Legal–Ethical Issues

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ISSUES

- Discharge from Hospital – Is this Senior Friendly?
- Admission to LTC
- Home First Philosophy
- ALC Co-payment and other fees at Hospitals
- Patients and SDMs and Capacity issues
- Misunderstandings about “Advance care Plans” and impact on decisions for incapable senior
- Mental Health Act
- Duty(?) or not of Families to provide care
Health System Challenges

- Higher percentage aging population
- People ending up in hospital ED because seemingly no alternatives
- Availability (or not) of publicly funded homecare through CCACs (timing, amount of services)
- Inability to pay for private services (and we have a public system so expectations are …)
- No actual “legal” obligation on families to care for seniors in their family
- Availability (or not) of SUITABLE spaces in Long term care homes (not all LTC homes are the same)
Health System Challenges

- LTC homes cannot be everything to everyone yet they are housing people with a wide range of needs and health conditions, range of ages (18 to 90 plus) and attitude by some is that person will be fine if housed and cared for there but it may not be as not set up to provide care to every need

- Retirement homes, which are TENANCIES, are NOT regulated health facilities, yet may be seen as alternative to LTC home but in law, they are not
Relating to discharge from hospital into long-term care

- “Requiring’ people to go into “wait at home” or “home first programs”
- Requiring spouse/family to care for person pending admission to LTCH
- Refusal to allow application to be made/preventing contact with CCAC
- Threats of monetary charges exceeding ALC rates
- Requiring person to go to a RH pending placement into a long-term care home
Hospital Discharge Policies – Problems

- Hospitals may attempt to control admission process even though CCAC responsible for admission
- Hospital cannot have discharge policies that are contrary to the law

For example:
- Cannot require certain number of choices or number of choices from “short lists”
- Cannot require patients to accept “available beds”
- Cannot prevent patients from applying to LTCHs from hospital
- Cannot require persons to go home or to a retirement home to “wait”
- Cannot be threatened with “discharge” and charges of a “daily rate” which often run from $500 – $1500 per day
- Cannot prohibit patients from making applications
**Public Hospitals Act**

- Physician can discharge patient pursuant to *Public Hospitals Act*

- If discharged, patient expected to leave within 24 hours

- However, if patient needs continued care, although not acute, cannot be “abandoned”

- If needs long term care and cannot return home with supports, then can remain at hospital pending transfer (alternative level of care)
Long-Term Care Homes Act, 2007

- Provides that the CCAC (Placement Coordinator) is responsible for applications to LTC homes NOT the hospital personnel
  - CCAC must determine eligibility for LTC home admission
  - CCAC must assist person to apply to LTC homes
  - Confirms requirement for CHOICE of homes is that of the person
  - Can choose maximum of 5 homes
  - In crisis – may (but CANNOT be required to) – choose MORE than 5 homes
  - Person cannot be required to go to any particular LTC home unless he or she consents
  - Consent must be INFORMED and voluntary and not based on misrepresentation
Admission

- CCAC to control process

- Can choose **maximum** of 5 homes – there is no **requirement** to choose 5 homes

- If in crisis – may choose more homes – not **required** to choose more

- Hospitals and CCACs have no authority to make person choose specific homes

- “Invite” yes, “require” no
Applications

- Can be made from hospital or community
- CCAC cannot refuse to take an application
- Important for application to be taken even if CCAC says person not eligible – as finding of ineligibility is appealable to HSARB

- Cannot require person to go to “Wait at Home” or “Home First” programs (people are sometimes told that they will get bed faster from home but this is not the law)
- Cannot require family to care for person
Applications

- People cannot be told that they can only apply for LTC after being discharged from hospital when out of hospital.

- Cannot set arbitrary “rules” about where and when applications can be made that takes away the right of choice of when to apply – NOT Senior Friendly.

- CAN encourage people to return home with home care if the person’s care needs could be managed at home with sufficient home care.

- Can talk with people about alternatives to long term care placement – but it they are eligible for long-term care cannot REQUIRE them to go to an alternative.
While retirement homes may be considered – they are not the equivalent of LTCHs and cannot be used as such (see Nineteenth Annual Report of the Geriatric and Long-term Care Review Committee to the Chief Coroner for the Province of Ontario – September 2009, page 35)

Retirement Homes are TENANCIES regulated by both the Retirement Homes Act and the RESIDENTIAL TENANCIES ACT

Care services in Retirement Homes are primarily PRIVATE PAY – Two Tier health care! – and only seniors with sufficient income can afford the cost – and the care services are not necessarily the same as in LTC
Retirement Homes Can’t Refuse to Let Tenant Return

- If senior lives in a retirement home and ends up in hospital, retirement home landlord cannot refuse to let senior return to his/her apartment/room at retirement home.

- Retirement Home landlord would have to take proceedings to evict if Landlord believes that senior requires more care services than available at retirement home and tenant doesn’t agree with proposal to move.
Information to be Provided by CCAC Placement Coordinator

- Information about alternative services
- Responsibility to pay and maximum amounts that may be charged
- Rate reductions that are available and application requirements
- Approximate length of waiting lists
- Vacancies
- How to obtain information, including compliance reports, from the Ministry of Health and Long-Term Care
- If person is incapable, how SDM is to make decision (*Benes* court case)
Choice of LTCHs
LTCHA s. 44

- Where the person/SDM wishes the CCAC shall assist the applicant in selecting homes

- Shall consider the applicant’s preferences relating to admission, based on ethnic, religious, spiritual, linguistic, familial and cultural factors

- Application can only be made with the consent of the applicant – therefore homes that have not been applied to cannot be “offered”

- Applicants may choose any home in the province of Ontario and the CCAC shall work with the CCAC in that area regarding the application
Some CCACs/Hospitals advise clients to apply for preferred accommodation as it has shorter wait lists – and then can transfer after 1 year. – NOT TRUE IN LAW

In fact, applications for transfer to basic accommodation can be made on the DAY OF ADMISSION to the long-term care home; HOWEVER, actual transfer may take years due to alternate waiting list regulation

Homes CANNOT “income test” or request income information and CANNOT refuse based on issues of income
Waiting Lists

- Applicant can only apply for a maximum of 5 LTCHs (except for crisis)

- Can apply to interim short stay, which are not included in the 5 maximum

- May, but is not required, to add homes if they are on crisis waiting list

- Can only be put on waiting list if there is valid consent unless it is crisis under HCCA
Can Choice List be Shared with Hospital?

- As with other types of consent – consent to release personal health information must be voluntary, knowledgeable, relate to the information, and not obtained through deception or coercion (PHIPA s. 18)

- Can choice of home be released without specific consent to CCAC to do so?
  - PHIPA allows information to be released if it for the provision of health care
  - Arguably the choice of facilities is not
  - Additionally – person/SDM can prohibit this information being released to the hospital
Home First/Wait at Home “Philosophy”

- Cannot do through the back-door what you cannot do through the front door – i.e. require person to choose short list, specific choices, homes that will place within a specified period of time

- In certain circumstances when awaiting LTC – no maximum amount of homemaking/personal support services

- CCAC may provide UNLIMITED amounts of care (both hours and time periods)
Expectations of CCAC in Home First “Philosophy”

- Provide information about type of service, amount of service, time periods, etc.

- The stated services will be provided

- In general, services will not be changed unless there is a change in the needs of the person

- But we get complaints that services are reduced/not as promised etc. – These situations are admittedly very FACT SPECIFIC
As of July 1, 2009, all acute and post-acute hospitals were required to use a standardized Provincial ALC Definition.

Designation as ALC does not mean person can be charged.

Can only be charged copayment if meet requirements set out in regulation to the *Health Insurance Act*.

Hospital cannot set a policy to charge a per diem in excess of ALC rate pending some management approval of ALC designation.
ALC Co-payment

- Attending physician must designate patient as requiring chronic care and being more or less permanently resident in a hospital or other institution

- Only applies to patients who are presently in certain types of public hospitals as set out in the regulations

- Cannot ever charge a patient who received services under the *Mental Health Act*—i.e. at any time was a mental health patient—even if are now ALC (s. 46 of the *Health Insurance Act*)
Maximum Allowable Rate for ALC Patients Under Health Insurance Act

- Maximum amount can be charged pursuant to regulations under Health Insurance Act is $56.14.

- Rate reductions are available – for both low income as well as spouses still in community. These rate reductions are not always being calculated/ offered.
Hospital Fees

- Increasing number of cases where people being charged for health services when should not be as not permitted under Health Insurance legislation

- ACE project – what do people have to pay for in the health system and what charges are regulated (max rates etc.)
Two types of “crisis” admits

- Person in E.D. is not a hospital inpatient therefore person can be a crisis admit from ED directly to a LTC home

- Other crisis admit from hospital is where the hospital is “in crisis” – see LTCH Act

- So is there a crisis admit from hospital – depends on the FACTS
Patients and “future” SDMs

- Senior is still own decision maker unless mentally incapable for particular health decision

- Health practitioner offering the “care” is responsible for determining capacity for particular health treatment decision

- Practical issues in the law and practice – when a person doesn’t have a POAPC and the decisions to be made are about moving to a Retirement Home or home care services that are not health services – who is the SDM if person incapable for those decisions?

- Practical issue– Capable senior living with family but refusing homecare and family burning out etc. .
Many embedded misunderstandings about advance care planning and wishes expressed when capable and how this connects with consent and other decision making

E.g. Have been told “stories” that EMS may try to refuse to take person to hospital from LTC home if indicated advance wish to not transfer to hospital or do have no resuscitation

Similarly have been told ‘stories” that hospital ED staff think person should just be transferred back to LTC without treatment if DNR at LTC home
Mistaken belief that if person while capable expressed wish to not go to LTC home that CCAC staff then can’t take direction from SDM to take application for admission

Or if incapable person stating that he/she not want to go to LTC, then SDM can’t act as SDM to make decision about admission
SDM decision making authority

- If person incapable then proper SDM gets authority
- Advance care plan / wishes “speak“ to the SDM Not the health provider
- SDM required to follow wishes/ act in best interests
- SDM responsible to determine if wish when expressed when capable, is relevant to decision to be made, and context of wish (what it MEANS)
SDM decision making authority

- Wish as expressed may now be “impossible” to honour so SDM may be able to not follow it.

- For admission decision, CCAC may apply to Consent and Capacity Board for review of how SDM is making decision and whether it complies with HCCA requirements (wishes/best interest).
SDMs including OPGT

- MANY health facilities staff not understanding who is the SDM and when SDM has authority

- Hospital and other facility forms and forms used in community health services may mislead as to SDMs – may refer to “next of kin” ; May ask for POA ; WRONG questions and forms perpetuate misunderstandings
SDMs including OPGT

- Even if a person is highest ranking in hierarchy, will NOT be SDM unless meet “requirements” of being capable, available, willing to act, not prohibited by court order etc.

- Health providers misunderstand particularly about capacity – if they think possible SDM is incapable, then should be turning to NEXT SDM – They do have authority to determine capacity of SDM.
OPGT

When OPGT is SDM

- When no one else higher on hierarchy that meets requirements
- When SDM is challenged (Form G) and CCB removes authority and no one else in hierarchy appropriate
- OPGT may end up as guardian if allegation of harm or possible harm (s27 and s. 62 of SDA)
- When conflict between equal ranking SDMs (i.e. two adult children disagree on treatment for incapable Mother and can’t resolve)
- Other situations .....

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Mental Health Act

- Misunderstandings about Form 1s
- Issues are VERY fact specific
- Examples
  - Hospital refusing admit as voluntary/involuntary patient under MHA because person lives in a LTC home
  - LTC homes transferring person to hospital under Form 1 and then refusing readmit after hospital assessment that patient does not need to be inpatient for care, observation and treatment of a mental disorder
Families and Duty of Not to Provide Care

- No specific legal duty on families to provide care to other family members

- Arguably may be a financial responsibility if senior has financial need and family has ability to pay (see Family Law Act) but no duty to care for a person unless a court ordered Guardian of the Person

- could be other times when has a duty but issue is VERY FACT SPECIFIC

- Different than duty of care of health practitioners to not “abandon” a patient
Resources

- Discharge from Hospital to Long-Term Care: Issues in Ontario, February 2014, Jane E. Meadus
- Tips & Traps When Dealing with Long-Term Care, Jane E. Meadus
- Provincial ALC Definition, Cancer Care Ontario
- Hospital Complex Continuing Care (CCC) Payment: Questions & Answers, Updated June 2008, Ministry of Health and Long-Term Care
- Issues with Long-Term Care Rate Reductions, Jane E. Meadus
- A Brand New World: Ontario’s New Long-Term Care Homes Act, Jane E. Meadus
- Every Resident: Bill of Rights for People Who Live in Long-Term Care Facilities – December 2011 – ACE/CLEO
Ministry of Health and Long-Term Care – Memos

- Crisis Designation and First Available Bed Policy, February 23, 2011, Ruth Hawkins ADM(A)
- ALC patients who refuse an offer of admission to a prior-chosen LTC home bed, May 23, 2012, Rachel Kampus, A/ADM
- The Home First Philosophy, January 9, 2013, Catherine Brown (ADM)
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