Court File No. CV-23-00698007-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E 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

Respondents

AFFIDAVIT OF DR. JORDAN PELC

I, DR. JORDAN PELC, of the City of Toronto, in the Province of Ontario, MAKE OATH AND SAY:

1. I am a physician and a Canadian College of Family Physicians certified specialist in Family Medicine, with additional fellowship training in Hospital Medicine. Over the last ten years, I have worked at a number of hospitals in Ontario, both rural and urban/academic. My fulltime clinical work has always focused on hospital medicine, though I also have experience in emergency medicine and primary care. I currently work as a hospitalist at Sinai Health. In this role, I act as the most responsible physician (MRP) for patients admitted both at our acute care site, Mount Sinai Hospital, and our post-acute (inpatient rehabilitation and complex continuing care) site, Hennick Bridgepoint Hospital. I am also an Assistant

Professor in the Temerty Faculty of Medicine at the University of Toronto. A copy of my curriculum vitae is attached hereto as Exhibit "A".

2. I have been retained by the Government of Ontario to address the following questions:

    a) What is your role at the hospital with respect to alternate level of care (ALC) patients?
    b) Please describe the process for designating a patient as ALC, for reviewing this designation and for un-designating an ALC patient. Please comment on what your role is and what role is played by others.
    c) Has the process for designating a patient as ALC changed as a result of Bill 7?
    d) At any given time, approximately how many patients designated ALC are there in your hospital?
    e) What effect does the presence of ALC patients in your hospital have on the availability of beds for patients in need of acute care?

A) <u>My role in ALC designation</u>

3. As MRP, I write orders to designate and de-designate patients alternate level of care (ALC) at both sites of Sinai Health. This includes patients on general internal medicine, surgery, rehabilitation, and complex continuing care floors.

4. I feel particularly close to work with ALC patients because of the context of my clinical work for the past several years. Historically, I worked on ALC-dedicated teams at both Mount Sinai Hospital and Hennick Bridgepoint. For this reason, I previously attended weekly ALC administrative huddles at both sites and became very familiar with care planning for this population. As a hospitalist working in both acute care and rehabilitation, I am likewise very familiar with the care trajectory of ALC-designated patients, as most patients transferred to my care for rehabilitation would first have been designated ALC in acute care.

5. Additionally, I am the hospital medicine director and medical informatics lead for Hennick Bridgepoint Hospital. In my role as hospital medicine director, I am involved in

administrative activities related to ALC designation for the hospital. I am a member of the Sinai Health ALC/Complex Transitions Steering Committee. I am involved in a number of quality improvement projects associated with ALC-designation which are intended to help implement Ontario Health's ALC-leading practices. I am likewise involved in education for hospital staff and physicians about the ALC designation process. I am a member of the Transitional Care Unit Science of Care group at Sinai Health, which is an interdisciplinary group working on academic projects related to patient care on our ALC unit at Hennick Bridgepoint Hospital. Through this and other collaborations, I have disseminated projects related to medication prescribing, group programming, periodic health reviews and bioethics, among others, in this population. I am currently collaborating on a project about patients transferred to the ALC unit from our inpatient palliative care unit. As such, in addition to my clinical work, I am very grounded in ALC work operationally and academically.

6. My expertise is in acute and post-acute inpatient care (including assessment and treatment) and hospital medical operations/administration. I understand that my role is to provide opinion evidence that is fair, objective and non-partisan, related only to matters that are within my area of expertise and to provide additional assistance as the court may require. My signed Acknowledgement of Expert's Duty is attached as Exhibit "B".

B) <u>The process for designating patients as ALC and for removing that designation</u>

7. Patients are not designated ALC arbitrarily. There is a specific definition and there are specific criteria which we use at my hospitals for ALC designation. These are standard and have been developed by Ontario Health. As an approximate rule of thumb, we ask ourselves if it would be clinically appropriate to discharge a patient if there were currently a bed available for them in their next destination. If the answer is yes, then in most cases the patient

would be designated ALC. A copy of Ontario Health's ALC Reference Manual is attached hereto as Exhibit "C".

8. It follows from this approach that ALC designation does differ in different contexts. This is not because the definition changes, but because different hospital services are designed to meet different patient needs. A patient who is appropriate to designate ALC while awaiting transfer from an acute care facility to rehab has different care needs from a patient who is appropriate to designate ALC when they are awaiting discharge from rehab to home.

9. From a process perspective, decisions to designate patients ALC are made at interdisciplinary rounds. A patient is designated ALC when there is consensus that they meet ALC criteria. The most responsible physician (or a physician trainee on their team) writes an ALC order. A social worker may take a 'verbal order' from the physician to designate a patient ALC, meaning they enter the electronic order into the electronic medical record with the approval of the most responsible physician. The team social worker ensures that ALC-designated patients are added to the hospital ALC list.

10. It is accurate to characterize the ALC designation as an administrative, rather than a diagnostic term. Moreover, ALC-designated patients may become medically active and at some point it may be appropriate to discontinue their ALC designation. It is also true that most ALC-designated patients are frail and elderly, and as such are at risk of future deterioration. Unfortunately, all patients – indeed all human beings – have some risk of becoming medically unwell in the future, even if they are well at present. The frail elderly population unfortunately has an elevated risk of becoming unwell. This is true for frail elderly patients in all care environments, including those appropriately admitted to long-term care (LTC).

11. Similarly, it is unfortunately true that patients discharged from hospital have a high risk of deterioration requiring presentation to the emergency department, though in most cases not for preventable reasons. People who have frailty and who have been sick enough to require hospitalization unfortunately often have intrinsic risk for becoming sick again. This does not necessarily mean that they were prematurely deemed stable. When ALC-designated patients have evidence of clinical status changes in hospital, they are reassessed by their clinical team.

12. ALC designated patients continue to receive care in the hospital. Often, the intensity of care they require from certain disciplines, for example nursing for basic care and social work for discharge planning, can be higher than for many other patients. Consultant services are often called for ALC designated patients, common examples being both Geriatrics and Geriatric Psychiatry. This demonstrates the expected process, namely, that when teams feel a patient (including those designated ALC) would benefit from medical reassessment, teams do indeed reassess them and offer appropriate intervention by consulting the appropriate specialty. If the consultant identifies clinical concerns that warrant removal of the ALC designation, teams appropriately follow this advice. In other words, ALC patients still receive care. If it is found that a patient is no longer appropriate for discharge, their ALC designation is removed.

13. Relatedly, it is true that some patients discharged from acute facilities may return ('bounce back') or may require take-back letters. A take-back letter is when the hospital agrees, in advance, to re-admit a patient if deemed necessary by the institution that is receiving the patient post-discharge. In my experience, this is not something we commonly see in the population being discharged from hospital to long-term care. At my hospital, there is rapid turnover of patients in the acute-care environment, with a goal of short, focused hospital stays for most patients, many of whom have significant underlying medical pathology and

social vulnerability. For many reasons, patients do have a high risk of returning to acute care shortly after they are discharged. The hospital population awaiting long-term care is different.

14. Patients who are awaiting long-term care are usually those who either presented with acute illness which has since resolved, or who presented with care needs that could not be met in the community. They generally are admitted to hospital for weeks, months, or longer, as teams try to develop clinically-appropriate discharge plans, work through the long-term care process, and ultimately await a bed offer for long-term care. In most cases, these patients have demonstrated exceptionally long periods of stability in hospital and do not rapidly return once discharged. As noted above, if their clinical status changes, their ALC status would be discontinued. I am not aware of a take-back letter ever being used for a long-term care discharge for a patient under my care.
15. At my hospital, we have a continuous quality improvement process for ALC-designation. There is an ALC steering committee that is implementing best practices directed by Ontario Health. The observation from the steering committee has been that there are far more patients appropriate for ALC who have not received this designation than there are patients inappropriately made ALC who need to be de-designated. A primary purpose of the continuous quality improvement work has been to provide education on when to designate patients ALC with the aim of consistency, so that we are approaching all patients equitably. The quality improvement work also provides us with data that allows us to better understand the care needs of the population we care for. A copy of Ontario Health's ALC Leading Practices Guide is attached hereto as Exhibit "D".
16. Finally, it is true that there are patients whose care needs don't fit well into the limited options available in our healthcare system. In my view, this is not a problem with the ALC

designation process per se. Whether or not these patients are designated ALC, they will either remain inappropriately hospitalized or be discharged to a suboptimal disposition.

D) <u>ALC designations after Bill 7</u>

17. Overall, the process for designating a patient ALC has not changed as a result of Bill 7. Patients are designated or de-designated ALC based on the Ontario Health definition, usually as part of a team discussion.

18. For as long as I have been in practice, all of the hospitals and homecare systems with which I have worked have been clear that the role of the hospital is to provide healthcare. The hospital is not a home. My understanding is that physicians are obligated by law to write a discharge order when a patient no longer requires hospitalization. We also have obligations to provide a clinically-appropriate discharge. There are very long wait times for long-term care. As I have already noted, patients have waited for months and even years in hospital for long-term care beds. If long-term care is required, it should be explored from the community; it should only be explored from the hospital when all other options for a clinically-appropriate discharge have been considered and are not feasible. This is the direction that clinicians and trainees have received from hospitals and local health integration networks for as long as I have been in practice.

19. Prior to the implementation of the measures introduced by Bill 7, care teams at my hospital did indeed always explore other discharge options and would only contemplate transfer from hospital to long-term care if there were no other clinically-appropriate discharge options. Waiting in hospital for long-term care required special approval by hospital management. We were always clear that if the hospital agreed to have a patient remain admitted until they could be transferred to long-term care, the patient or their substitute decision maker had to

choose multiple long-term care home options with reasonable wait times. Patients could not wait for only one choice and could not choose only facilities with long wait times. This was both because the long wait times would critically reduce the hospital's capacity to provide specialized hospital care to other patients, and also because the wait times for some homes are so long that patients sometimes die in hospital while awaiting an LTC transfer.

20. The actual process for applying for LTC is facilitated by social work and a Home and Community Care Support Services coordinator. There is a physician role in completing a health report, which is usually done through the electronic Resource Matching and Referral system. The remainder of the process – including completing the remainder of the application, assessing decision-making capacity, choosing which homes to apply to (and to send the patient's personal health information), and managing the bed offer when it comes – is not managed by physicians.

21. This process has not changed as a result of Bill 7. We still explore non-LTC options, contemplate waiting in hospital for LTC only if all other options have been exhausted, and work with patients and substitute decision makers to choose homes that balance their preferences with reasonable wait times. The mechanics of applying to LTC continue to be managed by social work and Home and Community Care Support Services as they were before Bill 7.

22. In my experience at the hospital, we have not had to charge any of the patients under my care the daily rate required by the changes brought in under Bill 7.

E) <u>ALC patient numbers and their impact on the availability of acute care beds</u>

23. The most recent numbers I have from Ontario Health indicate that there are 49 ALC patients at Mount Sinai, out of 294 operational acute beds, and 74 at Hennick Bridgepoint Hospital, out of a total of 473 operational post-acute beds, for a total of 123 at Sinai Health.

24. We have a limited number of beds in the hospital. High ALC numbers affect our ability to provide care to patients whose care needs can only be met in the bed types we offer. Based on the most recent numbers, we have twenty-one patients admitted to Mount Sinai Hospital who do not have beds. These are patients who require admission to hospital, but are physically unable to be moved from the emergency department. I have had acutely ill patients admitted under my care who have not yet been moved from the waiting room. This is dangerous for both Emergency Department flow and for access to appropriate nursing care for admitted patients.

25. In addition, many other specialty services can be affected. We have at times had to cancel surgeries because there are not enough inpatient beds to offer appropriate post-operative care. We have had fewer available inpatient rehabilitation beds and at one time converted an entire inpatient rehabilitation unit to an ALC unit because of very high ALC volumes.

26. Currently, there is massive demand for our post-acute services, with occupancy at Hennick Bridgepoint Hospital at times at 99% despite multiple recent increases in our bed capacity. All of these post-acute inpatient services, including rehabilitation, complex continuing care, and palliative care, can only provide their specialized services if their beds are available for patients who need them.

SWORN BEFORE ME in the City of Toronto by Dr. Jordan Pelc at the City of Toronto, before me on February 23, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

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Commissioner for the Taking of Affidavits

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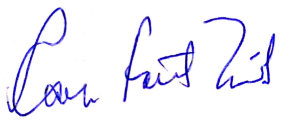
DR. JORDAN PELC

This is **Exhibit "A"** referred to in the Affidavit

of **Dr. Jordan Pelc,** sworn this 23rd day of

February, 2024, in accordance with O. Reg 431/20,

Administering Oath or Declaration Remotely



A Commissioner for taking Affidavits etc. (or as may be)

(pursuant to O. Reg. 431/20)

Curriculum Vitae

Jordan Pelc

BA&Sc, MSc, MD, CCFP

Primary office: Hennick Bridgepoint Hospital
5.158-1 Bridgepoint Drive, Toronto, ON M4M 2B5
Telephone: (416) 461 – 8251 x 2766
Email: jordan.pelc@sinaihealth.ca

A. Date Curriculum Vitae is Prepared: 2024 February 22

B. Biographical Information

1. EDUCATION

Degrees

2008 – 2012	Doctor of Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario
2006 – 2008	Master of Science, Chemical Physics Theory, Department of Chemistry, University of Toronto, Toronto, Ontario, Supervisor: Paul Brumer
2002 – 2006	Bachelor of Arts and Science**,** Physics and Philosophy, McGill University, Montreal, Quebec

Postgraduate Training

2014 – 2015	Hospitalist/Academic Family Medicine Fellow, Departments of Family and Community Medicine and Internal Medicine, Toronto Western Hospital, University Health Network and University of Toronto, Toronto, Ontario
2012 – 2014	Family Medicine Resident, Department of Family and Community Medicine, North York General Hospital and University of Toronto, Toronto, Ontario

Qualifications, Certifications and Licenses

2014 – Present	Certificate, Canadian College of Family Physicians
2012 – Present	Certificate, College of Physicians and Surgeons of Ontario

2023	Certificate, Advanced Cardiac Life Support (ACLS)
2023	Certificate, San'yas, Indigenous Cultural Safety Training
2016	Certificate, Advanced Cardiac Life Support (ACLS)
2014	Certificate, Advanced Trauma Life Support (ATLS)
2012	Licentiate, Medical Council of Canada

2. EMPLOYMENT

Current Appointments

2024	Hospital Medicine Operations Lead, Hennick Bridgepoint Hospital, Sinai Health, Toronto, Ontario
2022 – Present	Medical Informatics Lead, Rehabilitation and Specialized Medicine and Complexity Care, Sinai Health, Toronto, Ontario
2021 – Present	Assistant Professor, Department of Family and Community Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario
2018 – Present	Hospital Medicine Site Director, Hennick Bridgepoint Hospital, Sinai Health, Toronto, Ontario
2016 – Present	Clinician Teacher, Mount Sinai Hospital and Hennick Bridgepoint Hospital, Sinai Health, Toronto, Ontario
2016 – Present	Hospitalist, Active Provisional Privileges, Mount Sinai Hospital and Hennick Bridgepoint Hospital, Sinai Health, Toronto, Ontario
2016 – Present	Clinical Associate, General Internal Medicine, Toronto General Hospital, University Health Network, Toronto, Ontario

Previous Appointments

2016 – 2021	Lecturer, Department of Family and Community Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario
2015 – 2016	Locum Physician, Emergency Department, Haliburton Highlands Health Service, Haliburton, Ontario
2014 – 2016	Locum Physician, Emergency Department, South Bruce Grey Health Centre, Kincardine, Ontario
2014	Locum Physician, Emergency Department, Acute Care, and Family Practice, Blind River District Health Centre, Blind River, Ontario
2014	Locum Physician, Family Practice of Dr. D. Kornhauser and Dr. N. Anagnotopoulos, Toronto, Ontario

3. HONOURS AND CAREER AWARDS

Distinctions and Research Awards

INTERNATIONAL

Nominated

2022 **Puschart Prize, Best of the Small Presses Series**
For 'The Interpreter'; nominated by The Intima: A Journal of Narrative Medicine

NATIONAL

Received

2020 **Mimi Divinsky Award for History and Narrative in Family Medicine**, College of Family Physicians of Canada, Canada

PROVINCIAL/REGIONAL

Received

2023 **People's Choice Award, 1st Place Poster Presentation**, GTA Rehab Network Best Practices Day 2023, Toronto, Ontario (with S. Khalid, R. Macri, J. MacFadden, O. Ghaffar)

LOCAL

Received

2023 **Citizenship Award**, Division of Hospital Medicine, Sinai Health, Toronto, Ontario
2023 **Sinai Health Excellence in Quality and Safety Award**, Sinai Health, Toronto, Ontario (with J. Wolfstadt, M Guo, C. Fortin and C. Soong)
2023 **Best Poster Award**, UHN Brain Injury Conference, Toronto, Ontario (with S. Khalid, R. Macri, J. MacFadden, O. Ghaffar)
2021 **Citizenship Award**, Division of Hospital Medicine, Sinai Health, Toronto, Ontario
2018 **Leadership in Education Award**, Sinai Health System, Toronto, Ontario
2002 – 2006 **Great Distinction**, McGill University, Montreal, Quebec
2003 – 2004 **Dean's Honour List**, Faculty of Science, McGill University, Montreal, Quebec
2003 **McConnell Award**, Faculty of Science, McGill University, Montreal, Quebec

Teaching Awards

LOCAL

Received

2022	**Teaching Excellence Award**, Undergraduate Medical Education, University of Toronto MD Program, Toronto, Ontario
2022	**Teaching Award,** Division of Hospital Medicine, Sinai Health, Toronto, Ontario
2021	**Teaching Excellence Award**, Undergraduate Medical Education, University of Toronto MD Program, Toronto, Ontario
2020	**Distinguished Educator Award**, Sinai Health, Toronto, Ontario
2018	**Teaching Excellence Award**, Undergraduate Medical Education, University of Toronto MD Program, Toronto, Ontario
2018	**Individual Teaching Excellence Award in Undergraduate Education**, Whiteman-Berris Academy, University of Toronto, Toronto, Ontario

Nominated

2018	**Distinguished Educator Award**, Sinai Health System, Toronto, Ontario

Student/Trainee Awards

Received

2023	**Student Research Award**, Summer Research Student, Division of Hospital Medicine, Sinai Heath, Toronto, Ontario. 5,000.00 CAD

LOCAL

4. PROFESSIONAL AFFILIATIONS AND ACTIVITIES

Professional Associations

2012 – Present	Member, Canadian Medical Association
2012 – Present	Member, Ontario Medical Association

Administrative Activities

NATIONAL

2020	Member, Choosing Wisely Canada Advance Care Planning Group, Toronto, Ontario

PROVINCIAL/REGIONAL

2021 – Present Post Acute Care Hospital Physician Leadership Table, Greater Toronto Area, Toronto, Ontario

LOCAL

2024 – Present Member, Medication Reconciliation Committee, Sinai Health, Toronto

2023 – Present Member, ALC/Complex Transitions Steering Committee, Sinai Health, Toronto, Ontario

2023 – Present Member, HBH EPR Review Advisory, Sinai Health, Toronto, Ontario

2023 – Present Member, Digital Health Committee, Department of Family and Community Medicine, Temerty Faculty of Medicine, Toronto, Ontario

2022 – Present Member, HBH EPR Committee, Sinai Health, Toronto, Ontario

2022 – Present Member, E-Health Steering Committee, Sinai Health, Toronto, Ontario

2022 – Present Member, Advancing 9th Floor Complex Care Program Steering Committee, Sinai Health, Toronto, Ontario

2022 – Present Member, Hennick Bridgepoint Hospital Post-Graduate Education Committee, Sinai Health, Toronto, Ontario

2022 – Present Member, Hennick Bridgepoint Hosptial Department of Medicine Strategy Committee, Sinai Health, Toronto, Ontario

2021 – Present Co-Lead, Bridgepoint Physician Quality Huddles, Hennick Bridgepoint Hospital, Toronto, Ontario

2021 – 2022 Member, Accreditation Preparation – Principle-Based Decision Making, Sinai Health, Toronto, Ontario

2021 – Present Member, Exit-Seeking Patient Working Group, Bridgepoint Active Healthcare, Sinai Health, Toronto, Ontario

2021 Member, Antimicrobial Stewardship Committee, Bridgepoint Active Healthcare, Sinai Health, Toronto, Ontario

2021 Member, Family-Physician-in-Chief Search Committee, Sinai Health, Toronto, Ontario

2021 Member, Physiatry Recruitment Committee, Sinai Health, Toronto, Ontario

2020 – Present Member, Acquired Brain Injury Redesign Group, Bridgepoint Active Healthcare, Toronto, Ontario

2019 – Present Member, Transitional Care Unit Science of Care Group, Bridgepoint Active Healthcare, Toronto, Ontario

2019 – 2020 Academic Medical Rehab Unit Planning Group, Bridgepoint Active Healthcare, Toronto, Ontario

2019 – Present Member, Hospital Medicine Executive Committee, Sinai Health System, Toronto, Ontario

2019 – Present	Member, Medical Leadership Council, Bridgepoint Active Healthcare, Toronto, Ontario
2018 – 2019	Member, Physician Plan Working Group: Bridgepoint Bed Capacity Expansion, Bridgepoint Active Healthcare, Toronto, Ontario
2019 – 2019	Member, Bridgepoint Bed Capacity Expansion Med Rehab Working Group, Bridgepoint Active Healthcare, Toronto, Ontario
2017 – 2020	Member, Ethics Committee, Sinai Health System, Toronto, Ontario
2017 – 2018	Member, Transitional Care Unit Quality Improvement Steering Committee, Sinai Health System, Toronto, Ontario
2018	Member, Head of Hospital Medicine Search Committee, Sinai Health System, Toronto, Ontario
2017 – 2018	Member, Physiatry Recruitment Committee, Sinai Health System, Toronto, Ontario
2017	Member, Dementia Committee, Sinai Health System, Toronto, Ontario
2016 – 2017	Member, ALC Committee, Sinai Health System, Toronto, Ontario
2015	Member, Admissions Committee, Department of Family and Community Medicine PGY3 Hospital Medicine Program, University of Toronto, Toronto, Ontario

Peer Review Activities

MANUSCRIPT REVIEWS

2019	BMJ Open Quality, Number of Reviews: 1
2019	Journal of Hospital Medicine, Number of Reviews: 1

Other Professional Activities

2024	Sinai Health Physiatry Five-Year Division-Director Review
2023	Clinical Supervisor, College of Physician and Surgeons of Ontario physician undertaking (3 months)

C. Academic History

1. RESEARCH AWARDS

Grants, Contracts and Clinical Trials

PEER-REVIEWED GRANTS

2023 **Co-Investigator.** Triage On-Call Medical Safety. Hennick Bridgepoint Hospital Foundation Grant. 1,000.00 CAD.

2023 **Co-Investigator.** Substance Use Disorder and Acquired Brain Injury. Sinai Health Quality Improvement Funding Competition and Sinai Health Department of Psychiatry. 10,000.00 CAD.

2023 **Principal Investigator.** Therapeutic Relationships in Complex Continuing Care: A Qualitative Study. Science of Care Research Competition, Sinai Health. Collaborators: Jon Hunter, Mary Zheng. 9,877.36 CAD.

2021 **Principal Investigator.** My Flight got Cancelled, What Now? A Pilot Study of Examining the Qualitative Experiences of Palliative Care Patients who Experience Live Discharges from an Inpatient Palliative Care Unit, Their Family Caregivers and Clinical Teams**.** Comprehensive Research Experience for Medical Students (CREMS) Department of Family and Community Medicine (DFCM) matched funding. 2,750 CAD.

2020 – 2021 **Co-Investigator.** My Flight got Cancelled, What Now? A Pilot Study of Examining the Qualitative Experiences of Palliative Care Patients who Experience Live Discharges from an Inpatient Palliative Care Unit, Their Family Caregivers and Clinical Teams**.** Science of Care Innovation Grant, Sinai Health. Collaborators: Georgi Georgievsky, Brenda Stein, Jeff Myers. 5,000 CAD.

Salary Support and Other Funding

PERSONAL SALARY SUPPORT

2023 **Principal Investigator.** Medical Clearance? A Case of Acute Medical Illness Presenting as Psychiatric Decompensation. Faculty Development Grant, Department of Family and Community Medicine, Faculty of Medicine, University of Toronto. 750 CAD.

2018 – 2019 **Principal Investigator.** Voluntary Stopping Eating and Drinking (VSED): Another EoL Option or Unacceptable practice? Faculty Development Grant, Department of Family and Community Medicine, Faculty of Medicine, University of Toronto. 2,000 CAD.

D. Publications

1. PEER-REVIEWED PUBLICATIONS

Journal Articles

Coauthor. Rotteau L, Othman D, Dunbar-Yaffe R, Fortin C, Go K, Mayo A, **Pelc J**, Wolfstadt J, Guo M, Soong C. Physician engagement in organizational patient safety through the implementation of a Medical Safety Huddle initiative: A qualitative study. *BMJ Quality and Safety*. Published Online First: 19 July 2023. doi: 10.1136/bmjqs-2022-015725.

Coauthor. Guo M, Bayley M, Cram P, Dunbar-Yaffe R, Fortin C, Go K, Linett L, Matelski J, Mayo A, **Pelc J**, Robinson LR, Rotteau L, Wolfstadt J, Soong C. Protocol for a stepped wedge cluster randomized quality improvement project to evaluate the impact of medical safety huddles on patient safety. *Contemporary Clinical Trials Communications,* 30 (2022) 10099.

Principal author. Pelc J. The Interpreter. *Intima: A Journal of Narrative Medicine*, 2021.

Coauthor. Azimi M, Burry L, Duclos C, **Pelc J**, Upshur R. Medication Use by Alternate Level of Care Patients: A Descriptive Analysis. *Can J Hosp Pharm*, 2019;72(4):282-287. Impact factor: 0.37

Principal author. Pelc J, Gong, J, and Brumer P. Chaos and Correspondence in Classical and Quantum Hamiltonian Ratchets: A Heisenberg Approach. *Physical Review E*, 2009;79:066207. Impact factor: 2.35

Principal author. Pelc J. Developing the Ethics of Animal Research: A Scientific Solution to a Scientific Problem. *Philosophic Fragments: Undergraduate Journal of Philosophy (McGill University)*, 2006:22:29-46.

Abstracts

Senior Responsible Author. Georgievski G., Alfaro L., McClenaghan M., Soares D., Matheson M., Stanoulis K., Boyle D., Chau L., and **Pelc J**. Transitioning to transitional care: Optimizing responsive behaviour management of ALC patients with dementia through the Transitional Care Unit Transfer Checklist. *Canadian Geriatrics Journal,* 2020:23(1), 46-47.

Senior Responsible Author. McClenaghan M., Georgievski G., Alfaro L., Soares D., Matheson M., Stanoulis K., Boyle D., Byrne J., Chau L., and **Pelc J**. Evaluation and sustainability of Behaviour Huddles: Simple intervention for a complex issue. *Canadian Geriatrics Journal,* 2020:23(1), 48-49.

Senior Responsible Author. Alfaro L., Snash N., Georgievski G., Soares D., Matheson M., Stanoulis K., McClenaghan M., Boyle D., Chau L., and **Pelc J**. Supporting sexual expression in patients with dementia. *Canadian Geriatrics Journal,* 2020:23(1), 47.

Senior Responsible Author. Matheson M., Stanoulis K., Boyle D., McClenaghan M., Soares D., Georgievski G., Alfaro L., Chau L., and **Pelc J**. Collaboration in practice: Using group-based therapeutic programming to increase patient satisfaction and quality of life on a Transitional Care Unit. *Canadian Geriatrics Journal,* 2020:23(1), 47-48.

Senior Responsible Author. Soares D., Alfaro L., McClenaghan M., Matheson M., Stanoulis K., Georgievski G., Boyle D., Chau L., and **Pelc J**. Working together: Using group-based therapeutic programming to increase patient satisfaction and quality of life on a Transitional Care Unit. Canadian Geriatrics Journal, 2020:23(1), 48.

Coauthor. Azimi M, Burry L, Duclos C, **Pelc J**, Upshur R. A descriptive analysis of an alternate-level-of-care patient cohort: comprehensive medication overview. *Can J Hosp Pharm*, 2018;71(1): 59-60.

Book Chapters

Principal author. Pelc J. "Pandemic." (2023) In *The COVID journals: healthcare workers write the pandemic*, edited by Neilson S, Fraser S and Dhara A. Edmonston: University of Alberta Press. Page 67.

3. NON-PEER-REVIEWED PUBLICATIONS

Other Publications

Principal author. Pelc J. Alan. *Canadian Family Physician*, 2021:67(1):49-50. Impact factor: 3.112

Principal author. Pelc J. May. *Journal of Palliative Medicine*, 2019;22(8):1006. Impact factor: 2.48

E. Presentations and Special Lectures

1. INTERNATIONAL

Abstracts and Other Presentations

2020 Oct13 **Coauthor.** Voluntary Stopping Eating and Drinking (VSED): Another EoL Option or Unacceptable practice? 23rd International Congress on Palliative Care. Allatt P, **Pelc J** and Tracy S. (Accepted; conference cancelled because of COVID-19.)

2. NATIONAL

Abstracts and Other Presentations

2023 May 18 **Senior Responsible Author.** Toolkit for at-risk patients seeking discharge. Brain Injury Canada Conference. **Pelc** J, Macri R and Khalid S.

2021 Nov 10 **Principal Author.** Optimizing Primary Care for Long-Stay Hospital Patients. Family Medicine Forum 2021. Soong C and **Pelc J**.

2020 Nov 4 **Senior Responsible Author.** Rehab Against the Clock: Outcomes in Dialysis Rehabilitation. Family Medicine Forum 2020. Fernandes S and **Pelc J.**

2020 June 3 **Senior Responsible Author.** Voluntary Stopping Eating and Drinking (VSED): Another EoL Option or Unacceptable practice? Canadian Bioethics Society. Allatt P and **Pelc J**. (Accepted; conference cancelled because of COVID-19.)

2019 Oct 3 **Senior Responsible Author**. Evaluation & Sustainability of Behaviour Huddles: Simple Intervention for a Complex Issue. Canadian Conference on Dementia. McClenaghan M, Georgievski G, Alfaro L, Soares D, Matheson M, Stanoulis K, Boyle D, Byrne J, Chau L, **Pelc J**.

2019 Oct 3 **Senior Responsible Author**. Working Together – Using Group Based Therapeutic Programming to Increase Patient Participation and Satisfaction on a Transitional Care Unit. Soares D, Alfaro L, McClenaghan M, Matheson M, Georgievski G, Stanoulis K, Boyle D, Linh C, **Pelc J**.

2019 Oct 3 **Senior Responsible Author**. Collaboration in Practice – Using Group-Based Therapeutic Programming to Increase Patient Satisfaction and Quality of Life on a Transitional Care Unit. Stanoulis K, Boyle D, Matheson M, CDA, Georgievski G, Alfaro L, McClenaghan M, Soares D, Chau L, **Pelc J**.

2019 Oct 3 **Senior Responsible Author**. Supporting Sexual Expression in Patients with Dementia: An Educational Intervention. Alfaro L, Snash N, Georgievski G, Soares D, Matheson M, Stanoulis K, McClenaghan M, Boyle D, Chau L, **Pelc J**.

2019 Oct 3 **Senior Responsible Author**. Transitioning to Transitional Care: Optimizing Responsive Behaviour Management of ALC Patients with Dementia through the Transitional Care Unit Transfer Checklist. Georgievski G, Alfaro L, McClenaghan M, Soares D, Matheson M, Stanoulis K, Boyle D, Chau L, **Pelc J**.

3. PROVINCIAL/REGIONAL

Abstracts and Other Presentations

2023 May 5 **Co-Author.** Toolkit for at-risk patients seeking discharge. GTA Rehab Network Best Practices Day. Khalid S, McFadden J, **Pelc** J, Ghaffar O and Macri R.

2022 May 6 **Senior Responsible Author.** Repurposing Transitional Care: Lessons Learned from the Transformation of a Transitional Care Unit to a Temporary Rehabilitation Unit during the COVID-19 Pandemic in Toronto, Ontario. GTA Rehab Network Best Practices Day. Georgievski G, Alfaro L, Matheson M, McClenaghan M, Soares D, Chantziantoniou D, Chau L, and **Pelc J**.

2020 July 28 **Senior Responsible Author**. Voluntary Stopping Eating and Drinking (VSED): Another EoL Option or Unacceptable practice? AdvantAge Ontario Virtual Summer School. Allatt P and **Pelc J**.

2020 April 22 **Senior Responsible Author**. Voluntary Stopping Eating and Drinking (VSED): Another EoL Option or Unacceptable practice? AdvantAge Ontario. Allatt P and **Pelc J**. (Accepted; conference cancelled because of COVID-19.)

2020 May 1 **Senior Responsible Author.** Towards Transitional Care: Developing a New Approach to Care for Alternate Level of Care Patients. Best Practice Day 2020, GTA Rehab Network. Georgievski G, Alfaro L, Matheson M, McClenaghan M, Soares D, Chantziantoniou D, Chau L, and **Pelc J**. (Accepted; conference postponed because of COVID-19.)

2019 April 28 **Senior Responsible Author**. Voluntary Stopping Eating and Drinking (VSED): Another EoL Option or Unacceptable practice? Hospice Palliative Care Ontario. Allatt P and **Pelc J**.

4. LOCAL

Abstracts and Other Presentations

2024 Jan 31 **Co-Author.** ALC Definition and Designation: *Refresher*. Ramsden R, Sterling K, Macri R, **Pelc J**,

2023 Nov 9 **Principal Author.** An Approach to Working with At-Risk Patients Expressing a Desire for Discharge. Sinai Health Bioethics Grand Rounds. **Pelc J**, McFadden J Ghaffar O and Macri R.

2023 Oct 18 **Principal Author.** Toolkit for at-risk patients seeking discharge. Sinai Health Quality and Safety Symposium. **Pelc J**, McFadden J Ghaffar O and Macri R.

2023 Oct 18 **Principal Author.** My Flight Got Cancelled, Now What? Sinai Health Quality and Safety Symposium. **Pelc J**.

2023 Oct 18 **Principal Author.** Therapeutic Relationships in Complex Continuing Care: A Qualitative Study. Sinai Health Quality and Safety Symposium. **Pelc J**.

2023 Sept 29 **Co-Author.** Morbidity and Mortality Rounds. Sinai Health Division of Hospital Medicine. Joshi R and **Pelc** J.

2023 Feb 13 **Co-Author.** Toolkit for at-risk patients seeking discharge. University Health Network Annual Brain Injury Conference. Khalid S, McFadden J, **Pelc J**, Ghaffar O and Macri R.

2022 Oct 20 **Co-Author.** Capacity Opacity: Navigating the Muddy Waters of Consent, Capacity & Substitute Decision Making in Post-Acute Care. Sinai Health Interprofessional Medical Complexity Series. Cameron W, Ghaffar O, Macri R and **Pelc J**.

2022 April 5 **Principal Author.** The Medical Evaluation of Patients with Psychiatric Complaints. Bridgepoint Interprofessional Medical Grand Rounds. **Pelc J.**

2021 Oct 12 **Principal Author.** The Medical Evaluation of Patients with Psychiatric Complaints. Bridgepoint Interprofessional Medical Grand Rounds. **Pelc J.**

2021 June 3 **Senior Responsible Author.** Rehab Against the Clock: High Palliative Needs in Dialysis Rehabilitation. Department of Family and Community Medicine Conference, Faculty of Medicine, University of Toronto. Fernandes S and **Pelc J.** (Accepted; conference cancelled because of COVID-19.)

2021 June 3 **Senior Responsible Author.** ALC in Limbo: Optimizing Hospital Care for Long-Stay Patients in the Time of COVID-19. Department of Family and Community Medicine Conference, Faculty of Medicine, University of Toronto. Soong C and **Pelc J.** (Accepted; conference cancelled because of COVID-19.)

2020 April 24 **Senior Responsible Author.** Rehab Against the Clock: High Palliative Needs in Dialysis Rehabilitation. Department of Family and Community Medicine Conference, Faculty of Medicine, University of Toronto. Fernandes S and **Pelc J.** (Accepted; conference postponed because of COVID-19.)

2020 April 2 **Senior Responsible Author.** Voluntary Stopping Eating and Drinking (VSED): Acceptable practice? Brown Bag Ethics Lunch, Mount Sinai Hospital. Allatt P and **Pelc J**. (Accepted; presentation cancelled because of COVID-19.)

2020 March 9 **Senior Responsible Author.** Towards Transitional Care: Developing a New Approach to Care for Alternate Level of Care Patients. Sinai Health Science of Care Speaker Series. Georgievski G, Alfaro L, Matheson M, McClenaghan M, Soares D, Chantziantoniou D, Chau L, and **Pelc J**.

2018 Oct 10 **Senior Responsible Author.** Voluntary Stopping Eating and Drinking (VSED): Another EoL Option or Unacceptable practice? Joint Centre for Bioethics, University of Toronto. Allatt P and **Pelc J**.

2018 June 14 **Senior Responsible Author.** Voluntary Stopping Eating and Drinking (VSED): Acceptable practice? Brown Bag Ethics Lunch, Bridgepoint Hospital. Allatt P and **Pelc J**.

2018 April 13 **Senior Responsible Author.** The Challenges of Caring for Patients with Psychiatric and Medical Comorbidities in Hospital. Mount Sinai Hospital Psychiatry Grand Rounds. Rose R and **Pelc J**.

2018 Jan 11 **Senior Responsible Author.** Neurological Determination of Death and Accommodation: Implications for Bridgepoint. Brown Bag Ethics Lunch, Bridgepoint Hospital. **Pelc J,** Soluk-Figol I, Allatt P.

2017 Nov 9 **Principal author.** Conflicts with Substitute Decision Makers. Brown Bag Ethics Lunch, Bridgepoint Hospital. **Pelc J**.

2015 Aug 5 **Principal author.** The Medical Evaluation of Patients Presenting with Psychiatric Complaints. University Health Network Family Medicine Grand Rounds. **Pelc J.**

2015 March 11 **Senior Responsible Author.** Tailoring Teaching: What Does Your Learner Need. Interprofessional Applied Practical Teaching and Learning in the Health Professions, Department of Family and Community Medicine, University of Toronto. Khurana M, Leung D, Ma L, and **Pelc J**.

2010 April 1 **Principal author.** Ventral Frontal Function in Patients with Focal and Diffuse Injury. Medical Student Research Day, University of Toronto. **Pelc J** and Levine, B.

F. Teaching and Design

Teaching

2022 Tutor, Integrated Clinical Experience 1, Faculty of Medicine, University of Toronto, Toronto, Ontario

2022 Perioperative Medicine Tutor, Medicine Consults, Mount Sinai Hospital, University of Toronto, Toronto, Ontario

2021	Tutor, Integrated Clinical Experience 1, Faculty of Medicine, University of Toronto, Toronto, Ontario
2020	Tutor, Integrated Clinical Experience 1, Faculty of Medicine, University of Toronto, Toronto, Ontario
2020	Speaker, Bridgepoint Lunch and Learn teaching rounds (“Conflicts with Substitute Decision Makers”), Bridgepoint Active Healthcare, Toronto, Ontario
2019	Tutor, Integrated Clinical Experience 1, Faculty of Medicine, University of Toronto, Toronto, Ontario
2019	Tutor, Integrated Clinical Experience 2 (Geriatrics), Faculty of Medicine, University of Toronto, Toronto, Ontario
2018	Examiner, Clinical Skills 1 OSCE, Faculty of Medicine, University of Toronto, Toronto, Ontario
2018	Tutor Integrated Clinical Experience 1, Faculty of Medicine, University of Toronto, Toronto, Ontario
2018	Tutor, Integrated Clinical Experience 2 (Geriatrics), Faculty of Medicine, University of Toronto, Toronto, Ontario
2017	Speaker, General Internal Medicine Teaching Rounds (“Conflicts with Substitute Decision Makers”), Mount Sinai Hospital, Toronto, Ontario
2016 – 2017	Coach, Achieving Cognitive and Clinical Excellence in Training (AACE-IT), Toronto General Hospital, Toronto, Ontario

Mentorship

2022 – Present	Academic Mentor, Dr. Daniel Burd
2022	Career Mentor, Dr. Tony Chan
2021	Career Mentor, Dr. Lora Rotstein
2021	Peer Mentor, Dr. Rahul Joshi
2020	Peer Mentor, Dr. Isabelle Dobronyi
2020	Peer Mentor, Dr. Kaitlin Ianuzzi
2019	Peer Mentor, Dr. Joey Deveau
2019	Peer Mentor, Dr. Betty Chiu
2019	Peer Mentor, Dr. Dina Reiss
2019	Academic Mentor, Georgi Georgievsky
2019	Summer Student Mentor, Cornelius Beaver
2018	Career Mentor, Jarvie Alanan

Innovation

2021	Opioid Use Disorder Case, UHN/SH Medicine Consults *Developed an educational case about opioid use disorder for residents on the internal medicine consults service*
2020 – Present	Bridgepoint Interprofessional Medical Grand Rounds *Collaborating with Division of Hospital Medicine Education Lead to develop new lunchtime educational rounds for medical students, residents, and fellows*
2019 – 2020	Topics in Post-Acute Medicine *Develops and maintains a repository of post-acute care teaching materials for use for teaching faculty at Bridgepoint Active Healthcare*
2018 – Present	Bridgepoint Hospitalist Rotation Orientation *Develops and updates an orientation manual for Bridgepoint Active Healthcare hospital medicine trainees*
2018	Inpatient Rehabilitation: An Overview *Developed a review article on inpatient rehabilitation for Bridgepoint Active Healthcare hospital medicine trainees and faculty*
2017 – 2019	Academic Rehabilitation and Complexity Hospitalist Elective *Developed novel academic hospital medicine rotations at Bridgepoint Active Healthcare for medical students, residents, and fellows*

G. Research Supervision

1. GRADUATE EDUCATION

2023	**Supervisor**. Sharon Sukhdeo. MSc student, Institute for Health Policy, Management and Evaluation, Year 1. *Improving vaccination for long-stay patients in a chronic care facility*.
2019	**Supervisor.** Maria Magaz, MSc student, Institute for Health Policy, Management, and Evaluation, Year 1. *Improving interdisciplinary communication on an inpatient unit by replacing written communication with email communication.*

2. UNDERGRADUATE MD

2018 – 2020	**Supervisor.** Samantha Fernandes, CC2, University of Toronto MD Program. *Rehab Against the Clock: High Palliative Needs in Dialysis Rehabilitation.*

3. POSTGRADUATE MD

2018 – 2019 **Supervisor.** Riley Rose, R2, University of Toronto Psychiatry Residency. *The Challenges of Caring for Patients with Psychiatric and Medical Comorbidities in Hospital.*

4. SUMMER STUDENTS

2023 **Supervisor.** Armaan Babaei, York University undergraduate student. *My Flight got Cancelled, What Now? A Pilot Study of Examining the Qualitative Experiences of Palliative Care Patients who Experience Live Discharges from an Inpatient Palliative Care Unit, Their Family Caregivers and Clinical Teams*

2021 **Supervisor.** Jaqueline Chen, University of Toronto undergraduate student. *Changing the landscape for Alternate Level of Care patients by transforming Transitional Care: An example from a post-acute hospital in Toronto, Ontario.*

This is **Exhibit "B"** referred to in the Affidavit

of **Dr. Jordan Pelc,** sworn this 23rd day of

February, 2024, in accordance with O. Reg 431/20,

Administering Oath or Declaration Remotely

A Commissioner for taking Affidavits etc. (or as may be)

(pursuant to O. Reg. 431/20)

Court File No. CV-23-00698007-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY

Applicant

-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

ACKNOWLEDGMENT OF EXPERT'S DUTY

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1. My name is Dr. Jordan Pelc. I live at Toronto, in the Province of Ontario.
2. I have been engaged by or on behalf of the lawyers for the Respondent to provide evidence in relation to the above-noted court proceeding.
3. 3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:
    a. to provide opinion evidence that is fair, objective and non-partisan;
    b. to provide opinion evidence that is related only to matters that are within my area of expertise; and
    c. to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

4. 4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

February 16, 2024

DR. JORDAN PELC

This is **Exhibit "C"** referred to in the Affidavit

of **Dr. Jordan Pelc,** sworn this 23rd day of

February, 2024, in accordance with O. Reg 431/20,

Administering Oath or Declaration Remotely

A Commissioner for taking Affidavits etc. (or as may be)

(pursuant to O. Reg. 431/20)

Ontario Health

Alternate Level of Care (ALC)

Reference Manual

April 1, 2021
Version 3

Table of Contents

Acronyms

Acronym	Description
ACE	Acute Care Episode
AHF	Alternate Health Facility
ALC	Alternate Level of Care
ATC	Access to Care
BCS	Bed Census Summary
BD	Business Day
CCAC	Community Care Access Centre; to be renamed Home and Community Care Support Services (HCCSS)
CCC	Complex Continuing Care
CCO	Cancer Care Ontario
CCRS	Continuing Care Reporting System
CIHI	Canadian Institute for Health Information
DAD	Discharge Abstract Database
DD	Discharge Destination
DI	Diagnostic Imaging
ER	Emergency Room
FY	Fiscal Year
GUI	Graphical User Interface
HCD	Home Care Database
HL7	Health Level Seven International
interRAI-CA	Contact Assessment
interRAI-HC	Home Care Assessment
interRAI-PC	Palliative Assessment
LHIN	Local Health Integration Network
LOB	Line of Business
MADD	Most Appropriate Discharge Destination
Ministry	Ministry of Health
MLAA	Ministry LHIN Accountability Agreement
NACRS	National Ambulatory Care Reporting System

Acronym	Description
NRS	National Rehabilitation Reporting System
OACCAC	Ontario Association of Community Care Access Centres; now part of Ontario Health
ODB	Ontario Drug Benefit
OH	Ontario Health
OHA	Ontario Hospital Association
OHIP	Ontario Health Insurance Plan
OHQC	Ontario Health Quality Council
OMHRS	Ontario Mental Health Reporting System
OPCN	Ontario Palliative Care Network
ORB	Ontario Review Board
P	Percentile
PHI	Personal Health Information
RCA	Rehabilitative Care Alliance
RCC	Reactivation Care Centre
SNS	Specialized Needs and Supports
STTCM	Short Term Transitional Care Model
WTIS	Wait Time Information System
MFM	Message Failure Management
WT	Wait Time

1 – Overview: Alternate Level of Care (ALC) and Provincial Definition

This section provides an overview of the Emergency Room / Alternate Level of Care (ER/ALC Strategy), Access to Care at Ontario Health, as well as insight into the governance structure of the ALC program. This section ends with the provincial ALC definition and provides some guiding principles for designating a patient as requiring an alternate level of care.

Section Highlights

1.1 – Ontario's Emergency Room/Alternate Level of Care Strategy

Background

In 2004[1], the Ministry of Health and Long-Term Care (Ministry) announced **Ontario's Wait Time Strategy**, designed to reduce wait times by improving access to surgical and diagnostic imaging (DI) healthcare services in Ontario. To support this commitment, the Ministry appointed Cancer Care Ontario (CCO) (now part of Ontario Health) to lead the development and deployment of **Ontario's Wait Time Information System (WTIS).** The WTIS is a web-based information system for collecting surgical, diagnostic imaging and Alternate Level of Care (ALC) wait time information from across the Province. It is a tool that supports standardized wait time tracking and provide data vital to the reporting of wait time information (for more information, see Section 2 - Provincial ALC Information - the WTIS, pg. 15).

In 2008, the Ministry approved the **Emergency Room Information Strategy[2]** (later renamed to the ER/ALC Strategy). The strategy addresses the length of time patients spent in the ER. At the time and as seen historically, a contributor to long ER wait times was the high number of patients designated ALC occupying acute care beds and thus, preventing patients in the ER from being admitted to the hospital. Patients designated ALC are often not discharged because the appropriate level of care they require is not available when and where they need it.

Goal and Objectives

The overall goal of the ER/ALC Strategy was to reduce time spent in the ER and improve patient satisfaction by:

Reducing ER demand by providing people with appropriate community-based care

Increasing ER capacity, performance, and process so patients can access timely, quality care during emergencies

Improving bed utilization by enhancing timely discharge for patients requiring alternate levels of care and accessing the right resources in more appropriate settings

[1] https://news.ontario.ca/archive/en/2004/12/20/McGuinty-Government-launches-new-website-on-the-province039s-wait-time-strategy.html (Accessed Oct 2016)

[2] http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/strategy.aspx (Accessed Oct 2016)

Defining & Standardizing Alternate Level of Care

In 2009, most hospitals in Ontario began using a standardized Provincial Alternate Level of Care (ALC) definition to designate patients, where clinically appropriate, as requiring an alternate level of care.

A standardized ALC definition is an important step in capturing high-quality, near real-time data on all patients waiting in acute and post-acute hospitals for alternate levels of care. A standardized provincial definition allows for consistency and accuracy of ALC data captured across Ontario.

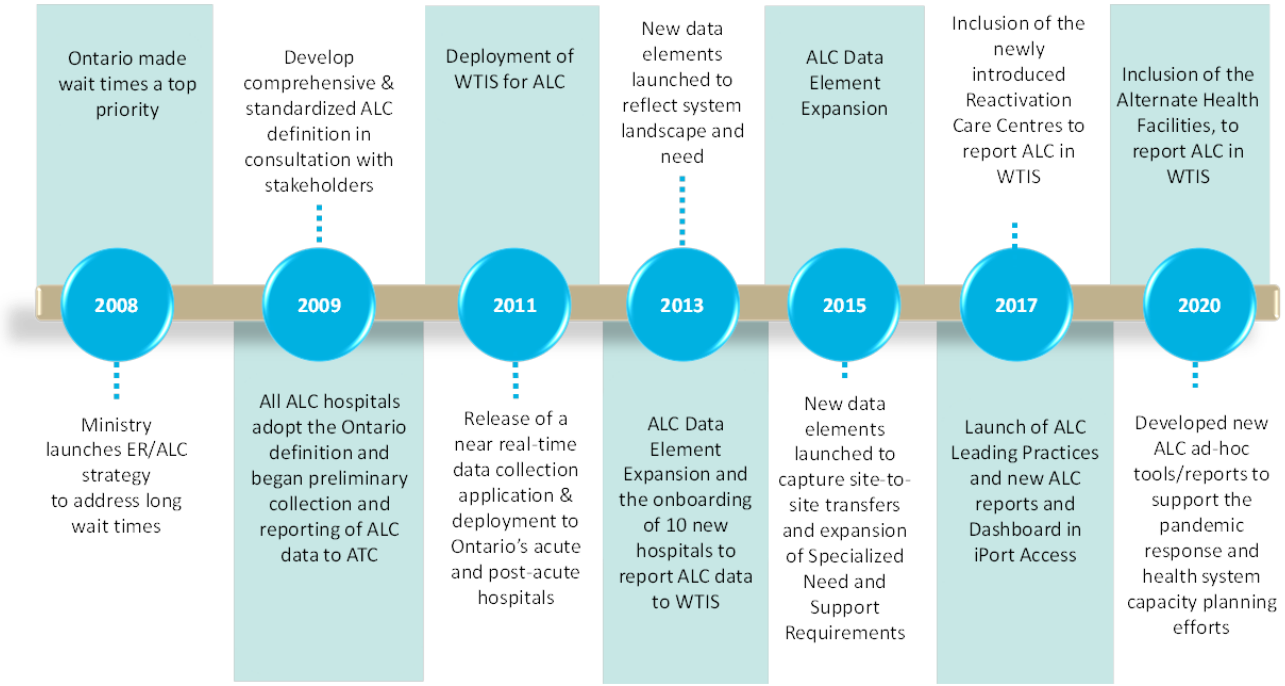
Contributors to the ALC Definition

The provincial ALC definition was developed in consultation with stakeholders from across the continuum of care, including, but not limited to:

- Acute and Post-Acute Hospitals
- Ontario Health (previously as Cancer Care Ontario)
- Regions (Community Care Access Centres and Local Health Integration Networks)
- The Ministry of Health and Long-Term Care
- Canadian Institute for Health Information (CIHI)
- Ontario Hospital Association (OHA)
- Ontario Health Quality Council (OHQC)

1.2 – Evolution of ALC Information Collection

Since the launch of the ER/ALC Strategy and the development of a standardized ALC definition, the number of facilities in Ontario submitting ALC information into the WTIS has grown, with the latest addition of Reactivation Care Centres (RCCs) beginning in 2017 and Alternate Health Facilities (AHFs) beginning in 2020 (in response to COVID-19). In addition, new ALC data elements were created and, existing ALC data elements were expanded to capture additional information related to the patient journey.



1.3 – The Provincial ALC Definition

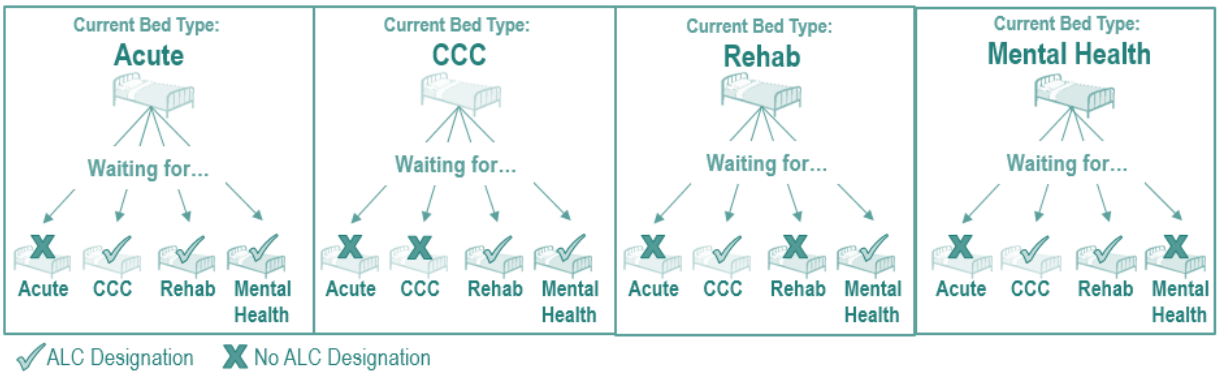
Provincial ALC Definition	
When a patient is occupying an inpatient bed in a hospital and **does not require the intensity of resources/services provided in this care setting** (Acute, Complex Continuing Care [CCC], Mental Health or Rehabilitation), the patient must be designated ALC[1] at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination[2] (or when the patient's needs or condition changes and the designation of ALC no longer applies).	
Note 1	**Note 2**
The patient's care goals have been met or: • Progress has reached a plateau or • The patient has reached her/his potential in that program/level of care or • An admission occurs for supportive care because the services are not accessible in the community (e.g. "social admission"). This will be determined by a physician/ delegate, in collaboration with an interprofessional team, when available.	Discharge/transfer destinations may include, but are not limited to: • Home (with/without services/programs), • Rehabilitation (facility/bed, internal or external), • CCC (facility/bed, internal or external), • Transitional Care Bed (internal or external), • Long-Term Care Home, • Group Home, • Convalescent Care Beds, • Palliative Care Beds, • Retirement Home, • Shelter, • Supportive Housing This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.
Final Note	
The definition does not apply to patients: • Waiting at home, • Waiting for an acute care bed, • Waiting in an inpatient service bed for another bed with the same designation (e.g., surgical bed for a medical bed or a mental health bed for another specialty mental health bed), • Waiting in a tertiary acute care hospital bed for transfer to a non-tertiary acute care hospital bed (e.g., repatriation to community hospital).	

1.4 – Guiding Principles for Designating a Patient ALC

Designating patients ALC is independent of:

- The planned ALC Discharge Destination being determined or available
- The patient meeting the eligibility criteria for the desired/recommended Discharge Destination

In addition, the Provincial ALC Definition does not apply to patients who are moving from one bed to another within the same level of care (e.g., Acute to Acute, CCC to CCC), although the services or programming provided within those beds may be different, or to a higher level of care (e.g., Rehab to Acute).



1.5 – Value of ALC Information

Timely and high quality ALC data provides the type of information necessary to help drive transformational change and improvements in the healthcare system. High-quality ALC data enables organizations to strategically plan for and improve critical areas in the healthcare system and enhance patient care and outcomes. ALC information:

- Supports monitoring of ALC volumes and patient flow across sectors and the province
- Highlights obstacles impacting patient discharge and opportunities for improving patient flow
- Assists healthcare planners and decision-makers to monitor and manage performance
- Enables stakeholders across the healthcare system to identify gaps in services
- Provides data critical to establish and monitor strategies to reduce wait times

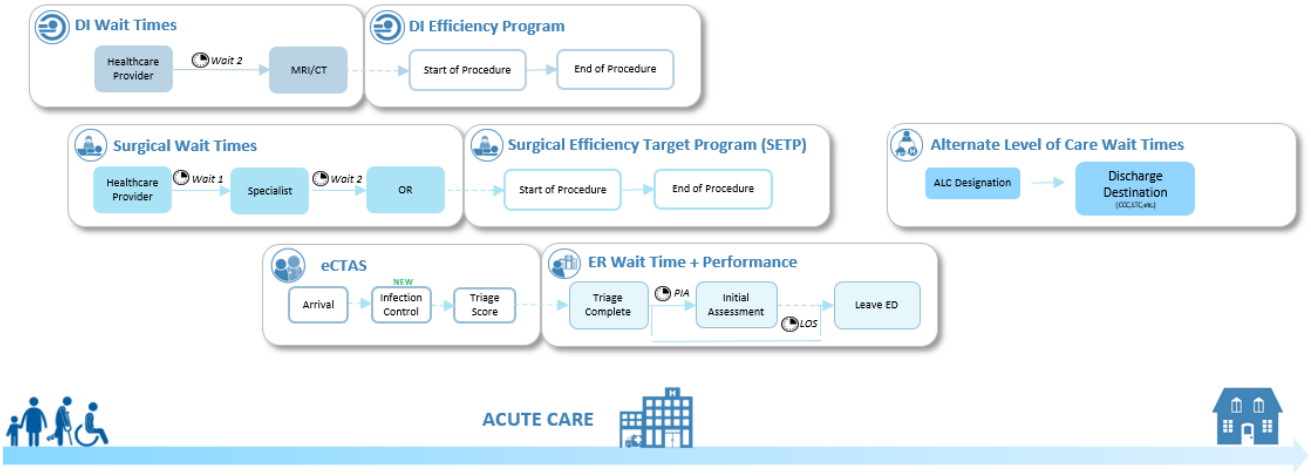
1.6 – Access to Care at Ontario Health

Access to Care (ATC) a business unit within the Health System Performance & Support portfolio at Ontario Health is the service delivery agent for Ontario's Wait Time and ER/ALC strategies on behalf of the Ministry of Health. ATC focuses on improving the access, quality, and efficiency of healthcare services for Ontarians.

ATC provides leadership, technology development, information system deployment, and informatics services to create information and knowledge that informs Ontario health system stakeholders such as policy planners and makers, administrators, and providers across four priority areas:

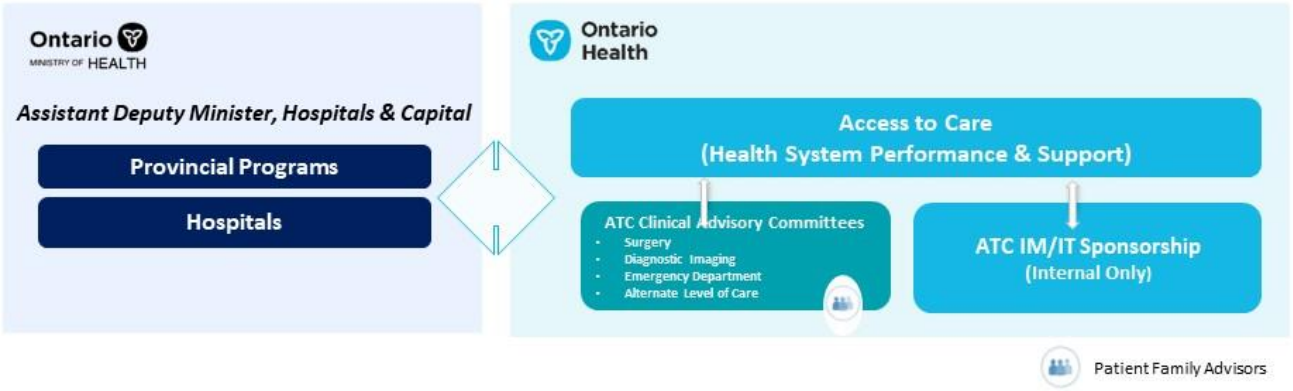
1. Emergency Room Information (including eCTAS).
2. Alternate Level of Care Information.
3. Surgical Wait Times and Efficiency.
4. Diagnostic Imaging – MRI/CT Scan Wait Times and Efficiency.

The diagram below provides an overview of the patient journey through ATC's four areas of focus:



1.7 – Access to Care's Governance Model

ATC directly partners with various branches of the Ministry of Health including, but not limited to, Hospitals Branch and Capacity and Health Workforce Planning Branch for evidence-based recommendations, data reporting and prioritization of initiatives. ATC engages with Clinical Leads (Advisory Committees) to provide expert input for recommendations to the Ministry and guide implementation efforts for ATC initiatives.



2 – Provincial ALC Information: The Wait Time Information System (WTIS)

This section describes how ALC information is collected in Ontario including a description of Ontario's Wait Time Information System (WTIS), the evolution of ALC data collection, and the value of ALC information.

Section Highlights

2.1 – Ontario's Wait Time Information System (WTIS)

Since 2006, the WTIS has been leveraged as the technology system for Ontario to collect accurate and timely surgery, DI and ALC wait time data as a key component of Ontario's Wait Time Strategy. The WTIS is a web-based application that collects surgery, diagnostic imaging (CT/MRI), ALC, and wait time data to inform the patient journey. The WTIS provides clinicians and other stakeholders with the information they need to effectively assess patient waits in a standardized manner. The WTIS is built on the foundation that timely, good quality information drives health system changes and improvements. In near real-time, personal health information (PHI) is submitted to the WTIS. In 2014, the WTIS was expanded to include MRI Efficiency data.

As of the end of 2020, the WTIS database has captured a total of 13.4 million MRI/CT scans, 4.8 million surgical patient waits, and 505,000 waits of patients designated ALC. Customized PHI data elements align with the patient experience and help identify access issues throughout the health system. With an extensive suite of products and services, the WTIS has a robust source of information that provides the public (through the ministry's website for publicly available data), ministry, regions hospitals, clinicians and health system stakeholders with wait time data information in Ontario. As of December 2020, more than 200 hospital sites across Ontario report ALC information using the WTIS. This is reflective of approximately over 98% of available hospital beds in the Province.

The WTIS	The WTIS Does Not
✓ Captures data electronically through a single provincial system ✓ Captures ALC wait time information in near real-time (i.e., within two business days) ✓ Is used as a waitlist management tool as part of the discharge planning process ✓ Provides ALC wait time data by Most Appropriate and planned ALC Discharge Destination, as well as specialized care needs to better inform resource allocation and decision-making.	× Replace independent clinical assessment × Replace the need for discharge planning × Automatically manage waitlist entries for ALC patients to support bed-level matching

2.2 – Other Ontario Health Data Holdings Supporting the ALC Population

To further understand the ALC population in Ontario, information collected in the WTIS is supplemented by many additional data holdings used to analyze the patient journey and health system factors. Additional data holdings available for analysis may include:

- Home Care Database (HCD)
- Home Care Assessment (interRAI-HC)
- Contact Assessment (interRAI-CA)
- Palliative Assessment (interRAI-PC)
- Daily Bed Census Summary (dBCS)
- Ontario Health Insurance Plan (OHIP)
- Vital Statistics-Death Database
- Ontario Drug Benefit (ODB)
- ArcGIS (Geospatial)
- Ontario Renal Reporting System (ORRS)
- Discharge Abstract Database (DAD)
- National Ambulatory Care Reporting System (NACRS)
- Continuing Care Reporting System (CCRS)
- National Rehabilitation Reporting System (NRS)
- Ontario Mental Health Reporting System (OMHRS)

2.3 – WTIS ALC Integration

WTIS integration involves the submission of wait time data through an exchange of Health Level Seven International (HL7) messages between a facility's technical systems and the WTIS. The data included in the messages is dependent on the level of integration at the facility.

Facilities can use one of two integration levels to submit required ALC data to the WTIS. The integration levels are:

Integration Level	Description
Basic	Waitlist entries are opened, modified, and closed manually using a web-based version of the WTIS. There are no HL7 messages involved in Basic Integration. This level of integration is available to all users.
Complex	All waitlist entries are submitted electronically via HL7 interface messaging. This level of integration is only available to users who have an appropriate technical system that will facilitate HL7 messages.

Assessing Integration Readiness

Facilities that would like to migrate from Basic ALC Integration to Complex ALC Integration are requested to complete a WTIS Complex ALC Integration Assessment. Completion of this assessment will provide a facility with the opportunity for early identification of any gaps, constraints, and limitations that may exist within current processes, allowing a facility to prepare for any changes to the submission of ALC data to the WTIS.

Several factors need to be considered prior to integrating with the WTIS at a Complex ALC integration level. Some considerations include:

- a facility's current methods of ALC data collection (e.g., paper as a method of data collection will not be accepted for Complex ALC integration)
- a facility system(s) ability to collect, or be modified to collect, the required ALC data electronically
- resource availability (e.g., internal or external technical resources)
- other initiatives currently underway or planned during the deployment timelines
- a facility's ability to provide resources for the ongoing management of the facility's interface, including ensuring high quality data is submitted to the WTIS

Important: Ongoing support of a Complex ALC interface can be very resource intensive. It is a requirement for a facility's integration migration to have ongoing, dedicated resources available post-implementation.

Technical Requirements

The HL7 specifications for Complex ALC Integration are available on the ATC Information Site. Please review the WTIS ALC Complex HL7 Specifications for more information on the technical requirements of complex integration.

Determining a WTIS Go-Live Date

A facility that would like to start reporting ALC data via Basic or Complex integration for the first time, or would like to transition from Basic to Complex integration, should email the completed assessment (see above) to ATC@ontariohealth.ca and ask for more information about upcoming opportunities.

Additional WTIS Information

- WTIS Train the Trainer Tip Sheet
- WTIS Reports, Extracts and Managing Waitlist Entries Training: ALC
- ALC WTIS End User Training Presentation

3 – WTIS-ALC Data Elements

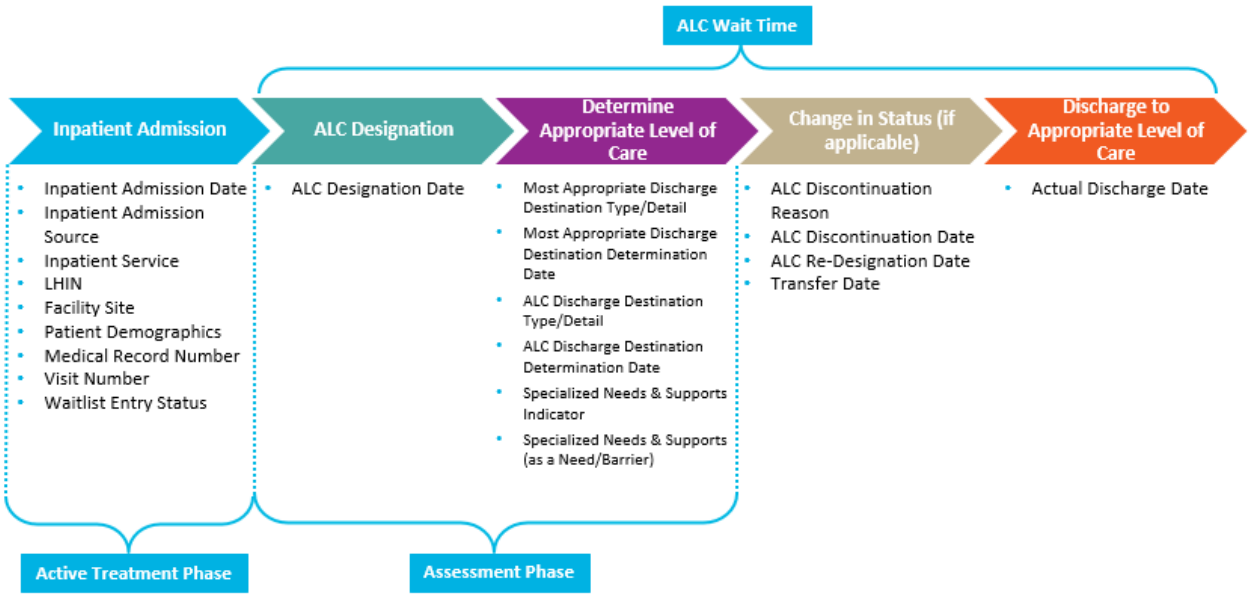
The section describes and defines all ALC data elements that are a part of a patient's waitlist entry in the WTIS. The section ends with a package of detailed clinical scenarios to illustrate how each defined ALC data element in the WTIS aligns to the clinical context.

Section Highlights

3.1 – WTIS-ALC Data Elements: Descriptions & Definitions

When a patient is designated as requiring an alternate level of care in hospital, a waitlist entry for that patient is opened in the WTIS. The following diagram provides a summary of each WTIS-ALC data element and illustrates where each data element aligns to the patient journey, through inpatient admission, ALC designation, determining the appropriate level of care, change in status (if applicable), and discharge to appropriate level of care:

3.2 – Inpatient Admission Data Elements Aligned with the Patient Journey



A – Inpatient Admission Date

Definition: The date when the patient is admitted to the bed type in which they are designated ALC.

Value of Collecting Data Element

Health system stakeholders use this data element to understand when a patient began their stay in hospital and allows us to determine how soon after admission a patient was designated ALC. This information is important because it could assist in informing where patients may be admitted to hospital and did not require hospitalization due to social reasons, for example.

B – Inpatient Admission Source

Definition: The location from which a patient is admitted to the hospital inpatient service bed, where the patient was eventually designated ALC. There are four types of inpatient admission sources as highlighted in the following table.

Inpatient Admission Source	Definition
Direct Admission	An admission directly to a hospital by a clinician that is unplanned, without requiring an emergency room visit.
Emergency Room	An admission to hospital through the emergency department.
Planned Admission	An admission to hospital for a planned surgery, procedure or treatment (e.g., ECT, chemotherapy, elective procedures).
Transfer from Another Facility	An admission to hospital through a direct transfer from another facility.

Value of Collecting Data Element

Health system stakeholders use this data element to understand where the patient originates from to be able to focus potential solutions based on various inpatient services and beds. (e.g., ER admission avoidance).

C – Inpatient Service

Definition: The designated bed where the patient designated ALC is currently waiting. There are four types of inpatient services where a patient can be designated ALC:

Inpatient Service	Definition
Acute Care – Non-Surgical	A designated bed providing care to patients who are receiving acute medical care but who are not waiting for or have not had surgical procedures.
Acute Care – Surgical	A designated bed providing care to patients who are waiting for or have already undergone surgical procedures.
Acute Care – Intensive/Critical Care	A designated bed providing care to patients with acute or potentially life-threatening conditions requiring advanced medical care and support.
Complex Continuing Care (CCC)	A designated bed providing specialized care to patients who are medically complex, require hospital stays, regular onsite physician care and assessment, and active management over extended periods of time.
Mental Health	A designated bed providing therapeutic services to patients with addictions, psychological, behavioural or emotional illnesses.
Rehabilitation	A designated bed providing care aimed at maximizing patients' overall physical, sensory, intellectual, psychological and social functions.

Value of Collecting Data Element

Health system stakeholders use this data element to understand where patients may be designated ALC. The Inpatient Service data element highlights the bed type in which patients are occupying while waiting for another level of care. This information can be used to examine how inpatient services beds are being used and whether resources are being used by patients who do not require the level of resources or intensity associated with this care setting.

Moving Between Inpatient Bed Types

A patient designated ALC in Acute Care can move between Acute Care bed types while keeping their ALC designation open (e.g., Acute Non-Surgical to Acute Surgical). In this case, the Inpatient Service can be updated in the ALC waitlist entry.

In contrast, if a patient moves from one of the four Inpatient Service levels to another Inpatient Service level (e.g., Acute Care to Mental Health, CCC to Rehabilitation, etc.), then the ALC waitlist entry is closed on discharge as per the Provincial ALC Definition. Therefore, each ALC waitlist entry in WTIS represents the amount of time a patient has been designated ALC, actively waiting for discharge in a single inpatient bed type.

D – LHIN

Definition: The Local Health Integration Network (LHIN) associated with the facility the patient is registered. LHINs are local not for profit organizations responsible for planning, integrating, and funding local health services in 14 different geographic areas of the province. In November 2019, as part of the Ministry of Health's ongoing work to transition LHIN functions and oversight responsibilities to Ontario Health, the 14 LHINs were re-organized into five interim and transitional geographical regions based on existing geographic boundaries as listed below:

LHIN ID	LHIN Name	Region
1	Erie St-Clair	West
2	South West	
3	Waterloo Wellington	
4	Hamilton Niagara Haldimand Brant	
5	Central West	Central
6	Mississauga Halton	
7	Toronto Central	Toronto
8	Central	Central
9	Central East	East
10	South East	
11	Champlain	
12	North Simcoe Muskoka	Central
13	North East	North
14	North West	

E – Facility

Definition: The healthcare facility associated with the site where the patient is registered.

F – Site

Definition: The healthcare site where the patient receives care. For example, Princess Margaret Hospital is a site under the University Health Network (UHN) facility.

Value of Collecting Data Elements D, E & F

LHIN, Facility, and Site information allows for the examination of regional variation in ALC performance and enables ALC reporting at the regional, hospital, and site-level to guide performance management at these levels. This information allows for the linking of WTIS-ALC data to other OH data holdings (e.g., ALC Patient Journey Analysis Report).

G – Patient Demographics

Patient Demographics data elements provide information that identifies an individual patient. There are 16 patient demographic data elements, each defined in the following table:

Patient Demographic	Definition
First Name	The patient's given name.
Middle Name	The patient's middle name or further given names.
Last Name	The patient's surname.
Date of Birth	The year, month, and day the patient was born.
Health Card Number	The health number (numeric portion) from the identification card issues to a healthcare recipient by a health card assigning authority.
Health Card Number Version	A 2-character alphanumeric code which uniquely identifies a health card version.
Authority Issuing	The name of the province that creates/issues the patient's health card.
Sex	The reported sex/gender of a patient at a given point in time used for administrative purposes.
Address	The street or mailing address of the patient.
Address Type	The type of address of the patient.
City	The city of the patient's address.
Province/State	The province or state of the patient's address.
Country	The country of the patient's address.
Postal/Zip Code	The postal or zip code of the patient's address.
Phone Number	The telephone number provided by the patient.
Phone Number Type	The type of phone number of the patient.

Value of Collecting Data Elements

Health system stakeholders use patient demographic information to link WTIS-ALC data to other OH data holdings and provides the ability to do specific analysis on different cohorts of patients (e.g., specific age cohort, such as seniors 65+).

H – Medical Record Number

Definition: A unique facility-specific identifier used to identify an individual and their medical record/information.

I – Visit Number

Definition: A unique number generated by the facility for each individual waitlist entry.

J – WTIS Patient Indicator

Definition: An indicator used to identify if the patient is already registered as a patient in the WTIS.

K – Wait Time Patient ID

Definition: The unique identifier assigned to a patient when registered in the WTIS.

L – Waitlist Entry ID

Definition: The unique identifier assigned to the waitlist entry by the WTIS.

M – Waitlist Entry Status

Definition: A status for the waitlist entry indicating whether the waitlist entry was closed or if it is still open and can be modified. Once a waitlist entry has been closed, the status cannot reverted back to open unless the waitlist entry was closed due to “Change in Medical Status”. Only then, can the waitlist entry be re-opened by re-designation.

N – Last Update Date

Definition: The date portion of the WTIS-generated timestamp of the last update made to a waitlist entry.

ALC Designation Data Elements

O – ALC Designation Date

Definition: The date when a physician or delegate determines a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting. This is the date when the patient meets the criteria of the Provincial ALC definition.

Value of Collecting Data Element

This data element is critical for the calculation of ALC wait times because it defines the beginning of the ALC wait.

Determining Level of Care Required Data Elements

P – Most Appropriate Discharge Destination (MADD)

Definition: The location determined by the physician or delegate, in collaboration with an interprofessional team (when available), as to where a patient would be discharged or transferred based on the patient's care needs. This decision is irrespective of whether the discharge destination is available, accessible and/or exists within the community. Because the MADD is reflective of the ideal discharge destination based on the patient's care needs irrespective of limitations, "Unknown" would be an inappropriate selection for MADD. However, the MADD data element can be updated within the waitlist entry throughout the patient's journey, if the patient's care need changes while designated ALC. In the WTIS, the MADD data element is composed of two elements:

MADD Data Element	Description
MADD Type	The most appropriate facility type or service required based on the care needs of the patient, irrespective of availability, accessibility, and/or existence.
MADD Detail	The most appropriate program specific detail associated with the facility type or service based on the care needs of the patient, irrespective of availability, accessibility, and/or existence.

Q – MADD Determination Date

Definition: The date when the decision is made by the physician or delegate in collaboration with an interprofessional team (when available), as to where a patient should be discharged or transferred based on the care needs of the patient, irrespective of whether or not the most appropriate discharge destination is available, accessible and/or exists within the community. In other words, it is the date the MADD was determined for the patient. If the patient's care needs changes while designated ALC, requiring updates to the MADD, then the MADD Determination Date should also be updated to the date when a new MADD has been determined.

Important: Within an ALC waitlist entry, there should not be a period of time where a MADD is not identified for the patient. Thus, the first/earliest MADD Determination Date in a waitlist entry should align with the ALC Designation Date.

Value of Collecting MADD Data Elements

MADD information is used to identify system and capacity gaps with respect to what is best for a patient clinically versus what is actually available and accessible for the patient in the healthcare system. This information allows us to determine the number of patients designated ALC waiting to be discharged to their most appropriate level of care versus the number of patients designated ALC waiting to be discharged to an alternate location that is different than the MADD.

In addition, MADD Determination Date is used in segmented ALC Wait Time Calculations (for more information about these calculations, see Section 6 - ALC Performance Indicators - ALC Wait Times, pg. 83.

R – ALC Discharge Destination

Definition: The location determined by the physician or delegate in collaboration with an interprofessional team (when available), as to where a patient is to be discharged or transferred.

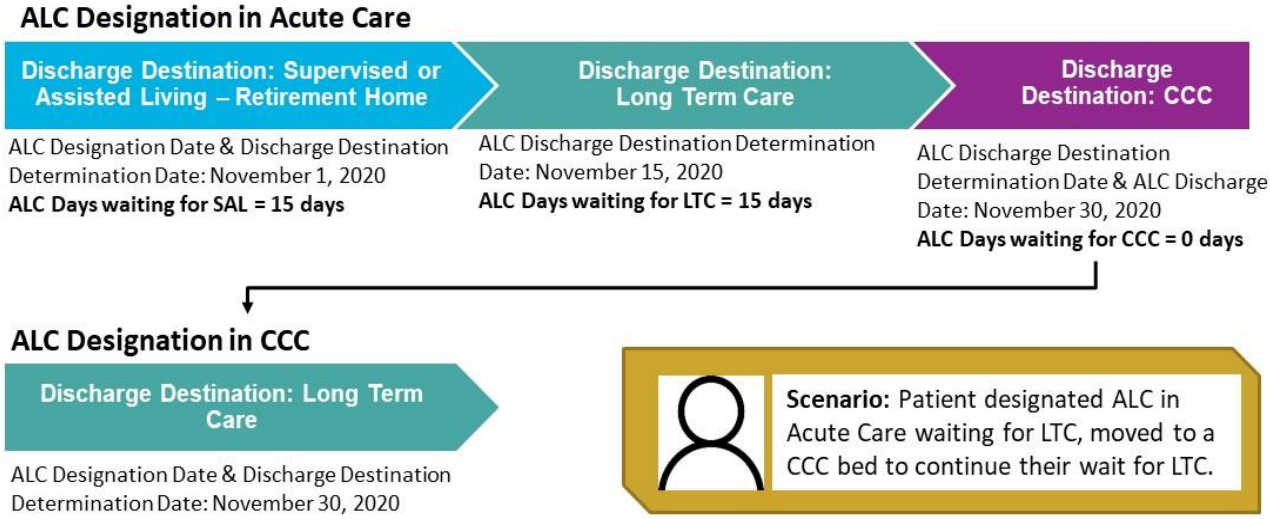
In the WTIS, the ALC Discharge Destination data element is composed of two elements:

ALC Discharge Destination Data Element	Description
ALC Discharge Destination Type	The facility type or service required by the patient at the point of discharge or transfer.
ALC Discharge Destination Detail	Program specific detail associated with the facility type or service required by the patient at the point of discharge or transfer.

During one patient journey, a patient may have waited for more than one ALC Discharge Destination before being discharged to a final location. In combination with the ALC Discharge Destination Determination Date, the ALC data collected can inform data users how long a patient has been waiting for each ALC Discharge Destination along with the cumulative ALC Wait Times attributed to the latest ALC Discharge Destination reported. This is also referred to as segmented ALC Wait Times by Discharge Destination.

When a waitlist entry is open, the Discharge Destination value indicates where the patient is waiting to be discharged. Once a waitlist entry has been closed, the ALC Discharge Destination value will indicate where the patient has been discharged.

The following diagram illustrates an example of how changes in a patient's ALC Discharge Destination is captured in WTIS and how to interpret the ALC Discharge Destination field throughout the patient's journey:



In the example above, when the ALC Discharge Destination has first changed from "Supervised or Assisted Living – Retirement Home" to "Long Term Care", it is interpreted as an update to the discharge plan only because the waitlist entry was not yet closed. On the other hand, when the waitlist entry is closed by discharge to a Complex Continuing Care (CCC) bed and both the ALC Discharge Destination Date along with the ALC Discharge Destination Date updated to November 30, it is understood that the patient has actually been discharged to a CCC bed. For this ALC waitlist entry, the patient has waited a total of 30 days while designated ALC before they were discharged to CCC. However, looking at segmented ALC days by Discharge Destination will show that 15 ALC days were attributed to the ALC Discharge Destination of Supervised or Assisted Living and another 15 ALC days were attributed to the ALC Discharge Destination of LTC.

S – ALC Discharge Destination Determination Date

Definition: The date when the decision is made by the physician or delegate in collaboration with an interprofessional team (when available), as to where a patient is to be discharged or transferred.

Important: Within an ALC waitlist entry, there should not be a period of time where a Discharge Destination is not identified for the patient. Thus, the first/earliest Discharge Destination Determination Date in a waitlist entry should align with the ALC Designation Date. If there is a period of time where Discharge Destination is not known, please reflect this by identifying Unknown as the Discharge Destination with the appropriate Determination Dates. For an example, please see Case Study 9 Unknown as Temporary Discharge Destination., pg. 42.

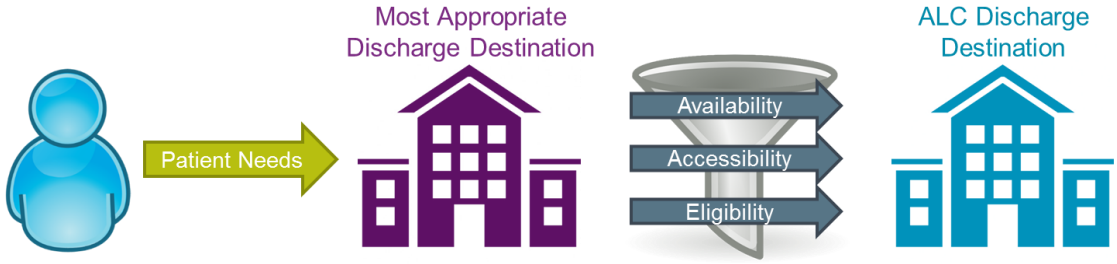
Value of Collecting ALC Discharge Destination Data Elements

Health system stakeholders use this information to understand which discharge destinations ALC designated patients are waiting to access from hospital. It provides the ability to know how many patients are waiting for each discharge destination and how long patients typically wait while designated ALC. This information allows us to identify how different discharge destinations are impacting ALC metrics and allows health system capacity planners to make informed decisions based on regional demands.

ALC Discharge Destination Determination Date is used in segmented ALC Wait Time Calculations (for more information about these calculations, see Section 6 – ALC Performance Indicators, pg. 83.

Most Appropriate Discharge Destination (MADD) versus ALC Discharge Destination (DD)

A patient's MADD reflects where the patient would be discharged to, based on their clinical needs. A patient's ALC Discharge Destination reflects where the patient will be or has been discharged, for open or closed status waitlist entry respectively. This means a patient's MADD may or may not be the same as the ALC Discharge Destination, because the latter is dependent on whether the location is currently available, accessible, or exists.



Discharge Destination Types and Details (for MADD and ALC Discharge Destination)

The Discharge Destination Types and Details are the same for MADD and ALC Discharge Destination (except for the ALC Discharge Destination = Unknown which is not applicable to MADD).

The following table provides the definitions for Discharge Destination Type and Detail:

Discharge Destination Type	Discharge Destination Detail	Definition
Complex Continuing Care (CCC) Bed		A designated bed providing specialized care to patients who are medically complex, require hospital stays, regular onsite physician care and assessment, and active management over extended periods of time.
	CCC – Low Tolerance Long Duration (LTLD)	Specialized inpatient rehabilitation suitable for individuals in need of a slower-paced program over a longer period of time than is offered in other programs. LTLD is used interchangeably with "slow stream rehab."
	CCC – Non-Low Tolerance Long Duration	This category would include all patients in complex continuing care beds who are not in an LTLD bed.
Convalescent Care Bed		Provision of care to support the gradual recovery of health and strength after illness or surgery. Convalescent Care programs provide 24-hour care to people who require specific medical and therapeutic services in supportive environments for defined periods of time.

Discharge Destination Type	Discharge Destination Detail	Definition
Home		Private residence, **not including** group home settings such as long-term care or retirement home, where a patient will live in the community upon discharge from hospital. Provision of an array of services that enables clients to live at home, often with the effect of preventing, delaying, or substituting for long-term care or acute care alternatives.
	Home with CCAC Services (To be renamed to "Home with Home and Community Care Support Services")	Patient is discharged home with services provided by a Home and Community Care Support Services, which acts as a local point of contact to co-ordinate community-based services. Home and Community Care Support Services will also determine eligibility for government-funded home and community support services and admission to a long-term care home.
	Home with Community Services	Patient is discharged home with community-based services not offered through the LHINs to support the patient's ability to live in the community. This may include, but is not limited to, day hospital, outpatient programs or clinics, and eldercare day programs such as Meals-on-Wheels.
	Home without Services	Patient is discharged home with no services required.
Long-Term Care Bed		A designated bed providing care to meet both the medical and non-medical needs of people with chronic illnesses or disabilities who require care that is not available in the community.
Mental Health Bed		A designated bed providing therapeutic services to patients with addictions, psychological, behavioural or emotional illnesses.
	Inpatient Dependency Treatment Services	Services designed specifically to care for and treat chemical dependency, under a prescribed treatment program.
	Inpatient Detoxification Services	Services designed to facilitate the process whereby an alcohol/drug intoxicated or alcohol/drug dependent person is assisted through the period necessary to eliminate the intoxicating substance, and/or the dependent factors, while keeping the physiological risk to the patient to a minimum.
	Inpatient Psychiatric Services	Services provided to patients with psychological, behavioural or emotional illnesses requiring voluntary or involuntary inpatient psychiatric care. This category would include all patients in mental health beds who are not in either detoxification or dependency beds.

Discharge Destination Type	Discharge Destination Detail	Definition
Palliative Care Bed		The scope of ALC-Palliative Care is focused on those patients waiting for palliative care programs or services delivered in a hospital placement or in a hospice residence setting. Provision of medical or comfort care to support end-of-life planning to reduce the severity of a disease or slow its progress. The focus is on quality of life measures rather than providing a cure.
	Palliative Hospital Placement	Palliative care delivered within a hospital environment. This Discharge Destination Detail does not include palliative care programs provided in Acute-designated bed types as a patient cannot be designated ALC waiting for an acute care bed.
	Residential Hospice Care (Hospice Residence)	Specialized residential care to palliative patients.
Rehabilitation Bed		A designated bed providing care aimed at maximizing a patient's overall physical, sensory, intellectual, psychological and social functions. This may include the acquisition of special equipment or other resources.
	Cardiac	Specialized inpatient rehabilitation program for patients with cardiac issues designed to maximize their overall function through interprofessional clinical expertise.
	Geriatric	Specialized inpatient rehabilitation program for geriatric patients (age as defined by the specific program) designed to maximize their overall function through interprofessional clinical expertise.
	Low Tolerance Long Duration Rehabilitation (LTLD)	Specialized inpatient rehabilitation suitable for individuals in need of slower-paced programs over longer periods of time than are offered in other programs. LTLD is often used interchangeably with "slow stream rehab."
	Musculoskeletal (MSK)	Specialized inpatient rehabilitation program for patients with musculoskeletal issues, designed to maximize their overall function through interprofessional clinical expertise. This may include, but is not limited to: arthritis, osteoporosis, and bone cancer.

Discharge Destination Type	Discharge Destination Detail	Definition
	Neurological	Specialized inpatient rehabilitation program for patients with neurologically related impairments, designed to maximize their overall function through interprofessional clinical expertise. This may include, but is not limited to, acquired brain injury (ABI), stroke, spinal cord injury and generalized neurological rehabilitation (e.g., degenerative neurological conditions such as Parkinson's and Multiple Sclerosis).
	Other Rehabilitation	Non-specialized inpatient rehabilitation program for patients not captured in the above categories, designed to maximize their overall function through interprofessional clinical expertise.
Supervised or Assisted Living		Provision of care for patients (e.g., the elderly or people with physical disabilities) who are able to mobilize independently but who may require assistance with activities of daily living.
	Retirement Home	A multi-unit residential facility providing optional services such as meals, housekeeping, recreational activities and personal support.
	Shelters	Temporary emergency housing for individuals in crisis or without other accommodations. This includes, but is not limited to, homeless patients and victims of domestic violence.
	Subsidized Housing	Government-supported accommodation for people with low to moderate incomes.
	Supportive Housing/ Group Homes/Assisted Living	Accommodation with services provided to an individual with chronic or complex needs as a means of maintaining them in the community. These services may include, but are not limited to, supervision, personal support, and counseling.
Unknown (applicable to ALC Discharge Destination only)		Assigned when a patient's ALC Discharge Destination is not known, not established, or does not exist.

T – Specialized Needs and Supports Indicator &

U – Specialized Needs and Supports as a Need or Barrier

Definition: Specialized Needs and Supports (SNS) are the specialized care needs/supports of the patient required at their ALC Discharge Destination.

Value of Collecting SNS Data Elements

SNS information allows us to understand which patient care needs are preventing or delaying discharge (i.e., a barrier) and will highlight specific barriers that exist within the healthcare system that are delaying/preventing patients from transitioning to appropriate levels of care.

SNSs are identified as either a *Need* or a *Barrier*:

Specialized Needs & Support: Need or Barrier	Description
Need	The specialized care needs/supports of the patient required at their ALC Discharge Destination that are not preventing or **are not known** to be preventing discharge.
Barrier	The specialized care needs/supports of the patient required at their ALC Discharge Destination that **are** preventing or delaying discharge.

In the WTIS, the SNS data element is composed of two components:

SNS Data Element in the WTIS	Description
SNS Indicator	Identifies whether the patient has any specialized care needs or supports (Yes or No).
SNS as a Need or Barrier	Identifies each of the individual SNSs of the patient and specifies whether each of them is a Need or a Barrier.

SNS Types and Details

The following table outlines each SNS Type and Detail:

SNS Type	SNS Detail	Definition
Bariatric Requirement		Services designed to provide care for patients diagnosed with obesity. This may include, but is not limited to: • lifts, • oversized beds, • larger doorways, • access to specialized equipment or • access to additional personnel for discharge and/or personal care at Discharge Destination.
Equipment/Structural Requirements		Patients requiring specialty equipment and/or modifications to the discharge destination required prior to the patients' discharge. This may include walkers, wheelchairs, equipment installation (e.g., lifts, grab bars), or structural changes (e.g., widening of doors, building ramps). **This category excludes bariatric requirements.**
Behavioural Requirements	**1:1 Support**	Services designed to provide care to patients identified by the physician and/or delegate to be requiring an elevated level of support, whereby one (or more) staff person(s) is assigned to be within close physical proximity to the patient for a period of time while maintaining constant visual observation. This may include one-to-one support for the entire duration of the patient stay, or for a limited time.
	Aggressive Behaviours	Services designed to provide care for patients who exhibit aggressive behaviours including but not limited to: pushing, spitting, hitting, property destruction, etc.
	Sexualized Behaviours	Services designed to provide care for patients who exhibit sexualized behaviours including but not limited to: inappropriate touching or grabbing, exposure of private parts, sexualized conversation, etc.
	Unspecified	Services designed to provide care for patients who have behavioural requirements that do not fall under the category of 1:1 support or require staff in close proximity at all times, aggressive or sexualized behaviours. This may include, but is not limited to, services or equipment supporting patient needs such as: impulsivity, hyperactivity, self-injury, safe smoking etc. Services may also be outpatient or community-based.
Developmental Requirements		Services designed to provide care for patients who have developmental requirements including but not limited to autism spectrum disorder (ASD), fetal alcohol spectrum disorder (FASD), attention deficit hyperactivity disorder (ADHD), learning disabilities, etc. This may include outpatient or community-based services.

SNS Type	SNS Detail	Definition
Dialysis Requirements		Services designed to provide care for patients with renal impairment necessitating hemodialysis or peritoneal dialysis.
Feeding Requirements		Patients with specific feeding requirements, including but not limited to: specialty diet, inability to independently dine at common dining hall and services designed to provide patients with a non-oral form of nutrition, with routes may include enteral (e.g., gastric tube or nasogastric tube), or total parenteral nutrition (TPN).
Infection Control/ Isolation Requirements	**Isolation**	Services designed to provide care for patients requiring isolation or negative ventilation accommodations due to an infectious or immune-compromised condition.
	Outbreak at Discharge Destination	When the discharge of a patient designated ALC is prevented or delayed due to an outbreak occurring at the facility in which the patient is expected to be discharged to. **Note: This is a Barrier Only.**
	Outbreak at Facility	When the discharge of a patient designated ALC is prevented or delayed due to an outbreak occurring at the facility in which the patient currently resides. **Note: This is a Barrier Only.**
Mechanical Ventilation Requirements		Services designed to provide care for patients who are mechanically ventilated.
Medications/Labs/Therapy Requirements		Services may include, but are not limited to: ECT access, physiotherapy, respiratory therapy, chemotherapy, radiation therapy, pain control (including but not limited to epidural infusion), intravenous medication administration, high-cost / difficult-access medications, ongoing lab work, and monitoring of medication levels.
Mental Health Requirements	**Addictions**	Services designed to provide care for patients who have an addiction including but not limited to: drugs (street, prescription), alcohol, tobacco, etc.
	Concurrent Disorders	Services designed to provide care for patients who have 'concurrent disorders' meaning that a patient has both a psychiatric diagnosis and a substance abuse diagnosis (which may include both drugs and alcohol).
	Unspecified	Services designed to provide care for patients who have mental health requirements that do not fall under the category of concurrent disorders or addictions. This may include, but is not limited to: eating disorders, mood disorders, personality disorders, bipolar disorder, schizophrenia, etc.

SNS Type	SNS Detail	Definition
Neurological Requirements	**Acquired Brain Injury**	Services designed to provide care for patients who have an Acquired Brain Injury including but not limited to: traumatic and non-traumatic brain injury. ***Traumatic Brain Injury****:* A traumatic brain injury can be classed as an open or closed injury. A closed injury is caused when the brain is bounced around in the skull due to a blow to the head or severe shaking such as in a road traffic accident. A closed motion can cause tearing, shearing or stretching of the brain tissue. An open injury occurs when an object such as a bullet, fractures the skull and enters the brain. ***Non-Traumatic Brain Injury****:* A non-traumatic injury is an injury that does not occur as a result of trauma. This includes stroke, tumours, infectious diseases, lack of oxygen or toxicity.
	Unspecified	Services designed to provide care for patients who have neurological impairments that do not fall under the category acquired brain injury including but not limited to: impairments of cognition, function and development, as well as access to additional personnel for discharge and/or personal care at Discharge Destination, which may include outpatient or community-based services.
Respiratory Requirements (excludes ventilation)		Services designed to provide care for patients with respiratory impairments necessitating care. This may include, but is not limited to:, tracheostomy, oxygen therapy, BIPAP/CPAP, and suctioning. This category excludes mechanical ventilation requirements.

SNS Type	SNS Detail	Definition
Social Requirements	Financial Constraints	Services designed to support patients who experience financial constraints including but not limited to: unemployment, job insecurity, fixed incomes, or who are receiving social assistance, etc.
	Homelessness	Services designed for patients who experience housing limitations or have homelessness issues. This may include but is not limited to patients who are: inadequately or insecurely housed, utilizing shelter services or subsidized housing, or have no fixed address, etc. ***Rooflessness***: Living without a shelter of any kind, (e.g., sleeping outdoors) often called absolute homelessness. ***Houselessness****:* Living in temporary facilities, (e.g., institutional shelters or healthcare facilities) often called sheltered or transitional homelessness. ***Insecurely Housed****:* Living precariously, (e.g. in insecure tenancies, close to eviction, in an unsafe situation, or subject to domestic violence) includes those who are among the hidden homeless or sometimes termed relative homeless. ***Inadequately Housed****:* Living in a home that does not meet basic standards (e.g., in substandard housing, suffering mold infestation, overcrowding, inaccessible for the person or family) includes people who are in core housing need.
	Lack of Social Support	Services designed to assist patients who experience a lack of social support including but not limited to: social exclusion, lack of emotional support or companionship, caregiver inability to provide care, etc.
	Legal Concerns	Services designed for patients who experience legal issues or requires legal documentations for discharge including but not limited to: guardianship, refugee and immigration status, divorce and separation, Ontario Review Board (ORB), Community Treatment Order (CTO), power of attorney, Children's Aid Society (CAS), etc.
	Unspecified	Services designed for patients who have social requirements that do not fall under the category of housing/homelessness, financial constraints, lack of social support or legal concerns. This may include, but is not limited to patients requiring: Ontario Disability Support Program (ODSP), domestic violence services, culturally-specific services, gender/sexuality-specific services, etc.
Wound Care Requirements		Services designed to provide care for patients with compromised skin or tissue integrity. This may include, but is not limited to: care of amputations or prosthetics, ostomy sites, VAC therapy, surgical wounds and pressure ulcer dressings.

Change in Status Data Elements

V – ALC Discontinuation Date

Definition: The date when a patient's needs or condition changes and the designation of ALC no longer applies, resulting in closure of the waitlist entry.

W – ALC Discontinuation Reason

Definition: The specific reason the ALC designation is discontinued.

There are seven types of ALC Discontinuation Reasons, each defined in the following table:

ALC Discontinuation Reason	Definition
Change in Destination Invalidates ALC Designation	Closure of a waitlist entry when a change in the discharge destination negates the ALC designation (e.g., ALC Discharge Destination has changed to another bed of the same Inpatient Service bed type the patient is waiting in).
Change in Medical Status	Closure of a waitlist entry when a patient experiences a significant change in medical condition requiring the level of services provided in the inpatient service bed the patient is in; therefore, the ALC designation no longer applies. Patient remains in the current bed type within the same hospital or at another hospital site / facility. This discontinuation reason is also applicable to patients with a palliative designation when the physician or his/her delegate would not issue a discharge order because the patient is actively dying. Note: When a waitlist entry is discontinued due to this reason, it is possible to re-open the waitlist entry if the patient is re-designated ALC within 40 weekdays of the discontinuation date. The time between the Discontinuation Date and the Re-Designation Date is referred to as the Acute Care Episode (ACE) period.
Data Entry Error	Closure of a waitlist entry due to a user data entry error.
Death	Closure of a waitlist entry when a patient is deceased.
Discharge Against Medical Advice	Closure of a waitlist entry when a patient, family member, or a third party other than the interprofessional team, decides that the patient should be removed from hospital, contrary to the established care plan and against the recommendations of the physician or delegate.

ALC Discontinuation Reason	Definition
Transfer to Acute Care	Closure of a waitlist entry when an ALC patient becomes acutely ill while designated ALC in a post-acute care bed and the patient requires discharge to acute care to receive treatment that cannot be provided in the current bed type. **The important qualifier is that the patient was ALC waiting for an alternate level of care other than an acute care bed.**
Unplanned Repatriation (To be interpreted as "Transferred to Another Facility")	Closure of a waitlist entry when a patient with an ALC designation is waiting for another bed type and then is transferred to another facility to continue the wait in the same bed type, resulting in the discontinuation of the ALC wait at the originating hospital. **The important qualifier is that the patient was ALC and not waiting for the same inpatient bed at another hospital. The patient is expected to be designated ALC again upon admission at the receiving facility.**

Value of Collecting ALC Discontinuation Data Elements

These data elements provide information related to a patient's ALC status and reasons for why an ALC designation may no longer be appropriate for a patient. ALC Discontinuation data elements also allow for the accurate calculation of ALC wait times by removing any ACE periods associated with a waitlist entry. In addition, the ALC Discontinuation Date is critical for the calculation of ALC wait time calculations as it can define the end of the ALC wait time.

X – ALC Re-Designation Date

Definition: The date when a physician or delegate determines that a patient is again occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting, following a period of time in which a patient's ALC status had been discontinued due to a 'change in medical status' (i.e., ACE period).

An ACE period represents the period of time when the patient's condition has deteriorated and the designation of ALC is no longer appropriate, because the patient requires the intensity of resources/services in the same care setting he/she was designated ALC. A waitlist entry may have more than one ACE periods. The start date of an ACE period is the Discontinuation Date where the reason for discontinuation is a Change in Medical Status. The end date of an ACE period is the Re-Designation date.

Please note – while ACE is an acronym for Acute Care Episode, it is applicable to patients designated ALC in either an Acute care bed or a Post-acute care bed. A patient's ALC designation may be discontinued due to change in medical status and then re-designated providing the patient remains in the same bed type.

Value of Collecting Re-Designation Date Data Element

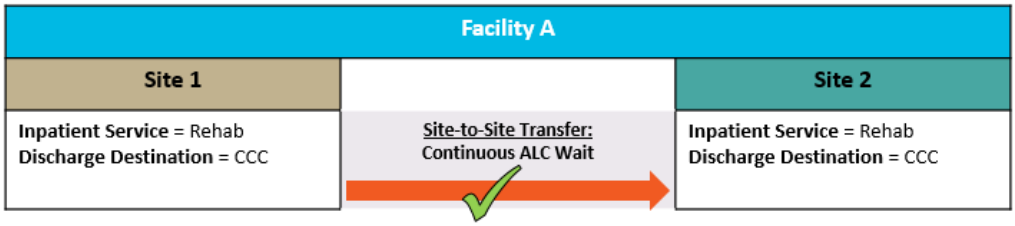
Health system stakeholders use this data element to correctly calculate ALC wait times by removing any ACE periods associated with a waitlist entry (ALC Re-Designation Date specifies the end of an ACE period).

Y – Transfer Date (for Site-to-Site Transfers)

Definition: The date when a patient designated ALC is moved from the same inpatient bed type at one site to the same inpatient bed type at another site, to continue their ALC wait, within the same multisite facility. In this case, the patient's waitlist entry is kept open.

This process is known as a Site-to-Site Transfer. In addition to a Transfer Date being entered into the WTIS, the Site must be updated in the patient's waitlist entry to signal that a Site-to-Site Transfer has occurred.

Note: Site-to-Site Transfer is a process and not a stand-alone data element.



When a Site-to-Site transfer takes place, the patient's ALC wait time continues and wait segments are attributed to each site. This allows for continuous wait times to be associated with one waitlist entry for a patient, as required.

To understand how WTIS-ALC data elements align to a site-to-site transfer scenario, see Case Study 10 - Site-to-Site Transfer, pg. 52. For clinical guidance, see Section 4 - Clinical Guidance - Site-to-Site Transfer, pg. 70.

Value of Collecting Site-to-Site Transfer Data Elements

This allows a continuous ALC wait time for a single patient regardless of the patient's movement across different locations within a facility (as long as the patient remains in the same inpatient bed type while maintaining an active ALC designation).

Discharge to Appropriate Level of Care Data Elements

Z – Actual Discharge Date

Definition: The calendar date when the patient is formally discharged from the facility or bed type in which they were designated ALC.

Value of Collecting Discharge Date Data Element

This data element is critical for the calculation of ALC wait times as it defines the end of the wait. Further, it signifies the day when the patient has been discharged to an alternate care setting from the inpatient bed type in which he/she was designated ALC.

3.3 – WTIS-ALC Data Elements Aligned to Clinical Scenarios

Even with a standardized Provincial ALC Definition, ALC clinical scenarios are varied and complex. This section provides 15 ALC clinical scenarios and. Each identifies key WTIS-ALC data elements to illustrate how they align to each scenario.

Notes

If a data element has more than one entry in the table, this means that at some point during the patient's wait time journey, that data element was updated to reflect the most accurate and up-to-date information.

Not all WTIS-ALC data elements are shown in each scenario.

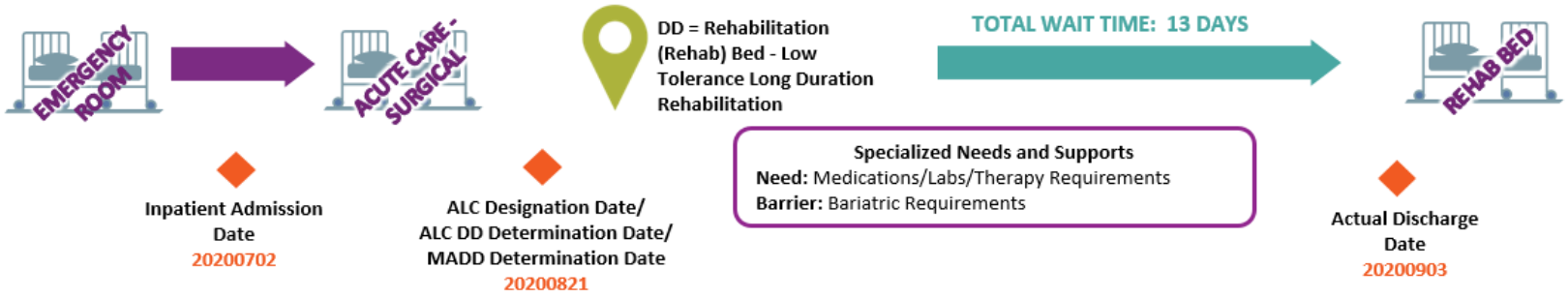
Clinical Scenario Index

1. Acute Care to Rehabilitation.
2. Acute Care to Supervised/Assisted Living.
3. Complex Continuing Care to Long-Term Care.
4. Acute Care to Mental Health.
5. Acute Care to Palliative Care in Community.
6. Complex Continuing Care to Palliative Care.
7. Acute Care to Supervised or Assisted Living.
8. Patient Discharged to Most Appropriate Discharge Destination (MADD).
9. Unknown as Temporary Discharge Destination.
10. Site-to-Site Transfer.
11. Bed Transfer to Continue ALC Wait.
12. Waiting for Supervised or Assisted Living (Behavioural and Mental Health Requirements)
13. Complex Continuing Care to Palliative Care (CCC); Change in Discharge Destination Invalidates ALC.
14. Patient Transitioned to an Alternate Care Setting.
15. ALC Discontinuation Reason = Unplanned Repatriation (Transfer to Another Facility).
16. ALC Discontinuation Reason: Change in Medical Status.

Clinical Scenario 1: Acute Care to Rehabilitation

CONNIE

- Connie is a 28-year-old female brought to the Emergency Room on July 2, 2020 with a left leg fracture. On the same day, Connie is admitted to the Acute Care - Surgical unit for treatment.
- On August 21, 2020 Connie is designated ALC; she no longer requires the intensity of resources/services provided in Acute Care.
- The interprofessional team determines the MADD Type/Detail for Connie is Rehabilitation (Rehab) Bed - Low Tolerance Long Duration Rehabilitation (LTLD). On the same day, the interprofessional team, in consultation with Connie, recommends an ALC Discharge Destination Type/Detail consistent with the MADD of Rehab Bed - Low Tolerance Long Duration Rehabilitation (LTLD).
- Connie has Specialized Needs and Supports of Medications/Labs/Therapy Requirements **and** Bariatric Requirements. Medications/Labs/Therapy Requirements are not preventing discharge, however the Bariatric Requirements are preventing discharge because bariatric equipment is not available at the selected ALC Discharge Destination.
- On September 3, 2020 bariatric equipment is installed at the selected ALC Discharge Destination and Connie is discharged to Rehab Bed - Neurological.

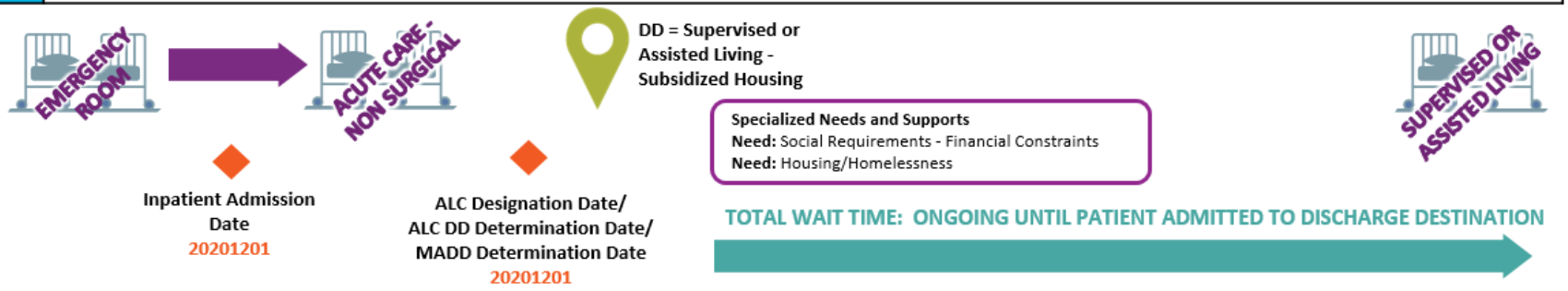


Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	Actual Discharge Date
20200702	Emergency Room	Acute Care - Surgical	20200821	Rehab Bed - LTLD	20200821	LTLD	20200821	Y	**Barrier**: Bariatric Requirements **Need**: Medications/ Labs/Therapy Requirements	20200903

Clinical Scenario 2: Acute Care to Supervised or Assisted Living

SAMSON

- Samson is a 65-year-old male brought to the Emergency Room on December 1, 2020 presenting signs of cardiac distress. While the attending physician cleared Samson to return home, because Samson was living without a shelter of any kind, he was admitted into an Acute Care Non-Surgical bed as a Social Admission.
- On the same day, Samson is designated ALC; he no longer requires the intensity of resources/services provided in Acute Care.
- The interprofessional team determines the MADD Type/Detail for Samson is Home - Home without Services. However, as Samson experiences temporary homelessness due to financial constraints, the interprofessional team in consultation with Samson recommends an ALC DD Type/Detail of Supervised or Assisted Living - Subsidized Housing.
- The following Specialized Needs and Supports of Social Requirements - Financial Constraints **and** Social Requirements - Housing/Homelessness are documented as Needs, since these conditions do not prevent or delay Samson's discharge to the selected Discharge Destination of Supervised or Assisted Living - Subsidized Housing.

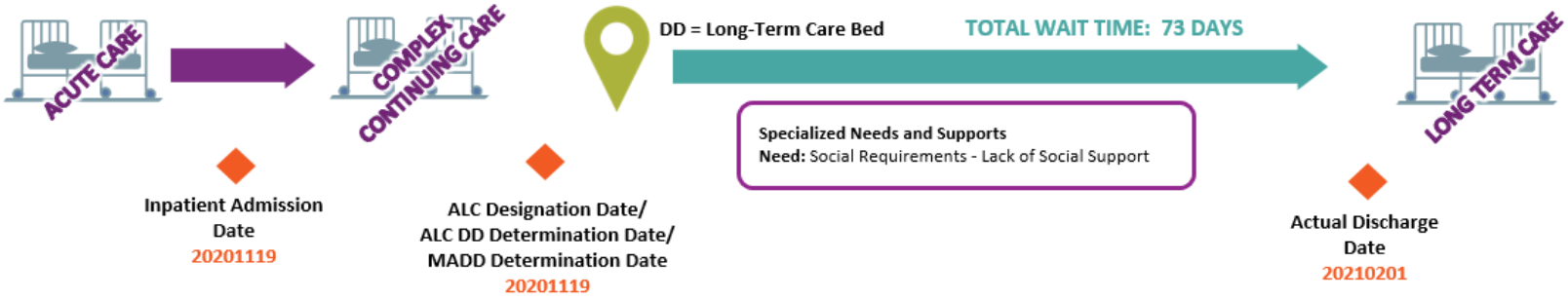


Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	ALC Discontinuation Date	ALC Discontinuation Reason	ALC Re-designation Date	Transfer Date	Actual Discharge Date
20201201	Emergency Room	Acute Care Non-Surgical	20201201	Home – Home without Services	20201201	Supervised or Assisted Living – Subsidized Housing	20201201	Y	**Need:** Social Requirements – Financial Constraints **Need:** Housing/ Homelessness	N/A	N/A	N/A	N/A	N/A

Clinical Scenario 3: Complex Continuing Care to Long-Term Care

FRANK

- Frank, an 82-year-old male was discharged from an Acute Care bed following his post-surgical treatments and admitted into a Complex Continuing Care (CCC) bed on November 19, 2020, because he is unable to be discharged home due to caregiver inability to provide support.
- He was designated ALC on the same day; he does not require the intensity of resources/services provided in a CCC setting. On the same day, the interprofessional team determines the MADD Type/Detail for Frank is Home - Home with CCAC Services but, in consultation with Frank, recommends an ALC DD Type/Detail of Long-Term Care (LTC) Bed because he is not able to return home.
- Frank has Specialized Needs and Supports of Social Requirements - Lack of Social Support as a Need only, since this factor is not preventing or delaying his discharge to LTC.
- On February 1, 2021 Frank is discharged to LTC.



Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs and Supports (SNS-Need or Barrier)	Actual Discharge Date
20201119	Planned Admission	CCC Bed	20201119	Home - Home with CCAC Services	20201119	Long-Term Care Bed	20201119	Y	**Need:** Social Requirements - Lack of Social Support	20210201

Clinical Scenario 4: Acute Care to Mental Health

JULIO

- Julio is a 35-year-old male brought to the Emergency Room on September 15, 2020 as a result of a drug overdose. On the same day, he is admitted to an Acute Care - Non-Surgical unit for treatment.
- On September 20, 2020 Julio is designated ALC; he no longer requires the intensity of resources/services in Acute Care. On the same day, the interprofessional team determines the MADD Type/Detail for Julio is Mental Health Bed - Inpatient Detoxification Services, and then, in consultation with Julio, recommends an ALC DD Type/Detail consistent with the MADD.
- Julio has Specialized Needs and Supports of Mental Health Requirements – Addictions as a Need only. It is not preventing his discharge to the planned Discharge Destination.
- Julio is discharged on September 30, 2020 to Mental Health Bed - Inpatient Detoxification Services.

Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	Actual Discharge Date
20200915	Emergency Room	Acute Care - Non Surgical	20200920	Mental Health Bed - Inpatient Detoxification Services	20200920	Mental Health Bed - Inpatient Detoxification Services	20200920	Y	**Need:** Mental Health Requirements - Addictions	20200930

Clinical Scenario 5: Acute Care to Palliative Care in Community

STACEY

- Stacey is a 94-year-old patient directly admitted to an Acute Care - Non-Surgical unit on December 13, 2020 with a palliative diagnosis.
- While in the hospital Stacey is admitted to an in-hospital palliative care program delivered from Acute Care designated beds. Stacey has requested palliative care outside of the hospital setting.
- On December 15, 2020 Stacey's condition stabilizes and she is designated ALC; she no longer requires the intensity of resources/services provided in Acute Care. On the same day, the interprofessional team in consultation with Stacey and her caregivers determine Stacey's pain and comfort measures would best be managed in Residential Hospice Care and therefore Palliative Care - Residential Hospice Care is documented as her MADD and ALC Discharge Destination.
- Stacey was discharged on December 19, 2020 to a nearby hospice.

Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	Actual Discharge Date
20201213	Direct Admission	Acute Care - Non-Surgical	20201215	Palliative Care - Residential Hospice Care	20201215	Palliative Care - Residential Hospice Care	20201215	N	N/A	20201219

Clinical Scenario 6: Complex Continuing Care to Palliative Care

EMILIO

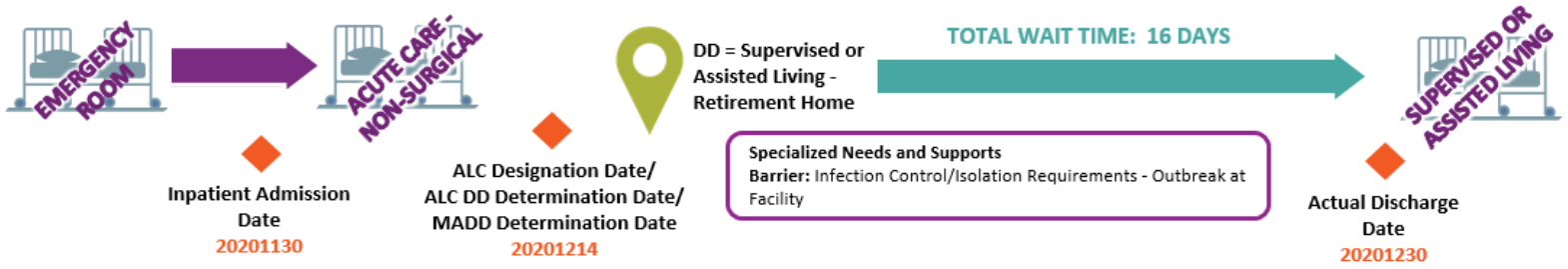
- Emilio is a 78-year-old patient admitted to Complex Continuing Care with a palliative diagnosis on January 9, 2021 following transfer from another facility.
- On January 15, 2021, Emilio decided to discontinue all other medical treatments except for comfort measures and pain management. A decision is made by the physician or delegate in collaboration with an interprofessional team to designate the Emilio ALC as he no longer requires the intensity of resources/services provided in the current care setting.
- Emilio is designated ALC awaiting an ALC Discharge Destination of Home - Home with CCAC Services and an application is made to the Community Care Access Centre (CCAC) for services to be put in place.

Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	ALC Discontinuation Date	ALC Discontinuation Reason	ALC Re-designation Date	Transfer Date	Actual Discharge Date
20210109	Transfer from another Facility	CCC	20210115	Home - Home with CCAC Services	20210115	Home - Home with CCAC Services	20210115	N	N/A	N/A	N/A	N/A	N/A	N/A

Clinical Scenario 7: Acute Care to Supervised or Assisted Living

BASHA

- Basha is an 88-year-old female admitted from the Emergency Department into an Acute Care - Non-Surgical bed on November 30, 2020, having difficulty with breathing.
- On December 14, 2020 Basha no longer requires the intensity of resources/services provided in Acute Care. On the same day, the interprofessional team determines Basha can be discharged back to the Retirement Home where she resides. However, Basha's originating Retirement Home is currently experiencing an outbreak and her discharge is delayed. As a result on December 14, 2020 Basha is designated ALC with the MADD and ALC Discharge Destination Type/Detail of Supervised or Assisted Living - Retirement Home.
- Specialized Need and Support of Infection Control/Isolation Requirements - Outbreak at Facility as a Barrier is documented because this is a factor known to be preventing/delaying Basha's discharge.
- On December 30, 2020 Basha is discharged to Supervised or Assisted Living - Retirement Home.

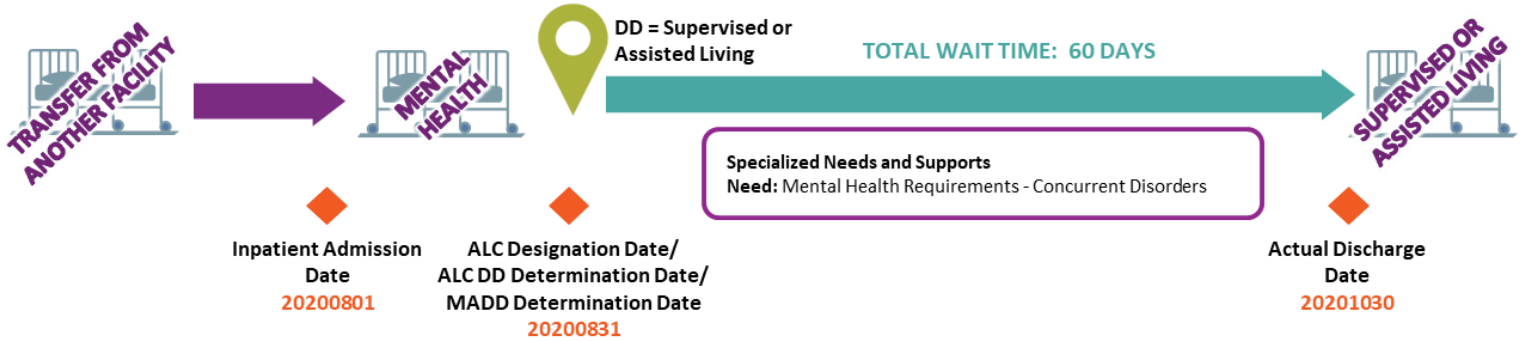


Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	Actual Discharge Date
20201130	Emergency Department	Acute Care - Non Surgical	20201214	Supervised or Assisted Living - Retirement Home	20201214	Supervised or Assisted Living - Retirement Home	20201214	Y	**Barrier:** Infection Control/Isolation Requirements - Outbreak at Facility	20201230

Clinical Scenario 8: Patient Directly Discharged to Most Appropriate Discharge Destination (MADD)

SHEILA

- Sheila is a 26-year-old female transferred from another facility to a Mental Health facility, into a Mental Health bed on August 1, 2020.
- On August 31, 2020 Sheila is designated ALC; she no longer requires the intensity of the Mental Health resources/services provided.
- The interprofessional team determines the MADD Type/Detail for Sheila is Supervised or Assisted Living-Supportive Housing/Group Home/Assisted Living.
- On August 31, 2020 the interprofessional team, in consultation with Sheila, recommends an ALC DD Type/Detail consistent with the MADD of Supervised or Assisted Living-Supportive Housing/Group Home/Assisted Living.
- Sheila has Specialized Needs and Supports of Mental Health Requirements - Concurrent Disorders as a Need since it is not preventing her discharge.
- On October 30, 2020 Sheila is discharged to Supervised or Assisted Living-Supportive Housing/Group Homes/Assisted Living.

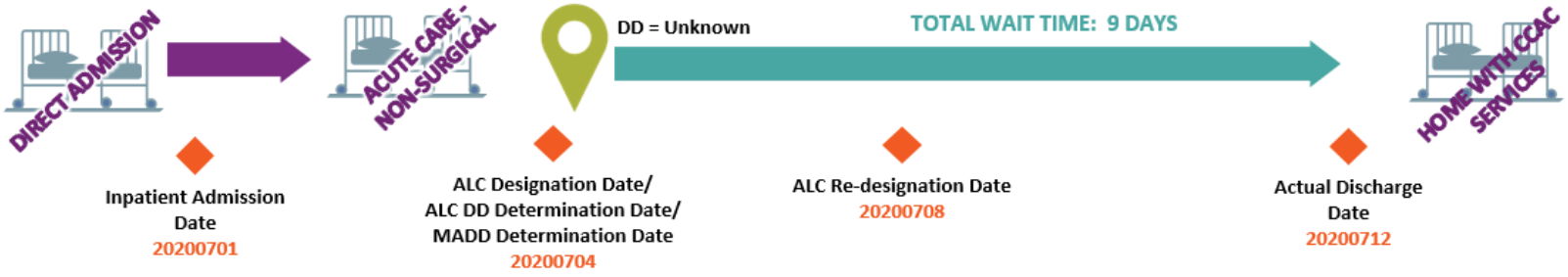


Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	Actual Discharge Date
20200801	Transfer From Another Facility	Mental Health	20200831	Supervised or Assisted Living - Supportive Housing/ Group Home/ Assisted Living	20200831	Supervised or Assisted Living - Supportive Housing/ Group Home/ Assisted Living	20200831	Y	**Need:** Mental Health Requirements- Concurrent Disorders	20201030

Clinical Scenario 9: Unknown as a Temporary Discharge Destination

ELENA

- Elena is a 79-year-old patient in a rural community, who was directly admitted to an Acute Care - Non-Surgical unit on July 1, 2020 with a palliative diagnosis.
- On July 4, 2020 Elena is designated ALC; she no longer requires the intensity of resources/services provided in Acute Care. On the same day, the interprofessional team determines Elena's pain and comfort measures would best be managed in Residential Hospice Care and notes the MADD Type/Detail for Elena is Palliative Care Bed - Residential Hospice Care. Unfortunately, palliative care services are not available in the community or at another local facility and Elena remains in the acute care bed. Elena is designated ALC awaiting an ALC DD Type/Detail of Unknown due to the unavailability of the patient's MADD and a suitable alternate Discharge Destination if found.
- On July 8, 2020 in consultation with the interprofessional team, Elena and her family decide to discontinue all other medical treatments except for comfort measures and pain management to palliate at home, given that there is no Residential Hospice available in the community. Elena's DD Type/Detail is updated to Home - Home with CCAC Services and an application is made to the Home and Community Care for services to be put in place.
- On July 12, 2020 Elena is discharged Home - Home with CCAC Services.

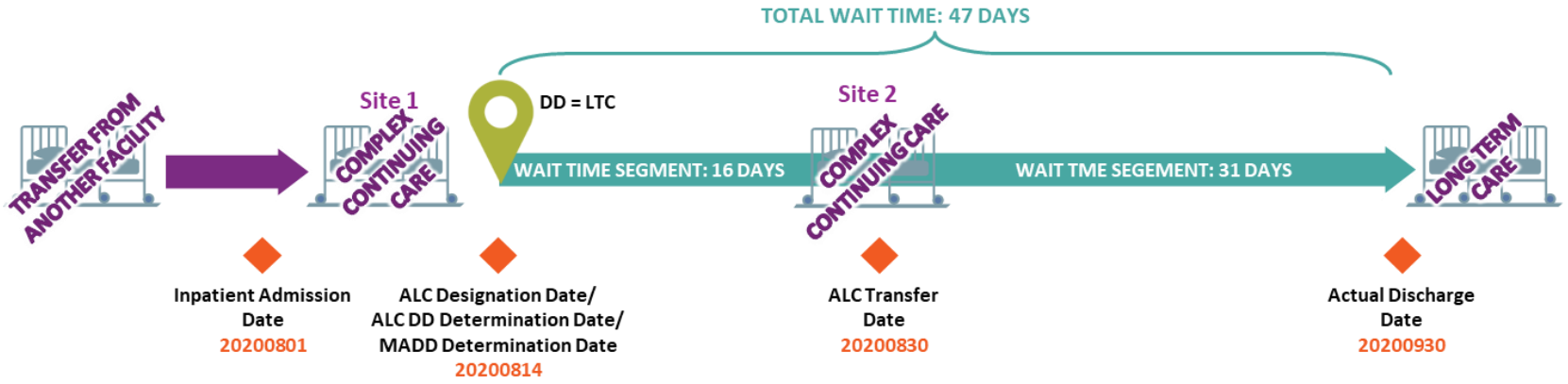


Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports (Indicator Y or N)	Specialized Needs & Supports Indicator (Y or N)	ALC Discontinuation Date	ALC Discontinuation Reason	ALC Re-designation Date	Transfer Date	Actual Discharge Date
20200701	Direct Admission	Acute Care - Non-Surgical	20200704	Palliative Care Bed - Residential Hospice Care	20200704	Unknown	20200704	N	N/A	N/A	N/A	20200708	N/A	20200712
						Home with CCAC Services	20200708							

Clinical Scenario 10: Site to Site Transfer

VINCENT

- Vincent is an 88-year-old male transferred from Facility A to a Complex Continuing Care bed at Facility B on August 1, 200.
- On August 14, 2020 Vincent is designated ALC; he no longer requires the intensity of resources/services provided in Complex Continuing Care. On August 14, 2020 the interprofessional team determines that the MADD Type/Detail for Vincent is LTC Bed, and then, in consultation with Vincent, recommends an ALC DD Type/Detail of LTC Bed, consistent with the MADD.
- Vincent has no Specialized Needs and Supports.
- On August 30, 2020 Vincent is moved from the Complex Continuing Care bed in Facility A/Site 1 to the same bed type (i.e. Complex Continuing Care) in Facility B/Site 2 to continue his wait for a LTC Bed closer to his home. The Transfer Date and change in site is captured in the WTIS (i.e. a Site to Site Transfer has occurred).
- On September 30, 2020 Vincent is discharged to LTC Bed.

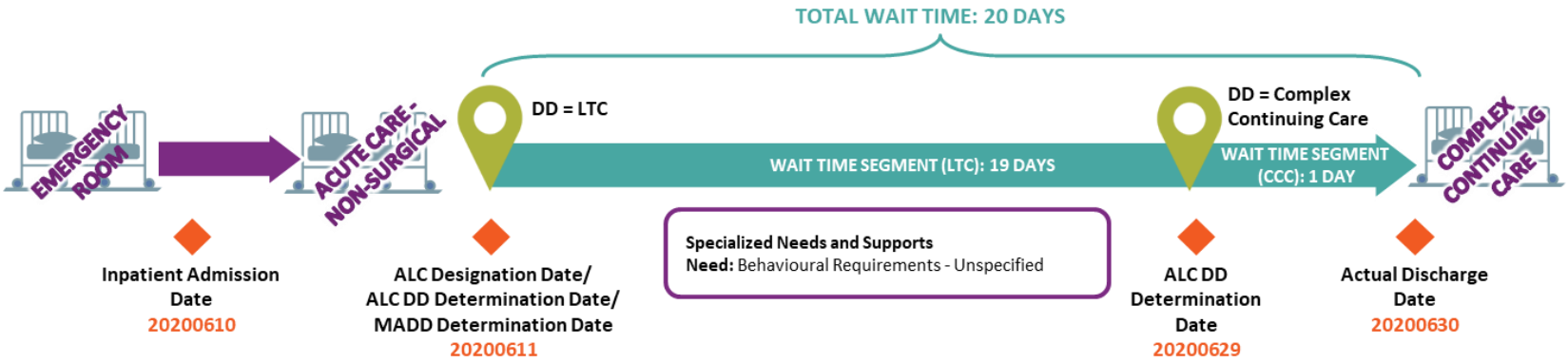


Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	Transfer Date	Actual Discharge Date
20200801	Transfer from Another Facility	Complex Continuing Care	20200814	LTC Bed	20200814	LTC Bed	20200814	N	N/A	20200830	20200930

Clinical Scenario 11: Bed Transfer to Continue ALC Wait

ERIC

- Eric, an 82-year-old male with a known diagnosis of dementia, is brought into the Emergency Room on June 10, 2020 after a fall; however, he did not sustain any injuries.
- On June 10, 2020 Eric is admitted to an Acute Care-Non-Surgical unit.
- On June 11, 2020 Eric is designated ALC; he does not require the intensity of resources/services provided in Acute Care.
- The interprofessional team determines that the MADD Type/Detail for Eric is LTC Bed.
- On June 11, 2020 the interprofessional team, in consultation with Eric, recommends an ALC DD Type/Detail of LTC Bed consistent with the MADD
- Eric has Specialized Needs and Supports of Behavioural Requirements - Unspecified as a Need as they are not preventing his discharge.
- On June 29, 2020, due to bed flow management reasons, Eric is moved to a Complex Continuing Care bed within the same facility to continue his wait for LTC, and Eric's ALC DD is changed to Complex Continuing Care bed to reflect this but the MADD remained the same as his care needs have not changed.
- On June 30, 2020, Eric was discharged to the Complex Continuing Care bed.
- On the same day, Eric was designated ALC and a new waitlist entry (WLE) was created for him to continue his wait for LTC (not shown below).

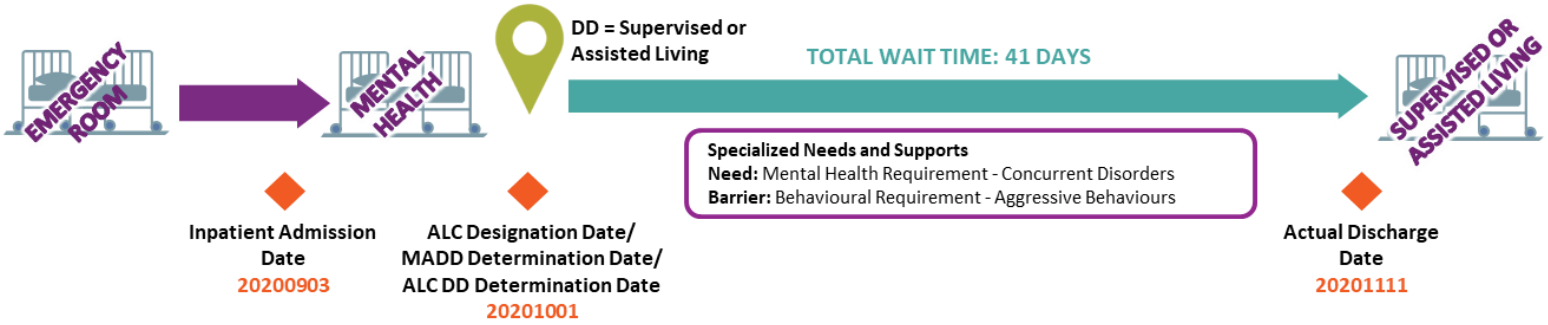


Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	Transfer Date	Actual Discharge Date
20200610	Emergency Room	Acute Care Non-Surgical	20200611	LTC Bed	20200611	LTC Bed	20200611	Y	**Need:** Behavioural Requirements - Unspecified	N/A	20200930
						Complex Continuing Care Bed	20200629				

Clinical Scenario 12: Waiting for Supervised or Assisted Living (Behavioural & Mental Health Requirements)

DAVID

- David is a 67-year-old male brought into the Emergency Room with suicidal ideation on September 3, 2020. The next day David is admitted to a Mental Health unit for treatment.
- On October 1, 2020 David is designated ALC; he no longer requires the intensity of resources/services of Mental Health. At the same time, the interprofessional team determines that the MADD Type/Detail for David is Supervised or Assisted Living - Supportive Housing/Group Homes/Assisted Living. Later in the day, the interprofessional team, in consultation with David, recommends an ALC DD Type/Detail of Supervised or Assisted Living - Supportive Housing/Group Homes/Assisted Living, consistent with the MADD.
- David has Specialized Needs and Supports of Mental Health Requirements - Concurrent Disorders as a Need (not preventing discharge), and Behavioural Requirements - Aggressive Behaviours as a Barrier (preventing/delaying discharge).
- On November 11, 2020 David is discharged to Supervised or Assisted Living - Supportive Housing/Group Homes/Assisted Living.



Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	Actual Discharge Date
20200903	Emergency Room	Mental Health	20201001	Supervised or Assisted Living - Supportive Housing/Group Homes/ Assisted Living	20201001	Supervised or Assisted Living - Supportive Housing/ Group Homes/ Assisted Living	20201001	Y	**Need:** Mental Health Requirements **Barrier:** Behavioural Requirement – Aggressive Behaviours	20201111

Clinical Scenario 13: Complex Continuing Care to Palliative Care; Change in Discharge Destination Invalidates ALC

EMILIO

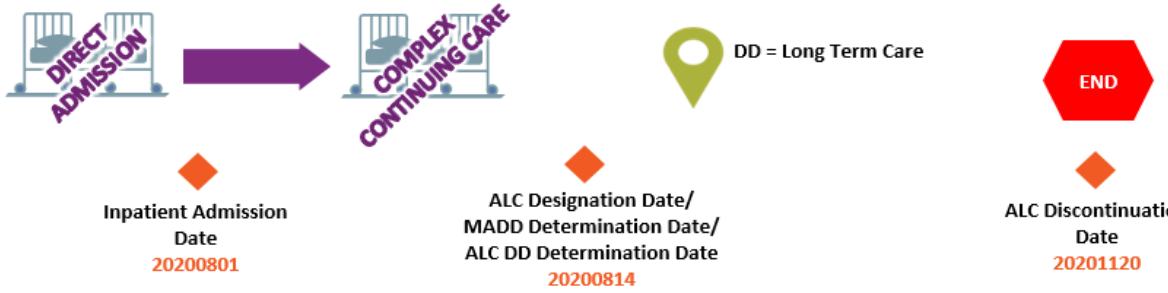
- Emilio is a 78-year-old patient admitted to a Complex Continuing Care bed through a planned admission. He is designated ALC on the same day, on January 15, 2021, waiting for Home - Home with CCAC Services, for the appropriate services to be put in place in order to palliate at home.
- On January 17, 2021 the interprofessional team transfers Emilio within the same hospital's in-hospital Complex Continuing Care - Palliative Care unit.
- The palliative care unit consists of Complex Continuing Care beds, same as the inpatient service Emilio is currently admitted in. As a result Emilio's ALC designation is discontinued with January 17, 2021 as the ALC Discontinuation Date and a Discontinuation Reason of *Change in Discharge Destination Invalidates ALC*.

Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	ALC Discontinuation Date	ALC Discontinuation Reason	ALC Re-designation Date	Transfer Date	Actual Discharge Date
20210115	Planned Admission	Complex Continuing Care	20210115	Home - Home with CCAC Services	20210115	Home - Home with CCAC Services	20210115	N	N/A	20210117	Change in Discharge Destination Invalidates ALC	N/A	N/A	N/A

Clinical Scenario 14: Patient Transitioned to an Alternate Care Setting

ELSA

- Elsa is an 68-year-old female admitted to a Complex Continuing Care bed at Hospital A on August 1, 2020.
- On August 14, 2020, Elsa is designated ALC as she no longer required the intensity of resources/services provided in Complex Continuing Care.
- On the same day, the interprofessional team determined that the MADD Type/Detail for Elsa is Long-Term Care, with an ALC Discharge Destination Type/Detail consistent with the MADD.
- After a few months, the inter-professional team subsequently recommended Elsa to be admitted to a transitional care unit, consisting of Acute Care designated beds located at Hospital B, focused on restorative care in hopes that her care needs will improve to a state where an alternative Discharge Destinations can be explored.
- On November 20, 2020, Elsa is discharged from Hospital A and admitted into Hospital B to continue her wait for a Long-Term Care bed, as per the team's recommendation and until her care needs change.
- Elsa's original ALC waitlist entry is discontinued with a Discontinuation Date of November 20, 2020 and a Discontinuation Reason of *Transferred to Acute Care*, since she moved from a post-acute care bed to an acute care bed.



Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	ALC Discontinuation Date	ALC Discontinuation Reason
20200801	Direct Admission	CCC Bed	20200814	Long-Term Care	20200814	Long-Term Care	20200814	N	N/A	20201120	Transferred to Acute Care
20201120	Planned Admission	Acute Care - Non Surgical	20201120	Long-Term Care	20201120	Long-Term Care	20201120	N	N/A		

Clinical Scenario 15: ALC Discontinuation Reason = Unplanned Repatriation (Transfer to Another Facility)

RICHARD

- Richard, a 55-year-old male, is directly admitted to a Rehab unit on February 3, 2021.
- On February 17, 2021 Richard is designated ALC; he no longer requires the intensity of resources/services provided in Rehab. On the same day, the interprofessional team determines a MADD Type/Detail for Richard of Complex Continuing Care Bed, and then, in consultation with Richard, recommends an ALC DD Type/Detail consistent with the MADD.
- On February 25, 2021 Richard is moved to another facility to continue his wait for Complex Continuing Care in a Rehab Bed.
- Richard's ALC Designation is Discontinued with a Discontinuation Date February 25, 2021 and an ALC Discontinuation Reason of *Unplanned Repatriation*.

Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	ALC Discontinuation Date	ALC Discontinuation Reason
20210203	Direct Admission	Rehab	20210217	CCC Bed	20210217	CCC Bed	20210217	N	N/A	20210225	Unplanned Repatriation

Clinical Scenario 16: Discontinuation Reason: Change in Medical Status

PENNY

- Penny is an 80-year-old patient directly admitted to an Acute Care - Non-Surgical unit on September 10, 2020 with a palliative diagnosis, waiting for admission into one of the hospital's partnering Hospice care, once a space becomes available.
- As she does not require the intensity of Acute Care, Penny was designated ALC on September 10, 2020 with an ALC Discharge Destination of Palliative Care - Residential Hospice Care.
- A few days later, on September 13, 2020, Penny's condition quickly deteriorates and is actively dying. The attending physician has decided not to issue a discharge order for Penny even if a bed becomes available in the hospice.
- Penny's ALC waitlist entry was discontinued with an ALC Discontinuation Date of September 13, 2020 and a Discontinuation Reason of *Change in Medical Status* as Penny then requires the level of care provided in the Acute Care bed.

Inpatient Admission Date	Inpatient Admission Source	Inpatient Service	ALC Designation Date	MADD Type & Detail	MADD Determination Date	ALC DD Type & Detail	ALC DD Determination Date	Specialized Needs & Supports Indicator (Y or N)	Specialized Needs & Supports (SNS-Need or Barrier)	ALC Discontinuation Date	ALC Discontinuation Reason
20200910	Direct Admission	Acute Care - Non-Surgical	20200910	Palliative Care - Residential Hospice Care	20200910	Palliative Care - Residential Hospice Care	20200910	N	N/A	20200913	Change in Medical Status

4 – Clinical Guidance

Through definitions, guiding principles, flow diagrams, clinical scenarios and case studies, this section provides clinical guidance to help you understand the nuances of ALC such as; when a patient does or does not meet the Provincial ALC Definition and how a patient's ALC information is in the WTIS to align with clinical best practices.

Section Highlights

4.1 – Designating a Patient as Requiring an Alternate Level of Care

Not all patients who occupy a hospital bed will be designated ALC. This designation is for a unique subset of patients who fit within the parameters of the ALC definition (provided in full below). This definition applies strictly to situations where a patient is both an inpatient occupying a hospital bed and does not require the level of care (resources or services) currently being provided.

Provincial ALC Definition Recap

Provincial ALC Definition
When a patient is occupying an inpatient bed in a hospital and **does not require the intensity of resources/services provided in this care setting** (Acute, Complex Continuing Care [CCC], Mental Health or Rehabilitation), the patient must be designated ALC[1] at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination[2] (or when the patient's needs or condition changes and the designation of ALC no longer applies).

The Provincial ALC Definition does not apply to patients:

- Waiting for another bed within the same level of care (i.e., Acute to Acute, CCC to CCC, Mental Health to Mental Health, and Rehab to Rehab)
- Waiting for Acute Care
- Waiting in a non-designated inpatient bed type (Acute, CCC, Rehab or Mental Health), including but not limited to bassinets; unconventional space (Medicine, 2019) or emergency department stretcher
- Waiting at home; or waiting in a tertiary acute care hospital bed for transfer to a non-tertiary acute care hospital bed (e.g., repatriation to a community hospital).

Designating a patient as ALC is independent of:

- The patient's final Discharge Destination or Most Appropriate Discharge Destination being determined or available
- The patient meeting the eligibility criteria for the desired/recommended Discharge Destination.
- Agreement from the patient/family on the ALC designation.

It is important to designate a patient as ALC when they no longer require the level of resources/services provided in their current care setting. This will allow for the capture of data to further understand the care needs of patients and the resource required in the community. This in turn, will allow for informed funding decisions to improve patient flow and support patients in receiving care in the appropriate setting.

4.2 – Guidance for Designating a Patient ALC in the WTIS

Two Business Day Rule

To ensure accurate and timely ALC data in the WTIS, information must be entered/updated in the system within two business days of the event happening/the information becoming available. This applies to:

- Opening a new ALC waitlist entry when a patient meets the definition of ALC
- Entering new information into a patient's existing ALC waitlist entry (e.g., SNS Need or Barrier as they arise)
- Updating existing information in a patient's waitlist entry (e.g., updating ALC Discharge Destination)
- Closing an existing ALC waitlist entry when the patient has been discharged or their ALC designation has been discontinued

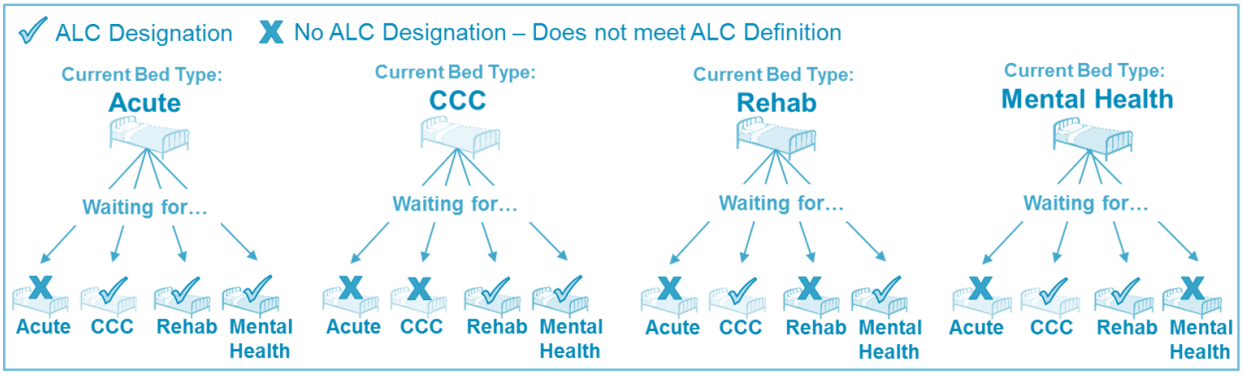
It is a requirement to keep ALC waitlist entries up-to-date and accurate at all times because the information is used to provide 'near-real time' ALC performance reporting and tools for waitlist management for stakeholders.

4.3 – Assigning Discharge Destinations

A patient's **Most Appropriate Discharge Destination (MADD)** refers to 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. This is irrespective of whether the discharge destination is available, accessible and/or exists within the community.

A patient's **ALC Discharge Destination** refers to the location determined by the physician or delegate in collaboration with an interprofessional team (when available), as to where a patient is to be discharged or transferred to.

The Provincial ALC Definition does not apply to patients who are waiting for a Discharge Destination within the same level of care or waiting for transfer to Acute Care. This is illustrated in the following diagram:



A Discharge Destination and MADD is mandatory. Within an ALC waitlist entry, there should not be a period of time where a MADD or a Discharge Destination are not identified for the patient. Thus, the first/earliest MADD and Discharge Destination Determination Dates in a waitlist entry should align with the ALC Designation Date.

4.4 – Most Appropriate Discharge Destination (MADD)

- A patient's MADD is based on the patient's care needs and **does not depend on** availability, eligibility, or approval of a discharge destination. Therefore, the destination of Unknown is not applicable to a patient's MADD.
- A patient's MADD may or may not be the same as their ALC Discharge Destination. A patient's MADD is based on the patient's clinical needs; the availability, accessibility, and eligibility of the patient in relation to their MADD results in the determination of their actual Discharge Destination. For more information about these data elements, see Section 3 - WTIS-ALC Data Elements, Determining Appropriate Level of Care, pg. 27.

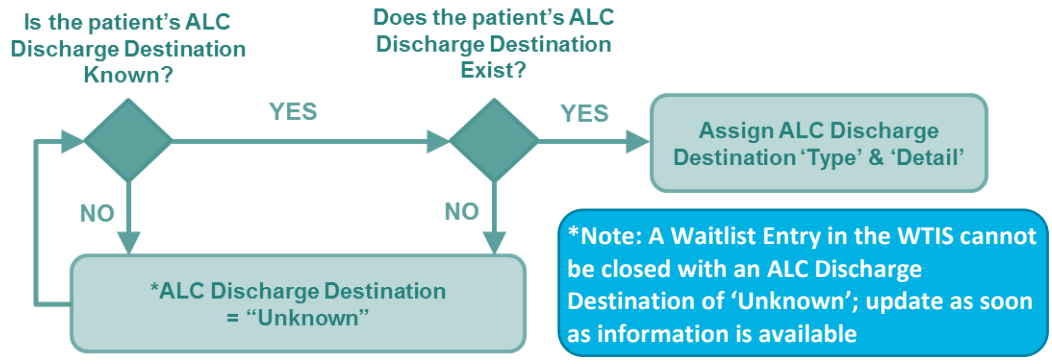
Clinical Scenarios: When a Patient's MADD is not the same as the Discharge Destination

Limited financial resources	A physician or delegate in collaboration with an interprofessional team designate a patient ALC as the patient no longer requires the intensity of resources/services provided in the patient's current care setting. The patient is designated ALC with a MADD of Supervised or Assisted Living - Retirement Home. However, the patient does not have the financial resources to reside in a Retirement Home. As a result, the ALC DD is Home - Home with CCAC Services. **Reported in the WTIS:** ✓ ALC Designation: YES ✓ MADD: Supervised or Assisted Living - Retirement Home ✓ ALC Discharge Destination: Home - Home with CCAC Services ✓ SNS: Social Requirements – Financial Constraints (Need)* *Note: If the ALC Discharge Destination had maintained as Supervised or Assisted Living - Retirement Home then the SNS of Social Requirements – Financial Constraints would be reported as a Barrier
Service not available in community	A physician or delegate in collaboration with an interprofessional team designate a patient ALC as the patient no longer requires the intensity of resources/services provided in the patient's current care setting – Intensive/Critical Care. The patient is designated ALC with a MADD of Palliative Care Bed - Residential Hospice Care. However, there are no residential hospices available in the patient's community. As a result, the patient is waiting for a Palliative Care Bed within a hospital and the ALC DD is Palliative Care Bed - Palliative Hospital Placement. **Reported in the WTIS:** ✓ ALC Designation: YES ✓ MADD: Palliative Care Bed - Residential Hospice Care ✓ ALC Discharge Destination: Palliative Care Bed - Palliative Hospital Placement

4.5 – Unknown ALC Discharge Destination

- If the ALC Discharge Destination is **not known or not available** at the time of ALC Designation, a waitlist entry should still be opened in the WTIS with the ALC Discharge Destination Type selected as Unknown and the initial ALC Discharge Destination Determination date aligns with the ALC Designation Date.
- ALC Discharge Destination = Unknown is intended to be temporary for circumstances in which the ALC Discharge Destination is not immediately known.
    - Once the interprofessional team and the patient have agreed to an ALC Discharge Destination, the waitlist entry in the WTIS should be updated to reflect the ALC Discharge Destination Type and Detail.
    - The patient does not have to be accepted to the destination or approved by the receiving organization in order to update the ALC Discharge Destination. In the event the patient's application is declined or the discharge plan changes, the waitlist entry should be updated to reflect the new Discharge Destination Type and Detail.
- ALC Discharge Destination = Unknown can be used at any point during a patient's ALC designation as required (i.e., selecting Unknown is ***not*** limited to being used only upon opening a waitlist entry)
- ALC Discharge Destination = Unknown is **not applicable** for the MADD of a patient

Flow Diagram for ALC Discharge Destination = Unknown



WTIS Data Collection Rules

- When Unknown is selected as an ALC Discharge Destination, the corresponding Discharge Destination Determination date must be provided.
- An ALC waitlist entry cannot be closed until the ALC Discharge Destination has been updated to a destination other than Unknown, except in situations where the ALC waitlist entry has been discontinued.

- ALC Discharge Destination can be updated at any point during a patient's wait (as determined by the physician or delegate and interprofessional team).

Clinical Scenario: Use of Unknown for ALC Discharge Destination

Service does not exist in the community	A physician or delegate in collaboration with an interprofessional team designate a patient ALC as the patient no longer requires the intensity of resources/services provided in the current care setting – Acute Care non-surgical bed. The patient is designated ALC awaiting an ALC Discharge Destination of Palliative Care Bed - Residential Hospice Care. Hospice Care currently does not exist in the patient's community and the team is in the process of determining an alternate destination for discharge. **Reported in the WTIS:** ✓ ALC Designation: YES ✓ MADD: Palliative Care Bed - Residential Hospice Care ✓ ALC Discharge Destination: Unknown

4.6 – Long-Term Care as an ALC Discharge Destination

Long-Term Care is a designated bed type providing care to meet both the medical and non-medical needs of people with chronic illnesses or disabilities who require care that is not available in the community.

- A patient **does not have to be eligible** for Long-Term Care to be assigned the MADD or ALC Discharge Destination of Long-Term Care. As soon as a patient's MADD or ALC Discharge Destination are known, the destination in the waitlist entry must be updated to that destination, regardless of the likelihood of final discharge to that destination.
- In the event that the patient is not eligible for Long-Term Care or the discharge plan changes, the ALC waitlist entry should be updated to reflect the new Discharge Destination.

New Guidance: If a patient is designated ALC waiting to return to his/her originating LTC home, the ALC Discharge Destination should still be captured as Long-Term Care bed.

Clinical Scenario: Long-Term Care Bed

Waiting for Long- Term Care with No Referral	A physician or delegate in collaboration with an interprofessional team designate a patient ALC as the patient no longer requires the intensity of resources/services provided in the current care setting - Acute Care. The patient is designated ALC awaiting for an ALC Discharge Destination of Long-Term Care Bed. A referral has not yet been submitted to the LHIN for eligibility determination. **Reported in the WTIS:** ✓ ALC Designation: YES ✓ MADD: Long-Term Care Bed ✓ ALC Discharge Destination: Long-Term Care Bed

4.7 – Palliative Care as an ALC Discharge Destination

Palliative Care, as defined within the confines of an ALC Discharge Destination, is the provision of medical or comfort care to support end-of-life planning to reduce the severity of a disease or slow its progress. The focus is on quality of life measures rather than providing a cure.

Palliative Hospital Placement: Palliative care delivered within a hospital environment, excluding Palliative programs delivered from Acute Care settings.

Residential Hospice Care (Hospice Residence): Specialized residential care for patients who are palliative.

Hospitals across Ontario offer palliative care services/programs in a variety of different care settings such as Acute Care and CCC. There are also residential hospices and community services.

Clinical Scenarios: Palliative Care

Acute → Palliative Hospital Placement on CCC Unit	A physician or delegate in collaboration with an interprofessional team designate a patient ALC as the patient no longer requires the intensity of resources/services provided in the current care setting – Acute Care, non-surgical. The patient is designated ALC awaiting an ALC Discharge Destination of Palliative Care Bed - Palliative Hospital Placement. A referral is made to a neighbouring hospital's palliative care unit, which is located in Complex Continuing Care (CCC). **Reported in the WTIS:** ✓ ALC Designation: YES ✓ MADD: Palliative Care Bed-Palliative Hospital Placement ✓ ALC Discharge Destination: Palliative Care Bed - Palliative Hospital Placement
No palliative services available in the community	A patient in a rural community is in an acute care bed in the local hospital has a palliative diagnosis. The decision is made by the physician or delegate in collaboration with an interprofessional team to designate the patient ALC as the patient no longer requires the intensity of resources/services provided in the current care setting, as the patient's pain and comfort measures could be managed in Residential Hospice Care. Unfortunately, palliative care services are not available in the community or at another local facility and the patient is remaining in an acute care bed. The patient is designated ALC awaiting an ALC Discharge Destination of Unknown. **Reported in the WTIS:** ✓ ALC Designation: YES ✓ MADD: Palliative Care Bed-Residential Hospice Care ✓ ALC Discharge Destination: Unknown

Home with CCAC Services	A patient has been a long-term resident of a CCC unit. The patient and family have decided to discontinue all other medical treatments except for comfort measures and pain management. The physician or delegate in collaboration with an interprofessional team designate the patient ALC as the patient no longer requires the intensity of resources/services provided in the current care setting. The patient is designated ALC awaiting an ALC Discharge Destination of Home - Home with CCAC Services and an application is submitted to the LHIN for home care services to be put in place. **Reported in the WTIS:** ✓ ALC Designation: YES ✓ MADD: Home – Home with CCAC Services ✓ ALC Discharge Destination: Home – Home with CCAC Services
CCC → Palliative Care Program in a CCC bed	A patient has been a long-term resident of a CCC unit. The patient's condition has been declining. The decision is made by the patient and interprofessional team to transfer her to one of the dedicated palliative care beds in the CCC unit once it becomes available. **Reported in the WTIS:** × ALC Designation: NO. The ALC definition does not apply to a transfer from one CCC bed to another CCC bed. Therefore, the patient is not designated ALC.
CCC → Palliative Care Program in an Acute Care bed	A patient has been a long-term resident of a CCC unit. The patient's condition has been declining. The decision is made by the patient and interprofessional team to transfer her to one of the dedicated palliative care beds in the Acute Care unit in a neighbouring hospital once it becomes available. **Reported in the WTIS:** × ALC Designation: NO. The ALC definition does not apply to patients waiting for an Acute Care bed. Therefore, the patient is not designated ALC.

4.8 – Specialized Needs and Supports Guidance

Specialized Needs and Supports (SNS) are the specialized care needs/supports of the patient required at the ALC Discharge Destination. In the WTIS, SNS are identified as either a Need or a Barrier, depending on whether or not the SNS is delaying or preventing discharge to the ALC Discharge Destination.

SNS as a Need: When the specialized needs and supports of the patient are not preventing or are not known to be delaying discharge to the ALC Discharge Destination.

SNS as a Barrier: When the specialized care needs and/or supports of the patient are delaying discharge to the ALC Discharge Destination.

Important: A patient can have more than one SNS reported in the WTIS. **It is important all SNSs required by the patient are identified to highlight specific barriers that exist within the healthcare system that delay or prevent patients from transitioning to appropriate levels of care.**

WTIS Data Collection Rules

- SNS must be entered into the WTIS **within 2 business days** from the time they are identified by the interprofessional team.
- In the WTIS, SNS information is reported via two data elements:
  - **SNS Indicator:** Identifies if the patient has any specialized care needs or supports (yes or no).
  - **SNS (as a Need and/or Barrier):** Identifies the individual specialized needs and supports as a Need or Barrier.
- The WTIS supports the capture of **multiple SNS**. It is **important** that all applicable SNSs of the patient are reported in the WTIS.
- SNS should be reviewed and updated in the WTIS based on the changing care needs/supports of the patient, in conjunction with changes to the patient's ALC Discharge Destination, if applicable.

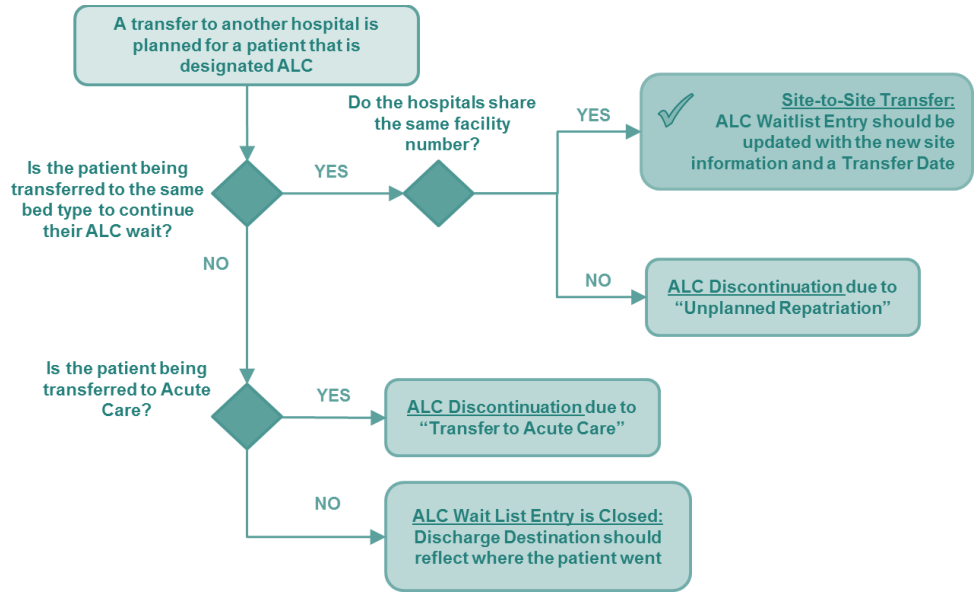
4.9 – Site-to-Site Transfers Guidance

A **Site-to-Site Transfer** occurs when a patient from the same inpatient bed type at one site is moved to the same inpatient bed type at another site within a multisite facility. A Site-to-Site Transfer takes place in the WTIS when the data element 'Site' is updated to a new site within a multi-site facility and a corresponding Transfer Date is selected.

Transfer Date: The calendar date when a patient is moved from the same inpatient bed type at one site to the same inpatient bed type at another site within the same multisite facility (i.e., the date the Site-to-Site transfer took place).

- Multi-site facilities may transfer a patient between sites within the same facility while keeping their ALC designation open only if transferring between the same inpatient bed types.
- When a Site-to-Site Transfer occurs for a patient designated ALC, the patient's ALC wait time continues and wait segments are attributed to each specific site. This will allow for continuous wait times to be associated with one waitlist entry for a patient designated ALC moving from one bed to another of the same inpatient bed type between sites within the same multi-site facility.
- When a patient is moved between different facilities (facilities with different facility numbers in WTIS), the ALC designation is Discontinued due to Unplanned Repatriation

Flow Diagram for Site-to-Site Transfers



WTIS Data Collection Rules

- Site-to-Site Transfers are not identified by a stand-alone data element, but instead are reflected through two data elements: Site and Transfer Date.

Clinical Scenarios: Site-to-Site Transfers

Transfer to the same bed type within the same multi-site facility	A patient designated as requiring an alternate level of care is in a Mental Health bed at one site of a multi-site facility. The patient is scheduled to be moved to a Mental Health bed at another site within the same multi-site facility for bed flow management reasons. **Reported in the WTIS:** ✓ Site-to-Site Transfer occurs ✓ Change in Site corresponds to a multi-site facility ✓ Transfer Date entered
Transfer from one facility to another	A patient designated as requiring an alternate level of care is in a Rehab bed at a single-site facility and has requested to be transferred to a hospital closer to their home where the patient will continue to wait in a Rehab bed. **Reported in the WTIS:** × No. Site-to-Site Transfer did not occur ✓ ALC Discontinuation due to "Unplanned Repatriation"
Transfer to a different bed type within the same facility	A patient designated as requiring an alternate level of care is in a CCC bed at a multi-site facility and will be transferred to a Rehab bed at another site within the same multi-site facility for bed flow management reasons. **Reported in the WTIS:** × No. Site-to-Site Transfer did not occur ✓ ALC Discharge Destination changed to 'Rehab' and the ALC Discharge Destination Determination Date is updated to align with the Discharge Date. The patient's waitlist entry is then closed, indicating that the patient's movement from a CCC bed to a Rehab bed on the day of discharge.

4.10 – Guidance for Discontinuing an ALC Designation

A patient's ALC Designation is Discontinued when the patient's needs or condition changes and the designation of ALC C no longer applies. This results in the closure (i.e., discontinuation) of the patient's ALC waitlist entry. The associated ALC Discontinuation Reason is the specific reason for discontinuing the ALC designation. There are seven ALC Discontinuation Reasons:

1. Change in Destination Invalidates ALC Designation.
2. Change in Medical Status.
3. Data Entry Error.
4. Death.
5. Discharge Against Medical Advice.
6. Transfer to Acute Care.
7. Unplanned Repatriation (Transferred to Another Facility).

- A patient's ALC waitlist entry is discontinued when the Provincial ALC Definition no longer applies to the patient prior to a patient's discharge to the planned ALC Discharge Destination.
- When a waitlist entry is discontinued due to a **Change in Medical Status**, it is possible to re-open the waitlist entry if the patient is re-designated ALC within 40 weekdays of the Discontinuation Date.

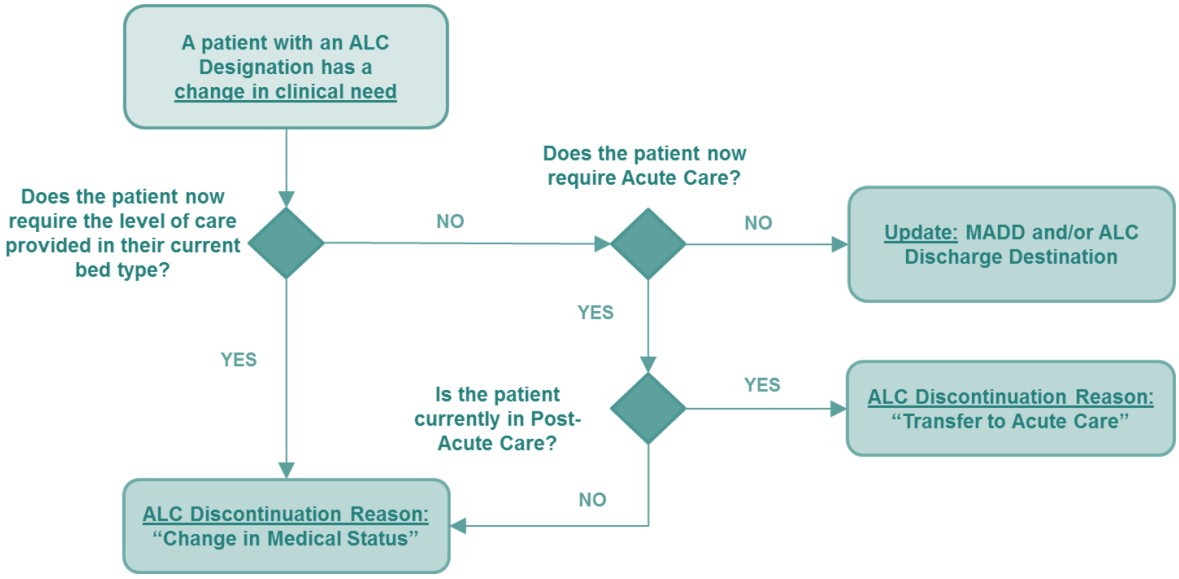
Note: Change in Medical Status is the only ALC Discontinuation Reason which allows a waitlist entry to be re-opened. The remaining six reasons will permanently close a waitlist entry.

Clinical Scenarios: ALC Discontinuation Reasons

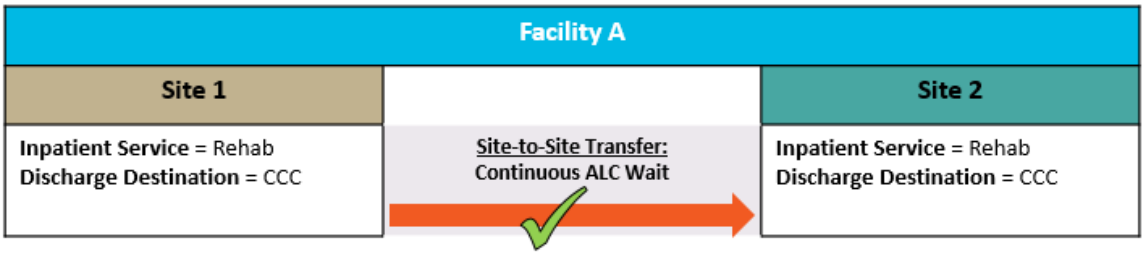
1 Change in Destination Invalidates ALC Designation	A patient in a Mental Health bed no longer requires the intensity of services/care provided in their current care setting. The decision is made by the physician or delegate in collaboration with an interprofessional team to designate the patient ALC awaiting an ALC Discharge Destination of Home - Home with CCAC Services. One month later, the patient's condition changes and it is determined the patient now needs a different type of Mental Health Bed - Inpatient Detoxification Services. The patient's ALC designation is discontinued as she is ALC waiting in a Mental Health bed for a Mental Health bed, which contradicts the Provincial ALC Definition. **Reported in the WTIS:** ✓ ALC Discontinuation Reason: Change in Destination Invalidates ALC Designation
2 Change in Medical Status	A patient is in an Acute Care bed and the decision is made by the physician or delegate in collaboration with an interprofessional team to designate the patient ALC as the patient no longer requires the intensity of resources/services provided in the current care setting. The patient is designated ALC awaiting an ALC Discharge Destination of Supervised or Assisted Living - Retirement Home. A week later, while waiting for a placement in the retirement home, the patient develops pneumonia requiring IV antibiotics and oxygen therapy. The patient's ALC designation is discontinued because he now requires the intensity of resources/services provided in the Acute Care setting. The patient is treated in the same Acute Care setting and a week later he stabilizes, and is re-designated ALC. **Reported in the WTIS:** ✓ ALC Discontinuation Reason: Change in Medical Status
3 Data Entry Error	A patient is in a Rehab bed and the decision is made by the physician or delegate in collaboration with an interprofessional team to designate the patient ALC as the patient no longer requires the intensity of resources/services provided in the current care setting. The patient is designated ALC awaiting an ALC Discharge Destination of Supervised or Assisted Living - Retirement Home, and the application is submitted. When the discharge planner went to update his discharge information, it was discovered that the waitlist entry was created with an incorrect ALC Designation Date. Since ALC Designation Date is a non-editable field, a new waitlist entry must be created to replace the one containing the error, after it has been discontinued using the reason of Data Entry Error. **Reported in the WTIS:** ✓ ALC Discontinuation Reason: Data Entry Error

4 Death	A patient is admitted to an Acute Care bed and the decision is made by the physician or delegate in collaboration with an interprofessional team to designate the patient ALC as the patient no longer requires the intensity of resources/services provided in the current care setting. The patient is designated ALC awaiting an ALC Discharge Destination of Home - Home with Community Services to support the patient and patient's family with end of life planning and comfort measures. A week later, the patient suffers from a sudden heart attack and dies in Acute Care. **Reported in the WTIS:** ✓ ALC Discontinuation Reason: Death
5 Discharge Against Medical Advice	Following an admission to an Acute Care bed, t the physician or delegate in collaboration with an interprofessional team designate the patient ALC as the patient no longer requires the intensity of resources/services provided in the current care setting. The patient is designated ALC awaiting an ALC Discharge Destination of Mental Health Bed - Inpatient Detoxification Services. A few days later, the patient wishes to return home. The patient does not have a discharge order and the team indicates the course of care is for the patient to remain in hospital until transfer to a Mental Health bed. The patient signs out of the hospital against medical advice and refuses any additional referrals for alcohol and drug treatment. **Reported in the WTIS:** ✓ ALC Discontinuation Reason: Discharge Against Medical Advice
6 Transfer to Acute Care	A patient is admitted to a Complex Continuing Care bed and designated ALC on the same day because the services required are not accessible in the community and it is deemed unsafe to discharge the patient. The patient is designated ALC waiting for Supervised or Assisted Living - Supportive Housing/ Group Homes/Assisted Living. During the wait, the patient suffers from a sudden heart attack and requires Acute Care services. **Reported in the WTIS:** ✓ ALC Discontinuation Reason: Transfer to Acute Care
7 Unplanned Repatriation (Transfer to Another Facility)	A patient is designated ALC in a CCC bed in Hospital As the patient no longer requires the intensity of resources/services provided in the current care setting. The patient is awaiting – to be discharged to a specialty rehabilitation program at another facility (Hospital B). After waiting for two days, it is decided to discharge the patient to Hospital B's CCC unit to continue the ALC wait until a Rehab bed at Hospital B becomes available. **Reported in the WTIS:** ✓ ALC Discontinuation Reason: Unplanned Repatriation

Flow Diagram: Transfer to Acute Care vs. Change in Medical Status



Site-to-Site Transfer vs. Unplanned Repatriation



4.11 – Post-Acute Care Bed Types Guidance

Complex Continuing Care (CCC) Beds: A designated bed providing specialized care to patients with are medically complex, require hospital stays, regular onsite physician care and assessment, and active management over extended periods of time.

Rehabilitation Beds: A designated bed providing care aimed at maximizing patient's overall physical, sensory, intellectual, psychological and social functions.

Mental Health Beds: A designated bed delivering therapeutic services to patients with addictions, psychological, behavioural, or emotional illness.

Provincially, there is a multitude of services provided in funded Post-Acute Care beds (CCC, Rehab, and Mental Health) and the types of patients who receive care in these settings. To apply the Provincial ALC Definition in these Post-Acute settings, clinicians should work with their interprofessional team, when available, to designate a patient ALC when they no longer require the intensity of services provided in the specific Post-Acute bed the patient is occupying.

Clinical Scenarios: CCC and Rehab

Rehab → Long-Term Care	Patient's progress has reached a plateau and the intensity of services in a Rehab bed is no longer required. The interprofessional team determines the patient can be discharged to Long-Term Care. **Reported in the WTIS:** ✓ ALC Designation: YES ✓ MADD: Long-Term Care ✓ ALC Discharge Destination: Long-Term Care
Rehab → CCC	Patient's progress has reached a plateau and the intensity of services in a Rehab bed is no longer required. The interprofessional team determines the patient can be transferred to a CCC bed to receive specialized services. **Reported in the WTIS:** ✓ ALC Designation: YES ✓ MADD: CCC ✓ ALC Discharge Destination: CCC

Specialized Rehab → General Rehab	Patient no longer requires the intensity of services provided in a Rehab bed and is awaiting transfer to another Rehab bed (e.g., patient is in a specialized rehab bed awaiting transfer to a general rehab bed). **Reported in the WTIS:** × ALC Designation: NO, The Provincial ALC Definition does not apply to patients waiting for transfer within the same bed types.
CCC → Acute	Patient is in a CCC bed awaiting discharge to an in-hospital palliative program delivered in an Acute Care bed. **Reported in the WTIS:** × ALC Designation: NO, The Provincial ALC Definition does not apply to patients waiting for transfer to Acute Care.

4.12 – Mental Health Beds

On June 23, 2009, a provincial Mental Health Expert Panel for ALC with representation from mental health facilities and acute care hospitals from across the province met to determine how the ALC definition should be applied to patients awaiting a mental health bed. It was determined that the Provincial ALC Definition should be applied in the same manner for Mental Health, CCC, and Rehabilitation beds.

For the purposes of the Provincial ALC Definition, a mental health bed includes the following bed types (note: bed types are defined through MIS functional/accounting centres):

- Acute Care Mental Health bed
- Addiction Inpatient bed
- Child/Adolescent Mental Health bed
- Forensic bed
- Psychiatric Crisis Unit bed
- Longer-Term psychiatry bed

Clients in hospital under the jurisdiction of the Ontario Review Board (ORB) who are detained and who do not have community living clause in their disposition should not be designated ALC, as discharge of the patient is not permitted given their status under the ORB.

Clinical Scenarios: Mental Health Bed

Acute → Mental Health	The physician or delegate in collaboration with an interprofessional team decide to designate the patient ALC as the patient no longer requires the intensity of resources/services provided in the current Acute Care bed setting. The patient is designated ALC awaiting an ALC Discharge Destination of Mental Health Bed - Inpatient Psychiatric Services. **Reported in the WTIS:** ✓ ALC Designation: YES ✓ MADD: Mental Health Bed - Inpatient Psychiatric Services ✓ ALC Discharge Destination: Mental Health Bed - Inpatient Psychiatric Services

Mental Health → Supervised or Assisted Living	The physician or delegate in collaboration with an interprofessional team designate a patient ALC as the patient no longer requires the intensity of resources/services provided in the current care setting of Mental Health bed). The patient is designated ALC awaiting an ALC Discharge Destination of Supervised or Assisted Living - Supportive Housing/Group Homes/Assisted Living. **Reported in the WTIS:** ✓ ALC Designation: YES ✓ MADD: Supervised or Assisted Living - Supportive Housing/Group Homes/Assisted Living ✓ ALC Discharge Destination: Supervised or Assisted Living - Supportive Housing/Group Homes/Assisted Living
Mental Health Bed in Acute Hospital → Mental Health Facility	A patient in a Mental Health bed (within an acute care hospital) is awaiting transfer to a Mental Health facility. **Reported in the WTIS:** × No. The Provincial ALC Definition does not apply to patients waiting for transfer within the same bed types.
Psychiatric Crisis Unit → Inpatient Dependency Treatment Services	A patient in a Mental Health bed is awaiting transfer to another type of Mental Health bed (e.g., patient is in a Psychiatric Crisis Unit bed awaiting transfer to a Mental Health - Inpatient Dependency Treatment Services bed). **Reported in the WTIS:** × No. The Provincial ALC Definition does not apply to patients waiting for transfer within the same bed types.

5 – ALC Status Definitions

This section reviews the four possible ALC statuses that patient's designated ALC may be assigned.

Section Highlights

5.1 – Open ALC Cases

Definition: Patients that have been designated/re-designated ALC and are still Open (i.e., still waiting) as of a specified date (e.g., end of a reporting period).

5.2 – Discharged ALC Cases

Definition: Patients that have been designated/re-designated ALC and were discharged to an ALC Discharge Destination within a specified period of time (e.g., within reporting month).

5.3 – Discontinued ALC Cases

Definition: Patients that have been designated/re-designated ALC and have had their ALC-designation discontinued within a specified period of time (e.g., within reporting month). ALC cases may be discontinued due to one of the following reasons:

- Change in Destination Invalidates ALC Designation
- Change in Medical Status
- Data Entry Error
- Death
- Discharge Against Medical Advice
- Transfer to Acute Care
- Unplanned Repatriation

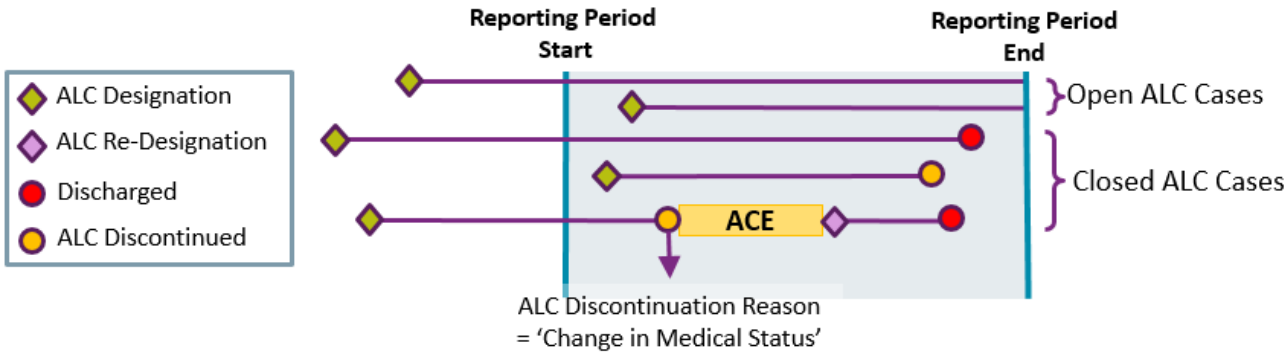
Note: Only ALC cases discontinued due to Change in Medical Status may be re-designated ALC.

5.4 – Acute Care Episode (ACE) Periods

An Acute Care Episode (ACE) period represents the period of time when the patient's condition has deteriorated and the designation of ALC is no longer appropriate, because the patient requires the intensity of resources/services in the same care setting he/she was designated ALC. A waitlist entry may have more than one ACE period. The start date of an ACE period is the Discontinuation Date where the reason for discontinuation is a Change in Medical Status. An ACE period may last for up to 40 consecutive weekdays. After 40 weekdays, the patient's waitlist entry must be closed and a new waitlist entry opened should the patient be designated ALC for another time. The end of the ACE period 40 weekdays or less is the Re-Designation Date.

Note: While ACE is an acronym for Acute Care Episode, it is applicable to patients designated ALC in either an Acute care bed or a Post-acute care bed. A patient's ALC designation may be discontinued due to change in medical status and then re-designated provided that the patient remains in the same bed type.

Diagram: ALC Statuses in ALC Reports



6 – ALC Performance Indicators

This section provides information about the ALC performance indicators reported by Access to Care on a monthly and quarterly basis, including definitions, calculation notes, and data source information. For the ALC Key Performance Indicators, methodology notes, a calculation example, and a description of what the indicator means conceptually is provided.

Section Highlights

6.1 – What is an Indicator?

A health indicator is a single measure that is monitored and reported to provide important actionable information about population health and/or health system performance and characteristics. An indicator can provide comparable information, track progress/performance over time, and can support different health system stakeholders to monitor and track how well their respective health systems are functioning.

6.2 – ALC Key Performance Indicators

Since the beginning of ALC data collection, a number of ALC performance indicators have been defined by provincial leaders and stakeholders. Together, these indicators reflect a patient's wait time journey at a patient-level, and ALC performance at a hospital/community/provincial-level. ALC indicators are reported in ATC's Operational ALC Reports (see Section 7 - ALC Reporting at Access to Care, pg. 97) and distributed to a diverse group of stakeholders on a monthly and quarterly basis.

Four ALC indicators are considered Key Performance Indicators:

1. ALC Volumes
2. ALC Throughput Ratio
3. ALC Wait Times: Cumulative/Total ALC Days
4. ALC Rate

ALC Volumes

Definition: ALC volumes refer to the number of ALC cases (i.e. patients designated ALC) that meet a select criteria. They may be presented/reported as a number or a percentage/proportion of cases.

Data Source	Ontario's Wait Time Information System (WTIS)
Calculation Notes	ALC Volumes can be calculated for a: • Specified point in time (e.g., as of the end of a reporting period) • Specified period of time (e.g., from the start-end of a reporting period)

There are two categories for ALC volumes based on the type of information they represent:

1. Occupancy/Flow of ALC Cases.
2. Characteristics of ALC Cases.

Occupancy/Flow of ALC Cases

Volume of Open Cases	The number of ALC waitlist entries open at a specified point in time (typically the last day of a reporting month/quarter/year). This indicator can be interpreted as the number of patients waiting for an alternate level of care at a specified point in time.
Volume of Closed Cases	The number of ALC waitlist entries discharged or discontinued within a specified period of time (inclusive of the first and last day of the month).
Volume of Discharged Cases	The number of ALC waitlist entries discharged to an ALC Discharge Destination (i.e., removed from the Wait List) within a specified period of time (inclusive of start and end dates).
Volume of Discontinued Cases	The number of ALC waitlist entries discontinued (with no corresponding re-designation date) within a specified period of time (inclusive of start and end dates).
Volume of Newly Added Cases	The number of ALC waitlist entries designated or re-designated ALC within a specified period of time (inclusive of start and end dates).
Volume of New ALC Designations	The number of patients designated ALC (i.e., new waitlist entry) in a specified period of time (inclusive of start and end dates).

Volume of Re-designations	The number of ALC waitlist entries with a Re-Designation Date in a specified period of time (inclusive of start and end dates). A patient can only be re-designated ALC when their ALC designation was discontinued due to a Change in Medical Status resulting in an Acute Care Episode (ACE) Period for 40 weekdays or less.
Volume of Transfer-In Instances	The number of patients designated ALC transferred to the reporting site from another site within the same facility using "Site-to-Site Transfer" functionality (only applies to multi-site facilities).
Volume of Transfer-Out Instances	The number of patients designated ALC transferred out of the reporting site to another site within the same facility using "Site-to-Site Transfer" functionality (only applies to multi-site facilities).

Characteristics of ALC Cases

Volume of ALC Cases where ALC Discharge Destination ≠ MADD	At a specific point in time, the number of ALC waitlist entries waiting for a Discharge Destination inconsistent with their Most Appropriate Discharge Destination.
Volume of ALC Cases where ALC Discharge Destination = MADD	At a specific point in time, the number of ALC waitlist entries waiting for a Discharge Destination consistent with their Most Appropriate Discharge Destination, at a specified point in time.
Volume of Long Waiters	At a specific point in time, the number of ALC waitlist entries with an ALC Wait Time of 30 days or greater, at a specified point in time.
Volume of ALC Cases with at least one Specialized Need and Support (SNS)	At a specific point in time, the number of ALC waitlist entries with at least one identified SNS, regardless of whether the SNS is a Need or a Barrier.
Volume of ALC Cases with SNS as a Need Only	At a specific point in time, the number of ALC waitlist entries that have ≥ 1 SNS that are all identified as a Need only.
Volume of ALC Cases with SNS as a Barrier (at least one)	At a specific point in time, the number of ALC waitlist entries that have ≥ 1 SNS that is identified as a Barrier.
Volume of ALC Cases Designated within 'X' Days of Admission	The number of ALC waitlist entries that have an ALC designation date within 'X' days of being admitted to hospital.

ALC Throughput Ratio

Definition: The ratio of the number of Discharged ALC Cases to Newly Added ALC Cases within a specified period of time.

Methodology

$$\text{ALC Throughput Ratio} = \frac{\text{Volume of Discharged Cases}}{\text{Volume of Newly Added Cases}}$$

Volume of Discharged Cases: The number of ALC-designated patients discharged to an ALC Discharge Destination within a specific period of time (inclusive of start and end dates).

Volume of Newly Added Cases: The number of ALC-designated patients that were designated or re-designated ALC within a specified period of time (inclusive of start and end dates).

Data Source: WTIS

Note: Discontinued ALC Cases are not included in the ALC Throughput Ratio calculation. For additional information on ALC Throughput Ratio, such as inclusion and exclusion criteria, please refer to the methodology tab within the ALC Throughput Report.

Conceptually – Patient Flow

The ALC Throughput Ratio reflects the rate at which patients are being discharged versus designated ALC. Conceptually, this indicator represents the flow of patients designated and discharged ALC at a particular hospital during a specified period of time. This indicator can be interpreted as follows:

> For every patient designated ALC at <Facility / Site> in <Inpatient Service>, who was discharged to <ALC Discharge Destination> in <reporting time period>, <Throughput Ratio> patient(s) with an ALC Designation is newly added.

Applying to the example below:

SELECTION:

Province/LHIN/Facility/Site	PROVINCIAL	Facility/Site #	N/A
Inpatient Service	Complex Continuing Care		
Discharge Destination	Long Term Care		

MONTHLY VIEW

Reporting Period	Queue at Start of Report Period	Volume of Newly Added Cases	Breakdown of the Volume of Newly Added Cases						Number of Transfer-In Instances	Number of Transfer-Out Instances	Volume of Discharged Cases	Throughput Ratio (N/E)
			New ALC Designations									
			f New ALC Des	Within 0 Days	d Within 1 Day	Within 2 Days	Within 3 Days	Volume of ALC Re-designations				
Aug 20	766	168	167	22.75%	32.93%	35.33%	36.53%	1	0	0	219	1.30
Sep 20	715	182	177	25.99%	31.64%	35.03%	35.59%	5	1	1	207	1.14
Oct 20	690	231	226	30.53%	43.36%	46.02%	46.90%	5	0	0	174	0.75
Nov 20	747	177	175	33.71%	45.71%	48.00%	49.71%	2	19	19	177	1.00

We can interpret the data from the above as “For every patient designated ALC provincially in a Complex Continuing Care bed, who was discharged to Long Term Care in August 2020, 1.3 patient with an ALC Designation is newly added.”

In summary, an ALC Throughput Ratio:

- Less than 1 indicates there were more newly added ALC cases than discharged ALC cases at a facility, indicating that there are growing pressures from patients waiting for an alternate level of care.
- Greater than 1 indicates there were more discharged ALC cases than newly added ALC cases, indicating that the queue of patients with an ALC designation will also decrease.

Calculation Example: ALC Throughput Ratio

During the month of June 2020 (June 1 – June 30), 37 patients were designated ALC, 3 patients were re-designated ALC, and 45 patients designated ALC were discharged to an ALC Discharge Destination at Hospital A. What is the ALC Throughput Ratio for the month of June at Hospital A?

Volume of New ALC Designations = 37
Volume of Re-designations = 3
Volume of Discharged Cases = 45

} Volume of Newly Added Cases + 37 + 3 = 40

ALC Throughput Ratio = $\frac{45}{40}$ = 1.125

Therefore during the month of June, the number of patients designated ALC that were discharged was **greater** than the number of patients who were designated/re-designated ALC.

ALC Wait Times

Definition: A Wait Time is the number of days between two specified points in time. In the ALC context, an ALC wait time is the number of days from ALC Designation Date to a specified point in time (see specific ALC Wait Time indicator definitions below).

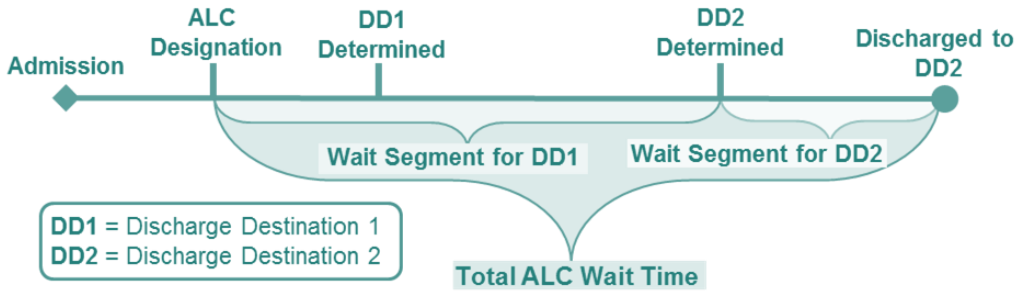
Methodology

ALC Wait Time = ALC Designation Date → Specified Point in Time

- ALC Wait Times account for the ALC Designation Date but not the end date (e.g. ALC Discharge Date, ALC Discontinuation Date or the last day of a reporting period)
- All Acute Care Episode (ACE) periods are excluded from the patient's ALC Wait Time.

Data Source: WTIS

ALC Wait Time Indicators

Wait Time for Open ALC Cases	The number of days from ALC Designation Date to a specified point in time (e.g., last day of a reporting month), inclusive of start/end dates, minus all ACE periods. The ALC waitlist entry must have an Open status at the specified point in time to be included in calculation.
Wait Time for Discharged ALC Cases	The number of days from ALC Designation Date to the date of discharge to an ALC Discharge Destination, inclusive of end date, minus all ACE periods.
Wait Time for Discontinued ALC Cases	The number of days from ALC Designation Date to the date the ALC Designation was discontinued, inclusive of end date, minus any ACE periods.
Wait Time Segmented by Discharge Destination	In the case where a patient's ALC Discharge Destination changes during their wait time journey, the patient's total ALC Wait Time is segmented into the number of days spent waiting for each specific discharge destination. 
Wait Time Segmented by Most Appropriate Discharge Destination	When a patient has multiple MADDs identified over their wait time journey, their total Wait Time is segmented into the number of days each MADD was selected for in their waitlist entry.

ALC Wait Time Metrics

There are four different metrics used to present ALC Wait Time indicators:

90th Percentile	The maximum ALC wait time 90% (i.e. 9 out of 10 patients) of patients have been waiting (Open ALC Cases) or have waited for (Closed Cases = Discharged or Discontinued Cases).
Median	The maximum ALC wait time 50% (i.e. 5 out of 10 patients) of cases have been waiting (Open Cases) or have waited for (Closed Cases = Discharged or Discontinued Cases).
Mean/Average	The total ALC wait time for all cases divided by the total number of ALC cases; this represents the average ALC wait time that cases have been waiting (Open Cases) or have waited (Closed Cases).
Cumulative/ /Total ALC Days	The sum of all ALC wait times (see following section focused on this metric for more details).

Cumulative/Total ALC Days

Definition: Cumulative ALC Days (also referred to as Total ALC Days) is the sum of all ALC wait times starting from ALC designation, typically for Open ALC Cases, at a specified point in time.

Methodology

Cumulative ALC Days = ∑ ALC Wait Times for Open ALC Cases*

ALC Wait Time for Open ALC Cases: The number of days from ALC Designation to a specified point in time, minus any ACE periods

*Wait Times are calculated for Open ALC Cases as of a specified point in time (e.g., end of reporting period)

Data Source: WTIS

Conceptually – Patient Experience

Conceptually, Cumulative ALC Days/Total ALC Days represents the total time the patient has waited to access the alternate level of care required; the impact of ALC days on patients designated ALC. This indicator represents the total number of days patients are actively waiting for an alternate level of care.

Calculation Example

On June 30, 2020 there are 3 open ALC cases at Hospital A: Jean, Tom and Catherine.

- Jean was designated ALC on June 20.
- Tom was designated ALC on May 1.
- Catherine was designated ALC on June 6.

What is the number of Cumulative ALC Days at Hospital A as of June 30?
ALC wait time for Jean = June 30 - June 20 = 11 days
ALC wait time for Tom = June 30 - May 1 = 61 days
ALC wait time for Catherine = June 30 - June 6 = 25 days

Cumulative ALC Days = 11 + 61+ 25 = 97 days

As of June 30, 2020 patients designated ALC at Hospital A have a cumulative total of 97 ALC days.

ALC Rate

Definition: The proportion of inpatient days in Acute and Post-Acute care beds that are spent designated ALC in a specific period of time.

Methodology

ALC Rate is:

$$\frac{\text{Total ALC Days in Reporting Period*}}{\text{Total Inpatient Days*}} \times 100\%$$

Total ALC Days in Reporting Period: The total number of days that patients spent designated ALC within the specified period of time.

Total Number of Inpatient Days: The total number of inpatient bed days contributed by patients within the specific period of time.

*Within a specified period of time

Data Sources: WTIS (Total ALC Days in Reporting Period)

Daily Bed Census Summary (Total Number of Inpatient Days)

To calculate the Total Number of Inpatient Days, an extract of the Daily Bed Census Summary (dBCS) is taken on the 6th business day of each reporting month to coincide with the WTIS data cut date. The following guiding principle is then used to calculate the Inpatient Bed Days by the designated bed types:

- **Acute Patient days** = the total number of patient days occupying acute beds (AT), inclusive of mental health children/adolescent
- **Post-Acute Patient days** = the total number of patient days occupying Complex Continuing Care (CR) + General Rehabilitation (GR) + Special Rehabilitation (SR) + Mental Health - Adult (MH) Beds
- **CCC Patient days** = the total number of patient days occupying Complex Continuing Care (CR) Beds
- **Rehab Patient days** = the total number of patient days occupying in General Rehabilitation (GR) + Special Rehabilitation (SR) Beds
- **Mental Health Patient days** = the total number of patient days occupying Mental Health - Adult (MH) Beds

For additional information on ALC Rate Calculation, such as inclusion and exclusion criteria, please refer to the methodology tab within the ALC Rate Report.

Conceptually – Capacity

The ALC Rate Indicator reflects the proportion of bed days utilized by patients identified as requiring a more appropriate care setting. The indicator is reflective of both acute and post-acute beds and reported based on a given time period.

The indicator supports the understanding of past and current occupancy and provides a key measure of ALC performance that can be trended over time.

As a result, the current ALC Rate is defined as the total ALC Days contributed to the total Inpatient Bed Days in a given time period, expressed as a percentage, the calculation of the denominator for ALC Rate is the sum of all patients residing in each inpatient bed type for each day of the month.

ALC Rate Calculation Example

Hospital A has 10 Rehabilitation beds. During the month of November 2020, 10 out of the 10 Rehabilitation beds were occupied by patients on every day of the month. During this month, three patients in these Rehabilitation beds were ALC-designated for 5, 30, and 10 days respectively. What is the ALC Rate at Hospital A for Rehabilitation?

Total Number of Inpatient Days = 10 occupied beds x 30 days = 300 days
Total Number of ALC Days Contributed = 5 + 30 + 10 = 45 days

$$\text{ALC Rate (November 2020)} = \frac{45 \text{ days}}{300} \times 100\% = 15\%$$

Therefore, 15% of the total inpatient days during the month of November were occupied by patients requiring an alternate level of care.

Provincial Target for ALC Rate

The ALC Rate indicator was integrated into the Ministry LHIN Accountability Agreement (MLAA) as a performance indicator (System Integration and Access) in 2015/2016. A provincial ALC Rate target of 12.7% was determined by the Ministry.

ALC Rate versus % ALC Days

The ALC Rate indicator is not the same indicator as the *% ALC Days* (Discharge Abstract Database [DAD]) indicator.

The following table presents key differences between the two indicators:

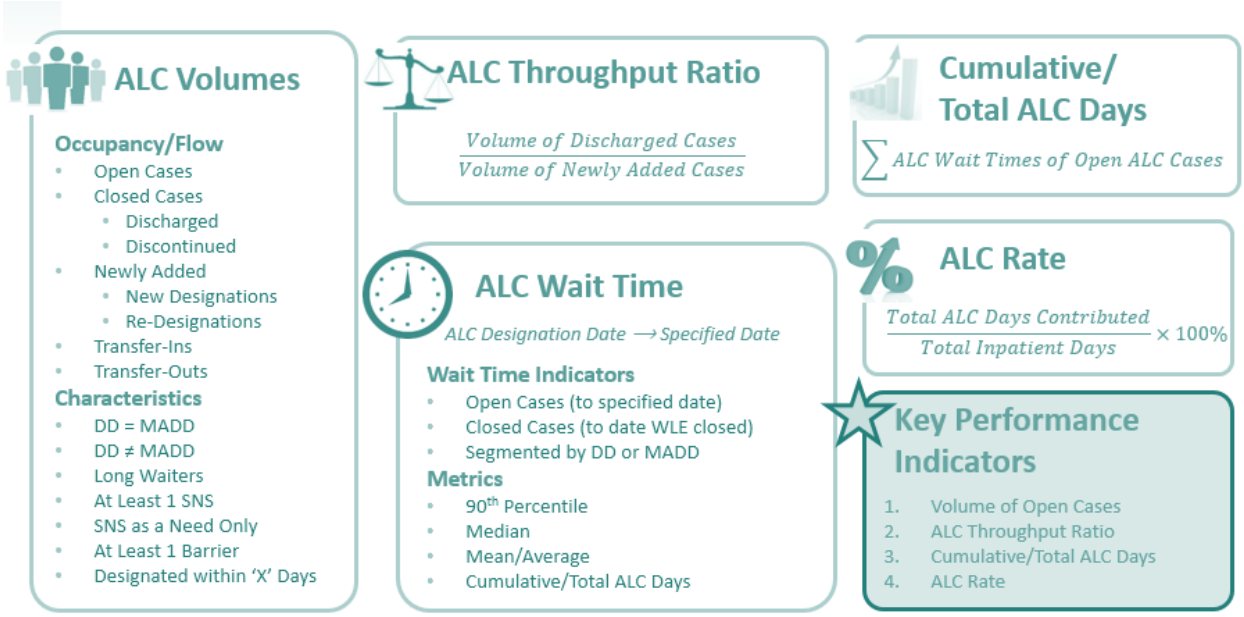
	% ALC Days	ALC Rate
In-scope Hospital Sectors	Acute Care	Acute Care and Post-Acute Care
In-scope ALC Cases	Reports on patients designated ALC discharged from an Acute Care hospital during the quarter	Reports on patients designated ALC still waiting (Open) and patients designated ALC discharged/discontinued (Closed) during the month/quarter/year
Exclusion Criteria	Newborns, stillborn, and records with missing or invalid "Discharge Date"	Acute and Post-Acute hospitals that do not report data to the WTIS and/or dBCS; Bed type = Emergency Room or Bassinets
ALC Days and Inpatient Days Calculation	Allocates all ALC days and total inpatient days for a patient to the quarter of discharge	Allocates only the ALC days and inpatient days that occurred during the month/quarter/year
Reporting Time Lag	4-5 month reporting time lag	1 month reporting time lag

Percent Contribution to Annual ALC Rate by Discharge Destination

This indicator shows the contribution of each discharge destination to the ALC Rate and is calculated by:

$$\text{\% Contribution to Annual ALC Rate by Discharge Destination} = \frac{\text{Total ALC Days by Discharge Destination in Reporting Period}}{\text{Total Inpatient Days in Reporting Period}}$$

Summary of ALC Performance Indicators



7 – ALC Reporting at Access to Care

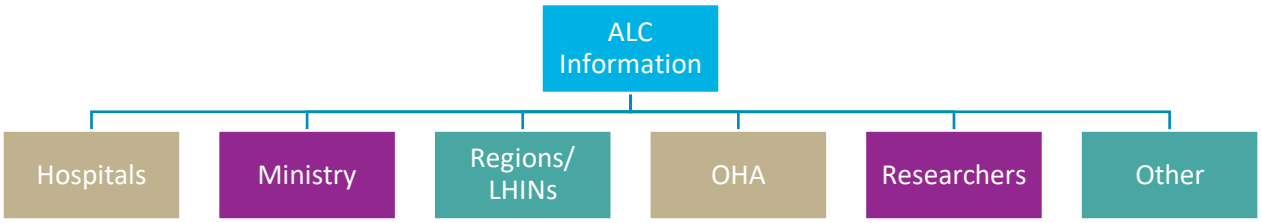
This section describes reporting of ALC information. Key topics covered include: an introduction to ALC reporting, a description of ALC data cut, what it means to have refreshed historical data, when/where operational reports are published, and how ALC data is displayed in each type of operational report design. This section also provides a detailed Report Catalogue which describes each operational ALC report, highlighting key characteristics of each report, the type of information each report contains, and how data in the report can be viewed and filtered.

Section Highlights

7.1 – Introduction to ALC Reporting

ATC currently does not report ALC wait times information publicly, however, ATC measures, manages, and reports ALC data from more than 180 acute care and post-acute care facilities, to a diverse audience including the Ministry, Regions, Local Health Integration Networks (LHINs), Ontario Hospital Association (OHA), and partnering hospitals. The near-real time ALC information captured in Ontario's Wait Time Information System (WTIS) enables the production of standard, consistent, and comparable ALC reports. These reports provide a picture of patient flow, resource allocation, and bed utilization as well as assist health system planners and decision-makers to monitor and manage performance, and identify gaps in services at the hospital, regional, and provincial level.

ALC Information Stakeholders



There is a diverse group of stakeholders of ALC information with a diverse set of needs. To accommodate the varying information/data needs of our stakeholders, ATC shares ALC information through a number of reporting products as permitted by the appropriate Data Sharing Agreements, including:

- Operational ALC Performance Reports
- WTIS data extracts
- Ad-hoc data requests
- iPort™ Access, ATC's business intelligence tool

Operational ALC Performance Reports

ATC produces 16 Operational ALC Performance and Data Quality Reports which are shared with hospitals, LHINS, the OHA, and the Ministry of Health on a monthly and quarterly basis:

ALC Provincial Performance Summary	ALC LHIN Performance Summary	ALC Trending Report	ALC Wait Times Distribution Report	ALC Throughput Ratio Report
ALC Rate Report	ALC Discharge by Disposition Report	ALC MADD Report	ALC MADD Segment Report	ALC Patient Journey Report
ALC Specialized Needs/Supports Report	OHA Report: Provincial ALC Summary	OHA Report: LHIN-Level ALC Summary	ALC Long Waiter Breakdown Report	ALC Data Quality and Stabilization Report*

*This report is only available to hospitals.

7.2 – ALC Data Cut & Report Publishing

Operational ALC Performance Reports are created and published on a monthly or quarterly basis. ALC data is cut (i.e., extracted from the WTIS) on the 6th business day (BD) of each month for data up to the last day of the previous month. This 6-business day lag allows for the compliance and data quality process to occur.

Operational ALC Performance Reports are published on the 1st BD of the month following data cut and are available through:

- Publication on the Ministry SharePoint Site
- ATC Information Site
- Distribution via email

Example: Data Cut and Report Publishing for July Reports

For July reports, ALC data up to and including July 31 is extracted from the WTIS on the 6th BD in August. The July Operational reports are then published on the 1st BD in September.

Ad Hoc Requests

As a customer-focused organization, ATC supports internal and external stakeholders through ad hoc data requests in addition to operational reporting activities. Data requests should be submitted to ATCDataRequest@ontariohealth.ca.

Refreshed Historical Data

Prior to April 2013, all trending information reported in ATC Excel-based reports (see below) included static historical data (i.e., when the data is cut for a given month, the performance reported for that month will not change over time unless a resubmission has been approved and processed). In April 2013, ATC began using refreshed historical ALC data in WTIS for all Excel-based reports. This means from this date forward, each historical month will be updated with the most up-to-date data in the WTIS for ALC information. This ensures that reports contain the most up-to-date information available.

Frozen Data: Each fiscal year data is frozen (i.e., no longer refreshed) as of the August data cut date in the following fiscal year. This means that data for that year will no longer be refreshed, unless extenuating circumstances warrant a data resubmission process where data would be refreshed in that instance. Facilities or sites identified with outstanding completeness and/or accuracy data quality issue(s) may risk data suppression from performance reporting at their site, facility and LHIN level based on the severity of issue.

Example: On August 10, 2021, data for FY20/21 will no longer refreshed.

7.3 – Operational Reports and Design

There are two types of report designs: Static Summaries and Dynamic, Excel-based reports.

Static Summaries

These reports contain static, summarized ALC information based on pre-defined reporting criteria, such as aggregation levels and ALC wait time metrics.

Dynamic, Excel-based Reports

Dynamic, Excel-based reports are interactive and as a result, more comprehensive and robust than static summaries. These reports contain multiple Excel “tabs” with the functionality to allow users to view and filter ALC data in different ways to suit their needs. Each dynamic, Excel-based report contains the following tabs:

- **Title Page Tab:** Includes the title of the report, the aggregation level of the report, and the reporting month.
- **Methodology Tab:** Includes detailed notes on the methodologies used in the report, including ALC indicator definitions and calculation; inclusion/exclusion criteria; and data source information.

- **Data Tab(s):** The focal component of each report which contains ALC data and analysis in the form of tables, graphs, and figures. Each report may have multiple data tabs.
- **Data Quality Tab:** Includes detailed notes regarding the quality of data used in the report; and the data cut schedule and refreshed schedule information. All data quality notes contained in each report are compiled into one document titled Data Quality Notes. This document is distributed on a monthly basis.

Data Filters

Dynamic, Excel-based reports allow users to filter information using different criteria. This means selecting a criteria by which to view the data presented. For example, a user may wish to filter ALC Volumes by Inpatient Service to see the ALC Volume for a specific Inpatient Service they have selected.

The following are examples of filters available in dynamic ALC reports:

- Aggregation Level (Provincial, LHIN, Facility, Site)
- Inpatient Service
- Discharge Destination
- ALC Status (Open, Discharged, Discontinued)
- ALC Wait Time Metric (90^{th} Percentile, Median, Mean, Cumulative/Total ALC Days)

Note: For the purpose of ALC reporting metric calculations for no volume (n= 0) will show as NV (no Value), while metric calculations for ALC volumes between one to 5 ($1 \leq n \leq 5$) will not be reported, showing LV (Low Volumes) instead, because the reported information could lead to the identification of a patient(s).

7.4 – ALC Reports Catalogue

The following section describes each operational ALC report, beginning with the static summaries and following with the dynamic, Excel-based reports. It provides key characteristics of the report (e.g., design, reporting frequency, stakeholder group, etc.), a description of the type of information the report contains (i.e., indicators, metrics, and comparisons) and how the information can be viewed and filtered. For reports with a large number of data tabs and a wide range of information, a description of each key data tab is provided.

For descriptions/definitions of each indicator, please refer to Section 6 - ALC Performance Indicators, pg. 83.

Operational ALC Report Index

1. ALC Provincial Performance Summary
2. ALC LHIN Performance Summary
3. ALC Trending Report
4. ALC Wait Time Distribution Report
5. ALC Throughput Ratio Report
6. ALC Rate Report
7. ALC Discharge by Disposition Report
8. ALC MADD Report
9. ALC MADD Segment Report
10. ALC SNS Report
11. ALC Patient Journey Report
12. ALC Long Waiter Breakdown Report
13. OHA Report: Provincial ALC Summary
14. OHA Report: LHIN-Level ALC Summary
15. ALC Data Quality and Stabilization Report*

* Note that these Data Quality reports are available to hospitals

1 – ALC Provincial Performance Summary and
2 – ALC LHIN Performance Summary

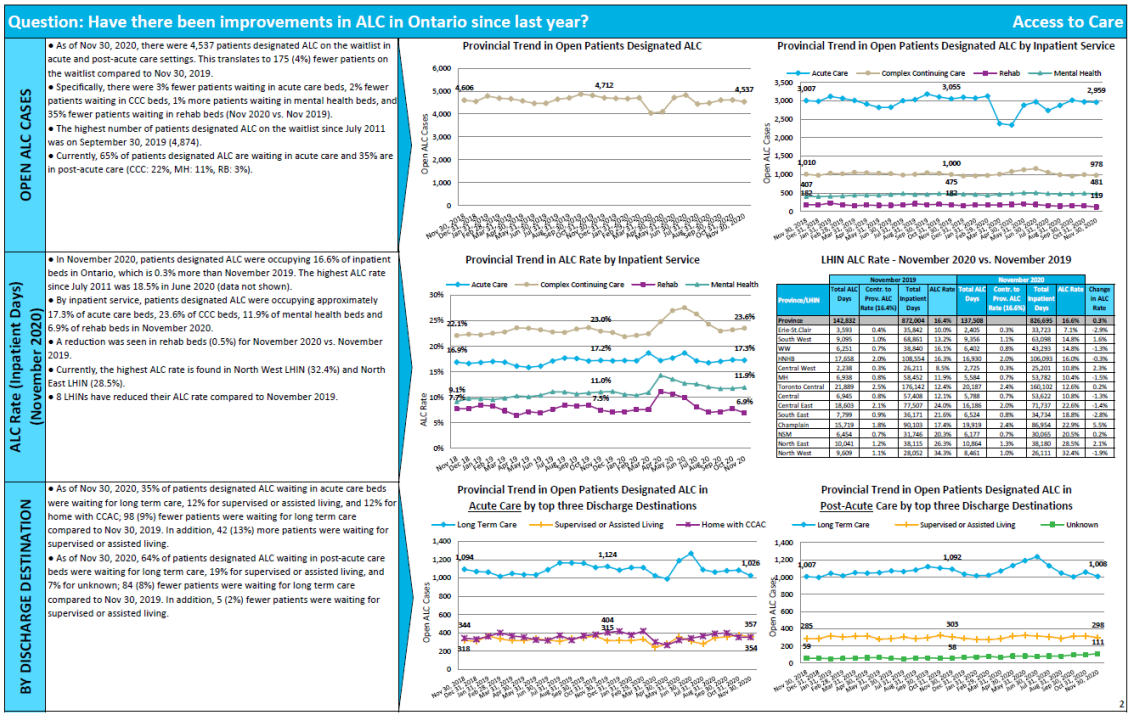
Design: Static Summary
Level: Provincial, LHIN (Provincial Summary); LHIN/ Facility (LHIN Summary)
Frequency: Monthly
Report Available Since: Provincial: Jan 2013; LHIN: Sep 2013

Reporting Period: Report Month and Preceding 24 months
Data Sources: WTIS, Daily Bed Census Summary (dBCS)
Audience: Hospitals, LHINs, Ministry

Description of Information in Report

The **ALC Provincial Performance Summary** and **ALC LHIN Performance Summary** reports answer key questions about ALC for the province and for each LHIN, including:

- Have there been improvements in ALC since the last year?
- What are the current patients designated ALC waiting for?
- Who are the current patients designated ALC?
- Who are the ALC Long Waiters (waiting for ≥30 days) and what are they waiting for?
- Where did discharged patients designated ALC go and how long did they wait?
- What impact do specialized needs and supports (SNS) have on patients designated ALC?
- Have there been improvements in ALC within the Seniors Population (65+) since last year?



3 – ALC Trending Report

Design: Dynamic, Excel-Based
Level: Provincial, LHIN, Facility, Site
Frequency: Monthly
Report Available Since: April 2013

Reporting Period: July 2011 – Report Month
Data Source: WTIS
Audience: Hospitals, LHINs, Ministry

Total ALC Cases Tab

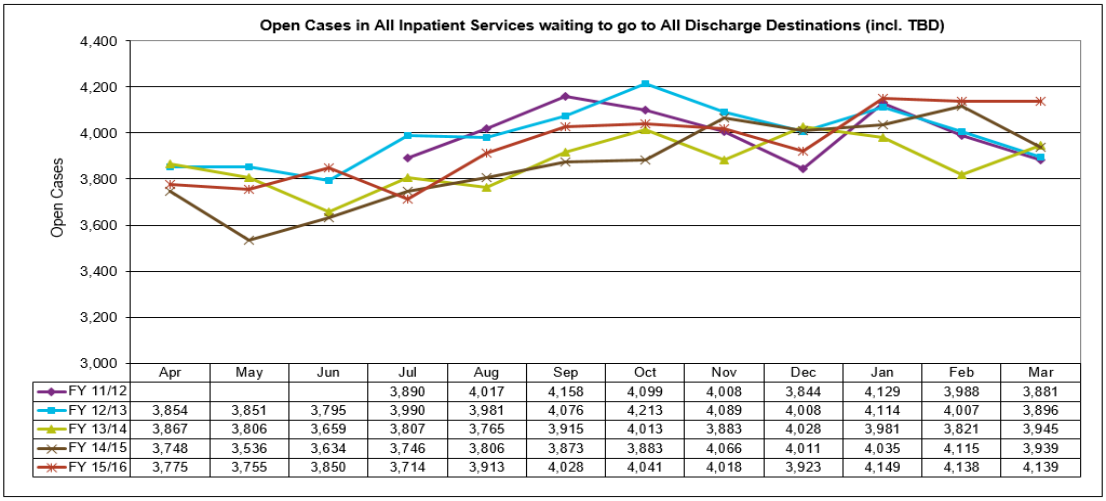
Provides the volume of ALC Cases trended over time, including the percent change in volume compared to the previous month and year.

Indicators

- Volume of ALC Cases
- Views
- Trended Monthly

Filters

- Province/LHIN/Facility/Site
- Inpatient Service
- Discharge Destination
- ALC Status (Open, Discharged, Discontinued)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
FY 11/12				3,890	4,017	4,158	4,099	4,008	3,844	4,129	3,988	3,881
FY 12/13	3,854	3,851	3,795	3,990	3,981	4,076	4,213	4,089	4,008	4,114	4,007	3,896
FY 13/14	3,867	3,806	3,659	3,807	3,765	3,915	4,013	3,883	4,028	3,981	3,821	3,945
FY 14/15	3,748	3,536	3,634	3,746	3,806	3,873	3,883	4,066	4,011	4,035	4,115	3,939
FY 15/16	3,775	3,755	3,850	3,714	3,913	4,028	4,041	4,018	3,923	4,149	4,138	4,139

Open Cases Tab | Open Cases-Long Waiters Tab | Discharged Cases Tab | Discontinued Cases Tab

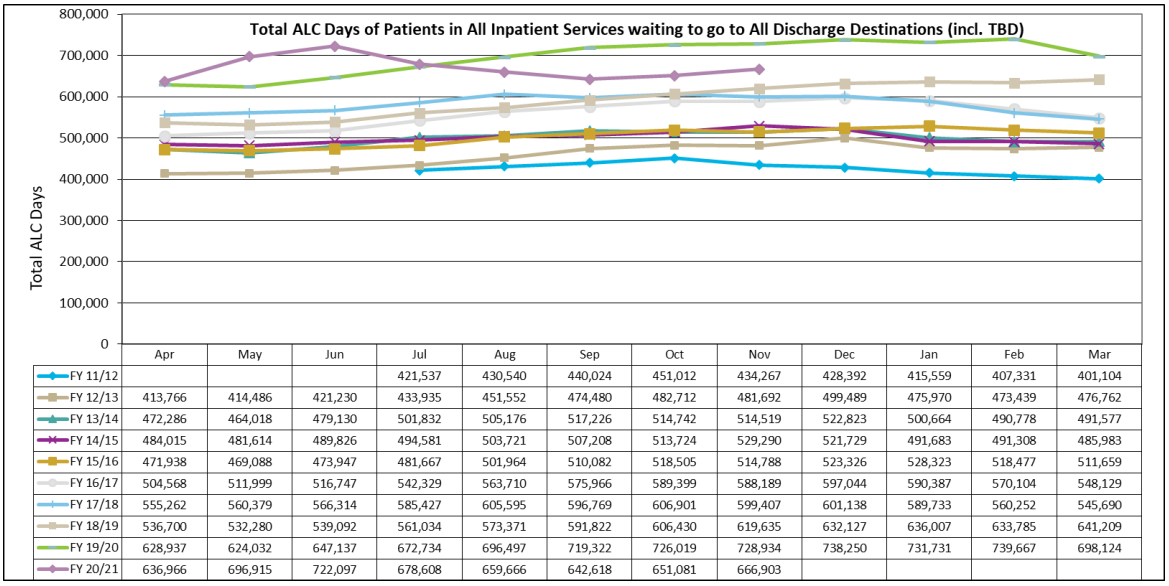
These four data tabs each present the Total ALC Days and ALC Wait Times metrics trended over time for a different population of ALC cases (Open, Long Waiters, Discharged, and Discontinued).

Indicators

- ALC Wait Time Metrics (Cumulative/Total ALC Days, 90th P, Median, Average)
- Volume of ALC Cases (Open, Long-Waiter, Discharged, Discontinued)
- Views
- Trended Monthly

Filters

- Province/LHIN, Facility, Site
- Inpatient Service
- Discharge Destination
- ALC Wait Time Metric



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
FY 11/12				421,537	430,540	440,024	451,012	434,267	428,392	415,559	407,331	401,104
FY 12/13	413,766	414,486	421,230	433,935	451,552	474,480	482,712	481,692	499,489	475,970	473,439	476,762
FY 13/14	472,286	464,018	479,130	501,832	505,176	517,226	514,742	514,519	522,823	500,664	490,778	491,577
FY 14/15	484,015	481,614	489,826	494,581	503,721	507,208	513,724	529,290	521,729	491,683	491,308	485,983
FY 15/16	471,938	469,088	473,947	481,667	501,964	510,082	518,505	514,788	523,326	528,323	518,477	511,659
FY 16/17	504,568	511,999	516,747	542,329	563,710	575,966	589,399	588,189	597,044	590,387	570,104	548,129
FY 17/18	555,262	560,379	566,314	585,427	605,595	596,769	606,901	599,407	601,138	589,733	560,252	545,690
FY 18/19	536,700	532,280	539,092	561,034	573,371	591,822	606,430	619,635	632,127	636,007	633,785	641,209
FY 19/20	628,937	624,032	647,137	672,734	696,497	719,322	726,019	728,934	738,250	731,731	739,667	698,124
FY 20/21	636,966	696,915	722,097	678,608	659,666	642,618	651,081	666,903				

Total ALC Cases – Graph Tab

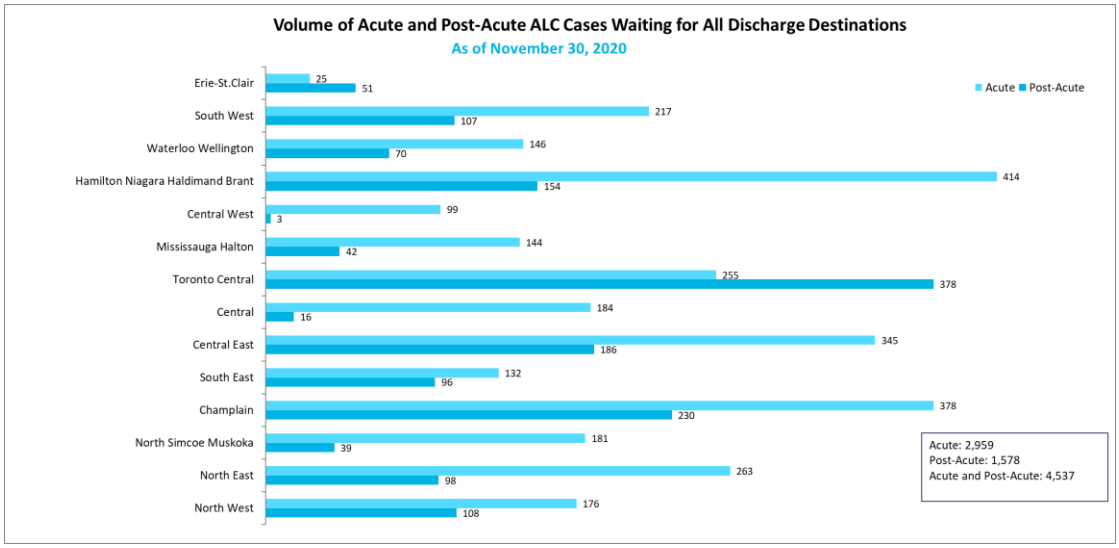
A bar graph shows the number of ALC cases waiting in Acute and Post-Acute beds by LHIN.

Indicators

- Volume of ALC Cases
- Comparisons
- LHINs
- Acute vs. Post-Acute Inpatient Service

Filters

- Discharge Destination
- ALC Status (Open, Discharged, Discontinued)
- Reporting Month
- Views
- One Month



4 – ALC Wait Time Distribution Report

Design: Dynamic, Excel-Based
Level: Provincial, LHIN, Facility, Site
Frequency: Monthly
Report Available Since: Apr 2013
Reporting Period: Reporting Month and Preceding 5 months
Data Source: WTIS
Audience: Hospitals, LHINs, Ministry

WT Distribution: Open Cases Tab | WT Distribution: Discharged Tab | WT Distribution: Discontinued Tab

The three data tables listed above provide information for a different population of ALC cases (Open, Discharged, and Discontinued), but have the same indicators, views, and filters. They present a distribution histogram of ALC Wait Times for a selected month.

Indicators

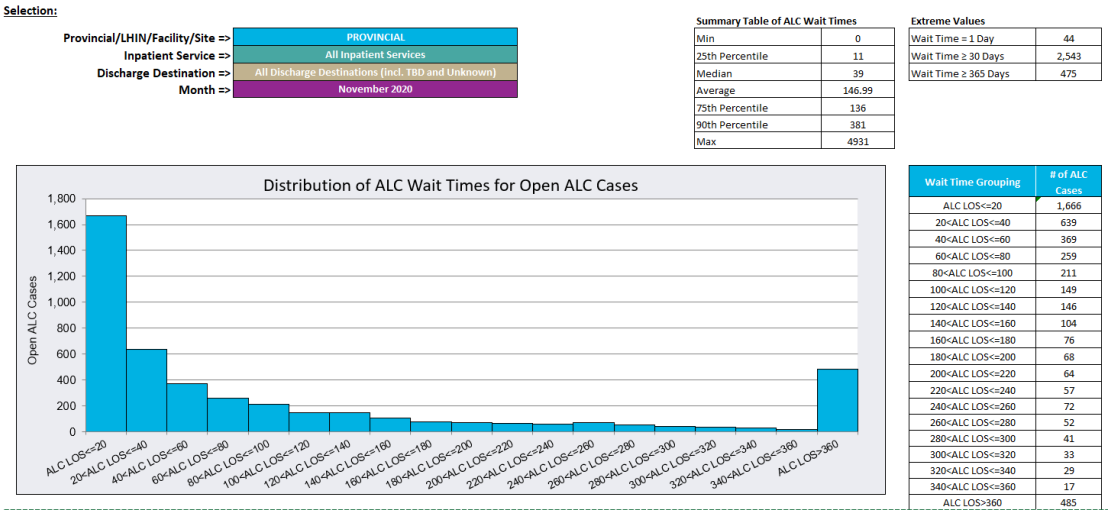
- ALC Wait Time Metrics (Cumulative/Total ALC Days, 90th P, Median, Average)
- Volume of Long Waiters

Filters

- Province/LHIN/Facility/Site
- Inpatient Service
- Discharge Destination
- Month

Views

- Distribution Histogram



5 – ALC Throughput Ratio Report

Design: Dynamic, Excel-Based
Level: Provincial, LHIN, Facility, Site
Frequency: Monthly
Report Available Since: Jan 2013

Reporting Period: July 2011 - Reporting Month
Data Source: WTIS
Audience: Hospitals, LHINs, Ministry

Throughput Ratio Tab

Provides data for the ALC Throughput Ratio indicator, which is the ratio of discharged ALC cases to newly added ALC cases during the reporting period.

Indicators

- Volume of Newly Added Cases
- Volume of New ALC Designations
- Volume of Re-Designations
- Volume of Discharged Cases
- Volume of Transfer-Ins
- Volume of Transfer-Outs
- Throughput Ratio
- Volume of ALC Cases Designated within 'X" Days of Admission

Views

- Trended Monthly
- Trended Quarterly

Filters

- Province/LHIN/Facility/Site
- Inpatient Service
- Discharge Destination

SELECTION:

Province/LHIN/Facility/Site	PROVINCIAL
Inpatient Service	All Inpatient Services
Discharge Destination	All Discharge Destinations (incl. TBD and Unknown)

Facility/Site # N/A

MONTHLY VIEW

Reporting Period	Queue at Start of Report Period	Volume of Newly Added Cases	Breakdown of the Volume of Newly Added Cases						Number of Transfer-In Instances	Number of Transfer-Out Instances	Volume of Discharged Cases	Throughput Ratio (N/E)
			New ALC Designations					Volume of ALC Re-designations				
			f New ALC Des	Within 0 Days	d Within 1 Day	Within 2 Days	Within 3 Days					
Jul 20	4,026	4,199	3,973	3.47%	6.32%	10.72%	16.79%	226	91	91	4,471	1.06
Aug 20	3,754	3,988	3,781	3.60%	6.93%	11.40%	17.11%	207	14	14	3,939	0.99
Sep 20	3,803	4,304	4,088	3.45%	6.46%	10.69%	16.54%	216	9	9	4,119	0.96
Oct 20	3,988	4,556	4,305	4.46%	7.48%	11.73%	16.89%	251	15	15	4,411	0.97
Nov 20	4,133	4,445	4,179	4.28%	7.23%	11.17%	17.04%	266	46	46	4,235	0.95

Designated ALC within 'X' Days Tab

Provides information regarding how soon after admission to hospital that patients were designated ALC; specifically the number of cases designated ALC on the same day, within 1 day, and within 2 days.

Indicators

- Volume of ALC Cases Designated within 'X" Days of Admission

Comparisons

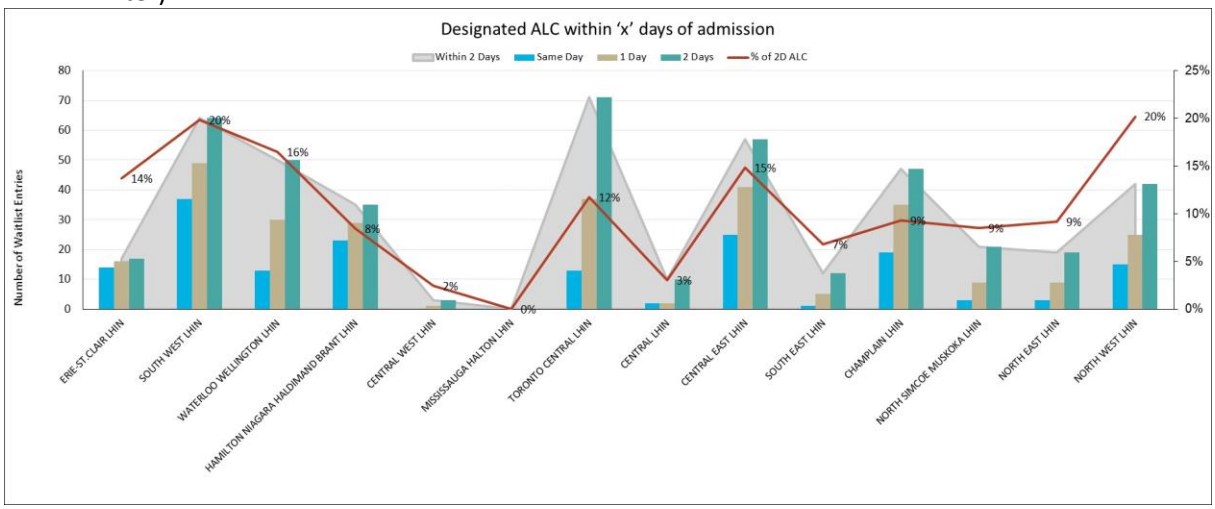
- LHINs (using Provincial/LHIN filter)
- Facilities within a LHIN (using Provincial/LHIN filter)

Views

- One Month

Filters

- Province/LHIN
- Inpatient Service
- Month



6 – ALC Rate Report

- **Design:** Dynamic, Excel-Based
  Level: Provincial, LHIN, Facility, Site
  Frequency: Monthly
  Report Available Since: Oct 2013; Change in Methodology beginning June 2017
- **Reporting Period:** July 2011 - Report Month
  Data Source: WTIS, dBCS
  Audience: Hospitals, LHINs, Ministry

ALC Rate: Dynamic Tab

Provides Total ALC Days, Total Inpatient Days, and ALC Rate trended over time.

Indicators

- Number of ALC Days in Reporting Period
- Total Inpatient Days in Reporting Period
- ALC Rate

Views

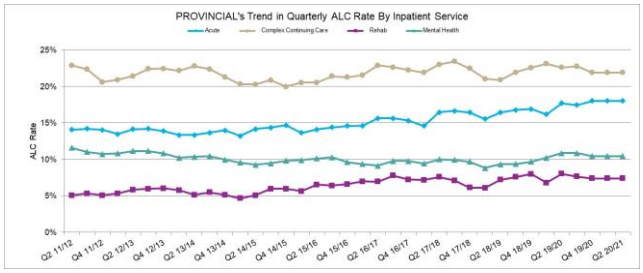
- Trended Monthly
- Trended Quarterly
- Trended Fiscal Year

Comparisons

- LHIN with Province
- Facility to LHIN and Province
- Site to Facility, LHIN, and Province

Filters

- Province/LHIN/Facility/Site
- Inpatient Service



Province/LHIN/Facility/Site => PROVINCIAL

Fac/Site # N/A

Quarterly View

Reporting Quarter	All Inpatient Service	Acute	Post-Acute			
			All Post-Acute	Complex Continuing Care	Rehab	Mental Health
Q2 11/12	14.5%	14.1%	15.2%	22.9%	5.1%	11.6%
Q3 11/12	14.4%	14.2%	14.8%	22.3%	5.3%	11.0%
Q4 11/12	13.9%	14.0%	13.8%	20.6%	5.1%	10.7%
Q1 12/13	13.7%	13.5%	14.0%	20.9%	5.3%	10.8%
Q2 12/13	14.3%	14.1%	14.5%	21.4%	5.8%	11.1%
Q3 12/13	14.4%	14.2%	14.8%	22.4%	6.0%	11.1%
Q4 12/13	14.2%	13.9%	14.7%	22.4%	6.0%	10.8%
Q1 13/14	13.7%	13.3%	14.3%	22.2%	5.8%	10.2%
Q2 13/14	13.8%	13.3%	14.5%	22.8%	5.1%	10.3%
Q3 13/14	13.9%	13.7%	14.4%	22.3%	5.5%	10.4%
Q4 13/14	13.8%	14.0%	13.6%	21.3%	5.1%	10.0%
Q1 14/15	13.1%	13.2%	13.0%	20.3%	4.6%	9.5%
Q2 14/15	13.7%	14.1%	12.9%	20.3%	5.0%	9.3%

Trend: Compare Inpatient Service Tab

Compares the ALC Rate for each Inpatient Service, quarterly and by fiscal year.

Indicators

- ALC Rate

Comparisons

- Inpatient Services

Views

- Trended Quarterly
- Trended Fiscal Year
- Province/LHIN/Facility/Site

Trend: Inpatient Service Focus Tab

Provides the trended Percent Contribution to Annual ALC Rate by Discharge Destination

Indicators

- Percent Contribution to Annual ALC Rate by Discharge Destination
- ALC Rate

Comparisons

- Discharge Destinations

Views

- Trended Fiscal Year

Filters

- Provincial/LHIN/Facility/Site
- Inpatient Service

FY Focus: Compare LHIN Tab

Provides Total ALC Days, Total Inpatient Days, Annual ALC Rate, and the Percent Contribution to Annual ALC Rate by LHIN and Discharge Destination.

Indicators

- Number of ALC Days in Reporting Period
- Number of Inpatient Days in Reporting Period
- ALC Rate
- Percent Contribution to Annual ALC Rate by Discharge Destination

Comparisons

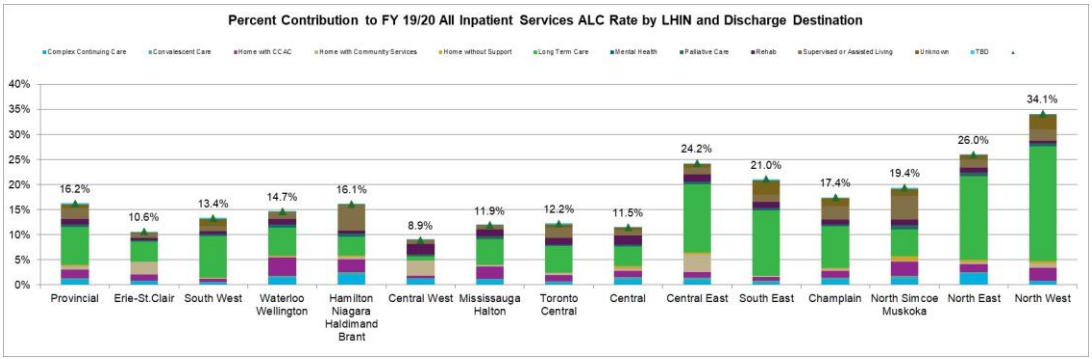
- LHINs
- Discharge Destinations

Filters

- Fiscal Year
- Inpatient Service

Views

- One Fiscal Year



Projection Tab

Provides a trajectory analysis based on historical trending for a 5-month projection of ALC Rate.

Indicators

- ALC Rate

Views

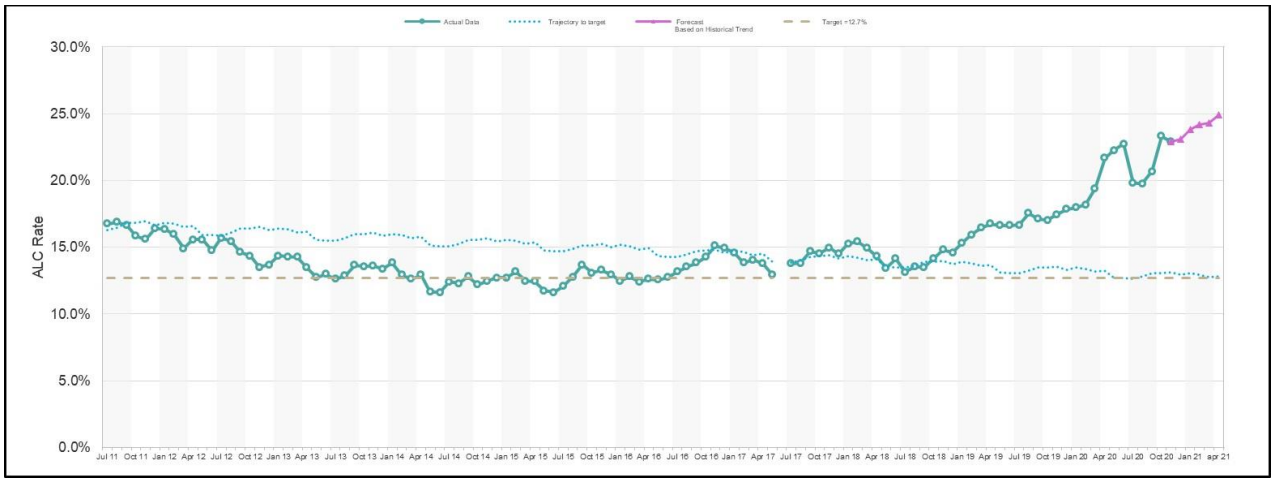
- Trended Forecast 5-months in the future

Comparisons

- ALC Rate against the Provincial Target for ALC Rate

Filters

- Province/LHIN



7 – ALC Discharge by Disposition Report

Design: Dynamic, Excel-Based
Level: Provincial, LHIN, Facility, Site
Frequency: Monthly
Report Available Since: May 2013

Reporting Period: Reporting month and preceding 5 months
Data Source: WTIS
Audience: Hospitals, LHINs, Ministry

Open Cases Tab | Closed Cases Tab

During one patient journey, a patient may have waited for more than one Discharge Destination before being discharged to a final destination. The Discharge by Disposition Report provides a breakdown of this journey into the different Discharge Destinations that a patient waited for, and segments the Total Wait Time into the time waited for each Discharge Destination. These two tabs each provide information for Open Cases and Closed Cases.

Indicators

- ALC Wait Time Segmented by Discharge Destination (Cumulative/Total ALC Days, 90th P, Median, Average)
- Volume of ALC Cases

Filters

- Provincial/LHIN/Facility/Site
- Inpatient Service
- Wait Time Metric
- Reporting Month

Views

- One Month

Comparisons

- Discharge Destinations

Open ALC Cases		Number of ALC Cases	ALC Wait (Days) for each Discharge Destination in Patient Journey												
			Long Term Care	Complex Continuing Care	Rehab	Home with Community	Home with CCAC	Home without Supports	Convalescent Care	Palliative Care	Mental Health	Supervised or Assisted Living	Unknown	TBD	All Destinations including TBD
Current Discharge Destination (As of Month's End)	Long Term Care	2034	378457	483	881	2406	4057	1326	411	198	601	7279	5659	2012	403770
	Complex Continuing Care	243	564	17750	62	12	152	8	53	0	52	290	242	31	19216
	Rehab	304	0	164	9272	115	85	3	12	0	28	58	135	20	9892
	Home with Community	250	79	178	118	20744	116	0	0	0	0	69	203	77	21584
	Home with CCAC	419	84	99	255	285	19545	17	0	15	0	208	340	257	21105
	Home without Supports	132	6	31	5	0	121	3269	0	1	0	61	36	12	3542
	Convalescent Care	38	0	2	10	23	0	0	1721	0	0	4	6	1	1767
	Palliative Care	69	134	0	62	25	51	9	0	1065	0	11	5	0	1362
	Mental Health	23	127	93	0	23	34	0	0	0	1695	159	19	7	2157
	Supervised or Assisted Living	655	1037	113	228	616	998	569	0	5	33	137312	1001	3333	145245
	Unknown	349	2906	38	48	155	22	0	0	8	0	1305	32004	619	37105
	TBD	21	126	0	0	0	0	7	0	0	0	0	0	25	158
	All Destinations including TBD	4537	383520	18951	10941	24404	25181	5208	2197	1292	2409	146756	39650	6394	666903

8 – ALC MADD Report

Design: Dynamic, Excel-Based
Level: Provincial, LHIN, Facility, Site
Frequency: Monthly
Report Available Since: July 2013; Enhancements in Oct 2013 and June 2015

Reporting Period: July 2011 – Report Month
Data Source: WTIS
Audience: Hospitals, LHINs, Ministry

DD = MADD vs. DD ≠ MADD Tab

A patient designated ALC may have a Discharge Destination (DD) that is inconsistent with their Most Appropriate Discharge Destination (MADD). This data tab provides information about the proportion of ALC cases that are waiting for a discharge destination that is the most appropriate for their clinical needs (i.e., DD = MADD) versus waiting for a discharge destination that is not the most appropriate (i.e., DD ≠ MADD), stratified by different Discharge Destinations. This tab also provides ALC Wait Time Metrics that can be compared between these two groups (i.e., those waiting for their MADD versus not waiting for their MADD).

Indicators

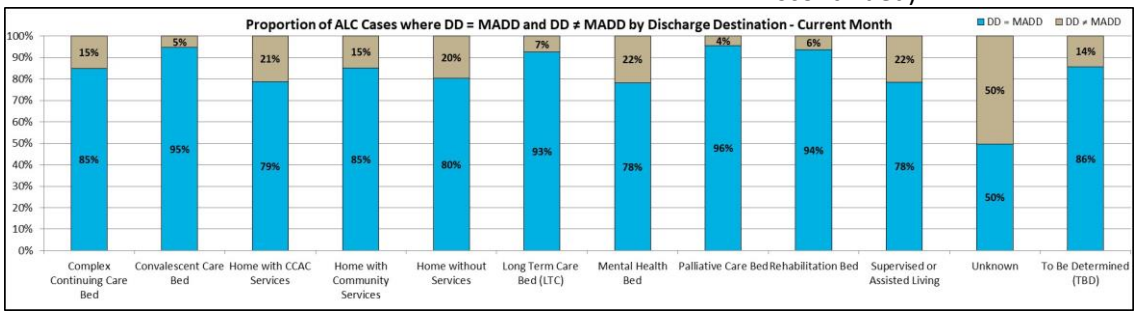
- Volume of ALC Cases where DD ≠ MADD
- Volume of ALC Cases where DD = MADD
- ALC Wait Time Metrics (90th P, Median, Average)
- Comparisons
- Discharge Destinations
- Cases with DD≠MADD to Cases with DD=MADD

Views

- Reporting Month

Filters

- Provincial/LHIN/Facility/Site
- Inpatient Service
- ALC Status (Open, Discharged, Discontinued)



DD vs MADD Tab

Provides Volume of Open ALC Cases and ALC Wait Time Metrics for each MADD.

Indicators

- Volume of Open ALC Cases
- ALC Wait Time Metrics (Cumulative/Total ALC Days, 90th P, Median, Average)
- Comparisons
- MADDs
- Discharge Destinations

Views

- Reporting Month

Filters

- Provincial/LHIN/Facility/Site
- Inpatient Service
- Discharge Destination
- Wait Time Metric

Trend: MADD Tab

This data tab compares the proportion of Open ALC cases where DD = MADD versus DD ≠ MADD and ALC Wait Time Metrics for these two groups, trended over time.

Indicators

- Volume of Open ALC Cases
- Volume of ALC Cases with DD ≠ MADD
- Volume of ALC Cases with DD = MADD
- ALC Wait Time Metrics (90th P, Median, Average)

Comparisons

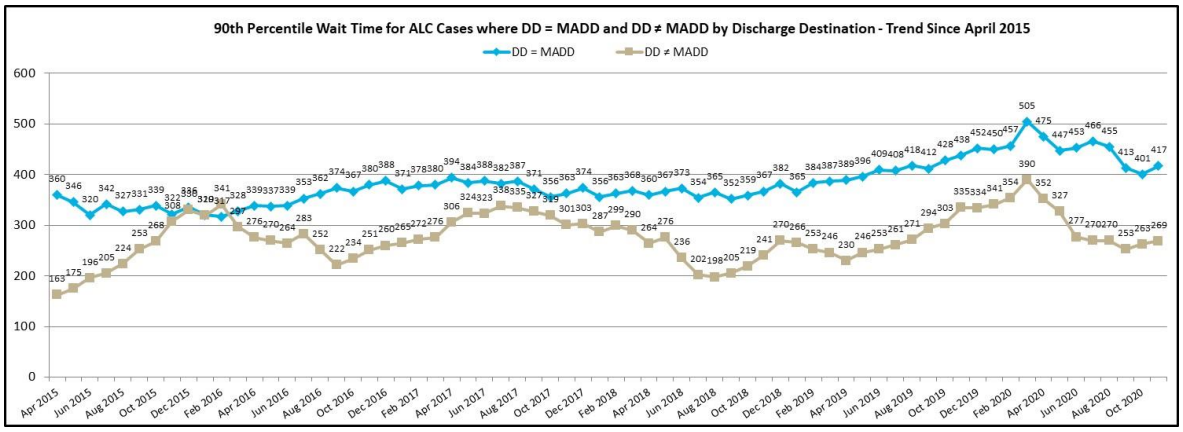
- ALC Cases with DD = MADD to ALC Cases with DD ≠ MADD

Filters

- Provincial/LHIN/Facility/Site
- Inpatient Service
- Discharge Destination
- Wait Time Metric

Views

- Trended Monthly



Long Waiters Tab

This tab provides the Cumulative/Total ALC Days and Volume of Open ALC Cases stratified by whether the patient has been waiting for less than 30 days, 30 days or more, or 365 days or more. The latter two groups are considered 'ALC Long Waiters'. Users can filter this information by whether the patient is waiting for their MADD or not.

Indicators

- Cumulative/Total ALC Days
- Volume of Open ALC Cases
- Volume of Long Waiters

Comparisons

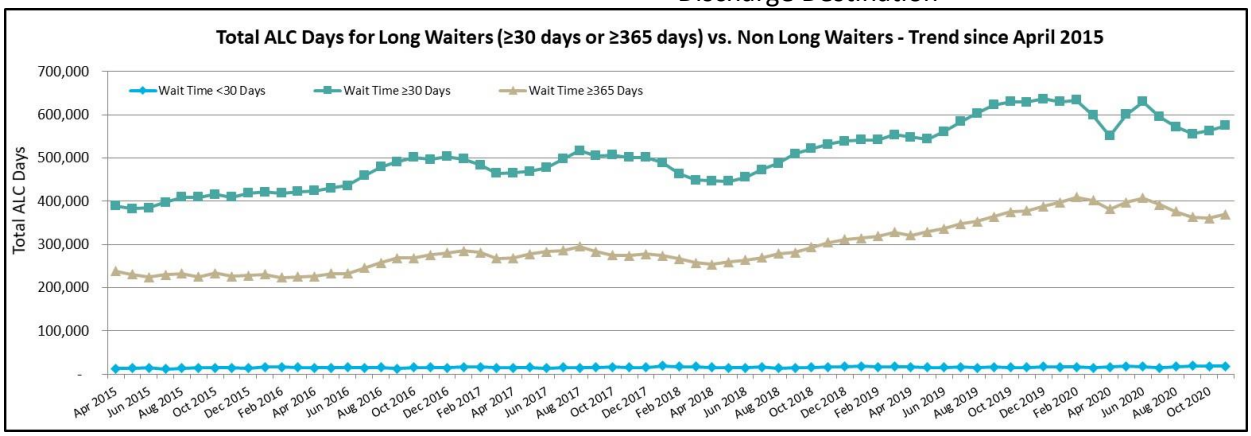
- Long Waiters to Non-Long Waiters

Views

- Trended Monthly

Filters

- Provincial/LHIN/Facility/Site
- DD=MADD vs. DD≠MADD
- Inpatient Service
- Discharge Destination



9 – ALC MADD Segment Report

Design: Dynamic, Excel-Based
Level: Provincial, LHIN, Facility, Site
Frequency: Monthly
Report Available Since: Oct 2015

Reporting Period: Reporting month and preceding 5 months
Data Source: WTIS
Audience: Hospitals, LHINs, Ministry

Open Cases Tab | Closed Cases Tab

During one patient journey, a patient's Most Appropriate Discharge Destination may change. The MADD Segment Report provides a breakdown of the different MADDs identified for patients during their journey, and segments the Total Wait Time into the time allocated to each MADD.

Indicators

- ALC Wait Time Segmented by MADD (Cumulative/Total ALC Days, 90th P, Median, Average)

Views

- One Month

Comparisons

- MADD

Filters

- Provincial/LHIN/Facility/Site
- Inpatient Service
- Wait Time Metric
- Month

Open ALC Cases		Number of ALC Cases	ALC Wait (Days) for each Most Appropriate Discharge Destination in Patient Journey												
			Long Term Care	Complex Continuing Care	Rehab	Home with Community	Home with CCAC	Home without Supports	Convalescent Care	Palliative Care	Mental Health	Supervised or Assisted Living	Unknown	TBD	All Destinations including TBD
Most Appropriate Discharge Destination	Long Term Care	2,178	380,770	856	840	1,132	2,904	1,001	411	271	481	5,014	2,759	2,312	398,751
	Complex Continuing Care	230	529	18,575	20	0	115	0	53	0	0	225	245	28	19,790
	Rehab	315	0	129	10,416	115	82	2	12	0	0	58	83	24	10,921
	Home with Community	239	27	178	120	20,675	259	2	0	0	0	190	174	73	21,698
	Home with CCAC	444	100	77	183	275	30,834	4	0	14	0	9	152	238	31,886
	Home without Supports	119	55	0	0	0	113	3,879	0	0	0	41	8	5	4,101
	Convalescent Care	42	0	2	10	23	0	0	1,764	0	0	0	2	0	1,801
	Palliative Care	91	132	0	62	8	54	0	0	2,452	0	20	8	3	2,739
	Mental Health	24	68	72	0	23	5	0	0	0	2,329	160	28	23	2,708
	Supervised or Assisted Living	636	775	68	102	532	298	524	0	10	49	145,477	603	5,054	153,492
	Unknown	201	1,859	0	404	14	7	0	0	0	0	1,090	15,584	45	19,003
	TBD	18	0	0	0	0	0	0	0	0	0	0	0	13	13
	All Destinations including TBD	4,537	384,315	19,957	12,157	22,797	34,671	5,412	2,240	2,747	2,859	152,284	19,646	7,818	666,903

10 – ALC SNS Report

Design: Dynamic, Excel-Based
Level: Provincial, LHIN, Facility, Site
Frequency: Monthly
Report Available Since: July 2013; Enhancements in Oct 2013

Reporting Period: July 2013 – Report Period
Data Source: WTIS
Audience: Hospitals, LHINs, Ministry

SNS Barrier vs. Need Tab

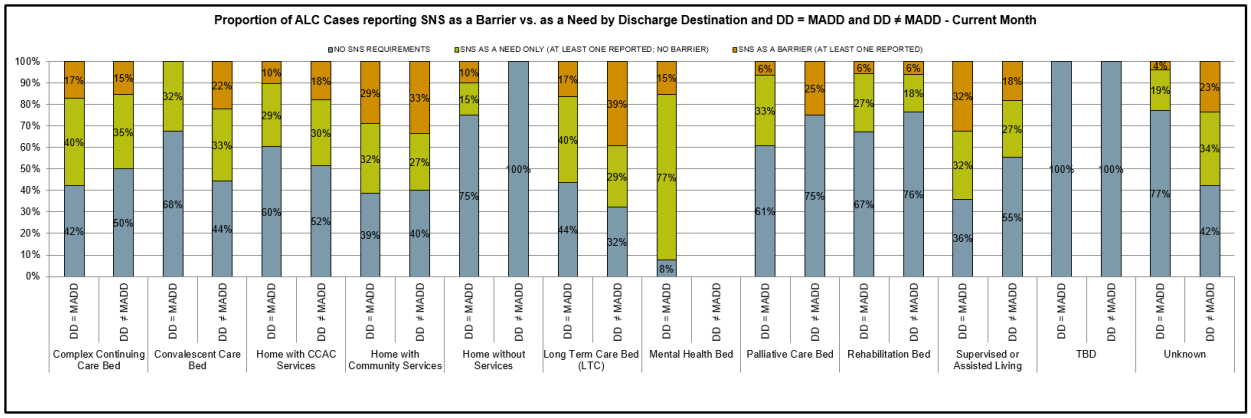
Provides the Volume/Proportion of ALC Cases and associated Wait Time Metrics for cases reporting No SNS requirements, SNS requirements as a Need only (i.e., no barriers), and SNS requirements as a Barrier (at least one), stratified by Discharge Destination and whether or not the patient is waiting for their Most Appropriate Discharge Destination (MADD).

- Volume of ALC Cases with at least one SNS
- Volume of ALC Cases with SNS as a Need Only
- Volume of ALC Cases with SNS as a Barrier (at least one)
- ALC Wait Time Metrics (90th P, Median, Average)

- Provincial/LHIN/Facility/Site
- Inpatient Service
- ALC Status (Open, Discharged, Discontinued)

- Discharge Destinations
- ALC Cases with DD = MADD to ALC Cases with DD ≠ MADD
- Cases with No SNS to Cases with SNS(s) as a Need Only to Cases with SNS(s) as a Barrier

- Reporting Month



Trend: SNS Wait Time Tab

Provides ALC Wait Time metrics for cases reporting No SNS requirements, SNS requirements as a Need only (i.e., no barriers), and SNS requirements as a Barrier (at least one), trended monthly.

Indicators

- ALC Wait Time Metrics (90th P, Median, Average)

Comparisons

- Cases with No SNS to Cases with SNS(s) as a Need Only to Cases with SNS(s) as a Barrier

Views

- Trended Monthly

Filters

- Provincial/LHIN/Facility/Site
- Inpatient Service
- ALC Wait Time Metric

SNS Detail Tab

For each Discharge Destination, this data tab provides the Volume/Proportion of Open ALC cases that have SNS requirements, including data for each specific SNS (i.e., SNS Type and Detail).

Indicators

- Volume of Open ALC Cases

Comparisons

- Discharge Destinations
- SNS Types and Details

Views

- Reporting Month

Filters

- Provincial/LHIN/Facility/Site
- Inpatient Service
- Need vs. Barrier vs. Need or Barrier

Specialized Needs and Supports	Discharge Destination																							
	All Destinations		Complex Continuing Care		Convalescent Care		Home with CCAC Services		Home with Community		Home without Supports		Long Term Care		Mental Health		Palliative Care		Rehabilitation		Supervised or Assisted Living		Unknown		TBD	
	vol	%	vol	%	vol	%	vol	%	vol	%	vol	%	vol	%	vol	%	vol	%	vol	%	vol	%	vol	%	vol	%
Total Open ALC Cases Volume	4537		243		38		419		250		132		2034		23		69		304		655		349		21	
Bariatric	50	1.1%	5	2.1%	1	2.6%	2	0.5%	3	1.2%	0	0.0%	27	1.3%	0	0.0%	0	0.0%	4	1.3%	5	0.8%	3	0.9%	0	0.0%
Behavioural	822	18.1%	15	6.2%	1	2.6%	57	13.6%	28	11.2%	3	2.3%	484	23.8%	13	56.5%	5	7.2%	8	2.6%	150	22.9%	58	16.6%	0	0.0%
Behavioural - 1:1 Support	126	2.8%	1	0.4%	1	2.6%	5	1.2%	1	0.4%	0	0.0%	71	3.5%	4	17.4%	1	1.4%	1	0.3%	23	3.5%	18	5.2%	0	0.0%
Behavioural - Aggressive Behaviours	229	5.0%	8	3.3%	0	0.0%	12	2.9%	2	0.8%	0	0.0%	130	6.4%	11	47.8%	0	0.0%	3	1.0%	41	6.3%	22	6.3%	0	0.0%
Behavioural - Sexualized Behaviours	45	1.0%	0	0.0%	0	0.0%	2	0.5%	1	0.4%	0	0.0%	23	1.1%	1	4.3%	0	0.0%	2	0.7%	9	1.4%	7	2.0%	0	0.0%
Behavioural - Unspecified	619	13.6%	10	4.1%	1	2.6%	47	11.2%	26	10.4%	3	2.3%	364	17.9%	5	21.7%	4	5.8%	6	2.0%	113	17.3%	40	11.5%	0	0.0%
Developmental	82	1.8%	1	0.4%	0	0.0%	4	1.0%	3	1.2%	2	1.5%	18	0.9%	1	4.3%	0	0.0%	2	0.7%	45	6.9%	6	1.7%	0	0.0%
Dialysis	73	1.6%	14	5.8%	1	2.6%	8	1.9%	6	2.4%	2	1.5%	21	1.0%	0	0.0%	0	0.0%	4	1.3%	8	1.2%	9	2.6%	0	0.0%
Equipment/Structural (No Bariatrics)	617	13.6%	28	11.5%	9	23.7%	45	10.7%	43	17.2%	6	4.5%	350	17.2%	0	0.0%	2	2.9%	38	12.5%	50	7.6%	45	12.9%	1	4.8%
Feeding	230	5.1%	38	15.6%	0	0.0%	18	4.3%	11	4.4%	1	0.8%	110	5.4%	0	0.0%	1	1.4%	3	1.0%	18	2.7%	30	8.6%	0	0.0%
Infection Control/Isolation	302	6.7%	31	12.8%	4	10.5%	25	6.0%	19	7.6%	49	37.1%	109	5.4%	0	0.0%	2	2.9%	17	5.6%	40	6.1%	6	1.7%	0	0.0%

SNS Detail Trend Tab	
Provides ALC Wait Time metrics for Open ALC Cases trended over time.	
Indicators • ALC Wait Time Metrics (90th P, Median, Mean) **Comparisons** • Cases reporting SNS as a Need to Cases reporting SNS as a Barrier	**Views** • Trended Monthly **Filters** • Provincial/LHIN/Facility/Site • Inpatient Service • SNS Type/Detail • ALC Wait Time Metric

Barrier: Long Waiter Tab	
Provides the Volume/Proportion of ALC Cases with a SNS as a Barrier. It is stratified by SNS Type/Detail and whether the patient has been waiting for less than 30 days, greater than or equal to 30 days, or 365 days or more. The latter two categories are considered ALC Long Waiters. This data tab allows us to compare SNS Barriers between Long Waiters and Non Long Waiters.	
Indicators • Volume of ALC Open Cases • Volume of Long Waiters **Comparisons** • Long Waiters to Non Long Waiters • SNS Types and Details	**Views** • Reporting Month **Filters** • Provincial/LHIN/Facility/Site • Inpatient Service

11 – ALC Patient Journey Report

Design: Dynamic, Excel-Based
Level: Provincial, LHIN, Facility, Site
Frequency: Quarterly
Report Available Since: Q1 (April-June) 2016/17

Reporting Period: Q1 2015/16 – Current Quarter
Data Source: WTIS, Home Care Database (HCD), RAI-HC
Audience: Hospitals, LHINs, Ministry

Patient Journey Snapshot Tab

Provides a snapshot view of the journey for patients designated ALC in the reporting quarter, including their admission source to hospital; the number of ALC designations, discharges, and discontinuations; and how many were still waiting at the end of the quarter and for which ALC discharge destinations. This tab also provides information about whether or not patients waiting for CCAC-mandated discharge destinations are known to the CCAC (i.e., have a CCAC referral) and their levels of clinical complexity.

Indicators

- Volume of New ALC Designations within Quarter
- Volume of Discharged ALC Cases
- Volume of Discontinued ALC Cases
- Throughput Ratio
- Volume of Open ALC Cases
- ALC Wait Time Metrics (Cumulative/Total ALC Days, 90th P, Median, Average)

Views

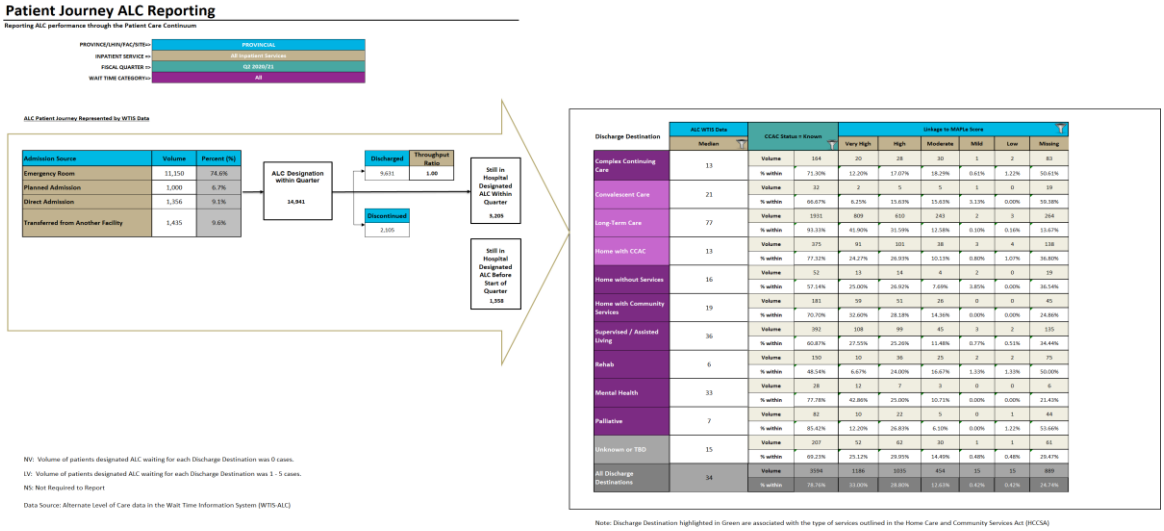
- Reporting Quarter

Filters

- Province, LHIN, Facility, Site
- Inpatient Service
- Fiscal Quarter
- Wait Time Category (all vs. ALC Long Waiters)

Comparisons

- Admission Sources
- Time of Designation (Before Quarter vs. During Quarter)
- Discharge Destinations
- CCAC Status (Known vs. Unknown)
- MAPLe Score Levels



Trending View Tab

This tab allows you to compare a selected Province/LHIN/Facility/Site to another selected Province/LHIN/Facility/Site on their Volume of ALC Cases and ALC Wait Time Metrics trended over time, stratified by a number of filters.

Indicators

- Volume of ALC Cases
- ALC Wait Time Metrics (Cumulative/Total ALC Days, 90th P, Median, Average)

Comparisons

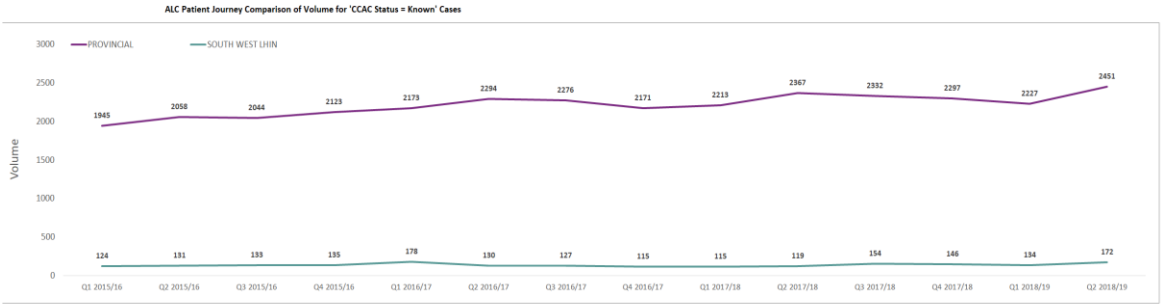
- Selected Province/LHIN/Facility/Site to another selected Province/LHIN/Facility/Site
- Quarters

Views

- Trended Quarterly

Filters

- Base: Province/LHIN/Facility/Site
- Comparison: Province/LHIN/Facility/Site
- Inpatient Service
- Discharge Destination
- CCAC Status (Known vs. Unknown)
- Wait Time Category (all vs. Long Waiters)
- Metric (Volume of ALC Cases, ALC Wait Time Metrics)



Volume	ALC Comparison of CCAC Status = Known Cases													
	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19
PROVINCIAL	1,945	2,058	2,044	2,123	2,173	2,294	2,276	2,171	2,213	2,367	2,332	2,297	2,227	2,451
SOUTH WEST LHIN	124	131	133	135	178	130	127	115	115	119	154	146	134	172

12 – ALC Long Waiter Breakdown Report

Design: Dynamic, Excel-Based
Level: Provincial, LHIN, Facility
Frequency: Monthly
Report Available Since: Apr 2016

Reporting Period: Reporting Month
Data Source: WTIS
Audience: Hospitals, LHINs, Ministry

Long Wait by DD Tab | Long Wait Barriers Tab | Long Waiter Histogram Tab

This report provides a graphical representation of patient groupings by wait times (e.g. <30 days, >= 30 days etc.) by discharge destination at the LHIN and facility level. The report also includes information on the SNS - Barrier trends per discharge destination type in order to provide some context around the volume of long waiters and how long they have waited since ALC designation.

Indicators

- Volume of Open Long Wait ALC Case by Discharge Destination (by volume and % of Open Cases)
- Volume of Open Long Wait ALC Case by Discharge Destination and Barrier (by volume and % of Open Cases)
- Volume of Open ALC Cases by Wait Time

Views

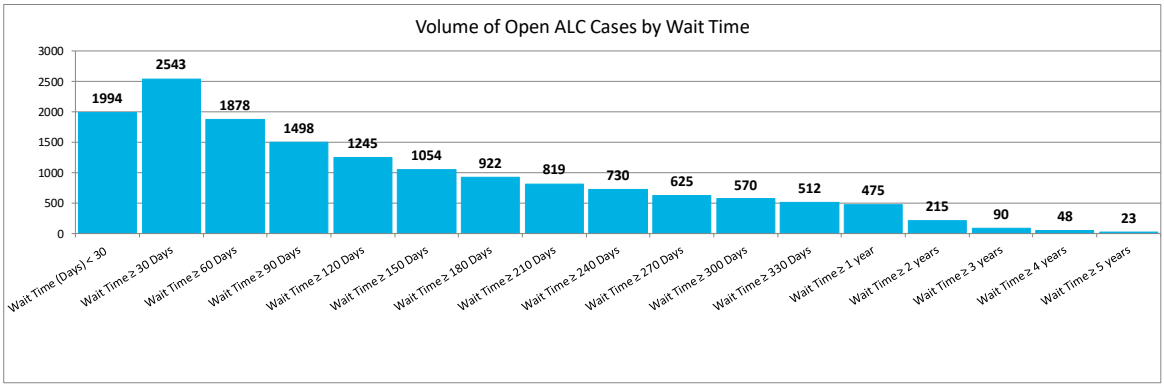
- Reporting Month

Filters

- Province, LHIN
- Inpatient Service
- Discharge Destination
- Wait Time Category (by increments of 30 days)

Comparisons

- Specialized Need and Support Requirement Type
- Open Cases with at least one barrier to discharge vs. Total Volume of Open Cases



13 – Ontario Hospital Association (OHA) Reports: Provincial ALC Summary

Design: Static, PDF-Based
Level: Provincial
Frequency: Monthly
Report Available Since: Jan 2014

Reporting Period: April 2014 to Current Reporting Month
Data Source: WTIS, dBCS
Audience: Ontario Hospital Association (OHA)

Description of OHA Reports

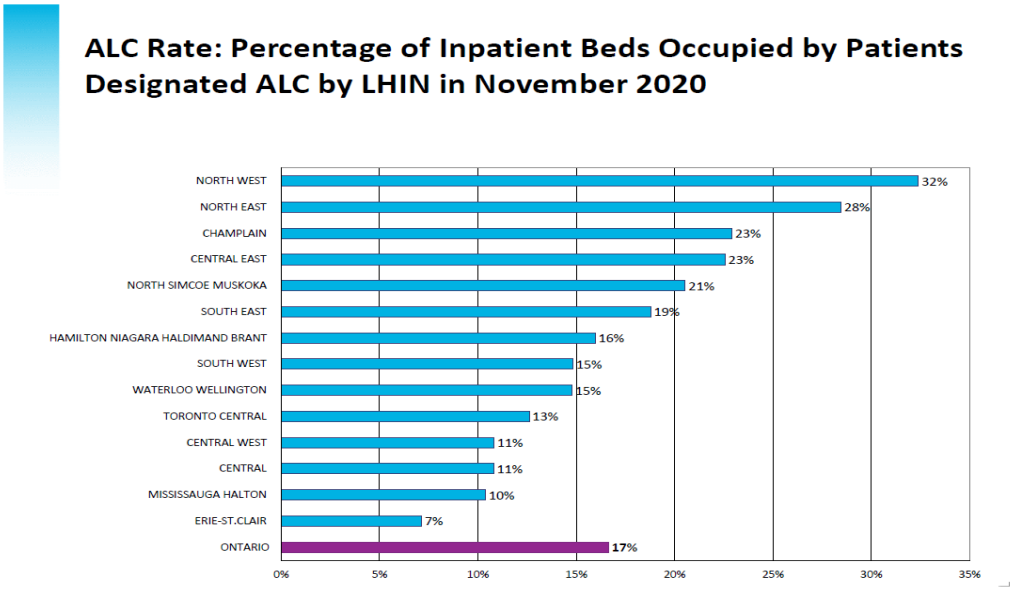
There are two monthly ALC reports produced for OHA; one that examines ALC information mainly at a provincial level, and another report that has LHIN level trending. The Provincial report contains ALC metrics such as ALC rate, trending, and volumes by DD with Acute, Post-Acute, and All Inpatient Services subsections. Within this report, there is also ER information provided (specifically, within the Acute section for daily average number of patients in the ER waiting for an inpatient bed at 8am).

Description of Information in OHA Provincial Report

Overview of Report Contents

Acute and Post-Acute Care:

- ALC Rate: Percentage of Inpatient Beds Occupied by ALC Patients by LHIN
- Number of ALC Patients on the Waitlist by LHIN
- Monthly Trend of Provincial ALC Rate and Volume of ALC Patients on the Waitlist
- Percentage of ALC Patients Waiting for Long Term Care by LHIN
- Number of ALC Patients Waiting for Long Term Care by LHIN
- Monthly Trend of the Percentage and Volume of ALC Patients Waiting for Long Term Care
- Monthly Trend of the Provincial Number of ALC Patients on the Waitlist by Discharge Destination

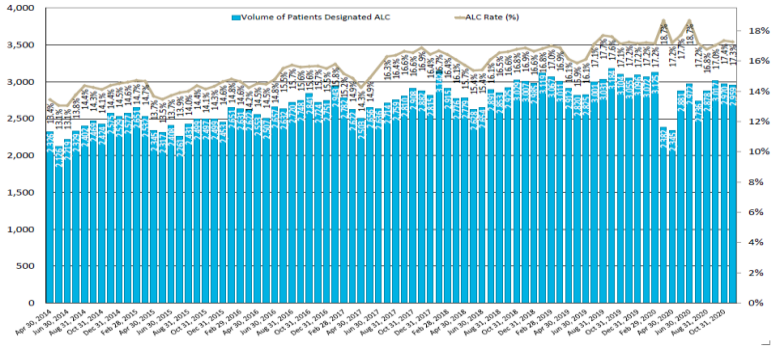


Acute Care:

- ALC Rate: Percentage of Acute Care Beds Occupied by ALC Patients by LHIN

- Number of ALC Patients on the Waitlist in Acute Care by LHIN
- Monthly Trend of Provincial ALC Rate and Volume of ALC Patients on the Waitlist in Acute Care
- Percentage of ALC Patients in Acute Care Beds Waiting for Long Term Care by LHIN
- Number of ALC Patients in Acute Care Beds Waiting for Long Term Care by LHIN
- Provincial Number of ALC Patients in Acute Care Beds by Discharge Destination
- Daily Average Number of Patients in the ER Waiting for an Inpatient Bed at 8 am by LHIN
- Provincial Monthly Trend of Daily Average Number of Patients in the ER Waiting for an Inpatient Bed at 8 am

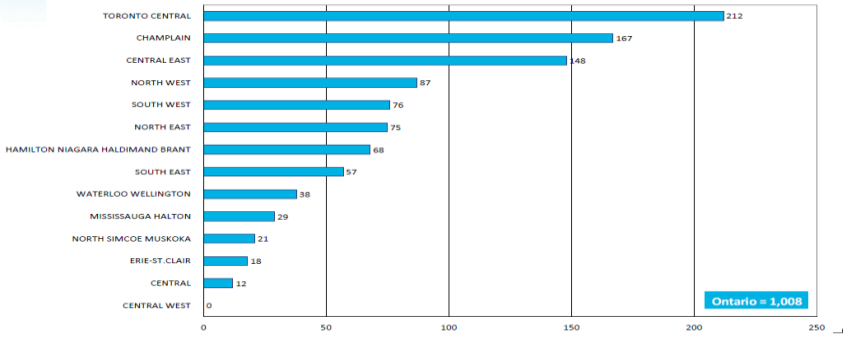
Monthly Trend of Provincial ALC Rate and Volume of Patients Designated ALC on the Waitlist in Acute Care: April 2014 to November 2020



Post-Acute Care:

- ALC Rate: Percentage of Post-Acute Care Beds Occupied by ALC Patients by LHIN
- Number of ALC Patients in Post-Acute Care on the Waitlist by LHIN
- Monthly Trend of Provincial ALC Rate and Volume of ALC Patients on the Waitlist in Post-Acute Care
- Percentage of ALC Patients in Post-Acute Care Beds Waiting for Long Term Care by LHIN
- Number of ALC Patients in Post-Acute Care Beds Waiting for Long Term Care by LHIN
- Provincial Number of ALC Patients in Post-Acute Care Beds by Discharge Destination

Number of Patients Designated ALC in Post-Acute Care Beds Waiting for Long-Term Care by LHIN as of November 30, 2020



14 – Ontario Hospital Association (OHA) Reports: LHIN-Level ALC Summary

Design: Static, PDF-Based
Level: LHIN
Frequency: Monthly
Report Available Since: Jan 2014

Reporting Period: Q2 FY 11/12 to Current Reporting Quarter
Data Source: WTIS, dBCS, CIHI-NACRS
Audience: Ontario Hospital Association (OHA)

Description of OHA Reports

There are two monthly ALC reports produced for OHA; one that examines ALC information mainly at a provincial level, and another report that has LHIN level trending. The LHIN level report contains ER and ALC metrics, specifically Quarterly 90thP ER LOS (hr) by Acuity (Low/High) and quarterly ALC rate (combined Acute and Post-Acute Care).

Description of Information in OHA LHIN-Level Report

Overview of Report Contents

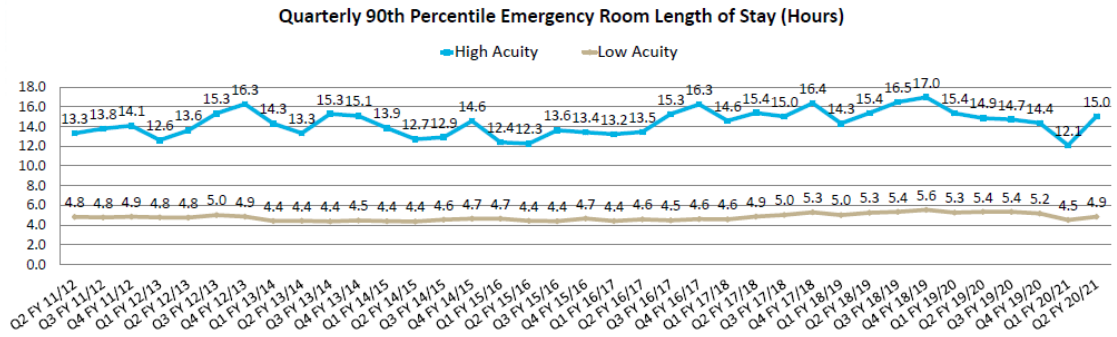
ER LHIN Information:

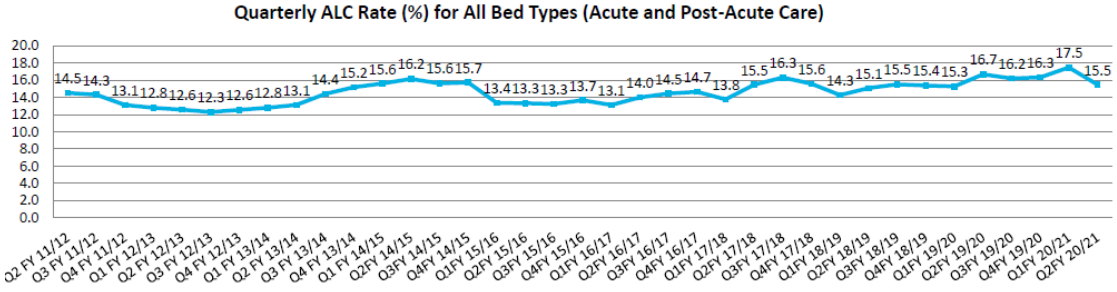
- Quarterly trend of the 90th percentile of total time spent in Emergency Room (Hours) by Acuity (Low/High)

ALC LHIN Information:

- Quarterly trend of ALC Rate for all bed types (Acute and Post-Acute Care)

Q2 FY 11/12 to Q2 FY 20/21





15 – ALC Data Quality and Stabilization Report

Design: Dynamic, Excel-Based
Level: Facility, Site
Frequency: 12th and 16th business day of the reporting month; 1st 3rd and 6th business day of the following month
Report Available Since: Q1 2013

Reporting Period: Q1 of current fiscal year – current reporting month
Data Source: WTIS,
Audience: Hospitals

Description of ALC Data Quality and Stabilization Report

The ALC Data Quality Report (DQR) provides facilities with a snapshot of their monthly ALC data at the facility and site level, using the compliance and informational indicators. ALC Coordinators review the report to proactively identify data collection or submission issues, and plan for resolution before the reporting month end. Please see the Data Quality Management section for complete information regarding compliance and data quality indicators and processes

The report provides the information in the areas below to allow users a comprehensive view of their ALC data:

- Summary of current reporting month's ALC data based on compliance indicators
- Trending data for compliance in the current fiscal year
- Summary of waitlist entries flagged for record level review
- Overview of additional DQ indicators around timeliness, completion and comprehensiveness indicators
- Detailed indicator and report methodology information

For more information on utilizing this report, please email ATC@ontariohealth.ca ATTN: Compliance.

8 – Data Quality Management

The following section provides information about ALC data quality management processes and the importance of submitting high quality data to the WTIS.

Section Highlights

8.1 – Data Quality Management Overview

High quality data is essential to ensure an accurate and representative picture of ALC across the province to support decision making in the management and improvement of access to healthcare services. Maintaining good data quality is a shared responsibility between ATC and facilities.

Facilities are responsible for ensuring data entered into the WTIS is accurate, complete, and of high quality. ATC supports facilities in achieving this mandate, by conducting monthly data quality reviews to identify possible data quality concerns and support the resolution of any data submission issues that may arise.

The ATC Data Quality Management process is comprised of a robust set of **indicators**, **tools** and **processes** that are designed to enable facilities to understand how their facility is adhering to submission requirements, and the reportability of their submitted data.

Note: For the purposes of ALC data collection, hospitals with only one location and hospitals with multiple locations under one umbrella corporation are considered Facilities. Each individual hospital is also considered to be a Site. Data quality management occurs at a Site-level but can also be rolled-up to a Facility-level for multi-site facilities. For sake of ease, the term facilities has been used to represent all hospitals collecting and reporting ALC information.

ALC Data Submission Requirements

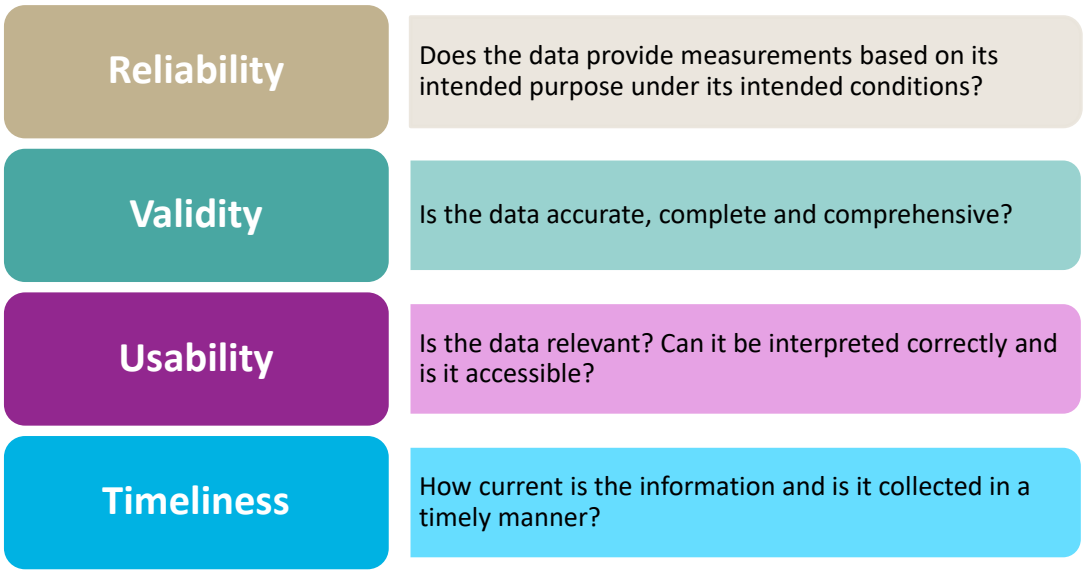
The submission of WTIS data from facilities must be both accurate and timely to meet data submission requirements.

To ensure timely data quality, updates to the waitlist entries should be made within two business days of a clinical event, for example:

- Opening and closing a waitlist entry within two business days of the actual ALC Designation Date and the actual Discharge Date
- Discontinuing a waitlist entry when a patient's needs, or condition changes, and the patient is no longer actively waiting for an alternate level of care
- Re-opening a waitlist entry when the patient is re-designated ALC, following a Change in Medical Status
- Updating Specialized Needs and Supports if there is a change in the patient's care requirements and/or discharge destination
- Facilities at a complex level of integration must also resolve Message Failure Management (MFM) errors within two business days of the error date for the waitlist entry to be corrected in a timely fashion

8.2 ALC Data Quality Indicators

ALC Data Quality Indicators (which are composed of compliance, informational and record level indicators) are based on ATC's Data Quality Framework, which aims to monitor submitted ALC data on the following **data quality dimensions**:



There are three types of data quality indicators measured monthly, each group serves a different purpose, and are defined in the table below. While it is the responsibility of the facility or site to submit accurate data, these indicators help to identify expected or unanticipated errors in the data.

Indicator Type	Description
Compliance	Measures the quality of the submitted data in relation to the core submission requirements for reporting (volumes, completeness, etc.)
Record Level	Identify anomalies within a specific patient record requiring validation and/or correction
Informational	Provides additional context for data quality, and the management of data quality issues. Aids in identifying areas for improvement and supports data quality conversations

As of the beginning of fiscal year 2021/22, the following table outlines the ALC Data Quality Indicators. Complete definitions, methodologies and exclusions for these indicators can be found in the methodology tab of the ALC Data Quality Report (DQR).

Data Quality Dimension	Indicators	Purpose
Compliance Indicators		
Comprehensiveness	1. **Volume of Discharged ALC Cases at site level**	To identify sites with newly added and/or discharged ALC volumes outside the expected range **Target:** A pre-calculated historical range based on 12 months of data
	2. **Volume of Newly Added ALC Cases at site level**	
	3. **Volume of transfer-in cases at site level (applies to RCC and AHF sites only)**	To identify RCC sites with transferred ALC volumes outside of the historical range. **Target:** A pre-calculated historical range based on 12 months of historical data
Informational Indicators		
Freshness	4. **Two business day Open Cases at site level**	To identify sites that are not opening/closing their ALC cases within 2 business days
	5. **Two business day Discharged/Discontinued Cases at site level**	
	6. **Unknown Long Waiters for ALC Discharge Destination**	To identify sites that are not updating their ALC DD in a timely fashion
Completeness	7. **Unknown Long Waiters for Most Appropriate Discharge Destination**	To identify sites that are not updating MADD for their open cases
	8. **Facilities with 100% of ALC Cases with SNS=Yes with no Barriers Indicated**	To notify sites of the proportion of ALC waitlist entries where SNS = Y and no barriers are indicated
Accuracy	9. **% of ALC Cases Excluded**	To notify sites of the proportion of waitlist entries that are being excluded from reporting
	10. **Facilities with 100% of cases with SNS=No**	To notify sites when there are no SNS reported for any ALC patient at the facility
	11. **Proportion of Open ALC Cases by DD/MADD**	To identify sites that have unusual patterns in or an unexpected change in

Data Quality Dimension	Indicators	Purpose
	12. **Proportion of Discharged Cases by DD/MADD**	reporting DD, MADD or discontinuation reason
	13. **Proportion of Discontinued Cases by DD/MADD and Discontinuation Reason**	
Completeness	14. **Proportion of ALC cases with a reported site-to-site transfer date.**	To inform multi-site facilities of patterns in ALC patient movement between sites.
Accuracy	15. **Proportion of ALC cases flagged with Record Level Indicators in the WTIS DQ Module**	To notify sites of waitlist entries that require their review in the WTIS DQ Module.
Record Level Indicators		
Accuracy	16. **ALC Waits Longer than 365 Days**	To encourage sites to validate their long waiters to confirm they are still waiting
	17. **Duplicate Waitlist Entries**	To notify sites when a patient has more than one ALC waitlist entry with all the same ALC event information
	18. **Overlapping Waitlist Entries**	To notify sites when a patient has more than one ALC waitlist entry with ALC days that overlap
	19. **ALC Same Inpatient Service as Discontinuation Reason**	To notify sites when a patient has been discontinued to acute care, when currently residing in an acute care bed
	20. **ALC Same Bed Type**	To notify sites when a patient does not meet the provincial ALC definition based on the bed type they reside in compared to the bed type they are waiting for

ALC Compliance Indicator Targets

ALC compliance indicator targets are derived from a site's historical pre-calculated range (based on 12 months of data) of discharged, newly added and transferred ALC cases. Targets are used as a benchmark for comparison when assessing monthly volume compliance. Sites are not required to meet their target for performance; rather they are displayed to provide an indication of normal range of volumes that month. Not meeting the target for the volume threshold indicates that you need to confirm the actual number of discharged, newly designated and/or transferred ALC waitlist entries for the reporting month.

8.3 – Data Quality Reports & Tools

ALC Data Quality Report (DQR)

The ALC Data Quality Report (DQR) is available on the ATC Information Site on the 12th and 16th business days in the reporting month, as well as the 1st, 3rd and 6th business days following the reporting month. The weekly ATC Bulletin includes a link to this report. These reports help Coordinators with proactive data monitoring and performance management within their organization. ATC uses this report to evaluate monthly data, identify potential issues and establish compliance designations. Both compliance and informational indicators are included in this report.

Interim Compliance Report (ICR)

The Interim Compliance Report (ICR) is available on the ATC Information Site on the 12th business day of the reporting month. This report includes only those facilities or sites with compliance indicators which are at risk of being outside of the acceptable threshold at month end. When a facility or site is flagged on this report, the primary and back-up Coordinators will receive an email notification. Coordinators are encouraged to examine their data carefully and ensure it is an accurate reflection of what has actually occurred at the facility.

Final Compliance Report (FCR) and Feedback Tool

The Final Compliance Report (FCR) and Feedback Tool is available on the ATC Information Site on the first business day of the subsequent reporting month. The primary and back-up Coordinators at the facilities or sites appearing on the FCR will receive an email notification. This report displays only those facilities and sites with compliance indicators that are outside of the acceptable threshold at month end. Facilities or sites listed on this report are required to provide feedback to ATC by the fourth business day.

Compliance Designations Report (CDR)

This report displays the final compliance designations for each site, by compliance indicator. This information, along with the feedback received through the feedback cycle is evaluated to determine the reportability of a site's data. Site's with significant data quality issues are suppressed from monthly reporting.

Record Level Data Quality Module (WTIS)

Record level data quality management is managed directly in the WTIS via the Data Quality Management module. ALC record level indicator methodologies are automatically applied when a wait list entry is created, edited or closed. The module links WTIS users with the appropriate access directly to wait list entries that have been flagged against ALC record level indicators. Coordinators receive email communications that align with the interim and final compliance reports if they have entries to review in the record level module. Record level DQ issues should be resolved before data cut whenever possible to ensure data used for reporting is accurate. The WTIS DQ module also allows coordinators to request wait list entries be excluded from reporting if they contain erroneous data.

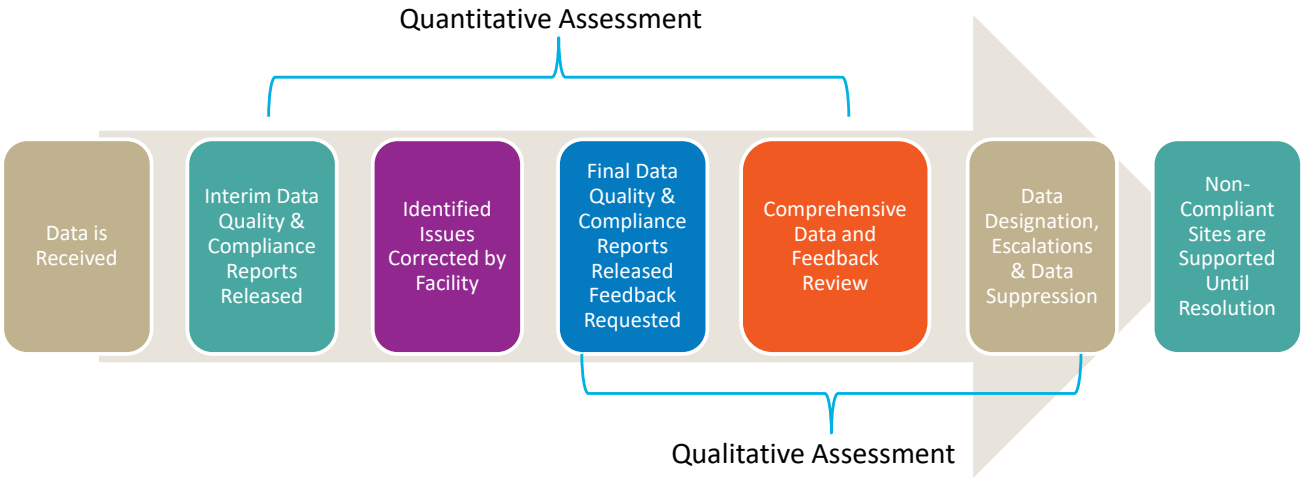
ALC Data Resubmission Policy

ATC recognizes there may be instances when a facility may need to resubmit ALC data for a given time period after the submission window has closed and/or the data has been extracted for reporting purposes. To address this need, ATC developed the https://share.ccohealth.ca/sites/ATC/Shared%20Documents/ATC_Data%20Resubmission%20Reference%20Manual_v1.0.pdfsupport facilities during the resubmission process.

Once confirmation and arrangements are made with ATC, ALC Coordinators may follow the guidelines in the policy to resubmit their previously missed or corrected records to the WTIS.

8.4 – Data Quality Management Monthly Process

ATC's data quality management processes are designed to proactively monitor key submission requirements, and to ensure complete and accurate data is available to inform wait time performance reporting. Each monthly cycle contains key milestones that allow facilities to track their progress. The diagram below outlines the process.



Twelfth business day of the reporting month: On this day, the first set of reports are released to monitor the data in the reporting month.

- DQR is posted on the ATC Information Site; Coordinators are notified through the weekly bulletin
- The Interim Compliance Report (ICR) is posted and a notification is sent to facilities and sites at risk of falling outside of the expected thresholds by month's end. This report helps Coordinators proactively identify issues and implement solutions before month's end.
- Coordinators are notified via email if they have any record level data quality indicators flagged through the WTIS Data Quality Management module

First business day of the subsequent month: On this day, the full month of data is available for data quality review, and a set of reports and tools are released to support data quality management.

- DQR is posted on the ATC Information Site; Coordinators are notified through the weekly bulletin
- The Final Compliance Report (FCR) and Feedback Tool is posted and a notification is sent to all facilities and sites that have not met the acceptable threshold for one or more compliance indicators. Receiving this report and the accompanying notification indicates feedback is required.
- Coordinators are notified via email if they have any record level data quality indicators flagged through the WTIS Data Quality Management module

Fourth business day of the subsequent month: On this day, feedback for compliance indicators falling outside of the acceptable thresholds must be uploaded to the Compliance & Data Quality Feedback area of ATC Information Site before the end of day, using the Final Compliance Report (FCR) and Feedback Tool.

First to Sixth business day of the subsequent month: During this period, ATC will contact facility Coordinators to clarify information or gather more details to understand the quality of the submitted data for monthly reporting and address any data quality issues.

Fifth business day of the subsequent month: On this day, wait list entries that have been flagged for exclusion by facility Coordinators are approved in the WTIS. These entries will not be included in monthly reporting based on the data cut taken the following day.

Sixth business day of the subsequent month: On this day, the information stored in the WTIS is extracted and used to generate monthly performance reports.

Twelfth business day of the subsequent month: On this day, the Compliance Designation Report (CDR) is posted on the ATC Information Site. This report displays the final compliance designations for each site, by compliance indicator. This information, along with the feedback received through the feedback cycle is evaluated to determine the reportability of a site's data. Site's with significant data quality issues are suppressed from monthly reporting.

Compliance Feedback

Feedback from participating facilities and sites provides qualitative context to the data reported to the WTIS. The initial compliance assessment is a 'quantitative' view of the data, comparing the actual data in the system to the expected or acceptable values. Further information is required to understand if the data in the system is accurate.

ATC notifies facilities or sites identified on the FCR by email on the first business day of the subsequent month. This email indicates feedback is required to explain the submitted data. Feedback must be uploaded to the Compliance & Data Quality Feedback area of ATC Information Site by the fourth business day of the subsequent month. This allows ATC enough time to assess the feedback and reach out for more information if required, in time for data cut date on the sixth business day. The FCR includes step-by-step instructions detailing the use of the report and feedback requirements.

Compliance feedback must include confirmation of the actual events (volume of newly designated cases, volume of discharged cases, etc.) that occurred at the site-level during the reporting month. If required, feedback must also contain appropriate action plan activities, including a date for when the data will meet the compliance reporting requirements and the issue will be resolved.

The facility or site risks receiving a non-compliant designation and a potential escalation when adequate rationale is not received by ATC by the feedback deadline.

Action Plan for Issue Resolution

Documenting and submitting an action plan are important steps in the data quality management process. An action plan helps ATC confirm the facility is addressing data submission issues in a timely and effective manner and will assist the coordinator in organizing an appropriate resolution. Action plans should be submitted directly in the Final Compliance Report (FCR) & Feedback Tool. Further supporting documents can also be provided with more details, if necessary. An action plan should include:

1. Detailed steps to resolve the issue.
2. Key stakeholders and/or resources accountable for completing the identified steps.
3. A final resolution date and/or interim milestone dates, where required.

Compliance Designations

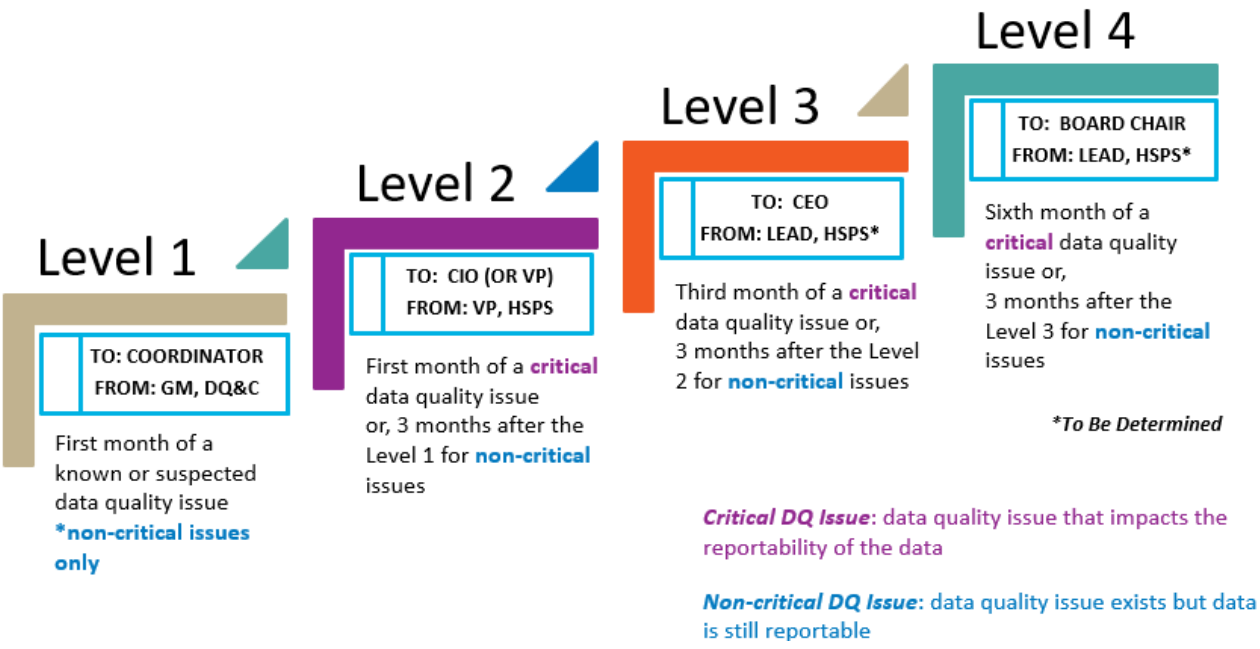
Facility data, in conjunction with feedback, are used to accurately assess a facility's data submission compliance. Facilities are designated Compliant or Non-Compliant for each compliance indicator:

Designation	Criteria
Compliant	Data has met the reporting requirement, as defined by the compliance indicator.
Non-Compliant	Data has not met the reporting requirement, as defined by the compliance indicator, and: • The Coordinator has provided inadequate or no feedback by the 4th business day deadline • The facility/site was not able to enter, close or update all required information in the WTIS by the data cut date and no resolution plan is in place • Ongoing data quality issues exist, and the targeted resolution date has not been met

8.5 – Data Quality Issue Communications & Management

The Data Quality Issue Communications & Management process is used to inform senior members at participating facilities of issues related to the accuracy and/or completeness of the data reported to provincial stakeholders. Communication is an important step to ensure transparency within the compliance process, and to gain support for issue resolution.

ATC initiates the DQ Communication process when a facility is designated Non-Compliant and is without a plan for resolution for one (1) or more consecutive months. The process can follow two different pathways based on the criticality of the issue. Critical issues are defined as those that impact ATC's ability to accurately reflect a facility's ALC activity in performance reports (e.g. only 50% of new ALC cases for the month were reported by data cut). Non-critical issues may have an impact on data quality, but do not impact the reportability of a facility's data.



9 – iPort™ Access

This section describes the Business Informatics tool available to users to generate customizable reports on ALC information.

Section Highlights

9.1 – iPort™ Access Overview

iPort™ Access is ATC's Business Intelligence tool. Available since September 2011, it provides secure, web-based strategic reporting and analysis capabilities. iPort™ Access provides users with near-real time data (24-hour lag) on ALC information at the Provincial, LHIN, Hospital and Site level. iPort™ Access supports operational, planning, and performance management functions by providing easy and timely access to ALC information in the form of customizable reports and operational dashboards.

iPort™ Access Features

- Customizable Reports
- Operational Performance Dashboards
- Common Attributes and Filters for reports
    - Type of case (Open, Discharged, Discontinued)
    - Province, LHIN, facility, site levels
    - Inpatient Admission Source & Inpatient Service
    - ALC Discharge Destinations & Discontinuation Reasons
    - Specialized Needs and Supports (SNS)
    - Most Appropriate Discharge Destination (MADD) Segments
- Common Metrics for reports
    - Volume of ALC Waitlist Entries
    - Mean Wait (in days)
    - Median Wait (in days)
    - 90th Percentile Wait (in days)

9.2 – Customizable ALC reports through iPort™ Access

ALC-DPE001 ALC Performance Summary Report

Provides information on Key Performance Indicators including the volume of ALC waitlist entries and the mean, median and 90th percentile ALC wait by various attributes such as ALC Discharge Destination and Specialized Needs and Supports (SNS). This report can be generated for Open, Discharged (Closed) and Discontinued (Closed) ALC waitlist entries.

ALC-DPE002 ALC Performance Comparison Report

Provides information on KPIs by various attributes at the Province, LHIN, Facility and Site level. This report can be executed for Open, Discharged (Closed), and Discontinued (Closed) ALC waitlist entries.

ALC-DPE003 ALC Performance Histogram Report

Provides a graphical distribution of ALC Days by various attributes. This report can be executed for Open, Discharged (Closed), and Discontinued (Closed) ALC waitlist entries.

ALC-DDE001 ALC Patient Age Demographics Report

This report provides information on Key Performance Indicators including the volume of ALC waitlist entries and the mean, median and 90th percentile ALC wait by patient age and various other attributes.

ALC-DTQ002 ALC Patient Throughput and Queue Analysis Report

Provides information to observe whether the ALC waitlist entry is increasing or decreasing over a specific time period. It provides queue information, volume of newly added and discharged cases, and the throughput ratio indicator by various attributes and reporting periods.

ALC-DTR001 ALC Trending Report

Provides information on KPIs (including volume of Open waitlist entries and Wait Time metrics) by various attributes, trended over time, at the Province, LHIN, Facility and Site level. This report can be generated for Open, Discharged (Closed) and Discontinued (Closed) ALC waitlist entries.

ALC-DTR002 Daily ALC Volumes by Discharge Destination

Provides daily volume summary of ALC cases by Discharge Destination and by various attributes at the Province, LHIN, Facility and Site level. This report can be generated for Open, Discharged (Closed) and Discontinued (Closed) ALC waitlist entries. This report can be generated to review daily volume information by Fiscal Year, Fiscal Quarter, Fiscal Month and Fiscal Week.

ALC-DOT0001 ALC Discharge Destination Segment Report

Provides information on KPIs including the volume of ALC Discharge Destination Segments in the ALC waitlist entries and the Mean, Median and 90th Percentile Wait Time for ALC Discharge Destination segments. This report includes Discharged (Closed) waitlist entries only.

ALC-DOT002 ALC Designated ALC within X Days of Admission Report

Provides information on KPIs including the volume of ALC waitlist entries where the patient was designated ALC within a specific number of days after admission, by various attributes. This report can be generated for Open, Discharged (Closed) and Discontinued (Closed) ALC waitlist entries.

ALC-DOT003 Most Appropriate Discharge Destination (MADD) Report

Provides information on Key Performance Indicators for MADD segments for open or closed ALC waitlist entries including the volume of ALC waitlist entries and the mean, median and 90th percentile ALC wait by various attributes.

ALC-DOT004 Most Appropriate Discharge Destination (MADD) Transfer Segment Report

Provides information on Key Performance Indicators for MADD/transfer segments for open or closed ALC waitlist entries including the volume of ALC waitlist entries and the mean, median and 90th percentile ALC wait by various attributes.

ALC-DOT005 Discharge Destination (DD) Transfer Segment Report

Provides information on Key Performance Indicators for DD/transfer segments for open or closed ALC waitlist entries including the volume of ALC waitlist entries and the mean, median and 90th percentile ALC wait by various attributes.

ALC-EXT001 ALC Patient Detail Report (Hospital Users Only)

Provides record-level detail for most ALC data elements entered into the WTIS, including ALC days and Acute Care Episode (ACE) days. This report can be generated for Open, Discharged (Closed) and Discontinued (Closed) ALC waitlist entries.

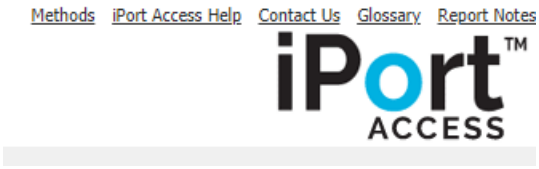
ALC-DSH001 ALC Operational Dashboard by Facility

ALC-DSH002 ALC Operation Dashboard by Site

These Operational Dashboards provide a monthly and daily operational summary of ALC performance by facility and site. These dashboard can be executed for Open, Discharged (Closed), and Discontinued (Closed) waitlist entries.

9.3 – More iPort™ Access Information

- ALC iPort™ Access Report Guide: *ALC iPA Report Guide*
- Click the "iPort™ Access Help" in iPort™ Access



- Questions: iPortAccess@ontariohealth.ca

Summary of Changes

Version 1: May 2016

Version 2: January 2017

Minor changes (e.g., language, formatting, organization) were made throughout the entire document to increase clarity and improve the flow of information throughout each section.

Summary of Major Changes

Section	Major Changes
1 – ALC Overview and Provincial Definition	• The Introduction and Provincial Alternate Level of Care Definition sections were combined to create Section 1 – ALC Overview and Provincial Definition • Inclusion of ATC Oversight and Governance subsection
2 – Provincial ALC Information: The WTIS	• Update to Evolution of the WTIS diagram
3 – WTIS-ALC Data Elements	• Inclusion of all ALC data elements collected in the WTIS (Version 1 included only key data elements). • Inclusion of detailed definitions for each individual data element value. • Inclusion of WTIS-ALC Data Elements Aligned to Clinical Scenarios subsection
4 – Clinical Guidance	• Removal of Flow Diagram: Palliative Care
5 – ALC Status Definitions	• Inclusion of new diagram: ALC Statuses in ALC Reports
6 – ALC Performance Indicators	• Removal of "Wait 3" and "Wait 4" terminology • Inclusion of indicator: Percent Contribution to Annual ALC Rate by Discharge Destination
7 – ALC Reporting	• Removal of *ALC Provincial Hospital Group Summary* from Report Catalogue as this report is no longer reported • Inclusion of new *ALC Patient Journey Report* to Report Catalogue • Inclusion of *Summary of ALC Performance Indicators and Performance Reports* table
8 – Data Quality Management	• Inclusion of *Refreshed Historical Data* subsection • Inclusion of *Treatment for Submitting Missing Records* subsection
9 – iPort™ Access	• No changes

Version 3: April 2021

Minor changes (e.g., language, formatting, organization) were made throughout the entire document to increase clarity and improve the flow of information throughout each section.

Summary of Major Changes

Section	Major Changes
1 – ALC Overview and Provincial Definition	• Added clarification to the Provincial ALC Definition; inclusion and exclusion criteria • Updated information regarding ATC's oversight and governance as part of Ontario Health
2 – Provincial ALC Information: The WTIS	• Update to Evolution of the WTIS diagram • Updated Information regarding WTIS ALC Integration and readiness assessment for integration migration
3 – WTIS-ALC Data Elements	• Added clarification to the definitions and usage for: Inpatient Service, Inpatient Admission Source, Most Appropriate Discharge Destination (MADD), ALC Discharge Destination (DD), Discharge Destination Types (Home, Palliative Care), Specialized Needs and Support Type and Details and Discontinuation Reasons • Inclusion of new diagram: ALC Segmentation by Discharge Destination • Replaced old case scenarios with 16 new clinical scenarios, with areas of focus including Palliative Care, Alternate Care Settings (such as transitional care) and application of the different ALC Discontinuation Reasons
4 – Clinical Guidance	• Revised guidance on reporting patients designated ALC waiting to return to their originating Long-Term Care home • Added new clinical scenario for waitlist entries being closed due to "Transfer to Acute Care" and "Unplanned Repatriation" (to be renamed to "Transfer to Another Facility" in future ALC WTIS implementations
5 – ALC Status Definitions	• Added clarification to the use of ALC Re-designations after a waitlist entry has been discontinued due to "Change in Medical Status"
6 – ALC Performance Indicators	• Updated methodology for ALC Rate calculation, following changes to Daily Bed Census Summary in 2017 • Enhanced interpretation guidance for ALC Throughput Ratio and ALC Rate
7 – ALC Reporting	• Removal of ALC Quarterly Data Quality Summary Report from Report Catalogue as this report will be decommissioned beginning April 2021 • Inclusion of new OHA ALC Reports to Report Catalogue • Removal of Summary of ALC Performance Indicators and Performance Reports table

Section	Major Changes
8 – Data Quality Management	• Updated Data Quality Management overview to include Record Level Data Quality Management within the WTIS, new Data Quality Indicators, Resubmission Policy and new Data Quality Issue Communications and Management process
9 – iPort™ Access	• Updated ALC Report Titles to match the exact labels found in iPort Access • Inclusion of new ALC-DTR002 Daily ALC Volumes by Discharge Destination report • Inclusion of new ALC-DOT004 Most Appropriate Discharge Destination (MADD) Transfer Segment Report • Inclusion of new ALC-DOT005 Discharge Destination (DD) Transfer Segment Report • Updated support email address to iPortAccess@ontariohealth.ca

This is **Exhibit "D"** referred to in the Affidavit

of **Dr. Jordan Pelc,** sworn this 23rd day of

February, 2024, in accordance with O. Reg 431/20,

Administering Oath or Declaration Remotely

A Commissioner for taking Affidavits etc. (or as may be)

(pursuant to O. Reg. 431/20)

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)

Dana Corsi, Chair	Regional Geriatric Rehab Lead North East Specialized Geriatric Center (NESGC), Health Sciences North (HSN) Interprofessional Implementation Fellow Provincial Geriatrics Leadership Ontario (PGLO)
Enza Ferro	Senior Advisor Ontario Hospital Association (OHA)
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Dr. Kerry Kuluski	Dr. Mathias Gysler Research Chair in Patient and Family-Centered Care Better Health Institute, Trillium Health Partners (THP)
Charissa Levy	Executive Director Rehabilitative Care Alliance
Dr. Barbara Liu	Executive Director Regional Geriatric Program (RGP) of Toronto
Lina Neves-Mera	Senior Policy Advisor Research and Discovery, Ontario Hospital Association (OHA)
Julie Sullivan	Director, Health System Planning and Design Ontario Health Central (2017 working group member)
Candice Tam	Group Manager, ALC and Mental Health, Health System Performance and Support Ontario Health (2017 working group member)
Wendy Zeh	Project and Quality Manager RGP of Toronto

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

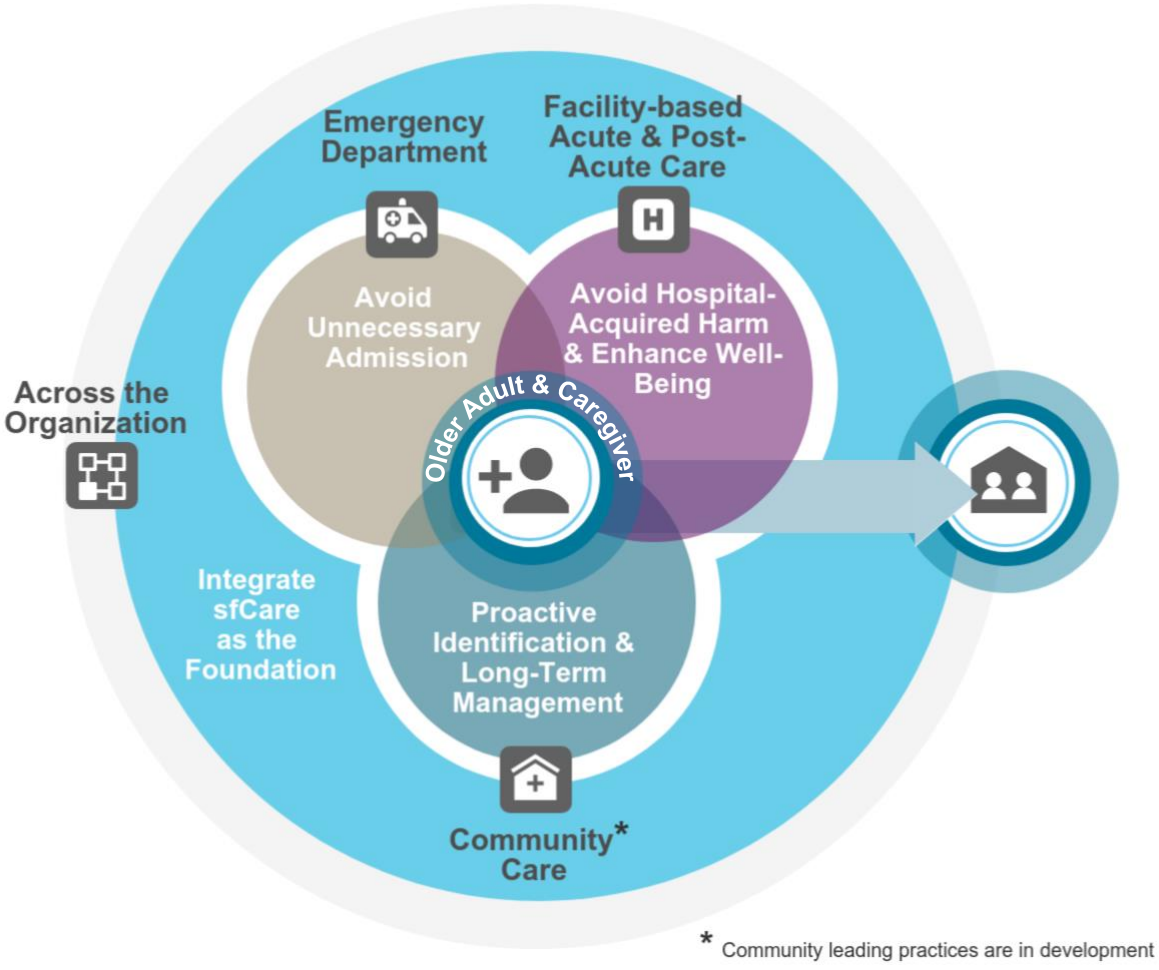
B. **Ensure practices and structures are in place in the Emergency Department (ED) to avoid unnecessary admission** - this goal is addressed by leading practices that focus on:

- 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)  Baseline Function_NESGC 202 (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)

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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
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