated bed providing care to meet both the medical and non-medical needs of people with chronic illnesses or disabilities who require care that is not available in the community.

> **Find Out More**
>
> The process for admission to a LTC home is addressed in more detail in Section 5.

- **Convalescent care beds** – Provision of care to support the gradual recovery of health and strength after illness or surgery. Convalescent care programs provide 24-hour care to people who require specific medical and therapeutic services in supportive environments for defined periods of time.
- **Supportive housing, group home, or assisted living** – Accommodation with services provided to an individual with chronic or complex needs as a means of maintaining them in the community. These services may include, but are not limited to, supervision, personal support, and counselling.
- **Shelters** – Temporary emergency housing for individuals in crisis or without other accommodations. This includes, but is not limited to, homeless patients, and victims of domestic violence.

Identifying a clinically appropriate discharge destination can be complex and involves collaboration between health care providers, patients, substitute decision-makers (SDMs), families, and caregivers.

Challenges in discharge planning may arise not only from differing perspectives or preferences but also from limitations in the availability of appropriate services or resources within the health and social care systems.

Impact of an ALC Designation

Discharge planning is a collaborative process that begins prior to a patient being ready for discharge from hospital and, ideally, prior to any ALC designation. Discharge planning for all patients, including those designated ALC, should start as early as possible to allow the patient/SDM and family/caregiver(s) enough time to understand and explore the options for the most appropriate plan.

The discharge planning process itself may not be impacted by an ALC designation, but there may be changes to the patient's care plan during their ongoing hospitalization until the appropriate destination is available to the patient.

For example, an ALC patient may be transferred to a different unit/ward within or outside the hospital and, in some situations, a co-payment may be charged.

Find Out More

Co-payments are discussed in more detail in Section 8.

Prior to the amendment of the *FLTCA*, it was not possible to refer or assess ALC patients for eligibility for admission to a LTC home or submit an application for admission to a LTC home without their consent. This sometimes resulted in situations where an ALC patient/SDM:

- Refused to consent to the patient being assessed for eligibility for admission to LTC
- Refused to apply to any LTC homes once determined to be eligible
- Only applied to a limited selection of LTC homes with significant wait lists

Following the 2022 amendments to the *FLTCA*, when reasonable efforts to obtain the appropriate consents have failed, certain steps may be taken without the consent of patients or their SDMs to investigate options for discharge to a LTC home.[10] These steps include:

- A placement coordinator[11] may determine eligibility for admission to a LTC home, select a LTC home (or homes), provide the LTC home(s) with assessments and information, and authorize the patient's admission to a LTC home
- An assessment of an ALC patient may be conducted for the purposes of determining eligibility for admission to a LTC home
- Personal health information may be disclosed to carry out the above steps

Once admission to a LTC home has been authorized and a bed offer is made, the patient will be discharged from the hospital. If the patient does not accept the bed and leave the hospital within 24 hours of discharge, a daily fee is charged as a contribution to the (uninsured) hospital services following discharge.

Find Out More

Further details on the admission process for LTC homes are outlined in Section 5. The daily fee charged as a contribution to uninsured services is outlined in Section 9.

Ultimately, the exercise of clinical judgment remains central to the discharge process outlined by the *FLTCA*.[12]

Home and Community Care

In hospitals, many steps are taken to arrange resources to support patients to return home upon discharge. All services and supports in the community are carefully explored before considering a referral to LTC. Discharge planning prioritizes collaboration with patients and caregivers to address challenges and ensure a safe return home and provides an opportunity to discuss interim and long-term care needs. Patients, when capable, have the right to choose to live at risk in their own home with the right level of supports. Whenever possible, major decisions, such as applying to LTC, are best made from home.

It will not be appropriate for all patients to be discharged to the community while awaiting placement in a LTC home, even with significant supports from Ontario Health atHome and community partners. Some patients designated ALC will not have a safe or clinically appropriate option to return home, even on a temporary or transitional basis.

SECTION 3

The Legislative Framework for Discharge Planning

Discharge Planning

Discharge planning is a collaborative process that includes patients, members of the health care team, family members and caregivers of patients, and, if applicable, substitute decision-makers (SDMs).

Discharge planning for a specific patient may involve many different elements, including, but not limited to:

- A plan of proposed treatment
- Providing information about a tenancy in a retirement home
- Arranging for in-home services provided by the hospital through hospital-to-home programs, Ontario Health atHome, or privately
- Accessing other community resources to support someone in the community
- Admission to a care facility (long-term care (LTC) home)[1]
- Where a patient is not appropriate for admission to a care facility (LTC home), and does not have a stable living situation, determining the appropriateness of discharge where patients refuse a shelter placement, or shelter space is not available

Find Out More

Navigating discharge for patients that are under-housed or experiencing homelessness is discussed in Section 4.

The discharge planning process may take time, and several different options may be explored simultaneously, with plans being arranged for both the shorter and longer terms.

Many different health care professionals and individuals may be working on options for a discharge plan from the hospital when the level of care provided in that setting is no longer required. Some health professionals, such as physicians, have specific guidance or policies on discharge planning set out by their professional College with which they must comply.[2] Close collaboration and consistent, aligned communication between the care team, the patient/SDM, and family/caregivers are key components of successful discharge planning. This is especially important given that some related responsibilities rest with Ontario Health atHome staff.

Legislation that Impacts Discharge Planning

The following is an introduction to the legislation that impacts the discharge planning process and governs the various administrative and legal processes that provide the foundation for an individual's transition through the health care continuum in Ontario.

Canada Health Act

The *Canada Health Act* (*CHA*), Canada's federal legislation for publicly funded health care insurance, is described by Health Canada as follows:

> The Act sets out the primary objective of Canadian health care policy, which is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."
>
> The *CHA* establishes criteria and conditions related to insured health services and extended health care services that the provinces and territories must fulfill to receive the full federal cash contribution under the Canada Health Transfer (CHT).

> The aim of the *CHA* is to ensure that all eligible residents of Canada have reasonable access to insured health services on a prepaid basis, without direct charges at the point of service for such services.[3]

The balance of the legislation referenced in this Guidance Document will be from the province of Ontario.

Connecting Care Act

The *Connecting Care Act, 2019* (*CCA*) establishes Ontario Health, a government agency tasked with connecting, coordinating, and modernizing Ontario's health care system.[4] It also governs the provision of home and community care services provided by Ontario Health atHome and other health service providers. Ontario Health atHome is overseen by Ontario Health and is responsible for providing:

- Home and community care services to patients of Ontario Health atHome
- Operational supports to home and community care services providers or Ontario Health Teams (OHTs) to enable them to deliver home and community care services to their patients, including:
  - Care coordination services
  - The assignment of Ontario Health atHome employees to work under the direction of a health service provider or OHT to deliver care coordination services
  - Shared services, including administrative or business support, patient care technology platforms, and other shared services or operational supports
- Information to the public about, and referrals to, health and social services
- Placement management services to patients of Ontario Health atHome, other health services providers, or OHTs[5]

"Health Service Provider" is defined to include Ontario Health atHome, public hospitals, psychiatric facilities, LTC homes, and not-for-profit entities that provide home and community care services, among other organizations.[6]

The Home and Community Care Services Regulation under the *CCA* sets out the criteria to determine eligibility for professional services, personal support services, and homemaking, and includes provisions related to payment for services, care planning, and a patient bill of rights.[7]

Fixing Long-Term Care Act

The *Fixing Long-Term Care Act, 2021* (*FLTCA*) came into effect in April 2022.[8] This legislation sets out the requirements for LTC homes in Ontario relating to resident rights, care and services, admissions, operations, funding, licensing, compliance and enforcement, and administrative matters.

The purpose of the *FLTCA* is to advance three priorities: (1) improve staffing and care; (2) protect residents through better accountability, enforcement, and transparency; and (3) build modern, safe, comfortable LTC homes for Ontario's seniors.[9]

The "fundamental principle" set out in this legislation is as follows:[10]

> The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.

Part IV of this legislation specifically deals with the admission of residents to LTC homes.

Find Out More

The process for admission to LTC homes is addressed in Section 5.

Health Care Consent Act

One of the primary sources of law with respect to consent in Ontario is the *Health Care Consent Act, 1996* (*HCCA*).[11] This legislation sets out the legal test for capacity and the requirements for obtaining consent, whether from a capable person or on behalf of an incapable person,[12] for treatment, admission to a care facility (LTC home),[13] and personal assistance services.

A fundamental principle of health care in Ontario is that a capable patient will decide whether or not to consent to a proposed treatment/plan of treatment. Where the person is lacking capacity, described in applicable legislation as "incapable person", there is a legal framework governing the making of treatment decisions.[14] These same fundamental principles apply to a decision to be made with respect to admission to a care facility (LTC home) or personal assistance services (when provided to a resident of a LTC home).

The stated purposes of the *HCCA* include the following:[15]

- To provide rules with respect to consent to treatment that apply consistently in all settings
- To facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters
- To enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed, and persons who are to receive personal assistance services by,
  - allowing those who have been found to be incapable to apply to a tribunal for a review of the finding
  - allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services
  - requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to
- To promote communication and understanding between health practitioners and their patients or clients
- To ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service
- To permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services

The terms "treatment", "personal assistance service", and "care facility" are all defined in the *HCCA*:[16]

> "treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include:
>
> - The assessment for the purpose of the Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose
> - The assessment or examination of a person to determine the general nature of the person's condition
> - The taking of a person's health history
> - The communication of an assessment or diagnosis
> - The admission of a person to a hospital or other facility
> - A personal assistance service
> - A treatment that in the circumstances poses little or no risk of harm to the person
> - Anything prescribed by the regulations as not constituting treatment
>
> "care facility" means,
>
> - A LTC home as defined in the *FLTCA*
> - A facility prescribed by the regulations as a care facility[17]

"personal assistance service" means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service.

Note:

At this time, the *HCCA* provisions dealing with substitute consent to personal assistance services on behalf of an incapable person currently apply only to residents of LTC homes. The *Substitute Decisions Act, 1992* (*SDA*) applies in other settings.

Decisions only fall within the parameters of the *HCCA* if they are within the scope of the above definitions.

Find Out More

The test for capacity under the *HCCA*, determining who should make decisions on behalf of an incapable person, and how those decisions are to be made are discussed in more detail in Section 7. The legal requirements relating to consent and capacity are addressed in Section 5 and Section 6.

Health Insurance Act

Ontario's *Health Insurance Act* (*HIA*) deals with the administration of the Ontario Health Insurance Plan (OHIP).[18] This legislation defines "insured service," or the services to which those with a valid OHIP card are entitled. There are aspects of health care in Ontario that are not insured services and that may be covered by other benefits or independently by individuals using the service.

Relevant specifically to discharge planning, the *HIA* sets out the law as it relates to OHIP coverage of hospital services and associated charges.

Find Out More

This legislation is discussed in more detail in Section 4, Section 8, and Section 9.

Public Hospitals Act

All hospitals in Ontario are operated in accordance with the *Public Hospitals Act* (*PHA*), as well as its Hospital Management Regulation.[19] Another regulation established under the *PHA* is the Classification of Hospitals Regulation.[20] This Regulation sets out the types of services provided at each public hospital in the province of Ontario. Relevant specifically to discharge planning, the *PHA* sets out the law as it relates to the admission and discharge of patients to and from hospitals in Ontario.

Find Out More

This legislation is discussed in more detail in Section 4, Section 8, and Section 9.

Personal Health Information Protection Act

The *Personal Health Information Protection Act, 2004* (*PHIPA*) governs the collection, use, and disclosure of personal health information (PHI). It also provides individuals with access to their own information and other rights, including a right to correct information and make complaints to the Information and Privacy Commissioner.[21]

PHI is identifying information about an individual that:[22]

- Relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family
- Relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual
- Is a plan that sets out the home and community care services for the individual to be provided by a health service provider or OHT pursuant to funding under section 21 of the *CCA*
- Relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual

- Relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance
- Is the individual's health number
- Identifies an individual's SDM

Much, if not all, of the information communicated by health care providers in discharge planning discussions is PHI. Health care providers, organizations, and service providers along the health care continuum may be "health information custodians" (HICs) and, therefore, may have access to, and control of, PHI of patients to whom they provide health care services.[23]

Specific to discharge planning, this legislation applies to the disclosure of PHI to other health care providers within the circle of care. The 'circle of care' is the phrase most commonly used to reference the range of HICs (professionals and organizations) involved in an individual's treatment and care along the health care continuum. There are provisions in *PHIPA* which, generally, allow for the disclosure of PHI within this circle of care, based on implied consent.

Find Out More

The 'circle of care' is discussed further in Section 10.

PHIPA also applies to the disclosure of PHI by HICs and their agents to SDMs, family members, and others close to the patient. Generally, PHI may be disclosed to a SDM "as necessary for, or ancillary to a decision" to be made on behalf of an incapable person.[24] A SDM may also consent to the collection, use, and disclosure of PHI on behalf of an incapable person. For family members and others close to the patient, PHI may only be disclosed with consent from either the capable patient or the appropriate SDM for an incapable person.

PHIPA impacts all areas of health care where the collection, use, and disclosure of PHI is involved. There are many resources available to address the specific provisions.[25]

Substitute Decisions Act

The *SDA* deals with how an individual may delegate the ability to make decisions about their property or personal care to another individual.[26] The *SDA* provides rules and guidelines for creating a power of attorney for property and/or a power of attorney for personal care. The *SDA* also provides rules for appointing a "guardian," which is a formal process involving the courts.

Generally, the *SDA* is designed to:[27]

- Give individuals more control over what happens to their lives if they later become incapable of making their own decisions
- Respect people's life choices, expressed before they become incapable, and take into account their wishes
- Recognize the important role of families and friends in making decisions for loved ones
- Clarify and expand the rights of adults who are mentally incapable, and the responsibilities of their SDMs
- Provide safeguards and accountability to protect mentally incapable people from harm
- Limit public guardianship and other government interventions to situations where there are no other suitable alternatives

Personal care decisions, as defined by the *SDA*, include decisions relating to health care, nutrition, shelter, clothing, hygiene, and safety.[28]

The *SDA* also has provisions for a "Guardian for Property" and a "Statutory Guardianship" in which the Public Guardian and Trustee may become involved in the management of property on behalf of an incapable person.[29]

Find Out More

Substitute decision-making, both under the *SDA* and the *HCCA*, is addressed in more detail in Section 7.

Retirement Homes Act and Residential Tenancies Act

The *Retirement Homes Act, 2010 (RHA)* is based upon the premise that a retirement home is to be a place where residents live with dignity, respect, privacy, and autonomy, in security, safety, and comfort, and can make informed choices about their care options.[30] Retirement homes are, by definition, a "residential complex," or part thereof, which is "occupied primarily by persons who are 65 years of age or older," not related to the operator of the home, and where there are "at least two care services available, directly or indirectly" for the residents.[31]

The *RHA* deals with licensing, residents' rights, safety standards, and administrative issues related to the operation of a retirement home. When living in a retirement home, the legal arrangement is a contractual relationship between a landlord and a tenant and is not an admission to a health care facility. This arrangement falls under the *Residential Tenancies Act, 2006*.[32]

Individuals receiving care services in a retirement home are expected to pay for care services provided through the retirement home as well as for the accommodation.[33] In addition, there is a formal eviction process to be followed if the home is looking to terminate the residency. This process applies even if the reason for the proposed termination of the tenancy is the changing care needs of a resident.

SECTION 4

Role of the Hospital and the Health Care Team

Roles and Obligations

Each hospital in Ontario has its own mission and values, in accordance with which it will provide direction to its staff and those working within the facility. In the discharge planning process, hospital staff work closely with care providers from a variety of regulated health professions and often with those associated with other organizations.

Many hospitals have developed detailed policies and procedures to facilitate a consistent and transparent approach to discharge planning. It is important to understand the parameters within which these tools operate.

Find Out More

Hospital policies and procedures are discussed in more detail in Section 10.

In addition to the legal requirements for admission and discharge from a hospital, each regulated health professional is required to act in accordance with the requirements of their individual College.

The discharge planning process often involves members of different regulated health professions, as well as staff from the hospital, Ontario Health atHome, and other community services providers. Communication and collaboration between care providers is often critical in working toward developing an appropriate and successful discharge plan for a patient.

Admission to Hospital

On admission to a hospital, a patient with Ontario Health Insurance Plan (OHIP) coverage will be entitled to "insured services" which generally include "services of hospitals".[1]

Hospitals in Ontario are required to accept as an in-patient anyone who is "admitted to the hospital pursuant to the regulation" and who "requires the level and type of hospital care" provided at that facility.[2] Patients are admitted by a physician, or other prescribed health care provider, when it is "clinically necessary that the person be admitted".[3]

Ontario Health has issued operational direction to hospitals requiring teams to assess, within 48 hours of admission, older adults (65 years and older) in the emergency department who may be at risk of adverse outcomes and having an alternate level of care (ALC) designation.[4]

Once admitted, a patient will remain in the hospital and is entitled to receive insured services until they are discharged.

Discharge from Hospital

Discharge Destinations

In recent years, Ontario Health has issued operational direction to hospitals, home and community care support services, and long-term care (LTC) homes that requires discharge teams to employ a "Home First" approach to discharge planning.[5] The "Home First" approach requires that "every effort is made to ensure adequate resources are in place to support patients to remain at home whenever possible, and ultimately return home upon discharge from all bedded levels of care."[6] Home should be the preferred discharge destination for a patient before an admission to LTC is considered.

Discussions regarding a patient's discharge destination should begin early in the patient's admission to hospital, ideally during the admission process, and clear, coordinated communication should continue throughout the discharge planning process. It is recommended that patients/substitute decision-makers (SDMs) and family/caregivers be meaningfully engaged as partners within the care team.

The team should work to explore **all clinically appropriate discharge options**, not only the patient's preferred discharge destination. In challenging situations, consideration should be given to involving an ethicist or spiritual care provider in the discharge planning process.

The discharge team should provide patients with information regarding the implications of remaining in hospital after being discharged, including that the daily rate for discharged patients will be charged. It is prudent to include documentation of these conversations in a patient's chart, and to provide a written summary to the patient, when relevant or appropriate.

When there are barriers to discharge or safety concerns that cannot be resolved, further consultation may be appropriate through complex discharge rounds or regional service resolution tables involving the care team, Ontario Health atHome, and representatives from community support services.

Home and Community Care Services

Discharge teams in the hospital can leverage the expertise of Ontario Health atHome care coordinators to identify and refer patients to appropriate community services.

Find Out More

Section 5 includes more information on Ontario Health atHome, admissions to LTC homes and referrals to home and community care services.

In recent years, some hospitals have implemented "Hospital-to-Home" programs to support patients in their return home. These transitional in-home support programs may include services such as nursing, occupational therapy, physiotherapy, social work, speech language pathology, personal support services, homemaking, care coordination, remote care monitoring, community paramedicine, and specialized geriatric services.

If a patient who no longer requires hospital services is found eligible for LTC prior to or during the hospital admission and is awaiting placement in a LTC home, the patient should not be designated ALC pending a LTC admission unless it is determined that the only clinically appropriate discharge destination is a LTC home.

If it is clinically appropriate for the patient to be discharged home or to another destination in the community while awaiting placement in LTC, the patient should be discharged to that destination while waiting for a LTC bed.

Discharge Orders

When a patient is no longer in need of treatment in the hospital, there shall be an order that the patient be discharged, made by the appropriate health care provider, and this shall be communicated to the patient/SDM, if appropriate.[7] The discharge order is written by a physician/delegate[8] and, when a discharge order has been made, the hospital shall discharge the patient and the patient shall leave the hospital on a date set out in the order.[9]

The decision to write a discharge order is a clinical one to be made by an attending health care provider. In some cases, discharge orders may be appropriate if written in anticipation of an event – for example, 'patient to be discharged when bed available at a specific discharge destination.' In other situations, it may be appropriate for a discharge order to be more specific – for instance, 'patient to be discharged tomorrow morning.'

A patient may be designated as ALC by the patient's attending clinician if the attending clinician is of the opinion that the patient does not require the intensity of resources or services provided in the hospital setting.[10] If a patient has been designated as ALC and the patient's admission to a LTC home has been authorized, a discharge order must be written.[11]

Find Out More

More information regarding admissions to LTC is set out in Section 5.

The hospital administrator may grant permission for a patient to remain in a hospital for a period of up to 24 hours after the date set out in the discharge order.[12]

Once a patient has been discharged, and an additional 24-hour period lapsed, that person is no longer entitled to 'insured in-patient services' at the hospital.

Within 48 hours after a patient's discharge, the physician must prepare a discharge summary, which will typically include recommendations for follow up care. It is prudent that the discharge plan for the patient be documented in the patient's chart.[13]

Discharge Against Medical Advice (AMA)

There are circumstances in which patients choose to discharge themselves against medical advice (AMA).

A capable patient can make a decision to discharge themselves AMA; however, if this occurs, steps should be taken to minimize the risks associated with the patient leaving and this may include offering and facilitating access to prescribed medications as well as offering and facilitating the arrangements for follow-up care and community based services, educating the capable patient about the risks of leaving AMA, and plans/options for further treatment and care if they change their mind or there is a change in their condition. Where appropriate, this may also include contacting family/caregivers for the patient. The risks, benefits, and alternatives to leaving should be discussed with the patient, and these conversations should be documented in detail in the patient's chart.

There are other issues to consider when an incapable person wants to leave AMA, or their substitute decision-maker (SDM) would like to remove them from hospital AMA, and they require medically necessary treatment. An incapable person cannot make the decision to withdraw consent to treatment. Steps should be taken to work with the incapable person and their SDM to understand the concerns with staying in hospital. In all these situations, the incapable person's SDM must follow the principles for giving or refusing consent on behalf of an incapable person set out in the *Health Care Consent Act, 1996* in making these decisions.

Find Out More

Section 7 includes more information on SDMs.

Scenario

There is a spectrum of scenarios in which a patient may be discharged AMA. On the one end of the spectrum are situations in which a patient chooses to leave against medical advice but their decision is still within the range of acceptable risk. Examples might include a stable patient choosing to leave the Emergency Department instead of undergoing further tests or awaiting consultation from a specialist the following day.

On the other end of the spectrum are circumstances in which it is not safe, and the authorities may need to be contacted if someone tries to remove an incapable person AMA. For example, a child in need of medical care and a parent indicates their intention to take the child home. Another example is an older incapable adult receiving palliative care, whose condition requires continued hospitalization to effectively manage symptoms and provide end-of-life support. One of the patient's SDMs, her son, consents to her continued stay in the hospital; however, the patient's other SDM, her daughter, is of the view the patient should return home with her and takes the patient home under the guise of taking her mother outside for a "smoke break".[14]

Find Out More

Refer to Section 7 for more information on making decisions in accordance with an incapable person's best interests.

Discharge to Community without Housing

Occasionally, clinicians are faced with situations where hospital patients are ready for discharge home but are under-housed or experiencing homelessness. In these circumstances, discharge destinations may include a shelter or, where a shelter placement is declined or not available, may include other destinations such as a tent encampment.

Clinicians may be hesitant to discharge a patient to these destinations. Given that some discharge destinations can be precarious, the steps to minimize risk outlined above on discharge AMA should be implemented as appropriate. In circumstances where a person lacks capacity to make decisions about discharge placements, identifying an appropriate SDM may be challenging. Where a valid power of attorney exists, this can assist clinicians in managing the process to try to identify alternative discharge options that are more appropriate. In the absence of a valid power of attorney, or any other appropriate SDM, the Public Guardian and Trustee may need to be engaged.

Ultimately, navigating this discharge option is challenging and an interdisciplinary approach is important.

Introduction to Co-Payments

A co-payment may be charged by certain designated hospitals when a patient is admitted but awaiting placement in certain non-acute institutions. At this point, there would be a charge associated with their stay.

One of the principles in support of a co-payment is that there should not be a financial incentive for patients to remain in the hospital instead of accepting a bed in a facility where a co-payment is charged (i.e., LTC or chronic care/complex continuing care (CCC) facility).[15] The maximum co-payment rate is the same for all patients and all hospitals, subject only to the ability to apply for a reduction based on specific circumstances.

A co-payment should be charged once the patient's attending physician determines the patient requires chronic care and is more or less permanently resident in a hospital or other institution where there is an applicable co-payment charge. This includes LTC and CCC. There are situations in which it may not be appropriate to charge a co-payment, even if the person is designated ALC. For example, if a patient is actively receiving treatment for an infection or illness, their ALC designation should be removed for the period of time that they are receiving acute care and a co-payment is not appropriate. Similarly, if a patient is awaiting or participating in a temporary course of treatment, such as a rehabilitation program, charging a co-payment may not be appropriate.

Whether a co-payment may be charged will depend on several factors in addition to a patient's ALC status. These include the designated discharge destination(s), if any, and the classification of the hospital where the patient is waiting for the next stage of their treatment and care.

The co-payment rate is separate from any additional charges that may be incurred during an admission to a hospital – for example, a charge for a preferred accommodation or TV services. These types of charges may be applied, regardless of a patient's ALC status.

Find Out More

See Section 8 for more information about co-payments.

Introduction to Daily Rate Charges for Discharged Patients

When a patient no longer requires the services provided at a hospital and has been discharged but does not leave, it may be appropriate to charge a daily rate for their continued stay. This daily rate is a contribution towards the uninsured services the patient is receiving. The Hospital Management Regulation under the *Public Hospitals Act* has set the daily rate at $400.[16]

A daily rate charge cannot be charged to an ALC patient. This rate may only be charged after a patient is discharged and a 24-hour period has passed where the patient has not left the hospital.

Find Out More

The policy recommendations and considerations relating to this rate are set out in Section 9.

SECTION 5

Ontario Health atHome and Community Resources

Ontario Health atHome

Ontario Health atHome coordinates in-home and community-based care for Ontarians. Ontario Health atHome care coordinators often work with members of the hospital-based interprofessional team in the discharge planning process. Ontario Health atHome care coordinators understand the services available in the community and can participate in comprehensive care planning. Ontario Health atHome makes every effort to ensure adequate resources are in place to support patients to remain at home, or return home upon discharge from hospital, wherever possible (the "Home First approach"). Ontario Health atHome care coordinators and placement coordinators facilitate the admission process for long-term care (LTC). With information and referrals from the hospital team, experience and information flowing from any pre-admission involvement, or direct inquiries from or on behalf of a patient, care coordinators may be involved in the consideration and development of several options or recommendations for a discharge plan.

One of the guiding principles of the Home First approach is that decisions about a possible admission to LTC are best made in a patient's home where the patient's day-to-day needs can best be evaluated and understood.[1]

It is recommended that Ontario Health atHome care coordinators be engaged early in the discharge planning process.

Find Out More

See Section 4 for further information regarding the Home First approach.

Ontario Health atHome has published a Patient Bill of Rights and Responsibilities, which outlines how Ontario Health atHome employees, board members, and contracted service providers will respect and promote a patient's rights, along with the patient's responsibilities when interacting with Ontario Health atHome or its service providers.[2]

Home and Community Care Services

In addition to its role with respect to LTC home admissions, Ontario Health atHome is also responsible for arranging, and in some cases providing, services in the community. As part of the discharge planning process, Ontario Health atHome can assist with the development of options and recommendations for community-based care, including relating to the care and services for which a patient may be eligible.[3]

In-Home Services

The in-home services provided through or by Ontario Health atHome may include homemaking services, personal support services, and professional services. Under the Home and Community Care Services Regulation, these services are defined as follows:[4]

- **Homemaking services** – Housecleaning, laundry, shopping, banking, paying bills, planning menus, preparing meals, caring for children, assisting with or training someone to do the preceding tasks.
- **Personal support services** – Personal hygiene activities, routine personal activities of living, assisting with or training someone to carry out or assist with either of the preceding activities.
- **Professional services** – Nursing services, occupational therapy services, physiotherapy services, social work services, speech-language pathology services, dietetics services, training a person to provide any of the aforementioned professional services, providing certain equipment and supplies necessary to the aforementioned services, diagnostic and laboratory services, pharmacy services, respiratory therapy services, social service work services, and psychology services.

The listed services are not all available throughout the province. Where they are available, they are provided either directly by Ontario Health atHome or through arrangements between Ontario Health and services providers.

Determinations of Eligibility and Care Plans

When an application or referral for services is received, Ontario Health atHome assesses a person's care needs, determines the person's eligibility for home care services, and, if the person is eligible, develops a care plan. The care plan sets out the amount of home and community care services to be provided, the duration of the service, the care goals, and whether the service will be provided in person or virtually.[5]

There are no longer legislated "service maximums" for homemaking, personal support services, and nursing services. Rather, when assessing a person's needs, determining eligibility, and developing a care plan, a health service provider or Ontario Health Team must consider the availability and capacity of family and other caregivers to provide care to the patient, the availability of publicly funded services that would meet the patient's needs, and the opportunity for referrals to providers of non-health services.[6]

If a person does not qualify for home care services and believes that they should, the person can file a complaint with Ontario Health atHome or appeal a decision by Ontario Health atHome to the Health Services Appeal and Review Board (HSARB).

Other Community Services

Ontario Health atHome also provides information about, and referrals to, other services and supports that people may need at home or in the community after discharge. These services include community support services, Indigenous services, care coordination services, and residential accommodation, such as assisted living and supportive housing, that may be available through other community-based organizations.[7]

- **Community support services** – Meal services, transportation services, caregiver support and respite services, adult day programs, home maintenance and repair services, friendly visiting services, security checks or reassurance services, client intervention and assistance services, emergency response services, foot care services, home help referral services, independence training, palliative care education and consultation services, psychogeriatric consulting services, psychogeriatric consulting services relating to Alzheimer's disease and related dementias, public education services relating to Alzheimer's disease and related dementias, services for persons with blindness or visual impairment, services for persons with deafness, congenital hearing loss or acquired hearing loss, bereavement services, behavioural supports, and education, prevention, and awareness services pertaining to home and community care services, mental health and addictions, chronic disease management, aphasia and communication disorders, and vocational training and education for persons with a cognitive or physical impairment.[8]
- **Indigenous services** – Traditional healing and Indigenous cultural support services.[9]
- **Supportive housing** – Supportive housing buildings are often owned and operated by not-for-profit corporations or groups, or housing cooperatives. Supportive housing can enable seniors, adults with physical or cognitive disabilities, mental health issues, and other conditions to live independently with some supports and shared accommodation.[10]
- **Assisted living** – Assisted living is available for individuals such as high-risk seniors, adults with an acquired brain injury or physical disability, and those living with HIV/AIDS who may need higher levels of support but do not require the level of services provided in a LTC home.[11]
- **Retirement homes** – Retirement homes provide care and services to residents with varying needs.[12] Retirement homes are privately owned and operated, regulated by the Retirement Homes Regulatory Authority (RHRA), and governed by the *Retirement Homes Act, 2010* (*RHA*).[13] The *RHA* includes a Residents' Bill of Rights, care standards, and circumstances in which an inspection by the RHRA is conducted. Residents of a retirement home are tenants of the retirement home and pay directly for the care services they receive.

Scenario

During discharge planning discussions, a patient's daughter has repeatedly shared her view that her mother (who is capable) can no longer manage at home as she requires a walker, has difficulty cooking meals, and has slipped in the shower a couple of times. A referral is made to Ontario Health atHome.

An Ontario Health atHome care coordinator assesses the patient's care needs and determines that they are eligible for in-home services. The care coordinator works with the patient and her daughter to develop a care plan that includes assistance with showering, community supports for meals and house cleaning, and an occupational therapy assessment to ensure the patient's home has the necessary equipment and modifications to enable the patient to perform her activities of daily living safely.

When she no longer requires the level of care provided at the hospital, the patient is discharged from home with services in place. Ontario Health atHome continues to be involved in supporting the patient in the community, and, when the patient is ready, can work with the patient and her family to determine eligibility for LTC as well as assist with LTC applications, if the patient is eligible.

Long-Term Care Homes

Process for Admission to Long-Term Care Homes

Ontario Health atHome care coordinators are the designated placement coordinators under the *Fixing Long-Term Care Act, 2021 (FLTCA)* responsible for managing the process for admission to LTC homes in Ontario.[14] While the *FLTCA* only uses the term "placement coordinator", in practice, Ontario Health atHome uses the terms "care coordinator" and "placement coordinator" to describe the different parts of the legislated placement coordinator role.[15]

Ontario Health atHome care coordinators are responsible for:

- Determining a person's eligibility for admission
- Working with patients to explore other housing options
- Providing applicants with information
- Assisting applicants with placement-related application processes

Ontario Health atHome placement coordinators are responsible for:

- Prioritizing admissions
- Monitoring and managing wait lists
- Authorizing admission to LTC homes

Ontario Health atHome's Guide to Placement in Long-Term Care Homes is a resource for patients outlining the process for applying to a LTC home.[16]

Ontario Health atHome must be involved when trying to determine if someone is eligible or may be admitted to a LTC home as part of their discharge plan.

Members of the hospital-based discharge team may be involved in discussions relating to a discharge plan that includes a LTC home and may be comfortable answering questions related to discharge. Given the complexity of the legislated process, early commencement and involvement of Ontario Health atHome care coordinators is beneficial to the discharge planning process.

Once Ontario Health atHome has received a referral or request for placement in a LTC home, a care coordinator must provide the person considering admission with information about:[17]

- Alternative services that the person may wish to consider
- The accommodation charges that LTC home residents are responsible for paying and the maximum amounts that a home may charge
- The application for a reduction in the basic accommodation charge that can be made to the Director (i.e., Ministry of LTC) and the supporting documentation required, including the person's Notice of Assessment under the *Income Tax Act* and proof of income statement from the Canada Revenue Agency

The *FLTCA* enables care coordinators to take certain steps in the LTC eligibility and admissions process without the consent of the patient or their substitute decision-maker (SDM) for hospital patients who, in the opinion of the patient's attending clinician, no longer require the intensity of resources or services provided in the

hospital setting (ALC patients).[18] These steps are described below in the sections addressing eligibility and admissions, and may only be taken without consent **if reasonable efforts have been made to obtain consent** from the patient or the patient's SDM.[19] If the patient or their SDM provide their consent to any stage of the process, then the usual process is followed.[20]

Eligibility for Admission to Long-Term Care Homes

The General Regulation under the *FLTCA* sets out the requirements to determine whether a person is eligible for an admission to a LTC home. Any person may apply for an assessment of eligibility for placement in a LTC home, regardless of the setting the person is in when they apply. In order to be eligible for a long-term placement in a LTC home, the person must:[21]

- Be at least 18 years old
- Be insured under the *Health Insurance Act*; and
- Require:
  - that nursing care be available on site 24 hours a day;
  - assistance with activities of daily living at frequent intervals throughout the day; or
  - on-site supervision or on-site monitoring to ensure their safety or well-being at frequent intervals throughout the day.

In addition, it is required that the publicly funded community-based services available to the person and the other caregiving, support or companionship arrangements available to the person are not sufficient, in any combination, to meet the person's requirements, and the person's needs can be met in a LTC home.

Two assessments must be conducted before Ontario Health atHome may determine whether a person is eligible for long-term care admission: a health assessment and a functional assessment.[22]

The health assessment involves an assessment of the person's physical and mental health, as well as their requirements for medical treatment and health care.[23] The health assessment must be completed by a physician or registered nurse.[24]

The functional assessment evaluates the person's functional capacity, requirements for personal care, current behaviour, and behaviour during the previous year.[25] The functional assessment must be completed by an employee or agent of Ontario Health atHome who is a registered: nurse, practical nurse, social worker, physiotherapist, occupational therapist, speech-language pathologist, or dietitian.[26] The health assessment and functional assessment may not be completed by the same individual.

Ontario Health atHome can only authorize admission to a LTC home if each of the health and functional assessment was completed within the three months prior to the authorization of admission, OR there was a significant change in the person's condition or circumstances which would prompt a reassessment.[27]

Eligibility Assessments for Patients/SDMs Who Do Not Consent

There are situations in which an ALC patient in hospital, or their SDM, may not agree to apply for admission to a LTC home. When this happens, a care coordinator may determine the ALC patient's eligibility for admission to LTC without the usual consent IF the patient's attending clinician reasonably believes that they may be eligible for admission and requests that their eligibility be determined. Additionally, a health assessment and a functional assessment may be requested. If a care coordinator requests an assessment of an ALC patient and the patient/SDM does not consent to the patient being assessed, the person conducting the assessment must base their assessment solely on a review of the existing hospital records relating to that patient.[28] There is specific information that a care coordinator must share with the patient, or their SDM, when a care coordinator receives a request from an attending clinician to determine the ALC patient's eligibility or they have already been determined eligible and an application to additional LTC homes is being considered.[29]

If a person is found ineligible for admission to a LTC home, Ontario Health atHome must provide them with written notice that outlines the reasons for the determination of ineligibility and explains the process for applying to HSARB for a review of the finding. Ontario Health atHome must also advise the applicant of alternative services and make referrals to such services, as appropriate.[30]

Application for Admission to Long-Term Care Homes

There are many considerations that a person may wish to take into account when applying for admission to a LTC home. Ontario Health atHome care coordinators are aware of the resources available at the LTC homes as well as other supports and resources available in the community.

The care coordinator who determined that the person is eligible for a LTC home admission is available to assist the person with selecting the LTC home(s) to which the person would like to apply, taking into consideration the person's preferences based on ethnic, religious, spiritual, linguistic, familial, and cultural factors.[31] An applicant who has been found eligible may select homes anywhere in Ontario.

For ALC patients/SDMs who do not consent to applying for admission to LTC, the care coordinator may select LTC home(s) for the ALC patient under section 60.1 of the *FLTCA* without the patient's/SDM's consent. This is likely to occur in circumstances in which a patient is designated ALC, all other discharge destinations have been explored, LTC is determined to be the only clinically appropriate option, and the patient does not consent to applying for LTC. The regulations describe the factors the care coordinator must consider in selecting a home, including its geographic location.[32] In these circumstances, the patient/SDM can still refuse placement.

The process to apply to a LTC home is set out in the *FLTCA* and is managed by Ontario Health atHome.[33] To apply for admission to a LTC home in the usual course, the applicant must provide to a care coordinator a written request for authorization of the applicant's admission to the LTC home, copies of the health and functional assessments, and written consent to the disclosure of all information necessary to deal with the application.[34] Where an application is made without consent, the care coordinator may provide LTC homes with assessments and information, including personal health information, without the patient's/SDM's consent.[35]

As part of the application process, the care coordinator gives the selected LTC home(s) copies of the assessments and other required information that was taken into account when determining the person's eligibility.[36] In the usual course, applications may be submitted for up to five LTC homes. There is no limitation on the number of applications that may be submitted on behalf of a person who has been given "crisis priority" for admission to LTC.

Generally, a LTC home is required to provide Ontario Health atHome with a response as to whether it will approve, or withhold approval of, the application for admission within five business days of receiving the application.[37] A LTC home must approve all applications for admission, including those from a care coordinator on behalf of an ALC patient, unless the home lacks the physical facilities (such as wheelchair accessible rooms) necessary to meet the applicant's care requirements or the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements.[38] Nursing expertise doesn't refer to nursing resources, but rather to the training and skills required to manage the complexity and acuity of the applicant's case.

When a LTC home withholds approval of an application for admission, the LTC home must provide written notice of this decision to the applicant and the care coordinator. The written notice must include the ground(s) for withholding approval, a detailed explanation of supporting facts, an explanation of how the supporting facts justify the decision, and the contact information for the Director (Ministry of LTC).[39]

Once a LTC home approves the application for admission, the applicant may be placed on a wait list if a bed is not immediately available. When a person applied to more than one LTC home, they may be on multiple wait lists. Each placement coordinator keeps a waiting list for admission to LTC homes for which they are designated.

There are several categories to the LTC home waitlists, including the Crisis Category, or Category 1, for applicants who require immediate admission as a result of a crisis arising from the applicant's condition or circumstances. Other categories include people who need to be reunified with spouses/partners who are currently residing in a LTC home, or people waiting for a LTC home serving those of a particular religion, ethnic origin, or culture.

In some circumstances, a hospital patient may be placed in the Crisis Category. If an ALC patient requires an immediate admission to a LTC home, the hospital is experiencing severe capacity pressures, and Ontario Health atHome has verified these pressures, the patient must be placed in the Crisis Category.

Authorization of Admission to Long-Term Care Homes

It is generally expected that the applicant will accept an offer from a LTC home to which an application was made. An applicant has 24 hours to accept or decline an offer of admission.[40]

If the offer is accepted, it is generally expected that the person will transition to the LTC home as promptly as possible and before noon on the fifth day following the offer. In some situations, arrangements may be made to move in at a later date.

If the ALC patient/SDM does not consent to authorize the patient's admission to the LTC home and reasonable efforts have been made to obtain consent, the placement coordinator may authorize the patient's admission to the home in the absence of consent.

Consent for Admission to Long-Term Care Homes

While a patient's admission to a LTC home may be **authorized** with or without their consent under the *FLTCA*, patients cannot be physically transferred to a LTC home without their or their SDM's consent if they refuse to go to a LTC home. The *FLTCA* requires consent for **admission** to a LTC home.[41]

To be able to give consent, a person must be found to be capable, as defined under the *Health Care Consent Act, 1996* (*HCCA*).

A person is capable of making a decision about their admission to a LTC home if they are able to:[42]

- Understand the information that is relevant to making a decision about the proposed admission; and
- Appreciate the reasonably foreseeable consequences of a decision, or lack of a decision.

A person is presumed capable with respect to admission to a care facility (LTC home) unless there are reasonable grounds to believe the person is incapable with respect to the admission. If a person's capacity to consent to an admission to a LTC home is in question, the person's capacity needs to be assessed by an evaluator. The evaluator can be a physician, nurse, occupational therapist, dietitian, audiologist, speech-language pathologist, physiotherapist, or psychologist.[43]

If an evaluator finds a person does not meet the requirements, then consent must be obtained from the person's SDM.[44]

Find Out More

Further information regarding substitute decision-making is available in Section 7.

The consent must be voluntary, informed, and specific to the LTC home to which an application has been submitted.[45] In addition, for consent to be considered "informed," the person making the decision (the patient/SDM) must be provided with the following information:[46]

- Details of the proposed admission, including what the admission entails
- The expected advantages and disadvantages of the admission
- Alternatives to the admission
- The likely consequences of not being admitted

It is part of Ontario Health atHome's responsibility and obligation to obtain valid, informed consent to an admission to a LTC home during the application process. Consent discussions should be clearly documented.

If the ALC patient/SDM does not consent to the admission, the patient is required to be discharged from hospital.[47]

Find Out More

Section 4 provides further information regarding discharge orders.

If the discharged patient does not leave the hospital within 24 hours, a fee of $400 per day must be charged for every day they remain in hospital.

Find Out More

The impact of this is discussed in more detail in Section 9.

Additionally, if the patient seeking a long-stay in a LTC home is offered a bed in a LTC home and does not consent to the admission, fails to move into the LTC home before noon on the fifth day following the offer, or refuses to enter into an agreement with the LTC home to move in by noon on the fifth day and pay the accommodation charges, they are removed from all LTC home waitlists.[48] Among other exceptions, this does not apply if the person is awaiting a LTC home placement while at a psychiatric facility within the meaning of the *Mental Health Act (MHA)* and is receiving in-patient services in accordance with the *MHA*.[49]

If the ALC patient/SDM consents to admission at a LTC home that is not their preferred home(s), they are permitted to remain on waitlists for their preferred LTC home(s) once admitted.

Scenario

An older adult is brought to the hospital following a stroke. They are left with significant deficits. Early in the admission, the care team started discussing possible discharge destinations with the patient and their family and involved Ontario Health atHome. Home care options were explored and the patient was assessed for eligibility for LTC. It was determined that given the patient's care needs, LTC was likely the only clinically appropriate option. The Ontario Health atHome care coordinator determined that the patient was eligible for LTC and met with them and their family to discuss LTC home options. While the hospital is located in Southwestern Ontario, the patient's applications were made to LTC homes close to Ottawa, where their daughter lived.

Applications were submitted to three LTC homes, with the top choice being a LTC home that provides care with a focus on the patient's religious/cultural community. The other two LTC homes did not have these affiliations.

There were waitlists for the first two homes on the list, but the application was accepted at, and admission authorized to, the third-choice home. The patient remained on the waitlist for the first choice LTC home and will be able to transfer there once a bed is available.

Crisis Admission: Guidance

The *HCCA* provides for an incapable person's admission to a LTC home without consent in limited circumstances. If the person responsible for authorizing admission to a LTC home is of the opinion that:

- An incapable person requires an immediate admission to a LTC home as a result of a crisis; and
- It is not reasonably possible to obtain an immediate consent or refusal on the incapable person's behalf,

the person's admission to LTC may be authorized, and the person may be admitted, without consent.[50]

Crisis is defined as "a crisis relating to the condition or circumstance of the person who is to be admitted" to the LTC home.[51] This provision is akin to the emergency treatment provisions under the *HCCA.* It is rare for these provisions of the *HCCA* to be relied upon. A "crisis admission" is not the same as a person being in the "crisis category" on the wait lists for a LTC home.[52]

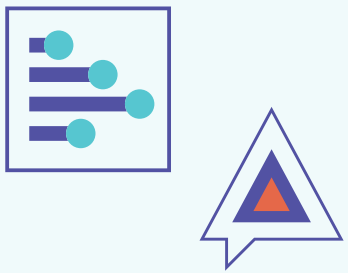
The person responsible for authorizing admissions to the LTC home shall obtain consent, or refusal of consent, from the incapable person's SDM promptly after the person's admission.

The crisis admission provisions do not apply with respect to the authorization for admission of an ALC patient.[53] However, an admission of an ALC patient to a LTC home under section 60.1 of the *FLTCA* does not preclude a crisis admission to a LTC home, if required.[54]

Scenario

A couple is living in the community with some home care services as one of them has middle-stage dementia. While there have been discussions about the need for LTC at some point, their plan had been to stay together in their home as long as possible. Spouse A is the primary caregiver and SDM for Spouse B, who has dementia.

Spouse A has a medical event and is taken to hospital where he remains unconscious in the intensive care unit (ICU). As there is no one immediately available to care for Spouse B, they are also brought to hospital. Social workers at the hospital connect with Ontario Health atHome. Both are unsuccessful in contacting another SDM for Spouse B. Arrangements are made for a “crisis admission” to LTC for Spouse B while efforts continue to contact an appropriate SDM to make decisions on their behalf until Spouse A is able to resume the SDM role.



SECTION 6

Role of the Patient, Substitute Decision-Maker, Family, and Caregivers

The focus of the discharge planning process is the individual for whom options and recommendations are being developed, and their care needs.

Some of these patients are capable of making decisions on their own and choose to involve friends and family in the process. Others may not be capable and have a substitute decision-maker (SDM) acting on their behalf, in consultation with the incapable person, their friends, and family.

Find Out More

SDMs are discussed in more detail in Section 7.

Capable Person

A capable person must make their own decisions. They may wish to include family and friends in the decision-making process, but ultimately, the decisions are theirs.

A capable person may feel strongly about a particular component of a discharge plan or may rely on the input of others in their life, such as a family member, caregiver, essential care partner, or friend. It is important for the health care providers working with a patient to focus on that person's decisions.

General Guidance for Decision Making

Discharge discussions with patients and their SDMs (if applicable) can be difficult. The discharge process may involve a number of significant decisions, within the context and stress of managing a patient's health. When engaging with patients and SDMs to reach decisions for discharge, consider:

- Having adequate time to explain what decisions are required and why
- Multiple modes of communication (e.g., verbal and written)
- Optimizing communication from all involved, such as active listening skills
- Providing reasonable time in which to make decisions, within the context of a patient's health status and administrative requirements (not in the moment or "by end of day")
- Offering supports to the family, such as spiritual care or an ethicist, to assist in the decision-making process

A capable person can make a decision that, in the opinion of a health care provider, is not a wise one. As a capable decision it needs to be respected.

For health care providers, it is also important to be aware of capacity concerns that may arise and the impact that they may have on the consent process.

A few reminders on capacity:

- There is no 'age of consent' in Ontario — there is no set age when a person can start or stop making their own decisions.
- Just because someone has completed a power of attorney for personal care, it does not mean that the person is not capable of making their own decisions.

- A person should not be considered to be incapable solely because they have been diagnosed with a particular illness or condition.
- A person may be capable with respect to certain treatments or decisions, but not others.
- A person may be capable with respect to some aspects of decision making (i.e., capacity with respect to personal health information), but not others (i.e. capacity with respect to treatment).
- Determining capacity is a point-in-time analysis. Capacity can fluctuate over time.

Consent and Capacity

When a health care provider has a concern about the capacity of a patient, they must consider whether the patient is 'capable.' The test for capacity with respect to treatment, admission to a care facility (long-term care (LTC) home) or a personal assistance service is set out in subsection 4(1) of the *Health Care Consent Act, 1996* (*HCCA*) and provides that a person is capable if they are:[1]

- Able to understand the information relevant to making a decision about the proposed treatment/admission/personal assistance service
- Able to appreciate the reasonably foreseeable consequences of their decision

A patient may be determined to be incapable if they fail to meet one or both parts of the test. A patient is presumed to be capable with respect to treatment, admission to a care facility (LTC home), and personal assistance services care absent reasonable grounds for a health care practitioner to think otherwise.[2]

Capacity can fluctuate – it is not static and must be considered at various points in time as well as in relation to different issues, treatments, and discharge planning decisions.

For some patients, capacity can be affected by medical conditions that are more common with advancing age. For example, delirium, a typically reversible condition, can temporarily impair decision-making capacity. Capacity may also depend on the stability of an underlying condition.

A patient with dementia may lose their capacity to make certain decisions as their condition worsens. They may well retain the ability to make some more basic decisions regarding their care and treatment, or aspects of their discharge plan.

In determining capacity, a health care provider can rely on previously documented evaluations and assessments of capacity, however, capacity needs to be carefully and routinely evaluated. A health care provider should review capacity as appropriate during clinical interactions with an individual.

For patients who are not capable, a SDM will become involved in the decision-making process.

Find Out More

See Section 7 for more information on SDMs.

Whether a decision for admission to a care facility (LTC home) is being made by a patient or a SDM, consent must be 'informed' to be valid.

Find Out More

The criteria for valid informed consent with respect to admission to a care facility is covered in Section 5.

There are provisions for consent with respect to treatment, which are as follows:[3]

- It must be related to the treatment;
- It must be informed;
- It must be given voluntarily; and
- It must not be obtained through misrepresentation or fraud.

In addition, for the consent to be considered 'informed', the person making the decision must be provided with information about, and have received responses to, any questions about:[4]

- The nature of the treatment
- The expected benefits of the treatment
- The material, special, or unusual risks of the treatment
- The material side effects of the treatment

- Alterative courses of action, and the relative and comparative risks of benefits between the options
- The likely consequences of not having the treatment

These obligations in obtaining valid informed consent to a proposed treatment are not specific to discharge planning and are addressed elsewhere in this Guidance Document as well as in other resources.

External Supports

It is important to acknowledge the essential role that external supports, such as family members, caregivers, essential care partners, or friends, play in the discharge planning process. These individuals may be involved as part of a support system for a capable or incapable person, acting as a SDM, taking on the role of a care provider, or otherwise providing care and support for their loved one. Health care providers will have to consider whether they have consent to disclose the patient's personal health information to a support person for the patient.

Support persons are not, and cannot be, required to participate in discharge planning, provide care in the community, or perform any other task/role that they are not willing to undertake.

In addition to exploring the willingness, capability, and ability of someone to take on the responsibility of caring for a patient, it should be considered whether there is any reason the caregiver may not be able to take on the level of care being contemplated in the plan. One example may be an adult child providing care for a parent whose needs conflict with the adult child's own parenting responsibilities.

Patients and family members should be encouraged to discuss a comprehensive discharge plan, as well as advance care planning in general. Discharge planning is an opportunity for patients to discuss their wishes, hopes, and plans for their future health care with their family/caregivers, potential/actual SDMs, and others.

Health care providers may be a resource to help facilitate and support these discussions as well as provide additional information that may be of assistance.

Find Out More

See Section 10 for more information on hospital policies and the importance of accuracy and consistency in the communication of information.

For health care providers, it is important to acknowledge and engage those helping the patient during their transition(s) through the health care system. This includes making sure that roles, responsibilities, and capabilities are understood by all involved.

Guardians and/or Powers of Attorney for Personal Care

A court-ordered guardian of the person is the highest-ranking SDM for treatment under the *HCCA*. This type of guardian is ordinarily appointed as a last resort, such as where there is no power of attorney for personal care or the identified attorney for personal care is not appropriate.[5] To be appointed, the Court must be satisfied that the person is incapable of making decisions in at least one aspect of personal care and also needs to have personal care decisions made. No guardian will be appointed if there is an alternative that does not require the person to be determined incapable of personal care or the alternative is less restrictive than the appointment of a guardian.

Attorneys for personal care are designated by persons while still capable, set out in a power of attorney document. A power for attorney for personal care may only be operative if (a) the *HCCA* applies to the decision, or (b) the person to whom the power of attorney applies is not believed to be capable of making personal care decisions. These powers of attorney may contain instructions, which the attorney must attempt to follow unless it is impossible to do so.

SECTION 7

Role of the Substitute Decision-Maker

The role of the substitute decision-maker (SDM) is to make decisions on behalf of an incapable person. The comments about informed consent in Section 5 and Section 6 are equally applicable when the consent is being given by a SDM. There are rules for determining who may act as a person's SDM as well as principles to be applied by the SDM when they are making decisions on behalf of an incapable person. The following is an overview of these rules and principles.

Identifying the SDM

One of the challenges in discharge planning may be identifying the appropriate SDM for an incapable person. This process includes determining who may be entitled to make decisions on behalf of an incapable person, as well as whether the proposed SDM is "qualified" to make the decisions.

General Guidance for Decision-Making

When engaging with potential SDMs, consider:

- Providing information on the role of a SDM (as outlined in legislation or a prepared handout)
- Having adequate time to explain what decisions are required and why
- Multiple modes of communication (e.g., verbal and written)
- Optimizing communication for all involved, such as active listening skills
- Providing reasonable time in which to make decisions, within the context of a patient's health status and administrative requirements (not in the moment or "by end of day")
- Exploring the values, beliefs and wishes of the patient (as previously documented, or shared during that admission)
- Confirming that the potential SDM is willing and able to make decisions on behalf of the patient, in light of the decisions to be made
- Offering supports to the family, such as spiritual care or an ethicist, to assist in the decision-making process

The *Health Care Consent Act, 1996* (*HCCA*) outlines the hierarchy for determining who may give substitute consent on behalf of an incapable person with respect to proposed treatment, admission to long-term care (LTC) and for personal assistive treatment. The *HCCA* does not apply to decisions beyond the scope of this legislation, including more general "personal care" decisions addressed in the *Substitute Decisions Act, 1992* (*SDA*).

The decisions that fall under the *HCCA*, compared to the *SDA*, are summarized below:

Decisions under the *HCCA*	Decisions under the *SDA*
• Medical treatment • Admission to care facilities • Services at care facilities	• Management of finances and/or property • Decisions relating to personal care (health care, food, living arrangements or housing, clothing, hygiene, and safety)

The following is the hierarchy in the *HCCA* that is used to identify the 'highest ranked' possible SDM to make decisions on behalf of an incapable person under that legislation:[1]

1. The incapable person's guardian, if the guardian has authority to give or refuse consent relating to the decision being made.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent, relating to the decision being made.
3. The incapable person's representative appointed by the Consent and Capacity Board (CCB), if the representative has authority to give or refuse consent relating to the decision being made, and if the decision falls within the scope of the *HCCA.*
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.

The highest-ranking person in the hierarchy is entitled to make decisions on behalf of the incapable person. A SDM who is lower in the hierarchy may give or refuse consent if they believe that a higher ranking SDM would not object to them making the decision, as long as the higher ranking SDM is not a guardian, attorney for personal care or CCB representative.[2] A more detailed review of the hierarchy is set out in Appendix A.

A potential SDM must also meet all the following criteria before being permitted to make decisions on behalf of an incapable person under the *HCCA*:[3]

- They must be capable with respect to the treatment or admission;
- They must be at least 16 years old, unless they are the incapable person's parent;
- They must not be prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on their behalf;
- They must be available; and
- They must be willing to assume the responsibility of giving or refusing consent.

A SDM is considered available if "it is possible, within a time that is reasonable in the circumstances, to communicate with the person and obtain a consent or refusal."[4] Examples of circumstances where a potential SDM is ***not*** available include:

- They failed to respond to documented communication, including phone, letter and email[5]
- They were not able to be contacted due to the absence of any available contact information[6]
- They were present in another country, without access to a cellphone or other means of being contacted[7]
- They insisted on communicating via email only, when there were concerns that email communications may not be coming from the SDM and where the SDM refused to attend an in-person meeting[8]

The fact that it may be inconvenient to communicate with a potential SDM does not, in and of itself, mean that they are not "willing and available." The following are examples where a potential SDM ***was*** found to be "willing and available:"

- They were located internationally, and not permitted to travel to Canada[9]
- They had a mental illness that previously required inpatient admission for treatment[10]
- They occasionally missed scheduled meetings or were delayed in returning phone calls or emails[11]
- They blocked or deferred decisions, were indecisive, sought additional information "to an excessive degree," challenged care providers, and raised numerous objections to potential discharge options[12]

Scenario

A patient with dementia and significant cognitive impairment is cleared for discharge from hospital. The acting SDM does not consent to a discharge placement, and the patient remains in hospital for a period of years.

The acting SDM is described by clinicians as "intransigent," "delayed," "unreasonable," and "avoidant." Nevertheless, the SDM engages with the treatment team and provides direction (namely a decision not to consent to an admission to LTC and/or treatment in the community).

Is the SDM "willing and available" within the meaning of the *HCCA*?

Answer: The SDM is "willing and available." The fact that a SDM may be challenging to engage with, or is making decisions that are contrary to the clinicians' recommendations, does not mean that they are not willing or available to act as SDM. However, these factors may give rise to a challenge of the SDM's ability to make decisions on behalf of a patient. In a case matching this scenario, the CCB determined that an alternative SDM was better qualified to perform the responsibilities of a SDM in the best interests of the patient.

Occasionally, members of the treatment team may have difficulty reaching or communicating with an identified SDM. Where this is the case, careful documentation of the efforts undertaken to engage with SDMs (and the results of those efforts) is critical.[13] Documenting attempts to locate a person to act as SDM is not a legal requirement, but strongly recommended.[14] Resorting to lower-ranking SDMs, or the PGT, without demonstrating that attempts have been made to obtain consent from any higher-ranking SDM may result in a determination that valid consent has not been obtained.[15]

Scenario

A patient with late-stage dementia is incapable with respect to making his own decisions regarding admission to a care facility (LTC home). The patient appointed his spouse and step-daughter as his attorneys for personal care, who then act as his SDM.

At an early stage of the process to identify an appropriate discharge placement, the SDMs complete a "Long-Term Care Homes Choice Sheet." Shortly thereafter, the SDMs disengage from the clinical team.

Clinicians then attempt to reach the SDMs via telephone, email, and couriered letter. The SDMs do not respond, and do not visit the patient in hospital.

Are the SDMs "willing and available" to act as SDMs?

Answer: The SDMs are neither willing nor available. It is not uncommon for clinicians to have difficulty engaging SDMs in discharge planning, particularly where there are emotional or other stressors. However, there is a distinction between having difficulty reaching SDMs and a complete absence of engagement.

In this case, the clinicians carefully documented their ongoing efforts to engage the SDMs, including telephone, email, and couriered letter. This documentation provided ample evidence to the CCB that the SDMs were neither willing nor available. In other decisions, clinicians who do not carefully document their efforts to contact SDMs may find that they have not discharged their burden to establish that the SDMs are not "willing and available."

The Role of the Public Guardian and Trustee

If there is no one listed in the hierarchy who meets the criteria to be the SDM, then the Public Guardian and Trustee (PGT) will make the decision on behalf of the incapable person.[16] This is often referred to as the PGT acting as the "SDM of last resort." For example, if a SDM cannot be located, the PGT will give, or refuse to give, consent to a proposed treatment, admission to a care facility (LTC home), or personal assistive service on behalf of an incapable person.

The PGT may try to locate someone listed in the hierarchy who may be a potential SDM. The authority of the PGT to make health care related decisions for an incapable person is generally limited to what is set out in the *HCCA*.

The other role of the PGT is to make a decision when there is disagreement between equally ranked SDMs. In such cases, the PGT is to step in to make the decision on behalf of the incapable person.[17]

In circumstances where the PGT is asked to make a decision on behalf of an incapable person, and there is insufficient evidence to demonstrate that no other SDMs are available (such as, for example, evidence documenting efforts to identify and contact SDMs without success), a request to engage the PGT to make decisions may be denied.[18]

Scenario

An incapable person has applied to multiple LTC homes based on substitute consent provided by her four children. A bed becomes available in one of the LTC homes, but only three of the four children consent to their parent's admission to the LTC home.

The majority does not rule in this situation. If the equally ranked SDMs do not agree on consenting to the LTC home admission and efforts to resolve the disagreement are unsuccessful, the PGT will be approached to make the decision on behalf of the incapable person.

Once involved in a particular situation, the PGT may try to explore if the disagreement between the SDMs can be resolved, or if there is another higher-ranking potential SDM. These situations tend to have unique characteristics and should be addressed on a case-by-case basis.[19]

Principles for Substitute Decision-Making

In 1997, the Ontario Superior Court commented that:[20]

> It is mental capacity and not wisdom that is the subject of the *SDA* and the *HCCA*. The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake.

While a capable patient can make any decisions on their own behalf, a SDM must be guided by the principles in the legislation. All SDMs are required to make decisions in accordance with the principles for substitute decision-making set out in the *HCCA*.[21]

Prior Capable Wish

A SDM who knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age shall give or refuse consent in accordance with the wish.[22]

This is generally referred to as a "prior capable wish." A prior capable wish can be very broad and the challenge is often the interpretation of a comment or possible wish.

A SDM must consider whether there may be a prior capable wish. In doing so, the SDM must consider whether it was expressed while the patient was capable and whether it is applicable to the circumstances. If these criteria are met, the wish should be followed with very limited exceptions.[23]

In considering the significance of a prior capable wish, the Court has commented that:[24]

> While the [Consent and Capacity] Board in a proper case may make a finding as to prior capable wishes that differs from the view of prior capable wishes expressed by the SDM, once the Board has found what the prior capable wishes are, it does not have a general discretion to override those wishes. That is not only, or primarily, a matter of interpretation of the statute,

> although it is that: it is also a matter of constitutional law. The whole of the Consent and Capacity Board should have this point brought home to it.
>
> With respect to prior capable wishes, there is a small amount of "wiggle room" for the Board in connection with whether the prior capable wishes are "applicable in the circumstances," but that should be approached with care and restraint because of the constitutional dimension. It is not discretion.

This is illustrative of the significant degree of deference that should be given to the decision of a SDM who is acting in accordance with a prior capable wish.

Both a SDM and a health care provider may apply to the CCB for directions to clarify a possible prior capable wish, or for permission to depart from a prior capable wish.[25]

Best Interests

In situations where there is no prior capable wish, or if it is impossible to comply with the wish, the SDM is required to act in the incapable person's best interests.[26] In determining what the incapable person's best interests are, a SDM must consider:

Treatment	Admission to a Care Facility (LTC Home)
• 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. • Any wishes expressed by the incapable person with respect to the treatment that are not required to be followed (because the patient was incapable or under the age of 16 at the time it was expressed); and • The following factors: – Whether the treatment is likely to · Improve the incapable person's condition or well-being; · Prevent the incapable person's condition or well-being from deteriorating; or · Reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate. – Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment. – Whether the benefit of the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her. – Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.	• 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. • Any wishes expressed by the incapable person with respect to admission to a care facility that are not required to be followed (because the patient was incapable or under the age of 16 at the time it was expressed); and • The following factors: – Whether admission to the care facility is likely to · Improve the quality of the incapable person's life; · Prevent the quality of the incapable person's life from deteriorating; or · Reduce the extent to which, or the rate at which, the quality of the incapable person's life is likely to deteriorate. – Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility. – 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. – Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances.

The best interests of the patient will be considered in the context of the proposed treatment or admission to a care facility (LTC home), taking into account the available information and options.

Other Obligations of a Substitute Decision-Maker

SDMs who assume the role as a result of being court-appointed guardians of the person or powers of attorney for personal care have additional duties and responsibilities, which include:[27]

- Explaining their role to the incapable person
- Encouraging the patient's participation in the decision-making process
- Fostering the independence of the incapable person
- Encouraging regular contact with family and friends
- Consenting to the least intrusive and restrictive action available and appropriate in the circumstances
- Refusing consent to confinement, monitoring devices or restraint (physically or by means of drugs) unless there is a risk of serious harm to the person or others, or it would permit greater freedom or enjoyment for the person
- Only giving consent to electric shock treatment if in accordance with the *HCCA*

While these are not binding responsibilities for a SDM not appointed by the Court, these duties provide a guide to assist all SDMs in fulfilling their obligations to an incapable person on behalf of whom they are making decisions.

Decisions Not Being Made in Accordance with SDM Principles

If a SDM is not making decisions in accordance with the legislated principles for substitute decision-making, an application may be brought to the CCB. This is a Form G application.[28] When the decision in question relates to treatment, a Form G application may be completed by the health care practitioner proposing the treatment.[29] If the decision in question relates to an admission to a care facility (LTC home), a Form G application may be completed by the person authorizing the admission at Ontario Health atHome.[30]

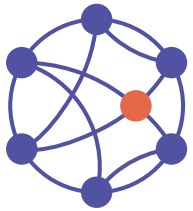
The purpose of this type of application is to ask the CCB to determine whether a SDM is complying with the principles for giving or refusing consent on behalf of an incapable person.[31] Form G applications do not result in the SDM being removed from their decision-making position, but rather, result in the CCB directing the SDM in a particular situation, with reference to the obligations of the SDM.

If the SDM does not comply with the direction of the CCB within the time set out in the CCB's decision, the SDM "shall be deemed not to meet the requirements" for being a SDM.[32] In this situation, the health care provider may seek substitute consent from the next appropriate person in the hierarchy who meets the criteria in subsection 20(1) of the *HCCA*.

A Form G application to the CCB is often considered to be a last resort when there is a concern about a decision being made on behalf of an incapable person.

The involvement of supports, including spiritual care, or engaging an ethicist and/or community-based supports for the SDM/family, may assist in navigating some of the challenging situations that arise when the SDM does not agree with the recommendations of the care team and a proposed plan of treatment or admission to a care facility (LTC home).

When further discussions to educate a SDM about the SDM's responsibilities and the reasons around a particular recommendation from a health care provider are not successful in resolving the concerns, a Form G may be an appropriate step. It is strongly recommended that health care providers considering a Form G application seek advice and recommendations on how to proceed in these situations.



SECTION 8

Co-Payments

What is a Co-Payment?

As indicated in Section 4, a co-payment may be charged by certain designated hospitals when a patient is admitted to the hospital but is awaiting placement in another institution, typically long-term care (LTC) or complex continuing care. The co-payment is the amount that an alternate level of care (ALC) patient would pay if admitted to the facility for which they are awaiting placement. This same amount is, instead, paid to the hospital where they are waiting.[1]

Co-payments are provided for in the General Regulation under the *Health Insurance Act* (*HIA*).[2] Specifically, subsection 10(1) of the *HIA* provide as follows: [3]

> 10.(1) A co-payment for accommodation and meals that are insured services shall be made by or on behalf of an insured person who, in the opinion of the attending physician, **requires chronic care** and **is more or less permanently resident in a hospital or other institution** [*emphasis added*].

In some hospitals and institutions, a patient need not be designated ALC to be charged a co-payment.

Co-payments are charged to the patient. If the patient is not capable of managing their finances, someone with the legal authority to make financial decisions on their behalf should be involved, ideally a power of attorney for property or a guardian of property.[4] Family members and others are not responsible to fund a co-payment on behalf of the patient.

Co-payment rates are determined in accordance with the General Regulation under the *HIA*.[5] This regulation also provides for any exceptions to co-payment charges and the grounds with respect to which a patient, or their spouse, can apply to the hospital for a reduction in the amount for an applicable co-payment.[6] Historically, co-payment rates have increased annually. Hospitals are required to give patients at least 30 days notice of an increase.[7]

The Ability of Hospitals to Charge Co-Payments

Hospitals in Ontario are classified into various "Groups" depending on which services they provide. The definitions of these Groups are set out in the Classification of Hospitals Regulation under the *Public Hospitals Act* (*PHA*).[8] Only hospitals in certain groups are permitted to charge co-payments.

Section 10 of the General Regulation under the *HIA,* which enables hospitals to charge co-payments, applies only with respect to an insured person receiving:[9]

- Insured in-patient services provided in a hospital listed in Part II of Schedule 1, Part II of Schedule 2 or Part II of Schedule 4 or a hospital graded, under the *PHA*, as a Group F, G or R hospital; or
- Insured in-patient services provided in a hospital graded, under the *PHA*, as a Group A, B or C hospital if the insured person is awaiting placement in a hospital referred to in clause (a) or another institution.

The following are the types of hospitals that may charge a co-payment:[10]

Part II of Schedule 1 – These are listed chronic care hospitals

Part II of Schedule 2 – These are listed federal chronic care hospitals

Part II of Schedule 4 – These are listed hospitals for psychiatric illness and for alcoholism and drug addiction

Group F hospitals, being hospitals for chronic patients having not fewer than 200 beds but not including Group R hospitals

Group G hospitals, being hospitals for chronic patients having fewer than 200 beds but not including Group R hospitals

Group R hospitals, being facilities for chronic patients that are called continuing care centres

In addition, patients waiting in one of the following types of hospitals for a bed at one of the facility types listed above, who would be designated ALC, may be charged a co-payment:[11]

Group A hospitals, being general hospitals providing facilities for giving instruction to medical students of any university, as evidenced by a written agreement between the hospital and the university with which it is affiliated, and hospitals approved in writing by the Royal College of Physicians and Surgeons for providing post-graduate education leading to certification or a fellowship in one or more of the specialties recognized by the Royal College of Physicians and Surgeons

Group B hospitals, being general hospitals having not fewer than 100 beds

Group C hospitals, being general hospitals having fewer than 100 beds

Hospitals that do not fall within these categories may not charge a co-payment, even in a situation where one would be charged if the patient was at another hospital that is included in the categories above.

The Psychiatric Patient Exception

Section 46(1) of the *HIA* provides that, for the purpose of that section, a "hospital" is a psychiatric facility under the *Mental Health Act* (*MHA*).[12] Section 46(2) of the *HIA* provides that:[13]

> An insured person who is entitled to insured services under this Act and the regulations and who is admitted to a hospital under this section is entitled to such services as are required for the person's maintenance, care, diagnosis and treatment in accordance with this Act and the regulations without being required to pay or have paid on his or her behalf any premium or other charge **other than a co-payment for accommodation prescribed in the regulations**. [*emphasis added*].

The government has not filed any specific regulations applicable to section 46(1) of the *HIA*. The General Regulation would apply to patients with mental illness.

According to the *MHA*, a person who is admitted for "observation, care and treatment" for a mental disorder at a hospital designated as a "psychiatric facility," is a "patient."[14] A person who is admitted to a hospital but is not admitted under the *MHA* is not a "patient" at a "psychiatric facility."

When a patient no longer requires "observation, care and treatment" for a mental disorder, they are usually discharged from the psychiatric facility. If it is not possible for the person to be discharged from the hospital entirely, as a clinically appropriate discharge destination is not available, they may be required to remain in the hospital as an ALC patient.

If, as a result of the person's clinical condition, they remain as a "psychiatric patient," then a co-payment is not appropriate.[15]

It may be appropriate for the patient to be charged the co-payment if:

- They are no longer considered a "psychiatric patient";
- The hospital is in a classification that is permitted to charge a co-payment; and
- The other criteria for a co-payment to be charged are met.

A co-payment may also be appropriate if a person undergoes a psychiatric assessment, either on arrival at the hospital or during an admission, but is not admitted as a patient in a "psychiatric facility" and would otherwise be charged a co-payment.[16]

If there is any uncertainty about whether a co-payment may be appropriate, there should be a review of the applicable co-payment legislation as it applies to a specific patient scenario at a particular hospital.

The Co-Payment Process and Communication

It is important that patients being asked to make a co-payment are provided with timely and accurate information about this fee. Consider using multiple modes of communication, such as verbal and written. There can be confusion and a lack of awareness among patients and families regarding co-payment policies, which can lead to frustration and complaints to the Patient Ombudsman or other entities.[17]

Some patients may be eligible to pay a reduced rate[18] or exempt from paying a co-payment.[19] Each hospital should have a process and support in place to help patients complete the necessary forms for co-payments.[20]

It is important that patients are given access to, and clear information about, payment calculations and reductions, where appropriate.

Determining When a Co-Payment May Be Charged

One of the challenges frequently faced by hospitals is determining when a co-payment may be charged to a particular patient.

The start date for a co-payment is when the attending physician determines the patient requires chronic care and is more or less permanently resident in a hospital or other institution, not when the patient has exceeded the expected length of stay at a hospital.

In many situations, it is straightforward – a patient was admitted for acute care, which is no longer required, and a LTC home has been determined to be the only clinically appropriate discharge option for that patient. In other situations, it may be more complicated.

There is no formal definition for "chronic care" in the *HIA* or the General Regulation. This term is generally considered to be synonymous with "complex continuing care" and "complex care," but this does not always assist in determining whether a patient "requires chronic care and is more or less permanently resident in a hospital or other institution" for the purpose of determining whether a co-payment is appropriate.

It is often the discharge destination that is used to consider whether someone requires chronic care, but this is also not always determinative as the designation of beds may be different from one hospital to another. What is clear is that a patient who has an immediate or longer-term discharge destination in the community cannot be charged a co-payment.

While working through the analysis of when a co-payment may be charged can be complicated, it is important to consider the individual situation of a particular patient, their plan of treatment, and care needs, as well as the type of bed they are in and/or their discharge designation.

Patients waiting for and/or admitted to rehabilitation programs are a useful example. It is not generally appropriate to charge a co-payment to a patient waiting for and/or admitted to a rehabilitation program. The plan of treatment in this program is aimed at "maintaining or restoring functionality or developing adaptive capacity," presumably for a discharge to the community.[21]

Find Out More

See Section 2 for more information on discharge destinations and their definitions.

If, in the course of this person's treatment and care, there is a change in the patient's condition, such that it is determined that a return to the community is no longer a clinically appropriate discharge option and LTC is the only option, the patient may be designated "ALC for LTC" at the end of the rehabilitation program. While "ALC for LTC," it may be appropriate for a co-payment to be charged to this patient during their wait for a LTC bed offer. This may be the case even if the patient is waiting in a "rehabilitation" bed.

If a patient has completed the plan of treatment for which they were admitted and is waiting for a bed at another location, it may be appropriate to charge a co-payment, if a co-payment will be charged at the destination for which they are waiting.

SECTION 8: Co-Payments

Where the hospital is one that is permitted to charge a co-payment and the other criteria for a co-payment to be charged are met (i.e., the patient requires chronic care and is more or less a permanent resident), it may be appropriate for the patient to be charged the co-payment. This analysis may be applicable in other contexts as well, for example, palliative care.

Examples of when charging a co-payment is not permissible:

- A patient at an acute care hospital has been designated ALC and is waiting for a bed to become available in a particular retirement home
- A patient admitted to a hospital classified as a complex continuing care hospital (a Group G hospital) and receiving rehabilitation with the goal of discharge to the community
- A patient designated ALC whose family is refusing to take the patient home
- A patient in a complex care facility awaiting placement in a LTC facility who has been charged a co-payment for six months but is deteriorating and is now receiving palliative care

In dealing with the complexities in determining whether a co-payment is appropriate in a particular situation, it is recommended that consideration be given to obtaining specific legal advice with respect to the interpretation and applicability of the legislation.

There are several factors to be considered in analyzing when a co-payment may be applicable. General comments, such as those in the Ministry of Health Hospital Chronic Care Co-Payment document[22] and in this Guidance Document, may not always take into account the individual nuances of a particular patient situation. While the purpose of these resources is to assist hospitals in working through challenges, they cannot anticipate and account for all possible scenarios.

SECTION 9

Daily Rate Charges for Uninsured Services

When a patient is discharged from hospital, they are no longer entitled to receive "insured services."[1] If the patient does not leave within 24 hours of being discharged, hospitals are required to charge $400/day.[2]

Unlike co-payments, which **may** be charged in certain circumstances, the Hospital Management Regulation under the *Public Hospitals Act* provides that hospitals **must** charge patients $400/day if the prescribed criteria are met. With this daily rate for discharged patients, patients are required to contribute to the cost of the services they are continuing to receive after being discharged from the hospital.

Patients are discharged from hospital when they are no longer in need of treatment in the hospital.[3] This includes, but is not limited to, patients who are designated as alternate level of care (ALC), for whom admission to a long-term care (LTC) home has been authorized.[4]

It is recommended that hospitals have a clear policy/process that supports proactive communications with patients, families and, where appropriate, substitute decision-makers (SDMs) about the potential daily rate for discharged patients, and which outlines internal escalation processes to address patient, family, or SDM concerns regarding the daily rate for discharged patients.

Scenarios

A patient is admitted to hospital after a fall in her home and is designated as ALC after two weeks, as she no longer requires acute care. Due to a decline in functional status, she is unable to return home safely. She has been determined to be eligible for LTC and is on waiting lists at a number of homes. With no other clinically appropriate discharge options available, she remains in hospital four months later.

In this scenario, it is expected that the patient would be making co-payments, but it would be inappropriate to charge the cost of the services they are continuing to receive after being discharged from the hospital.

A patient who is incapable of managing her property is admitted to hospital for six months for treatment of a complicated illness. The treatment is successful and the patient is able to return home. The patient's physician writes an order for the patient to be discharged on a specific date, when their treatment will be complete. Two weeks prior to the planned discharge date, the patient's daughter, who is also their attorney for property, tells the team that she gave up the patient's apartment to save money on rent. The daughter takes no steps to arrange for alternate housing and the discharge date arrives.

In this scenario, it would be appropriate for the patient to be charged $400/day, starting 24 hours after discharge, if the patient does not leave the hospital.

A capable person is admitted to hospital for acute care, and following consultation with Ontario Health atHome it becomes clear that the only clinically appropriate discharge option is a LTC home. They are designated as ALC, and there is an order that they are discharged when a LTC home bed is available. The patient refuses to consent to, or participate in, the process to determine if they are eligible for admission to a LTC home. In accordance with the provisions of section 60.1 of the *Fixing Long-Term Care Act, 2021*, Ontario Health atHome has determined that the patient is eligible for admission. The patient is subsequently authorized for admission and offered a bed in a LTC home, which they decline.

In this scenario, it would be appropriate for the patient to be charged $400/day, starting 24 hours after discharge, which is to occur after the patient is authorized for admission to LTC.

SECTION 10

Discharge Planning

Preparing to discharge a patient can be a significant undertaking. Complex discharge planning situations often involve multiple stakeholders, a variety of clinicians in different settings, concerned and engaged family members, and multiple overlapping layers of legislative requirements.

This section of the Guidance Document addresses general best practices for discharge planning, how to address challenges that may arise in the discharge planning process, and identifies some tools and resources.

Best Practices for Discharge Planning

Generally, an approach that is collaborative, transparent, and organized will result in a successful discharge. Discharge planning also needs to be flexible and responsive as the patient's health (and needs) may change during the discharge planning process.

Ontario Health's Alternate Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults and Transitions Between Hospital and Home Quality Standards[1] describe what is considered high-quality care and how to proactively support hospitalized older adults at risk of delayed transitions. These documents form the foundation of Ontario Health's operational direction to hospitals, home and community care support services, and long-term care (LTC) homes that requires discharge teams to employ a "Home First" approach to discharge planning.[2]

When faced with complex discharge planning situations, including with alternate level of care (ALC) patients, it is important to support channels of communication between members of the 'circle of care.' It is also important to have consistency and accuracy in the information being communicated with and between patients/substitute decision-makers (SDMs) and family members/caregivers, as well as the health care providers involved.[3] Best practices for effective communication, including active listening skills and incorporating both verbal and written communication, are strongly recommended.

Patients/SDMs and family members/caregivers should be encouraged to engage in a constructive dialogue with health care providers about their concerns and the individual circumstances of the person for whom a discharge plan is being discussed. While the decision will rest with the patient (if capable) or SDM (if patient is not capable), the process is collaborative. If health care providers, patients/SDMs, or family members/caregivers are concerned that the process is not constructive, steps should be taken to engage other resources and, if necessary, escalate to a different forum.

Productive and well-organized meetings with stakeholders and family members are often helpful to keeping a discharge plan on track.

Communication Between Discharge Planning Partners

The sharing of personal health information (PHI) among health care providers is most commonly referred to as disclosure within the 'circle of care.' The phrase 'circle of care' is not a defined term in the *Personal Health Information Protection Act, 2004 (PHIPA)* but is a way of describing the provisions of the Act that enable health information custodians (HICs) to assume implied consent.[4]

HICs rely on this 'assumed implied consent' for the disclosure of PHI in their communications with each other to provide or assist in the provision of health care for a patient.[5] HICs who are members of the circle of care may rely on implied consent for disclosure of PHI when the following conditions are met:[6]

- The HIC must fall within a category of HICs that are entitled to rely on assumed implied consent. These HICs include the following:[7]
  - Health care practitioners
  - LTC homes
  - Retirement homes
  - Integrated community health services centres
  - Hospitals, including psychiatric facilities
  - Some community-based care providers
  - Public Health Units
  - Pharmacies
  - Specimen collection centres, laboratories, independent health facilities
- The PHI to be collected, used or disclosed by the HIC must have been received from the individual, his or her SDM or another HIC
- The HIC must have received the PHI that is being collected, used or disclosed for the purpose of providing or assisting in the provision of health care to the individual
- The purpose of the collection, use or disclosure of PHI by the HIC must be for the provision of health care or assisting in the provision of health care to the individual
- In the context of disclosure, the disclosure of PHI by the HIC must be to another HIC
- The HIC that received the PHI must not be aware that the individual has expressly withheld or withdrawn his or her consent to the collection, use or disclosure (subject to the ability to share PHI in the context of assessing the appropriateness of an ALC patient for admission to a LTC home as set out in section 60.1 of the *Fixing Long-Term Care Act, 2021 (FLTCA)*)

HICs within the circle of care cannot share PHI if an individual or their SDM has expressly withdrawn consent for the disclosure.[8]

HICs outside the circle of care must rely on other provisions of *PHIPA*, and other legislation, to be able to share a patient's PHI.

Find Out More

See Section 3 for more information about "PHI" and "HIC."

Policies

Hospital Policies

Most hospitals have comprehensive discharge planning polices and procedures. Discharge planning policies should promote open communication with patients/SDMs. These policies should also promote a transparent process with respect to expectations and responsibilities of all involved in the discharge planning process. Many hospitals also have "escalation" or "approval" policies to address patients who remain in hospital while awaiting admission to a LTC home.

For the purpose of this Guidance Document, the discussion of policies takes into account the various aspects of discharge planning, including the discharge planning process, ALC patients, co-payments, and other related issues. In practice, these policies should be set up in a manner that is consistent with the practice(s) at each individual hospital organization, with consistent application of terminology.

To set out the expectations and guidance for those involved in the discharge planning process, policies must be clear that expectations are not requirements.

The discharge planning policies are a 'who does what' for health care providers and confirms the role of the patients, SDMs, family members, and caregivers. While patients/SDMs cannot be compelled to make certain choices or to comply with deadlines in a hospital policy, the hospital can set out requests for the scope and timing of decisions.

In addition to referencing other hospital policies that may be applicable to discharge planning (for example, related to co-payments, consent, daily rate charges, and ALC), discharge planning policies should encourage reference to other hospital and non-hospital resources for patients/SDMs and family members/caregivers.

Find Out More

See Section 8 for information on co-payments and Section 9 for information on daily rate charges.

Policies may also set out the chain of communication and provide for consultations and escalation in the event of a perceived or actual challenge arising in discharge planning. Having this mapped out supports the staff in dealing with challenges and promotes communication and consistency in messaging.

One tool that may be helpful to include in a discharge planning policy is a draft communique. It must be recognized that each situation will be unique and may require its own special considerations. Providing a draft communique for staff to use to guide communication is one way to support consistency and accuracy in messaging.

Implementation of a discharge planning policy can be challenging. The education and awareness of a policy, with emphasis on the roles of those involved in the discharge planning process and the underlying legal basis for process, are critical to success in discharge planning.

Ontario Health atHome and its staff are not bound by hospital policies. In working collaboratively with hospital staff in the discharge planning process, it is helpful for Ontario Health atHome staff to understand a hospital's policies and practices and vice versa.

Home and Community Care Support Services Policies

Ontario Health atHome will have their own policies and practices relating to the components of a discharge plan with which they are involved. Ontario Health atHome staff have their own professional obligations to their patients, whether those patients are located in a hospital or in the community. Ontario Health atHome staff may be confronted with the challenges set out previously when dealing with a patient in any setting.

When dealing with patients in a hospital, Ontario Health atHome will usually have the benefit of information from the health care providers involved with the patient during the admission. While this information will assist, it does not replace the review and evaluation to be performed by Ontario Health atHome staff.

Within Ontario Health atHome, it is equally important to have an escalation process to support staff members who encounter challenges in working with patients/SDMs. Initial escalation of a concern or challenge is likely to be referred to a manager, who may then consider whether it is appropriate to involve a director, senior director, risk management staff, or some combination thereof.

Ontario Health atHome cannot rely entirely on the communications from the hospital relating to components of a discharge plan. For example, in situations in which an admission to a LTC home is being contemplated, Ontario Health atHome must communicate directly with a patient/SDM about challenges in the process.

As with patients in a hospital, it is important that the individual considerations impacting a patient's decision relating to admission or community services are taken into account when looking at recommendations for care.

Challenges in Discharge Planning

Some of the challenges that may arise in the course of discharge planning include:

- Concerns about the capacity of the patient relating to some or all aspects of a proposed discharge plan(s)
- Difficulty identifying an appropriate SDM when the patient has been determined not to be capable of some or all aspects of a proposed discharge plan(s)
- A SDM not understanding the role and responsibility associated with making decisions on behalf of an incapable person
- Communication issues with a patient/SDM, including refusal by a patient/SDM to make a decision or participate in some or all of the planning process

The above are generalizations of the types of challenges that may be faced by both hospital and Ontario Health atHome staff when working toward a successful discharge for a patient. It is important to have a process in place to manage these types of challenges, while recognizing there is no "one size fits all" solution.

Managing Challenging Situations and Complaints

For hospitals, it is very helpful to have an escalation process specific to discharge planning. Challenges in discharge planning often arise because there is no immediately available ideal solution that the health care team, patient/SDM, and/or family members/caregivers can agree is appropriate. It is prudent to have resources in place to respond to such concerns. The involvement of supports for the family and clinical team, such as spiritual care or engaging an ethicist, will often assist to manage and resolve challenging situations.

Both hospitals and Ontario Health atHome have established processes for managing and responding to complaints within their own organizations. Each organization has its own complaints process. Patients/SDMs and family members/caregivers may choose to access the formal complaints process if they are concerned with discharge communications.

For Ontario Health atHome, in addition to a client services complaint process, patients with concerns may also be directed to Ontario's "Long-Term Care Support and Action Line."[9]

Through the action line, patients who need assistance in resolving complaints may be referred to independent complaints facilitators for mediation services. The Minister of LTC has the authority to carry out an inspection of a LTC home if there is a complaint that the LTC home is not acting in compliance with the *FLTCA.*

Ontario Health has also issued a directive recommending complex discharge rounds,[10] to assist in reviewing patient care plans and complex situations. These rounds may be comprised of interdisciplinary team members, caregivers, Ontario Health atHome and community social service providers.

Finally, hospitals and Ontario Health atHome fall under the jurisdiction of the Patient Ombudsman, whose role is to "help resolve complaints from current or former patients, residents or their caregivers about experiences with public hospitals, LTC homes, home care, and community surgical and diagnostic centres."[11]

The Patient Ombudsman may accept complaints from current or former patients. Family, friends, and caregivers may make complaints on a patient's behalf. Complainants may contact the office by phone, but a written complaint is required for consideration. The Patient Ombudsman is an office of last resort and it is necessary for a complainant to first try to address the complaint through other existing processes.[12]

The Role of the Public Guardian and Trustee (PGT)

The Public Guardian and Trustee (PGT) is the SDM of last resort when there is no one listed in the hierarchy set out in the *Health Care Consent Act, 1996* (*HCCA*) that meets the requirements to act as a SDM.[13] A failure to properly investigate the availability of SDMs other than the PGT may result in consent offered by the PGT being invalid. The PGT has an obligation to investigate concerns that an incapable person may be at risk of "serious adverse effects"[14] occurring. This investigation may arise from concerns relating to potential financial concerns or personal care.[15]

Depending on the results of any investigation, the PGT may conclude that a form of temporary guardianship may be necessary.[16]

For hospital and Ontario Health atHome staff working with a patient/SDM and/or family/caregiver on a discharge plan, resorting to the PGT under these provisions would be a very rare occurrence.

Find Out More

See Section 6 and Section 7 for more information on identification of a SDM and the PGT.

Legal Steps to Resolve Conflicts in Discharge Planning

Consent and Capacity Board

The Consent and Capacity Board (CCB) is an independent provincial tribunal established to provide "fair and accessible adjudication of consent and capacity issues, balancing the rights of vulnerable individuals with public safety."[17]

The CCB has the jurisdiction to hold many different types of hearings. Specific to discharge planning, these hearings include reviews of the following:

- To confirm whether someone is capable to make a decision with respect to a proposed treatment, admission to a care facility (LTC home), or personal assistance services (Form A)[18]
- To appoint a representative to make a decision on behalf of an incapable person and to amend/terminate the conditions of such an appointment (Forms B, C, and H)[19]
- To determine whether a wish expressed by an incapable person is clear, applicable in the circumstances, and/or a prior capable wish (Form D)[20]
- To seek permission to depart from a prior capable wish (Form E)[21]
- To review consent given on behalf of an incapable person relating to their admission to a hospital, psychiatric facility, or other health facility for the purpose of treatment (Form F)[22]
- To determine whether a SDM is complying with the "principles for giving or refusing consent" (Form G)[23]

The *HCCA* sets out who can bring one of the above applications to the CCB, as well as the process and requirements for bringing an application. Not all aspects of discharge planning fall within the jurisdiction of the CCB.

When considering whether an application to the CCB may be necessary as part of the discharge planning process, or if an application is brought to which a health care provider is required to respond, it is recommended this be discussed with risk management or other available resources, which may include a referral to, or request for support from, an ethicist. There are steps that can be taken to support health care providers appearing before the CCB.[24]

Health Services Appeal and Review Board (HSARB)

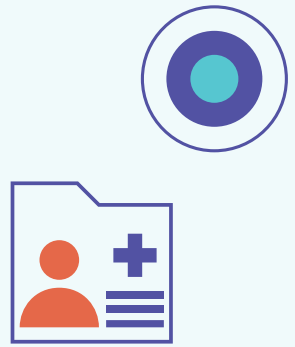
The Health Services Appeal and Review Board (HSARB) is tasked with conducting appeals and reviews, in both oral and written formats, under 12 different statutes,[25] including decisions relating to:

- Eligibility for "insured services"[26]
- Eligibility for, amount of, exclusion of, and termination of the "community services" someone may receive[27]
- Whether to include or exclude certain services in the person's plan of care
- Determinations of eligibility for admission to a LTC home[28]

HSARB is a "quasi-judicial" tribunal and has its own Rules of Practice and Procedure.[29]

Find Out More

See Section 4 for more information on insured services and Section 5 for information about community support services.



Conclusion

The Ontario Hospital Association (OHA) recognizes that providing the best care possible during care transitions relies on successful collaboration among health care providers, patients, substitute decision-makers, families, and caregivers. Additionally, engagement with legal counsel can help support decision-making through these complex processes.

This guidance document was designed to serve as a valuable, supplementary resource for those navigating these transitions. It is meant to support the identification and clarification of the provincial legislation and the roles of care team members in facilitating transitions. This guidance document also provides general best practices, addresses potential challenges that may arise in the discharge planning process, and highlights tools and resources to support those involved.

To ensure individuals receive timely care in the most appropriate setting and to effectively manage the capacity strains facing Ontario's hospitals, appropriately managing patient transitions across the health system is essential.

APPENDIX A

Substitute Decision-Maker Hierarchy

The following is a more detailed commentary of the various rankings within the hierarchy for substitute decision-makers (SDMs) under the *Health Care Consent Act, 1996* (*HCCA)* as presented in Section 7.

1. The Incapable Person's Guardian of the Person where the Guardian has Authority to Give or Refuse Consent to the Treatment or Admission to a Care Facility (LTC home)

A "guardian of the person" is someone who has a court order for guardianship. The application process to be appointed as a guardian is set out in the *Substitute Decisions Act, 1992* (*SDA*).[1] When appointing a guardian, the Court must specify the functions over which the guardian has decision-making power. This can be limited in time or by any conditions the Court wishes to impose.[2]

Full guardianship may be ordered when the individual is fully incapable of all personal care decision-making.[3] In all other cases, the Court will award a partial guardianship outlining the exact role of the guardian.[4]

Where the guardian has authority to give or refuse consent to a proposed treatment or admission to a care facility (LTC home), the guardian will be the SDM for the incapable person as there is no higher-ranking option.

Examples of situations in which a Guardianship Application may be made:

- Equally-ranked SDMs disagree on a proposed treatment and one (or more) is seeking to be appointed the guardian (which ranks higher than the category to which the other SDMs belong).
- A close friend of the patient applies to be appointed if the patient does not have any family.

As stated in the *SDA*, the Court will only appoint a guardian as a last resort:

- The Court shall not appoint a guardian if it is satisfied that the need for decisions to be made will be met by an alternative course of action that:
  - Does not require the Court to find the person to be incapable of personal care; and
  - Is less restrictive of the person's decision-making rights than the appointment of a guardian[5]

The Court will also consider: whether the proposed guardian is the incapable person's attorney under a continuing power of attorney; the incapable person's wishes, if they can be ascertained; and the closeness of the relationship between the proposed guardian and the incapable person.[6]

The court will not appoint a person who is paid to provide health care, social, training, or other support services, unless this person is also a family member or there is no other suitable and available person.[7]

Where the SDM for an incapable person is a guardian of the person, it is strongly recommended that a copy of the Court order be placed in the incapable person's chart/record.

2. The Incapable Person's Attorney for Personal Care where the Power of Attorney Confers Authority to Give or Refuse Consent to the Treatment or Admission to a Care Facility (LTC home)

A "power of attorney for personal care" is a document completed in accordance with the legal requirements set out in the *SDA*.[8] The test for capacity to grant a power of attorney for personal care is not the same as the test for capacity to consent to treatment

or admission to a care facility (LTC home). A person is capable of granting a power of attorney for personal care if:[9]

- The person can understand whether the proposed attorney has a genuine concern for their welfare; and
- The person can appreciate that the attorney may need to make decisions regarding personal care on their behalf.

To be valid, the power of attorney document must be signed in front of two witnesses, and the witnesses must also sign the document.[10]

The attorney may have authority to make decisions about treatment or admission to a care facility (LTC home) on behalf of a person who has been determined not to be capable under the *HCCA*.[11] Provisions may be included in a power of attorney which restrict the attorney from making any decisions until it has been formally determined that the person is not capable, and may outline the method to be used and factors to be considered to make this determination in situations to which the *HCCA* does not apply.[12]

Several provisions that may be included in the power of attorney are considered to have such significant consequences for the person that additional requirements must be met before these provisions are valid. These provisions include:[13]

- Authorizing the reasonable use of force to:
  - Determine if the person is incapable
  - Confirm if the person is incapable of personal care when there is a condition that no decisions may be made by the attorney until this is confirmed
  - Obtain an assessment for any reason the person outlines in the power of attorney
- Authorizing the reasonable use of force to admit and/or detain the person in the place where the patient is receiving care or treatment
- Waiving the person's right to a review by the Consent and Capacity Board (CCB) of a finding of incapacity by a health practitioner or an evaluator

In order to make these provisions effective, the power of attorney must include:[14]

- A statement from the person, on the prescribed form, indicating that within 30 days after executing the power of attorney the person understood its effect; and
- A statement from an assessor, on the prescribed form, dated within 30 days after the power of attorney was executed, indicating that at the time of the assessment the person was capable of personal care, they understood the effect of the document, and the facts upon which the assessor's opinion is based

A court has the power to validate any power of attorney that is otherwise ineffective.[15]

Where the SDM for an incapable person is acting in this role pursuant to a power of attorney for personal care, it is recommended that a copy of the power of attorney document be placed in the incapable person's chart/record.

3. The Incapable Person's Representative Appointed by the Consent and Capacity Board

The procedure and process for an application to the CCB to be appointed as a "representative" is set out in the *HCCA*.[16] This type of application can be brought by an incapable person for the appointment of someone to make decisions for them, or by another person who wants to make decisions for the incapable person.[17]

The scope of authority of the SDM appointed by the CCB will be limited to decisions that fall within the *HCCA*. In dealing with discharge planning, this may mean that the SDM does not have the legal authority to make decisions about all aspects of a comprehensive proposed discharge plan.

If the incapable person has a court-appointed guardian or an attorney pursuant to a power of attorney for personal care with the authority to give or refuse consent, the CCB does not have the authority to appoint a representative.[18]

Where the SDM for an incapable person is a representative appointed by the CCB, it is recommended that a copy of the order of the CCB be placed in the incapable person's chart/record.

4. The Incapable Person's Spouse or Partner

Unless two people are living separate and apart as a result of a breakdown in their relationship,[19] they are considered to be "spouses" if:[20]

- They are married to each other; or
- They are living in a conjugal relationship outside marriage and,
  - have cohabited for at least one year
  - are together the parents of a child; or
  - have together entered into a cohabitation agreement under section 53 of the *Family Law Act*

"Partner" is not gender-specific and is defined as "either of two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives."[21]

5. A Child or Parent of the Incapable Person, or a Children's Aid Society, or Other Person Who Is Lawfully Entitled to Give or Refuse Consent to the Treatment or Admission to a Care Facility (LTC home) in the Place of the Parent

This category does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent in the place of the parent, this category does not include the parent.

If both parents have custody (i.e., living together or through a joint custody agreement following a marital separation), both are equally entitled to make decisions.

"Child" is not defined in the *HCCA*. A "child" includes any child of their natural parents, whether born within or outside marriage, and any child who has been formally adopted.[22] There is also a "presumption of paternity" in a variety of circumstances.[23] If there is more than one child of the incapable person, all children rank equally as SDMs.

Note that, in certain circumstances, the involvement of a Children's Aid Society is not determinative as to whether or not they are entitled to give or refuse consent to treatment in the place of a parent. Often, when children are first found in need of protection and brought to a place of safety pursuant to the *Child, Youth and Family Services Act, 2017*, a court will grant temporary or interim custody until a full hearing on appropriate evidence may be conducted. Agencies relying upon the consent of a Children's Aid Society should ensure that they have reviewed the form of order justifying the society's involvement and ensured that consent is validly obtained.[24]

6. A Parent of the Incapable Person Who Has Only a Right of Access

When dealing with parents who are making decisions for their incapable children, a parent with custody ranks highest in the SDM hierarchy and is entitled to make decisions. Where parents are separated, and one has custody while the other has access, the custodial parent is a higher-ranked SDM and can make all decisions.

In situations where there is an apparent dispute between parents of an incapable person, and there are issues of custody or access, or children's aid society involvement, it is recommended that a copy of the applicable court order be obtained for the chart/record.

7. A Sibling of the Incapable Person

If the incapable person has more than one sibling, they may all rank equally as SDMs.

8. Any Other Relative of the Incapable Person

A "relative" under this section is someone "related by blood, marriage, or adoption" to the incapable person.[25]

APPENDIX B

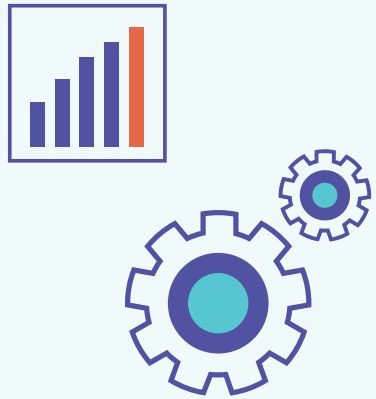
Additional Resources

Although not exhaustive, the following are helpful resources for review when managing certain aspects of discharge planning:

- **Guidance and tools to support discharge from hospital:**
  - Ontario Health atHome
  - Ontario Health (February 2026): Quality Standards: Transitions Between Hospital and Home Care for People of All Ages
  - Ontario Health: Alternate Level of Care (ALC) Reference Manual, Version 3
  - Ontario Health (October 2022): Operational Direction Implementation of the *More Beds, Better Care Act, 2022*: Discharge Planning Policy
  - Ontario Health (August 2024): Operational Direction: Home First
  - Ontario Health (November 2023): Memo re Applying an Alternative Level of Care (ALC) Designation in Alignment with ALC Leading Practices
  - Ontario Health (September 2021): The Alternate Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults
  - Ontario Health (September 2021): Self-Assessment Tool: Alternate Level of Care (ALC) Leading Practices to Prevent Hospitalization and Extended Stays for Older Adults
  - Ontario Health atHome: Guide to Placement in Long-Term Care Homes
  - Ontario Ministry of Health: Admissions to Long-Term Care Homes for ALC Patients from Public Hospitals
  - Registered Nurses' Association of Ontario (June 2023): Clinical Best Practice Guidelines: Transitions in Care and Services
  - College of Physicians and Surgeons of Ontario (September 2019): Transitions in Care Policy
  - PODS: Patient Oriented Discharge Summary
  - North East Specialized Geriatric Centre: The NESGC Implementation Playbook - Standard of Care for Older Adults Living with or At-Risk of Frailty Across the North East
- **Guidance and tools related to consent and capacity:**
  - Consent and Capacity Board
  - Office of the Public Guardian and Trustee
  - Law Commission of Ontario: Legal Capacity, Decision-making and Guardianship
  - Ontario Government (May 2022): Instructions and Forms for Continuing Power of Attorney for Property and Personal Care
  - College of Physicians and Surgeons of Ontario: Guide to the *Health Care Consent Act*
  - Office of the Public Guardian and Trustee: The Capacity Assessment Office – Questions and Answers"
  - Ontario, Ministry of the Attorney General (2007): Guide to the *Substitute Decisions Act*
  - Ontario, Ministry of the Attorney General: Guardianship
  - Advocacy Centre for the Elderly: Health Care Consent & Advance Care Planning Resources
- **Other resources for consideration:**
  - Ontario Hospital Association, Katharine Byrick & Barbara Walker-Renshaw: A Practical Guide to Mental Health and the Law" (Fourth Edition)
  - Patient Ombudsman
  - Ontario Retirement Communities Association: Resources
  - Ontario Health: Minister's Designation of Placement Coordinator under s. 47 of the *Fixing Long-Term Care Act, 2021* – Ontario Health atHome

APPENDIX B: Additional Resources

- Ministry of Health, (June 2025): Hospital Chronic Care Co-Payment
- Information and Privacy Commissioner of Ontario (August 2015): Circle of Care: Sharing Personal Health Information for Health-Care Purposes
- Inclusion Canada: Supporting Choice: A Practical Guide to Advance Care Planning with Supported Decision-Making for Healthcare Professionals
- Ontario Health and Provincial Geriatric Leadership Ontario: Quality Standards: Delirium – Care for Adults



Endnotes

Section 2: Alternate Level of Care

1 Peter Nord, "Alternative Level of Care: Ontario Addresses the Long Waits" (August 2009) 55(8): Can Fam Physician 786 online: https://pmc.ncbi.nlm.nih.gov/articles/PMC2726089/ [Nord].

2 Ontario Health, "Memo re Applying an Alternative Level of Care (ALC) Designation in Alignment with ALC Leading Practices" (November 27, 2023) [2023 Ontario Health Memo re ALC].

3 Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, 43rd Parl, 1st Sess, No 8 (23 August 2022), p 327 (Paul Calandra).

4 *More Beds, Better Care Act, 2022*, SO 2022, c 16.

5 *Fixing Long-Term Care Act, 2021,* SO 2021, c 39, Sched 1, s 60.1 [*FLTCA*].

6 *FLTCA*, s 60.1.

7 Ontario Health atHome, "Community Care" (2025), online: <https://ontariohealthathome.ca/community-care/>.

8 Complex continuing care is also referred to as 'complex care' or 'chronic care.'

9 Reactivation care centre" beds are one type of transitional care bed that provides support for patients who are ready to leave the hospital and who will benefit from support and rehabilitation to safely transition to their next care setting.

10 *FLTCA*, s 60.1.

11 Although the applicable legislation refers to a "placement coordinator," in practice it is typically a "care coordinator" that assesses and determines eligibility.

12 *Ontario Health Coalition and Advocacy Centre for the Elderly v His Majesty the King in Right of Ontario*, 2025 ONSC 415.

Section 3: The Legislative Framework for Discharge Planning

1 At the time of publication, the definition of "care facility" in the *Health Care Consent Act, 1996* only refers to a LTC home.

2 CPSO, "Transitions in Care Policy" (September 2019), online: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Transitions-in-Care>.

3 *Canada Health Act*, RSC 1985 c C-6; Government of Canada, "*Canada Health Act"* (2025-01-10) online: <https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act.html>.

4 Ontario Health, "About Us" (March 28, 2023), online: <https://www.ontariohealth.ca/about-us>.

5 *Connecting Care Act, 2019*, SO 2019, c 5, Sched 1, s 27.6 [*CCA*].

6 *CCA*, s 1(2).

7 *Home and Community Care Services*, O Reg 187/22 [*HCCS*].

8 *Fixing Long-Term Care Act, 2021,* SO 2021, c 39, Sched 1 [*FLTCA*].

9 OHA, "Backgrounder: *Fixing Long-Term Care Act, 2021* and Ontario Regulation 246/22" (April 2022), online: <https://www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/Backgrounder%20-%20Fixing%20Long-Term%20Care%20Act,%202021%20and%20Regulation.pdf>.

10 *FLTCA*, s 1.

11 *Health Care Consent Act, 1996*, SO 1996, c 2, Sched A [HCCA].

12 The language of "incapable person" comes from applicable legislation. Although this may also be described as a "person lacking capacity", this Guidance Document uses the term used in legislation.

13 At the time of publication, the definition of "care facility" in the *HCCA* only refers to a LTC home.

14 The remainder of this Guidance Document uses the language of "incapable person" when referring to a person lacking capacity to align with the legislation.

15 *HCCA*, s 1.

16 *HCCA*, s 2.

17 At the time of publication, there are no facilities prescribed by regulation.

18 *Health Insurance Act*, RSO 1990, c H.6 [HIA].

19 *Public Hospitals Act*, RSO 1990, c 40 [PHA]; *Hospital Management*, RRO 1990, Reg 965 [HM].

20 *Classification of Hospitals*, RRO 1990, Reg 964 [CH]. Information with respect to the classification of hospitals is also available on the Ministry of Health website at: <https://www.ontario.ca/page/classification-hospitals>.

21 *Personal Health Information Protection Act, 2004*, SO 2004, c 3, Sched A, s 1 [*PHIPA*].

22 *PHIPA*, s 4.

23 *PHIPA*, s 3.

24 *PHIPA*, ss 5, 21-28.

25 For OHA resources, see: <https://www.oha.com/guidance-and-resources/privacy-and-freedom-of-information>.

26 *Substitute Decisions Act, 1992*, SO 1992, c 30 [SDA].

27 Ontario, Ministry of the Attorney General, "Guide to the Substitute Decisions Act" (Queens Printer for Ontario, 2007, Reprinted 2020), online: <https://www.publications.gov.on.ca/300635>.

28 *SDA*, s 45.

29 *SDA*, ss 15, 22.

30 *Retirement Homes Act, 2010,* SO 2010, c 11, s 1 [*RHA*]. Please refer to s 51 respecting Residents' Bill of Rights.

31 *RHA*, s 2.

32 *Residential Tenancies Act, 2006*, SO 2006, c 17. This also applies to supportive housing arrangements.

33 Residents in a retirement home may still be eligible for home care through Ontario Health atHome. There is no charge for home care services provided through Ontario Health atHome.

SECTION 4: Role of the Hospital and the Health Care Team

1 *Health Insurance Act*, RSO 1990, c H.6 [*HIA*]; There are also provisions for out-patients to receive insured services, but these are outside the scope of this Guidance Document.

2 *Public Hospitals Act*, RSO 1990, c 40, s 20 [*PHA*].

3 *Hospital Management,* RRO 1990, Reg 965 [*HM*]; This regulation provides for admission by a registered nurse in the extended class, dentist, or midwife, but for this discussion the reference is solely being made to admission by a physician.

4 Ontario Health, "Operational Direction: Home First" (August 14, 2024), online: <https://www.ontariohealth.ca/content/dam/ontariohealth/documents/operational-direction-home-first-2024-aug-14.pdf>[Operational Direction: Home First].

5 Operational Direction: Home First.

6 Operational Direction: Home First.

7 *PHA*, s 16(1).

8 Please see footnote 3 above, regarding other health care professionals who may make an admission under the *PHA*. These same health care professionals may also make a discharge order under the *PHA*.

9 *HM*, s 16(2).

10 *HM*, s 16(5).

11 *HM*, s 16(4).

12 *HM*, s 16(3).

13 CPSO, "Transitions in Care Policy" (September 2019), online: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Transitions-in-Care>; *AB v RW*, 2021 CanLII 10900 at paras 11, 42, and 53, online: https://www.canlii.org/en/on/onhparb/doc/2021/2021canlii10900/2021canlii10900.pdf.

14 Leaving AMA is a withdrawal of consent to treatment and the SDM needs to make that decision in accordance with the incapable person's wishes or, if unknown or impossible to comply with, in accordance with the patient's best interests.

15 At the time of publication, co-payments are typically charged for patients whose discharge destination is LTC or complex continuing care.

16 *PHA*, s 16(3.1).

SECTION 5: Ontario Health atHome and Community Resources

1 Ontario Health atHome, "Guide to Placement in Long-Term Care Homes" (June 2024), online: <https://ontariohealthathome.ca/wp-content/uploads/2022/10/OHaH-Long-Term-Care-Placement-Guide-EN.pdf>; Ontario Health, "Operational Direction: Home First" (August 14, 2024), online: <https://www.ontariohealth.ca/content/dam/ontariohealth/documents/operational-direction-home-first-2024-aug-14.pdf>[Operational Direction: Home First].

2 Ontario Health atHome, "Patient Bill of Rights and Responsibilities", online: <https://ontariohealthathome.ca/patient-bill-of-rights-responsibilities/>.

3 Ministry of Health, "Home and Community Care" (October 14, 2024), online: <https://www.ontario.ca/page/home-community-care#section-1>.

4 *Home and Community Care Services*, O Reg 187/22, s 2 [*HCCS*].

5 *HCCS*, s 18.

6 *HCCS*, s 16.

7 *HCCS*, s 1.

8 *HCCS*, s 1.

9 *HCCS*, s 1.

10 Ontario Health atHome, "Supportive Housing" (2025), online: <https://ontariohealthathome.ca/supportive-living/supportive-housing/>.

11 Ontario Health atHome, "Assisted Living" (2025), online: <https://ontariohealthathome.ca/supportive-living/assisted-living/>.

12 Ontario Health atHome, "Retirement Homes" (2025), online: <https://ontariohealthathome.ca/supportive-living/retirement-homes/>.

13 *Retirement Homes Act, 2010*, SO 2010, c 11.

14 *Fixing Long-Term Care Act, 2021*, SO 2021, c 39, Sched 1, s 47 [*FLTCA*]; Ministry of Long-Term Care Memorandum to the Long-Term Care Sector, "Minister's Designation of Placement Coordinator under s. 47 of the *Fixing Long-Term Care Act, 2021* – Ontario Health atHome" (no date), online: <https://ltchomes.net/LTCHPORTAL/Content/Snippets/MLTC-DM-Memo-Ministers-Designation-Placement-Coordinator-under-the-FLTCA-OHaH-EN.pdf>.

15 The terminology used in the remainder of this Guidance Document will align with Ontario Health atHome titles rather than the *FLTC*A.

16 Ontario Health atHome, "Guide to Placement in Long-Term Care Homes" (June 2024), online: <https://ontariohealthathome.ca/wp-content/uploads/2022/10/OHaH-Long-Term-Care-Placement-Guide-EN.pdf>.

17 *General*, O Reg 246/22, s 171 [*General*].

18 *FLTCA*, s 60.1. The amendments to the FLTCA from Bill 7, More Beds Better Care Act, 2022 were upheld by the Ontario Superior Court following a constitutional challenge. For more information about this, please see Ontario Health Coalition and Advocacy Centre for the Elderly v His Majesty the King in Right of Ontario, 2025 ONSC 415.

19 *FLTCA*, s 60.1(4).

20 *FLTCA*, s 60.1(6).

21 *General*, s 172.

22 *FLTCA*, s 50(4); *General*, s 177(1).

23 *FLTCA*, s 50(4); *General*, s 177(1)(c).

24 *FLTCA*, s 50(5).

25 *General*, s 177.1(d).

26 *General*, s 177.1(d).

27 *FLTCA*, s 51(11).

28 *General*, s 240.1.

29 *General*, s 240.1(5).

30 *FLTCA*, s 51(8).

31 *FLTCA*, s 51(3).

32 *General*, s 240.2.

33 *FLTCA*, s 51.

34 This application process is referred to in the *FLTCA* as an application for authorization of admission; *FLTCA*, s 51(1); *General*, s 178(1).

35 *FLTCA*, s 60.1(3)(2).

36 *FLTCA*, s 51(7).

37 *General*, s 179(3).

38 *FLTCA*, s 51(7).

39 *FLTCA*, s 51(9).

40 *General*, s 203(1).

41 *FLTCA*, ss 51(11)(d), 60.1(7).

42 *HCCA*, s 4(1).

43 *HCCA*, ss 40(1)-(2).

44 *FLTCA*, s 40.

45 *FLTCA*, s 52(1).

46 *FLTCA*, s 52(3).

47 Generally, a patient's discharge will have already been ordered before this stage. *Hospital Management*, RRO 1990, Reg 965 requires a discharge order to be written if a patient has been designated as ALC and the patient's admission to a LTC home has been authorized. If the application to LTC is made pursuant to s. 60.1 of the *FLTCA*, the patient is deemed ready for discharge and a discharge order is not needed.

48 *General*, s 184(1). Note there are exceptions set out in s 184(2).

49 *General*, s 184(2).

50 *HCCA*, s 47(1).

51 *HCCA*, s 39.

52 "Crisis category" is discussed in more detail earlier in this section of the Guidance Document.

53 *HCCA*, s 47(3).

54 *HCCA*, s 47(4).

SECTION 6: Role of the Patient, Substitute Decision-Maker, Family, and Caregivers

1 *Health Care Consent Act, 1996*, SO 1996, c 2, Sched A [HCCA]. For more on determining capacity to consent to treatment, please see: Katharine Byrick & Barbara Walker-Renshaw, "A Practical Guide to Mental Health and the Law," Chapter 2, section 2 (Fourth Edition, June 2023), Ontario Hospital Association, online: <https://www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/A%20Practical%20Guide%20to%20Mental%20Health%20and%20the%20Law%2C%20Fourth%20Edition%2C%202023.pdf>.

2 *HCCA*, ss 4(2)-(3).

3 *HCCA,* s 11(1).

4 *HCCA,* ss 11(2)-(3). See also *Denman v Radovanovic*, 2024 ONCA 276 at paras 42-48.

5 For example, it could be that the identified attorney has either resigned or has become incapable.

SECTION 7: Role of the Substitute Decision-Maker

1 *Health Care Consent Act, 1996*, SO 1996, c 2, Sched A, ss 20(1), 41 [*HCCA*].

2 *HCCA*, s 20(4).

3 *HCCA*, s 20(2).

4 *HCCA*, 20(11).

5 See *MZ (Re)*, 2022 CanLII 45520 (ON CCB) [*MZ (Re)*].

6 See *MS (Re)*, 2023 CanLII 81738 (ON CCB) *[MS (Re)*].

7 See *SM (Re)*, 2024 CanLII 55687 (ON CCB).

8 See *AH (Re)*, 2013 CanLII 49770 (ON CCB). In this case, physicians made efforts to accommodate the potential SDM by offering to fly her from British Columbia to Toronto or have the physicians fly from Toronto to British Columbia. Both offers were refused.

9 In *BS (Re)*, 2021 CanLII 13718 (ON CCB), a SDM was located in the United States during the COVID-19 pandemic. Due to public health restrictions in place at the time, the SDM was not permitted to travel from the United States to Canada.

10 *RR (Re)*, 2016 CanLII 58683 (ON CCB) [*RR (Re)*].

11 *RR (Re)*.

12 *RR (Re)*.

13 See, for example, *MZ (Re).*

14 See *MS (Re)*, which involved a finding of incapacity where substitute consent was obtained from the PGT rather than a brother or niece. The treatment team's position was that neither of the higher-ranking SDMs were "willing" or "available." The evidence was that the brother refused to act as SDM and that the contact information for the niece was unknown. The Board commented that "No chart entries corroborated that evidence [relating to the unwillingness and unavailability of the potential SDMs]. We think there should have been chart entries, something with which [the physician] agreed without prompting…We saw no legal requirement that attempts to locate a relative to act as SDM had to be charted, preferable though chart entries would have been, if only to abbreviate this Hearing."

15 See, for example, *LD (Re)*, 2020 CanLII 75913 (ON CCB).

16 *HCCA*, s 20(5).

17 *HCCA*, s 20(6).

18 See *GV (Re*), 2016 CanLII 98576 (ON CCB).

19 For more information on the role of the PGT, please refer to The Office of the Public Guardian and Trustee website at https://www.ontario.ca/page/office-public-guardian-and-trustee.

20 *Koch (Re)*, 1997 CanLII 12265 (ON SC) at para 17.

21 *HCCA*, s 21.

22 *HCCA*, ss 21(1), 42(1).

23 *Conway v Jacques* (2002), 59 OR (3d) 737, 214 DLR (4th) 67, 2002 CarswellOnt 1920 (CA).

24 *L(L) v T(I)*, 1998 CarswellOnt 4097 (Gen. Div.), [1998] OJ No. 4205 at 30-31.

25 *HCCA*, ss 35, 36, 52, 53. A Form E is an Application to the Consent and Capacity Board for Permission to Depart from Wishes.

26 *HCCA*, ss 21(2), 42(2).

27 *Substitute Decisions Act, 1992*, SO 1992, c 30, ss 66-67.

28 *HCCA*, ss 37, 54.

29 *HCCA*. s 37.

30 *HCCA*, s 54.

31 *HCCA*, ss 37(1), 54(1).

32 *HCCA* ss 37(6), 54(6).

SECTION 8: Co-Payments

1 For information from the Ministry of Health on co-payments, please go to: https://www.ontario.ca/page/hospital-chronic-care-co-payment.

2 *General*, RRO 1990, Reg 552 [*HIA General*].

3 *HIA General*, s 10(1).

4 For information on power of attorneys for property and guardians of property, please go to: https://www.ontario.ca/page/guardianship.

5 *HIA General*, ss 10(4), (6).

6 *HIA General*, s 10(7).

7 *HIA General*, s 10(4).

8 *Classification of Hospitals*, RRO 1990, Reg 964 [CH]; *Public Hospitals Act*, RSO 1990, c 40 [PHA].

9 *HIA General*, s 10(2).

10 *HIA General*, s 10(2); CH, s 1. The Schedules are listed in *HIA General*. The Groups are listed in CH, s 1.

11 *HIA General*, s 10(2)(b); CH, s 1.

12 *Health Insurance Act*, RSO 1990, c H.6 [*HIA*].

13 *HIA*.

14 *Mental Health Act*, RSO 1990, c M.7, s 1 [*MHA*]. See also Katharine Byrick & Barbara Walker-Renshaw, "A Practical Guide to Mental Health and the Law" (Fourth Edition, June 2023), Ontario Hospital Association, online: <https://www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/A%20Practical%20Guide%20to%20Mental%20Health%20and%20the%20Law%2C%20Fourth%20Edition%2C%202023.pdf> [MHLT].

15 This would include if the patient continued to meet the criteria for involuntary admission under the *MHA*, (Form 3 or 4) or was admitted as a "voluntary" or "informal" patient under the *MHA*. For more information on these designations please see MHLT.

16 This would include patients seen under a Form 1 or 2 as they are not considered to be "patients" under the *MHA*, ss. 1, 15 and 16.

17 Patient Ombudsman, "Year 3 Highlights: Confusion about the hospital chronic care co-payment" (2018/2019), online: <https://www.patientombudsman.ca/year-three/spotlights/03/>.

18 For example, low-income patients and patients with dependents are eligible to apply for a reduced co-payment rate.

19 *HIA General*, s 10(10)(b). For example, a patient under the age of 18 who, on the day before the patient was admitted to the hospital was receiving income support under the *Ontario Disability Support Program Act, 1997* or income assistance under the *Ontario Works Act, 1997*.

20 For more information on the forms, please go to: https://forms.mgcs.gov.on.ca/en/.

21 Ontario Health, "ALC Leading Practice Guide" (2021), online: <https://geriatricsontario.ca/wp-content/uploads/2023/06/ALC-Leading-Practices-Guide-v1-2021-_-Updated-Links-June-2023_Accessibility.pdf>.

22 Ministry of Health, "Hospital Chronic Care Co-Payment" (June 30, 2025), online: <https://www.ontario.ca/page/hospital-chronic-care-co-payment>.

SECTION 9: Daily Rate Charges for Uninsured Services

1 *Health Insurance Act*, RSO 1990, c H.6, s 11.2(1) [*HIA*].

2 *Hospital Management*, RRO 1990, Reg 965, s 16(3.1) [*HM*].

3 *HM*, s 16(1).

4 *HM*, s 16(4)(5). The amendments to the *HM* requiring these charges for ALC patients for whom a LTC home bed is available were upheld by the Ontario Superior Court following a constitutional challenge. For more information about this, please see *Ontario Health Coalition and Advocacy Centre for the Elderly v His Majesty the King in Right of Ontario,* 2025 ONSC 415 at para 212.

SECTION 10: Discharge Planning

1 Ontario Health, "The Alternate Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults" (September 2021), online: < https://quorum.hqontario.ca/Portals/0/Indicators-and-change-ideas/ALC%20Leading%20Practices%20Guide%20v1%202021%20(2).pdf?ver=2022-03-30-133617-273>; Ontario Health, "Quality Standards: Transitions Between Hospital and Home" (November 2019), online: < https://hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-transitions-between-hospital-and-home-quality-standard-en.pdf>.

2 Ontario Health, "Operational Direction Implementation of the *More Beds, Better Care Act, 2022*: Discharge Planning Policy", released October 21, 2022, online: <https://www.oha.com/Bulletins/Operational%20Direction%20-%20Implementation%20of%20the%20More%20Beds,%20Better%20Care%20Act,%202022%20-%202022-10-21.pdf>; Ontario Health, "Operational Direction: Home First" (August 14, 2024), online: <https://www.ontariohealth.ca/content/dam/ontariohealth/documents/operational-direction-home-first-2024-aug-14.pdf> [Operational Direction: Home First]. As noted earlier in this Guidance Document, the "Home First" approach requires that "every effort is made to ensure adequate resources are in place to support patients to remain at home whenever possible, and ultimately return home upon discharge from all bedded levels of care." Home should be the preferred discharge destination for a patient before an admission to LTC is considered.

3 For more information on the "circle of care," see: Information and Privacy Commissioner of Ontario, "Circle of Care: Sharing Personal Health Information for Health-Care Purposes Information and Privacy Commissioner, Ontario" (August 16, 2015), online: <www.ipc.on.ca/resource/circle-of-care-sharing-personal-health-information-for-health-care-purposes/> [IPC].

4 *Cianfrone (Re)*, 2016 CanLII 85807 (ON IPC) at paras 23-24 [*Cianfrone (Re)*].

5 *Personal Health Information Protection Act, 2004*, SO 2004, c 3, Sched A, ss 18(3), 20(2) [*PHIPA*]. It is important to note consent may be express or implied.

6 IPC. See also *PHIPA*, s 3(1) and *Cianfrone (Re)*. The custodians listed here are not all of the custodians identified by *PHIPA* but are the ones most likely to be encountered in the context of discharge planning.

7 IPC at Part 1. See also *PHIPA*, ss 3(1)1-4. Some health information custodians are not entitled to rely on assumed implied consent, including an "evaluator" under the *Health Care Consent Act, 1996*, an "assessor" under the *Substitute Decisions Act, 1992*, the Minister or Ministry of Health, and the Minister or Ministry of Long-Term Care.

8 *PHIPA*, ss 19(1), 20(2).

9 Ministry of Long-Term Care, "Long-term care home complaint process" (May 7, 2024), Ministry of Long-Term Care, online: <https://www.ontario.ca/page/long-term-care-home-complaint-process#section-2>.

10 Operational Direction: Home First.

11 Ontario, Patient Ombudsman "Frequently Asked Questions" (2025), online: <https://patientombudsman.ca/Complaints/Resources/FAQs>.

12 For more information on the Patient Ombudsman, please see: https://www.patientombudsman.ca/.

13 *Health Care Consent Act, 1996*, SO 1996, c 2, Sched A, s 20 [*HCCA*].

14 *Substitute Decisions Act, 1992*, SO 1992, c 30, s 27 [*SDA*]. Section 27(1) states "serious adverse effects" are a "loss of a significant part of a person's property or a person's failure to provide necessities of life for himself, herself or dependants."

15 *SDA*, s 62. Section 62(1) states "serious adverse effects' are "serious illness or injury, or deprivation of liberty or personal security."

16 *SDA*, ss 27(3.1), 62(3.1).

17 Ontario, Consent and Capacity Board, "About Us," online: <https://www.ccboard.on.ca/scripts/english/aboutus/index.asp>.

18 *HCCA*, ss 32(1), 50(1), 65(1).

19 *HCCA*, ss 33(1)(2)(7)(8), 51(1)(2)(6), 66(1)(2)(6).

20 *HCCA*, ss 35(1), 52(1), 67(1).

21 *HCCA*, ss 36(1), 53(1), 68(1).

22 *HCCA*, s 34(1).

23 *HCCA*, ss 37(1), 54(1), 69(1).

24 In addition to the resources on the CCB's website, referenced above, there is detailed commentary on the CCB process on the OHA website: Katharine Byrick & Barbara Walker-Renshaw, "A Practical Guide to Mental Health and the Law" (Fourth Edition, June 2023), Ontario Hospital Association, online: <https://www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/A%20Practical%20Guide%20to%20Mental%20Health%20and%20the%20Law%2C%20Fourth%20Edition%2C%202023.pdf>.

25 *Ministry of Health and Long-Term Care Appeal and Review Boards Act, 1998*, SO 1998, c 18, Sched H. See also: www.hsarb.on.ca/scripts/english/default.asp.

26 *Health Insurance Act*, RSO 1990, c H.6, s 11.2(1).

27 *Connecting Care Act, 2019*, SO 2019, c 5, Sched 1.

28 *Fixing Long-Term Care Act, 2021*, SO 2021, c 39, Sched 1. Also addresses eligibility appeals related to LTC home admissions.

29 For more information on HSARB, go to: https://www.hsarb.on.ca/scripts/english/legal.asp.

APPENDIX A: Substitute Decision-Maker Hierarchy

1 *Substitute Decisions Act*, 1992, SO 1992, c 30, ss 55-65 [*SDA*]. These sections in Part II of the *SDA* cover applications for guardianship of the person.

2 *SDA*, s 58(1)(2).

3 *SDA*, s 59(1). The test for determining capacity to consent to "personal care" is in section 45 of the *SDA*.

4 *SDA*, ss 58(3), 60.

5 *SDA*, s 55(2).

6 *SDA*, s 57(3).

7 *SDA*, s 57(1). Unless the person is also the guardian of property, power of attorney for personal care or continuing power of attorney, as per s 57(2) of the *SDA*.

8 *SDA*, ss 46-54. These sections cover powers of attorney for personal care.

9 *SDA*, s 47.

10 *SDA*, s 48. Section 10(2) of the *SDA* provides a list of individuals who are excluded from acting as a witness to a power of attorney which includes the attorney or the attorney's spouse/partner; the grantor's spouse/partner; a child of the grantor or a person whom the grantor has demonstrated a settled intention to treat as his or her child; a person whose property is under guardianship or who has a guardian of the person; and a person who is less than eighteen years old.

11 *SDA*, ss 49(1), (2).

12 *SDA*, ss 49(1)(b), 49(2)(3).

13 *SDA*, s 50(2).

14 *SDA*, s 50(1).

15 *SDA*, s 48(4).

16 *Health Care Consent Act, 1996*, SO 1996, c 2, Sched A, ss 33, 51, 66 [*HCCA*].

17 *HCCA*, ss 33, 51, 66.

18 *HCCA*, ss 33, 51, 66.

19 *HCCA*, s 20(8).

20 *HCCA*, s 20(7).

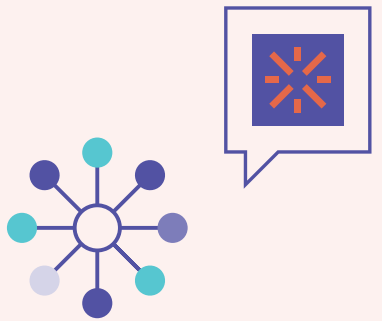
21 *HCCA*, s 20(9)(b).

22 *Children's Law Reform Act*, R.S.O. 1990, c 12, s 1 [*CLRA*].

23 *CLRA*, s 8(1). These circumstances include: when the person is married to the mother of the child at the time of the birth; the person was married to the mother of the child by a marriage that was terminated by death or judgment of nullity within 300 days before the birth of the child or by divorce where the decree nisi was granted within 300 days before the birth of the child; when the person marries the mother of the child after the birth of the child and acknowledges that he is the natural father, when the person was cohabiting with the mother of the child in a relationship of some permanence at the time of the birth of the child or the child is born within 300 days after they ceased to cohabit; the person has certified the child's birth, as the child's father, under the Vital Statistics Act or a similar Act in another jurisdiction in Canada; and when the person has been found or recognized in his lifetime by a court of competent jurisdiction in Canada to be the father of the child.

24 See, for example, *Children's Aid Society of Toronto v AVG*, 2024 ONCJ 157. In this sad case, a critically ill infant was placed into the temporary care of a Children's Aid Society pending a full hearing. The child had a poor prognosis. Although efforts were taken by the society to obtain the mother's consent to withdraw treatment, the mother was unwilling or unable to provide consent. The society ultimately provided consent to withdraw life support. The Court determined that a Children's Aid Society was not permitted to exercise its authority to consent to the withdrawal of life support for a child in its temporary care/interim custody without a court order explicitly authorizing the decision.

25 *HCCA*, s 20(10).



Ontario Hospital Association