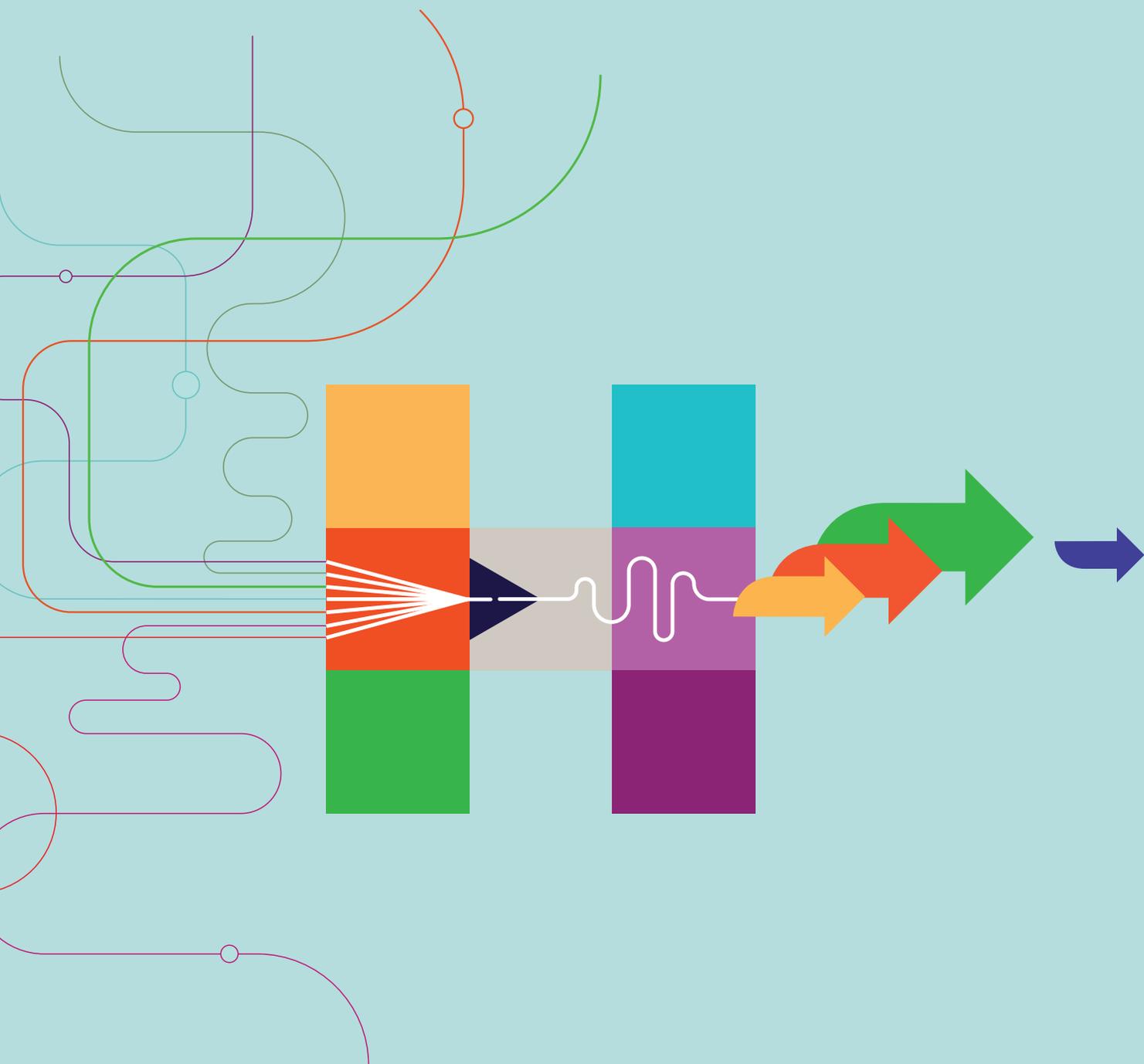


Managing Transitions

A GUIDANCE DOCUMENT - SECOND EDITION



Disclaimer

This resource document was prepared as a general guide to assist hospitals and other entities in understanding Ontario legislation related to transitions from one health care setting to another, including 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 or professional advice. The Ontario Hospital Association (OHA) will not be held responsible or liable for any harm, damage, or other losses resulting from reliance on, or the use or misuse of the general information contained in this document.

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Table of Contents

Disclaimer	I
Acknowledgements	II
Section 1: Introduction	1-1
Section 2: Alternate Level of Care	
(a) The ALC Designation	2-1
(b) Definition	2-1
(c) Discharge Destinations	2-2
(d) Impact of an ALC Designation	2-4
(e) Home- and Community-Based Care	2-4
Section 3: The Legislative Framework for Discharge Planning	
(a) Discharge Planning	3-1
(b) Legislation that Impacts Discharge Planning	3-1
(i) <i>Canada Health Act</i>	3-1
(ii) <i>Health Insurance Act</i>	3-2
(iii) <i>Public Hospitals Act</i>	3-2
(iv) <i>Local Health System Integration Act</i>	3-2
(v) <i>Health Care Consent Act</i>	3-3
(vi) <i>Substitute Decisions Act</i>	3-4
(vii) <i>Long-Term Care Homes Act</i>	3-5
(viii) <i>Home Care and Community Services Act</i>	3-5
(ix) <i>Personal Health Information Protection Act</i>	3-6
(x) <i>Retirement Homes Act and Residential Tenancies Act</i>	3-7
Section 4: Role of the Hospital and the Health Care Team	
(a) Roles and Obligations	4-1
(b) Admission to Hospital	4-1
(c) Discharge from Hospital	4-1
(d) Introduction to Co-Payments	4-2
(e) Introduction to ‘Per Diems’ or ‘Daily Rates’	4-3
Section 5: Role of the LHIN	
(a) Part of the Discharge Planning Team	5-1
(b) Process for Admission to Long-Term Care Homes	5-1
(c) Eligibility for Admission to Long-Term Care Homes	5-2
(d) Application for Admission to Long-Term Care Homes	5-2
(e) Consent for Admission to Long-Term Care Homes	5-3
(f) Authorization of Admission to Long-Term Care Homes	5-4
(g) Home Care and Community-Based Services	5-4
(i) In-Home Services	5-4
(ii) Determinations of Eligibility and Plans of Service	5-5
(iii) Service Maximums	5-5
(h) Other Community Services	5-6

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

- (a) Capable Patient 6-1
- (b) Consent and Capacity 6-1
- (c) Family Members 6-2
- (d) Caregivers 6-3

Section 7: Role of the Substitute Decision Maker

- (a) Identifying the SDM 7-1
- (b) The Role of the Public Guardian and Trustee 7-2
- (c) Principles for Substitute Decision Making 7-2
 - (i) Prior Capable Wish 7-3
 - (ii) Best Interests 7-3
- (d) Other Obligations of a Substitute Decision Maker 7-5
- (e) Decisions Not Being Made in Accordance with these Principles 7-5

Section 8: Co-Payments

- (a) What Is a Co-Payment? 8-1
- (b) The Ability of Hospitals to Charge Co-Payments 8-1
- (c) The Psychiatric Patient Exception 8-2
- (d) The Co-Payment Process and Communication 8-3
- (e) Determining When a Co-Payment May Be Charged 8-3

Section 9: Unregulated Charges or ‘Per Diems’

- (a) What Is a Per Diem? 9-1
- (b) Situations in which Per Diems May Be Appropriate 9-1
- (c) Recommendations for Hospital Policy 9-1

Section 10: Dealing with Challenges in Discharge Planning

- (a) Communication between Discharge Planning Partners 10-1
- (b) Escalation and Complaints Process for Hospitals and LHINs 10-2
- (c) The Patient Ombudsman 10-2
- (d) Public Guardian and Trustee 10-3
- (e) Consent and Capacity Board 10-3
- (f) Health Services Appeal and Review Board 10-4

Section 11: Tools for Discharge Planning

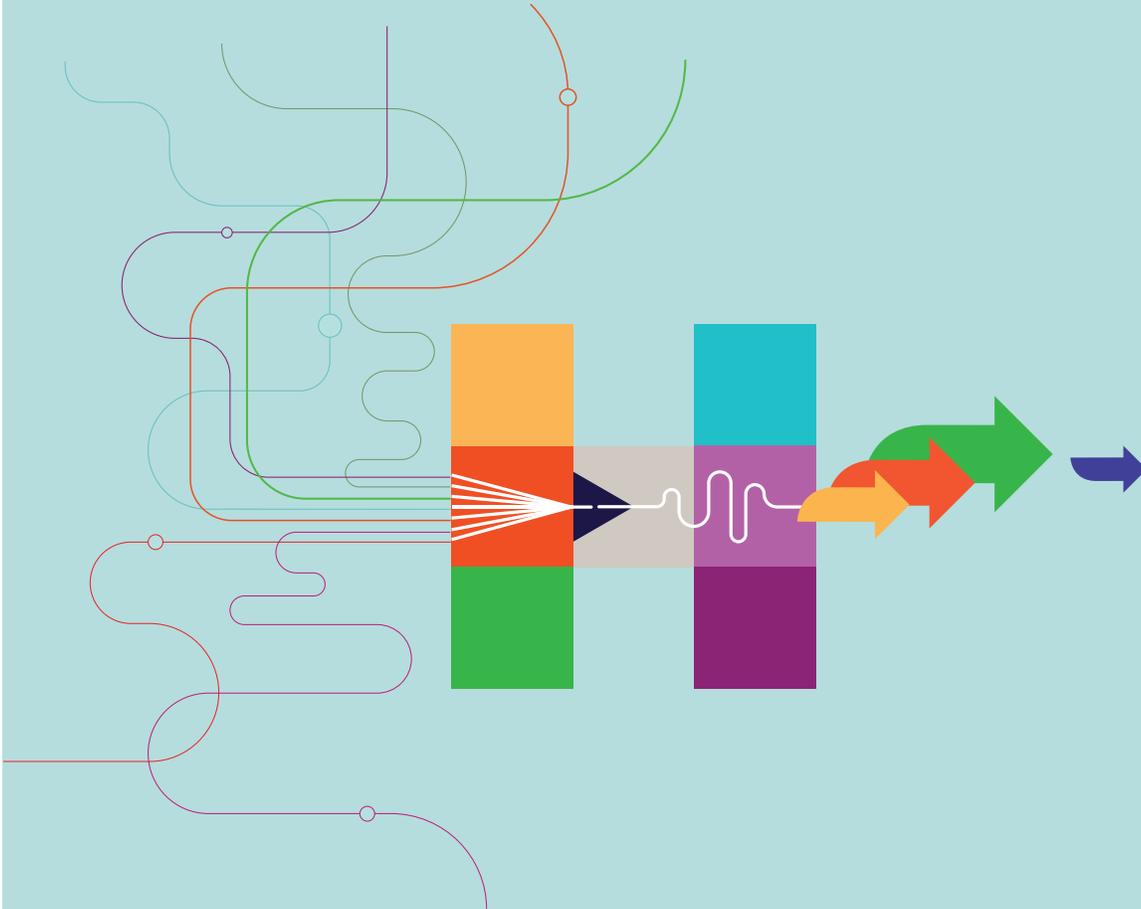
- (a) Challenges in Discharge Planning 11-1
- (b) Hospital Policies 11-1
- (c) LHIN Policies 11-2

Section 12: Additional Information

- (a) Substitute Decision Maker Hierarchy 12-1

SECTION 1

Introduction



Introduction

Many patients wait far too long in hospitals for access to a different level of service or care better suited to their needs, such as home care, long-term care, community care, and supportive housing. This is because the current levels and types of services available do not line up with the demographic characteristics and needs of the populations who require them. These prolonged waits have contributed to heightened capacity challenges within Ontario's health care system and longer wait times for patients admitted through emergency departments. This strain on the system will only increase as the number of seniors aged 65 and older is expected to almost double from 2.3 million today to 4.6 million by 2041.

Part of the answer to these capacity challenges is developing and implementing solutions that enable patients to access more appropriate care designed to meet their unique needs, including those designated as waiting for an alternate level of care (ALC). Not only will this offer higher quality and safer care to patients, but it will also help alleviate capacity challenges by improving patient flow through the system. Critical to improving patient flow is transition planning.

The way in which patients are transitioned through the health care system is an important factor in designing a successful, patient-centred discharge from hospital. This theme emerges repeatedly in the discussion about discharge planning and ALC issues. Several years ago, the Ontario Hospital Association (OHA) and the Ontario Association of Community Care Access

Centres (OACCAC), prior to their integration with the province's Local Health Integration Networks (LHINs), worked together to develop the original version of this Guidance Document. Its purpose remains the same: to help support the standardization of policies and programs related to the discharge of patients from hospitals once they no longer require the level of treatment and care offered at that facility.

The OHA has updated this Guidance Document to reflect recent changes within Ontario's health care landscape. For example, care coordination, which had previously been the responsibility of Ontario's 14 CCACs, is now the responsibility of the 14 LHINs. As well, Ontario's first-ever Patient Ombudsman's office officially opened in July 2016, tasked with developing recommendations for the system to deliver on the promise of a more coordinated patient and caregiver experience.

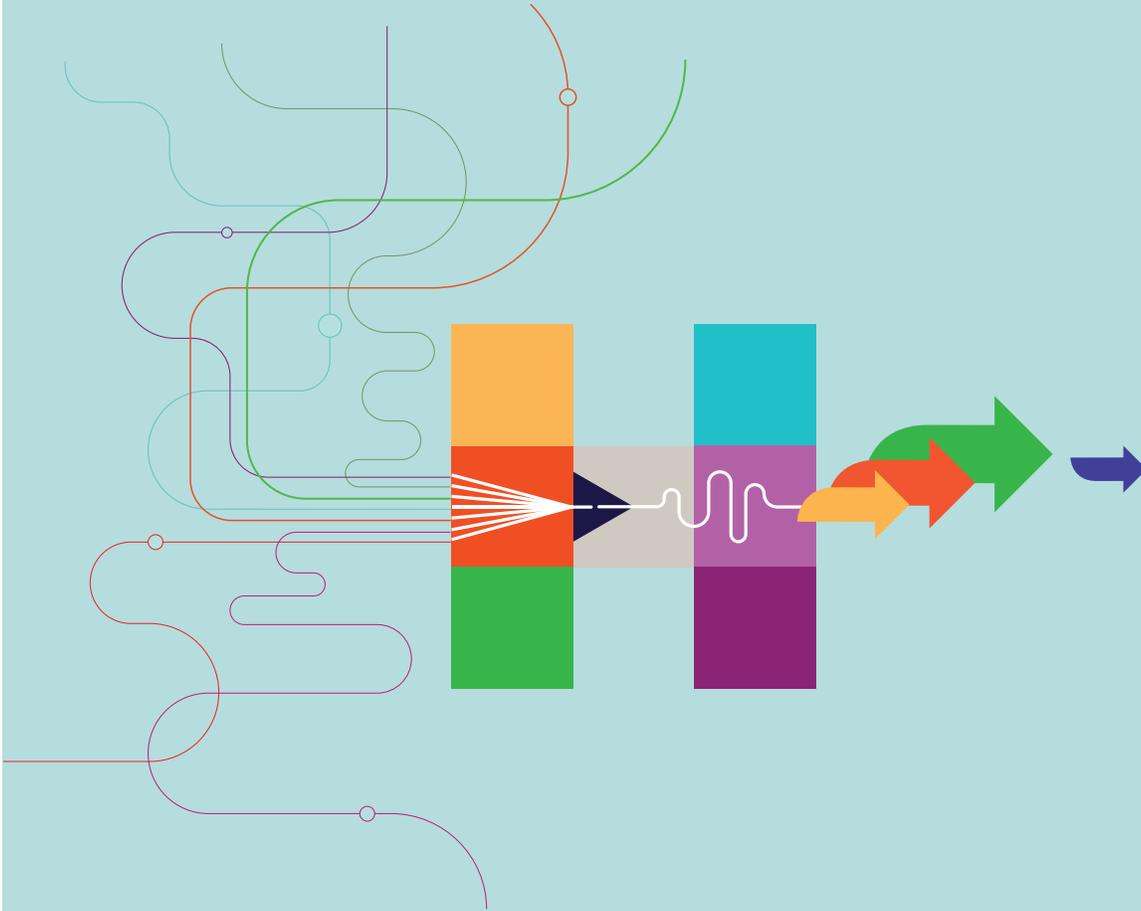
Accurate, clear and coordinated communication is key to successful discharge planning. This Guidance Document outlines some of the tools that can be used to manage the discharge planning process and some of the challenges that may be encountered when navigating this process. It also reviews the legislative framework for discharge planning and the different roles and responsibilities of those involved.

The individual nature of each patient's discharge plan or transition through the health care system cannot be captured in one document due to the variety of operational and organizational challenges throughout the health care continuum. This Guidance Document is not a template, nor does it set out one way of doing things. It is intended to serve as a helpful resource for identifying and understanding the provincial legislation and policy direction pertaining to transitioning patients from one care setting to another, as well as the roles members of the patient care team play in facilitating those transitions, especially in light of new models of care emerging within the system.

The OHA recognizes that health care providers working with patients, substitute decision makers, families, and caregivers is crucial to provide the best care possible during what can be a challenging period of transition. The hope is that this Guidance Document will serve as an informative, supplementary resource for those working through these issues.

SECTION 2

Alternate Level of Care



Alternate Level of Care

(a) The ALC Designation

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

On July 1, 2009, all acute and post-acute hospitals in Ontario began using a standardized definition to designate patients as ALC.¹ This provincial ALC definition is located on the Cancer Care Ontario website and is reproduced, with comments and notes, in the section below. In accordance with this definition, 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).

¹ Ontario, Cancer Care Ontario, “Alternate Level of Care”, (21 September 2016) online: <http://ocp.cancercare.on.ca/cms/One.aspx?portalId=77515&pageId=43214>. There is more information in the official Alternative Level of Care definition about the need for a standardized definition and its development.

The exceptions to this definition are set out in the Final Note below. 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.

The designation of a patient as ALC is determined by a patient’s physician or their delegate, in collaboration with members of that patient’s interprofessional team, when available.²

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.

It is often the identification of an appropriate discharge destination that is the challenge in a difficult discharge situation.

(b) Definition

As noted above, the provincial ALC Definition has been used by all acute and post-acute hospitals in Ontario since July 2009.³ The health care system aspires to deliver care in a setting that is congruent with the clinical needs of a patient, as defined by the patient’s health status, treatment plan, and goals.

The definition applies to all patient populations waiting in all patient care beds in an acute or post-acute care hospital in Ontario.

² For more information on ALC designation visit: www.accesstocare.on.ca.

³ *Supra* note 1.

Definition:⁴ 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 Alternate Level of Care (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, or
- Progress has reached a plateau, or
- 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”).

This 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),
- Long-term Care 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).

This formal definition was last updated on September 21, 2016.

Explanatory Note: Determination of destination is part of the interprofessional team designation.

⁴ *Ibid.*

(c) Discharge Destinations

There are a number of discharge and transfer destinations for patients who, under the definition of ALC, no longer require the level of care they are receiving in their hospital setting. Many of these destinations are addressed in more detail throughout this Guidance Document.

The list of discharge and transfer destinations for patients no longer requiring acute care under the ALC definition includes:⁵

- *Home* – This discharge destination is for individuals discharged to a private residence, with or without support. Support may be through the Local Health Integration Network (LHIN). There may also be other community organizations and resources to support a patient on a discharge home.⁶
- *Rehabilitation* – This discharge destination provides care that is aimed at improving and maximizing patients' overall functioning, including physical, sensory, intellectual, psychological, and social functions.
- *Complex continuing care* – This discharge destination is appropriate for individuals who are medically complex, require specialized skilled nursing care, regular on-site physician care and assessment, and active management over extended periods of time.⁷
- *Transitional care bed* – This discharge destination is designed to provide restorative care, with a goal of returning individuals to independence in the community. This care setting is meant to be short-term and is located at a facility where other types of care are provided.
- *Long-term care home* – This discharge destination is appropriate for individuals with chronic health conditions or disabilities who cannot be cared for in the community. These are individuals who require that nursing care be available 24 hours a day for assistance with activities of daily living at frequent intervals, on-site supervision, or monitoring at frequent intervals. Discharge to a long-term care home is an involved process. This process may be commenced prior to, during, or following a patient's admission to hospital. Practically, this discharge destination should not be designated unless it has been determined by the LHIN that the patient is eligible for admission to a long-term care home.⁸
- *Group home* – This discharge destination provides services to individuals with chronic or complex needs as a means of maintaining them in the community. This may include services such as supervision, personal support, and counselling.
- *Convalescent care beds* – This discharge destination is appropriate for individuals who require support during recovery from illness or a medical procedure. These beds are located in long-term care facilities and are for patients who might benefit from a short stay in a long-term care setting while they recover strength, endurance, or functioning. The goal for these individuals is to return to independent living in the community and it is anticipated that they transition home within 90 days of their admission. This discharge destination should not be designated unless it has been determined by the LHIN that the patient is eligible for admission to a short-stay convalescent care bed in a long-term care home.
- *Palliative care beds* – This discharge destination provides medical or comfort care to support end-of-life planning to reduce the severity of a disease or slow its progress. This may also include hospice beds.

5 Cancer Care Ontario, Data Book 2017-2018, Appendix 2C.22-Most Appropriate Discharge Destination Type/Detail.

6 Local Health Integration Networks, as well as the support and services they provide and arrange, will be addressed in more detail in [Section 3](#) of this Guidance Document.

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

8 The process for admission to a long-term care home or a care facility will be addressed in more detail in [Section 5](#) of this Guidance Document.

- *Retirement home* – 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 long-term care services. Services offered may include meals, housekeeping, recreational activities, and personal support.⁹
- *Shelter* – This discharge destination provides temporary emergency housing for individuals in crisis or without alternative accommodations.
- *Supportive housing* – This discharge destination provides housing and support services for individuals with chronic or complex needs (individuals with a physical disability, acquired brain injury, HIV/AIDS, seniors, people with mental health and/or addiction issue) to maintain independence and stable housing in the community.

As noted above, many of these destinations are discussed in more detail throughout this Guidance Document.

It is often the identification of a clinically appropriate discharge destination that is challenging. Complications may arise in situations where the recommendations of the health care providers are not consistent with the destination desired by the patient/substitute decision maker (SDM) and/or family/caregivers.

(d) Impact of an ALC Designation

Discharge planning is a collaborative process that begins prior to a patient being ready for discharge from acute care, and therefore, prior to an ALC designation. Discharge planning for all patients, including those designated ALC, should start as early as possible to allow the patient/SDM and family/caregivers enough time to understand and explore the options for the most appropriate plan.

⁹ More information regarding Retirement Homes is set out in Section 3 of this Guidance Document.

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 on-going hospitalization until the appropriate destination is available to the patient. For example, an ALC patient may be transferred to a different unit/ward within the acute care facility, and, in some situations, a co-payment may be charged. Co-Payments will be discussed in more detail in Section 8 of this Guidance Document.

(e) Home- and Community-Based Care

Patients should, where clinically appropriate, return to a home environment in the community following an acute care admission. ‘Home’ may mean very different things for different patients. For some, this return home may be a transition to another setting on the health care continuum. For others, it may be a move to a new ‘home’ environment or a return to where they were living prior to their admission to the hospital.

Not all patients will be appropriate for discharge to the community while awaiting placement in a long-term care home, even with significant support from the LHIN and others in the community.

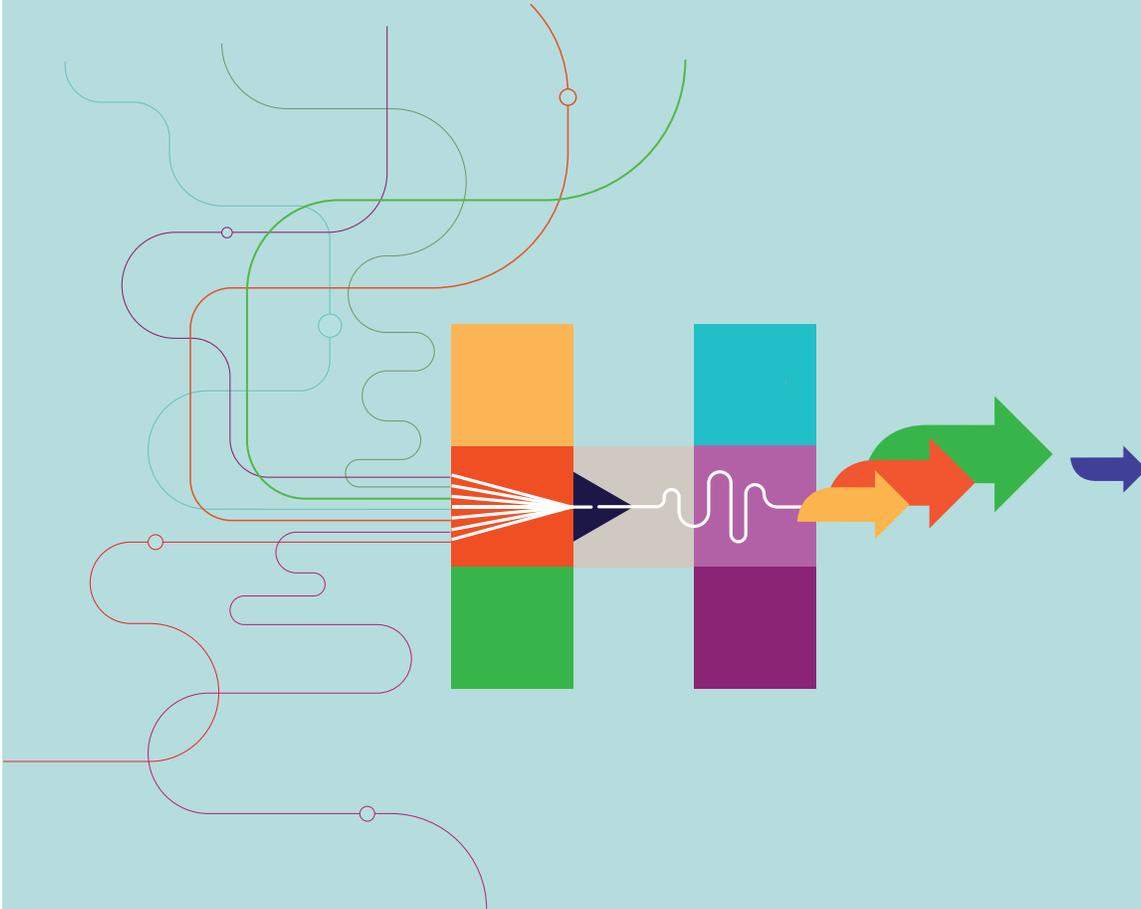
There will always be some ALC patients for whom a discharge ‘home’, even on an interim or transitional basis, is not an appropriate option.

For most patients, the discharge planning efforts focus on putting together clinically appropriate options and plans to support a discharge ‘home’ when their acute care stay is at an end and the physician/delegate has written a discharge or ALC order. This should be done in consultation with the patient/SDM and family/caregivers.

For all patients, discharge planning is an opportunity to discuss the various options for the patient. This may include a discussion of both interim and longer-term care needs, as well as other issues relating to an individual’s on-going health care.

SECTION 3

The Legislative Framework for Discharge Planning



The Legislative Framework for Discharge Planning

(a) Discharge Planning

‘Discharge planning’ is a collaborative process that includes patients, members of the health care team, family members 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;
- Admission to a care facility (long-term care home);
- Providing information about a tenancy in a retirement home;
- Arranging for in-home services either through the LHIN or privately; and
- Accessing other community resources to support someone in the community.

This process may take time and several different options may be explored simultaneously, with plans being arranged for both the interim and longer term.

Many different health care professionals and individuals may be working on options for a discharge plan with a patient, to put plans in place for a discharge from the hospital when the level of care provided in that setting is no longer required. Close collaboration and consistent, aligned communication between the

care team, the patient/SDM, and family members/caregivers are key components of successful discharge planning.

(b) 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.

(i) *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.¹

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

¹ Government of Canada, “*Canada Health Act*” (09 November 2017) online: <https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act.html>.

(ii) *Health Insurance Act*

Ontario's *Health Insurance Act* (HIA) deals with the administration of the Ontario Health Insurance Plan or OHIP.² 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.

This legislation is reviewed in more detail in [Sections 4, 8 and 9](#) of this Guidance Document.

(iii) *Public Hospitals Act*

All hospitals in Ontario are operated in accordance with the *Public Hospitals Act* (PHA), as well as its *Hospital Management* regulation.³

Another regulation established under the PHA is the *Classification of Hospitals*.⁴ 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.

This legislation will be reviewed in more detail in [Sections 4, 8 and 9](#) of this Guidance Document.

² *Health Insurance Act*, RSO 1990, c H.6 [HIA].

³ *Public Hospitals Act*, RSO 1990, c 40 [PHA]; *Hospital Management*, RRO 1990, Reg 965 [HM].

⁴ *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: www.health.gov.on.ca.

(iv) *Local Health System Integration Act*

The *Local Health System Integration Act, 2006* (LHSIA) establishes the Local Health Integration Networks (LHINs) with the mandate to create an integrated health system. The LHINs have three primary functions:

1. *Plan* – LHINs identify and plan for the health service needs of the local health system in alignment with provincial plans and priorities, as well as make recommendations to the Ministry of Health and Long-Term Care (MOHLTC) about that system. LHINs must engage their communities (including providers, patients, health care workers, etc.) when developing their Integrated Health Service Plans;
2. *Fund* – LHINs fund many of Ontario's health service providers and can reallocate this funding based on local needs and priorities. Funding parameters are set in the Ministry-LHIN Accountability Agreement (MLAA), ministry financial policies, and in the terms and conditions of funding letters; and
3. *Integrate* – LHINs, along with their health service providers, are required to identify opportunities to integrate services of the local health system to better coordinate health care and use health resources more efficiently.

The *Patients First Act, 2016* expanded the LHINs' mandate to include the management and delivery of home and community care services as well as determinations of eligibility, admissions, and placement into long-term care homes. These are the services previously provided through the Community Care Access Centres (CCACs). The transition from the CCACs to the LHINs was completed between May and June 2017.

LHINs also play an important role in primary health care planning.

The role of the LHINs is discussed in more detail in [Section 5](#) of this Guidance Document.

(v) *Health Care Consent Act*

One of the primary sources of law with respect to consent in Ontario is the *Health Care Consent Act* (HCCA).⁵ 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, for treatment, admission to a care facility, and personal assistance services.

A fundamental principle of health care in Ontario is that a capable patient will decide whether to consent to, or refuse to consent to, a proposed treatment/plan of treatment. Where the patient is not capable, there is a legal framework governing the making of treatment decisions. These same fundamental principles apply to a decision to be made with respect to admission to a care facility (a long-term care home) or personal assistance services (when provided to a resident of a long-term care home).

The stated purposes of the HCCA include the following:⁶

- (a) To provide rules with respect to consent to treatment that apply consistently in all settings;
- (b) To facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;
- (c) 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,

- (i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,
- (ii) 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, and
- (iii) 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;
- (d) To promote communication and understanding between health practitioners and their patients or clients;
- (e) 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; and
- (f) 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:⁷

“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:

⁵ *Health Care Consent Act*, SO 1996, c 2, Schedule A [HCCA].

⁶ *Ibid* at s 1.

⁷ *Ibid* at s 2.

- (a) 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;
- (b) The assessment or examination of a person to determine the general nature of the person’s condition;
- (c) The taking of a person’s health history;
- (d) The communication of an assessment or diagnosis;
- (e) The admission of a person to a hospital or other facility;
- (f) A personal assistance service;
- (g) A treatment that in the circumstances poses little or no risk of harm to the person; or
- (h) Anything prescribed by the regulations as not constituting treatment.

“care facility” means,

- (a) A long-term care home as defined in the *Long-Term Care Homes Act*, 2007; or
- (b) A facility prescribed by the regulations as a care facility.⁸

“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:

The HCCA provisions dealing with substitute consent to personal assistance services on behalf of an incapable patient currently apply only to residents of long-term care homes. The *Substitute Decisions Act* (SDA) applies in other settings.

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

If a discharge plan, or a component of a discharge plan, includes elements that fall within the HCCA, any decision will need to be made in accordance with this legislation.

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](#) of this Guidance Document.

The legal requirements relating to consent and capacity are addressed in more detail in [Sections 5](#) and [6](#) of this Guidance Document.

(vi) *Substitute Decisions Act*

The *Substitute Decisions Act* (SDA) deals with how an individual may delegate the ability to make decisions about their property or personal care to another individual.⁹ 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.

⁸ As of the date this Guidance Document is being finalized, there are no facilities prescribed by regulations.

⁹ *Substitute Decisions Act*, SO 1992, c 30 [SDA].

Generally, the SDA is designed to:¹⁰

- 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 mentally 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 substitute decision makers;
- Provide safeguards and accountability to protect mentally incapable people from harm; and
- 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.¹¹

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.¹²

Substitute decision making, both under the SDA and the HCCA, will be addressed in more detail in [Section 7](#) of this Guidance Document.

(vii) *Long-Term Care Homes Act*

The *Long-Term Care Homes Act* (LTCHA) came into effect in July 2010.¹³ This legislation sets out the requirements for long-term care homes in Ontario relating to resident rights, care and services, admissions, operations, funding, licensing, compliance and enforcement, and administrative matters.

The purpose of the LTCHA is to improve and strengthen care for residents in Ontario’s long-term care homes. The “fundamental principle” set out in this legislation is as follows:¹⁴

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 III of this legislation specifically deals with the admission of residents to long-term care homes. The process for admission to long-term care homes is addressed in more detail in [Section 5](#) of this Guidance Document.

(viii) *Home Care and Community Services Act*

The *Home Care and Community Services Act* (HCCSA) governs the provision of home care and community services by approved agencies, including LHINs.¹⁵ The *Provision of Community Services* regulation under the HCCSA sets out the criteria to determine eligibility for homemaking, personal support, and professional services, as well as the maximum amounts for these services.¹⁶

10 Ontario, Ministry of the Attorney General, “Guide to the Substitute Decisions Act” (Queens Printer for Ontario, 2000), online: www.attorneygeneral.jus.gov.on.ca/english/family/pgt/pgtsda.pdf.

11 *SDA*, *supra* note 9 at s 45.

12 *Ibid* at ss 15, 16 and 22.

13 *Long-Term Care Homes Act*, SO 2007, c 8 [*LTCHA*].

14 *Ibid* at s 1.

15 *Home Care and Community Services Act*, SO 1994, c 26 [*HCCSA*].

16 *Provision of Community Services*, RRO 386/99 [*PCS*].

The types of services and the limits on the services available will be addressed in more detail in [Section 5](#) of this Guidance Document.

(ix) *Personal Health Information Protection Act*

The *Personal Health Information Protection Act* (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.¹⁷

PHI is identifying information about an individual that:¹⁸

- (a) Relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family;
- (b) 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;
- (c) Is a plan of service for the individual within the meaning of the *Home Care and Community Services Act, 1994*;
- (d) Relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual;
- (e) 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;

- (f) Is the individual's health number; or
- (g) Identifies an individual's substitute decision-maker.

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.¹⁹

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.²⁰

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.²¹ A SDM may also consent to the collection, use, and disclosure of PHI on behalf of an incapable patient. 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 patient.

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.²²

¹⁷ *Personal Health Information Protection Act*, 2004, SO 2004, c 3 Schedule A, s 1 [PHIPA].

¹⁸ *Ibid* at s 4.

¹⁹ *Ibid* at s 3.

²⁰ The "Circle of Care" will be discussed in more detail in [Section 10](#) of this Guidance Document.

²¹ PHIPA, *supra* note 17 at s 5 and ss 21-28.

²² For OHA resources, see: www.oha.com/legislative-and-legal-issues/privacy-and-freedom-of-information.

(x) *Retirement Homes Act and Residential Tenancies Act*

The *Retirement Homes Act* (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.²³

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.²⁴

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*.²⁵

Individuals receiving care services in a retirement home are expected to pay for these services as well as for the accommodation. 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.

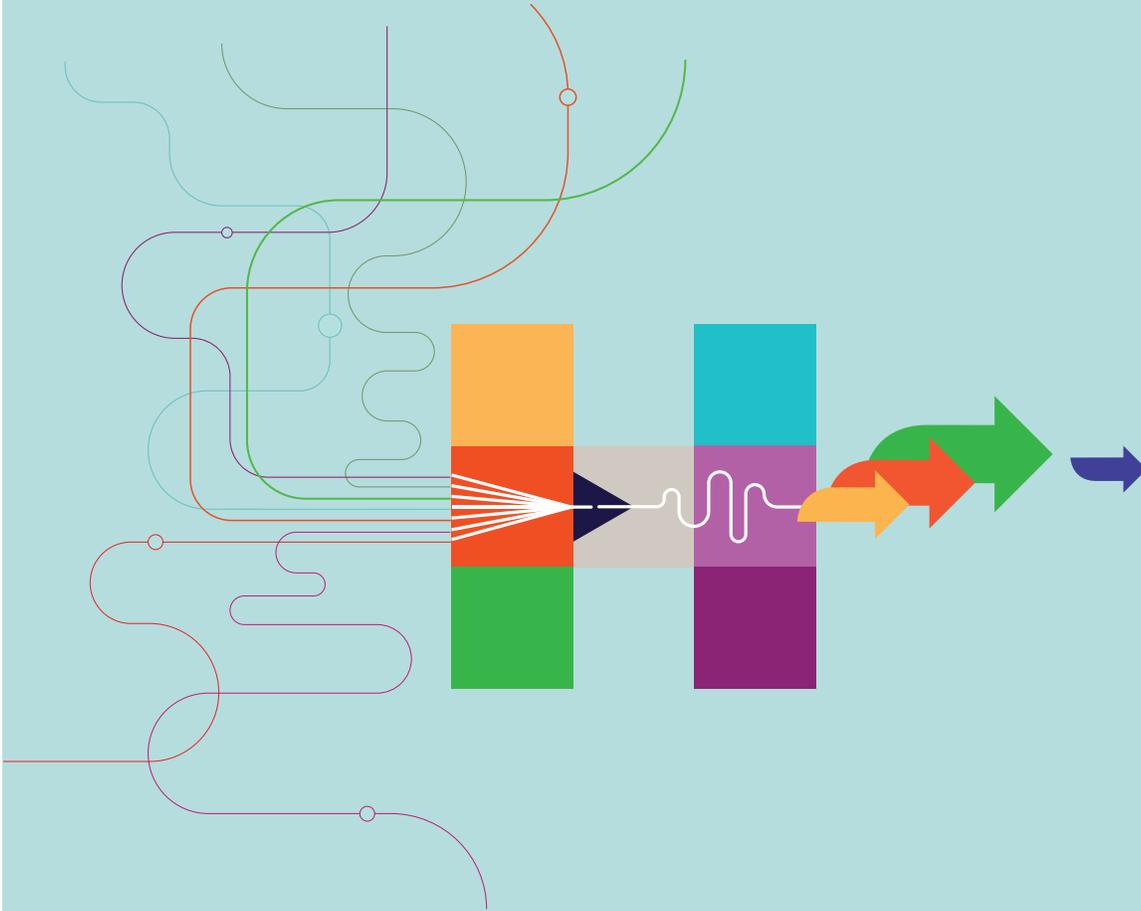
²³ *Retirement Homes Act*, SO 2010, c 11, s 1 [RHA]. Please refer to s. 51 respecting Residents’ Bill of Rights.

²⁴ *Ibid* at s 2.

²⁵ *Residential Tenancies Act, 2006*, SO 2006, c 17 [RTA]. This also applies to supportive housing arrangements.

SECTION 4

Role of the Hospital and the Health Care Team



Role of the Hospital and the Health Care Team

(a) Roles and Obligations

Each hospital in Ontario will have 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.

To facilitate a consistent and transparent approach to discharge planning, many hospitals have developed detailed policies and procedures for dealing with this process. While these policies and procedures are addressed in more detail in [Section 11](#) of this Guidance Document, it is important to understand the parameters within which these tools operate.

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, the Local Health Integration Network (LHIN), and other community providers who may be involved. Communication and collaboration between care providers is often critical in working toward developing an appropriate and successful discharge plan for a patient.

(b) Admission to Hospital

On admission to a hospital, a patient with the 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

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

(c) Discharge from Hospital

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.⁴ The discharge order is written by a physician/ delegate⁵ and when a discharge order has been

1 *Health Insurance Act*, RSO 1990 c H.6, s 11.2(1)(3) [*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, s 11(1)(2) [*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 *Ibid* at s 16(1).

5 Please see footnote 3 above, regarding other health care professionals who may make an admission or discharge order under the *PHA*.

made, the hospital shall discharge the patient and the patient shall leave the hospital on a date set out in the order.⁶

The decision to write a discharge order is a clinical one to be made by an attending health care provider. It is not an administrative decision. 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’.

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.⁷

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.

(d) Introduction to Co-Payments

A co-payment may be charged by certain designated hospitals when a patient is admitted to the hospital, but is awaiting placement in a non-acute institution. 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 long-term care or chronic care (complex continuing care) facility where a co-payment is charged. The maximum co-payment rate is the same for all patients and all hospitals, subject only to an ability to apply for reduction based on specific circumstances.

A co-payment may be charged when the patient has been designated as alternate level of care (ALC) and an application has been made to a discharge destination where a co-payment will be charged. There are situations where it may not be appropriate to charge a co-payment, even if the person is designated ALC. This may be the case where a patient is involved in an active plan of treatment (for example, they may receive treatment for an infection or illness which arises during their ALC stay). This may also be the case where a patient is waiting for or participating in an interim course of treatment that is another ALC destination, such as a rehabilitation program.

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.

More information about co-payments is set out in detail in [Section 8](#) of this Guidance Document.

⁶ *HM, supra* note 3 at s 16(2).

⁷ *Ibid* at s 16(3).

(e) Introduction to 'Per Diems' or 'Daily Rates'

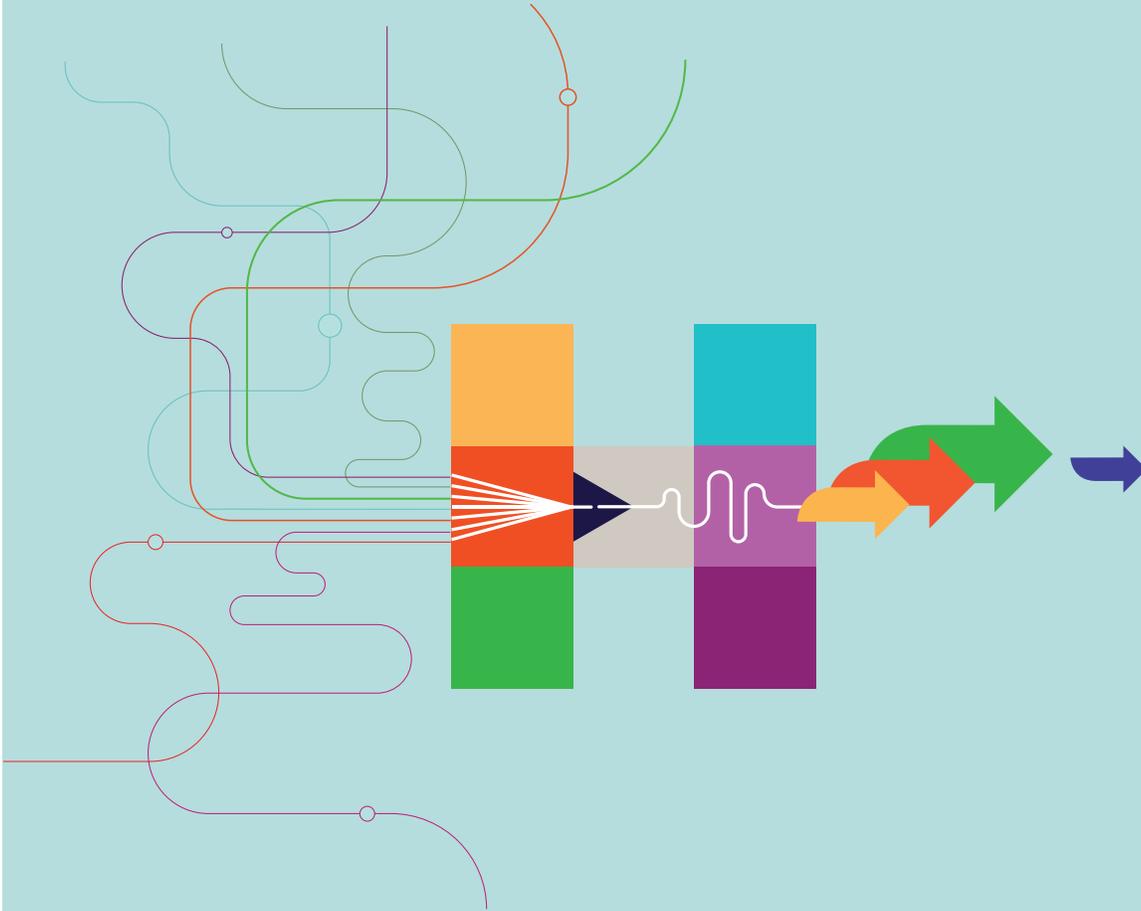
When a patient no longer requires the services provided at a hospital and has been discharged but does not leave, it may be appropriate to charge a daily rate for the continued stay. This 'per diem' or 'daily rate' is a charge which reflects more closely the actual cost of providing care. This rate may be determined by the hospital and may be based on the intra-provincial OHIP rate (e.g., the rate the province of Ontario would charge the province of British Columbia if a British Columbian patient was admitted to the hospital).

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

The policy recommendations and considerations relating to this rate are set out in more detail in [Section 9](#) of this Guidance Document.

SECTION 5

Role of the LHIN



Role of the LHIN

(a) Part of the Discharge Planning Team

Local Health Integration Networks (LHINs) often work with members of the hospital-based multi-disciplinary team in the discharge planning process. LHINs understand the services available in the community and can participate in comprehensive care planning. LHINs are the designated placement co-ordinators for long-term care (LTC) homes and are also responsible for the provision, or arrangement for the provision of, publicly funded home care and community services. 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, the LHIN may be involved in the consideration and development of several options or recommendations for a discharge plan.

(b) Process for Admission to Long-Term Care Homes

LHINs are the designated placement co-ordinators charged with managing the process for admission to LTC homes in Ontario.¹ The LHINs, as placement co-ordinators, are responsible for:

- Determining a person's eligibility for admission;
- Providing applicants with information;

- Assisting applicants with the placement-related application processes;
- Prioritizing for admission;
- Monitoring and managing wait lists; and
- Authorizing admissions to LTC homes.

When an admission to a LTC home is part of a discharge planning discussion, it is important that the LHIN completes its mandated role in the process.

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

The formal determination of eligibility and application to a LTC home are completed by the LHIN. The mandate of the LHINs includes completing assessments to determine eligibility for admission to a LTC home when they receive a referral or a request. It does not matter if the individual for whom the determination is to be made is at home, in a hospital, or in another setting at the time of the referral/request. In addition, there is information that the LHIN is required to provide to applicants, even if discussions have taken place with other members of the care team.

Once the LHIN has received a referral/request to determine eligibility for a LTC home, they must also provide the person considering admission with information about:²

- 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; and

¹ *Long-Term Care Homes Act, 2007*, SO 2007, c 8, s 40 [LTCHA]; in conjunction with *General O Reg 79/10*, s 153 [O Reg 79/10].

² *O Reg. 79/10*, *supra* note 1 at s 154.

- The application for a reduction in the basic accommodation charge that can be made to the Director (i.e., the Ministry of Health and Long-Term Care (MOHLTC)) and the supporting documentation required, including the person's Notice of Assessment under the *Income Tax Act*.

Determinations of eligibility are completed in accordance with the process in the *Long-Term Care Homes Act (LTCHA)*.

(c) Eligibility for Admission to Long-Term Care Homes

Section 43 of the LTCHA sets out the requirements to determine whether a person is eligible for admission to a LTC home. Two assessments must be conducted before the LHIN may determine whether a person is eligible for admission: a health assessment and a functional assessment.

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. The health assessment must be completed by a physician or registered nurse.³

The functional assessment evaluates the person's functional capacity, requirements for personal care, current behaviour, and behaviour during the previous year.⁴ The functional assessment must be completed by an employee or agent of the LHIN (the placement co-ordinator) who is a: registered nurse, social worker, physiotherapist, occupational therapist, speech-language pathologist, or registered dietitian.⁵

The health assessment and functional assessment may not be completed by the same individual.

³ *Ibid* at ss 43(4) and (5).

⁴ *Ibid* at s 43(4).

⁵ *Ibid* at ss 43(5); and 160(1)(d).

The LHIN can only authorize admission to a LTC home if each of the health and functional assessments 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.

If the person is found ineligible for admission to a LTC home, the LHIN must provide the person with written notice that outlines the reasons for the determination of ineligibility and explains the process for applying to the Health Services Appeal and Review Board (HSARB) for a review of the finding. The LHIN must also advise the applicant of alternative services and make referrals to such services, as appropriate.

If it is determined that a person is eligible for admission to a LTC home, the next step is the formal application for authorization of admission.

(d) 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. LHINs are aware of the resources available at the LTC homes within their geographic area, as well as what other supports and resources may be available in the community.

The application process is set out in the LTCHA and is managed by the LHIN.⁶ The LHIN provides the person, or substitute decision maker (SDM) where applicable, with information about the following:

- The admission processes, including the choices that the applicant has in the process and the implications of those choices;⁷
- The length of waiting lists and approximate wait times for admission to LTC homes;

⁶ *Ibid* at s 44(1).

⁷ *Ibid* at s 43(7).

- Vacancies in LTC homes; and
- How to obtain information from the MOHLTC about LTC homes.⁸

If requested, the LHIN can assist the applicant in selecting the LTC homes to which the applicant would like to apply, taking into consideration the applicant's preferences based on ethnic, religious, spiritual, linguistic, familial, and cultural factors.

The LHIN will submit two copies of the assessments and other required information to each of the LTC homes selected by the applicant. Applications may be submitted for up to five LTC homes. This limitation does not apply to a person determined by the LHIN to be appropriate for "crisis" placement. However, it is rare for a patient in a hospital to receive a "crisis" designation.

The decision as to which homes an application may be made is one of individual choice. The applicant cannot be compelled to apply to: a specific home; a specific number of homes; a home with a short wait list; or a home either outside of, or within, a particular geographic region. These choices will often be influenced by a patient's care needs and preferences.

Generally, a LTC home is required to provide the LHIN 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.⁹ A LTC home must approve all applications for admission unless the home lacks the physical facilities necessary to meet the person's care requirements, or the staff lack the nursing expertise necessary to meet the applicant's care requirements.

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 applies to more than one LTC home, they may be on

multiple wait lists. It is also possible for applicants to remain on wait lists for their preferred choice LTC homes once admitted to another home to which they applied.¹⁰

Where a LTC home withholds approval of an application for admission, a written notice of this decision must be provided to the applicant, the LHIN (the placement co-ordinator), and the MOHLTC. The written notice must include the ground(s) for withholding approval, a detailed explanation of supporting facts, an explanation of how these facts justify the decision, and the contact information for the Director (MOHLTC).¹¹

(e) Consent for Admission to Long-Term Care Homes

The LTCHA requires consent for admission to a LTC home. To be able to give consent, a person must be found to be capable, as defined under the *Health Care Consent Act* (HCCA). The consent must be voluntary, informed, and specific to the LTC home to which an application has been/is being submitted.¹²

A person is capable of making a decision about their admission to a LTC home if they are able to:¹³

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

Section 6 of this Guidance Document provides further information about capacity and consent.

⁸ *Ibid* at s 154(4).

⁹ *Ibid* at s 162(3).

¹⁰ For more information with respect to wait lists and wait list management, please contact the appropriate LHIN.

¹¹ *LTCHA*, *supra* note 1 at s 44(9).

¹² *Ibid* at ss 44(1) and 44(11)(d).

¹³ *Health Care Consent Act*, 1996, SO 1996, c 2, Schedule A, s 4(1) [HCCA].

If a person does not meet the above requirements, then consent must be obtained from the person's SDM. Further information regarding substitute decision making is available in [Section 7](#) of this Guidance Document.

The LHIN is responsible for obtaining consent from a person/SDM as part of the application and admission process. For consent to be valid for the process of applying to a LTC home, it must meet the following criteria:¹⁴

- The consent must relate to the admission;
- The consent must be informed;
- The consent must be given voluntarily; and
- The consent must not be obtained through misrepresentation or fraud.

In addition, for consent to be considered “informed”, the person making the decision (patient/SDM) must be provided with the following information:¹⁵

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

It is part of the LHIN's responsibility and obligation to obtain a valid, informed consent to an admission to a LTC home during the application process.

(f) 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 refuse an offer of admission.

If the offer is accepted, it is generally expected that the person will make the 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.

Declining a bed once an offer has been made is a “withdrawal of consent to the admission”. The impact of this will be discussed in more detail in [Section 10](#) of this Guidance Document.

(g) Home Care and Community-Based Services

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

(i) In-Home Services

The in-home services provided through or by the LHINs include homemaking services, personal support services, and professional services. These services are provided either directly by LHINs or indirectly through arrangements between LHINs and service providers. Some professional services may be provided in congregate or group settings (such as clinics) outside the home.

¹⁴ *Ibid* at s 46(1).

¹⁵ *Ibid* at s 46.

Under the *Home Care and Community Services Act* (HCCSA), these services are defined as follows:

Homemaking Services – housecleaning doing laundry, ironing, mending, shopping, banking, paying bills, planning menus, preparing meals, caring for children, assisting with or training someone to do the preceding tasks and providing prescribed equipment;¹⁶

Personal Support Services – personal hygiene activities, routine personal activities of living, assisting with the preceding activities and training someone to carry out or assist with these activities and providing certain equipment and supplies and services; and¹⁷

Professional Services – nursing services, occupational therapy services, physiotherapy services, social work services, speech-language pathology services, dietetics services, training someone to provide these aforementioned professional services, providing certain equipment and supplies, diagnostic and laboratory services, pharmacy services, respiratory therapy services, social service work services and providing medical supplies, dressings and treatment, equipment necessary to the provision of nursing services, occupational therapy services, physiotherapy services, speech-language pathology services or dietetics services.¹⁸

(ii) Determinations of Eligibility and Plans of Service

When an application or referral for services is received, the LHIN must first determine whether the person is eligible for services.¹⁹ For each person who is determined to be eligible for services, a “plan of service” is developed. The plan of service sets out the details and amount of service to be provided and/or arranged by the LHIN.²⁰ Determinations of eligibility and assessment/communications relating to the development of a plan of service are typically done by the LHIN (the care co-ordinator).²¹ These individuals are regulated health or other professionals (e.g., nurses, social workers, and occupational therapists).

In developing a plan of service, the legislated “service maximums” for homemaking, personal support services, and nursing services, must be considered. Only the LHIN can advise a patient as to the availability of services and duration for which they are eligible.

(iii) Service Maximums

The LHIN can provide up to 120 hours of homemaking and personal support services in any 30-day period. LHINs may be able to arrange for a plan of service that exceeds the service maximums when there are “extraordinary circumstances”. These may include:²²

- To a person who is in the last stages of life;
- To a person who is on a waiting list for admission to a LTC home;
- To a person with complex care needs;

¹⁶ *Home Care and Community Services Act*, SO 1994, c 26, s 2(5) [HCCSA]. At the time of the preparation of this Guidance Document, some of these services are not provided through LHINS and / or are available on a limited basis. The criteria for eligibility for these services is set out in *Provision of Community Services*, RRO 386/99, s 2.1 [PCS].

¹⁷ *Ibid* at s 2(6). Eligibility for these services is determined in accordance with the criteria found at PCS, *supra* note 16 at s 2.1.

¹⁸ *Ibid* at s 2(7). Eligibility for these services is determined in accordance with the criteria found at PCS, *supra* note 16 at s 3.1.

¹⁹ PCS, *supra* note 16 at ss 2.1, 3.4 and 3.6.

²⁰ *Ibid* at ss 3 and 4. Section 3 in reference to Homemaking and Personal Support and Section 4 in reference to Nursing Service.

²¹ As of the date of this Guidance Document, all 14 LHINs are using a standardized tool, the interRAI Home Care (HC) instrument, to assist with these assessments and the determination of a patient’s care needs, as well as to measure changes in a patient’s clinical status.

²² PCS, *supra* note 16 at s 3.

- For personal support services and homemaking services, to any other person, for no more than 90 days in any 12-month period; or
- For nursing services, to any other person, for no more than 30 days in any 12-month period.

Whether a person is eligible for service beyond the legislated maximums is a determination made by the LHIN, based on the person's individual situation and care needs.

(h) Other Community Services

LHINs also manage the placement of persons into supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under HCCSA.

LHINs also provide information about, and referral to, other services and supports that people may need at home or in the community after discharge. These include “community support services” that may be available through other community-based organizations.²³

Community support services – meal services, transportation services, caregiver support services, adult day programs, home maintenance and repair services, friendly visiting services, security checks or reassurance services, social or recreational services, aboriginal support 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 relating to Alzheimer's disease and related dementias, public education services relating to Alzheimer's disease and related

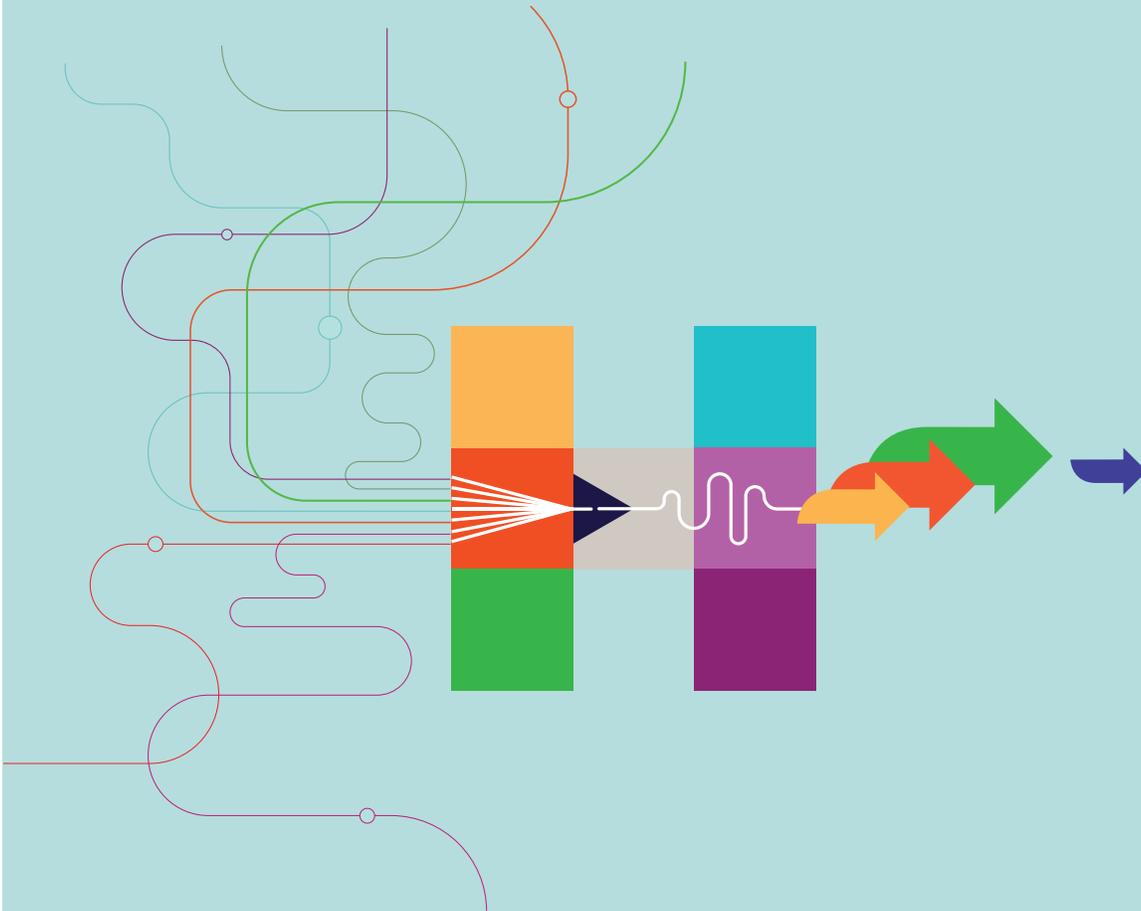
dementias, services for persons with blindness or visual impairment, and services for persons with deafness, congenital hearing loss or acquired hearing loss.

LHINs can facilitate the identification of, and access to, a wide range of resources for patients, either independently or with other health care providers.

²³ *Ibid* at s 1.1(1); HCCSA, *supra* note 16 at s 2(4).

SECTION 6

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



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. This applies whether they are an in-patient in a hospital or receiving services from the Local Health Integration Network (LHIN).

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 patient, their friends, and family. SDMs will be discussed in [Section 7](#) of this Guidance Document.

(a) Capable Patient

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

A capable patient may feel strongly about a particular component of a discharge plan or may rely on the input of family members. It is important for the health care providers working with a patient to focus on that person's decisions.

A capable patient can make a decision that, in the opinion of a health care provider, is not a wise one.

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.
- 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.

(b) 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 is set out in subsection 4(1) of the *Health Care Consent Act (HCCA)* and provides that a person is capable if they are:¹

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

A patient may be determined to be 'not capable' 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, and personal assistance services care absent reasonable grounds for a health care practitioner to think otherwise.²

1 *Health Care Consent Act*, SO 1996, c 2, Schedule A, s 4(1) [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. (Revised Edition, September 2016), Ontario Hospital Association, online: [https://www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/OHA_Mental%20Health%20and%20the%20Law%20Toolkit%20-%20Revised%20\(2016\).pdf](https://www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/OHA_Mental%20Health%20and%20the%20Law%20Toolkit%20-%20Revised%20(2016).pdf).

2 *Ibid* at ss 4(2) and 4(3).

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 health care conditions that develop as a result of the aging process. 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. Please see [Section 7](#) of this Guidance Document for more on SDMs.

Whether a decision for a proposed treatment is being made by a patient or a SDM, consent must be ‘informed’ to be valid. The criteria for valid informed consent with respect to admission to a care facility was reviewed in [Section 5\(e\)](#). There are similar 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 risks of the treatment;
- The material side effects of the treatment;
- Alternative courses of action; and
- 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.

(c) Family Members

It is important to acknowledge the essential role family members play in the discharge planning process. Family members may be involved as part of a support system for a capable or incapable patient, 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 family member or other support person for the patient.

Family members 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.

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.

³ *Ibid* at s 11(1).

⁴ *Ibid* at ss 11(2) and 11(3).

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.⁵ 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.

(d) Caregivers

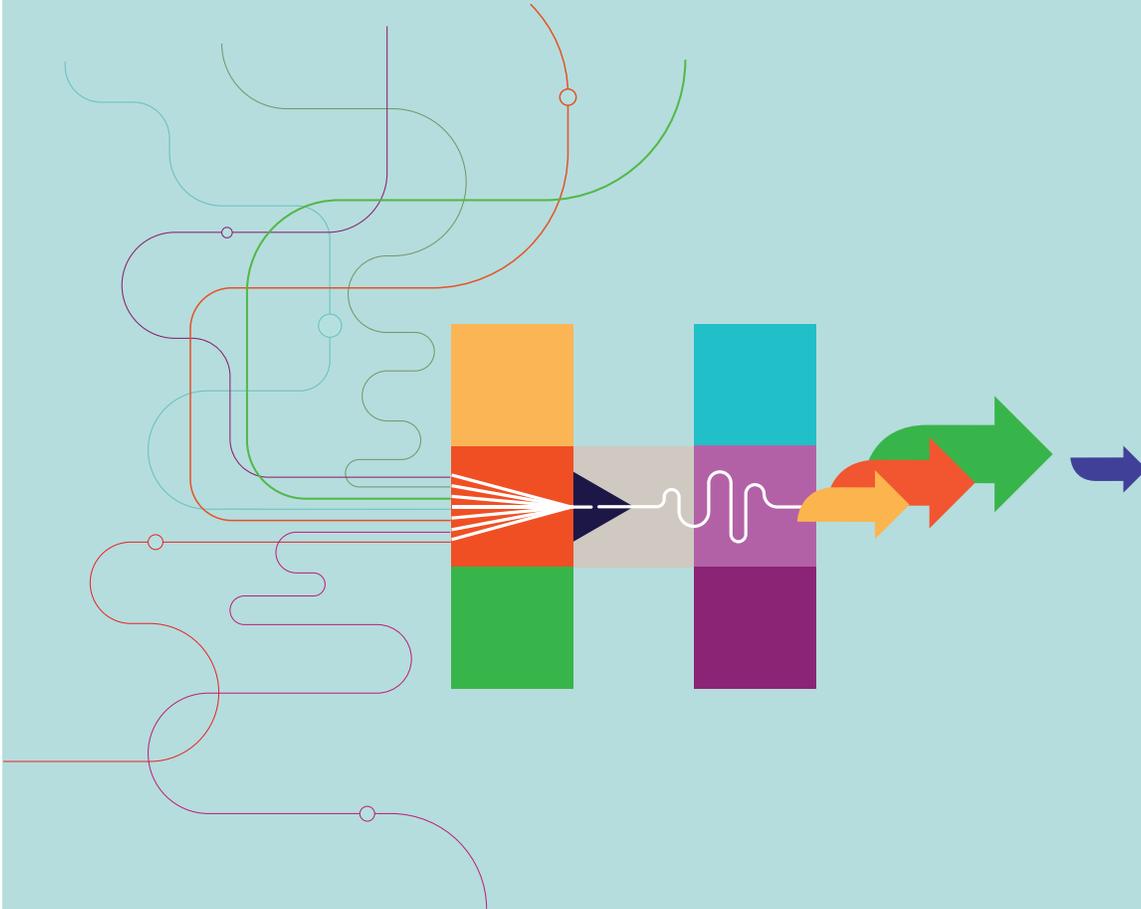
A friend or family member may be taking on the role of caregiver in the community. Friends and family are not required to assume this responsibility.

In addition to exploring the willingness, capability, and ability of someone to take on this responsibility, 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.

⁵ Please see the comments in [Section 11\(b\)](#) of this Guidance Document about hospital policies and the importance of accuracy and consistency in the communication of information, as well as the options that may be available for a particular patient.

SECTION 7

Role of the Substitute Decision Maker



Role of the Substitute Decision Maker

The role of the substitute decision maker (SDM) is to make decisions on behalf of an incapable patient. The comments about informed consent in [Sections 5 and 6](#) of this Guidance Document are equally applicable when the consent is being given by a SDM on behalf of an incapable patient. 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 patient. The following is an overview of these rules and principles.

(a) Identifying the SDM

One of the challenges in discharge planning faced by health care providers may be identifying the appropriate SDM for an incapable patient.

The *Health Care Consent Act* (HCCA) outlines the hierarchy for determining who may give substitute consent on behalf of an incapable patient. The following is the hierarchy which is used to identify the 'highest ranked' possible SDM for an incapable patient: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, 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; or
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 patient. 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 Consent and Capacity Board (CCB) representative.² A more detailed review of the hierarchy is set out in [Section 12](#).

¹ *Health Care Consent Act*, 1996, SO 1996, c 2, Schedule A, s 20(1) [HCCA].

² *Ibid* at s 20(4).

A potential SDM must also meet all the following criteria before being permitted to act as a SDM:³

1. They must be capable with respect to the treatment or admission;
2. They must be at least 16 years old, unless he or she is the incapable person's parent;
3. They must not be prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;
4. They must be available; and
5. 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

(b) 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 patient.⁵ 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, consent to a proposed treatment, admission, or personal assistive service on behalf of an incapable patient.

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.

³ *Ibid* at s 20(2).

⁴ *Ibid* at s 20(11).

⁵ *Ibid* at s 20(5).

The other role of the PGT is to make a decision when there is disagreement between equally ranked SDMs. In such cases, the PGT will step in to make the decision on behalf of the incapable patient.⁶

Examples of Conflict between Equally Ranked SDMs

An incapable patient is receiving treatment based on substitute consent provided by her four children. A new treatment is recommended and only three of the four children consent.

The majority does not rule in this situation. If the equally ranked SDMs cannot agree on a proposed treatment, the PGT will be approached to make the decision on behalf of the incapable patient.

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.⁷

(c) Principles for Substitute Decision Making

In 1997, the Ontario Superior Court commented:⁸

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.

⁶ *Ibid* at s 20(6).

⁷ For more information on the role of the PGT, please refer to The Office of the Public Guardian and Trustee website at www.attorneygeneral.jus.gov.on.ca/english/family/pgt/.

⁸ *Koch (Re)* (1997), 35 OR (3d) 71 at para 17, 1997 CanLII 12265 (ONSC).

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.⁹

(i) Prior Capable Wish

An 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.¹⁰

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.¹¹

In considering the significance of a prior capable wish, the Court has commented that:¹²

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 “wobble 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.¹³

(ii) Best Interests

In situations where there is no prior capable wish, or if it is impossible to comply with the wish, then the SDM is required to act in the incapable person’s best interests.¹⁴ In determining what the incapable patient’s best interests are, a SDM must consider:

⁹ *Supra* note 1 at s 21.

¹⁰ *Ibid* at ss 21(1) and 42(1).

¹¹ *Conway v Jacques* (2002), 59 OR (3d) 737, 214 DLR (4th) 67, 2002 CarswellOnt 1920 (CA).

¹² *L(L) v T(I)*, 1998 CarswellOnt 4097 (Gen. Div.) at 30 – 31.

¹³ *HCCA*, *supra* note 1 at ss 35, 36, 52 and 53. A Form E is an Application to the Consent and Capacity Board for Permission to Depart from Wishes.

¹⁴ *Ibid* at ss 21(2) and 42(2).

Treatment	Admission to a Care Facility
<ol style="list-style-type: none"> 1. 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; 2. Any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and 3. The following factors: <ol style="list-style-type: none"> a. Whether the treatment is likely to <ol style="list-style-type: none"> i. Improve the incapable person's condition or well-being; ii. Prevent the incapable person's condition or well-being from deteriorating; or iii. Reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate. b. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment. c. Whether the benefit of the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her. d. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed. 	<ol style="list-style-type: none"> 1. 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; 2. Any wishes expressed by the incapable person with respect to admission to a care facility that are not required to be followed under paragraph 1 of subsection (1); and 3. The following factors: <ol style="list-style-type: none"> a. Whether admission to the care facility is likely to <ol style="list-style-type: none"> i. improve the quality of the incapable person's life, ii. prevent the quality of the incapable person's life from deteriorating, or iii. reduce the extent to which, or the rate at which, the quality of the incapable person's life is likely to deteriorate. b. Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility. c. 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. d. Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances.

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

(d) 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:¹⁵

- (a) Explaining their role to the incapable patient;
- (b) Encouraging the patient's participation in the decision-making process;
- (c) Fostering the independence of the incapable patient;
- (d) Encouraging regular contact with family and friends;
- (e) Consenting to the least intrusive and restrictive action available and appropriate in the circumstances;
- (f) 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 to permit greater freedom or enjoyment for the person; and
- (g) 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 patient on behalf of whom they are making decisions.

(e) Decisions Not Being Made in Accordance with these Principles

If a SDM is not making decisions in accordance with the principles for substitute decision making, an application may be brought to the CCB. This is a Form G application.¹⁶ The purpose of this type of application is to commence a proceeding at which there will be a determination as to whether a SDM is complying with the principles for making decisions on behalf of an incapable patient.¹⁷ These applications (Form G) 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.¹⁸ 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 by health care providers when there is a concern about a decision being made on behalf of an incapable patient. 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, this may be an appropriate step. It is recommended that health care providers considering a Form G application seek advice and recommendations on how to proceed in these situations.

¹⁵ *Substitute Decisions Act*, SO 1992, c 30, ss 66 and 67.

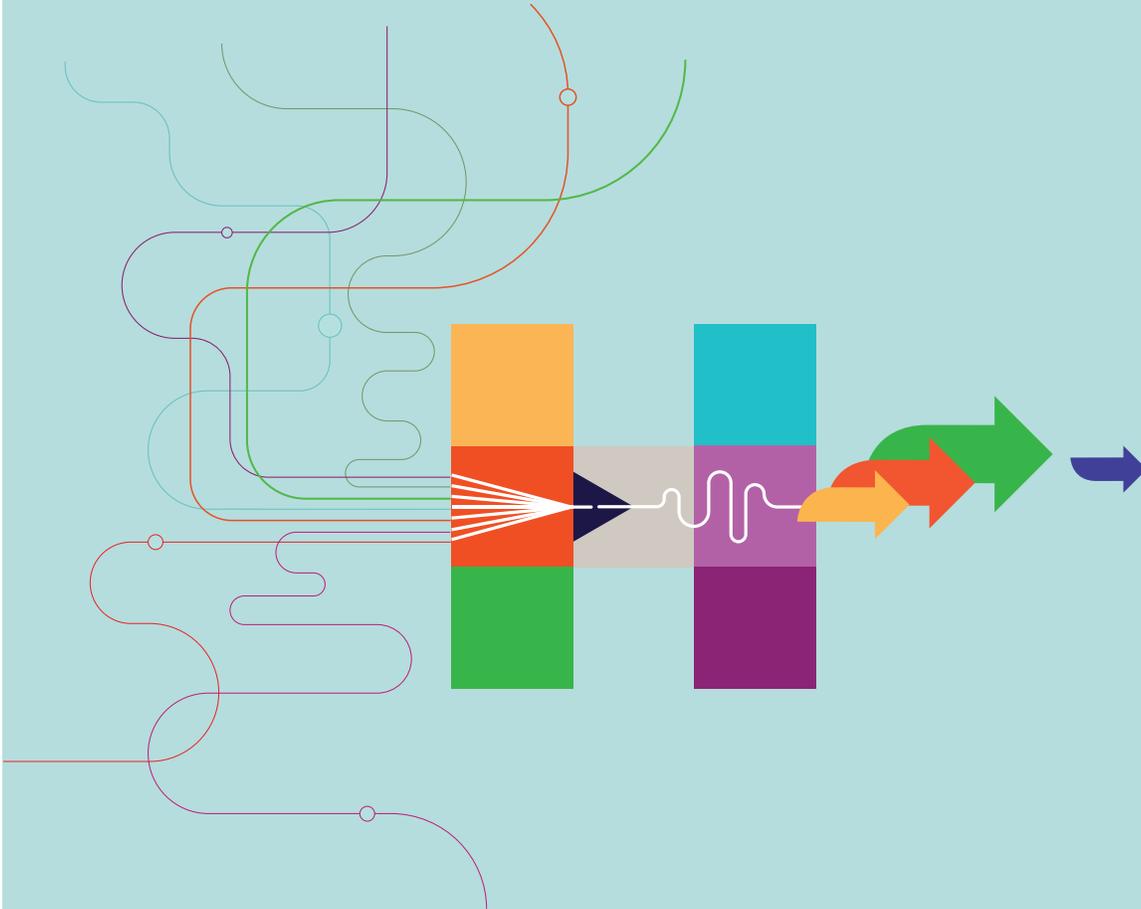
¹⁶ *HCCA*, *supra* note 1 at ss 37 and 54.

¹⁷ *Ibid* at s 37(1) and 54(1).

¹⁸ *Ibid* at s 37(6) and 54(6).

SECTION 8

Co-Payments



Co-Payments

(a) What Is a Co-Payment?

As indicated in Section 4 of this Guidance Document, 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. The co-payment is the amount that an alternate level 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.

In some types of hospitals, a patient need not be ‘ALC’ to be charged a co-payment.

Co-payments are charged to the patient. If the patient is not capable of managing their finances, a substitute decision maker (SDM) should be involved on the patient’s behalf. Family members and others (with the exception of a SDM for finances) are not responsible for a co-payment on behalf of the patient.

Co-payment rates are determined in accordance with the *General Regulation* under the HIA.⁴ 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.⁵ If there is an adjustment to the prescribed rate, the amount charged to a patient may be adjusted if the patient is provided with notice of the rate increase.⁶

For more information on co-payments, including examples of when they may and may not be charged, please see the comments from the Ministry of Health and Long-Term Care (MOHLTC) at: www.health.gov.on.ca/en/public/publications/chronic/chronic.aspx.

(b) 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).⁷

Section 10 of the *General Regulation* under the HIA applies only with respect to an insured person receiving:⁸

1 For information from the Ministry of Health and Long-Term Care’s on co-payments, please go to: www.health.gov.on.ca/en/public/publications/chronic/chronic.aspx.

2 *General*, RRO 1990, Reg 552.

3 *Ibid* at ss 10(1) and (2).

4 *Ibid* at ss 10(4) and (6).

5 *Ibid* at ss 10(7) and (15).

6 Ontario, Ministry of Health and Long-Term Care, “Hospital Chronic Care Co-Payment Rate Information (2014)”, Memorandum from the Ministry of Health and Long-Term Care to Chief Executive Officers of all public and private hospitals, (29 July 2014).

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

8 *Supra* note 2 at s 10.

- (a) 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
- (b) 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:⁹

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:¹⁰

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.

(c) 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).¹¹ Section 46(2) of the HIA provides that:¹²

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.

⁹ *Ibid* at s 10(2)(a). See also, www.health.gov.on.ca/en/common/system/services/hosp/hospcode.aspx.

¹⁰ *Ibid* at s 10(2)(b).

¹¹ *Health Insurance Act*, RSO 1990, c H.6 [HIA].

¹² *Ibid*.

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”.¹³ 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.¹⁴

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

- (a) They are no longer considered a “psychiatric patient”;
- (b) the hospital is in a classification that is permitted to charge a co-payment; and
- (c) 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.¹⁵

13 *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, Chapter 3” (Revised Edition, September 2016), online: [www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/OHA_Mental%20Health%20and%20the%20Law%20Toolkit%20-%20Revised%20\(2016\).pdf](http://www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/OHA_Mental%20Health%20and%20the%20Law%20Toolkit%20-%20Revised%20(2016).pdf) [MHLT].

14 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, *ibid*.

15 This would include patients seen under a Form 1 or 2 as they are not considered to be “patients” under the MHA, s 1, 15 and 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.

(d) 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.

Some patients may be entitled to pay a reduced rate. Each hospital should have a process and support in place to help patients complete the necessary forms for co-payments.¹⁶

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

(e) 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. In many situations, it is straightforward – a patient was admitted for acute care, which is no longer required, and a long-term care (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

16 For more information on the forms, please go to: www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/QuickResults?Openform&ENV=WWE&MIN=&BRN=&PRG=&TIT=co-payment&NO=&SRT=T&NEW=&STR=1&MAX=10.

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.¹⁷

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 in a particular program may be different from one hospital to another, or from one Local Health Integration Network (LHIN) to another.

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 “improving and maximizing patients’ overall functioning”, presumably for a discharge to the community.¹⁸

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 long-term care 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 an 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.

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.

The MOHLTC has published several ‘Frequently Asked Questions’ documents specific to the “Chronic Care Hospital Co-Payment”.¹⁹ This Guidance Document sets out information relating to the rate as set by the MOHLTC, as well as interpretation of the legislation as it relates to the applicability of the co-payment. It is recommended that MOHLTC materials be reviewed when considering issues and/or challenges relating to co-payments.

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 MOHLTC Questions and Answers document 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.

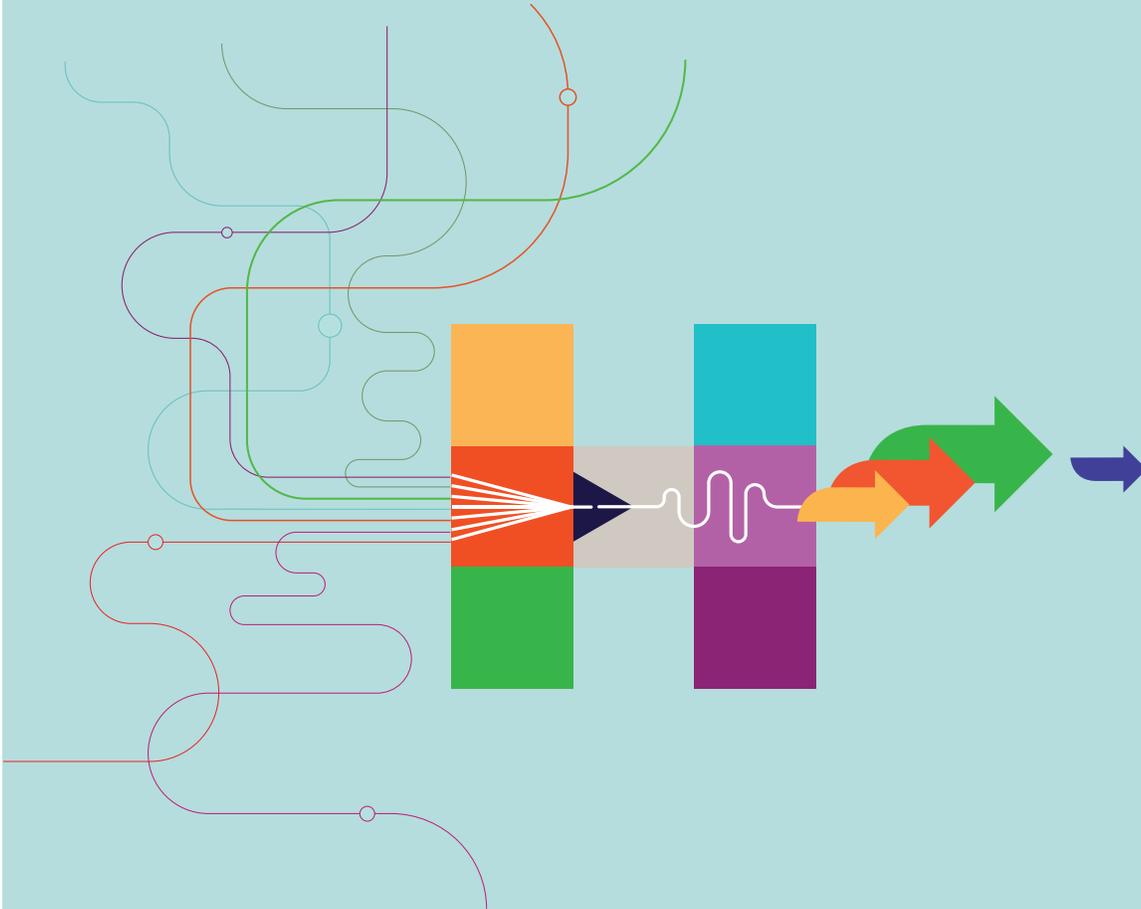
¹⁷ Please see the start of Section 8 of this Guidance Document for more information on the co-payment criteria.

¹⁸ “Rehabilitation” as defined in Cancer Care Ontario’s Data Book 2013-2014, Appendix 2C.15-ALC Discharge Destination Detail. Please see Section 2 of this Guidance Document for more information on discharge destinations and their definitions.

¹⁹ Please see “Hospital Chronic Care Co-Payment: Questions and Answers” (July 2018) health.gov.on.ca/en/public/publications/chronic/chronic.aspx

SECTION 9

Unregulated Charges or 'Per Diems'



Unregulated Charges or ‘Per Diems’

(a) What Is a Per Diem?

As indicated in [Section 4](#) of this Guidance Document, when a patient is no longer entitled to receive “insured services” at a hospital but they do not leave, it may be appropriate to charge a daily rate for the continued stay.

This per diem or daily rate is very rarely charged in Ontario. The rate itself is a charge that reflects more closely the actual cost of providing care. This rate is not prescribed, may be determined by the hospital, and may be based on the intra-provincial OHIP rate (e.g., the rate the province of Ontario would charge the province of British Columbia if a British Columbian patient was admitted to the hospital).

A per diem or daily rate cannot be charged to an alternate level of care (ALC) patient. This rate may only be charged after a patient has been discharged and 24 hours have passed with the patient not having left the hospital.¹

¹ A discharge order is one made in accordance with s 16 of the *Public Hospitals Act*. Please see “Discharge from Hospital” in [Section 4](#) of this Guidance Document for more details.

(b) Situations in which Per Diems May Be Appropriate

A hospital may charge a per diem after the effective date of a discharge order, when a patient has refused to leave and/or has declined to accept a long-term care bed that has been offered by one of the homes to which they applied.

Practically, when a patient is discharged and refuses to leave, options include sending accounts for accommodation to the former patient with possible enforcement action (collection proceedings), or removing the former patient from the hospital.

Patients cannot be charged a per diem solely because they do not comply with hospital policies related to discharge planning.

Reminder:

Before charging a per diem, it is important to ensure that the process for discharging the patient to a long-term care home has been followed, in accordance with the requirements of the applicable legislation. This includes seeking the patient’s consent, ensuring the patient received all the necessary information, and respecting the patient’s choices. Refer to [Section 5](#) and [Section 6](#) of this Guidance Document.

(c) Recommendations for Hospital Policy

In developing a policy related to per diems or unregulated charges, it is recommended that the following requirements be included:

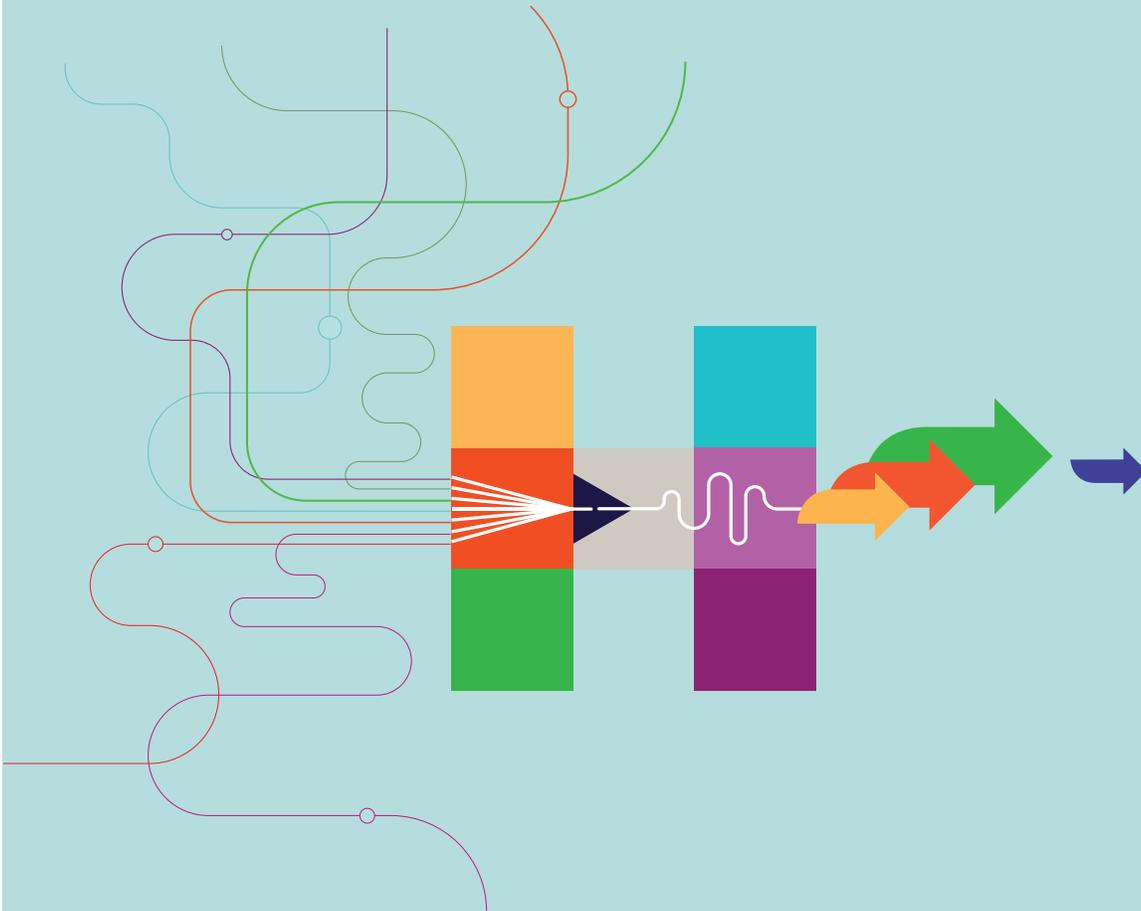
1. The attending physician:
 - (a) has discharged the patient, or

- (b) is aware that a patient to be discharged is in receipt of a long-term care bed offer from among his or her facility choices, and discharges that patient effective the date that the bed becomes available;
2. The per diem for uninsured services that will be charged to a patient who remains in the hospital past his or her discharge date is set out;
 3. A rational explanation of the per diem for uninsured services is included; and
 4. Any in-patient who is put on a long-term care home waiting list shall be immediately notified of the hospital's policy that the patient will be discharged as of the date that a bed becomes available at any one of his or her facility choices, and that they will be charged the per diem for uninsured services from that date forward.

It is important that the communication related to the potential for per diem charges be proactive and provide the basis for the rate and the circumstances in which it may be applied.

SECTION 10

Dealing with Challenges in Discharge Planning



Dealing with Challenges in Discharge Planning

When dealing with complex discharge planning situations, including the management of alternate level of care (ALC) patients, it is important to support channels of communication so that all members of the ‘circle of care’ are on the same page. It is also important to have consistency and accuracy in the information being communicated to patients/substitute decision makers (SDMs) and family members/caregivers, as well as between the health care providers involved.¹

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 the health care providers, patient/SDM, or family members/caregivers are concerned that the process is not constructive, steps should be taken to engage other resources and, if necessary, escalated to a different forum.

1 For more information on the “Circle of Care”, see: Ann Cavoukian, *Circle of Care: Sharing Personal Health Information for Health-Care Purposes* Information and Privacy Commissioner, Ontario www.ipc.on.ca/resource/circle-of-care-sharing-personal-health-information-for-health-care-purposes/ [Cavoukian].

(a) Communication between Discharge Planning Partners

The sharing of personal health information (PHI) among health care providers (who are also health information custodians) is most commonly referred to as disclosure within the ‘circle of care’. Health information custodians 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.² Health information custodians who are members of the circle of care may rely on implied consent for disclosure of PHI when the following conditions are met:³

1. The health information custodian must fall within a category of health information custodians that are entitled to rely on assumed implied consent. These health information custodians include the following:⁴
 - a. Health care practitioners;
 - b. Long-term care homes;
 - c. Retirement homes;
 - d. Local Health Integration Networks (LHINs);
 - e. Hospitals, including psychiatric facilities;
 - f. Some community-based care providers; and
 - g. Specimen collection centres, laboratories, independent health facilities.

2 *Personal Health Information Protection Act*, SO 2004, c 3 Schedule A, s 11 (4) [*PHIPA*]. It is important to note consent may be express or implied.

3 Cavoukian, *supra* note 1. Please also see the *PHIPA* commentary in Section 3 of this Guidance Document for more information about “personal health information” and “health information custodian”.

4 See Cavoukian, *ibid* at part 1. See also *PHIPA*, *supra* note 2 at s 3(1)1-4. Health information custodians are not entitled to rely on assumed informed consent including an “evaluator” under the *Health Care Consent Act*, an “assessor” under the *Substitute Decision Act* and the Minister or Ministry of Health and Long-Term Care.

2. The PHI to be collected, used or disclosed by the health information custodian must have been received from the individual, his or her SDM or another health information custodian.
3. The health information custodian 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.
4. The purpose of the collection, use or disclosure of PHI by the health information custodian must be for the provision of health care or assisting in the provision of health care to the individual.
5. In the context of disclosure, the disclosure of PHI by the health information custodian must be to another health information custodian.
6. The health information custodian 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.

Health information custodians within the circle of care cannot share PHI if an individual or their SDM has expressly withdrawn consent for the disclosure.⁵

Health information custodians outside the circle of care must rely on other provisions of the *Personal Health Information Protection Act* (PHIPA), and other legislation, to be able to share a patient's PHI.

(b) Escalation and Complaints Process for Hospitals and LHINs

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/

⁵ PHIPA, *supra* note 2 at ss 19(1) and 20(2).

caregivers can agree is appropriate. It is prudent to have resources in place to respond to such concerns.

Both hospitals and LHINs 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 LHINs, in addition to a client services complaint process, patients with concerns may also be directed to the Ministry of Health and Long-Term Care's (MOHLTC) "Long-Term Care ACTION LINE".⁶

Through the ACTION LINE, patients who need assistance in resolving complaints may be referred to independent complaints facilitators for mediation services. The MOHLTC has the authority to carry out an inspection of a LHIN if there is a complaint that the LHIN is not acting in compliance with the *Long-Term Care Homes Act, 2007*.

(c) The Patient Ombudsman

The role of the Patient Ombudsman is described as follows:⁷

The Patient Ombudsman is a champion for fairness in Ontario's health sector organizations. The office facilitates resolutions and investigates patient and caregiver complaints – without taking sides – about patient care and health care experiences in public hospitals, long-term care homes and home and community care services coordinated by the LHINs (including services formerly coordinated by the Community Care Access Centres (CCACs)).

⁶ "Community Care Access Centres: Long-Term Care ACTION Line" (20 August 2012), online: Ontario Ministry of Health and Long-Term Care www.health.gov.on.ca.

⁷ Ontario, Patient Ombudsman "Frequently Asked Questions" (2018), online: www.patientombudsman.ca/Complaints/Resources/FAQs

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

(d) Public Guardian and Trustee

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 (HCCA)* that meets the requirements to act as a SDM.⁸ The PGT has an obligation to investigate concerns that an incapable patient may be at risk of “serious adverse effects”⁹ occurring. This investigation may arise from concerns relating to potential financial concerns or personal care.¹⁰

Depending on the results of any investigation, the PGT may conclude that a form of temporary guardianship may be necessary.¹¹

For hospital and LHIN 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.

8 *Health Care Consent Act*, 1996, SO 1996, c 2, Schedule A, s 20 [HCCA]. (Please see Section 7 of this Guidance Document for more information on identification of a substitute decision maker).

9 *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”.

10 *Ibid* at s 62. Section 62(1) states “serious adverse effects” are “serious illness or injury, or deprivation of liberty or personal security”.

11 *Ibid* at ss 27(3.1) and 62(3.1).

(e) 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.”¹²

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, or a personal assistance services (Form A);¹³
- 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);¹⁴
- To determine whether a wish expressed by an incapable person is clear, applicable in the circumstances, and/or a prior capable wish (Form D);¹⁵
- To seek permission to depart from a prior capable wish (Form E);¹⁶
- 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); and¹⁷

12 Ontario, Consent and Capacity Board, “About Us” (10 December 2010) online: www.ccbboard.on.ca/scripts/english/aboutus/index.asp.

13 *HCCA*, *supra* note 8 at ss 32(1), 50(1) and 65(1).

14 *Ibid* at ss 33(1)(2)(7)(8), 51(1)(2)(6) and 66(1)(2)(6).

15 *Ibid* at ss 35(1), 52(1) and 67(1).

16 *Ibid* at ss 36(1), 53(1) and 68(1).

17 *Ibid* at s 34(1).

- To determine whether a SDM is complying with the “principles for giving or refusing consent” (Form G).¹⁸

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. As discussed in [Section 3](#), 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.¹⁹

(f) Health Services Appeal and Review Board

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,²⁰ including decisions relating to:

- Eligibility for “insured services”;²¹
- Eligibility for, amount of, exclusion of, and termination of the “community services” someone may receive;²²
- Whether to include or exclude certain services in the person’s plan of care; and
- Determinations of eligibility for admission to a long-term care home.²³

HSARB is a “quasi-judicial” tribunal and has its own Rules of Practice and Procedure.²⁴

¹⁸ *Ibid* at s 37(1), 54(1) and 69(1).

¹⁹ In addition to the resources on the CCB’s website, referenced above, there is detailed commentary on the CCB process in the OHA website: Katharine Byrick & Barbara Walker-Renshaw, “A Practical Guide to Mental Health and the Law” (Revised Edition, September 2016), Ontario Hospital Association, online: [www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/OHA_Mental%20Health%20and%20the%20Law%20Toolkit%20-%20Revised%20\(2016\).pdf](http://www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/OHA_Mental%20Health%20and%20the%20Law%20Toolkit%20-%20Revised%20(2016).pdf).

²⁰ *Ministry of Health and Long-Term Care Appeal and Review Boards Act*, SO 1998, c 18, Schedule H. See also: www.hsarb.on.ca/scripts/english/default.asp.

²¹ *Health Insurance Act*, RSO 1990, c H.6 [HIA]. Please see [Section 4](#) of this Guidance Document, under “Admission to Hospital”, for more information on insured services.

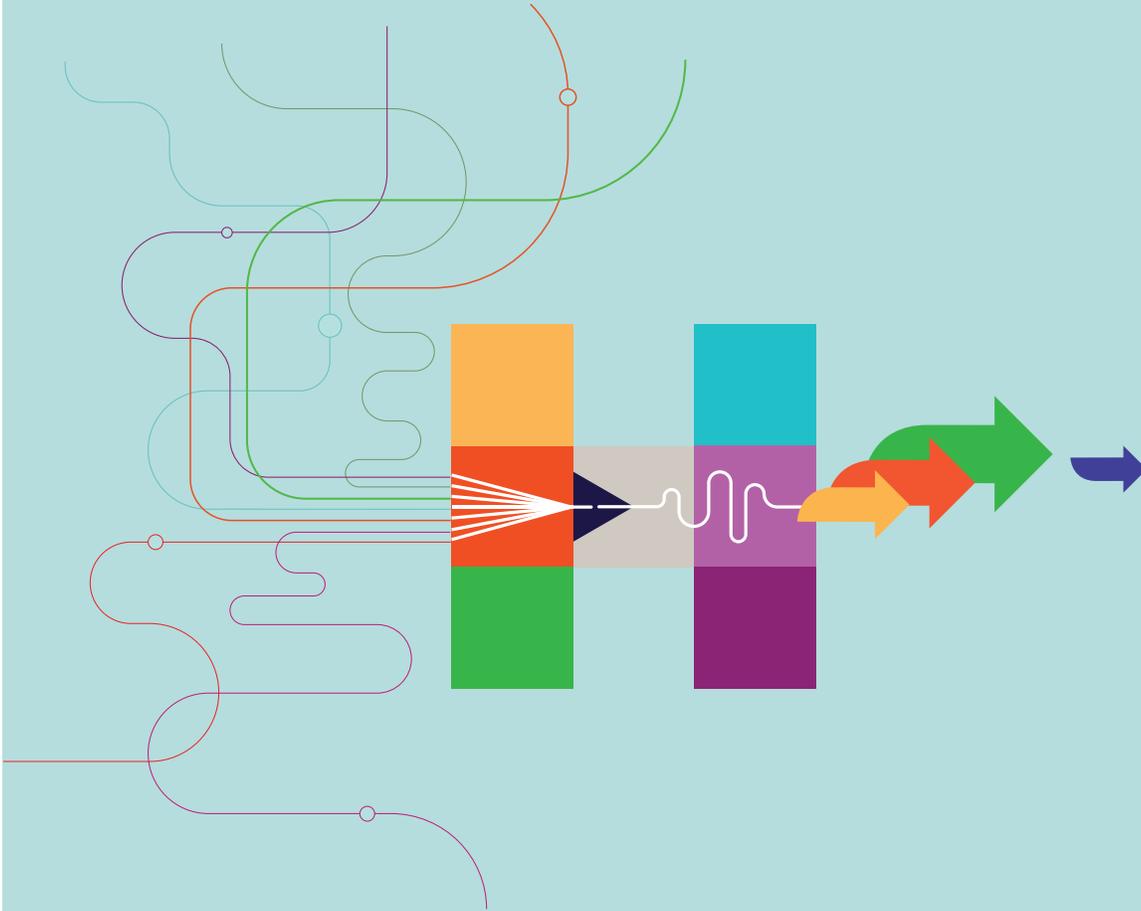
²² *Home Care and Community Services Act*, SO 1994, c 26 [HCCSA]. Please see [Section 5](#) of this Guidance Document, under “at Home with Services” for more information about community support services and service maximums.

²³ *Long-Term Care Homes Act, 2007*, SO 2007, c 8, ss 43 and 53. Also addresses eligibility appeals related to long-term care home admissions.

²⁴ For more information on HSARB go to: www.hsarb.on.ca/scripts/english/default.asp.

SECTION 11

Tools for Discharge Planning



Tools for Discharge Planning

Both hospitals and Local Health Integration Networks (LHINs) have policies and procedures to assist staff in working with patients/substitute decision makers (SDMs) and family members/caregivers during the discharge planning process.

In order to develop and implement discharge plans that are patient-centred, it is important that health care providers at all stages of the health care continuum have an appreciation of the legal obligations and requirements for other stages, as well as an understanding of the process involved in arranging for certain types of care.

(a) 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 proposed 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 plan(s);
- A SDM not understanding the role and responsibility associated with making decisions on behalf of an incapable person; and

- 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 LHIN staff when working toward a successful discharge for a patient.

(b) Hospital Policies

Most hospitals have comprehensive discharge planning policies 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.

For the purpose of this Guidance Document, the discussion of policies will be in terms of discharge planning, taking into account the various associated aspects. There may be several such policies, dealing with the discharge planning process, alternate level of care (ALC) patients, co-payments, per diems, and other related issues. In practice, these policies should be set up in a manner that is consistent with the practice at each individual hospital organization.

It is important to ensure that there is consistent application of the terminology. For example, the hospital's definition of ALC should be the same as the provincial definition.

In setting out the expectations for those involved in the discharge planning process, the policies must be clear that expectations are not requirements. The discharge planning policies are a 'who does what' for the 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 mandated in a hospital policy, the hospital can set out their request for the scope and timing of decisions.

In addition to referencing other hospital policies that impact discharge planning (for example, related to co-payments, consent, per diems,¹ and ALC), discharge planning policies should encourage reference to other hospital and non-hospital resources for patients/SDMs and family members/caregivers.

Policies should also set out the chain of communication and provide for consultations and escalation in the event of a perceived or actual challenge arising in the discharge plan. 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 is very significant. 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.

LHINs and their staff are not bound by hospital policies. In working collaboratively with hospital staff in the discharge planning process, it is helpful for LHIN staff to have an understanding of a hospital's policies and practices.

(c) LHIN Policies

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

When dealing with patients in a hospital, LHINs 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 LHIN staff.

Within LHINs, 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.

LHINs 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 long-term care home is being contemplated, the LHIN 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.

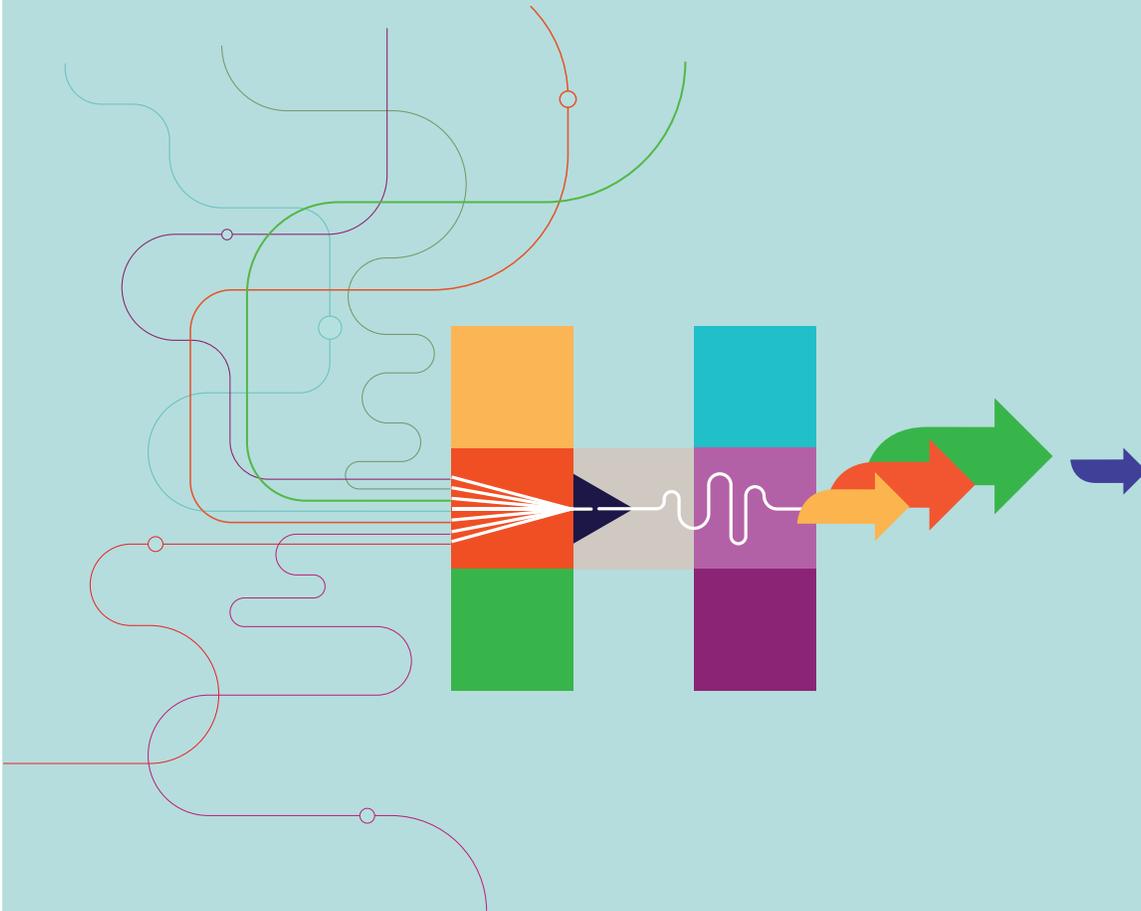
Reminder:

All hospital and LHIN policies should be in accordance with the applicable legislation.

¹ Please see notes on per diem policy in Section 9 of this Guidance Document.

SECTION 12

Additional Information



Additional Information

(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* (HCCA) as presented in Section 7 of this Guidance Document.

(i) The Incapable Person's Guardian of the Person where the Guardian has Authority to Give or Refuse Consent to the Treatment

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* (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

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

2 *Ibid* at ss 58(1)(2).

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

4 *Ibid* at ss 58(3) and 60.

Where the guardian has authority to give or refuse consent to a proposed treatment or admission to a care facility (long-term care 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

5 *Ibid* at s 55(2).

6 *Ibid* at s 57(3).

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.

(ii) The Incapable Person's Attorney for Personal Care where the Power of Attorney Confers Authority to Give or Refuse Consent to the Treatment

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. A person is capable of granting a Power of Attorney for Personal Care if:⁹

- (a) The person can understand whether the proposed attorney has a genuine concern for their welfare; and
- (b) 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

⁷ *Ibid* at 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 *Ibid* at ss 46-54. These sections cover Powers of Attorney for Personal Care.

⁹ *Ibid* at s 47.

¹⁰ *Ibid*. 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.

The attorney may have authority to make treatment decisions if the patient 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 patient that additional requirements must be met before these provisions are valid. These provisions include:¹³

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

¹¹ *Ibid* at ss 49(1) and (2).

¹² *Ibid* at ss 49(1)(b) and (2)(3).

¹³ *Ibid* at s 50(2).

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

- (a) 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
- (b) 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.

(iii) 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.

(iv) 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

- (a) They are married to each other; or
- (b) They are living in a conjugal relationship outside marriage and,
 - i. have cohabited for at least one year,
 - ii. are together the parents of a child, or
 - iii. have together entered into a cohabitation agreement under section 53 of the *Family Law Act*, 1996.

"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

¹⁴ *Ibid* at s 50(1).

¹⁵ *Ibid* at s 48(4).

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

¹⁷ *Ibid*.

¹⁸ *Ibid*.

¹⁹ *Ibid* at s 20(8).

²⁰ *Ibid* at s 20(7).

²¹ *Ibid* at s 20(9)(b).

(v) 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 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.

“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.

(vi) 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.

²² *Children’s Law Reform Act*, R.S.O. 1990, c 12, s 1.

²³ *Ibid* at 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.

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.

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.

(vii) A Sibling of the Incapable Person

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

(viii) Any Other Relative of the Incapable Person

A “relative” under this section is someone “related by blood marriage or adoption” to the incapable person.²⁴

²⁴ *HCCA*, *supra* note 16 at s 20(10).

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