Court File No.: CV-23-00698007-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E N:

ONTARIO HEALTH COALITION and ADVOCACY CENTRE FOR THE ELDERLY

Applicants

-and-

HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO, THE MINISTER OF HEALTH, and THE MINISTER OF LONG-TERM CARE

Respondent

AFFIDAVIT OF DAVID MUSYJ
(Affirmed February 23, 2024)

I, DAVID MUSYJ, of the City of Windsor in the Province of Ontario, **AFFIRM**:

1. I am the President and Chief Executive Officer of the Windsor Regional Hospital ("WRH") in Ontario, Canada. I have held this position since 2007.

2. I served as the Vice President of Corporate Services and Medical Affairs of the WRH from 2000-2007.

3. WRH operates out of two campuses and is the 15th largest hospital and the 7th largest community teaching hospital in Ontario. WRH serves a population of about 400,000 people in Windsor and Essex County and provides tertiary and quaternary care to thousands more.

4. WRH is the regional provider of advanced care in areas that include Complex Trauma, Renal Dialysis, Cardiac Care, Stroke and Neurosurgery, Intensive Care, Acute Mental Health,

Family Birthing Centre, Neonatal Intensive Care, Paediatric Services, Regional Cancer services and a broad range of medical and surgical services.

5. A copy of my *curriculum vitae* is attached hereto as **Exhibit "A".**

6. On the basis of the above, I have personal knowledge of the contents of this affidavit. Where my knowledge is based on information and belief, I state the source of information and I believe it to be true.

7. I have been asked to provide evidence about the nature and impacts of the *More Beds, Better Care Act* (hereinafter referred to as "Bill 7") as it pertains to the WRH. Specifically, I was asked to answer the following questions:

A. Please describe the process for designating patients as Alternate Level of Care ("ALC") at WRH.
B. What are your concerns, if any, about ALC patients remaining in hospital? Is it good for the hospital, the patient, and the community if ALC patients remain in hospital?
C. What happens when a patient is designated ALC at WRH? Does Bill 7 assist in alleviating any of your concerns about ALC patients remaining in hospital?
D. Please review the affidavits relied on by the applicants. Are their descriptions accurate with respect to WRH?

A. Please describe the process for designating patients as Alternate Level of Care ("ALC") at WRH.

8. An ALC patient is someone who occupies a bed in a hospital under the *Public Hospitals Act* who has been designated as requiring alternate level of care because they do not require the intensity of resources and/or services provided in the hospital care setting.

9. At WRH, ALC designations are assigned to patients by their Most Responsible Physician. WRH's unattached patient group is the practice group where the majority of ALC designations are made. This group is made up of family doctors or general practice physicians who also practice in the hospital.

10. Physicians at WRH who make ALC designations are guided by federal, provincial and internal WRH guidelines, standards, and tools including, for example:

a) The Canadian Institute for Health and Information Definitions and Guidelines, and Guidelines to Support ALC Designation, attached hereto as **Exhibit "B" and Exhibit "C",** respectively**.**

b) The Ontario Health Alternate Level of Care (ALC) Leading Practices Guide, and ALC Self-Assessment Tool provided through Ontario Health, attached hereto as **Exhibit "D" and Exhibit "E",** respectively.

c) The WRH "ALC Clinical Care Guideline" attached hereto as **Exhibit "F".**

11. Physicians who make ALC designations at WRH work collaboratively with the patient's entire healthcare team, the utilization team (described below), and the patient and their family to determine a plan of care. The plan of care is tailored to the individual needs of the patient and is updated weekly to follow the patient's clinical progression. Physicians at WRH engage in regular meetings and discussions aimed at assessing patients' length of stay and any new definitions or practices related to ALC designations. This helps ensure consistent and accurate ALC designations.

12. WRH's utilization team is a key component in managing ALC designated patients and maintaining patient flow. Our utilization team consists of 42 Patient Flow Leads, including a Behavioural Support Worker and two Patient Flow Managers.

13. ALC designations are reviewed daily with Patient Flow Leads and Patient Flow Managers at each campus and weekly with the social work teams during complex discharge huddles. ALC designations that have been identified for long term care ("LTC") are also reviewed weekly, and as needed, with Home and Community Care Support Services ("HCCSS") management.

14. This process is supported by policies, standards and reporting documents, including, for example, WRH's "ALC Huddle" standard attached hereto as "**Exhibit G**", WRH's "Patient Flow – Discharge Planning" standard attached hereto as **"Exhibit H"** and WRH's "Systems Huddle" Report attached hereto as **"Exhibit I"**.

15. ALC patients continue to be monitored and assessed by the health care team. If an ALC patient's condition changes and acute care needs are detected, then the patient will be undesignated as ALC.

B. What are your concerns, if any, about ALC patients remaining in hospital? Is it good for the hospital, the patient, and the community if ALC patients remain in hospital?

16. When a patient is designated as ALC, that means that they no longer require hospital level care. When a patient who no longer requires this level of care remains in the hospital, it has negative effects on both the health care system and the ALC patient themselves.

17. The health care system is impacted through decreased access to acute care hospital services for patients who truly require them. WRH typically has 620 beds available for patients. An average of 3.4 patients at WRH are newly designated ALC daily, leading to an average of approximately 105 new ALC designations every month. Out of these monthly designations, only approximately 10 patients are re-designated as needing acute care following changes in their health status. The remainder of ALC patients who no longer require acute level care but continue to occupy hospital beds create a constraint on WRH's ability to provide acute level care to new patients who do require it.

18. For example, with limited beds available for acute care, WRH is unable to transfer patients out of the emergency room. This, in turn, means that WRH is not able to accept new patients from the waiting room or ambulances into the emergency room. When emergency medical services

bring a patient requiring emergency care into the emergency room, but there is no bed available for them, the paramedics are unable to transfer the patient from their stretcher and cannot leave to attend other emergency calls. This can result in a 'code black' or 'code zero' where there are not enough emergency medical services available in the community for the number of calls being received.

19. In the evening, WRH is the only option for emergency services in the Windsor and Essex County and, while construction on a new campus is set to break ground in the coming years, we are consistently at capacity and are often forced to admit patients with no beds available for them. People in the Windsor-Essex community who need hospital level now cannot wait years for the new campus to be built to receive that care.

20. ALC patients remaining in hospital also limit the availability of beds available for patients being moved from the intensive care unit ("ICU") into a general medicine unit, similarly limiting the ability of the ICU to accept patients. If the ICU does not have capacity to accept a patient who needs intensive care, the patient must be transferred to another facility and this introduces a level of unnecessary risk to that patient.

21. ALC patients remaining in hospital also limit the availability of beds required for patients to recover from surgery. This can lead to surgeries being postponed or cancelled.

22. In summary, ALC patients remaining in hospital reduces the number of hospital beds available for patients who require hospital care.

23. It is also not good for patients who no longer need hospital level care to remain in the hospital. For patients who do not require an acute level of care, the hospital environment is not an ideal place for them due to the risk of infection and lack of mobility. Patients in the hospital also

do not have the same access to enriching services, activities or supports, such as the social and physical activity, entertainment, and organized dining often available in LTC settings.

C. What happens when a patient is designated ALC at WRH? Does Bill 7 assist in alleviating any of your concerns about ALC patients remaining in hospital?

24. Bill 7 assists by allowing for quicker and more efficient transfers of ALC patients who no longer require hospital level care out of the hospital. Bill 7 supports and improves the flow of hospital operations, creating a greater likelihood that a bed will be available to patients who do require acute hospital level care.

25. If a patient is designated ALC, the attending clinician will issue a Discharge Order and the WRH policy for discharging a patient is followed. Our Discharge Planning Policy used prior to Bill 7 is attached hereto as **Exhibit "J"** and our current Discharge Planning Policy is attached hereto as **Exhibit "K".**

26. If a patient is designated ALC, they are sent letters explaining the designation, options for next steps, and the co-payment rate. Examples of these letters are attached hereto as **Exhibit "L"** and **Exhibit "M".**

27. The health care team, including the hospital and HCCSS, will ensure all options have been considered prior to assigning a patient ALC with a designation of waiting for LTC. When a patient is designated ALC, we work with them to determine if there are community supports available, even if only while they are applying to LTC homes. Bill 7 assists in transferring ALC patients out of hospital and into community care because it helps open discussion, as I will describe below.

28. It is not often that a patient designated as ALC will be able to return home or into community care. In that case, they are designated as ALC waiting for LTC. This designation is supported by the ALC LTC Sign Off Sheet attached hereto as **Exhibit "N".** The changes under Bill 7 help to facilitate transfer of these patients from the hospital directly to LTC homes.

29. For example, there is now a requirement that hospitals charge a standardized rate of $400 for each day that a discharged patient chooses to remain in hospital instead of moving to an LTC placement that has become available to them, following the expiry of a 24-hour waiting period.

30. Prior to Bill 7, WRH had a similar internal policy in place where a patient who was accepted to an LTC home, but refused to leave the hospital, would be subject to a $600 daily rate. The purpose of the rate was to represent a contribution to the cost associated with remaining in a hospital treatment bed (approximately $1600 per day) when acute hospital treatment services were no longer required. It is my understanding that a number of hospitals in Ontario had similar policies in place prior to Bill 7. A copy of the letter that was sent to patients informing them of WRH's rate is attached hereto as **Exhibit "O".**

31. Because this was only a hospital policy, though, and not required by law, I would often be contacted by ALC patients pushing back on the policy because they did not want to leave the hospital and did not want to pay the rate. They would suggest that since it was only a hospital policy it could be waived, or amended, and that they should be able to remain in the hospital without paying. Front line staff would also face verbal abuse regarding the hospital policy. Now that the rate is mandated by legislation, I no longer receive complaints like this, and I am informed by hospital staff that they are no longer confronted with similar complaints or frustration from patients. ALC patients in hospitals across the province are subject to the same rate, which cannot be waived or amended by individual hospitals. The standardized rate acts as an incentive for ALC patients to accept LTC placements available to them, thereby freeing up an acute care bed for another patient.

32. The changes under Bill 7 allow for faster transfer of ALC patients from the hospital directly into an LTC placement by other means, as well.

33. For example, it is now easier for HCCSS placement coordinators to facilitate application and admission of ALC patients into LTC homes by authorizing them to take certain steps that previously could not be taken without patient consent.

34. The selection of LTC homes by a HCCSS placement coordinator is unlimited in number, considers the patient's condition and circumstances, and is based on the criteria set out in the legislation. In 2023, the changes under Bill 7 facilitated the placement of 15 WRH ALC patients into HCCSS selected LTC homes.

35. I understand that patients can be put on the existing long stay waitlist in the crisis category for the homes selected by the HCCSS placement coordinator and their preferred homes and they remain in the crisis category of the waitlist until they are placed in a preferred home.It is my understanding that most ALC patients who are transferred from WRH into an LTC home chosen by an HCCSS coordinator are eventually accepted into their preferred home, and we have never had a patient placed in an LTC home chosen by an HCCSS coordinator outside of the region.

36. Prior to Bill 7, when a patient remained in hospital to await transfer to an LTC home, the only recourse open to the hospital would be to ask the patient (or their family, SDM, etc.) to consider choosing a short-listed facility to assist in a timely transition to an LTC home on their list. Crisis designation was not an option, and if a choice on a patient's list did not have a short-listed bed, often the patient would remain in an inpatient unit for months, or even years, taking up a bed that they did not require and that could not be used for another patient in need.

37. The process under Bill 7 encourages patients and their families to not be too restrictive when applying to LTC homes and allows for fuller and more detailed discussions of the options open for ALC patients other than remaining in hospital when they no longer need hospital level

care. This new process helps to eliminate the option of ALC patients staying in the hospital while waiting for a particular LTC home of their choosing to have an opening.

38. The changes under Bill 7 help to facilitate timely discharge of ALC patients which, in turn, helps to ensure that acute care beds remain available for individuals who require hospital level care. It minimizes confrontation between patients and staff, facilitates discussion and open dialogue, and provides incentives and eliminates barriers to transferring ALC patients into available LTC placements. These changes benefit patients and staff at WRH, as well as the broader Windsor-Essex community.

D. Please review the affidavits relied on by the applicants. Are their descriptions accurate with respect to WRH?

Affidavit of Dr. Samir Sinha

39. Paragraph 5(a) of Dr. Samir Sinha's affidavit states that "it is not uncommon to see patients prematurely or incorrectly designated as ALC patients when active acute issues still require the services and care of the environment they are in." In my experience at WRH, it is uncommon that patients are prematurely designated as ALC. If careful review is taken, in line with the guidelines and definitions, designations will not be made prematurely.

40. Paragraph 10 of Dr. Sinha's affidavit suggests that "take back" policies are becoming increasingly common for receiving institutions. In my experience, this is rare, not common. WRH does not have "take back" letters or policies.

41. I disagree with the statement at paragraph 13 of Dr. Sinha's affidavit that "no action has been taken to provide better access to rehabilitation or complex continuing care beds." In my experience, there is active work ongoing province wide to provide better access to care. See, for example, operational directions from Ontario Health attached hereto as **Exhibit "P"** and **Exhibit "Q"**, respectively.

Affidavit of Jane Meadus

42. Paragraph 87 of Jane Meadus' affidavit states that "the key element of [Bill 7] is that it empowers placement co-ordinators to make all placement decisions on behalf of ALC patients and takes away their autonomy as to where they wish to live for what could be the rest of their lives." I disagree that it takes away patient autonomy regarding where they will live for the rest of their lives. Patients and families are able to remain a part of all decisions and create a list of LTC homes themselves. HCCSS then adds a short-listed bed after lengthy discussions with patients and families. Patients are allowed to stay on the crisis list for their home of choice if the patient is offered a bed from a short-listed LTC home that was short-listed from the HCCSS instead of the patient.

43. Paragraph 83 of Ms. Meadus' affidavit states that "more complex, higher needs patients are being admitted to long-term care, such as incapable ventilator patients being pressured to move from chronic care to long-term care as the hospital no longer wished to provide this important care." This has not happened at WRH. I have never seen a patient, including on chronic ventilation, be pressured to leave simply because the hospital no longer wants to provide a service. Patients are only designated ALC and discharged if they do not require the level of care that the hospital provides.

Affidavit of Dr. Pat Armstrong

44. At paragraph 5 of Dr. Pat Armstrong's affidavit, she states that Bill 7 only takes hospital resources and services into account and allows patients to be transferred out of hospital into LTC placements regardless of whether the resources and services at the LTC home can accommodate their needs. This is contrary to my experience. Physician and impatient teams at WRH do not discharge to fail.

45. As outlined above, we follow a comprehensive discharge process and only discharge a patient when they no longer require hospital level care. We will not discharge a patient to an LTC home that cannot provide the level of care required, and patients are assessed by the LTC home prior to being offered a bed. LTC homes will not accept patients unless, following the assessment, they identify that they will be able to provide the required care. LTC homes can also utilize high intensity funding to put towards certain complex care needs for specific patients.

46. A patient who is discharged to an LTC home and whose medical needs change may be readmitted to hospital, just as a patient who is discharged to go home may subsequently require readmission to hospital. In neither case does that result mean that the patient was improperly or prematurely discharged. It just means that, inevitably, some patients who are discharged later require readmission to hospital.

Affidavit of Dr. George Heckman

47. At paragraph 36 of Dr. George Heckman's affidavit, he states that the health care system is not designed in a way to consider alternative ways of meeting the needs of ALC patients apart from moving them out of hospitals and into long-term care homes, making it difficult to find alternative options for placing ALC patients. I disagree. As outlined above, WRH adopts a home first philosophy and is able to implement creative ways to provide services and care to patients at home and in the community. Our team is consistently looking for ways to provide diagnostics, healthcare plans, and placements outside of the hospital, including for ALC patients, and we work with a number of organizations to implement this.

AFFIRMED remotely by David Musyj stated as being located in the City of Windsor in the Province of Ontario, before me at the City of Toronto in the Province of Ontario on the 23rd day of February, 2024, in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Adam Kouri

A Commissioner for Taking Affidavits

Adam John Kouri, a Commissioner, etc., Province of Ontario, while a Student-at-Law. Expires August 16, 2026

David Musyj

David Musyj

This is Exhibit "A" to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

Adam John Kouri,
A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

David Mark Musyj, LL.B., J.D.

2007-present **Windsor Regional Hospital, Windsor, Ontario**
PRESIDENT AND CEO

- Report to a Board of Directors

- Windsor Regional Hospital is one of the largest community teaching hospitals in the Province of Ontario, serving a population of more than 400,000 people in Windsor and Essex County. It is the regional provider of advanced care in areas that include Complex Trauma, Renal Dialysis, Cardiac Care, Stroke and Neurosurgery, Intensive Care, Acute Mental Health, Family Birthing Centre, Neonatal Intensive Care, Paediatric Services, Regional Cancer services and a broad range of medical and surgical services required to support these specialized areas.

  Through a major initiative involving the two hospitals in Windsor, a realignment of programs and services was achieved on October 1, 2013, when Windsor Regional Hospital became responsible for the governance, management and operations of the Ouellette Campus along with continuing its responsibility for the Metropolitan Campus. The ultimate vision is to design and construct a new state-of-the-art acute hospital healthcare facility serving the needs of Windsor-Essex for generations to come.

2000–2007 **Windsor Regional Hospital, Windsor, Ontario**
VICE-PRESIDENT CORPORATE SERVICES/MEDICAL AFFAIRS

- Report to President and CEO

- Responsible for working directly with the Chief of Staff on all issues related to the 500 medical/dental staff

- Direct responsibility for all non-clinical operations of the organization and acted as General Counsel to the organization

1998-1999 **Paroian Raphael Law Firm, Windsor/Toronto, Ontario**
PARTNER

- Carried on private practice as a lawyer specializing in corporate, labour and employment law.

1994-1998 **Paroian Raphael Law Firm, Windsor/Toronto, Ontario**
ASSOCIATE LAWYER

1991-1992 **Levine Benjamin Law Firm, Bloomfield Hills, Michigan**
LAW CLERK

EDUCATION AND DEGREES

1992	Called to the State of Michigan Bar
1994	Called to the Province of Ontario Bar
1992	Bachelor of Laws, University of Windsor
1992	Juris Doctor, University of Detroit Mercy

AWARDS AND RECOGNITION

2006	SWOMEN WINDSOR - Advancement of Medical Education Award
2011	Harmony Award - Multicultural Society of Windsor/Essex
2014	Honorary Membership - Essex County Medical Association
2018	Windsor Roseland Rotary - Paul Harris Award

This is Exhibit “B” to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

Adam John Kouri,
A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

Job Aid

Definitions and Guidelines to Support ALC Designation in Acute Inpatient Care

Introduction

Alternate level of care (ALC) is a system classification used in Canada that is applied when there is a mismatch between the intensity of care needs in relationship to the intensity of services/resources in that setting. This can occur in acute inpatient, mental health, rehabilitation, and chronic or complex continuing care. It has been recognized that there is a need for a standardized approach in considering patient status in ALC designation.

Definitions

Alternate level of care (ALC): When a patient is occupying a bed in a facility and does not require the intensity of resources/services provided in that care setting.

Contextual information

Why: The consistent use of ALC designation facilitates measurement of the access gap from one care setting to another. These gaps, once defined, inform system level planning to improve access.

Where: This guideline applies specifically to acute inpatient care.

Who designates: The patient must be designated ALC by the most appropriate care team member, which may be a physician, long-term care assessor, patient care manager, discharge planner or other care team member. The decision to assign ALC status is a clinical responsibility.

When: The ALC time frame starts on the date and at the time of designation as documented in the patient chart or record. The ALC time frame ends (1) on the date and at the time of departure from the ALC setting or (2) on the date and at the time the individual's care needs change such that the ALC designation no longer applies. For a patient who is ALC and reverts to acute status and then becomes ALC again, the patient's total count of ALC days should resume and not start again from 0. **Note: The discharge or transfer destination need not be known at the time of ALC designation.**

CIHI

How: The ALC status is clearly documented in the patient record by clinical staff, preferably on an approved ALC Designation form. **Acute care patients require daily assessment; therefore, the assessment for ALC designation takes place daily.** The Health Information Management Professional will record the pertinent ALC information in the Discharge Abstract Database (DAD) abstract. In order to enter the ALC service in the abstract, the duration of the ALC portion of the patient's stay must be at least 24 hours.

Acute inpatient care: An active, short-term care episode including facility-based overnight stay and the presence of one of the following:

- The need for active treatment of serious injury or illness, urgent medical or mental health condition or during initial recovery from surgery
- Care/monitoring provided 24/7 by a multidisciplinary team, which may include physicians, nurses (registered or practical), nurse practitioners, and other allied health professionals (pharmacist, physiotherapist, occupational therapist, registered dietitian, social worker, etc.)
- Services provided at a minimum level of certain frequencies and intensity levels:
  - Attendance and charting by a physician or delegate at least once per day
  - Close clinical monitoring at least 3 times daily based on delegated functions by the physician
- Access to diagnostic tests required to stabilize plan of care

Acute inpatient care encompasses a range of clinical health care functions and treatments, including emergency medicine, trauma care, acute medicine, acute care surgery, critical care, obstetrics, gynecology, acute pediatric care, acute mental health, acute rehabilitation, acute palliative care and inpatient stabilization.

Job Aid

Guidelines to support ALC designation by clinicians

The following table is intended to support clinical decision-making to determine whether an individual's inpatient status should be designated ALC. **The guidelines are intended to prompt questions for clinicians to consider for ALC designation. In all cases, application of clinical judgment and adherence to best practice is expected judgment for final designation decisions.**

Patient status	Acute inpatient care (if any one of the following criteria are met)	ALC
Patient characteristic		
Clinical status	• Unstable and/or deteriorating • Anticipated risk for rapid decline • Actively under investigation and diagnoses under revision	• Stable and/or patient's status has plateaued • Low risk for rapid decline • No longer searching for new additional diagnoses
Safety risk: Self and others	• Progressive acute behavioural or neurological difficulties requiring acute inpatient care • Evidence of actual or potential danger to self or others • Requires protection for self and/or others from aggression/self-injurious behaviour • Requires one-on-one observation	• Cognitive impairment including dementia, with stable treatment plan, not requiring acute care services • Behavioural or neurological difficulties that can be managed with interventions in the community as specified in the care plan
Team requirements		
Activity tolerance	• Activity level markedly below baseline or new baseline; requires assistance • Anticipated to require access to the full range of professional therapies to achieve client goal • Altered cognition or physical symptoms impair rehabilitation services • If dominant treatment plan is rehabilitation, can tolerate intensity of 2 professional therapeutic services (e.g., nursing, occupational therapy [OT], physical therapy [PT])	• Baseline independence recovered or new baseline established • Can receive activity support in a different setting • Assisting patients in returning home or moving to another level of care (e.g., waiting for specialized rehabilitation care beds)
Clinical practice and process	• A minimum of 2 professional therapeutic services are required daily (e.g., any combination of nursing, OT, PT, etc.) • Close monitoring at least 3 times daily (e.g., vital signs) • Plan actively changing • Clinical status or need requires at least one daily doctor visit	• Required professional therapeutic services and monitoring can be provided in a different setting (e.g., in specialized rehabilitation care beds/facilities) • Stable treatment plan • Requires less than one daily doctor visit

Job Aid

Patient status	Acute inpatient care (if any one of the following criteria are met)	ALC
Clinical interventions		
Medication and fluid administration	• Requires multiple assessments and/or titrations • Requires special routes of administration that must be performed in hospital (e.g., IV, epidural, intrathecal)	• Frequency of assessment and/or titration per administration can be accomplished in another setting • Route of administration could be done on an outpatient basis (e.g., IV) regardless of service availability in the community
Diagnostics and therapeutics	• Requires access to diagnostics/procedures and results or pre-/post-testing care	• Service as well as pre-/post-care available in a setting other than hospital • No immediate results requirement
Specialized care or scenarios		
Palliative care	• Medically unstable with potentially reversible conditions requiring diagnostics and treatments not available outside the hospital setting; the goal is life prolongation • Complex symptom control issues and required support for imminent death within the acute care environment (e.g., a patient on a medical ward, palliating without a plan to move to another level of service) • End-of-life care focused on comfort only, with unstable complex symptoms that require the support of the interdisciplinary team and specialist palliative care services	• Medically stable with gradual progression of non-reversible illness; stable treatment plan may be supported outside of acute inpatient care • Care requirements may be delivered in another setting (e.g., chronic or complex continuing care, home with home care, hospice care) • Comfort care can be supported within the community setting • Patient-centred care can be creatively planned to support dying at home
Mental health	• Suffers from sudden and severe psychiatric symptoms; can include patients who are suicidal, or who have hallucinations, extreme feelings of anxiety, paranoia or depression • Progressive acute behavioural or neurological difficulties requiring acute clinical or psychiatric care • Therapeutic pass to inform clinical readiness for discharge	• Can be managed with individual or group therapy, or relapse prevention services • Clinically stable or has plateaued and is able to participate in recovery plan in the community, including in designated non-acute mental health treatment facilities • Overnight or greater than a 24-hour trial discharge where treatment plan supports care in an alternate setting
Respiratory care	• On a ventilator with a new tracheostomy (cuffed), requiring at least 3 assessments/day	• On a ventilator, chronic respiratory care
Companion	• Not applicable	• Companion — well baby/adult (if registered)

How to cite this document:
Canadian Institute for Health Information. *Definitions and Guidelines to Support ALC Designation in Acute Inpatient Care*. Ottawa, ON: CIHI; 2016.

This is Exhibit “C” to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

Adam John Kouri,
A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

Guidelines to Support ALC Designation

Alternate level of care (ALC) is used in hospitals to describe patients who occupy a bed but do not require the intensity of services provided in that care setting. Clinical and physician leaders can use the following information to support ALC designation of patients in acute inpatient care. It is intended to prompt questions for clinicians to consider for ALC designation.

Clinical Status

Acute Inpatient Care
If any one of the following criteria is met:

- Unstable and/or deteriorating
- Anticipated risk for rapid decline
- Actively under investigation and diagnoses under revision

Alternate Level of Care

- Stable and/or patient's status has plateaued
- Low risk for rapid decline
- No longer searching for new additional diagnoses

Safety Risk: Self and others

Acute Inpatient Care
If any one of the following criteria is met:

- Progressive acute behavioral or neurological difficulties requiring acute inpatient care
- Evidence of actual or potential danger to self or others
- Requires protection for self and/or others from aggression/self-injurious behaviour
- Requires 1:1 observation

Alternate Level of Care

- Cognitive impairment including dementia, with stable treatment plan, not requiring acute care services
- Behavioral or neurological difficulties that can be managed with interventions in the community specified in the care plan

Activity Tolerance

Acute Inpatient Care

If any one of the following criteria is met:

- Activity level markedly below baseline or new baseline; requires assistance
- Anticipated to require access to the full range of professional therapies to achieve client goal
- Altered cognition or physical symptoms impair rehabilitation services
- If dominant treatment plan is rehabilitation, can tolerate intensity of 2 professional therapeutic services (e.g., nursing, occupational therapy, physical therapy)

Alternate Level of Care

- Baseline independence recovered or new baseline established.
- Can receive activity support in a different setting
- Assisting patients in returning home or moving to another level of care (e.g. waiting for specialized rehabilitation care beds)

Clinical Practice & Process

Acute Inpatient Care

If any one of the following criteria is met:

- >/= 2 professional therapeutic services are required daily (e.g. any combination of Nursing, OT, PT, etc.)
- Close monitoring at least 3 times daily (e.g. vital signs)
- Plan actively changing
- Clinical status or need requires >/= 1 daily doctor visit

Alternate Level of Care

- Required professional therapeutic services and monitoring can be provided in a different setting (e.g. in specialized rehabilitation care beds/facilities)
- Stable treatment plan
- Requires < 1 daily doctor visit

Medication and Fluid Administration

Acute Inpatient Care

If any one of the following criteria is met:

- Requires multiple assessments and/or titrations
- Requires special routes of administration that must be performed in hospital (e.g., IV, epidural, intrathecal)

Alternate Level of Care

- Frequency of assessment and/or titration per administration can be accomplished in another setting
- Route of administration could be done on an outpatient basis (e.g. IV medication) regardless of service availability in the community

Diagnostics and Therapeutics

Acute Inpatient Care

If any one of the following criteria is met:

- Requires access to diagnostics / procedures and results or pre-/post-testing care

Alternate Level of Care

- Service as well as pre/post care available other than in hospital
- No immediate results requirement

Palliative Care

Acute Inpatient Care

If any one of the following criteria is met:

- Medically unstable with potentially reversible conditions requiring diagnostics and treatments not available outside the hospital setting. The goal is life prolongation.
- Complex symptom control issues and required support for imminent death within the acute care environment (e.g. a patient on a medical ward, palliating without a plan to move to another level of service.)
- End of life care focused on comfort only; with unstable complex symptoms that require the support of the interdisciplinary team and specialist palliative care services

Alternate Level of Care

- Medically stable with gradual progression of non-reversible illness; stable treatment plan may be supported outside of acute inpatient care
- Care requirements may be delivered in another setting (e.g. chronic or complex continuing care, home with home care, hospice care)
- Comfort care can be supported within the community setting
- Patient centered care can be creatively planned to support dying at home

Mental Health

Acute Inpatient Care

If any one of the following criteria is met:

- Suffers from sudden and severe psychiatric symptoms; can include patients who are suicidal, have hallucinations, extreme feelings of anxiety, paranoia or depression
- Progressive acute behavioural or neurological difficulties requiring acute clinical or psychiatric care
- Therapeutic pass to inform clinical readiness for discharge

Alternate Level of Care

- Can be managed with individual or group therapy, or relapse prevention services
- Clinically stable or has plateaued and able to participate in recovery plan in the community, including in non-acute designated mental health treatment facilities
- Overnight or >24 hr trial discharge where treatment plan supports care at an alternate setting

Respiratory Care

Acute Inpatient Care

If any one of the following criteria is met:

- On a ventilator with a new tracheostomy (cuffed), requiring >= 3 assessments/day

Alternate Level of Care

- On a ventilator, chronic respiratory care

Companion

Alternate Level of Care

- Companion - well baby/adult (if registered)

Featured resource

- Definitions and Guidelines to Support ALC Designation in Acute Inpatient Care (PDF)

This is Exhibit “D” to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

Adam John Kouri,
A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

Ontario Health

The Alternate Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults

September 2021

Document Version: V1

This guide was developed in 2021 by the Ontario Alternate Level of Care (ALC) Leading Practices Working Group as an update to the 2017 ALC Leading Practices User Guide,[8] and the 2019 Rural Hospital ALC Leading Practices Guide[30]. **V1 of this guide is applicable to hospitals**. **V2 is in development and will include community care.**

Ontario ALC Leading Practices Working Group (2021)

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A message from the Ontario ALC Leading Practices Working Group: September 2021

The COVID-19 pandemic has brought the issues of alternate level of care (ALC), patient flow, and the care provided to older adults to the forefront. Focus has shifted from decreasing ALC days to preventing the phenomenon of ALC altogether. With 80% of Ontario's ALC designations being attributed to older adults (65+), ensuring that older adults receive evidence-based care that meets their needs is a key factor in improving health outcomes and, in turn, improving flow by reducing length of stay (LOS) and ALC. These efforts are viewed as part of an approach to integrated patient care across the continuum where the right care is provided in the right place at the right time.

The causes of delayed transitions are often identified as capacity issues in other parts of the health care system, such as "not enough home care" and "not enough Long Term Care (LTC) beds". Beyond capacity however, it is equally important that hospitals examine how their own care processes may contribute to ALC rates and delayed transitions (1). This is particularly important for older adults living with frailty, where specific hazards of hospitalization, including falls and delirium, directly impact patient outcomes, safety and health system flow (2–4). Evidence and experience demonstrate that quality improvement efforts that prioritize senior friendly approaches to care, such as a focus on delirium prevention and early mobilization, can prevent hospital-acquired harm and delayed transitions. Not doing so directly contributes to ALC rates. (5–8).

Many new beds are now being added across the system to help address capacity. These beds will require intentional design to ensure that they support improved health outcomes for older adults by providing the right care in the right place at the right time.

This guide was developed as an update to the 2017 ALC Leading Practices User Guide (9). The updates include: a focus on assessing older adults for risks that may lead to delayed transitions in care; better engaging families and caregivers; embedding senior friendly care (sfCare) as essential, foundational care; and replacing the word "discharge" with "transition" to better reflect that older adults receive services across a continuum of care (10). Creation of leading practices for the Community sector is integral to a successful integrated care approach and is under development.

We gratefully acknowledge the valuable contributions to this guide from older adults, caregivers and frontline clinicians.

About this Guide

This guide identifies evidence-based leading practices for the care and proactive management of hospitalized older adults at risk of delayed transition to an appropriate setting that can be implemented in the emergency department, acute care and post-acute care settings. While the focus of this guide is on ALC prevention and management in hospitalized older adults, many of these leading practices can be applied to other patient populations.

The leading practices describe WHAT care should look like. Organizations determine HOW to implement these

practices by prioritizing change ideas and developing action plans. Users of this guide are encouraged to begin their reflection with the *Leading Practices Self-Assessment Tool.* It provides an approach to defining current state, where the results identify opportunities for quality improvement (QI) and can be used to inform the Quality Improvement Plan (QIP). While individual organizations can implement leading practices on their own, they are encouraged to ensure that integrated care is woven into improvement plans by co-developing their QI plans with organizations in other sectors. This can be achieved as part of an Ontario Health Team's (OHT) Collaborative QIP (cQIP) or for organizations who are not part of an OHT in collaboration with one or more of their care delivery partners.

Individual QI targets can simultaneously address multiple priority initiatives (ALC, sfCare, accreditation, etc.). This guide integrates many of the practices from the sfCare Framework (11), the Frail Seniors Guidance on Best Practice Rehabilitative Care in the Context of COVID-19 (12), the Transitions Between Hospital and Home - Care for People of All Ages Quality Standard (10) the Delirium Quality Standard (13) and insights from research conducted with patients designated as ALC, their designated caregiver / substitute decision maker (SDM) and providers (14,15). As a result, the ALC Leading Practices guide aligns directly with specific Required Organizational Practices (ROP) and High Priority criteria in the 2019 Accreditation Canada Standards (16–19) and with all ten recommendations that comprise the Regional Geriatric Program (RGP) of Toronto's sfCare Self-Assessment Tool (20).

Leading Practices that demonstrate alignment to Accreditation Canada (AC) Standards are identified by an * throughout this guide. A supplementary document is available that includes a full list of the aligned AC Standards.

Leading Practices that demonstrate alignment to the sfCare Self-Assessment tool are identified by sf throughout this guide. A supplementary document is available that demonstrates specific alignment to the sfCare Self-Assessment tool.

Who is "At Risk" of Delayed Transitions in Care

All older adults who receive care in the emergency department or in acute or post-acute care may be at risk of protracted stays (signalled by an ALC designation) unless leading practices for the prevention and management of ALC are in place. This risk increases when older adults live with multiple, complex and often interacting health and social conditions.

In the hospital setting (emergency department, acute care and post-acute care), common characteristics of individuals at risk of delayed transitions in care (hereinafter referred to as "at-risk") include:

- Over the age of 65, with increasing risk noted over the age of 75 (21–24);
- An admitting diagnosis that includes general medical illness (e.g. infections), falls, and dementia (21,25,26);
- Presence of functional or cognitive impairments, and multiple comorbidities (27–29);
- Experience of adverse events during admission – functional decline, delirium, falls, social isolation (14,21–23,25,27,30–33); and
- Caregiver stress (34)

Glossary

ALTERNATE LEVEL OF CARE (ALC) – is defined by the Canadian Institute for Health Information as a description used in hospitals to refer to patients who occupy a bed but do not require the intensity of services provided in that care setting (35).

ALC DISCHARGE DESTINATION (DD) - refers to the location determined by the physician or delegate in collaboration an interprofessional team (when available), as to where a patient is to be discharged or transferred to (36).

AT RISK – older adults at risk of delayed transitions in care.

DESIGNATED CAREGIVER – is defined in the context of the sfCare Framework. Caregivers are people who are involved in an older adult's care, but who are not paid, such as family or friends. Older adults are partners in care, as are their caregivers, when identified as such by the older adult. A "designated caregiver" is someone who the older adult identifies as their care partner.

GERIATRIC CARE – is provided by health care professionals who specialize in the care of older adults (e.g. Geriatricians, GEM nurses). Geriatric specialists use a comprehensive geriatric assessment to diagnose, treat and rehabilitate older adults with frailty (or those at risk of becoming frail) with complex and multiple medical, functional, and psychosocial issues.

NEXT BEST LEVEL OF CARE –is the location determined by the physician or delegate, in collaboration with an interprofessional team (when available), as to where a patient should be discharged or transferred to, based on the care needs of the patient, irrespective of whether or not the discharge destination is available, accessible and/or exists within the community (36). May also be known by clinicians as "most appropriate discharge destination" (MADD)).

OLDER ADULT – is defined in the context of the sfCare Framework as someone who is 65 years or older, with the understanding that adults with complex age-related conditions may be younger than this and also benefit from senior friendly care (11).

PERSON-CENTRED CARE – is a care approach that focuses on the needs of the person and their goals for care. These principles are part of sfCare.

REHABILITATIVE CARE – is a care approach that focuses on maintaining or restoring functionality or developing adaptive capacity. Rehabilitative Care for older adults aligns with Senior Friendly Care (sfCare) and is part of an interprofessional approach to care. It is delivered by geriatric specialists and health care providers who have the knowledge and skill in the provision of sfCare. *The Framework for Rehabilitative Care* (12) provides the foundation for what rehabilitation of older adults looks like in an organization.

SENIOR FRIENDLY CARE (sfCare) – is evidence-based, preventive and proactive care for the unique needs of older adults. It is not an add-on to care; it is essential care that should be provided at all times. Senior friendly processes of care include: delirium, mobilization, social engagement, nutrition, pain, polypharmacy, and urinary incontinence. *The sfCare Framework* (11) provides the foundation for what sfCare looks like in an organization, including the need for all care providers to have the knowledge and skill required to provide sfCare.

STAFF – is any individual who may provide care or interact with an older adult and their designated caregiver / Substitute Decision Maker (SDM).

The Leading Practices

The leading practices defined within this guide were developed based on the best available evidence and are organized around the older adult's journey in the hospital setting. The guide describes the leading practices that are required to achieve three key goals:

A. **Integrate sfCare as the foundation of care across the organization** – this goal is addressed by leading practices that focus on:

- Organizational Leadership & Support; and
- Older Adult & Caregiver Communication & Involvement

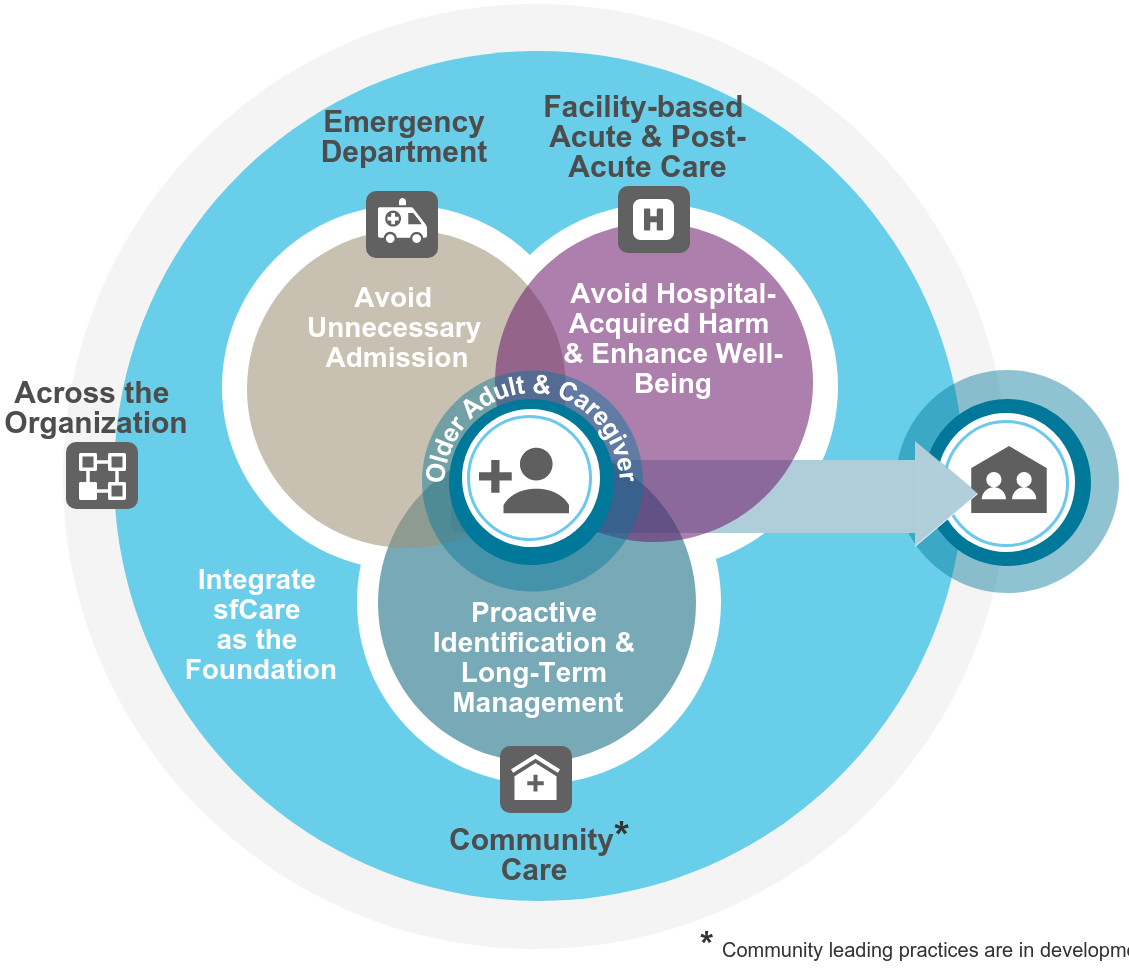
B. **Ensure practices and structures are in place in the Emergency Department (ED) to avoid unnecessary admission** - this goal is addressed by leading practices that focus on:

- Early Identification & Assessment;
- Care Plan Development & Ongoing Reassessment;
- Intervention/ Senior Friendly Care Processes; and
- Proactive Transitions

C. **Avoid hospital-acquired harm & enhance well-being in Facility-based Acute and Post-Acute Care areas** – consistent with the ED, this goal is addressed by leading practices that also focus on:

- Early Identification & Assessment;
- Care Plan Development & Ongoing Reassessment;
- Intervention/ Senior Friendly Care Processes; and
- Proactive Transitions

Leading Practices across the Older Adult & Caregiver Journey



A. Leading Practices across the organization

Embedding sfCare as the foundation of care requires an organization-wide approach and the commitment of senior leaders. sfCare approaches improve the quality of patient care, foster desired outcomes and contribute to reduced length of stay (LOS) and ALC.

GOAL: Integrate sfCare as the foundation of care

This goal aligns to the Accreditation Canada (AC) Standard "Services are co-designed to meet the needs of an aging population"(17) and is considered High Priority criteria.

Organizational Leadership & Support	
Leading Practices	**Tool(s)**
1. A member of the Senior Leadership team (such as a vice president) is designated as accountable for sfCare (8). **sf**	sfCare-Hospital-Policy-Brief (8)
2. Commitments to sfCare are included in the organization's strategic plan, operating plan, and/or corporate goals and objectives (11,37). **sf**	sfCare Self-Assessment

Organizational Leadership & Support	
Leading Practices	**Tool(s)**
3. A sfCare self-assessment is completed to understand the current state of senior friendly care delivery within the organization and opportunities for improvement. **sf** 4. A set of ALC-related process and outcome measures are collected, monitored and regularly reviewed by senior leaders, managers, physicians and staff.* **sf** 5. Functional decline and delirium are recognized as preventable harms and risk to the safety of older adults (8). **sf** 6. The structures, spaces, equipment, and furnishings provide an environment that minimizes the vulnerabilities of older adults and promotes safety, comfort, functional independence and well-being (37). **sf** 7. Clinicians who specialize in geriatric care are available 7 days a week to support a comprehensive assessment and care of older adults (38). **sf** 8. A training plan is in place for all staff, physicians, and volunteers so that they are proficient in the provision of sfCare, including (8,11,14,37): a. Seniors' sensitivity - i.e., communication, general awareness on aging and the special needs of older adults with frailty, and recognizing and addressing ageism; **sf** b. Delirium prevention and management* **sf**; and c. Mobilization* **sf** 9. Training is provided to hospital staff and physicians to ensure clarity about: a. How early transition planning is incorporated into the admission process and monitored (9); b. when to recommend an ALC designation (9). 10. Guiding documents (e.g., polices, standards, procedures, guidelines, care pathways etc.) reflect senior friendly values and principles; promote older adults' health, autonomy, dignity and participation in care; and ensure that an older adult will not be denied access to care or the opportunity to participate in research or quality improvement activities based solely on their age, as applicable (11,37). **sf** 11. Formal partnerships are in place with care delivery partners to support smooth and timely transitions from the ED, acute and post-acute care (e.g., pre-arrangements negotiated through Memoranda of Understanding and/or Purchase of Service Agreements) (10).* **sf** 12. Policies and procedures are in place to ensure ongoing reassessment occurs over the course of an older adult's admission. This includes intensive assessment of older adults who are long-stay ALC (22). 13. An escalation process is in place which provides clear direction about when and how to engage leadership in discussions around challenging barriers to transition for older adults at risk of an avoidable admission or potential ALC designation. (9). This	Tool (20) sfCare Toolkit - RGP Toronto (37) OHQ - Transitions in Care Quality Standard (10)

Organizational Leadership & Support	
Leading Practices	**Tool(s)**
includes non-punitive audit and feedback as part of an overall performance and quality improvement evaluation.	
Older Adult & Caregiver Communication & Involvement	
Leading Practices	**Tool(s)**
14. A process is in place to ensure that the older adult and their designated caregiver / Substitute Decision Maker (SDM) are included as part of the care team (11). * sf 15. The care plan, goals of care, and expected results of care are developed in collaboration with all members of the care team and the older adult and their designated caregiver / SDM, and are flexible and aligned with the older adult's preferences (what matters most) (11,14,37,39). * sf 16. The older adult and their designated caregiver are provided with information in their preferred format to let them know what to expect in their care, help them make decisions, and better self-manage their conditions (11,37). This includes being provided with: * sf a. Information on mobilization and delirium prevention to support the prevention of functional decline (8); b. The tools to support health literacy and language needs (an advocate, interpreter, etc.) so they can fully participate in their care; and c. Information on the role of the hospital, the SDM, co-payment costs, and a plan to participate in transition planning (9). 17. A system is in place to measure the experience and outcomes of older adults and their designated caregivers /SDMs and make improvements based on the results (9,11,37). sf	The Caregiver Identification (ID) Initiative (40) Communication Tool.pdf (14,41) Caregiving Strategies - RGPs of Ontario (42)

B. Leading Practices in the ED

The care provided in ED has the opportunity to 'set the stage' for subsequent care provided throughout the older adult's care trajectory (43). The older adult population accounts for a large, and ever increasing proportion of ED visits (43). The majority of "at-risk" older adults ultimately designated ALC are admitted through the emergency department (23).

GOAL: Avoid Unnecessary Admission

Early Identification & Assessment

Leading Practices	Tool(s)
1. A screening process/tool is used for early identification of "at risk" older adults presenting to the ED, regardless of presenting issue and inclusive of social factors, (24,43,44). The risk screen should tie directly into the comprehensive assessment (45).* **sf** 2. An interprofessional team who has skills and expertise in the assessment and management of older adults with frailty is available to support assessment and care of the older adult including (45):* **sf** a. Geriatric Emergency Management Nurse (GEM); b. Social Worker; c. Home and Community Care case manager; d. Physiotherapist, Occupational Therapist, Pharmacist, Behavioural Support clinicians, and other health professionals as needed; and e. Consultation with geriatric physician specialists (geriatric medicine, geriatric psychiatry, Care of the Elderly) as indicated. 3. A comprehensive assessment is initiated, which accounts for physical, cognitive, functional, and psychosocial domains, and includes:(45,46).* **sf** a. A collateral history from a designated caregiver / SDM, or primary care provider (47). b. Identification of baseline functional status (e.g. two weeks prior to illness onset). This is essential to determining the nature of the presenting complaint c. Identification of goals of care, outstanding care needs, and what matters most to the older adult and designated caregiver / SDM (e.g., what are they most concerned about in the short term and long-term?) (14,48,49).	CTAS Frailty Modifier (50) The Identification of Seniors at Risk (ISAR) (51) Blaylock (52) Clinical Frailty Scale (CFS)(53) Interprofessional Comprehensive Geriatric Assessment (54) Baseline Function_NESGC 202 (55) Geri-EM (45) Trial Tool (56) 'Information about me' (57)

Care Plan Development & Ongoing Reassessment

Leading Practices	Tool(s)
4. A plan of care is developed by all members of the care team with the older adult and their designated caregiver / SDM and relevant community partners to address care needs with a focus on transition to the pre-admission destination (11,22,48).* **sf**	

5. Frequent re-assessment of an older adult's status is an essential part of the care process so that changes and resulting support needs are identified as early as possible, and the care plan and goals of care are adjusted accordingly (23). **sf**	
Intervention/Senior Friendly Care	
Leading Practice	**Tool(s)**
6. A senior friendly care approach is implemented and includes: a. Processes for screening, prevention, management, and monitoring of functional decline (8). * **sf** b. Processes for screening, prevention, management, and monitoring of delirium (37,44). * **sf**	Senior Friendly Care Learning Series (58)
Proactive Transitions	
Leading Practices	**Tool(s)**
7. Transition protocols are in place that facilitate the timely communication of clinically relevant information to the older adult and their designated caregiver / SDM and primary care providers, including long term care homes (43). **sf** 8. Where appropriate, a clinical decision unit/short stay unit has been considered to support the development of a more comprehensive plan for their transition to the next best level of care or place for care. A protocol is developed and in-place (e.g. pre-printed order set) (24,43). 9. In partnership with the older adult and their designated caregiver / SDM, the medication reconciliation process is initiated for older adults with a decision to admit, and can be completed on the receiving unit (18).* **sf** 10. Processes are in place to transition individuals directly to the next best level of care to meet their presenting needs e.g., bedded rehabilitative care.* **sf**	Transitions into Long-Term Care for Older Adults with Responsive Behaviours (59) RCA Direct Access Priority Process (DAPP) (60) RCA ED Post Falls Pathway (61)

C. Leading Practices in Facility-based Acute and Post-Acute Care Areas

GOAL: Avoid Hospital-Acquired Harm & Enhance Well-Being

Processes are in place to prevent avoidable harm such as delirium and functional decline while treating and providing rehabilitation from acute illness, and to transition older adults to their next best level of care or place for care promptly.

Early Identification & Assessment	
Leading Practices	**Tool(s)**
1. Care delivery partners from all sectors who are already involved in the older adult's care are identified, contacted, and documented when the decision to admit is being made and collaborative information sharing is facilitated (10,37). **sf** 2. A designated caregiver / Substitute Decision Maker (SDM) or emergency contact is confirmed and documented (including contact details) within 48-hours of admission for all older adults.***** 3. The older adult has a medication review on admission. The review includes information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered and options are provided for those unable to afford these costs (10,17). *** sf** 4. Prior to ALC designation, a process is in place to ensure that the following occurs in partnership with older adults and their designated caregiver / SDM: **sf** a. Screening for early identification and risk-stratification as soon as possible upon admission (if not already completed in ED or if the older adult is a direct admission from the community) (9). This includes identification and documentation of baseline functional status (e.g. two weeks prior to admission/onset of illness) (25,32,48,49,62). b. An interprofessional team continues the comprehensive assessment (physical, cognitive, functional, and psychosocial domains), building from and integrating screening and assessment information that has already been collected (e.g., from care delivery partners, collateral history from the designated caregiver / SDM (10,45–47).***** c. A comprehensive geriatric assessment is completed when appropriate (e.g. when an increase in care for an extended length of time is anticipated), in partnership with the older adult and their designated caregiver / SDM (17).***** d. Determination of the older adult's functional goals and restorative potential to inform the plan of care (22,44,48,63). ***** e. Identification of barriers to transition (physical, social, financial, etc.). f. A referral, if appropriate, to relevant home and community care services or programs (9).	OH-Q Quality Standard: Transitions (10)  (55) Trial Tool (56) 'Information about me' (57) ISAR (51); CFS (53) Interprofessional Comprehensive Geriatric Assessment (54) RCA Referral Decision Tree (48)

Care Plan Development & Ongoing Reassessment	
Leading Practices	**Tool(s)**
5. Care needs are clearly identified and person-centred goals are developed to address these needs (e.g., what is the change between baseline and current state across the physical, cognitive, functional, and psychosocial domains) (14,48,49). **sf** 6. A plan of care is developed with the older adult and their designated caregiver / SDM and relevant community partners to address the identified care needs with a focus on transition to the community (11,22,48).* **sf** 7. There is a process for establishing the Estimated Discharge Date (EDD)(9). This process must be specific to each older adult and not dependent upon blanket EDD assumptions. **sf** 8. All older adults and their designated caregiver / SDMs are provided with an (EDD): within 48 hours of admission to acute care and within 4 days of admission to post-acute care. This also includes a conversation around the transition plan. EDD is reassessed frequently and adjusted to reflect changing clinical need and communicated with the older adult and designated caregiver/SDM (24,44).* **sf** 9. All older adults are assessed daily in acute care and post-acute care so that changes in medical/functional status and resulting support needs are identified as early as possible. The care plan and EDD, and any updates, are reviewed with the older adult and their designated caregiver/SDM and adjusted (23,49,64). **sf**	
Intervention/Senior Friendly Care	
Leading Practices	**Tool(s)**
10. A minimum standard of daily care (7days/week) delivered by an interprofessional team is in place for all older adults (regardless of ALC designation/discharge destination) to help them maintain and restore function while in hospital so that they are not prevented from returning home as a result of hospital-acquired deconditioning (23). The standard of care includes general hygiene, and senior friendly processes of care that address:* **sf** a. Mobilization: screening for functional decline; re-assessment of functional status at least weekly (8); and tailored mobilization interventions specific to their level of mobility and functional goals which supports participation in activities of daily living, physical activity, and self-care. b. Delirium: screening and monitoring for delirium(37,44); tailored intervention to prevent delirium; and older adults with delirium having a multicomponent interprofessional management plan (8). c. Social engagement d. Nutrition e. Pain	sfCare Toolkit - RGP Toronto (37) PIECES of my Personhood (65)

f. Polypharmacy g. Continence	

Proactive Transitions	
Leading Practices	**Tool(s)**
11. The older adult has a named health care professional who is responsible for timely transition planning, coordination, and communication, and the older adult and designated caregiver /SDM will have their contact information in case they have questions (10,14). Before the older adult leaves the hospital, this person ensures an effective transfer (early and timely) of transition plans and information related to the older adult's care (10,14). **sf** 12. A transition plan is developed with the older adult and their designated caregiver / SDM and relevant community partners early in the admission to address care needs, care preferences, and barriers to discharge, with a focus on transition to the community first (9).* **sf** 13. An approach is in place to support the older adult, their designated caregiver / SDM, and staff in challenging ethical situations such as when there are differing perspectives around the EDD or transition plan. This could include holding a family meeting and/or consulting additional resources. **sf** 14. There is a scheduled opportunity for the interdisciplinary team to review all older adults identified as "at-risk"(e.g. "at-risk" (ALC) rounds) at least weekly (9). 15. "At-risk" (ALC) rounds include the following: a. Chaired and/or attended by a representative at a director/vice-president-level (9). b. Internal stakeholders (i.e., managers, front line staff etc.). The older adult and their designated caregiver / SDM, along with physicians, are also included in team rounds (14,24). c. Key external agencies are invited to participate as required (i.e., home care coordinator or community support services representatives) (9). d. Discussion includes a review of risks for each older adult (e.g. outstanding	Communication Tool.pdf (14,41) OH-Q Transitions Quality Standard (10)

care needs and impact on delayed discharge) (9). 16. An "at-risk" resolution table is developed, where challenging barriers to transition can be discussed and addressed. 17. The older adult has a final medication review before returning home. This review includes information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and options are provided for those unable to afford these costs (10,17).* **sf** 18. The older adult is assessed for the type, amount, and appropriate timing of home care and community support services they and their caregivers need. When these services are needed, they are arranged before the older adult leaves the hospital and are in place when they return home (10). **sf** 19. A written transition plan, developed by and agreed upon in partnership with the older adult and their designated caregiver / SDM, the hospital team, and primary care and home and community care providers is given to the older adult 2 days prior to leaving hospital. Transition plans are shared with the person's primary care and home and community care providers and any relevant specialist providers within 48 hours of discharge (10). **sf** 20. Transition plans incorporate referrals and consideration for programs, services or self-care activities to restore/maintain function recognizing the prevalence of functional decline after a hospital stay (49,66). **sf** 21. The health care team explains to the older adult what publicly-funded services are available to them and what services they will need to pay for. The older adult's ability to pay for any out-of-pocket health care costs is considered by the health care team. Options for those unable to afford these costs are included in transition plans. (10). **sf**	June 2019 TCLHIN Final Service Resoluti OH-Q Transitions Quality Standard (10) Patient Oriented Discharge Summary (PODS) Toolkit (67) Transitions into Long-Term Care for Older Adults with Responsive Behaviours (59) OH-Q Transitions Quality Standard (10)

References

1. Institute for Healthcare Improvement. Achieving Hospital-wide Patient Flow (Second Edition). 2020.
2. Kleinpell RM, Fletcher K, Jennings BM. Reducing Functional Decline in Hospitalized Elderly. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Agency for Healthcare Research and Quality (US); 2008.
3. Canadian Patient Safety Institute. What is Quality and Patient Safety? [Internet]. [cited 2021 Jan 30]. Available from: https://www.patientsafetyinstitute.ca/en/toolsResources/GovernancePatientSafety/Pages/WhatisQualityandPatientSafety.aspx
4. Guilcher SJT, Everall AC, Cadel L, Li J, Kuluski K. A qualitative study exploring the lived experiences of deconditioning in hospital in Ontario, Canada. BMC Geriatr [Internet]. 2021 Dec 1 [cited 2021 May 23];21(1):1–9. Available from: https://doi.org/10.1186/s12877-021-02111-2
5. Covinsky KE, Palmer RM, Fortinsky RH, Counsell SR, Stewart AL, Kresevic D, et al. Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: Increased vulnerability with age. J Am Geriatr Soc [Internet]. 2003 Apr 1 [cited 2020 Nov 25];51(4):451–8. Available from: https://pubmed.ncbi.nlm.nih.gov/12657063/
6. Sager MA. Functional Outcomes of Acute Medical Illness and Hospitalization in Older Persons. Arch Intern Med [Internet]. 1996 Mar 25 [cited 2020 Nov 25];156(6):645. Available from: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/621749
7. Gill TM, Allore HG, Holford TR, Guo Z. Hospitalization, Restricted Activity, and the Development of Disability Among Older Persons [Internet]. jamanetwork.com. [cited 2020 Nov 25]. Available from: https://jamanetwork.com/
8. Regional Geriatric Program of Toronto. Policy Brief - Guidance for hospital senior leaders as they re-design care in pandemic times and beyond. 2020.
9. Cancer Care Ontario - Access to Care. Alternate Level of Care Leading Practices User Guide. 2017.
10. Ontario Health Quality. Transitions Between Hospital and Home Care for People of All Ages. 2020.
11. Regional Geriatric Program of Toronto. The Senior Friendly Care Framework [Internet]. 2017 [cited 2020 Sep 2]. Available from: https://www.rgptoronto.ca/wp-content/uploads/2018/04/sfCare-Framework-and-10-Recommendations.pdf
12. Rehabilitative Care Alliance. Frail Seniors - Guidance on Best Practice Rehabilitative Care in the Context of COVID-19 [Internet]. 2020 [cited 2020 Nov 15]. Available from: http://www.rehabcarealliance.ca/uploads/File/Initiatives_and_Toolkits/Frail_Seniors/Frail_Seniors_Guidance_Document.pdf
13. Ontario Health Quality. Delirium Care for Adults Quality Standard. 2021.
14. Kuluski K, Ho JW, Cadel L, Shearkhani S, Levy C, Marcinow M, et al. An alternate level of care plan: Co-designing components of an intervention with patients, caregivers and providers to address delayed hospital discharge challenges. Heal Expect [Internet]. 2020 Jun 30 [cited 2020 Sep 2];hex.13094. Available from: https://onlinelibrary.wiley.com/doi/abs/10.1111/hex.13094
15. Kuluski K, Im J, McGeown M. “It’s a waiting game” a qualitative study of the experience of carers of patients who require an alternate level of care. BMC Health Serv Res. 2017 May 2;17(1).
16. Accreditation Canada. Leadership. 2019.
17. Accreditation Canada. Inpatient Services. 2019.

18. Accreditation Canada. Emergency Department. 2019.
19. Accreditation Canada. Rehabilitation Services. 2019.
20. Regional Geriatric Program of Toronto. sfCare Self Assessment Tool [Internet]. 2021 [cited 2021 Feb 5]. Available from: https://forms.rgptoronto.ca/sfcare-self-assessment-tool/
21. Costa AP, Hirdes JP. Clinical characteristics and service needs of alternate-level-of-care patients waiting for long-term care in Ontario hospitals. Vol. 6, Healthcare Policy. Longwoods Publishing Corp.; 2010. p. 32–46.
22. Walker D, Lead A. Caring For Our Aging Population and Addressing Alternate Level of Care Report Submitted to the Minister of Health and Long-Term Care. 2011.
23. Bender D, Holyoke P. Why some patients who do not need hospitalization cannot leave: A case study of reviews in 6 Canadian hospitals. Healthc Manag Forum. 2018;3(4):121–5.
24. Burr E, Dickau S, McLead AM, Neary MA, McCarthy MK, Morey-Hollis M, et al. Alternate Level of Care Leading Practices User Guide. 2017.
25. McCloskey R, Jarrett P, Stewart C et al. Alternate level of care patients in hospital: What does dementia have to do with htis? Can Geriatr J [Internet]. 2014;17(3):88–94. Available from: http://dx.doi.org/10.5770/cgj.17.106
26. Manville M, Fcfp MD, Klein MC, Fcps F, Med LB. Improved outcomes for elderly patients who received care on a transitional care unit. Can Fam Physician. 2014;60:263–71.
27. Bhatia D, Peckham A, Abdelhalim R, King M. Alternate Level of Care and Delayed Discharge: Lessons Learned from Abroad. Toronto North Am Obs Heal Syst Policies [Internet]. 2020 [cited 2020 Sep 2];(22). Available from: https://ihpme.utoronto.ca/research/research-centres-initiatives/nao/rapid-reviews/rapid-review-22/
28. Moore G, Hartley P, Romero-Ortuno R. Health and social factors associated with a delayed discharge amongst inpatients in acute geriatric wards: A retrospective observational study. Geriatr Gerontol Int [Internet]. 2018 Apr 1 [cited 2020 Sep 2];18(4):530–7. Available from: http://doi.wiley.com/10.1111/ggi.13212
29. Turcotte LA, Perlman CM, Fries BE, Hirdes JP. Clinical predictors of protracted length of stay in Ontario Complex Continuing Care hospitals. BMC Health Serv Res [Internet]. 2019 [cited 2020 Sep 2];19(1). Available from: https://doi.org/10.1186/s12913-019-4024-2
30. Cheng I, Baker GR, Carew D, Landau S, Walko D, Li W, et al. Improving the Use of Healthcare Resources in Canadian Hospitals: The Impact of a Reintegration Unit in Expanding Acute Care Capacity and Resource Use in Sunnybrook Health Sciences Centre. BMC Health Serv Res [Internet]. 2020 May 1 [cited 2020 Sep 2]; Available from: https://www.researchsquare.com/article/rs-23776/v1
31. Mcgilton KS, Vellani S, Babineau J, Bethell J, Bronskill SE, Burr E, et al. Understanding transitional care programmes for older adults who experience delayed discharge: a scoping review protocol. BMJ Open [Internet]. 2019;9:32149. Available from: http://bmjopen.bmj.com/
32. Peel NM, Hubbard RE, Gray LC. Impact of Post-Acute Transition Care for Frail Older People: A Prospective Study. J frailty aging [Internet]. 2013 [cited 2020 Sep 2];2(3):165–16571. Available from: https://pubmed.ncbi.nlm.nih.gov/27070816/
33. Fox MT, Persaud M, Maimets I, O'brien K, Brooks D, Tregunno D, et al. Effectiveness of Acute Geriatric Unit Care Using Acute Care for Elders Components: A Systematic Review and Meta-Analysis. J Am Geriatr Soc. 2012;60:2237–45.
34. Everall AC, Guilcher SJT, Cadel L, Asif M, Li J, Kuluski | Kerry, et al. Patient and caregiver experience with

delayed discharge from a hospital setting: A scoping review. Heal Expect. 2019;22:863–73.

35. Canadian Institute for Health Information (CIHI). Guidelines to Support ALC Designation [Internet]. 2020 [cited 2020 Dec 7]. Available from: https://www.cihi.ca/en/guidelines-to-support-alc-designation
36. Ontario Health Access to Care. Alternate Level of Care (ALC) Reference Manual, version 2. 2017.
37. Regional Geriatric Program of Toronto. sfCare Getting Started Toolkit. 2018.
38. Horgan S. Designing Integrated Care for Older Adults Living with Complex and Chronic Health Needs: A Scoping Review. 2020.
39. Valenzuela PL, Ortiz-Alonso J, Bustamante-Ara N, Vidán MT, Rodríguez-Romo G, Mayordomo-Cava J, et al. Clinical Medicine Individual Responsiveness to Physical Exercise Intervention in Acutely Hospitalized Older Adults. J Clin Med [Internet]. 2020:797. Available from: www.mdpi.com/journal/jcm
40. The Change Foundation. Visually Recognizing Caregivers: The Caregiver Identification (ID) initiative [Internet]. 2019 [cited 2020 Nov 27]. Available from: https://changefoundation.ca/caregiver-id/
41. Trillium Health Partners Institute for Better Health. Communication Tool for ALC Patients, Caregivers and Care Providers. 2020.
42. Regional Geriatric Programs of Ontario. Caregiving Strategies - RGPs of Ontario [Internet]. 2019 [cited 2020 Sep 26]. Available from: https://rgps.on.ca/caregiving-strategies/
43. American College of Emergency Physicians. POLICY STATEMENT Geriatric Emergency Department Guidelines. 2019.
44. NELHIN. Rural Hospital ALC Leading Practices Guide. 2019.
45. Melady D. Geri-EM Personalized E-learning in Geriatric Emergency Medicine. 2013.
46. Sanon M, Hwang U, Abraham G, Goldhirsch S, Richardson L. ACE Model for Older Adults in ED. Geriatrics [Internet]. 2019 Feb 21 [cited 2020 Sep 18];4(1):24. Available from: http://www.mdpi.com/2308-3417/4/1/24
47. Fitzpatrick D, Doyle K, Finn G, Gallagher P. The collateral history: an overlooked core clinical skill. Eur Geriatr Med [Internet]. 1999;1:3. Available from: https://doi.org/10.1007/s41999-020-00367-2
48. Rehabilitative Care Alliance. Referral Decision Tree for Rehabilitative Care [Internet]. 2014 [cited 2020 Sep 2]. Available from: http://www.rehabcarealliance.ca/uploads/File/Toolbox/Definitions/Referral_Decision_Tree_for_Rehabilitative_Care_FINAL__Dec_11_2014_.pdf
49. Covinsky KE, Pierluissi E, Johnston CB. Hospitalization-associated disability “She was probably able to ambulate, but i’m not sure.” JAMA - J Am Med Assoc [Internet]. 2011 Oct 26 [cited 2020 Sep 2];306(16):1782–93. Available from: https://pubmed.ncbi.nlm.nih.gov/22028354/
50. Bullard MJ, Musgrave E, Warren D, Unger B, Skeldon T, Grierson R, et al. Revisions to the Canadian Emergency Department Triage and Acuity Scale (CTAS) Guidelines 2016. [cited 2020 Sep 26]; Available from: https://doi.org/10.1017/cem.2017.365
51. McCusker J, Bellavance F, Cardin S, Trépanier S, Verdon J, Ardman O. Detection of older people at increased risk of adverse health outcomes after an emergency visit: The ISAR screening tool. J Am Geriatr Soc [Internet]. 1999 Oct 1 [cited 2020 Sep 26];47(10):1229–37. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/j.1532-5415.1999.tb05204.x
52. Alberta Health Services. Blaylock Discharge Planning Risk Assesment Screen [Internet]. [cited 2020 Sep 26]. Available from: https://www.albertahealthservices.ca/frm-09373.pdf
53. Rockwood K. Clinical Frailty Scale - Geriatric Medicine Research - Dalhousie University [Internet]. [cited

2020 Sep 26]. Available from: https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html

54. Kay K, Hawkins SA, Day AM, Briscoe M, Reg O, Daly D, et al. A Competency Framework for Interprofessional Comprehensive Geriatric Assessment Final Report RGP Project Team. 2017.
55. North East Specialized Geriatric Centre. Baseline Functional Status. 2021.
56. Mount Sinai Hospital. Baseline Functional Assessment Tool. 2013.
57. Applied Research Collaboration - West. "Sometimes more fundamental information is needed, not just what's medically wrong" [Internet]. 2020 [cited 2020 Nov 25]. Available from: https://arc-w.nihr.ac.uk/news/sometimes-there-is-more-fundamental-information-thats-needed-not-just-whats-medically-wrong-with-a-person/
58. Regional Geriatric Program of Toronto. Senior Friendly Care Learning Series | Regional Geriatric Program of Toronto [Internet]. 2019 [cited 2020 Sep 26]. Available from: https://www.rgptoronto.ca/resources/senior-friendly-care-learning-series/
59. Behavioural Supports Ontario. Supporting Successful and Sustainable Transitions into Long-Term Care for Older Adults with Responsive Behaviours/Personal Expressions Critical Elements & Guiding Checklist [Internet]. 2019 [cited 2021 Jan 30]. Available from: www.behaviouralsupportsontario.cawww.brainxchange.ca
60. Rehabilitative Care Alliance. Direct Access Priority Process (DAPP) | Rehab Care Alliance [Internet]. 2014 [cited 2020 Sep 19]. Available from: http://www.rehabcarealliance.ca/direct-access-priority-process-dapp
61. Rehabilitative Care Alliance. Pathway to rehabilitative care for frail older adults in the community presenting to Emergency Department post-fall and not requiring acute hospitalization [Internet]. 2019 [cited 2020 Sep 19]. Available from: http://www.rehabcarealliance.ca/uploads/File/Initiatives_and_Toolkits/Frail_Seniors/ED_Post-fall_Rehabilitative_Care_Pathway_-_FINAL_DRAFT.pdf
62. Na L, Hennessy S, Xie D, Saliba D, Pan Q, Kwong PL, et al. Premorbid Activity Limitation Stages Are Associated with Posthospitalization Discharge Disposition. Am J Phys Med Rehabil [Internet]. 2018 Jun 1 [cited 2020 Sep 3];97(6):440–9. Available from: /pmc/articles/PMC5955772/?report=abstract
63. Rehabilitative Care Alliance. Frail Seniors Rehabilitative Care Best Practice Framework Bedded Levels of Care [Internet]. 2020 [cited 2020 Sep 2]. Available from: https://www.rgps.on.ca/wp-content/uploads/2019/03/A-Competency-Framework.pdf
64. Liebzeit D, King B, Bratzke L, Boltz M. Improving Functional Assessment in Older Adults Transitioning from Hospital to Home. Prof Case Manag [Internet]. 2018 Nov 1 [cited 2020 Sep 3];23(6):318–26. Available from: /pmc/articles/PMC6176726/?report=abstract
65. Northeast Behavioural Supports Ontario. PIECES of my Personhood [Internet]. [cited 2021 Jan 30]. Available from: https://northeast.behaviouralsupportsontario.ca/335/PIECES_of_my_Personhood/
66. Fimognari FL, Pierantozzi A, De Alfieri W, Salani B, Zuccaro SM, Arone A, et al. Medical Sciences cite as. J Gerontol A Biol Sci Med Sci [Internet]. 2017;72(1):102–8. Available from: https://academic.oup.com/biomedgerontology/article/72/1/102/2629923
67. University Health Network OpenLab. PODS | A toolkit to create your own patient oriented discharge summary. [Internet]. [cited 2021 Jan 30]. Available from: https://pods-toolkit.uhnopenlab.ca/

This is Exhibit “E” to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

Adam John Kouri,
A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

Ontario Health

Self-Assessment Tool: Alternate Level of Care (ALC) Leading Practices to Prevent Hospitalization and Extended Stays for Older Adults

September 2021

Document Version: V1

HOW TO USE THIS TOOL

This implementation tool is intended to be used in conjunction with the *Leading Practices to Prevent Hospitalization and Extended Stays for Older Adults (2021)*. *<ADD LINK>*

For each leading practice: Under "Status", click "Select", then click the arrow beside "Select". A drop-down menu appears. Click one of the three drop-down choices to indicate your organization's status in implementing the leading practice:

Met	Your organization(s) or OHT can clearly demonstrate that the leading practice has been implemented and **sustained**. The leading practice occurs 80% of the time.
Partial	Your organization(s) or OHT has taken SOME steps towards implementing the leading practice. The leading practice occurs between 60-80% of the time.
Unmet	Your organization(s) or OHT has taken NO steps towards implementing the leading practice. The leading practice being assessed occurs less than 60% of the time.

NOTE: For acute and post-acute areas, all applicable units must have implemented and sustained the leading practice in order to select the status of "Met".

If some units have not implemented and sustained the leading practice, select "Partial" instead.

For OHT's, all applicable organizations must have implemented and sustained the leading practice in order to select the status of "Met".

If some organizations have not implemented and sustained the leading practice, select "Partial" instead.

Use the "Implementation Notes" section to add details about how your hospital has met the leading practice, plans to meet it, or any identified challenges in meeting the practice. Refer to the *Hospital Alternate Level of Care (ALC) Leading Practices Guide* (2021) for suggested implementation tools.

Designate an implementation team- ideally, an interdisciplinary team (which may include clinical leaders with geriatric expertise, quality improvement staff and individuals focusing on transitions and flow as part of their core portfolios) would take the lead in championing the leading practices by working across the ED and applicable hospital units to review and complete the self-assessment and set priorities moving forward for ongoing implementation, monitoring and assessment.

Develop a manageable plan: Celebrate the successes that your organization has already accomplished, and build on these successes by creating a manageable plan. To do this, decide on a few priorities, including some "quick wins" to start with and make a plan to achieve these goals.

LEGEND

*** -** Leading Practices that demonstrate alignment to Accreditation Canada (AC) Standards. A supplementary document is available that includes a full list of the aligned AC Standards.

sf - Leading Practices that demonstrate alignment to the sfCare Self-Assessment tool. A supplementary document is available that demonstrates specific alignment to the sfCare Self-Assessment tool.

SELF-ASSESSMENT TOOL

A. Priority Leading Practices across the Organization

GOAL: Senior friendly care (sfCare) as the foundation of care

Senior Friendly Care (sfCare) is evidence-based, preventive and proactive care for the unique needs of older adults. It is not an add-on to care; it is essential care that should be provided at all times. Senior friendly processes of care include: delirium, mobilization, social engagement, nutrition, pain, polypharmacy, and urinary incontinence. *The sfCare Framework* provides the basis for what sfCare looks like in an organization, including the need for all care providers to have the knowledge and skill required to provide sfCare.

Embedding sfCare as the foundation of care requires an organization-wide approach and the commitment of the senior leaders. sfCare approaches improve the quality of care for older adults, foster desired outcomes and contribute to reduced length of stay (LOS) and ALC.

This goal aligns directly to the Accreditation Canada (AC) Standard "Services are co-designed to meet the needs of an aging population" and is considered High Priority criteria.

Organizational Leadership & Support	Overall Assessment of this Practice		Supporting Information
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
1. A member of the Senior Leadership team (such as a vice president) is designated as accountable for sfCare. **sf**	Select		
2. Commitments to sfCare are included in the organization's strategic plan, operating plan, and/or corporate goals and objectives. **sf**	Select		
3. A sfCare self-assessment is completed to understand the current state of senior friendly care delivery within the organization and opportunities for improvement. **sf**	Select		

4. A set of ALC-related process and outcome measures are collected, monitored and regularly reviewed by senior leaders, managers, physicians and staff.* **sf**	Select		
5. Functional decline and delirium are recognized as preventable harms and risk to the safety of older adults. **sf**	Select		
6. The structures, spaces, equipment, and furnishings provide an environment that minimizes the vulnerabilities of older adults and promotes safety, comfort, functional independence and well-being. **sf**	Select		
7. Clinicians who specialize in geriatric care are available 7 days a week to support a comprehensive assessment and care of older adults. **sf**	Select		
8. A training plan is in place for all staff, physicians, and volunteers so that they are proficient in the provision of sfCare, including: a. Seniors' sensitivity - i.e. communication, general awareness on aging and the special needs of older adults with frailty, and recognizing and addressing ageism; **sf**	Select		
b. delirium prevention and management* **sf**	Select		
c. mobilization* **sf**	Select		

9. Training is provided to hospital staff and physicians to ensure clarity and consistency regarding: a. How early transition planning is incorporated into the admission process and monitored.	Select		
b. When to recommend an ALC designation.	Select		
10. Guiding documents (e.g. polices, standards, procedures, guidelines, care pathways etc.) reflect senior friendly values and principles; promote older adult's health, autonomy, dignity and participation in care; and ensure that an older adult will not be denied access to care or the opportunity to participate in research or quality improvement activities based solely on their age, as applicable. **sf**	Select		
11. Formal partnerships are in place with care delivery partners to support smooth and timely transitions from the ED, acute and post-acute care (e.g. pre-arrangements negotiated through Memoranda of Understanding and/or Purchase of Service Agreements).***** **sf**	Select		
12. Policies and procedures are in place to ensure ongoing reassessment occurs over the course of an older adult's admission. This includes intensive assessment of older adults who are long-stay ALC.	Select		

13. An escalation process is in place which provides clear direction about when and how to engage leadership in discussions around challenging barriers to transition for older adults at risk of an avoidable admission and potential ALC designation. This includes non-punitive audit and feedback as part of an overall performance and quality improvement evaluation.	Select		
Older Adult & Caregiver Experience & Communication	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
14. A process is in place to ensure that the older adult and their designated caregiver / Substitute Decision Maker (SDM) are included as part of the care team.* sf	Select		
15. The care plan, goals, and expected results of care are developed in collaboration with all members of the care team and the older adult and their designated caregiver / SDM, and are flexible and aligned with the older adult's preferences (what matters most). * sf	Select		
16. The older adult and their designated caregiver / SDM are provided with information in their preferred format to let them know what to expect in their care, help them make decisions, and better self-manage their conditions (10,32). This includes being provided with: * sf	Select		

a. Information on mobilization and delirium prevention to support the prevention of functional decline;			
b. The tools to support health literacy and language needs (an advocate, interpreter, etc.) so they can fully participate in their care; and	Select		
c. Information on the role of the hospital, the SDM, co-payment costs, and a plan to participate in transition planning.	Select		
17. A system is in place to measure the experience and outcomes of older adults and designated caregivers / SDMs and make improvements based on the results. **sf**	Select		

B. Priority Leading Practices in the ED

GOAL: Ensure Practices & Structures are in Place to Avoid Unnecessary Admission

The care provided in the ED has the opportunity to 'set the stage' for subsequent care provided throughout the older adult's care trajectory. The older adult population accounts for a large and ever increasing proportion of ED visits. The majority of "at-risk" older adults ultimately designated ALC are admitted through the emergency department.

Early Identification & Assessment	Overall Assessment of this Practice		Supporting Information
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
1. A screening process/tool is used for early identification of "at risk" older adults presenting to the ED, regardless of presenting issue and inclusive of social factors. The risk screen should tie directly into the comprehensive assessment.* **sf**	Select		
2. An interprofessional team who has skills and expertise in the assessment and management of older adults with frailty is available to support assessment and care of the older adult including:* **sf**	Select		
a. Geriatric Emergency Management Nurse (GEM);	Select		
b. Social Worker;	Select		
c. Home and Community Care coordinator;	Select		
d. Physiotherapist, Occupational Therapist, Pharmacist, Behavioural Support clinicians, and other health professionals as needed; and	Select		

e. Consultation with geriatric physician specialists (geriatric medicine, geriatric psychiatry, Care of the Elderly) as indicated.	Select		
3. A comprehensive assessment is initiated, which accounts for physical, cognitive, functional, and psychosocial domains, and includes:* **sf**	Select		
a. A collateral history from a designated caregiver, SDM, or primary care provider.	Select		
b. Identification of baseline functional status e.g. 2 weeks prior to illness onset.	Select		
c. Identification of goals of care, outstanding care needs, and what matters most to the older adult and designated caregiver / SDM (e.g., what are they most concerned about in the short term and long-term?).	Select		
Care Plan Development & Ongoing Reassessment	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practice	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
4. A plan of care is developed by all members of the care team with the older adult and their designated caregiver / SDM and relevant community partners to address care needs with a focus on transition to the pre-admission destination.* **sf**	Select		

5. Frequent re-assessment of an older adult's status is an essential part of the care process so that changes and resulting support needs are identified as early as possible, and the care plan and goals of care are adjusted accordingly. **sf**	Select		
Intervention/sfCare	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
6. A senior friendly approach to care is implemented and includes: a. Processes for screening, prevention, management, and monitoring of functional decline.* **sf**	Select		
b. Processes for screening, prevention, management, and monitoring of delirium.* **sf**	Select		
Proactive Transitions	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
7. Transition protocols are in place that facilitate the timely communication of clinically relevant information to the older adult and their designated caregiver / SDM and primary care providers, including long term care homes. **sf**	Select		

8. Where appropriate, a clinical decision unit/short stay unit has been considered to support the development of a more comprehensive plan for their transition to the next best level of care or place for care. A protocol is developed and in-place (e.g. pre-printed order set).	Select		
9. In partnership with the older adult and their designated caregiver / SDM, the medication reconciliation process is initiated for older adults with a decision to admit, and can be completed on the receiving unit.* sf	Select		
10. Processes are in place to transition individuals directly to the next best level of care to meet their presenting needs e.g. bedded rehabilitative care.* sf	Select		

C. Priority Leading Practices in Facility-based Acute and Post-Acute Care Areas

GOAL: Avoid Hospital-Acquired Harm & Enhance Well-being

Processes are in place to prevent avoidable harm such as delirium and functional decline while treating and providing rehabilitation from acute illness, and to transition older adults to their next best level of care or place for care promptly.

Early Identification & Assessment	Overall Assessment of this Practice		Supporting Information
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
1. Care delivery partners from all sectors who are already involved in the older adult's care are identified, contacted, and documented when the decision to admit is being made and information sharing is facilitated. **sf**	Select		
2. A designated caregiver / SDM or emergency contact is confirmed and documented (including contact details) within 48-hours of admission for all older adults.*	Select		
3. The older adult has a medication review on admission. The review includes information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and	Select		

options are provided for those unable to afford these costs.* **sf**			
4. Prior to ALC designation, a process is in place to ensure that the following occurs in partnership with older adults and their designated caregiver / SDM: **sf** a. Screening for early identification and risk-stratification as soon as possible upon admission (if not already completed in ED or if the older adult is a direct admission from the community). This includes identification and documentation of baseline functional status e.g. 2 weeks prior to admission/onset of illness.	Select		
b. An interprofessional team continues the comprehensive assessment (physical, cognitive, functional, and psychosocial domains), building from and integrating screening and assessment information that has already been collected (e.g. from care delivery partners, collateral history from the designated caregiver / SDM).*	Select		
c. A comprehensive geriatric assessment is completed, when appropriate (e.g. when an increase in care for an extended length of time is anticipated), in	Select		

partnership with the older adult and their designated caregiver / SDM.*			
d. Determination of the older adult's functional goals and restorative potential to inform the plan of care.*	Select		
e. Identification of barriers to discharge (physical, social, financial, etc.).	Select		
f. A referral, if appropriate, to relevant home and community care services or programs.	Select		
Care Plan Development & Ongoing Reassessment	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
5. Care needs are clearly identified and person-centred goals are developed to address these needs (e.g. what is the change between baseline and current state across the physical, cognitive, functional, and psychosocial domains). **sf**	Select		
6. A plan of care is developed with the older adult and their designated caregiver / SDM and relevant community partners to address the identified care needs with a focus on transition to the community.* **sf**	Select		
7. There is a process for establishing the Estimated Discharge Date (EDD). This process must be	Select		

specific to each older adult and not dependent upon blanket EDD assumptions. **sf**			
8. All older adults and their designated caregivers / SDMs are provided with an Estimated Discharge Date (EDD): within 48 hours of admission to acute care and within 4 days of admission to post-acute care. This also includes a conversation around the transition plan. EDD is reassessed frequently and adjusted to reflect changing clinical need and communicated with the older adult and designated caregiver / SDM.* **sf**	Select		
9. All older adults are assessed daily in acute care and post-acute care so that changes and resulting support needs are identified as early as possible. The care plan and EDD are reviewed with the older adult and their designated caregiver / SDM and adjusted accordingly. **sf**	Select		
Intervention/sfCare	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
10. A minimum standard of daily care (7days/week) delivered by an interprofessional team is in place for all older adults (regardless of ALC designation/discharge destination) to help them maintain and restore function while in hospital so that they are not prevented from returning home as a result of hospital-acquired deconditioning. The standard of care includes general hygiene,	Select		

and senior friendly processes of care that address:* **sf**			
a. Mobilization: screening for functional decline; re-assessment of functional status at least weekly; and tailored mobilization interventions specific to their level of mobility and functional goals which supports participation in activities of daily living, physical activity, and self-care.	Select		
b. Delirium: screening and monitoring for delirium; tailored intervention to prevent delirium; and older adults with delirium having a multicomponent interprofessional management plan.	Select		
c. Social engagement	Select		
d. Nutrition	Select		
e. Pain	Select		
f. Polypharmacy	Select		
g. Continence	Select		
Proactive Transitions	**Overall Assessment of this Practice**		**Supporting Information**
Leading Practices	**Status**	**Implementation notes**	**Validation (Data, Forms, Processes, etc.)**
11. The older adult has a named healthcare professional who is responsible for timely transition planning, coordination, and	Select		

Ontario Health

communication, and the older adult and designated caregiver /SDM will have their contact information in case they have questions. Before the older adult leaves the hospital, this person ensures an effective transfer (early and timely) of transition plans and information related to the older adult's care. **sf**			
12. A transition plan is developed with the older adult and their designated caregiver / SDM and relevant community partners early in the admission to address care needs, care preferences, and barriers to discharge, with a focus on transition to the community first.***** **sf**	Select		
13. An approach is in place to support the older adult, their designated caregiver / SDM, and staff in challenging ethical situations such as when there are differing perspectives around the EDD or transition plan. This could include holding a family meeting, and/or consulting additional resources **sf**	Select		
14. There is scheduled opportunity for the interdisciplinary team to review all older adults identified as "at-risk"(e.g. "at-risk" (ALC) rounds) at least weekly .	Select		
15. "At-risk" (ALC) rounds include the following: a. Chaired and/or attended by a representative at a director/vice-president-level;	Select		

b. Internal stakeholders (i.e., managers, front line staff etc.). The older adult and their designated caregiver / SDM, along with physicians, are also included in team rounds;	Select		
c. Key external agencies are invited to participate as required (i.e., home care coordinator or community support services representatives); and	Select		
d. Discussion includes a review of risks for each older adult (e.g. outstanding care needs and impact on delayed discharge).	Select		
16. An "at-risk" resolution table is developed, where challenging barriers to transition can be discussed and addressed.	Select		
17. The older adult has a final medication review before returning home. This review includes information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and options are provided for those unable to afford these costs.* **sf**	Select		
18. The older adult is assessed for the type, amount, and appropriate timing of home care and community support services they and their caregivers need. When these services are needed,	Select		

they are arranged before the older adult leaves the hospital and are in place when they return home. **sf**			
19. A written transition plan, developed by and agreed upon in partnership with the older adult and their designated caregiver / SDM, the hospital team, and primary care and home and community care providers is given to the older adult 2 days prior to leaving hospital. Transition plans are shared with the person's primary care and home and community care providers and any relevant specialist providers within 48 hours of discharge. **sf**	Select		
20. Transition plans incorporate referrals and consideration for programs, services or self-care activities to restore/maintain function recognizing the prevalence of functional decline after a hospital stay. **sf**	Select		
21. The healthcare team explains to the older adult what publicly-funded services are available to them and what services they will need to pay for. The older adult's ability to pay for any out-of-pocket health care costs is considered by the healthcare team. Options for those unable to afford the costs are included in transition plans. **sf**	Select		

This is Exhibit “F” to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

Adam John Kouri,
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While a Student-at-Law
Expires August 16, 2026.

Alternate Level of Care (ALC) Clinical Care Guideline

PURPOSE

To deliver care that is congruent with patient needs as defined by the patient's health status, treatment plan and goals.

BACKGROUND

A patient is designated "Alternate Level of Care" (ALC) when they are occupying a bed in a hospital and do not require the intensity of resources/services provided in unit's care setting. The ALC wait period starts at the time of designation and ends either 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.

In order to provide care congruent with the discharge destination, this guideline outlines the appropriate level of interventions and monitoring associated with the ALC designation. Discussion with the entire healthcare team, including the patient and their family, is needed to assess appropriate plan of care; but, the patient can only be designated or removed from ALC designation by the physician or their delegate.

DEFINITIONS

ALC: Alternate Level of Care

EXPECTED OUTCOMES

1. A plan of care will be developed when designation changes from acute to ALC Status and should be developed in collaboration with the patient/family/substitute decision maker that is tailored to the individual patient care needs. The plan of care should be documented in Cerner to improve communication and continuity of care.
2. The plan of care will be updated weekly and PRN during "Care Rounds." Revisions and updates to the plan should be completed by the assigned nurse in collaboration with the patient/family.
3. A complete head-to-toe assessment will be performed and documented with designation change and weekly as appropriate every Monday.
4. Vital signs which includes Temperature, Pulse, Respiratory Rate, Blood Pressure and Oxygen Saturation and PCNA / NEWS will be completed once weekly on Mondays and PRN if warranted by a medication or a change in patient condition.

   NOTE: Physician's order is required to change monitoring level, and discussion with MRP is necessary to ensure appropriate monitoring.
5. In addition to daily hygiene care (i.e. oral, peri. etc.), all ALC patients will receive a bath/shower weekly and PRN, on a specific day of the week as indicated in Nurse View Documentation. Braden Score/ skin assessment to be completed every shift and documented accordingly in nurse documentation.
6. ALC patients are weighed on admission, at designation change to ALC and every 4 weeks. Weights may be done more often if warranted by patient condition or by plan of care.

7. All care provided should be documented each shift in Nurse View Documentation as appropriate and a narrative note is to be completed every 24 hours e.g. Hygiene, Bowel Movement, Nutrition Intake, MFS, safety.
8. If at any time there is a change in the patient's condition, the nurse can escalate the frequency of patient assessments and vital signs monitoring to reflect the change in care requirements while awaiting orders from the MRP.

If patient needs or condition changes and the ALC designation no longer applies; the NP or MRP should change the patient's designation should be changed back to Acute Care.

Duties once ALC Designation Confirmed		
Duty	Frequency	Details:
Plan of Care	• Update at change of designation • Update weekly • PRN during Care Rounds	• Develop/Update in collaboration with patient/family
Head-to-Toe Assessment	• Update at change of designation • Update weekly (Mondays) as appropriate • PRN during Care Rounds	• Document in chart
Vital Signs (Includes Temp, Pulse, Resp Rate, BP & O_2 Saturation) PCNA, NEWS	• Update at change of designation • Update weekly with PCNA/ NEWS (Mondays) • PRN (i.e. a medication, change in condition)	• Document in chart • Physician's order is required to change monitoring level, discuss with MRP before changing
Hygiene Care	• Daily Hygiene Care (i.e. oral, peri, etc.,) • Weekly bath/shower & PRN • Braden Scale/ Skin assessment every shift	• Bath/Shower on a specified day of week as documented in Nurse View Documentation • Document skin assessment every shift
Weight	• On admission • At change of designation • Every 4 weeks • PRN if warranted	• Document in chart
All care	• Every shift - Document via Nurse View Documentation as appropriate • Include MFS and safety documentation • Every 24 hours - Document narrative note (i.e. Hygiene, Bowel Movement, Nutrition Intake)	
Change in patient's condition	• Nurse can escalate patient assessments & vital signs monitoring while awaiting MRP Orders • If ALC no longer applies - NP or MRP to change status back to Acute Care	

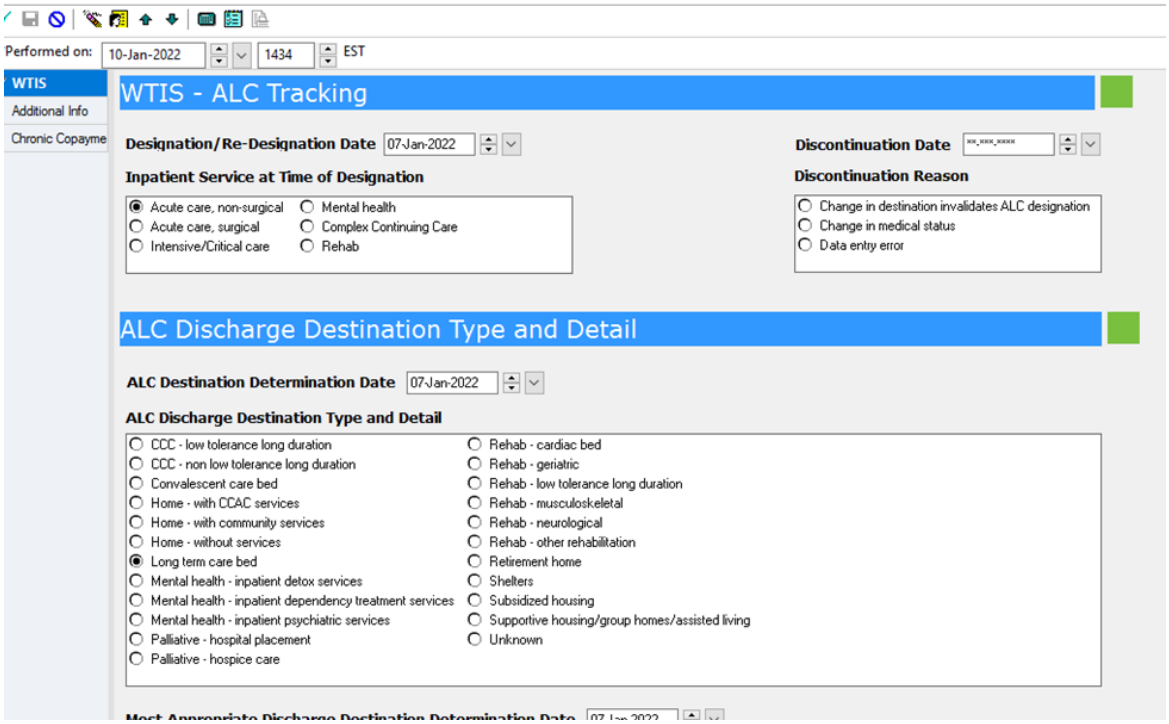
INTERVENTIONS

Once a patient is designated ALC implementation of this policy will occur. NOTE: A Physician's order is required to change monitoring level, and discussion with MRP is necessary to ensure appropriate monitoring.

REFERENCES

Guidelines to Support ALC Designation | CIHI, Definitions and Guidelines to Support ALC Designation in Acute Inpatient Care (cihi.ca)

RESOURCES


Performed on: 10-Jan-2022 1434 EST
WTIS
Additional Info
Chronic Copayme
WTIS - ALC Tracking
Designation/Re-Designation Date 07-Jan-2022
Discontinuation Date
Inpatient Service at Time of Designation
Acute care, non-surgical
Acute care, surgical
Intensive/Critical care
Mental health
Complex Continuing Care
Rehab
Discontinuation Reason
Change in destination invalidates ALC designation
Change in medical status
Data entry error
ALC Discharge Destination Type and Detail
ALC Destination Determination Date 07-Jan-2022
ALC Discharge Destination Type and Detail
CCC - low tolerance long duration
CCC - non low tolerance long duration
Convalescent care bed
Home - with CCAC services
Home - with community services
Home - without services
Long term care bed
Mental health - inpatient detox services
Mental health - inpatient dependency treatment services
Mental health - inpatient psychiatric services
Palliative - hospital placement
Palliative - hospice care
Rehab - cardiac bed
Rehab - geriatric
Rehab - low tolerance long duration
Rehab - musculoskeletal
Rehab - neurological
Rehab - other rehabilitation
Retirement home
Shelters
Subsidized housing
Supportive housing/group homes/assisted living
Unknown

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Standard Work

Job Name	ALC Huddle Standardized Work	Objective:	To standardize the escalation of corporate ALC numbers and review of ALC patient discharge plans with executive team	Date:	07-Feb-24
				Owner	VP of Access & Flow

	Process Steps	Freq
1	Director of Access and Flow will conduct bi weekly ALC Huddles with Patient Flow Managers	Bi Weekly
2	Director of effected program to notify Director of Access and Flow of ALC challenges as needed	As Needed
3	ALC Huddle is to be held at 1100 via Zoom between Met and OUE	2x Per Week
4	Patient Flow Manager to Include Manager of Social Worker/Social Designate of effected area to ALC Huddle as needed	As needed
5	Patient Flow Managers will update ALC Tracker on X-drive	Daily
6	Manager of Patient Flow to begin report our starting with MET Campus followed by Ouellette Campus 1. **Total number** of ALC patients and how many for **each ALC destination** 2. The # of patients being discharged this week, in next 2 weeks, in next 3 weeks & in next 4 weeks. Using the ALC tracking tool in the UNIT ROUNDS: X-drive folder 3. How many new potential NEW ALC patients are there? 4. Report if there is a patient waiting for a chronic vent bed?	Each Patient
7	4. Patient Flow Manager to report each patient (except patients who are waiting for a chronic vent bed): a) Room # & Patient Last Name c) How long has the patient been ALC? b) ALC for what destination? d) Barriers to discharge? (high level, ex. Finances, Trach, Competency, POA/SDM) e) Is there a solid discharge plan in place? 1) If no, what is the immediate 24hr action plan? (Including timeline) f) What is plan b? h) Is the Patient/SDM/POA in agreement with the discharge plan? g) What is the patients EDD?	Each Patient
8	Social Work Manager/Social Worker to support PFM in above and answer questions as needed	As Needed
9	Manager of Patient Flow to report out on the number of social admissions over the weekend/last 24 hours.	Daily
10	All other patient specific questions & additional conversations are to be left to the end of the huddle for discussion by individuals needed.	Daily

Visual Aid

ALC Huddle Threshold

Campus	Service	Campus Threshold
OUE	MED	18
	SURG	
MET	MED	10
	SURG	

Standardization & Optimization Process

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE—NO EXCEPTIONS!

Revision Date :

Review Date:

ALC Huddle Threshold		
Campus	**Service**	**Campus Threshold**
OUE	MED	18
	SURG	
MET	MED	10
	SURG	

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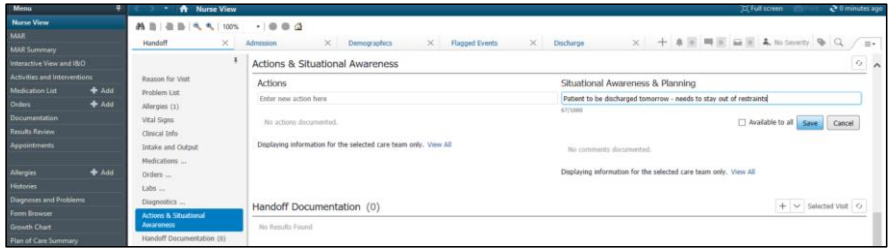
Standard Work

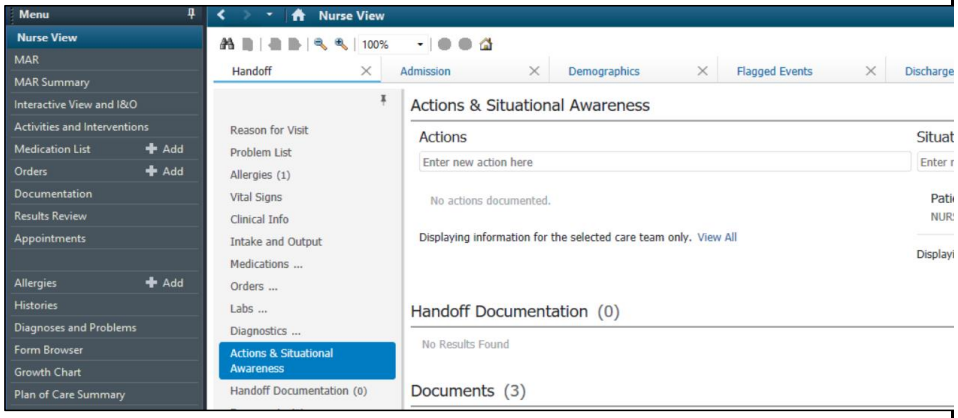
Job Name	Patient Flow - Discharge Planning - Standardized Work	Objective:	To standardize the discharge planning process to promote safe and timely discharges.	Date:	01-Mar-23
				Owner	VP of Patient Flow

		Process Steps	Freq
1	Admitting Nurse	**Within 4 hours of admission, completes:** - Blaylock assessment and tool - Complete mobility assessment and documentation - Discusses with MRP if PT or OT needed. Enter verbal order. (See PT/OT referral criteria) - If patient appropriate for Ambulation Assistant Mobilization, Enter AA referral	**Each Patient**
2	Patient Flow Lead	Within 24 hours(weekday)/72 hours(weekend) of admission review and confirms Blaylock tool face to face with patient	**Each Patient**
3	Patient Flow Lead	While confirming blaylock tool with patient - completes the following: 1) Introduces themselves as "Patient Flow Lead" who will oversee planning for discharge 2) Confirms information Admitting nurse assessed during Blaylock/Discharge Barriers 3) Asks patient what their plan/wishes for discharge are 4) Give patient Discharge Brochure	**Each Patient**
4	Patient Flow Lead	If Patient 10-20 or >20, communicate with POA/SDM/Family within first 3 days of admission (phone or in person). 1) Introduces themselves as "Patient Flow Lead" who will oversee planning for discharge 2) Discuss brief care plan and discharge considerations 3) Review with Family Discharge options - May need to arrange family meeting 4) Assess if Social Work/HCCSS consult appropriate. If appropriate, discuss with MRP. If MRP agrees, enter verbal order.	**Each Patient**
5	Patient Flow Lead	If Patient 0-9 after confirmation of Blaylock, Patient Flow Lead is needed minimally in patient Discharge Planning. Team to continue to review at Care Rounds and ensure no barriers arise.	**Each Patient**
7	Allied Health	If referred, assess patient within 24 hours of referral. If Unable to see within 24 hours. If unable to meet timeline, escalate to Manager of Allied Health for support.	**Each Patient**
8	Allied Health	Follow standard work for initial assessment, documenting appropriate initial assessment in Cerner. Sign off or Continue to follow as appropriate.	**Each Patient**
9	Patient Flow Lead	Determine EDD using EDD tool.	**Each Patient**
10	Patient Flow Lead	Within 24 hours(weekday)/72 hours(weekend) of admission, document in patients chart using charting template including the following: HEADER - "Patient Flow Lead" a) Patient Admitted from: b) Discharge Destination c) Transportation Arranged (Yes/No) d) Planned Discharge Date e) What is the current discharge plan? f) What needs to be done for the patient to be discharged? Patient and/or decision maker aware of plan?	**Each Patient**

Visual Aid

A





11	Patient Flow Lead	Document in patients chart - daily for acute patients. Every 3 days for ALC patients. Option to copy and paste previous note and update what has happened in previous 24/72 hours.	**Each Patient**
12	Patient Flow Lead	During first Care Rounds after admission, ensure EDD is added to the EDD space on staytrack board during care rounds	**Each Patient**
13	Patient Flow Manager	Update the FLOW Tracker on X-Drive daily for ALC/RRP/CMC patients.	**Each Patient**
14	Patient Flow Lead	Text Command Centre Nurse by 7:45am with all confirmed and possible discharges. Texts should continue throughout the day for any changes or new discharges.	**Each Patient**
15	Patient Flow Lead	MED ONLY - Lead Discharge Touchpoint following discharge touchpoint standard work.	**Daily**
16	Patient Flow Lead	Plan family meeting when SW not involved in case (within 3 days of admission if appropriate). Attendees include - Patient Flow Lead, HCSS (if needed), MRP (first 10 minutes if clinical concerns), and Patient Flow Manager (if escalations).	**As Needed**
17	Social Work	Plan family meetings when involved in case (within 3 days of admission if appropriate). Attendees include Patient Flow Lead (if needed), HCSS (if needed), MRP (first 10 minutes if clinical concerns), and Patient Flow Manager (if patient >20 / LTC trend).	**As Needed**
18	Social Work	Document in patients chart family meeting outcome. If Social Worker not present, Patient Flow Lead to document outcome.	**Each Patient**
19	Patient Flow Lead	As discharge plans change, communicate discharge plan with family, primary care nurse and MRP.	**Each Patient**
20	Patient Flow Lead	Add to Situational Awareness section of patients chart all pertinent goals for discharge/notify CPM (i.e. Mobility, patient to stay out of restraints) to flag care team. (Image A)	**As Needed**
21	Social Work	Collaborate with team and community partners for patients who will be discharged to a destination different then admission, New LTC, ODSP, OHIP, PG&T, Form Status, SDM, homeless, etc.	**As Needed**
22	Patient Flow Lead	Collaborate with team and ensure all appropriate steps are taken for patients who will be discharged to the same destination as admission/HDGH/returning to LTC.	**As Needed**
23	HCCSS	Collaborate with team and ensure all appropriate steps are taken for patients who will be discharged home with support.	**Each Patient**
24	Patient Flow Lead	Collaborate with Command Centre Nurse for all outgoing repatriations.	**As Needed**
25	Patient Flow Manager	Prepare all co-pay/refusal letters. If unable to give to patient/family in person, Medicine Administrative Assistant to send via mail.	**As Needed**
26	Patient Flow Lead	Notify Unit Clerk and primary care nurse of time to book transportation and discharge time.	**As Needed**
27	Unit Clerk	Using information provided by Patient Flow Lead, book all discharge transportation and fax/send paper work to discharge destination.	**As Needed**

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MET CAMPUS			OUE Campus		
Maryanne / Marie	Use Vibe/Firstnet		**Maryanne / Marie**	Use Vibe/Firstnet	
	Occupancy %,			Occupancy %	
	# of ALC			# of ALC	
	COVID +			COVID +	
	Dept in COVID-19 outbreak			Dept in COVID-19 outbreak	
IPAC					
Erika V	If outbreak units, are there are any restrictions with patient admissions/movement?		**Erika V**	If outbreak units, are there are any restrictions with patient admissions/movement?	
EMERGENCY DEPARTMENT					
Lisa/Charge/Covering	Staffing Up/Down/ Base		**Kuljeet/Charge/Covering**	Staffing Up/Down/ Base	
	Current available spaces			Current available spaces	
	# Admits in ED with Assigned bed			# Admits in ED with Assigned bed	
	ANB in ED			ANB in ED	
	ANB >24 hrs			ANB >24 hrs	
	Code 7s			Code 7s	
	# of Patients in Waiting Room			# of Patients in Waiting Room	
	Clinical Escalations			Clinical Escalations	
Director Plan **Kristen**	- If green for staffing = State If able to support other areas with staffing or beds. - If red for staffing = State plan - Flow Challenges = State plan and action items for team		**Director Plan** **Kristen**	If green for staffing or beds = state if able to support other areas with staffing or beds. If red/Yellow for staffing or beds = Plan needed	
OR DEPARTMENT					
Jennie or OM	PACU Staffing Up, Down or at Baseline		**Jennie or OM**	PACU Staffing Up, Down or at Baseline	
	# on NSSL list / # in Beds			# on NSSL list / # in Beds	
	Add on getting done during the day/night			Add on getting done during the day/night	
	Of those not getting done, how many are in beds?			Of those not getting done, how many are in beds?	
	Plan?			Plan?	

FAMILY BIRTHING PAEDS

Devon / Deb / Covering	Staffing Up/down/Base	
	State Current available beds	
	# available for female surgical patients	

PAEDS

Jen / Deb / Covering	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct Admissions	
Director Plan Deb	- If green for staffing = State If able to support other areas with staffing or beds. - If red for staffing = State plan - Flow Challenges = State plan and action items for team	

MENTAL HEALTH

Rio / Covering	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED/MHAU	
	ANB in ED/MAU	
	Confirmed/Predicted Discharges	
	PICU Beds Available	
	PICU ANB vs. Transfer Out	
	MHAU patients in ED	
Director Plan Luke	- If green for staffing = State If able to support other areas with staffing or beds. - If red for staffing = State plan - Flow Challenges = State plan and action items for team	

ICU

Lindsay / Cover	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Transfers out and transfer up greater than 24 hours	
	# OR's to place	
Katie / Cover	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Transfers out and transfer up greater than 24 hours	
	# OR's to place	
Director Plan Nicole	- If green for staffing = State If able to support other areas with staffing or beds. - If red for staffing = State plan - Flow Challenges = State plan and action items for team	

CCU

Elena / Cover	Staffing Up/down/Base	
Charge / Covering	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Transfers out and transfer up greater than 24 hours	
	# OR's to place	

4 MEDICAL

Amanda / Cover	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	# OR's to place	
	Direct Admissions	
Agnes / Cover	# of confirmed D/C	
	Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	

	<u>Director Plan</u> **Nicole**	- If green for staffing = State If able to support other areas with staffing or beds. - If red for staffing = State plan - Flow Challenges = State plan and action items for team

MEDICINE

6N		
Jeanette	Staffing Up/down/Base	
	Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
Lori/Covering	# of confirmed D/C	
	Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	

5N		
Jeanette	Staffing Up/down/Base	
	Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
Diane / Covering	# of confirmed D/C	
	Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	

4N		
Suanne	Staffing Up/down/Base	
	Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
Katie / Covering	# of confirmed D/C	
	Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	

4W		
Jen	Staffing Up/down/Base	
	Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
Cheryl / Cover	# of confirmed D/C	
	Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	
<u>Director Plan</u> Kristi	If green for staffing or beds = state if able to support other areas with staffing or beds If red/Yellow for staffing or beds = Plan needed Flow Challenges = State plan and action items for team	

7E		
Heather	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
Lisa/ Covering	State # of confirmed D/C	
	Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	

7W		
Heather	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
Cindy / Covering	State # of confirmed D/C	
	Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	

CTU		
Sommer	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
Kelly / Covering	State # of confirmed D/C	
	Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	

2N		
Sommer	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
Jeanine/ Covering	State # of confirmed D/C	
	Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	

IAU		
Sommer	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	

		ANB in ED	
		Direct admissions coming in	
	Jeanine / Covering	State # of confirmed D/C	
		Predicted discharges for today	
		Confirmed d/c by 11	
		Barriers PFM can't resolve	
	<u>Director Plan</u> Kristi	If green for staffing or beds = state if able to support other areas with staffing or beds If red/Yellow for staffing or beds = Plan needed Flow Challenges = State plan and action items for team	

SURGERY

8N

Daniella / Covering	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
	Number of beds need for surgeries today	
	SDJ Today	
Gloria / Covering	State # of confirmed D/C	
	# Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	
	Where will the unit land	

8W

Lynda / Covering	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
Jessica / Covering	State # of confirmed D/C	
	# Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	
	Where will the unit land	

7N

Daniella / Covering	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
Brenda / Covering	State # of confirmed D/C	
	# Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	
	Where will the unit land	

8E

Lynda / Covering	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
Lenore / Covering	State # of confirmed D/C	
	# Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	
	SDJ for today	
	Where will the unit land	

<u>Director Plan</u> **Kelly**	If green for staffing or beds = state if able to support other areas with staffing or beds If red/Yellow for staffing or beds = Plan needed Flow Challenges = State plan and action items for team

6E

Amy / Covering	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
	# of beds needed for surgeries today	
	SDJ today	
Lisa / Covering	State # of confirmed D/C	
	Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	

	# of surgical patients in a bed with no surgical date	
	Where will the unit land	
6W		
Amy / Covering	Staffing Up/down/Base	
	State Current available beds	
	Assigned admissions in ED	
	ANB in ED	
	Direct admissions coming in	
	# of beds needed for surgeries today	
	SDJ today	
Laurie / Covering	State # of confirmed D/C	
	Predicted discharges for today	
	Confirmed d/c by 11	
	Barriers PFM can't resolve	
	# of surgical patients in a bed with no surgical date	
	Where will the unit land	
<u>Director Plan</u> **Kelly**	If green for staffing or beds = state if able to support other areas with staffing or beds If red/Yellow for staffing or beds = Plan needed Flow Challenges = State plan and action items for team	

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Adam Kouri

A Commissioner for Taking Affidavits, etc.

Adam John Kouri,
A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

WRH Discharge Planning Policy

TABLE OF CONTENTS

PURPOSE

Windsor Regional Hospital (WRH) is required to promptly discharge patients when their acute medical needs have been met. Our goal is to provide all patients with the appropriate care and ensure hospital beds are available for patients who require surgery or are admitted from the emergency department. The purpose of Windsor Regional Hospital's Discharge Planning Policy is to set out principles and practices to follow when working with patients and families to support them in being discharged from hospital, and ensure patients have access to and receive care in the community most suited to their needs.

This policy also provides guidance on the recent legislative and regulatory changes. The newly enacted More Beds, Better Care Act, 2022 (Bill 7) is legislation aimed at facilitating the admission of eligible patients who are clinically determined as needing an Alternate Level of Care (ALC), from a hospital into a long term care home. In addition, the Bill amends the regulations under the Fixing Long Term Care Act (FLTCA) (2021) and the Public Hospital Act (PHA) to help to improve the flow of eligible Alternate Level of Care (ALC) patients to Long Term Care (LTC). Collectively, these key strategies support Ontario's Stay Open: Health System Stability and Recovery Plan. These changes help enable the health care system to provide the right care at the right time in the right place.

The More Beds, Better Care Act, 2022 (Bill 7) is intended to stabilize the health and long term care sectors and preserve hospital capacity. Bill 7 amends the Fixing Long Term Care Act (2021) and adds a new provision for patients who occupy a bed in a public hospital and are designated by an attending clinician as requiring an alternate level of care. The new provisions authorize certain actions to be carried out without the consent of the patient, provided that reasonable efforts have been made to obtain consent. The actions include having a Home and Community Care Support Services (HCCSS) placement coordinator determine the patient's eligibility for a long term care home, select a home and authorize their admission to the home. These legislative and regulatory changes went into effect **September 21, 2022.** Further regulatory amendments were made to the Public Hospitals Act (PHA), effective **November 20th, 2022**, requiring hospitals to charge discharged patients a standardized fee of $400 for every day they remain in hospital after discharge (following a 24 hour period).

SCOPE

This policy applies to all admitted patients being discharged from WRH.

POLICY

The hospital's discharge policy is grounded in a 'home first' philosophy, ensuring that, whenever possible, patients arriving in hospital are supported in returning to their home. However, when it is determined that long term care can best meet a patient's needs, it is essential that patients are compassionately and respectfully supported and informed at every stage in transitioning to long term care. In long term care, their health and personal care needs can be met and their independence, safety and quality of life enhanced. Coordinated and integrated communication between hospital staff, Home and Community Care Services (HCCSS) placement coordinators, patients, families, caregivers and substitute decision makers (SDMs) about hospital discharge and long term care placement will occur.

The transition process to long term care is rooted in the following evidence based guidelines:

1. Early and coordinated communication regarding discharge planning during the admission process
2. Patients, family, caregivers, and/or SDMs are meaningfully engaged as partners within the care team
3. A patient centered approach to care is taken that considers the unique needs of every patient
4. An equity lens is applied to all discharge planning processes
5. Clear, coordinated, comprehensive and timely dialogue and communication throughout the care transition process.

This policy sets out the following key principles:

KEY PRINCIPLES

1) Identify patients at risk at the earliest possible opportunity.

a. Windsor Regional Hospital will begin discharge planning at the earliest possible opportunity. Screening for risk of a complex discharge is a component of determining the need for early discharge planning.

b. Patients will be assessed on admission by a health care team member for current living arrangements and supports using the **Blaylock Discharge Planning Tool (in Cerner). See APPENDIX A: Blaylock Discharge Planning Tool Power Form.**

c. Discharge planning is a collaborative process which begins as early as possible to allow the patient, substitute decision maker (SDM), family and the care providers enough time to understand and explore the options for the most appropriate discharge plan.

2) Collaborate to promote patient flow throughout the organization and provide patient and family with the most relevant information throughout their hospital stay.

a. The hospital will have an established process to ensure timely access to an inpatient bed from the Emergency Department (ED).
b. The hospital will provide the patient and the interdisciplinary clinical team an Expected Date of Discharge (EDD), promoting home as the primary discharge destination.
c. The hospital will complete the repatriation/transfer process, utilizing the Provincial Hospital Resource System (PHRS) where applicable, returning a patient to their home acute care hospital, where applicable.
d. The Hospital will refer/transfer the patient to tertiary care where applicable e.g. Complex Continuing Care/ Palliative Care /Rehabilitation/Specialized Mental Health.

e. The hospital, in collaboration with Home and Community Support Services (HCSS) where applicable, will provide patient and family with all relevant information pertaining to their discharge, at admission and throughout their stay and prior to leaving the hospital. At admission a patient handout will be provided to facilitate early discussions about discharge. **See Appendix B: Handout for Patients and their Families/Caregivers Upon Admission.**

3) For residents of long term care homes that are under outbreak at the time of the resident's discharge from hospital.

Follow the Sample Transfer & Return Algorithm (page 77) for use during Outbreaks.

4) Discharge Order

When a patient no longer requires hospital care, the attending clinician will issue a Discharge Order that indicates the patient is ready for discharge. The discharge date will be communicated and reinforced by the clinical team to the patient/Substitute Decision Maker (SDM). Each member of the health care team, including Home and Community Care Support Services (HCSS), will be involved in the discharge planning process. Patient/Family discharge meetings will include the health system partners that are required to support the patient's discharge home. The discharge of a patient remains a clinical decision and is undertaken in consultation with the interdisciplinary health care team that facilitate ongoing dialogue with the patient, family, caregiver, or substitute decision maker.

5) Alternate Level of Care (ALC) Designation and Long-Term Care (LTC) Application

As part of the planning to help each patient safely transition home, the health care team, that includes the hospital and Home and Community Care Support Services (HCCSS), will ensure all options have been considered prior to designating a patient ALC for LTC. An ALC patient is defined as someone who occupies a bed in a hospital under the Public Hospital's Act, and has been designated by an attending clinician in the hospital as requiring alternate level of care because in the clinician's opinion, the person does not require the intensity of resources and/or services provided in the hospital care setting. This also allows for patients to receive those enriching services, activates and supports, such as social and physical activity, entertainment and organized dining that are available in long term care settings.

If the patient is designated as Alternate Level of Care (ALC) for a bed in Long Term Care and is waiting in an acute hospital bed, the hospital will provide the patient/SDM a letter informing them they have been designated ALC with a destination of long term care. In addition, the patient will be charged a daily hospital copayment charge. This copayment charge is the patient's contribution towards the cost of meals and accommodations. Hospitals are required to charge the daily chronic care copayment charge to ALC patients who are awaiting placement in a long term care home. Effective October 1, 2022, the maximum copayment rate is $63.73 per day or $1,938.46 per month. **See Appendix C: Windsor Regional Hospital Patient Co-Payment Letter.**

In addition, regulatory changes made to the Fixing Long Term Care Act (FLCTA), 2021, supporting Bill 7, provides authority to Home and Community Care Services (HCCSS) placement coordinators to admit a patient designated as ALC to a long term care home without their consent, as long as reasonable efforts have been made to obtain their consent. The selection of LTC homes by a HCCSS placement coordinator will be unlimited in number and will consider the patient's condition and circumstances and is based on the criteria set out in this amended regulation, such as: preferred class accommodation, proximity of the home to the preferred location within set geographic parameters (e.g. 70 km radius from the preferred location). Patients will be put on the existing long stay waitlist in the crisis category for the homes selected by the HCCSS placement coordinator and their preferred homes. They will remain in the crisis category of the waitlist until they are placed in a preferred home. Similar to the current process, the patient must move into the LTC home within five (5) days otherwise the bed may be offered to the next person on the waiting list.

Patient refusal to leave hospital.

The purpose of the Patient Refusal to Leave Letter is to set out guidelines for patients who are no longer in need of treatment in the hospital, yet want to remain in hospital. Under the amended Regulations under the *Public Hospitals Act*, (effective November 20, 2022), if a discharged patient remains in hospital for more than 24 hours after the date set out in the discharge order, the hospital shall charge the patient a fee of

$400 for each day that the patient remains in hospital. When a patient is in hospital waiting to be placed in a LTC Home, Home and Community Care will meet with the patient/SDM when a bed offer becomes available for them. If the patient/SDM decline the bed offer and refuse to leave the hospital, a letter will be issued implementing the $400 a day charge rate.

RESOURCES:

ONTARIO HOSPITAL ASSOCIATION (OHA)

- Media Statement on Bill 7
- Backgrounder - Bill 7: More Beds, Better Care Act 2022. August 2022.
- Backgrounder - Bill 7: Regulation Changes under the Fixing Long-Term Care Act, 2021. September 2022.
- Managing Transitions: A Guidance Document 2nd Ed.

  This guidance document was developed to support the standardization of policies and programs related to the transition and discharge of patients from hospitals once they no longer require the type of treatment and care offered at a particular facility. The guide will be updated to reflect Bill 7.
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- Summary of Regulation Changes under the *Fixing Long-Term Care Act*, 2021 (FLTCA)

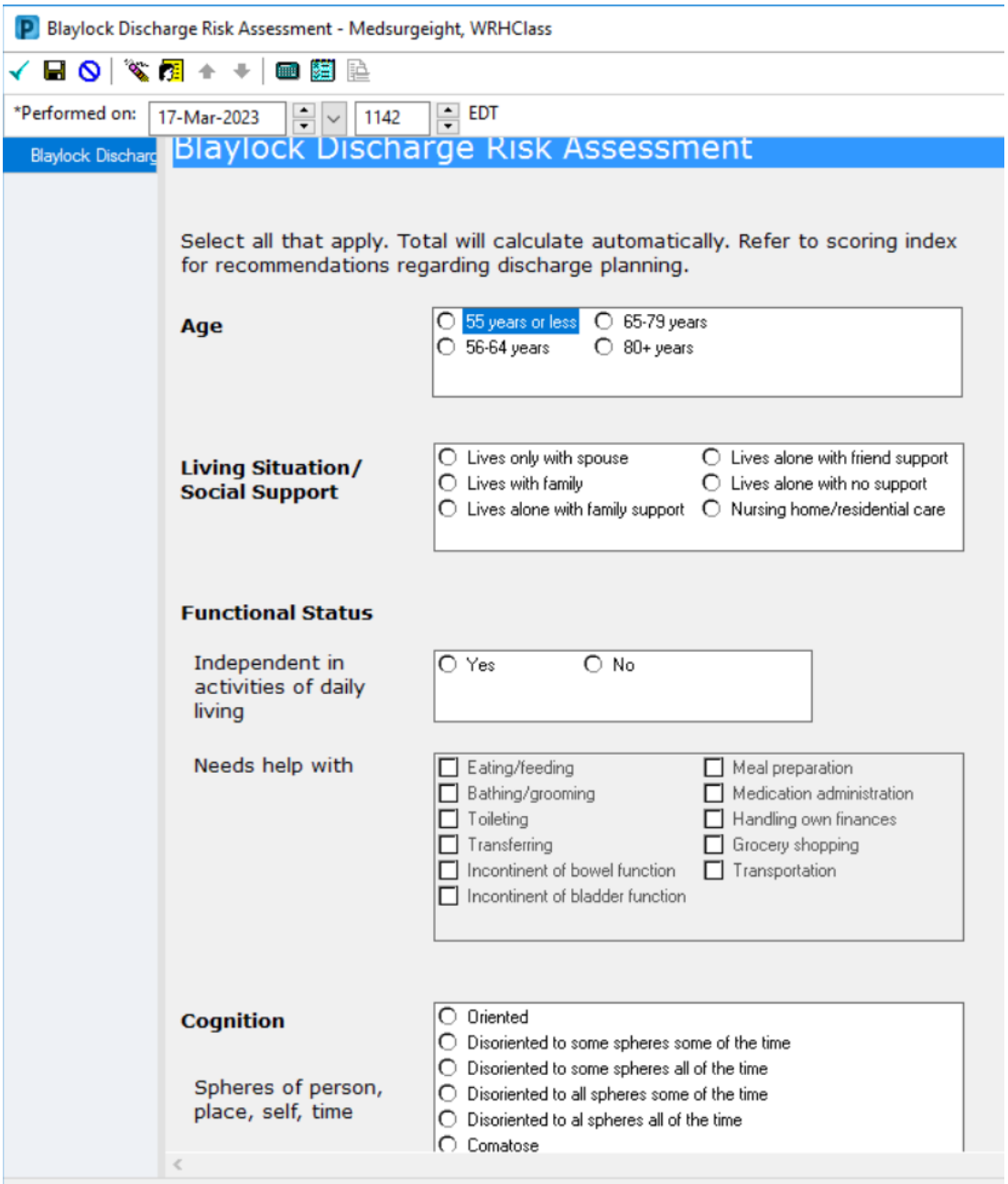
  Ministry of Health and Ministry of Long Term Care
- Hospital Chronic Care Co-Payment Questions and Answers

Hospital Communications on Bill 7

- On September 22, 2022, a number of Ontario hospital CEOs published an open letter that was featured in the Toronto Star.
- Windsor Regional Hospital / Erie Shores HealthCare / Chatham-Kent Health Alliance

APPENDIX A: BLAYLOCK DISCHARGE PLANNING TOOL (CERNER POWER FORM)

- Screenshots from Cerner:



Mobility
- ○ Ambulatory
- ○ Ambulatory with mechanical assistance
- ○ Ambulatory with human assistance
- ○ Non-Ambulatory

Sensory Deficits
- ☐ None
- ☐ Visual or hearing deficit
- ☐ Visual and hearing defici
- ☐ Speech deficit

Number of Active Medical Problems
- ○ Up to 3 medical problems
- ○ 3 to 5 medical problems
- ○ More than 5 medical probl

Number of Drugs
- ○ Fewer than 3
- ○ 3 to 5 drugs
- ○ More than 5 drugs

Number of Previous Admissions/ Emergency Visits
- ○ None in the last 3 months
- ○ One in the last 3 months
- ○ Two in the last 3 months
- ○ More than 2 in last 3 mon

Family Doctor
- ○ Yes ○ No

Number of Active Medical Problems
- ○ Up to 3 medical problems
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Number of Drugs
- ○ Fewer than 3
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Family Doctor
- ○ Yes ○ No

Behaviour Pattern
- ☐ Appropriate ☐ Other
- ☐ Wandering
- ☐ Agitated
- ☐ Confused

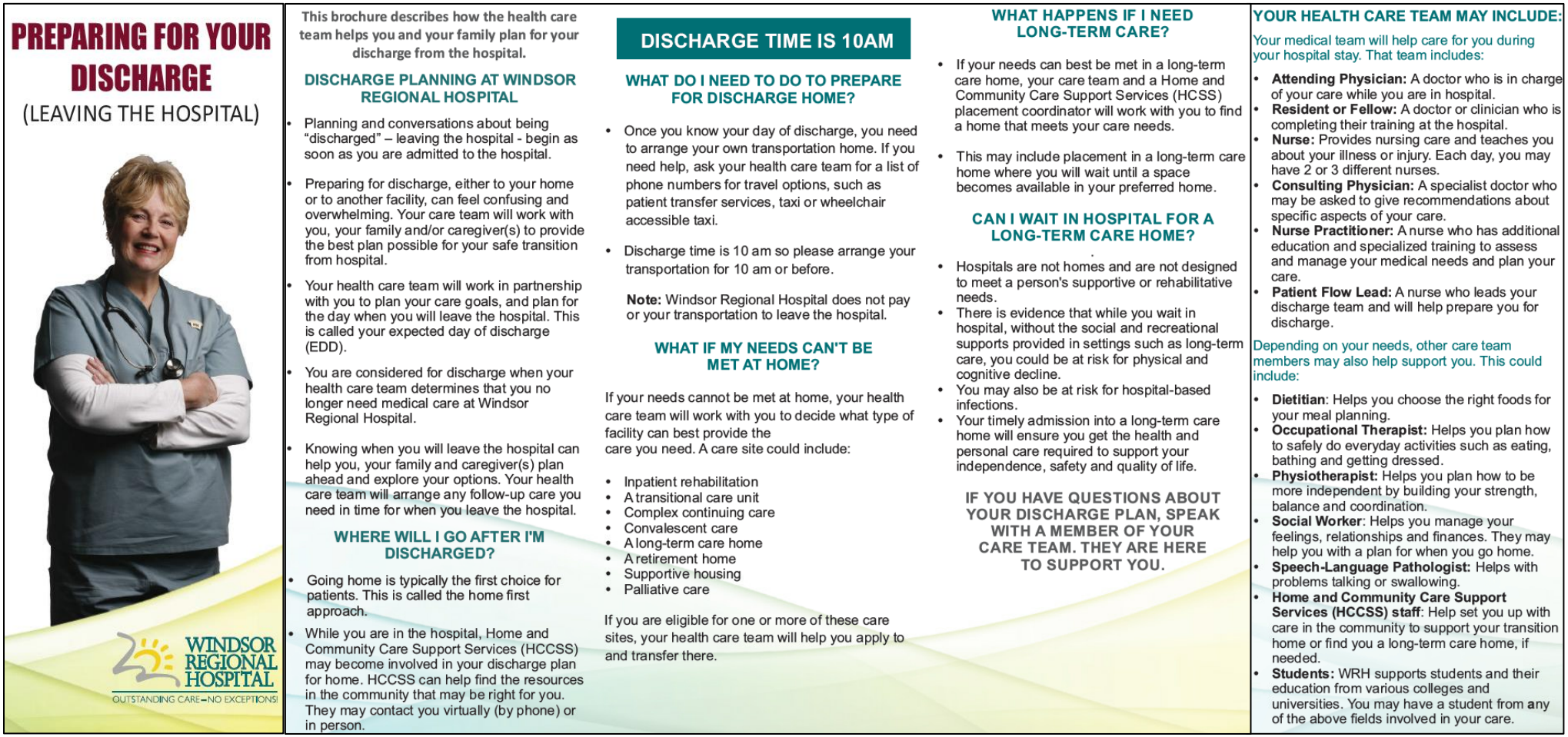
Total score

Scoring Index

0 to 9 : Probable outpatient physiotherapy or occupational therapy follow up
10 to 19 : May require Home and Community services
>20 : May require alternate level of care

APPENDIX B: HANDOUT FOR PATIENTS AND THEIR FAMILIES/CAREGIVERS UPON ADMISSION

- Link to Printable version
- Screenshot:



PREPARING FOR YOUR DISCHARGE

(LEAVING THE HOSPITAL)

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE—NO EXCEPTIONS!

This brochure describes how the health care team helps you and your family plan for your discharge from the hospital.

DISCHARGE PLANNING AT WINDSOR REGIONAL HOSPITAL

- Planning and conversations about being "discharged" – leaving the hospital - begin as soon as you are admitted to the hospital.
- Preparing for discharge, either to your home or to another facility, can feel confusing and overwhelming. Your care team will work with you, your family and/or caregiver(s) to provide the best plan possible for your safe transition from hospital.
- Your health care team will work in partnership with you to plan your care goals, and plan for the day when you will leave the hospital. This is called your expected day of discharge (EDD).
- You are considered for discharge when your health care team determines that you no longer need medical care at Windsor Regional Hospital.
- Knowing when you will leave the hospital can help you, your family and caregiver(s) plan ahead and explore your options. Your health care team will arrange any follow-up care you need in time for when you leave the hospital.

WHERE WILL I GO AFTER I'M DISCHARGED?

- Going home is typically the first choice for patients. This is called the home first approach.
- While you are in the hospital, Home and Community Care Support Services (HCCSS) may become involved in your discharge plan for home. HCCSS can help find the resources in the community that may be right for you. They may contact you virtually (by phone) or in person.

DISCHARGE TIME IS 10AM

WHAT DO I NEED TO DO TO PREPARE FOR DISCHARGE HOME?

- Once you know your day of discharge, you need to arrange your own transportation home. If you need help, ask your health care team for a list of phone numbers for travel options, such as patient transfer services, taxi or wheelchair accessible taxi.
- Discharge time is 10 am so please arrange your transportation for 10 am or before.

Note: Windsor Regional Hospital does not pay or your transportation to leave the hospital.

WHAT IF MY NEEDS CAN'T BE MET AT HOME?

If your needs cannot be met at home, your health care team will work with you to decide what type of facility can best provide the care you need. A care site could include:

- Inpatient rehabilitation
- A transitional care unit
- Complex continuing care
- Convalescent care
- A long-term care home
- A retirement home
- Supportive housing
- Palliative care

If you are eligible for one or more of these care sites, your health care team will help you apply to and transfer there.

WHAT HAPPENS IF I NEED LONG-TERM CARE?

- If your needs can best be met in a long-term care home, your care team and a Home and Community Care Support Services (HCSS) placement coordinator will work with you to find a home that meets your care needs.
- This may include placement in a long-term care home where you will wait until a space becomes available in your preferred home.

CAN I WAIT IN HOSPITAL FOR A LONG-TERM CARE HOME?

- Hospitals are not homes and are not designed to meet a person's supportive or rehabilitative needs.
- There is evidence that while you wait in hospital, without the social and recreational supports provided in settings such as long-term care, you could be at risk for physical and cognitive decline.
- You may also be at risk for hospital-based infections.
- Your timely admission into a long-term care home will ensure you get the health and personal care required to support your independence, safety and quality of life.

IF YOU HAVE QUESTIONS ABOUT YOUR DISCHARGE PLAN, SPEAK WITH A MEMBER OF YOUR CARE TEAM. THEY ARE HERE TO SUPPORT YOU.

YOUR HEALTH CARE TEAM MAY INCLUDE:

Your medical team will help care for you during your hospital stay. That team includes:

- **Attending Physician:** A doctor who is in charge of your care while you are in hospital.
- **Resident or Fellow:** A doctor or clinician who is completing their training at the hospital.
- **Nurse:** Provides nursing care and teaches you about your illness or injury. Each day, you may have 2 or 3 different nurses.
- **Consulting Physician:** A specialist doctor who may be asked to give recommendations about specific aspects of your care.
- **Nurse Practitioner:** A nurse who has additional education and specialized training to assess and manage your medical needs and plan your care.
- **Patient Flow Lead:** A nurse who leads your discharge team and will help prepare you for discharge.

Depending on your needs, other care team members may also help support you. This could include:

- **Dietitian**: Helps you choose the right foods for your meal planning.
- **Occupational Therapist:** Helps you plan how to safely do everyday activities such as eating, bathing and getting dressed.
- **Physiotherapist:** Helps you plan how to be more independent by building your strength, balance and coordination.
- **Social Worker**: Helps you manage your feelings, relationships and finances. They may help you with a plan for when you go home.
- **Speech-Language Pathologist:** Helps with problems talking or swallowing.
- **Home and Community Care Support Services (HCCSS) staff**: Help set you up with care in the community to support your transition home or find you a long-term care home, if needed.
- **Students:** WRH supports students and their education from various colleges and universities. You may have a student from any of the above fields involved in your care.

APPENDIX C: WINDSOR REGIONAL HOSPITAL PATIENT COPAYMENT LETTER

- Click here for link to letter template

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

[DATE]

Dear [Patient/Family],

You have been identified for Alternative Level of Care (ALC) following the completion of your acute care treatment. With limited exceptions, the Ministry of Health and the Ministry of Long Term Care have directed Ontario Hospitals to charge a co-payment for each day you (or your family member) are in hospital in ALC status, even if you or your family member are still in an acute care unit of the hospital. This co-payment is your contribution towards the cost of your room and meals. Your health insurance (OHIP) will continue to pay the hospital for the services of your health care team.

The ALC co-payment fee is set by the Ministry of Health and the Ministry of Long-Term Care and changes yearly. As of November 1, 2022 the rate is $63.73. The amount you will actually pay is determined by the completion of a co-payment assessment which takes into consideration the individual's income (based on the prior year's income tax return). If your conditions change, and you need acute care, your health record will be changed and you will not be billed for the days you require acute care services.

Joshua LeClair at (519) 254-5577 ext. 51012 will set up an appointment with you and/or your family for this required co-payment assessment. Mr. LeClair will inform you as to what information will be required to help you and him complete this assessment.

Our staff is dedicated to providing you with the information and support you need while awaiting your alternative level of care placement. If you have any questions, please speak with them.

Sincerely,

WINDSOR REGIONAL HOSPITAL

Karen Riddell

Karen Riddell
COO/CNE, VP Critical Care & Cardiology, Diagnostic Imaging & Organizational Effectiveness

OUELLETTE CAMPUS: 1030 OUELLETTE AVE., WINDSOR, ONTARIO, N9A 1E1	**MET CAMPUS:** 1995 LENS AVE, WINDSOR, ONTARIO, N8W 1L9
AUTOMATED ATTENDANT (519) 254-5577 **WEBSITE:** www.wrh.on.ca	

WINDSOR REGIONAL HOSPITAL OUTSTANDING CARE – NO EXCEPTIONS! COMPASSION is our PASSION

OUR VISION: OUTSTANDING CARE – NO EXCEPTIONS!
OUR MISSION: DELIVER AN OUTSTANDING CARE EXPERIENCE DRIVEN BY A PASSIONATE COMMITMENT TO EXCELLENCE

8000-U FLOW (Rev. 04/12/2023) PC

This is Exhibit “K” to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

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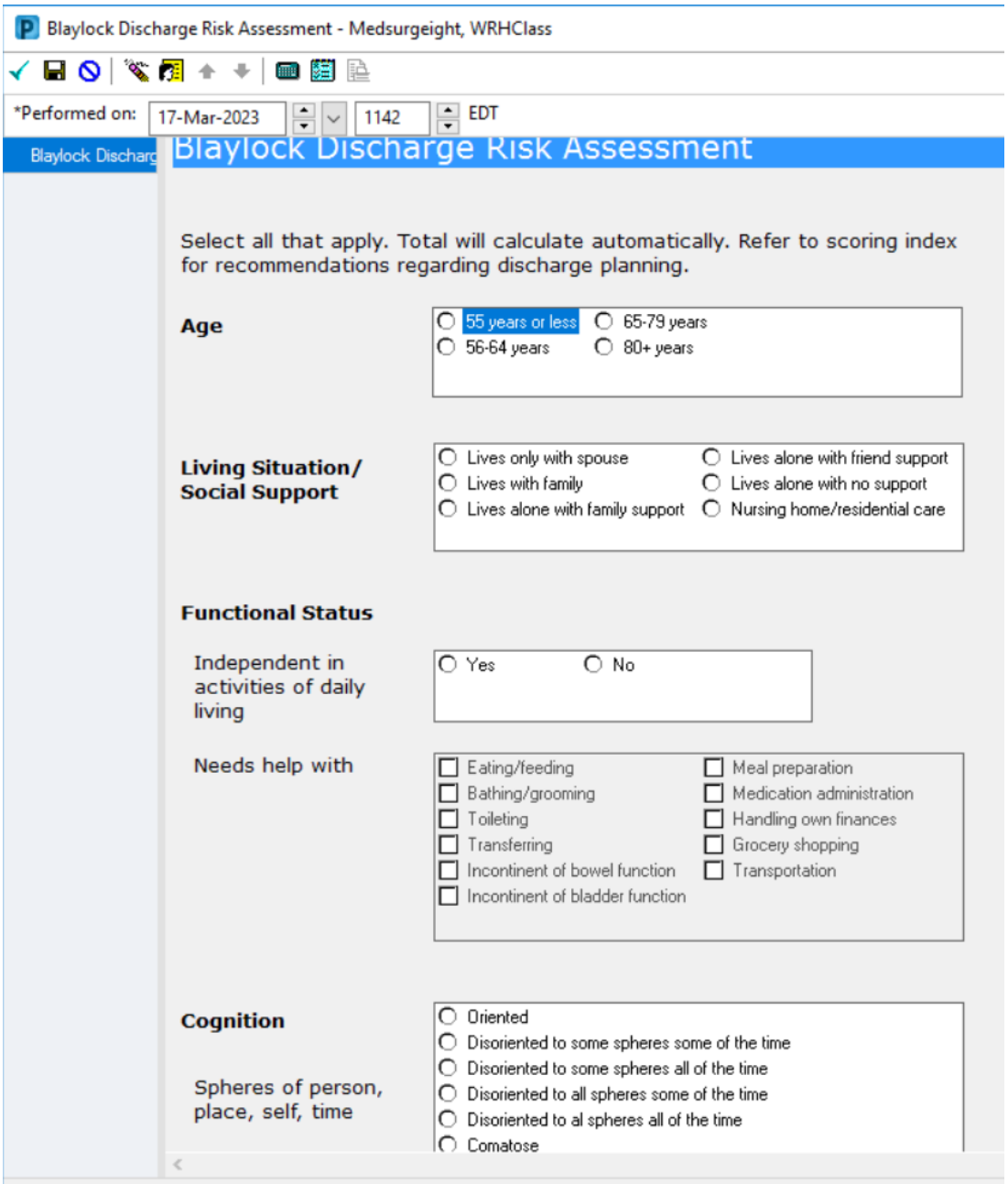
- Hospital Chronic Care Co-Payment Questions and Answers

Hospital Communications on Bill 7

- On September 22, 2022, a number of Ontario hospital CEOs published an open letter that was featured in the Toronto Star.
- Windsor Regional Hospital / Erie Shores HealthCare / Chatham-Kent Health Alliance

APPENDIX A: BLAYLOCK DISCHARGE PLANNING TOOL (CERNER POWER FORM)

- Screenshots from Cerner:



Mobility
- ○ Ambulatory
- ○ Ambulatory with mechanical assistance
- ○ Ambulatory with human assistance
- ○ Non-Ambulatory

Sensory Deficits
- ☐ None
- ☐ Visual or hearing deficit
- ☐ Visual and hearing defici
- ☐ Speech deficit

Number of Active Medical Problems
- ○ Up to 3 medical problems
- ○ 3 to 5 medical problems
- ○ More than 5 medical probl

Number of Drugs
- ○ Fewer than 3
- ○ 3 to 5 drugs
- ○ More than 5 drugs

Number of Previous Admissions/ Emergency Visits
- ○ None in the last 3 months
- ○ One in the last 3 months
- ○ Two in the last 3 months
- ○ More than 2 in last 3 mon

Family Doctor
- ○ Yes ○ No

Number of Active Medical Problems
- ○ Up to 3 medical problems
- ○ 3 to 5 medical problems
- ○ More than 5 medical probl

Number of Drugs
- ○ Fewer than 3
- ○ 3 to 5 drugs
- ○ More than 5 drugs

Number of Previous Admissions/ Emergency Visits
- ○ None in the last 3 months
- ○ One in the last 3 months
- ○ Two in the last 3 months
- ○ More than 2 in last 3 mon

Family Doctor
- ○ Yes ○ No

Behaviour Pattern
- ☐ Appropriate ☐ Other
- ☐ Wandering
- ☐ Agitated
- ☐ Confused

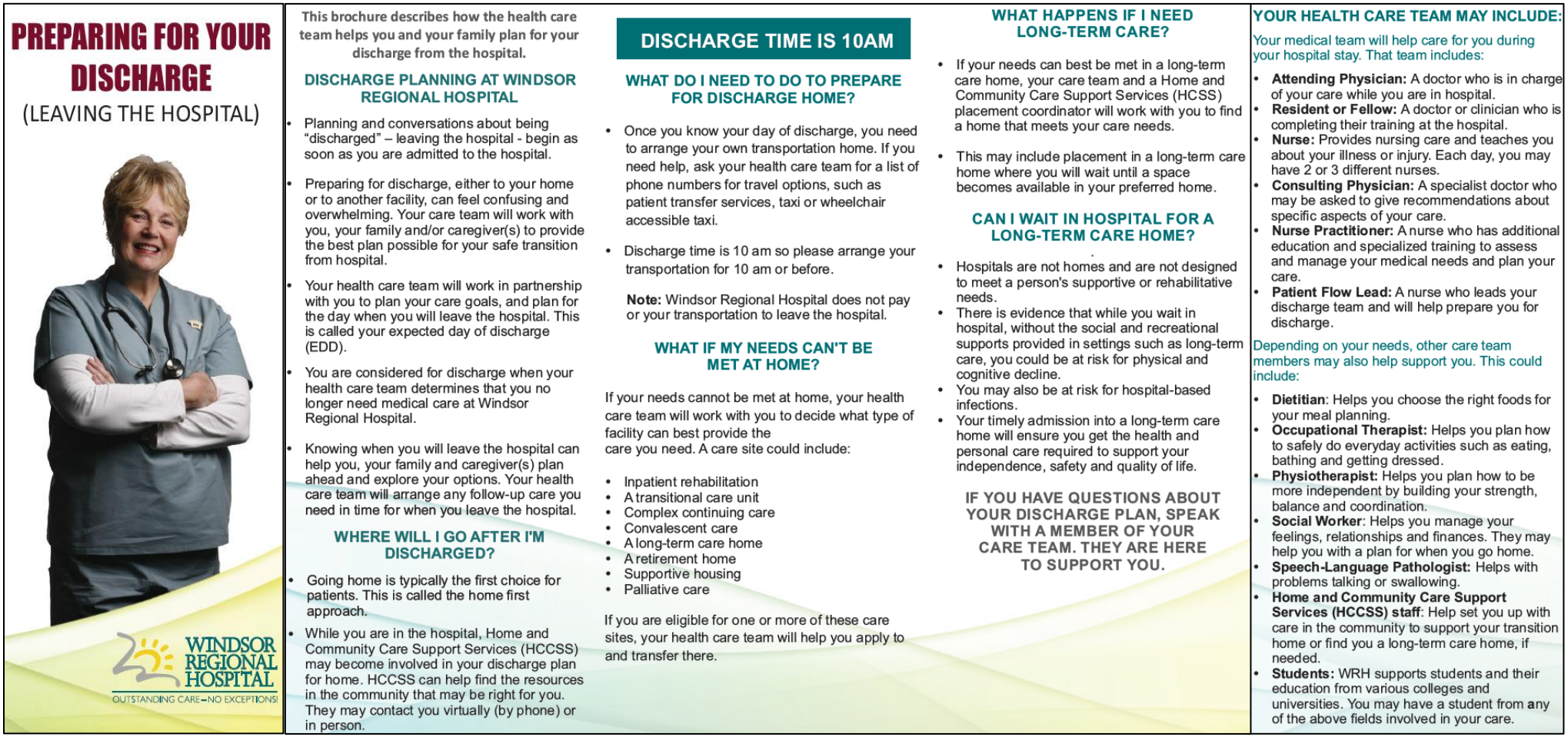
Total score

Scoring Index

0 to 9 : Probable outpatient physiotherapy or occupational therapy follow up
10 to 19 : May require Home and Community services
>20 : May require alternate level of care

APPENDIX B: HANDOUT FOR PATIENTS AND THEIR FAMILIES/CAREGIVERS UPON ADMISSION

- Link to Printable version
- Screenshot:



PREPARING FOR YOUR DISCHARGE

(LEAVING THE HOSPITAL)

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE—NO EXCEPTIONS!

This brochure describes how the health care team helps you and your family plan for your discharge from the hospital.

DISCHARGE PLANNING AT WINDSOR REGIONAL HOSPITAL

- Planning and conversations about being "discharged" – leaving the hospital - begin as soon as you are admitted to the hospital.
- Preparing for discharge, either to your home or to another facility, can feel confusing and overwhelming. Your care team will work with you, your family and/or caregiver(s) to provide the best plan possible for your safe transition from hospital.
- Your health care team will work in partnership with you to plan your care goals, and plan for the day when you will leave the hospital. This is called your expected day of discharge (EDD).
- You are considered for discharge when your health care team determines that you no longer need medical care at Windsor Regional Hospital.
- Knowing when you will leave the hospital can help you, your family and caregiver(s) plan ahead and explore your options. Your health care team will arrange any follow-up care you need in time for when you leave the hospital.

WHERE WILL I GO AFTER I'M DISCHARGED?

- Going home is typically the first choice for patients. This is called the home first approach.
- While you are in the hospital, Home and Community Care Support Services (HCCSS) may become involved in your discharge plan for home. HCCSS can help find the resources in the community that may be right for you. They may contact you virtually (by phone) or in person.

DISCHARGE TIME IS 10AM

WHAT DO I NEED TO DO TO PREPARE FOR DISCHARGE HOME?

- Once you know your day of discharge, you need to arrange your own transportation home. If you need help, ask your health care team for a list of phone numbers for travel options, such as patient transfer services, taxi or wheelchair accessible taxi.
- Discharge time is 10 am so please arrange your transportation for 10 am or before.

Note: Windsor Regional Hospital does not pay or your transportation to leave the hospital.

WHAT IF MY NEEDS CAN'T BE MET AT HOME?

If your needs cannot be met at home, your health care team will work with you to decide what type of facility can best provide the care you need. A care site could include:

- Inpatient rehabilitation
- A transitional care unit
- Complex continuing care
- Convalescent care
- A long-term care home
- A retirement home
- Supportive housing
- Palliative care

If you are eligible for one or more of these care sites, your health care team will help you apply to and transfer there.

WHAT HAPPENS IF I NEED LONG-TERM CARE?

- If your needs can best be met in a long-term care home, your care team and a Home and Community Care Support Services (HCSS) placement coordinator will work with you to find a home that meets your care needs.
- This may include placement in a long-term care home where you will wait until a space becomes available in your preferred home.

CAN I WAIT IN HOSPITAL FOR A LONG-TERM CARE HOME?

- Hospitals are not homes and are not designed to meet a person's supportive or rehabilitative needs.
- There is evidence that while you wait in hospital, without the social and recreational supports provided in settings such as long-term care, you could be at risk for physical and cognitive decline.
- You may also be at risk for hospital-based infections.
- Your timely admission into a long-term care home will ensure you get the health and personal care required to support your independence, safety and quality of life.

IF YOU HAVE QUESTIONS ABOUT YOUR DISCHARGE PLAN, SPEAK WITH A MEMBER OF YOUR CARE TEAM. THEY ARE HERE TO SUPPORT YOU.

YOUR HEALTH CARE TEAM MAY INCLUDE:

Your medical team will help care for you during your hospital stay. That team includes:

- **Attending Physician:** A doctor who is in charge of your care while you are in hospital.
- **Resident or Fellow:** A doctor or clinician who is completing their training at the hospital.
- **Nurse:** Provides nursing care and teaches you about your illness or injury. Each day, you may have 2 or 3 different nurses.
- **Consulting Physician:** A specialist doctor who may be asked to give recommendations about specific aspects of your care.
- **Nurse Practitioner:** A nurse who has additional education and specialized training to assess and manage your medical needs and plan your care.
- **Patient Flow Lead:** A nurse who leads your discharge team and will help prepare you for discharge.

Depending on your needs, other care team members may also help support you. This could include:

- **Dietitian**: Helps you choose the right foods for your meal planning.
- **Occupational Therapist:** Helps you plan how to safely do everyday activities such as eating, bathing and getting dressed.
- **Physiotherapist:** Helps you plan how to be more independent by building your strength, balance and coordination.
- **Social Worker**: Helps you manage your feelings, relationships and finances. They may help you with a plan for when you go home.
- **Speech-Language Pathologist:** Helps with problems talking or swallowing.
- **Home and Community Care Support Services (HCCSS) staff**: Help set you up with care in the community to support your transition home or find you a long-term care home, if needed.
- **Students:** WRH supports students and their education from various colleges and universities. You may have a student from any of the above fields involved in your care.

APPENDIX C: WINDSOR REGIONAL HOSPITAL PATIENT COPAYMENT LETTER

- Click here for link to letter template

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

[DATE]

Dear [Patient/Family],

You have been identified for Alternative Level of Care (ALC) following the completion of your acute care treatment. With limited exceptions, the Ministry of Health and the Ministry of Long Term Care have directed Ontario Hospitals to charge a co-payment for each day you (or your family member) are in hospital in ALC status, even if you or your family member are still in an acute care unit of the hospital. This co-payment is your contribution towards the cost of your room and meals. Your health insurance (OHIP) will continue to pay the hospital for the services of your health care team.

The ALC co-payment fee is set by the Ministry of Health and the Ministry of Long-Term Care and changes yearly. As of November 1, 2022 the rate is $63.73. The amount you will actually pay is determined by the completion of a co-payment assessment which takes into consideration the individual's income (based on the prior year's income tax return). If your conditions change, and you need acute care, your health record will be changed and you will not be billed for the days you require acute care services.

Joshua LeClair at (519) 254-5577 ext. 51012 will set up an appointment with you and/or your family for this required co-payment assessment. Mr. LeClair will inform you as to what information will be required to help you and him complete this assessment.

Our staff is dedicated to providing you with the information and support you need while awaiting your alternative level of care placement. If you have any questions, please speak with them.

Sincerely,

WINDSOR REGIONAL HOSPITAL

Karen Riddell

Karen Riddell
COO/CNE, VP Critical Care & Cardiology, Diagnostic Imaging & Organizational Effectiveness

OUELLETTE CAMPUS: 1030 OUELLETTE AVE., WINDSOR, ONTARIO, N9A 1E1	**MET CAMPUS:** 1995 LENS AVE, WINDSOR, ONTARIO, N8W 1L9
AUTOMATED ATTENDANT (519) 254-5577 **WEBSITE:** www.wrh.on.ca	

WINDSOR REGIONAL HOSPITAL OUTSTANDING CARE – NO EXCEPTIONS! COMPASSION is our PASSION

OUR VISION: OUTSTANDING CARE – NO EXCEPTIONS!
OUR MISSION: DELIVER AN OUTSTANDING CARE EXPERIENCE DRIVEN BY A PASSIONATE COMMITMENT TO EXCELLENCE

8000-U FLOW (Rev. 04/12/2023) PC

This is Exhibit “L” to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

Adam John Kouri,
A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

_____, 2023

Dear Patient/Family:

You have been identified for Alternative Level of Care (ALC) following the completion of your acute care treatment. With limited exceptions, the Ministry of Health and the Ministry of Long Term Care have directed Ontario Hospitals to charge a co-payment for each day you (or your family member) are in hospital in ALC status, even if you or your family member are still in an acute care unit of the hospital. This co-payment is your contribution towards the cost of your room and meals. Your health insurance (OHIP) will continue to pay the hospital for the services of your health care team.

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Joshua LeClair (519) 254-5577 ext. 51012 joshua.leclair@wrh.on.ca will set up an appointment with you and/or your family for this required co-payment assessment. Mr. LeClair will inform you as to what information will be required to help you and her complete this assessment.

Our staff is dedicated to providing you with the information and support you need while awaiting your alternative level of care placement. If you have any questions, please speak with them.

Sincerely,

WINDSOR REGIONAL HOSPITAL

Karen Riddell

Karen Riddell
Chief Operating Office/Chief Nursing Executive,
VP Critical Care & Cardiology, Diagnostic Imaging,
Organizational Effectiveness

Our Vision: Outstanding Care - No Exceptions!
Our Mission: Deliver an outstanding care experience driven by a passionate commitment to Excellence.

This is Exhibit “M” to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

Adam John Kouri,
A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

[DATE]

[ADDRESS]

Dear [NAME]

Your / family member's doctor has determined that you no longer require acute hospital care. Your doctor has indicated that you/your family member will be discharged from the hospital on or about [DATE]. Windsor Regional Hospital is required to promptly discharge patients when their medical needs have been resolved. Our goal is to provide all patients the appropriate care and to ensure we have hospital beds available for the most ill or injured patients.

A supportive discharge plan designed to meet your needs has been developed by your health care team with you. This plan includes the following: [Insert detailed overview of the plan here, with references to the resources available in the community, if applicable]

As of the date of this letter, you or your Substitute Decision Maker (SDM), have indicated that you are not prepared to leave the hospital. I am writing to tell you about the options if you are not prepared to leave the hospital. These can include:

- Transitioning to a retirement home, with additional services to be purchased
- Applying to a long term care facility with a vacancy
- Returning home with supports and services

Of course, the discharge plan as developed with the health care team remains an available option for you.

If you choose not to leave the hospital (or your SDM does not facilitate you leaving the hospital), the discharge will still proceed as ordered by Dr. [NAME]. Within 24 hours of discharge you will not be insured for hospital services. Without coverage for insured services, there will be a daily rate billed to you. This daily rate will be charged effective [DATE] and you will be billed weekly.

Please consider the option set above and please let us know if you require additional information, if we can be of assistance in further discharge planning. We are asking that you advise us of your decision, with respect to your discharge plan as of [DATE]. We would like to continue to work with you through the process of discharge and are available to answer any questions or address concerns that you may have. If you have any questions you can call the Utilization Manager at each site (Ouellette Campus or Metropolitan Campus).

Thank you for your assistance as we work with you during this discharge plan.

Karen McCullough
CNE/COO
Our Vision: Outstanding Care - No Exceptions!
Our Mission: We provide Outstanding Care with Compassion

This is Exhibit “N” to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

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A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

Addressograph

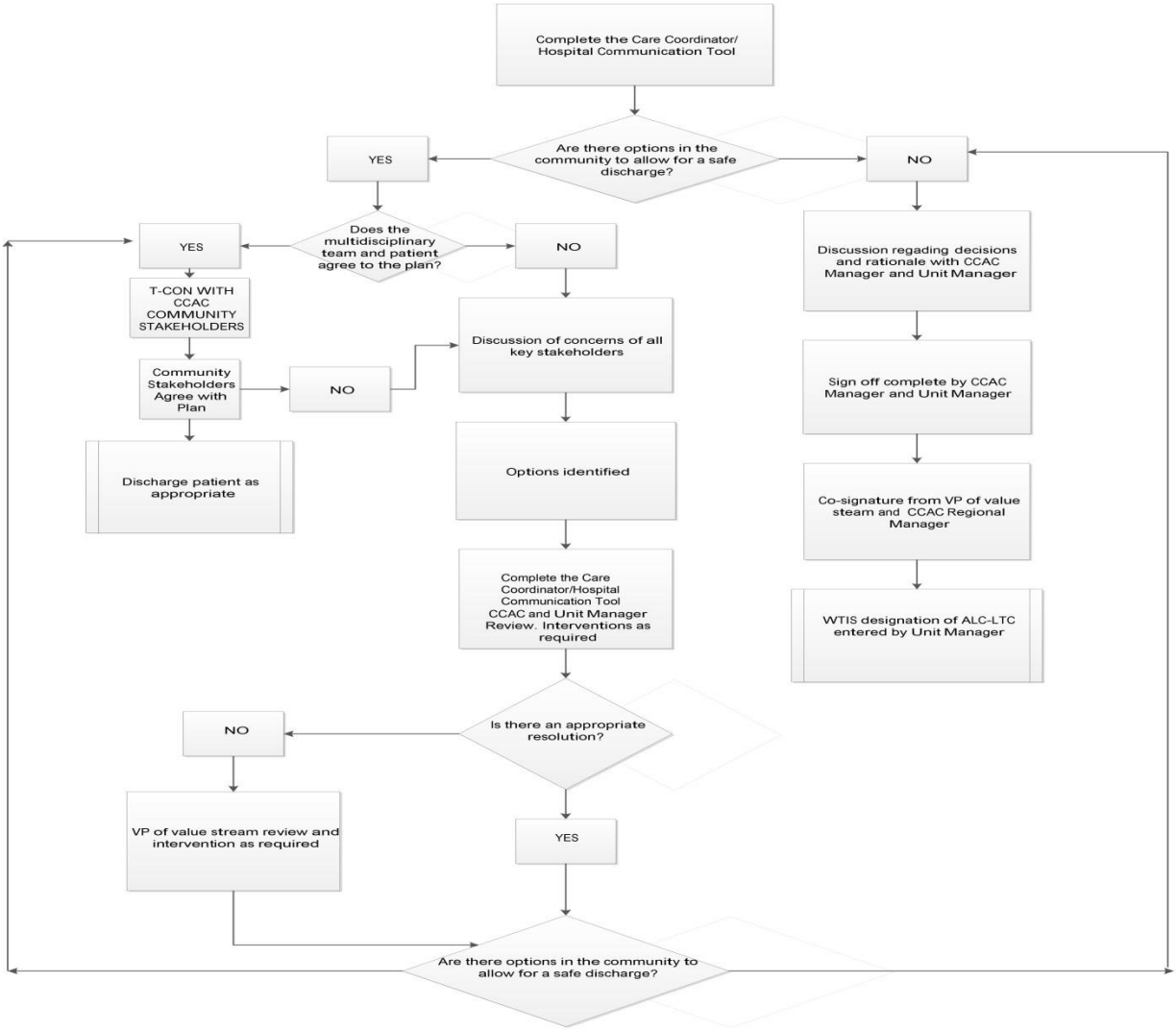
Windsor Regional Hospital ALC-LTC Sign-Off Sheet

(Patient Name)_____ (MRN)_____ (SE)_____ was identified as being at risk for a complicated discharge and required an Intensive Care Coordinator Review. The patient's review was completed (date) _____, all options for discharge explored and at this time must remain in Hospital to await LTC placement. The outcome of the Intensive Care Coordinator Review has been discussed with both the ESC CCAC Director of Patient Services and WRH VP and all agree upon ALC-LTC designation.

ESC CCAC Patient Services Manager:	**Date:**
ESC CCAC Director of Patient Services:	**Date:**
WRH Unit Manager/Utilization Manager:	**Date:**
WRH Utilization Director:	**Date:**
WRH VP/CNE/CNO:	**Date:**

The ALC-LTC process involves three components:

1) Thorough documentation in both hospital and CCAC chart demonstrating that all discharge options have been explored and exhausted:
   A documentation template to be used for patients identified as being at risk for a more complicated discharge that outlines clearly that all discharge options other than LTC have been considered. The function of this template is to document that all options are being considered prior to ALC-LTC designation and will take the place of the typical 'narrative' that care coordinators use to document case conferences and assign some of the accountability for actions related to discharge planning on the part of both the Hospital and the CCAC. This tool, as completed, is to be placed in CHRIS and in the Hospital Chart. Should the CCAC Care Coordinator and Hospital team be satisfied that all options for discharge have been explored and the only option at this time is to have the client remain in Hospital to wait for LTC. This tool provides the documentation required for review by both the CCAC and Hospital Managers/Leadership, to satisfy them that there are no discharge options and ALC-LTC designation is appropriate.
2) An Escalation process: Use when barriers to discharge or discharge planning arise for those patients identified as a more complicated discharge and requiring case conferencing and intensive case management in the hospital.
   For example:
   a) the family/client refuses to explore options for discharge,
   b) when a member of multidisciplinary team does not agree to plan,
   c) when a member of community team does not agree with plan.
   This procedure is used to support CCAC and Hospital staff in moving towards home as the preferred discharge destination. It may involve additional support of CCAC and Hospital administration, clinical staff (physicians, etc.) to support and encourage patients and families to consider home as the discharge destination if safe and possible.
3) ALC-LTC sign off document:
   After documentation has been completed, and the escalation process has been followed, and the team (hospital and CCAC) determines that the only option for a patient is to remain in hospital to await Long-Term Care, there must be sign-off by leadership of both organizations. The ALC-LTC sign-off document, once signed, will be placed on the hospital chart and in CHRIS (CCAC e-document) demonstrating consensus between Hospital and CCAC leadership that ALC-LTC is the only possible designation option.


Complete the Care Coordinator/ Hospital Communication Tool
Are there options in the community to allow for a safe discharge?
YES
NO
Does the multidisciplinary team and patient agree to the plan?
YES
NO
T-CON WITH CCAC COMMUNITY STAKEHOLDERS
Community Stakeholders Agree with Plan
NO
Discharge patient as appropriate
Discussion of concerns of all key stakeholders
Options identified
Complete the Care Coordinator/Hospital Communication Tool CCAC and Unit Manager Review. Interventions as required
Is there an appropriate resolution?
NO
VP of value stream review and intervention as required
YES
Are there options in the community to allow for a safe discharge?
Discussion regading decisions and rationale with CCAC Manager and Unit Manager
Sign off complete by CCAC Manager and Unit Manager
Co-signature from VP of value steam and CCAC Regional Manager
WTIS designation of ALC-LTC entered by Unit Manager

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in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

Adam John Kouri,
A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

[DATE]

Dear [NAME]

On [DATE], your physician documented on your Clinical Record that you were ready for discharge either home or to another level of care.

I understand that, upon admission, you were advised of our hospital discharge policy. At that time it was also mentioned that you could await placement in an interim facility while remaining on a list for your preferred Long Term Care Home. I understand that you and/or your family have made a decision regarding your care and have chosen to remain in hospital while awaiting the bed of your choice.

This means that you will be charged a per diem rate for your care which is $600 commencing [DATE]

This charge represents a contribution to the cost associated with remaining in a hospital treatment bed when acute hospital treatment services are no longer required.

If you wish to change your decision regarding this hospital accommodation, please advise us immediately through the Utilization Nurse who is working with you. If you have further concerns or questions, please do not hesitate to contact the Operational Manager on your unit.

Proceeding in this manner is in accordance with our policy regarding the optimal use of our hospital beds for necessary hospital treatment.

Sincerely,

Karen McCullough
CNE/COO
Our Vision: Outstanding Care - No Exceptions!
Our Mission: We provide Outstanding Care with Compassion

WINDSOR REGIONAL HOSPITAL
1995 Lens Avenue' Windsor, Ontario, N8W 1L9
1030 Ouellette Ave, Windsor, Ontario, N9A 1E1

This is Exhibit “P” to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

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Adam John Kouri,
A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

Ontario Health

Operational Direction
Rehabilitation and Complex Continuing Care
Capacity and Flow

ISSUED TO:	Acute Care and Rehabilitation/Complex Continuing Care Hospital CEOs
ISSUED FROM:	Susan deRyk, Chief Regional Officer, Central and West Regions Anna Greenberg, Chief Regional Officer, Toronto and East Regions Brian Ktytor, Chief Regional Officer, North West and North East Regions
CC:	Matthew Anderson, President & CEO
RELEASE DATE:	July 12, 2023

Ensuring patients across Ontario receive the right care in the right place at the right time is a key priority for our health system. Thank you to you and your teams for the work you do every day in support of this goal.

Currently in Ontario, there are more than 4,500 patients designated as requiring an alternate level of care (ALC) in acute care and rehabilitation/complex continuing care (CCC) hospitals, with approximately 25% of patients in acute care waiting for rehabilitation and CCC. As we look ahead to the fall/winter and the accompanying resurgence of respiratory viruses, we anticipate capacity pressures across the health system. Given this context, it is increasingly important to optimize rehabilitation and CCC capacity to support ALC reduction efforts and improve patient access to care.

Acknowledging implementation of the Operational Guidance may be nuanced depending on geography and in rural and remote locations, Ontario Health remains committed to working with system partners to improve access, occupancy, throughput, and flow in all sectors across the province. A province-wide target of reducing ALC volumes by 10% per year over the next 3 years has been set to help concentrate our collective efforts to improve access to care.

To support target achievement, improved utilization, patient flow, and overall system capacity, Ontario Health is issuing the following direction and guidance (below) to hospitals and health service providers that operate rehabilitation and CCC beds as a free-standing facility or integrated within an acute care facility:

1. All rehab and CCC hospitals will work towards a target occupancy rate of >95%
2. All hospitals will work towards achieving ALC throughput targets of >1
3. All hospitals will work to implement the actions and approaches outlined in the attached Operational Guidance that apply to them, recognizing rural and northern constraints
4. All hospitals will work with their Ontario Health region on the above noted improvement efforts

Your Ontario Health regional team will continue to work closely with you on local capacity, access and flow efforts and will follow up with organizations shortly to support implementation efforts over the summer.

Thank you for all that you are doing to provide care for the people of Ontario.

Operational Guidance

Provincial Target: All CCC hospitals/facilities/bedded programs will work towards a target occupancy rate of >95%

For acute care hospitals:

1. Implement processes to work towards 7 day/week discharges to rehab and CCC.
2. Ensure a proper discharge plan is established and communicated to rehab and CCC hospitals/bedded programs and other discharge destinations including:
    - A transfer of accountability process,
    - A comprehensive discharge summary, including the latest medication information, as outlined in the GTA Rehab Network Discharge Checklist, and
    - Physician-to-physician phone calls using a standardized tool such as IPASS (as required).

For rehab and CCC hospitals/facilities/bedded programs:

3. Develop a plan to implement 7 day/week rehab and CCC admissions, with consideration for:
    - Medical coverage,
    - Clinical support staff (i.e., pharmacy, admitting),
    - Rehabilitation therapy staff, and
    - Access to environmental services to facilitate room cleaning and bed turn around.
4. Develop a plan to establish expanded hours of rehab and CCC admission which may include implementation of after-hour medical coverage, expanded therapy and clinical support coverage, including pharmacy.
5. Stagger discharges throughout the week to facilitate continuous acute care flow and avoid fluctuations in occupancy.
6. Create flex beds to accommodate any late or failed complex or rehabilitation discharges to ensure same-day acute care admissions are not cancelled. Ideally, admissions including transportation should be pre-booked where possible.
7. Ensure bed holding policies align with the Guidance to support the Repatriation of Patients to Bedded Levels of Rehabilitative Care in Freestanding Rehab/Complex Continuing Care Hospitals.
8. Develop proactive surge strategies for rehab and CCC occupancy to support capacity pressures across hospitals, particularly during respiratory viral season and other increases in acute care demand.
9. Adopt flexible admission criteria to accommodate patients on the wait list for rehab and CCC and respond to changing demand (i.e., summer surgical ramp downs, low occupancy periods for speciality programs). Consider off-service admissions and mixed units for non-specialized programs to enable opportunities to flex resources between different bed types (*see*: Rehab Care Alliance Bedded Levels of Rehab).
10. Ensure COVID-19 infection prevention and control (IPAC) measures (i.e., admission testing, isolation requirements and duration, management of aerosol-generating medical procedures) are adapting to the current phase of the pandemic and community viral transmission rates. Recommendations based on best practices and the current phase of the pandemic include the following:
    - All patients should be screened upon admission and actively monitored while in hospital for COVID-19 and respiratory virus-compatible symptoms.

- Routine COVID-19 testing of asymptomatic patients is no longer required on admission.
- Routine isolation of asymptomatic patients on admission is no longer recommended.
- All patients with suspected or confirmed COVID-19 or respiratory illness should be placed on Droplet and Contact Plus precautions (personal protective equipment [PPE] includes fit-tested N95 respirator, eye protection, gloves, and gown) until reassessed by the IPAC team at the earliest possible opportunity to determine testing requirements and duration of isolation. Note: access to timely diagnostic testing will facilitate the determination of a plan of care and the requirement for ongoing isolation.
- All staff must use Airborne/Droplet Contact precautions and PPE (N95 respirator, face shield, gown, gloves) when performing aerosol-generating medical procedures on patients with suspected or confirmed respiratory virus infection. Note: Asymptomatic patients with a tracheostomy, chronic continuous positive airway pressure (CPAP) or on high-flow oxygen/mechanical ventilation will no longer require negative pressure rooms and airborne/droplet/contact precautions.
- In general, movement of patients to and from an outbreak unit is not recommended; however, given the importance of access to rehab/CCC for system flow and patient needs, transfers may be considered after a discussion between IPAC programs and agreement from public health. The accepting facility should admit the patient preferably into a private room, if this is possible, and maintain Additional Precautions as required.

Provincial Target: All hospitals will work towards achieving ALC throughput targets of >1

For all hospitals:

11. Implement the ALC Leading Practices and the Rehab Care Alliance and Provincial Geriatrics Leadership Ontario Framework for Older Adults Living with Frailty: Older Adults with Frailty Rehab Guidelines to prevent delays in transitions of care and improve the quality of care, including patient and caregiver engagement in care/discharge planning, access to specialized supports, and transitions from hospital to the next level of care.
12. Ensure a plan of care is developed by all members of the care team with the patient and relevant community partners to address care needs with a focus on transition to the pre-admission destination where possible.
13. Ensure frequent re-assessment of patient status, an essential part of the care process so that changes and resulting support needs are identified as early as possible, and the care plan and goals of care are adjusted accordingly.
14. Ensure there is a scheduled opportunity for the interdisciplinary team to review patients identified as "at-risk" (e.g., "at-risk" ALC rounds) at least weekly. "At-risk" ALC rounds include a representative at a director/vice-president-level, internal stakeholders, key external agencies, and discussion around a review of risks for each patient to optimize discharge options, develop creative discharge solutions, and provide appropriate transitional supports, including augmentation of community supports to facilitate timely discharge.
15. An "at-risk" resolution table is developed, where challenging barriers to transition, including the need for specialized equipment and behavioural supports, can be discussed, and addressed.
16. Develop strategies to support patient transfer back to rehab and CCC from the ED as quickly as possible with added supports as required.
17. Develop a workforce sustainability strategy that includes key concepts such as staff wellness/resilience, recruitment, and retention to ensure we have appropriate staff to meet patient needs.

18. Build partnerships between acute care and rehab and CCC hospitals/bedded programs where necessary to educate rehab and CCC staff to meet the rehabilitative care needs of patients (i.e., dialysis training for nurses so patients can be admitted and still receive home hemodialysis and peritoneal dialysis treatment; administration of specialty medication and treatment such as parenteral nutrition).

For acute care hospitals:

19. Ensure ALC patients are accurately designated, not only based on medical stability in acute care, but also based on restorative potential[1] and completion of investigations and/or treatments that can only be offered in acute care.
20. Align referral processes with the Provincial Referral Standards Reference Guide. Note that patients do not need to be designated ALC for a referral to take place.
21. Develop and implement forecasting processes within team rounds, leveraging length of stay best practices for targeted populations, to provide a best estimate of when admitted patients will be ready to transfer to the next level of care.
22. Consider opportunities in the ED to support avoidance of acute care admissions or reduce functional decline of patients who are no-bed admits (i.e., GEM, rehab staffing), in alignment with senior friendly care principles.
23. Enable review of newly designated ALC patients by rehab and CCC admissions coordinators to seek out appropriate referrals.

For rehab and CCC hospitals/facilities/bedded programs:

24. Develop a plan to maintain daily rehabilitation care by allied health team members while also expanding to a minimum of 6 days/week, and ideally 7 days/week, to decrease length of stay and improve flow.
25. Follow best practices in rehabilitative care as outlined in best practice documents for key populations including: Hip Fracture, Older Adults with Frailty, Total Joint Replacements, Stroke Rehab.
26. Implement group programs and optimize models of care where all team members are working to maximize rehabilitation therapy to mitigate impact of health human resources shortages. Be creative in the staffing model and consider how to use other disciplines (i.e., therapy assistants, social services workers, kinesiologists, dietician assistant).
27. Work with acute care to develop “pull strategies” to maintain flow, especially during surge periods. Include patient flow coordinators onsite at referring facilities where possible, otherwise ensure regular contact with referring facilities to identify potential patients.

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[1] Restorative Potential means that there is reason to believe (based on clinical assessment and expertise and evidence in the literature where available) that the patient's/client’s condition is likely to undergo functional improvement and benefit from rehabilitative care. The degree of restorative potential and benefit from rehabilitative care should take into consideration the patient’s/client’s:

1. Baseline level of functioning
2. Medical diagnosis/prognosis and co-morbidities (i.e., is there a maximum level of functioning that can be expected owing to the medical diagnosis /prognosis?)
3. Ability to participate in and benefit from rehabilitative care within the context of the patient’s/client’s specific functional goals and direction of care needs.

NB: Determination of whether a patient/client has restorative potential includes consideration of all three of the above factors. Cognitive impairment, depression, delirium, or discharge destination should not be used in isolation to influence a determination of restorative potential.

28. Work with acute care to implement guidelines for direct admission to rehab and CCC from the community or emergency department. Consider referral pathways and steps outlined in the RCA Direct Access Priority Process document.

Enablers to support this guidance

- In collaboration with system partners, revisit admission criteria, programs, services, and staff skill sets at least annually to ensure they are responsive to changing demand and can address gaps in services.
- Ensure established best practice rehab care for key populations (i.e., stroke, older adults, orthopedics) is initiated in acute care.
- Review medical model to ensure alignment in terms of physician hours, presence on unit, admissions and throughput priorities, speed to action particularly on high admission and discharging units. Review on call stipends or billing guidelines to support admissions on weekends.
- Explore centralized referral and triage for rehab and CCC to create one point of access to these programs from acute care.
- Explore options to adopt eReferral processes to support flow and develop a performance scorecard to monitor key access and flow metrics at your hospital.
- Plan proactively for appropriate transportation to reduce potential admission delays.
- Partner with organizations to ensure access to Indigenous Healing Practices and culturally safe care.

This is Exhibit "Q" to the Affidavit of
David Musyj affirmed before me at the City of Toronto,
in the Province of Ontario on this **23rd day of February 2024**

Adam Kouri

A Commissioner for Taking Affidavits, etc.

Adam John Kouri,
A Commissioner, etc.,
Province of Ontario,
While a Student-at-Law
Expires August 16, 2026.

Ontario Health

Operational Direction:
Fall/Winter Readiness and Response

ISSUED TO:	Health System Partners
ISSUED FROM:	Susan deRyk, Chief Regional Officer, Central and West Regions Anna Greenberg, Chief Regional Officer, Toronto and East Regions Brian Ktytor, Chief Regional Officer, North West and North East Regions
CC:	Dr. Chris Simpson, Executive VP and Chief Medical Executive Judy Linton, Executive VP and Chief Nursing Executive Dr. Sacha Bhatia, Senior VP, Population Health and Value-Based Health Systems
RELEASE DATE:	October 3, 2023

Thanks to the dedicated efforts of health care organizations and providers across the province, we have continued to make progress in enhancing access to health services as we transition to a post-pandemic environment. Our goal in preparing for a surge in respiratory viruses this fall/winter is to maintain this momentum, support ongoing efforts, and minimize impact on patient care.

At this point, while we are seeing a rise in COVID-19 transmission, the overall risk to Ontarians has been diminished through increased immunity, high vaccination rates, and the availability of tools such as antivirals to manage the impacts of the virus. However, the overall risk posed by seasonal viruses this fall/winter is expected to continue to be atypical compared to pre-pandemic years based on observations from the southern hemisphere in summer 2023. We anticipate an early start to the influenza season, co-circulation of influenza A and B, and low-to-moderate RSV levels in most regions, including increased respiratory illness burden among pediatric populations.

Working in collaboration with our Ministry colleagues, the Office of the Chief Medical Officer of Health, and other partners, we have identified several actions to support our collective efforts to prepare for these anticipated pressures this fall and winter, consistent with our actions in previous years. As always, we encourage you to reach out to your Ontario Health regional teams for questions and support.

Thank you for your attention to this information and for your continued dedication to providing safe, high-quality care.

Operational Direction

All sectors:

- Actively coordinate and support local surge, inter-region and provincial responses with Ontario Health regional teams and Ontario Health Teams (OHTs, where appropriate).
- Promote equitable access to care for First Nations, Inuit, Métis and urban Indigenous; Black; racialized; newcomer; and low-income populations, with a strategic focus on high-priority communities.
- Prioritize provincial and regional alternate level of care (ALC) reduction targets, including prompt implementation of funded initiatives.
- Maximize health human resource (HHR) capacity by utilizing innovative models of care and expanded scopes of practice where needed.
- Implement strategies to maximize influenza and COVID-19 vaccine uptake among health care providers, patients, residents, clients, and caregivers.
- Utilize existing virtual care pathways to improve access to care, where appropriate and consistent with guidance.
- Encourage patients and clients to access Health811 for non-urgent health inquiries and questions.
- Ensure patients are aware of services available through pharmacies, including influenza and COVID-19 vaccines, COVID-19 treatment, and treatment for minor ailments.
- Share information about available mental wellness supports for health care workers.

Primary care:

- Continue to be instrumental in prevention and care of respiratory illness for your patients through testing, immunization, and treatment, in particular early identification of those who would benefit from COVID-19 treatment (nirmatrelvir/ritonavir or remdesivir).
- Review the latest clinical guidance and information about COVID-19 vaccination, treatment, and testing as it becomes available.
    - Review Ontario Health's website for resources related to COVID-19 treatment. New resources include:
        - Ontario Health Recommendations for Outpatient Use of Intravenous Remdesivir (Veklury) in Adults
        - Information about how to access antiviral treatments for COVID-19 in the community
    - Review the Ministry of Health's COVID-19 Vaccine-Relevant Information and Planning Resources
- Review the infection prevention and control guidance from the Ontario College of Family Physicians.
- Ensure adequate PPE supplies are on hand.
    - Register and order supplies through the Provincial PPE Supply Portal.
- Continue to order COVID-19 PCR testing supplies through your usual channels, and order COVID-19 rapid antigen tests through the Provincial PPE Supply Portal to distribute to your patients.

- Where appropriate, connect with your local OHT, public health unit, and other local primary care partners to explore opportunities to collaborate and coordinate services.

All hospitals:

- Prepare surge plans to accommodate 120% inpatient capacity and increased emergency department volumes. For post-acute care hospitals, prepare surge plans to match the occupancy levels of surrounding acute care hospitals.
- Continue to prioritize ALC reduction and implement initiatives to improve access and flow while maximizing diversion strategies away from acute care.
- Aim to maintain scheduled surgeries and procedures, prioritizing patients waiting beyond clinical access targets ("long waiters") and ramp up scheduled surgeries that do not require any inpatient footprint.
- Connect with your local OHT where appropriate to identify care options in the community for those who do not require emergency or acute care services.
- Utilize supports and resources provided by the Ontario Caregiver Organization (the Essential Care Partner Support Hub) to ensure that caregivers are identified, included, and supported as essential care partners.
- Collaborate with IMS and/or regional and provincial tables to balance capacity, including accepting transfers of patients in a timely manner (ideally within 24 hours) when directed.
- Continue to use a standard person-centred admission process that includes consent to transfer to another hospital, if required.
    - Review the Ontario Hospital Association's patient transfer resources.

Emergency departments:

- Continue to follow the Emergency Department Mitigation and Closure Protocol for reporting potential and confirmed closures.
- Ensure HHR preparedness (e.g., staff are alerted, and back-up/fan-out contact lists are complete and up to date).
- Utilize the Emergency Nursing Pediatric Course and Pediatric Advanced Life Support recertification programs to prepare teams in high-acuity pediatric patient care.
- For small, rural, and remote hospitals with emergency departments, utilize the educational opportunities available through the ED Nurse Education Program, which provides nurses (RNs/RPNs) with immediate access to ED nursing education.
- Leverage the Emergency Department Peer-to-Peer program for 24/7 access to coaching or support from emergency medicine physicians.
- Continue to prioritize patient safety in the context of extended wait times, including ensuring timely triage of arriving patients and offload of ambulance arrivals, and regular check-ins with waiting patients and families.
- Identify additional space for patient care. This may include cohorting of patients (where appropriate and with advice from infection prevention and control teams).
- Where appropriate, work with your local OHT, primary care teams, community pediatricians, and family physicians to support after-hours coverage.

Pediatric specialty hospitals and community hospitals with pediatric programs:

- Prepare surge plans to accommodate up to 120% capacity.
- Continue to prioritize surgeries and procedures, including prioritizing patients waiting beyond clinical access targets ("long waiters") and ramp up scheduled surgeries that do not require any inpatient footprint.
- Collaborate with other hospitals providing pediatric care to share best practices and support a unified, coordinated pediatric system.
- Support timely repatriation from pediatric specialty hospitals to community hospitals, ideally within 24 hours.
- Utilize peer-to-peer channels between pediatric specialty hospitals and community hospitals to support health care providers when faced with challenging care situations.
- Implement newly funded initiatives that will support fall/winter surge response, including rapid assessment clinics to support emergency department diversion.
- Collaborate with IMS and/or regional tables, including accepting transfers of patients. Ensure transfers to community hospitals are accepted within 24 hours when directed.

Rehabilitation and complex continuing care:

- Implement the Operational Direction on Rehabilitation and Complex Continuing Care Capacity and Flow (released July 12, 2023), including working towards implementing a 7-day-a-week discharge and admissions process.
- For post-acute care hospitals, prepare surge plans to match the occupancy levels of surrounding acute care hospitals.

Long-term care homes:

- Proactively assess residents for COVID-19 therapeutics prior to potential infection, as outlined in COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings.
    - Review Ontario Health's resources related to COVID-19 therapeutics.
- Reduce potentially unnecessary ED visits by maximizing the availability of in-house clinical support for acute illnesses, ensuring access to primary care, and leveraging in-house or community diagnostic resources.
- Utilize supports and resources provided by the Ontario Caregiver Organization (the Essential Care Partner Support Hub) to ensure that caregivers are identified, included, and supported as essential care partners.
- Promptly repatriate residents who have been in hospital and have been discharged, ideally within 24 hours, inclusive of weekends.
- Connect with local Infection Prevention and Control (IPAC) Hubs to access IPAC expertise and support where needed (contact IPACHubs@ontario.ca for more information).
- Ensure adequate PPE supplies are on hand.
    - Register and order supplies through the Provincial PPE Supply Portal.

Community support services providers:

- Continue to provide patient programming that enables patients/clients to maintain independence in the community.
- Communicate with clients about the importance of vaccinations against influenza and COVID-19.

Home and community care providers:

Direction provided in partnership with Home and Community Care Support Services

- Continue to support service continuity.
- Collaborate with hospitals to support safe and timely transitions of patients from hospital to home.
- Continue to implement capacity planning initiatives, particularly in hard-to-serve areas, including virtual care, shift-based care and approved new models of care.
- Maintain and strengthen regional pathways for administration of intravenous COVID-19 therapeutics (remdesivir) to keep people out of emergency departments and hospitals.
- Work collaboratively with Regional Tables and regional strategies to support local emergency department diversion strategies and support the transition of ALC patients to home and community settings.
- Communicate with clients about the importance of vaccinations against influenza and COVID-19.

ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY (Applicants)	HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO, THE MINISTER OF HEALTH, and THE MINISTER OF LONG-TERM CARE (Respondents)	Court File No.: CV-23-00698007-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

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