Ontario Hospital Association

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LEGISLATIVE UPDATE

September 2022

Backgrounder
Bill 7: Regulation Changes under the Fixing Long-Term Care Act, 2021 and the *Public Hospitals Act*

Context

On August 31, 2022, the new *More Beds, Better Care Act (*Bill 7*)* received royal assent. Bill 7 formed part of the provincial government's five-point plan named ""A Plan to Stay Open: Health System Stability and Recovery", meant to stabilize the health and long-term care sectors and preserve hospital capacity. Bill 7 includes provisions related to alternate level of care (ALC) patients and would allow certain acts to be performed without consent, provided that reasonable efforts had been made to obtain consent. The provincial government indicated that further details would be provided through regulation. For further details regarding Bill 7, please refer to the OHA's Backgrounder here.

On September 14, 2022, regulatory amendments under the *Fixing Long-Term Care Act, 2021* (FLTCA) and under the *Public Hospitals Act* (PHA) were filed. These regulatory amendments are meant to provide added clarity and specific requirements enabling and supporting the changes outlined in Bill 7. The remaining provisions under Bill 7, and most of the regulatory amendments noted above will take effect on **September 21, 2022**. The amendment related to hospital fees under the PHA will take effect on **November 20, 2022.**

For further information on FLTCA and these regulatory amendments, please refer to the joint memo prepared by the Ministry of Health, Ministry of Long-Term Care and Ontario Health. You may also wish to refer to the Ministry of Long-Term Care's field guidance to home and community care support services placement coordinators.

Key Highlights of the Regulations

Amendments to the FLTCA

Regulation 484/22 amends **O.Reg 246/22** under the FLTCA, as follows:

- Sets out the placement process under s. 60.1 of the FLTCA (s.60.1 Process) by which a patient deemed to be an ALC patient, can be authorized admission to a long-term care (LTC) home without their consent, as long as reasonable efforts have been made to obtain their consent.
- Sets out details of the s 60.1 process including:
  - Waiting lists;
  - Geographic scope;
  - Obligations on LTC homes; and,
  - Applicability of the FLTCA on the s.60.1 process,

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Amendments to the PHA

Regulations 485/22 and 486/22 amend the discharge provisions under **Regulation 965** (Hospital Management) of the PHA, as follows:

- Amends the discharge order provisions, related to patients deemed to be an ALC patient.
- Adds a requirement for hospitals to charge a fee for a discharged patient who remains in hospital, following a 24-hour waiting period.

I. Placement Process (FLTCA)

S.60.1 of the FLTCA, added by Bill 7, provides authority for a process by which a patient deemed to be an ALC patient, can be authorized admission to a LTC home without their consent, as long as reasonable efforts have been made to obtain their consent. The revised process applies to long-stay beds except High Priority Access Beds, Direct Access Beds, and beds in the four Indigenous LTC homes.

Through the regulatory amendments, the details of this process are now outlined under s.240.1 – s.240.3 of Regulation 246/22 under the FLTCA, as follows:

Eligibility[1]

- Where a placement coordinator receives a request from an attending clinician to determine an ALC patient's eligibility for admission to a LTC home, the placement coordinator is required to meet with the patient or substitute decision-maker and provide them with the following information:
    - The placement process under s. 60.1 of the FLTCA;
    - The admission process under s. 49 to 54 of the FLTCA;
    - Options available to them to apply for a reduction in the charge for basic accommodation;
    - Inform them that the placement coordinator will proceed to determine eligibility, if they do not consent to an application and the implications of doing so; and
    - Ask the patient or substitute decision-maker whether they will submit an application for determination of eligibility for admission to a LTC home.

- If the patient or substitute decision-maker refuses to apply for determination of eligibility, then the placement coordinator shall proceed to make determination of eligibility based on "as much information as is available" regarding the patient's:
    (a) physical and mental health;
    (b) requirements for medical treatment and health care;
    (c) functional capacity;
    (d) requirements for personal care; and,
    (e) behaviour.

- The placement coordinator may request a physician or registered nurse to conduct an assessment on any one of the above-noted factors.

[1] s. 240.1(4)-(11)

- In a situation where the patient or substitute decision-maker does not consent to an assessment, then the person conducting the assessment shall base their assessment solely on a review of existing hospital records related to the patient.
- A placement coordinator may collect additional information, including personal health information, from primary care providers, home and community care service providers who provided care to the patient immediately before the patient was admitted to the hospital and agencies under the *Services and Supports to Promote the Social Inclusion of Persons with Development Disabilities Act, 2008*.
- The amendment also provides authority to the above-noted parties to collect, use and disclose personal health information for purposes of determining the patient's eligibility for admission.

Application[2]

- Once the patient is determined to be eligible, the placement coordinator will provide them or their substitute decision-maker with the following information:
  - Length of waiting lists and approximate times to admission for relevant LTC homes;
  - Vacancies in relevant LTC homes; and,
  - How to obtain information from the Ministry about LTC homes.
- If, after being provided the above-noted information, the patient or substitute decision-maker refuses to submit an application to a LTC home, then the placement coordinator shall select one or more homes for the patient. This occurs even if the patient is already on a waiting list for one or more homes.

Selection[3]

- In selecting a LTC home for the patient, the placement coordinator must consider the following:
  - The patient's condition and circumstances;
  - The class of accommodation requested by the patient, if any; and,
  - The proximity of the home.

"Ethnic, religious, spiritual, linguistic, familial and cultural factors" as required under s. 51 of the FLTCA are notably absent under the s.60.1 process. However, the Ministry has indicated in guidance materials, that placement coordinators *should* consider circumstances that may be unique to the patient, including religious, ethnic and linguistic factors, when selecting a LTC home.

The obligation on the LTC home to include religious and spiritual care aspects in the patient's plan of care still apply under this process.

II. Geography (FLTCA)

Under the s.60.1 process, the placement coordinator must select a LTC home for the patient that is within[4]:

a) A 70-kilometre radius from the patient's preferred location; or
b) A 150-kilometre radius from the patient's preferred location, if the preferred location is in the North East or North West Local Health Integration Network region.

[2] s.240.2(1)-(4)
[3] s.240.1(5)-(6)
[4] s.240.1(7)

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If the patient or substitute decision-maker does not select a preferred location, then the radius will be calculated from the patient's residence.

III. Waiting Lists (FLTCA)

Under the s.60.1 process, ALC patients will be placed in category 1 on every LTC waiting list on which they are placed. Any additional homes selected by the placement coordinator will not count toward the limit of five (5) homes, outlined in s.181 of the Regulation. Where applicable, their place on a waiting list for a reunification priority access bed would be maintained.[5]

IV. Long-term Care Homes (FLTCA)

The amendments add a requirement for LTC homes to provide a decision, in writing, to an application "promptly."[6] The requirement to provides reasons for withholding an approval remain.

The Ministries' joint memo notes that in practice, this would ideally occur within less than five (5) days. It also suggests that LTC homes should work proactively to identify available specialized supports and services for patients that could enable admissions that would otherwise not be possible.

V. Application of FLTCA (FLTCA)

The amendments provide for an exemption on the application of Part IV of the FLTCA (s.46-61) when using the s.60.1 process "*to the extent necessary to effect the admissions*."

However, if at any time during the process, the patient or substitute decision-maker submit an application or consent to admission, then the applicable provisions of Part IV will apply to the application and admission.[7]

VI. Discharge Provisions (PHA)

Regulation 485/22 amends the discharge provisions under Regulation 965 (Hospital Management) of the PHA. Regulation 965 requires that the attending physician, nurse, midwife or oral and maxillofacial surgeon discharge a patient when the patient is *"no longer in need of treatment in the hospital".* The amendment in subsection 16(4) clarifies when this would be applicable in the case of an ALC patient.

A patient is "*no longer in need of treatment in the hospital*" if (a) the patient is designated as an ALC patient by an attending clinician ***and*** (b) the patient's admission to a LTC home has been authorized according to the s.60.1 provisions.

As a reminder, Bill 7 defines an ALC patient as someone who (1) occupies a bed in a hospital under the PHA and (2) has been designated by an attending clinician in the hospital as requiring an alternative level of care. An attending clinician *may* designate a patient as ALC, if in their opinion, the patient does not require the intensity of resources or services provided in the hospital care setting.

[5] s.240.3
[6] s.240.2(11)
[7] s.240.1(2)-(3)

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This amendment will come into effect on **September 21, 2022.**

The Ministries' joint memo clarifies that the discharge of a patient from a hospital remains a clinical decision and is undertaken in consultation with the interdisciplinary care team that facilitates ongoing dialogue with the patient, family, caregiver, or substitute decision-maker.

VII. Mandatory Fee (PHA)

Regulation 486/22 also amends the discharge provisions under Regulation 965 (Hospital Management) of the PHA. The amendment places a requirement on hospitals to charge a fee of $400 for each day that a discharged patient remains in hospital, following the expiry of a 24-hour waiting period.

This amendment will come into effect on **November 20, 2022.**

Hospitals will continue to be required under the *Health Insurance Act* to charge the daily chronic care co-payment to ALC in-patients who are awaiting placement in a LTC home, subject to any applicable reductions or exemptions. The Hospital Chronic Care Co-Payment Rate is set to increase from $62.18 to $63.73 per day on October 1, 2022.

Timeline and Next Steps

Most of the requirements under the new framework will come into force on **September 21, 2022.** However, the provision related to mandatory hospital fees will take effect on **November 20, 2022.**

The Ministry of Health will conduct a second technical briefing and Q&A with hospitals within the next week. The OHA is collaborating with HIROC and will host a Risk Forum on **September 23, 2022**. Further details will be circulated in the coming days. Finally, the OHA is currently engaging with Ontario Health and other system stakeholders to develop consistent and practical guidance for the sector.

The OHA will continue to closely monitor developments related to the FLTCA and these amendments. For more information, please contact *Lindsay Carbonero, Senior Legal Advisor* at lcarbonero@oha.com or at 416-205-1305 or *Melissa Prokopy, Chief, Legal and Policy Issues* at mprokopy@oha.com