Coffee Talk
A Health Industry Seminar Series
Parameters and Pitfalls of Patient Discharge and Alternate Level of Care

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Agenda

1. Legal framework
2. Common pitfalls
3. Tools
Public Hospitals Act (PHA) – Reg 965

• *Public Hospitals Act* and Regulation 965 thereunder establish the legal requirements for admission and discharge to a public hospital in Ontario

• Admission:
  • No person shall be admitted to a hospital as a patient except on the order or under the authority of a physician, registered nurse in the extended class (RN(EC)), midwife or dentist who is a member of the hospital’s professional staff (s. 11(1))
  • No physician, RN(EC), dentist or midwife shall order the admission of a person to a hospital unless, in their opinion, it is clinically necessary that the person be admitted (s. 11(2))
  • Authority to admit is subject to the granting of admitting privileges by the Board of the hospital
Regulation 965 - Discharge

16. (1) If a patient is no longer in need of treatment in the hospital, one of the following persons shall make an order that the patient be discharged and communicate the order to the patient:

1. The attending physician, registered nurse in the extended class or midwife or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.

2. A member of the medical, extended class nursing, dental or midwifery staff designated by a person referred to in paragraph 1.

(2) Where an order has been made with respect to the discharge of a patient, the hospital shall discharge the patient and the patient shall leave the hospital on the date set out in the discharge order.

(3) Despite subsection (2), the administrator may grant permission for a patient to remain in the hospital for a period of up to twenty-four hours after the date set out in the discharge order.
Discharge (as described by PHA)

1. **Attending Physician Responsibility**: Write discharge order
2. **Discharge Responsibility**: Discharge patient
3. **Patient Responsibility**: Leave hospital on date set out in discharge order
Discharge – The Reality

- Discharge subject to a complex legal and regulatory framework that includes:
  - *Canada Health Act, Commitment to the Future of Medicare Act and Health Insurance Act*
  - *Health Care Consent Act*
  - *Long-Term Care Homes Act*
  - *Retirement Homes Act*
  - *Local Health System Integration Act*
  - Ministry policies and directives
  - Direction from LHIN
The Reality

In addition to PHA, discharge from hospital is contingent on:

• Common law responsibility to discharge to a safe discharge environment
• Consent, where discharge is to certain environments (i.e. long-term care, retirement home)
• Resource availability and constraints, including alternative settings (transitional, LTC, hospice, supportive housing, etc.), bed availability, home and community support services
Alternate Level of Care (ALC)

- Increasing number of patients in hospital who are “ALC”

- “When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated ALC at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient’s needs or condition changes and the designation of ALC no longer applies)”

- Provincial ALC Definition
**... ALC**

- Ministry definition – intended to ensure accurate and timely data on patient waiting in hospital for ALC as part of provincial Wait Times Strategy
- Sometimes confused with “Complex Continuing Care” or “Chronic Care” (CCC) designation under the *Health Insurance Act*
  - CCC triggers requirement for hospital to charge and patient to pay a **co-payment** where, in the opinion of the attending physician, the patient requires chronic care and is more or less permanently resident in a hospital or other institution (HIA - Regulation 552, s. 10)
Rights and Obligations - Patients

• The right to a hospital bed as long as he or she requires hospital treatment
• In considering discharge options, the right to choose a bed in a preferred facility
• Hospitals cannot require or force patients to comply with discharge planning nor can hospitals require an individual to accept any LTC placement
Rights and Obligations - Hospitals

Systems obligations to:

• Ensure every patient receives the care and services that meet his or her needs
• Ensure that each hospital bed is used for the benefit of the community
• Develop plans for appropriate and timely discharge of patients
• Establish policies and systems to ensure the appropriate use of resources
Rights and Obligations – Hospitals

Patient-Specific:

• Timely discharge of patients who are no longer in need of treatment in the hospital
• Need to be able to enforce discharge order in compliance with legislative requirements
• Authority to charge patients for services rendered where patient is uninsured
Common Issues

• Discharge issues are fact-specific and often complex
• Generally will fall in one (or more) of 3 categories:
  1. Refusal to engage in discharge planning process
  2. Lack of safe discharge environment
  3. Refusal to leave hospital in accordance with discharge order
Response

• Hospital response to discharge issue **must** be compliant with applicable legal and regulatory requirements

• Increasing level of scrutiny

• May be subject to challenge – patients/family may engage patient advocate, legal counsel or complain to oversight/regulatory authority
Pitfalls – Discharge Planning & Communication

• Need to ensure that you are dealing with the correct person(s)
  • Capable patient
  • Authorized substitute decision-maker where patient is incapable - who is SDM may depend on decision (e.g. health care, shelter vs. financial)
• Where Power of Attorney or Guardianship is in place – confirm documentation
• Practical – begin discharge planning early (at or before admission)
Pitfalls – Discharge Order

- Triggers hospital’s legal authority to effect discharge – must be in place for hospital to act
- Physician/RN(EC)/Midwife/Dentist = “gatekeeper”
  - Discharge is a clinical decision – where criteria for discharge met – required to write discharge order and communicate it to patient
  - Also responsible to determine parameters for patient discharge incl. safe discharge environment
- Multidisciplinary team may provide input/support
Pitfalls - Consent

- No requirement for patient/SDM consent to “discharge”
- *Health Care Consent Act* – requires consent to treatment (regardless of setting), admission to care facility (i.e. LTC), personal assistance services (in LTC)
- *Long-Term Care Homes Act* and *Retirement Homes Act* – requirements for consent to admission
Pitfalls – Discharge Destination

• Discharge to “home” does not require consent
• “Home” = where patient lived prior to admission - incl. LTC, retirement home or other facility
• LTC/retirement home cannot simply refuse to take back – this would constitute discharge from facility and be subject to own legal requirements
Discharge Destination

- Where discharge to “home” is not appropriate – explore all appropriate discharge options
- Where LTC is appropriate option – cannot legally force patient/SDM to choose any particular home but can encourage to maximize choices
- Cannot prohibit application to LTC from hospital – but can discharge patient to community to wait where appropriate discharge environment (“Home First”)
Pitfalls – Charging for Services

• Distinction between CCC co-payment and daily uninsured rate (per diem)

• Hospital **obligated** to charge co-payment where patient designated CCC in accordance with HIA

• Where discharge order has been written and patient discharged but refuses to leave – patient becomes **uninsured** pursuant to the HIA and thus subject to per diem for bed

• Includes when patient declines available LTC bed from among facility choices
Tools

• Clear, public-facing policies or processes
  • Consider addressing admission and discharge together

• Should address:
  • Criteria for admission/discharge
  • Discharge planning and process – including roles and responsibilities
  • Discharge destination
  • Enforcement of discharge obligations
  • Dispute resolution (resources and processes)

• Need to align with other related policies and procedures (e.g. ALC)
. . . Tools

Internal processes and flow charts
• Set out roles/responsibilities of various key individuals
• Steps to be followed
  • e.g. ALC → LTC Processes / LTC Consult Process, Non-Compliance with Discharge Planning Process
• Mechanisms for identifying issues and resolving disputes
Tools

• Processes for communication with patients
  • **Must** be consistent with legal and regulatory responsibilities

• “Templates” can be helpful for initial, up-front communications

• Where patient-specific, tread carefully
  • Increased legal risk – seek legal counsel
. . . Tools

Useful tools:

• Letters:
  • Discharge planning conference notification
  • Discharge expectations
  • Co-payment notification
  • Non-compliance with discharge policies

• Information sheets:
  • Discharge obligations
  • Transfer to LTC facilities

• Patient specific correspondence where issues arise - needs to be specific to the patient and circumstances
Risk Management Strategies

• Balance between patients’ rights and systems management of hospitals
• Introduction of education programs for patients and families
• Implementation of patient flow policies
Questions?

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