This resource document was prepared for the ownership and use of the Ontario Hospital Association (OHA) and the Ontario Association of Community Care Access Centres (OACCAC) as a general guide to assist hospitals, Community Care Access Centres (CCAC) and others 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, CCACs 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, and is not intended as, nor should be construed as, legal or professional advice or opinion. Hospitals, CCACs and other entities concerned about the applicability of specific legislation to their activities are advised to seek legal or professional advice. Neither the OHA nor the OACCAC, jointly or individually, will 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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Section 1: Introduction
Introduction

Over the past five years, the Ontario Hospital Association (OHA) and the Ontario Association of Community Care Access Centres (OACCAC) have been working together on several projects involving the alternate level of care, or “ALC” challenges facing Ontarians and our health system. As a result of these initiatives, it was determined that a Guidance Document would be of assistance to support the standardization of policies and programs relating to the discharge of patients from hospital, once they no longer require the type of treatment and care offered at a particular facility.

While ALC rates in hospitals have decreased, as of the time of publication of this guidance document, there are still thousands of patients waiting in hospitals for alternate levels of care.

A recurrent theme in the discussion of discharge planning and ALC issues is that the manner in which patients are transitioned throughout the health care system is an important factor in creating a successful, patient-centred, discharge from hospital.

The individual nature of each patient’s discharge plan or transition through the health care system cannot be captured in one document as the operations and challenges of organizations throughout the health care continuum are not all the same. 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 that pertains to transitioning patients from one care setting to another and the roles members of the patient care team play in facilitating those transitions.

Accurate, clear and coordinated communications are key to successful discharge planning. In this guidance document, the legislative framework for discharge planning and the different roles and responsibilities of those involved in that process will be reviewed. Throughout this document, there will be discussion of some of the “tools” to assist in managing the discharge process, as well as discussion of some of the challenges that may be encountered.

The OHA and the OACCAC recognize that health care providers working with patients, substitute decision makers (“SDM”) and their families are committed to providing the best care possible during what can be a challenging period of transition. The hope is that this Guidance Document will provide a further resource for those working through these issues.
Section 2: Alternate Level of Care
Alternate Level of Care

(a) The ALC Designation

The acronym “ALC” stands for “alternate level of care” and is used to identify patients who are admitted to 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. 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; or
- their progress has reached a plateau; or
- they have reached their potential in that program / level of care; or
- their admission occurs for supportive care because services are not accessible in the community (e.g. “social admission”).

The exceptions to this 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 his/her delegate, in collaboration with members of that patient’s interprofessional team, when available. It is not necessary that a discharge destination 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 that there may be more than one clinically appropriate discharge destination.

(b) Definition

As noted above, the Provincial ALC Definition has been used by all acute and post-acute hospitals in Ontario since July 2009. The health care system aspires to deliver care in a setting which 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.

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1 Ontario Cancer System, Alternate Level of Care (7 October 2011), online: Cancer Care Ontario www.cancercare.on.ca. There is more information in the official Alternative Level of Care definition about the need for a standardized definition and its development.

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

3 Supra note 1.
**Definition:** When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated 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 beds,
- palliative care beds,
- 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 October 7, 2011.

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

- **Home** – This discharge destination is for individuals discharged to a private residence, with or without support. Support may be arranged by the Community Care Access Centre (CCAC) and/or through other community organizations.

- **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, requiring specialized skilled nursing care; regular on-site physician care and assessment; and active management over extended periods of time.

- **Transitional care bed** – This discharge destination is designed to provide restorative care, with a goal of returning individuals to independence in the community.

- **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 on-site 24-hour nursing care, assistance with activities of daily living at frequent intervals or 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 that the patient is eligible for a long-term care home.

- **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 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. The goal for these individuals is to return to independent living in the community.

- **Palliative care beds** – This discharge destination provides medical or comfort care to support end-of-life planning, and/or to reduce the severity of a disease or slow its progress. This may also include hospice beds.

- **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 agreement. This is not a private home with long-term care services. Services offered may involve meals, housekeeping, recreational activities, and personal support.

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4 Cancer Care Ontario’s Data Book 2013-2014, Appendix 2C.15-ALC Discharge Destination Detail, online: www.cancercare.on.ca.

5 Community Care Access Centre support and services will be addressed in more detail in Section 3 of this Guidance Document.

6 “Complex continuing care” is also referred to as “complex care”, or “chronic care”.

7 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.

8 More information regarding Retirement Homes is set out in Section 3 of this Guidance Document.
• **Shelter** – This discharge destination provides temporary emergency housing for individuals in crisis or without alternative accommodations.

• **Supportive housing** – This discharge destination is similar to a group home, as the goal is to provide services to individuals with chronic or complex needs as a means of maintaining them 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 makers and/or family.

### (d) Impact of an “ALC” Designation

“Discharge planning” is a collaborative process which 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, substitute decision maker (“SDM”) (if applicable), family and the care providers’ enough time to understand and explore the options for the most appropriate plan.

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

The principle of a “Home First” philosophy is that patients should, where clinically appropriate, return to a home environment in the community following an acute care admission. “Home” may be very different things for different patients. For some, this return home may be a transition to another stage on the health care continuum, and for others it may be a move to a new “home” environment, or a return to where they were living prior to the admission to hospital.

As noted in the Ministry for Health and Long-Term Care’s memorandum entitled “The Home First Philosophy”, Home First is not a mandatory program—it is a philosophy intended to promote the Ministry’s overarching goal of “providing appropriate care in the appropriate setting”.

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 CCAC 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, in consultation with the patient, SDM (if applicable) and family, 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.

For all patients, discharge planning is an opportunity for the patient, SDM (if applicable), family and care team 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.

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9 Memorandum from the Ministry of Health and Long-Term Care to LHIN CEOs (January 9, 2013) *The Home First Philosophy*, online: Additional Resources and Sources of Information www.oha.com/managingtransitions.
Section 3: The Legislative Framework for Discharge Planning
The Legislative Framework for Discharge Planning

(a) “Discharge Planning”

“Discharge planning” is a collaborative process which 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, providing information about a tenancy in a retirement home, arranging for in-home services either through the CCAC or privately and in 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 interim and longer term plans.

Many different health care professionals and individuals may be working on options for a discharge plan with a particular patient, in order to put things in place for a discharge from hospital when care is no longer required. Close collaboration and consistent, aligned communication between the care team, the patient, family members and SDMs are key components of successful discharge planning.

(b) Legislation that impacts discharge planning

The following is an introduction of the legislation that has a bearing on the discharge planning process and which 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" or "the Act"), Canada’s federal legislation for publicly funded health care insurance, is described by Health Canada as follows:1

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.

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

(ii) **Health Insurance Act**

Ontario’s *Health Insurance Act* (“HIA”) deals with the administration of the Ontario Health Insurance Plan, or OHIP. This legislation sets out what is considered to be an “insured service”, or the services to which those with a valid OHIP card are entitled. There are aspects of health care in Ontario which are not insured services, and which may be covered by other benefits or individuals using the service(s).

Specifically relevant 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.

Specifically relevant 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.5

This legislation will be reviewed in more detail in Sections 4, 8 and 9 of this Guidance Document.

(iv) **Community Care Access Corporations Act**

CCACs, established under the *Community Care Access Corporation Regulation*, were established to pursue the following objectives:6

1. To provide, directly or indirectly, health and related social services and supplies and equipment for the care of persons.

2. To provide, directly or indirectly, goods and services to assist relatives, friends and others in the provision of care for such persons.

3. To manage the placement of persons into long-term care facilities.

4. To provide information to the public about community-based services, long-term care facilities and related health and social services.

5. To co-operate with other organizations that have similar objects.

6. To carry out any charitable object that is prescribed and that is related to any of the objects described in paragraphs 1 to 5.

CCACs take on many roles in working on these objectives, and the additional objectives outlined in the regulations in navigating people to different places within the health care system.7 These include comprehensive assessment and community care planning, authorizing admission to long-term care homes, managing referrals and admissions to other facilities and programs and coordinating care in the community, all of which are key to this discussion of discharge planning.

This legislation is reviewed in more detail in Section 5 of this Guidance Document.

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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*].

5 Information with respect to the classification of hospitals is also available on the Ministry of Health website at: www.health.gov.on.ca.

6 *Community Care Access Corporation*, O Reg 554/06; *Community Care Access Corporations Act*, SO 2001, c 33, s 5 [*CCACA*].

7 *Community Care Access Corporations*, O Reg 554/06 [*CCAC*].
SECTION 3: THE LEGISLATIVE FRAMEWORK FOR DISCHARGE PLANNING

(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”). This includes 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. Equally important, there is a legal framework for a decision to consent to, or refuse to consent to, a proposed treatment or plan of treatment on behalf of an incapable person. These same fundamental principles apply to a decision to be made with respect to admission to a care facility or personal assistance services.

The stated purposes of the HCCA include the following:

(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 services” and “care facility” are all defined in the HCCA:

“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:

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9 Ibid at s 1.
10 Ibid at s 2.
(a) the assessment for the purpose of this 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,

(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.11

“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 person currently apply only to residents of long-term care homes. The Substitute Decisions Act 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 components 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, as well as 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.

There are legal requirements relating to capacity, as well as consent, which 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 his or her property or personal care to another individual.12 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.

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

Generally, the SDA is designed to:  

- 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;  
- 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.  

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.  

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. 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:  

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”) sets out the types of services available in the community, that are often arranged through the CCACs. The HCCSA’s Provision of Community Services regulation sets out some of the parameters impacting the availability of these services, including eligibility and maximum

14 SDA, supra note 12 at s 45.  
15 Ibid at ss 15, 16, 22.  
16 Long-Term Care Homes Act, SO 2007, c 8 [LTCHA].  
17 Ibid at s 1.  
18 Home Care and Community Services Act, SO 1994, c 26 [HCCSA].
service levels.\(^\text{19}\) Both the types of services and the limits on what may be 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"), as well as providing 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.\(^\text{20}\)

PHI is identifying information about an individual which: \(^\text{21}\)

(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 within the meaning of the Home Care and Community Services Act, 1994 for the individual,

(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 of the information communicated by health care providers in discharge planning discussions is PHI. Health care providers, organizations and service providers through the health care continuum are, as a general rule, considered to be “health information custodians” who have access to, and control of PHI of patients and clients to whom they provide health care services.\(^\text{22}\)

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 professionals and organizations involved in an individual’s treatment and care throughout 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.\(^\text{23}\)

PHIPA also applies to the disclosure of PHI to family members and SDMs. 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.\(^\text{24}\) This is not the same for family members or others, where, generally speaking, PHI may not be disclosed without consent.

PHIPA impacts all areas of health care where the collection, use and disclosure of PHI is involved, and there are many resources available to address the specific provisions.\(^\text{25}\)

\(^\text{19}\) Provision of Community Services, RRO 386/99 [PCS].  
\(^\text{20}\) Personal Health Information Protection Act, 2004, SO 2004, c 3 Schedule A, s 1 [PHIPA].  
\(^\text{21}\) Ibid at s 4.  
\(^\text{22}\) Ibid at s 3.  
\(^\text{23}\) The “Circle of Care” will be discussed in more detail in Section 10 of this Guidance Document.  
\(^\text{24}\) PHIPA, supra note 20 at s 5.  
\(^\text{25}\) For example, the OHA has prepared a Hospital Privacy Toolkit which is available at: www.oha.com/KnowledgeCentre/Library/Toolkits/Pages/Default.aspx.
(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 operated so that it is 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.26

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.27

The RHA deals with the licensing, residents’ rights, safety standards, and administrative issues related to the operation of retirement homes. The legal arrangement associated with living in a retirement home is a contractual relationship between a landlord and a tenant, and not an admission to a health care facility. These arrangements fall under the Residential Tenancies Act.28

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

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

27 Ibid at s 2.

28 Residential Tenancies Act, 2006, SO 2006, c 17 [RTA]. This also applies to supportive housing arrangements.
Section 4: Role of Hospital and the Health Care Team
Role of 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 hospital, each regulated health professional is required to act in accordance with the requirements of their individual College. As the discharge planning process often involves members of different regulated health professions, as well as staff from the hospital, the CCAC and other community providers who may be involved, the communication and collaboration between care providers is often critical to working toward developing an appropriate and successful discharge plan for a patient.

(b) Admission to Hospital

On admission to hospital, a patient with OHIP coverage will be entitled to “insured services” which generally include “services of hospitals and health facilities”, “medically necessary services rendered by physicians” and “health care services rendered by prescribed practitioners”.1

These insured services are available when the person has been “admitted as an in-patient” by a physician when it is considered “clinically necessary that the person be admitted”.2

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.3

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

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1 Health Insurance Act, RSO 1990 c H.6, s 11.2(1)(3) [HIA].
2 Hospital Management, RRO 1990, Reg 965, ss 11(1)(2) [HM].
3 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 HM, supra note 2 at s 16(1).
5 Please see footnote 2 above, re: other health care professionals who may make an admission or discharge order under the Public Hospitals Act.
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 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 services” at the hospital.

(d) Introduction to Co-payments

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 in which a patient may be involved in an active plan of treatment. For example, they may receive treatment for an infection or illness which arises during their ALC stay. There may also be situations in which a patient may be waiting for or participating in an interim course of treatment that is another ALC destination, such as a rehabilitation program. In these situations, it may not be appropriate to charge a co-payment, even if the person has ALC as longer-term discharge destination.

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 2 at s 16(2).
⁷ Ibid at s 16(3).
(e) Introduction to “per diems” or “daily rates”

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 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 hours have 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 CCAC
SECTION 5: ROLE OF THE CCAC

Role of the CCAC

(a) Part of the Discharge Planning Team

Community Care Access Centres (CCACs) often work with members of the hospital based multi-disciplinary team in the discharge planning process. CCACs have an understanding of the services available in the community and can participate in comprehensive care planning. With information and referrals from the hospital team, as well as experience and information flowing from any pre-admission involvement or direct inquiries from, or on behalf of, a patient, the CCAC may be involved in the consideration and development of several options or recommendations for a discharge plan.

(b) Admission to Long-Term Care Homes

CCACs are the “placement co-ordinators” for admission to long-term care homes (“LTCH”) in Ontario. This role is designated in legislation and cannot be delegated. This means that CCACs are responsible for the following functions:

- Determining a person’s eligibility for admission, including conducting, collecting and reviewing the required assessments;
- Providing applicants with information related to admission;
- Assisting applicants with the placement related application processes;
- Prioritizing for admission;
- Monitoring and managing wait lists; and
- Authorizing admission.

When an admission to a LTCH is part of a discharge planning discussion, it is important that the CCAC 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 which includes a LTCH, and be comfortable answering some questions about this process. Given the complexity of the legislated process, early involvement of the CCAC and commencement of this process is beneficial to the discharge planning process.

The formal determination of eligibility and application to a LTCH are completed by the CCAC. The mandate of the CCACs includes proceeding with the assessments to determine the eligibility for admission to a LTCH 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 hospital or in another setting at the time of the referral / request. In addition, there is information that the CCAC is required to provide to applicants, even if discussions have taken place with other members of the care team.

On receiving a referral / request to determine eligibility for a LTCH, the CCAC must also provide the person considering admission with information about:

- Alternative services that the person may wish to consider;
- The accommodation charges that LTCH residents are responsible for paying and the maximum amounts that a licensee may charge; and

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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) and the supporting documentation required including the person’s Notice of Assessment under the *Income Tax Act*.

If the person, or the person’s substitute decision maker (SDM) (if the person is incapable), requests a determination of eligibility, the CCAC will provide further information about the process.³

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

Section 43 of the *Long-Term Care Homes Act* (“LTCHA”) sets out the requirements to determine whether a person is eligible for admission to a LTCH.

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.⁴

The “functional assessment” must be completed by an employee or agent of the CCAC that is a registered nurse, social worker, physiotherapist, occupational therapist, speech-language pathologist or registered dietitian. The functional assessment will evaluate the person’s functional capacity, requirements for personal care, current behaviour, and behaviour during the previous year.⁵

To ensure a comprehensive view of a person’s health care, functional and social requirements, the health assessment and functional assessment may not be completed by the same individual, in the course of the determination, of a person’s eligibility for admission.

The health and functional assessments must have been completed either within the three months prior to the application for authorization of admission to a LTCH or more recently if there has been a significant change in the person’s condition or circumstances.

If the person is found ineligible for admission to a LTCH, the CCAC must provide the person with written notice, which 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 findings. The CCAC 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 LTCH, the next step is the formal application for authorization of admission.

(d) Application for Admission to Long-Term Care Homes

The application process is also set out in the *LTCHA*, and is managed by the CCAC.⁶ The CCAC provides the person with information about the following:

• The admission processes including the choices that the applicant has in the process and the implications of those choices⁷;
• The length of waiting lists and approximate times to admission for LTCHs;
• Vacancies in LTCHs; and
• How to obtain information from the Ministry about LTCHs.⁸

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³ *LTCHA*, supra note 1 at s 43(7).
⁴ *Ibid* at ss 43(4).
⁵ *Ibid* at ss 43(4).
⁶ *Ibid* at s 44(1).
⁷ *Ibid* at s 43(7).
⁸ O Reg 79/10, supra note 1 at s 154(4).
If requested, the CCAC placement co-ordinator can assist the applicant in selecting the LTCHs to which the applicant would like to apply, taking into consideration the applicant’s preferences based on ethnic, religious, spiritual, linguistic, familial, geographical and cultural factors.

Applications may be submitted for up to five LTCHs. There are a few exceptions to this, for example when an application is being made for an “interim bed” or when a person requires “crisis placement”. The CCAC will be able to provide more information about whether someone is eligible and wishes to have applications submitted beyond the maximum of five. Very rarely do patients have a “crisis designation” while in hospital.

The decision as to which homes an application may be made is one of individual choice. A patient/SDM 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.

A LTCH that received an application is required to provide the CCAC with a response within five business days as to whether or not the person will be accepted to the home’s wait list.9

If a LTCH determines that it will not accept the person to the wait list, a written notice must be provided to the individual (or SDM), the CCAC and the Ministry outlining the ground for withholding approval. The written notice must include the grounds upon which approval was withheld, as well as an explanation of the facts for the decision as they relate to both the applicant and the home.10

There are many considerations which are taken into account by an individual, or SDM, when an application for a LTCH is being submitted. For example, the care needs of the patient may limit the options as to which homes may be appropriate. CCACs are aware of the resources available within the individual LTCHs, as well as what other supports and resources may be available to a particular patient in the community.

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

The LTCHA requires that the person seeking admission to a LTCH has provided their voluntary and informed consent to admission to the specific home to which admission is being proposed.11

A person is capable if they:12

1. Are able to understand the information that is relevant to making a decision about the proposed admission; and

2. Are able to 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.

If a person is not capable with respect to the proposed admission, then the person’s SDM must provide their consent. Further information regarding substitute decision making is available in Section 7 of this Guidance Document.

In order for the consent to be valid for the process of applying to a LTCH, the consent must meet the following criteria:13

9 Ibid at s 162(3).
10 LTCHA, supra note 1 at s 44(9).
11 Ibid at ss 44(1) & 44(11)(d).
13 Ibid at s 46(1).
• It must be related to the admission;
• 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 (the person or their SDM) must be provided with the following information:14

• Details on the proposed admission;
• 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 CCAC’s responsibility and obligation to obtain a valid, informed consent to an admission to a LTCH, during the application process.

(f) Authorization of Admission to Long-Term Care Homes

It is generally expected that the person or their SDM will accept an offer from a LTCH to which an application was made. It is also generally expected that, once the bed is available, a patient will make the transition to the LTCH as promptly as possible. To decline a bed when the 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) “At Home with Services”

In addition to its role as the placement co-ordinator for LTCH admissions, the CCAC carries out comprehensive assessment and care planning, and arranges for community based care. The “services” provided through CCACs may include homemaking services,15 personal support services and professional services.

Personal Support Services include: personal hygiene activities, routine personal activities of living, assisting with the preceding activities and training someone to assist, and providing certain equipment and supplies.16

Professional Services include: nursing services, occupational therapy services, physiotherapy services, social work services, speech-language pathology services, dietetics services, training someone to provide these services; providing certain equipment and supplies, diagnostic and laboratory services, pharmacy services, respiratory therapy services, social 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.17

14 Ibid at s 46.
15 Home Care and Community Services Act, SO 1994, c 26, s 2(5) [HCCSA]. Homemaking services include: 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, supplies or other goods. At the time of the preparation of this Guidance Document, these services are available on a limited basis and in conjunction with other personal support services.
16 Ibid at s 2(6).
17 Ibid at s 2(7). And also Provision of Community Services, RRO 386/99, s 3.1 [PCS].
The CCAC determines eligibility for and coordinates these services, which are usually provided by service providers with whom the CCAC has contractual agreements.\(^{18}\)

There are “maximum amounts” of services which may be provided through the CCAC.\(^{19}\) Only the CCAC can advise a client as to the availability of services, and the duration for which these services may be available. For example, the CCAC can provide up to 120 hours of homemaking and personal support services in the first 30 days of service, and up to 90 hours in any subsequent 30-day period.\(^{20}\) Additional care may be provided above and beyond these maximum amounts, in the following exceptional circumstances:\(^{21}\)

- A person in their last stages of life;
- A person currently on a CCAC waiting list for admission to LTCH; or
- Any other person for up to 90 days in any 12 month period.

In preparing options and recommendations for discharge home, it is important that the CCAC be involved in order to advise as to the levels of service that are, and will continue to be, available to support the discharge based on each person’s assessed needs.

\(^{18}\) PCS, supra note 17 at ss 2.1, 3.4 and 3.6.
\(^{19}\) Ibid at ss 3 and 4. Section 3 in reference to Homemaking and Personal Support and section 4 in reference to Nursing Service.
\(^{20}\) Ibid.
\(^{21}\) Ibid at s 3.

(h) Other Community Services

In addition, CCACs 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. As defined in the Home Care and Community Services Act, community support services include:\(^{22}\)

Community support services include: 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 recreations 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, and public education services, relating to Alzheimer disease and related dementias, and services for persons with blindness, visual impairment, deafness, congenital hearing loss or acquired hearing loss.

CCACs are very knowledgeable about the resources in their communities. CCACs may facilitate the identification of, and access to, a wide range of resources for patients, either independently or with other health care providers.

\(^{22}\) Ibid at s 1.1(1); HCCSA, supra note 1 at s 2(4).
Section 6: Role of the Patient/Client, Family and Care Providers
Role of the Patient/Client, Family and Care Providers

The focus of the discharge planning process is the individual for whom options and recommendations are being developed, whether they are an inpatient in a hospital, or receiving services from the Community Care Access Centre (CCAC), and their care needs.

Some of these patients/clients are capable of making decisions on their own, and choose to involve friends and family in the process. Others may not be capable, and have a substitute decision maker (“SDM”) acting on their behalf, in consultation with the incapable person, friends and family. SDMs will be addressed in Section 7 of this Guidance Document.

(a) Capable Patient / Client

A capable patient/client must make their own decisions. They may wish to include family and friends in this process.

A capable patient/client 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 the patient/client to focus on that person’s decisions. A capable person can make a decision which, 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 which may arise and the impact that may have on the process.

(b) Consent and Capacity

When a health care provider has a concern about the capacity of a patient or client, they must consider whether that person 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:

(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 person may be determined to be incapable if the person does not meet one part of the test, or both. A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services absent “reasonable grounds” for a health care practitioner to think otherwise.\footnote{Health Care Consent Act, 1996, SO 1996, c 2, Schedule A, s 4(1) HCCA.}

\footnote{Ibid at ss 4(2), 4(3).}
Capacity can fluctuate – it is not static, and must be considered at various points in time and in relation to different issues, treatments, and discharge planning decisions. A health care provider can rely upon previously documented evaluations and assessment of capacity; however, the health care provider should review capacity as appropriate during clinical interactions with an individual.

For some patients/clients, capacity can be affected by a myriad of health care conditions that develop as a result of the aging process. Capacity needs to be carefully and routinely evaluated. Capacity can fluctuate and at times may depend on the stability of an underlying condition.

Example of Incapacity under this Part of the Test:

A patient with dementia may lose her capacity to make certain decisions as her condition worsens. She may well retain the ability to make lower level decisions regarding her care and treatment, or aspects of her discharge plan.

Patients/clients for whom capacity is a concern may be in a position to make some of their own decisions. Capacity should be evaluated with care, and with consideration of changing clinical conditions.

For patients/clients 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 is being made by a patient or a SDM, the consent must be “informed” to be valid. Criteria for a valid informed consent with respect to admission to a care facility were reviewed in Section 5(e). There are similar provisions for consent with respect to treatment, which are as follows:

- 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 response to any questions about:

- The nature of the treatment;
- The expected benefits of the treatment;
- The material risks of the treatment;
- The material side effects of the treatment;
- Alterative courses of action;
- The likely consequences of not having the treatment.

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

(c) Family members

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

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3 Ibid at s 11(1).
4 Ibid at ss 11(2) and 11(3).
Family members are not, and cannot be, required to participate in discharge planning, providing care in the community or any other task/role that they are not willing to assume.

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 individuals to discuss with their family, potential/actual SDMs, care providers and others about their wishes, hopes and plans for their future health care. Health care providers may be a resource to support these discussions and provide additional information that may assist.\(^5\)

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

### (d) Care Providers

A friend or family member may be taking on the role of a care provider 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 also be considered whether there are any reasons the care provider 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.

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\(^5\) 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 about these, 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 person. 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 set rules for determining who should be a person’s SDM, and there are also principles to be applied by the SDM when they are making decisions on behalf of an incapable person. The following is an overview of these rules and principles.

(a) Identifying the SDM

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

The Health Care Consent Act (“HCCA”) has a “hierarchy” for determining who may give substitute consent on behalf of an incapable person. The following is the hierarchy which is used to identify the “highest ranked” possible SDM for an incapable person:

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 Health Care Consent Act;

4. The incapable person’s spouse or partner;

5. A child or parent of the incapable person, or a children’s aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children’s aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent;

6. A parent of the incapable person who has only a right of access;

7. A brother or sister of the incapable person;

8. Any other relative of the incapable person.

As stated above, the highest-ranking person in the “hierarchy” is entitled to make decisions on behalf of the incapable person. An SDM who is lower in priority may give or refuse consent if they believe that a higher ranking SDM would not object to him or her making the decision, as long as the higher ranking the SDM is not a guardian, attorney for personal care or CCB representative.

A more detailed review of the “hierarchy” is set out in Section 12.

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

2 Ibid at s 20(4).
In addition to being the “highest ranking” on the list, in order to be an SDM there are additional criteria, all of which must be met. The proposed SDM must meet the following criteria:\(^3\)

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;
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 who meets the criteria to be the SDM, then the Public Guardian and Trustee (“PGT”) shall make the decision on behalf of the incapable person.\(^5\) This is often referred to as the PGT acting as the “SDM of last resort”. One of the steps taken by the PGT will be to try to locate an SDM who meets the criteria in section 20 of the *HCCA*. For example, if an 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 person.

The authority of the PGT to make health care related decisions for an incapable person is generally limited to that prescribed in the *Health Care Consent Act*.

The other role of the PGT, as suggested above, is to make a decision when there is disagreement as between equally ranked SDMs. If SDMs, with equal authority to make the decision and meeting all the requirements, disagree on whether to give or to refuse consent, then the PGT shall make the decision for them.\(^6\) For example, if four adult children are SDMs for an incapable parent, it is not “majority rules”. If all four do not agree with respect to a particular decision, it is appropriate to seek the involvement of the PGT.

(c) Principles for Substitute Decision Making

All SDMs, regardless of the basis by which they came to take on this responsibility, are required to make decisions in accordance with the principles for substitute decision-making set out in the *HCCA*.\(^7\) 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.*

While a capable person can make “any” decisions on their own behalf, an SDM must be guided by the principles in the legislation.

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\(^{3}\) *Ibid at s 20(2).*

\(^{4}\) *Ibid at s 20(11).*

\(^{5}\) *Ibid at s 20(5).*

\(^{6}\) *Ibid at s 20(6).* For more information on the role of the PGT, please refer to their website at [www.attorneygeneral.jus.gov.on.ca/english/family/pgt/](http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/).

\(^{7}\) *Ibid at s 21.*

\(^{8}\) *Koch (Re), 35 OR (3d) 71 at para 17, 1997 CanLII 12265 (ONSC).*
(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.9

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.

An 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 that it is applicable to the circumstances. As long as these criteria are all met, the wish should be followed with very limited exceptions.10

In considering the significance of a “prior capable wish”, the Court has commented that:11

> While the Board in a proper case may make a finding as to prior capable wishes that differs from the view of prior capable wishes expressed by the SDM, once the Board has found what the prior capable wishes are, it does not have a general discretion to override those wishes. That is not only, or primarily, a matter of interpretation of the statute, although it is that; it is also a matter of constitutional law. The whole of the Consent and Capacity Board should have this point brought home to it.

With respect to prior capable wishes, there is a small amount of “wiggle room” for the Board in connection with whether the prior capable wishes are “applicable in the circumstances”, but that should be approached with care and restraint because of the constitutional dimension. It is not discretion.

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

Both a SDM and a health care provider proposing a particular treatment may apply to the Consent and Capacity Board for “directions” to clarify a possible prior capable wish, or for permission to depart from a prior capable wish.12

(ii) **“Best Interests”**

In situations in which 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”.13 In determining what the incapable person’s best interests are, a SDM is to consider:

9 *HCCA*, *supra* note 1 at ss 21(1) and 42(1).
12 *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.
13 *Ibid* at ss 21(2) and 42(2).
SECTION 7: ROLE OF THE SUBSTITUTE DECISION MAKER

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Admission to a Care Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>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;</td>
<td>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;</td>
</tr>
<tr>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>3. The following factors:</td>
<td>3. The following factors:</td>
</tr>
<tr>
<td>a. Whether the treatment is likely to</td>
<td>a. Whether admission to the care facility is likely to</td>
</tr>
<tr>
<td>i. Improve the incapable person’s condition or well-being;</td>
<td>i. improve the quality of the incapable person’s life,</td>
</tr>
<tr>
<td>ii. Prevent the incapable person’s condition or well-being from deteriorating; or</td>
<td>ii. prevent the quality of the incapable person’s life from deteriorating, or</td>
</tr>
<tr>
<td>iii. Reduce the extent to which, or the rate at which, the incapable person’s condition or well-being is likely to deteriorate.</td>
<td>iii. reduce the extent to which, or the rate at which, the quality of the incapable person’s life is likely to deteriorate.</td>
</tr>
<tr>
<td>b. Whether the incapable person’s condition or well-being is likely to improve, remain the same or deteriorate without the treatment.</td>
<td>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.</td>
</tr>
<tr>
<td>c. Whether the benefit of the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.</td>
<td>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.</td>
</tr>
<tr>
<td>d. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.</td>
<td>d. Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances.</td>
</tr>
</tbody>
</table>
The application of “best interests” to a specific case will be considered in the context of the proposed treatment, or admission to a care facility, for a specific patient, taking into account the available information and options.

**(d) Other Obligations of a Substitute Decision Maker**

SDMs who come to the role as the result of being Court appointed guardians of the person or Powers of Attorney for Personal Care have additional duties and responsibilities, which include:14

(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 the SDM not appointed by the court, these duties provide a guide to assist all SDMs in fulfilling their obligations to an incapable person on whose behalf 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.15 The purpose of this type of application is to commence a proceeding at which there will be a determination whether a SDM is complying with the principles for making decisions on behalf of an incapable person.16 These applications (Form G) do not result in the substitute being “removed” from their decision making position, but rather in the CCB directing the SDM as 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.17 In this situation, the health care provider may seek substitute consent from the next appropriate person who meets the criteria in subsection 20(1) of the HCCA.

A Form G application to the Consent and Capacity Board is often considered to be a “last report” by health care providers when there is a concern about a decision being made on behalf of an incapable patient or client. When further discussion efforts 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 and for support with this process.

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16 *Ibid* at s 37(1) and 54(1).
17 *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 acute care hospitals when a patient is admitted to the hospital but is awaiting placement in a non-acute institution. The co-payment is the charge that an alternative level care (“ALC”) patient would pay if admitted to the facility in which they are awaiting a bed.1

Co-payments are provided for in the General Regulation under the Health Insurance Act (“HIA”).2 Specifically, subsections 10(1) and (2) 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.

The co-payment rate is set by the Ministry of Health and Long-Term Care (“MOHLTC”). As this rate is adjusted, the charges to a patient may be adjusted if the patient is provided with notice of the rate increase.4

(b) Hospitals are able 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 to the Public Hospitals Act (“PHA”).5

Section 10 of the General Regulation under the HIA applies only with respect to an insured person receiving:6

(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.

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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 Memorandum from the Ministry of Health and Long-Term Care to Chief Executive Officers – All Public and Private Hospitals, “Hospital Chronic Care Co-payment Rate Information (2014)”, (July 29, 2014) – online - Additional Resources and Sources of Information www.oha.com/managingtransitions.
5 Classification of Hospitals, RRO 1990, Reg 964 [CH]; Public Hospitals Act, RSO 1990, c 40 [PHA].
6 Supra note 2 at s 10.
The following are the types of hospitals that may charge a co-payment:

**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:

**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 which 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"). Section 46(2) of the *HIA* provides that:

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 this section of the *HIA*. The *General Regulation* provides for the chronic care co-payment and, as discussed above, is therefore prescribed by regulation and would be applicable to this section.

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7 Ibid at Schedule 1, 2 & 4. See also, www.health.gov.on.ca/en/common/system/services/hosp/hospcode.aspx.


9 Ibid at s 46(2).
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”. A person who is admitted to hospital but does not meet these criteria is not considered to be a “patient” at a “psychiatric facility” under the *MHA*.

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 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. It may be appropriate for the patient to be charged the co-payment if they are no longer considered a “psychiatric patient”, and the hospital is in a classification that is permitted to charge a co-payment, and the other criteria for a co-payment to be charged are met.

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

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 these fees.

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

It is important that patients are given access to, and clear information about, the information relating to co-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 not a 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

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11 This would include if the patient continued to meet the criteria for involuntary admission under the *Mental Health Act*, (Form 3 or 4) or was admitted as a “voluntary” or “informal” patient under the Mental Health Act. For more information on these designations please see *MHLT*, ibid.

12 This would include patients seen under a Form 1 or 2, as they are not considered to be “patients” under the *Mental Health Act*, s 1, 15 and 16.

13 For more information on the forms, please go to: www.forms.ssb.gov.on.ca/mbs/ssb/forms/sbforms.nsf/GetFileAttach/014-3264-54E-1/$File/3264-54E.pdf.
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.\textsuperscript{14}

It is often the discharge destination which 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, and 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”,\textsuperscript{15} presumably for a discharge to the community. 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 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 which 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”.\textsuperscript{16} 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 this 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 an analysis of when a co-payment may be applicable. General comments, such as those in the MOHLTC “Frequently Asked Questions”, 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.

\textsuperscript{14} Please see the start of Section 8 for more information on the co-payment criteria.

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

\textsuperscript{16} Please see “Chronic Care Hospital Co-Payment: Frequently Asked Questions – See Additional Resources and Sources of Information www.oha.com/managingtransitions.
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 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 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

(b) Situations in which Per Diems may be appropriate

A hospital may charge a per diem rate 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 from one of the homes to which they applied.

Practically, when a patient is discharged and refuses to leave, options include sending accounts for accommodation at the per diem rate 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 relating 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 relating 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 rate 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 rate for uninsured services is included.

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 s/he will be charged the per diem rate for uninsured services from that date forward.

It is important the communication relating to the potential for per diem charges be proactive and provides 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 that channels of communication be supported so that all members of the “circle of care” are “on the same page” and that there is consistency and accuracy in the information being communicated to patients, substitute decision makers (“SDMs”), family members and care givers, as well as between the health care providers involved.

Patients, SDMs and family members should be encouraged to engage in a constructive dialogue with the 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 are concerned that the process is not constructive, steps should be taken to engage other resources and, if necessary, escalate to a different forum.

(a) Communication between Discharge Planning Partners

The sharing of personal health information (PHI) among health care providers is most commonly referred to as disclosure within “the circle of care”. Health care providers rely on these individuals’ “implied consent” for the disclosure of PHI in their communications. Health care providers who are members of the circle of care may rely on implied consent for disclosure of PHI when the following conditions are met:

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:
   - Health care practitioners;
   - Long-term care homes;
   - Retirement homes;
   - CCACs;
   - Hospitals, including psychiatric facilities;
   - Some community-based care providers;
   - Specimen collection centres, laboratories, independent health facilities;

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1 For more information on the “circle of care”, please see: Ann Cavoukian, “Circle of Care: Sharing Personal Health Information for Health-Care Purposes”, online: Information and Privacy Commissioner, Ontario www.ipc.on.ca/images/Resources/circle-care.pdf [Cavoukian].

2 Personal Health Information Protection Act, 2004, 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, and references for, “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 not entitled to rely on assumed informed consent include 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 personal health information 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 personal health information 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 personal health information 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 personal health information by the health information custodian must be to another health information custodian.

6. The health information custodian that received the personal health information must not be aware that the individual has expressly withheld or withdrawn his or her consent to the collection, use or disclosure.

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

Health information custodians with the primary purpose of the provision of health care will often be able to rely on assumed implied consent. Health information custodians outside the circle of care must rely on other provisions of the Personal Health Information Protection Act (PHIPA), and other legislation, for the disclosure of personal health information.

(b) Escalation, complaints and appeals processes for Hospitals and CCACs

For hospitals, it is very helpful to have an escalation process specific to discharge planning. Recognizing that challenges in discharge planning often arise as a result of no immediately available ideal solution that the health care team and patient family/SDM can agree is appropriate, it is prudent to have resources in place to respond to such concerns.

Both hospitals and Community Care Access Centres (“CCACs”) have established processes for managing and responding to complaints within their own organizations. Each organization has its own complaints process. Patients, family members and SDM may choose to access the formal complaints process if they are concerned with discharge communications.

For CCACs, in addition to a client services complaint process, clients with concerns may also be directed to the MOHLTC’s “Long-Term Care ACTION Line”6.

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

(c) Public Guardian and Trustee

In addition to its role as a SDM when there is not an identifiable under the hierarchy in the Health Care Consent Act (“HCCA”), the Public Guardian and Trustee (“PGT”) has an obligation to investigate concerns that an incapable person may be at risk of “serious adverse

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

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.
effects” occurring.\(^7\) This investigation may arise from concerns\(^8\) relating to potential financial concerns or personal care.\(^9\)

Depending on the results of any investigation, the PGT may conclude that a form of temporary guardianship may be necessary.\(^10\)

For hospital and CCAC staff working with a patient, family or SDM on a discharge plan, a report to the PGT under these provisions would be a very rare occurrence.

**SECTION 10: DEALING WITH CHALLENGES IN DISCHARGE PLANNING**

\(^7\) 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.

\(^8\) 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”.

\(^9\) Ibid at s 62. Section 62(1) states “serious adverse effects’ are “serious illness or injury, or deprivation of liberty or personal security”.

\(^10\) Ibid at ss 27(3.1) and 62(3.1).

\(^11\) “About Us” (10 December 2010), online: Ontario – Consent and Capacity Board www.ccboard.on.ca.

\(^12\) HCCA, supra note 7 at ss 32(1), 50(1) and 65(1).

\(^13\) Ibid at ss 33(1)(2)(7)(8), 51(1)(2)(6) and 66(1)(2)(6).

\(^14\) Ibid at ss 35(1), 52(1) and 67(1).

\(^15\) Ibid at ss 36(1), 53(1) and 68(1).

\(^16\) Ibid at s 34(1).

\(^17\) Ibid at s 37(1), 54(1) and 69(1).
There are steps that can be taken to support health care providers appearing before the CCB.\textsuperscript{18}

\textbf{(e) Health Services Appeal and Review Board (HSARB)}

The Health Services Appeal and Review Board (“HSARB”) is tasked with conducting appeals and reviews, in both oral and written formats, under twelve different statutes\textsuperscript{19}, including decisions relating to:

- eligibility for “insured services”\textsuperscript{20}

- eligibility for, amount of, exclusion of, and termination of the “community services” someone may receive;\textsuperscript{21}

- 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.\textsuperscript{22}

HSARB has its own Rules of Practice and Procedure, and is a “quasi-judicial” tribunal.\textsuperscript{23}

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\textsuperscript{18} 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” (October 2012), Ontario Hospital Association www.oha.com/KnowledgeCentre/Library/Toolkits/Pages/Default.aspx.

\textsuperscript{19} Ministry of Health and Long-Term Care Appeal and Review Boards Act, 1998, SO 1998, c 18, Schedule H. See also: www.hsarb.on.ca/scripts/english/default.asp.

\textsuperscript{20} 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.

\textsuperscript{21} 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.

\textsuperscript{22} Please see Long-Term Care Homes Act, 2007, SO 2007, c 8, ss 43 and 53 with respect to the eligibility appeals related to long-term care home admissions.

\textsuperscript{23} See: www.hsarb.on.ca/scripts/english/default.asp for more information on HSARB.
Section 11: Tools for Discharge Planning
Tools for Discharge Planning

Both hospitals and community care access centres ("CCACs") have policies and procedures to assist staff in working with patients, substitute decision makers ("SDMs") and family members/care givers during the discharge planning process.

In order to develop and implement discharge plans that are “patient or client 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 / client relating to some or all aspects of proposed plan(s).
- Difficulty identifying an appropriate SDM when the patient/client 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 that is associated with making decisions on behalf of an incapable person.
- Communication issues with a patient/SDM, including refusal by patient/SDM to make a decision or participate in some or all of the planning process.

The above are, of course, generalizations of the types of challenges that may be faced by both hospital and CCAC staff when working toward a successful discharge for a patient / client.

(b) Hospital Policies

Most hospitals have comprehensive discharge planning polices, and procedures. Discharge planning policies should promote open communication with patients/SDMs. These policies should also promote a transparent process with respect to expectation 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 care givers. 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, relating to co-payments, consent, per diem,1 ALC), discharge planning policies should encourage reference to other hospital and non-hospital resources for patients/SDMs and family members/care givers.

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 dealing with the challenges, and promotes communication and consistency in messaging.

One tool that may be helpful in a 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 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.

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

(c) CCAC Policies

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

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

Within CCACs, it is equally important to have an escalation process to support staff members who encounter challenges in working with clients or SDMs. Initial escalation of a concern/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.

CCACs 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 long-term care home is being contemplated, the CCAC should communicate directly with a client/SDM about challenges in the process.

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

Reminder:

All hospital and CCAC 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 Heirarchy

The following is a more detailed commentary of the various rankings within the hierarchy for SDMs under the Health Care Consent Act (“HCCA”) as presented in Section 7 of this Guidance Document.

1. The incapable person’s guardian of the person, if 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.1

When appointing a guardian, the court must specify the functions over which the guardian has decision making power. This can be limited in time or by any conditions the court wishes to impose.2 Full guardianship may be ordered when the individual is fully incapable of all personal care decision making.3

In all other cases, the court will award a partial guardianship outlining the exact role of the guardian.4

Where the guardian has authority to give or refuse consent to the proposed treatment or admission, the guardian will be the substitute decision maker (“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 so as to be in a position of higher rank in the determination of who is the SDM.
- A close friend of the patient applies to be appointed if the patient does not have any family.

The court will only appoint someone to this role if it is satisfied that there is no other alternative action which does not require the person to be found incapable by the court and which is less restrictive on the person’s decision making rights.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 applicant and the incapable person.6

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

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

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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.
5 Ibid at s 55(2).
6 Ibid at s 57(3).
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.
2. The incapable person’s attorney for personal care, if
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. 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 if:

(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
his or her 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.

The attorney may have authority to make treatment
decisions if the patient has been determined not to
be capable under the HCCA. 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 grantor 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.

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

(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;

(c) Waiving the patient’s right to a review by the CCB
of a finding of incapacity by a health practitioner or
an evaluator.

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

(a) A statement from the grantor, on the prescribed
form, indicating that within 30 days after executing
the power of attorney the grantor 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 grantor was capable
of personal care, he or she understood the effect
of the document and the facts upon which the
assessor’s opinion is based.

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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.
11 Ibid at ss 49(1)(2).
12 Ibid at ss 49(1)(b), (2)(3).
13 Ibid at s 50(2).
14 Ibid at s 50(1).
A court has the power to validate any power of attorney that is otherwise ineffective.\textsuperscript{15}

Where the SDM for an incapable person is acting in this role pursuant to a Power of Attorney for Personal Care, it is recommended that a copy of the power of attorney document be placed in the incapable person’s chart / record.

3. \textit{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 \textit{HCCA}.\textsuperscript{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.\textsuperscript{17}

The scope of authority of the SDM appointed by the CCB will be limited to decisions that fall within the \textit{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.\textsuperscript{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.

4. \textit{The incapable person’s spouse or partner.}

Unless two people are living separate and apart as a result of a breakdown in their relationship,\textsuperscript{19} they are considered to be “spouses” if:\textsuperscript{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 \textit{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.”\textsuperscript{21}

5. A child or parent of the incapable person, or a Children’s Aid Society or other person who is lawfully entitled to give or refuse consent to the treatment 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 in the place of the parent, this paragraph does not include the parent.

A “child” is not defined in the \textit{HCCA}. A “child” includes any child of their natural parents, whether born within or outside marriage, and any child who has been formally adopted.\textsuperscript{22} There is also a “presumption of

\textsuperscript{15} \textit{Ibid} at s 48(4).
\textsuperscript{17} \textit{Ibid}.
\textsuperscript{18} \textit{Ibid}.
\textsuperscript{19} \textit{Ibid} at s 20(8).
\textsuperscript{20} \textit{Ibid} at s 20(7).
\textsuperscript{21} \textit{Ibid} at s 20(9)(b).
\textsuperscript{22} \textit{Children’s Law Reform Act}, R.S.O. 1990, c 12, s 1 [\textit{CLRA}].
paternity” in a variety of circumstances. If there is more than one child of the incapable person, all children rank equally as SDMs.

6. A parent of the incapable person who has only a right of access.

When dealing with parents who are making decisions for their incapable children, the highest ranking parent is the one who has custody. 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.

As indicated by the numbering above, where the parents are separated and one has custody and the other access, the custodial parent is a higher ranked SDM.

In situations in which there is an apparent dispute between parents of an incapable person, and there are issues of custody, access or Children’s Aid Society involvement, it is recommended that a copy of the applicable Court Order be obtained for the chart.

7. A brother or sister of the incapable person.

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

8. Any other relative of the incapable person.

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

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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.

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