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. TRAVIS CARPENTER

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

1. I am a physician and a Royal College of Physicians and Surgeons of Canada certified subspecialist in General Internal Medicine (and specialist in Internal Medicine) with extensive clinical, personal, and academic experience in a variety of settings, both urban and rural, within and outside of Ontario.

2. I currently practice clinically at St. Joseph's Health Centre, a large hybrid community-academic hospital in west Toronto. In a typical year I provide care for approximately 1800-2000 acute medical patients almost exclusively on the inpatient ward or in the emergency department. In this capacity, I have coupled bedside medicine with quality improvement

activities including improving care for seniors and enhancing transitions of care. A copy of my curriculum vitae is attached as Exhibit "A".

3. I am my hospital lead for the Ontario General Medicine Quality Improvement Network (GeMQIN) and am currently a primary or co-investigator on many active research projects (>$2 million in total current grant funding) including assessing health system performance and how health system strain affects quality of care. Many of these projects incorporate qualitative methodology to assess and analyze the viewpoints of front-line providers, a critical and often underutilized resource in constructing health system reforms.

4. With respect to advancing health system improvement, I have extensive experience with health policy evaluation, research, and advocacy both within and outside Ontario. I currently serve on faculty at the University of Toronto, as a Research Fellow at the School of Public Policy at the University of Calgary, and as the Chair of the Health Policy Committee at the Ontario Medical Association. For the past 7 years, my formal evaluation and research activities have included a diverse array of projects including primary care physician compensation reform, nurse practitioner integration into primary care, improving evaluation of effectiveness for pediatric mental health programs, evaluating virtual care in concussion management, strategies to better manage hospital ALC patient populations, improving effectiveness of EMS services, improving human resources management in EMS, implementing more inclusive municipal sport policy, and structural health care reform to improve chronic pain management.

5. I have advanced training in Public Health and the broader determinants of health including completing my graduate degree at the Harvard Chan School of Public Health. I am a strong

advocate for improving the care of the elderly,[1] improving end-of-life care, and balanced priority-setting in resource allocation to support broader determinants of health.[2] I also recently completed a 3-year term as a representative with my institution's Council for Anti-Racism, Equity and Social Accountability.

6. As set out further below, I do not agree with the contentions made by the physicians who have given evidence for the Applicants that the provisions of Ontario's Bill 7 are unusual, unnecessary, or counter to the overall well-being of seniors and other Ontarians. In my opinion, Bill 7 brings practices in Ontario in line with established norms in other jurisdictions and helps meaningfully address a worsening and increasingly dangerous situation in acute care in Ontario. A policy paper I co-authored for the University of Calgary's School of Public Policy on policy responses to this situation is attached as Exhibit "B".

7. My expertise is in acute inpatient care (including assessment and treatment), health system improvement, public health, and health policy. 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 "C".

8. 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?

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[1] Travis Carpenter & Lucas Vivas, "Military help lays bare how misplaced health care priorities have harmed our seniors", *Toronto Star* (May 28, 2020), online: <https://www.thestar.com/opinion/contributors/military-help-lays-bare-how-misplaced-health-care-priorities-have-harmed-our-seniors/article_9afb1a63-5b16-54ea-b22b-d31965cc8c8c.html>.
[2] Travis Carpenter, "Advocate or Allocate (or both)? What are the ethical responsibilities of the medical profession during and after the COVID-19 pandemic?" *Canadian Family Physician* (October 30, 2020), online: <https://www.cfp.ca/news/2020/10/30/10-30>.

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?

f) Do you agree with the description by witnesses for the Applicants of ALC patients and the process for designating patients as ALC?

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

9. A great deal of my clinical practice consists of providing MRP (most responsible physician) services for medical patients admitted to or being admitted to hospital. As MRP, I admit patients to and discharge patients from hospital and have overall responsibility for directing and coordinating the care and management of the patient while they are in hospital.

10. This role regularly involves making decisions about whether and when to designate patients as ALC. These determinations would be a daily occurrence while on inpatient service, representing assessments for hundreds of patients each year. In the 2024 context of increasing numbers of increasingly complex and frail medical patients, many or most medium and large Canadian hospitals are transitioning this care to designated subspecialists in this area like me, given the obvious requirements for specific knowledge and skills generally not possessed by or exercised with the same degree of proficiency by other specialists.

11. The Royal College of Physicians and Surgeons of Canada has recognized General Internal Medicine as a designated subspecialty since 2010, requiring its own 5-year specialty and subspecialty post-graduate training program after medical school. From the perspective relevant to the management of the medical and psychosocial needs of ALC patients in acute

care, the Royal College would define the role of a subspecialty General Internist as including: providing care for patients with medical conditions across all organ systems and disease mechanisms, at all phases of illness; managing the care of patients with multi-system diseases, multiple co-morbidities, competing conditions, and/or undifferentiated presentation when the patient's disease burden is beyond the scope of the primary care physician or organ- or disease-focused subspecialist; approaching patient care in a holistic manner; playing a central role in the provision and coordination of medical care; and assessing the current, unmet or emerging health needs of the communities they serve.[3]

12. General internists in hospital practice that are seeing an adequate volume of patients, such as myself, possess the deepest skills and experience for completing assessments and determinations for ALC status. Other physicians, such as geriatricians, would typically only be involved in select cases, often for a 'second opinion' or to address specific management questions relevant to the older patient for which their expertise would be thought to be useful.

13. Based on the difficulty of the work, especially in the context of the increasing needs of an older, more complex, and frail population, the subspecialty has recently been under immense physical and emotional stress seeking to provide adequate care in an increasingly strained health system.

14. While the structures and processes of care will differ from hospital to hospital, at my own institution, we practice a team-based model where a single general internist is assigned to an inpatient unit consisting of 25 to 35 patients. To support this practitioner, there is an available

[3] Royal College of Physicians and Surgeons of Canada, General Internal Medicine Competencies, (2018, version 1.0), online: <https://www.royalcollege.ca/content/dam/documents/ibd/general-internal-medicine/general-internal-medecine-competencies-e.pdf>.

team for each unit which would usually include a team leader (charge nurse), physiotherapist, occupational therapist, speech pathologist, transition planner and/or social worker, and pharmacist. Through close collaborative practice with this large patient load, each unit is expected to meet the clinical and psychosocial needs of all assigned patients from admission to discharge. This would include all ALC and non-ALC patients on the unit. For me personally, this would involve direct care of many dozens or even hundreds of ALC patients in a typical year.

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

15. Given the need for close collaborative practice as described, the most valuable venue for discussing and determining a patient's plan of care is usually the daily patient care rounds, typically lasting 45 minutes to an hour each morning. While ad hoc discussions may continue throughout the day as needed with individual team members, the most valuable conversations are usually within these rounds. These rounds would typically be attended by all team members (indicated above) and ideally the patient's bedside nurse as well. During such rounds, the overall condition of the patient is discussed and a treatment plan for the day and for the rest of the week or hospitalization is determined. I highly value the insight of all my colleagues from the different disciplines into the overall condition and needs of the patient and what needs to be done to facilitate clinical or functional improvement, and eventually hospital discharge.

16. In this context, ALC status will be discussed when appropriate. ALC has a specific technical administrative and research definition as highlighted by the Canadian Institute for Health Information (CIHI). However, the practical colloquial use of the term by most physicians in daily practice would be approximated as: "Would you feel comfortable as the most

responsible physician discharging the patient from acute care at this point in time?" The CIHI guidelines to support ALC designation are attached hereto as Exhibit "D".

17. In my clinical practice, I will usually take the team rounds as an opportunity to assess whether the entire team has the consensus opinion that the patient is discharge ready. ALC status in this context does somewhat resemble a clinical syndrome like frailty: it is easy to identify on either end of a spectrum, but in the middle there will definitely be some disagreement amongst team members as to a patient's overall discharge readiness. In most cases, the determination should be the result of collective decision-making with multiple opinions for input. In my experience and as supported in previous research,[4] health professionals tend to be risk-averse and less likely to apply an ALC designation if there are any concerns.

18. The formal designation would typically occur by the MRP writing or entering an ALC designation order in the patient's chart or patient care orders (or sometimes by a delegate such as a team leader conveying such an order under the expected explicit direction and authority of the MRP). Similarly, removing a patient's ALC designation is a simple exercise once an appropriate clinical decision has been made, specifically activating an equivalent order to cancel the designation.

19. I would note that ALC designation is often an important administrative signal to members of the care team to advance care in the patient's interests. Common examples would include a stroke patient who is now "rehab ready" and would benefit from expedited placement in a

[4] Chidwick, Paula, Jill Oliver, Daniel Ball, Christopher Parkes, Terri Lynn Hansen, Francesca Fiumara, Kiki Ferrari et al., 2017. "Six Change Ideas that Significantly Minimize Alternate Level of Care (ALC) Days in Acute Care Hospitals." Healthcare Quarterly 20(2), 37-43.

rehabilitation hospital, or a patient who is eager to be discharged home and would benefit from expediting the initiation of necessary home care services.

20. A full appreciation of the role of physicians in making ALC designations requires an understanding about the relationship between physicians and hospitals. Most physicians in Ontario practising as inpatient hospital MRPs are independent contractors and are not employees of their respective hospitals. Physicians have professional ethical and clinical responsibilities to their patients that fall outside of their responsibilities to their hospital. Similarly, physicians are subject to patient and family complaints outside of hospital jurisdiction (through the College of Physicians and Surgeons of Ontario) and possible legal or financial sanction through a civil suit regarding the care that they provide.

21. Overall, as physicians are independent contractors, hospitals typically have insufficient levers to drive 'desirable' behaviour (from their perspective) in attending physicians. Requests from the hospital will almost universally be overridden by physicians' own ethics and values, or their desire to avoid patient complaints or civil lawsuits related to the provision of potentially suboptimal care. Stated another way, potentially inappropriate discharges that are likely to result in preventable hospital readmission or an adverse event are highly undesirable professionally and personally for physicians, and a significant effort will be made to avoid such outcomes.

22. Operationalizing the role of the MRP in this way helps avoid undesirable conflicts of interest from the physician's perspective and allows physicians to be strong advocates for their patients. For example, I am quite frequently presented with the dilemma where a hospital might prefer to avoid an 'ALC-for-LTC' designation that is likely to result in a long length of stay; however, a patient's physical or social circumstances may preclude a safe or durable

discharge home. In such circumstances, I will not hesitate to indicate that I do not believe the patient should be discharged home and that an 'ALC-for-LTC' designation is appropriate.

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

23. At my hospital, Bill 7 has not noticeably altered the process for or assessment of whether a patient should be designated ALC. Discharge planning for complex and frail patients takes a significant amount of time, often many days or longer. In many cases, given handovers between prior and subsequent MRPs week to week, a patient being presented with discharge plans (including plans made based on provisions of Bill 7) would often have been designated ALC by a different MRP. However, as part of the typical comprehensive assessment completed by each MRP assuming care, the main consideration remains whether the patient is "discharge ready" from a medical standpoint. This has not been altered by the implementation of Bill 7.

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

24. Most Canadian hospitals will have ALC patients occupying between 10% and 20% of their acute beds at any given time.[5] At my hospital, our ALC rate for the internal medicine service averaged 24% of bed-days in 2021-2022 and between 16% and 22% for the final 3 months of 2023.

25. The consequences of such a large cohort of ALC patients on access to care is extremely pronounced, resulting in massive direct and indirect harm to other patients, including seniors. Likely the most visible effect (and the most common in public consciousness) is emergency department overcrowding: an acute care bed that is occupied by an ALC patient is not

[5] See Exhibit "B".

available for a patient waiting in the emergency department who requires admission to hospital.

26. Media commentary is full of examples where emergency department staff describe the main impediment to providing adequate quality care as the presence of large numbers of admitted patients with high care needs who lack an available bed in the main hospital.[6] This is not a new phenomenon in Canada,[7] but recent months have been especially dire with Canada seeing record-setting wait times for emergent care. Increasing risks to the health and lives of patients, as well as increasing distress by providers that adequate care cannot be provided, has resulted in stakeholders increasingly calling for practical and immediate steps to be taken at all levels of the health care system to mitigate these harms.[8] A 2013 position statement from the Canadian Association of Emergency Physicians that speaks to issues of overcrowding and access block is attached hereto as Exhibit "E".

27. I have seen innumerable examples of direct adverse outcomes resulting from admitted patients, who are often frail and elderly, being boarded in the emergency department for prolonged periods because no hospital bed is available. These include nosocomial infections, unnecessary falls, bedsores, and delirium. In one particularly egregious example, in a context where our own emergency department will frequently have greater than 40 or 50 patients

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[6] Kenyon Wallace, "'You are always rushing': A Toronto doctor offers a glimpse of emergency room chaos," *Toronto Star* (February 2, 2024), online: <https://www.thestar.com/news/gta/you-are-always-rushing-a-toronto-doctor-offers-a-glimpse-of-emergency-room-chaos/article_f0bc2378-c079-11ee-b77d-070d0f4eb66b.html>.

[7] Andrew Affleck, MD et al, "Emergency department overcrowding and access block" (2013)15(6) CJEM 359, online: <https://caep.ca/wp-content/uploads/2016/03/cjem_2013_overcrowding_and_access_block.pdf>.

[8] Catherine Varner, "Emergency departments are in crisis now and for the foreseeable future," Editorial, (June 2023) 195(24) CMAJ, online: <https://www.cmaj.ca/content/195/24/E851>, DOI: < https://doi.org/10.1503/cmaj.230719>.

admitted without an available bed in the main hospital, I had a patient in their late 90s spend over a week in the emergency department while awaiting a bed upstairs.

28. This extreme anecdotal example of a frail senior enduring greater than 7 days in the emergency department awaiting admission to a hospital bed represented a particular moment of significant duress for our institution, however, similar occurrences are not uncommon with the frequency and severity of this manner of suboptimal care likely being borderline unimaginable for many outside of emergency medicine or hospital medicine. In addition to impacting the entire potential patient population, these circumstances pose particular risks to seniors. Recent research confirms that seniors staying overnight in the emergency department while awaiting a bed are significantly more likely to die in hospital,[9] testifying to the importance of any of the multifaceted and required measures to mitigate 'bed block' in the emergency department. In my view, the measures enacted in Bill 7 are an important means of ensuring that hospital beds are available for people who need hospital level of services, including admitted patients who are waiting in the emergency department.

F) <u>Commentary on the evidence of physicians who have given evidence for the Applicants</u>

29. I have reviewed the affidavits of Drs. Arya, Heckman, St. Martin and Sinha (collectively the "physician affidavits"). In my opinion, their statements do not reflect the realities of current medical practice in hospitals and oversimplify what is an extremely challenging and multifaceted problem.

[9] Melanie Roussel et al., "Overnight Stay in the Emergency Department and Mortality in Older Patients," (2023) 183(12) JAMA Intern Med. 1378, online: <https://pubmed.ncbi.nlm.nih.gov/37930696/>, DOI: <https://doi.org/10.1001/jamainternmed.2023.5961>.

30. Dr. Sinha describes Bill 7's provisions as novel "fundamental violations of people's human rights"[10] and "'structural coercion'… that is neither ethical nor appropriate."[11] I do not agree. As I have stated above regarding the Canadian context, these types of policies are generally not novel or unusual and have not historically generated the same level of controversy elsewhere. Rather, this change in the law brings Ontario's practices in line with other Canadian jurisdictions, such as Nova Scotia, which has had similar regulations in place for nearly a decade. Materials for patients and caregivers summarizing Nova Scotia's current policy reads:

> What do I need to know if I am in the hospital waiting for long-term care placement?
>
> Every effort will be made to place you in the home of your choice. However, when a suitable bed is not available in your chosen home, you will be asked to move to the first available bed within 100 kilometers of the community of your choice. When a suitable bed becomes available in one of your selected home(s), you will have the option to transfer there. If you decline a placement, the hospital may discharge you or charge you a daily fee to stay in the hospital.[12]

31. I have attached information about provincial policies in several other Canadian jurisdictions. The fact sheet about entering long-term care in Nova Scotia, referenced above, is attached hereto as Exhibit "F". A webpage on long-term care services in British Columbia is attached hereto as Exhibit "G".[13] It notes that patients that cannot wait safely at home will be offered a bed in an interim care home until a bed is available in their preferred care home. The document "Designated Living Option: Access and Waitlist Management" from Alberta

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[10] Dr. Sinha's affidavit at para. 62.
[11] Dr. Sinha's affidavit at para. 35.
[12] Online: <https://novascotia.ca/dhw/ccs/FactSheets/Entering-Long-Term-Care.pdf>.
[13] Online: <https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/long-term-care-services>.

Health Services is attached hereto as Exhibit "H".[14] Section 6 of this document describes what happens when a patient's most preferred designated living site is not available. A webpage from Social Supports New Brunswick is attached hereto as Exhibit "I".[15] It states in part: "If there's no vacancy in the nursing homes you prefer, you may be offered an interim placement. An interim placement is a non-preferred placement which is 100 kms or less from your residence and offers services in your official language of choice." Similarly, Prince Edward Island has a "first available bed" policy for patients awaiting long-term care in hospital. A webpage setting out this policy is attached here as Exhibit "J".[16]

32. The physician affidavits also repeatedly assert that the measures in Bill 7 would simply not be required if financial and other resources were better optimized in their quantity or distribution.[17] I disagree and believe that this is an oversimplification of a massive and multifaceted problem.

33. I do not agree with the contention in some of the physician affidavits[18] that after discharging ALC patients from hospital to long-term care, a readmission to the hospital or death within 30 days of hospital discharge somehow represents an unusual or unexpected failure of appropriate decision making or quality medical care. Most of the patients discharged from medical services to long-term care will be among the sickest and most frail in the healthcare system. Readmission or death within 30 days is unfortunately unavoidable and expected, even with optimal medical care. As an example of this, the large Virtual Ward randomized

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[14] Online: <https://extranet.ahsnet.ca/teams/policydocuments/1/clp-designated-living-option-access-waitlist-mgmt-continuing-care-hcs-117-01-procedure.pdf>.
[15] Online: <https://socialsupportsnb.ca/en/program/nursing-homes>.
[16] Online: <https://www.princeedwardisland.ca/en/information/health-pei/long-term-care>.
[17] See e.g. Dr. Sinha's affidavit at paras. 63-9; Dr. Heckman's affidavit at paras. 18-22; Dr. Arya's affidavit at paras 42-49.
[18] See Dr. Heckman's affidavit at para. 31; Dr. Arya's affidavit at paras. 37-39.

clinical trial completed in Toronto demonstrated that in a similar patient population, rates of readmission or death within 30 days of hospital discharge were between 21% and 25%, even for patients provided with well-resourced monitoring and medical assessment and treatment options beyond the standard of care.[19]

34. The physician affidavits also fail to adequately recognize the specific and quantifiable harms resulting from an ALC patient remaining 'inappropriately' in an acute care bed compared to a long-term care bed. As an example, a 2022 study titled "Healthcare-Associated Adverse Events in Alternate Level of Care Patients Awaiting Long-Term Care in Hospital" is attached hereto as Exhibit "K". That study concluded as follows:

> ALC patients incur adverse events while waiting for LTC in an acute care environment maladapted for their needs. This results in a number of downstream effects in an already vulnerable population, disfavored by the limitations of our healthcare system and unfairly perceived as a burden due to associated care costs and bed strain. The predictability of adverse events in relation to length of ALC stay should be used to educate patients and families regarding risk of waiting for LTC in hospital. At a systems level, prevalence of adverse events in ALC patients should be used to advocate for improved homecare resources to support patients at home and solutions to improve access to LTC to minimize waiting in hospital, such as the use of TCUs [Transitional Care Units]. Direct comparison to adverse events in LTC and TCUs are avenues for further research.[20]

35. I also disagree with Dr. Arya that "under Bill 7, physicians have been accorded new authority and responsibilities."[21] While Bill 7 changes what the hospital does with an ALC designation

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[19] Irfan Dhalla et al., "Effect of a Postdischarge Virtual Ward on Readmission or Death for High-Risk Patients" (2014) 312(13) JAMA 1305, online: <https://jamanetwork.com/journals/jama/article-abstract/1910109>, DOI: <10.1001/jama.2014.11492>.

[20] Guillaume J. Lim Fat, et al., "Healthcare-Associated Adverse Events in Alternate level of Care Patients Awaiting Long-Term Care in Hospital," (2022) 7(4) Geriatrics 81, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9407811/>, DOI: <https://doi.org/10.3390%2Fgeriatrics7040081>.

[21] Dr. Arya's affidavit at para. 30.

(i.e. the potential consequences of a designation), there have always been financial consequences to an ALC designation for patients awaiting long-term care – specifically the expected payment to the hospital of the equivalent of the daily rate in long-term care in Ontario. The criteria for ALC status and the designation process remain the same. Physicians functioning as independent contractors and not hospital employees should therefore in most cases experience little overall change from Bill 7 in their bedside responsibilities.

36. If the patient has already had an assessment completed by a physician for admission to one or more preferred LTC homes, then this information may be shared with other homes under Bill 7 seemingly without any new assessment necessary on the part of the physician. In a scenario where the patient or their substitute decision-maker refuses to be involved in any discharge planning activity, including by not consenting to apply to any LTC homes at all, this has historically been an administrative issue typically dealt with without any involvement of the physician (e.g. the hospital can consider use of 'per diem' rates as they see fit). Under the *Fixing Long-Term Care Act*, the physician can now be requested to complete an LTC assessment for a non-consenting patient based only on a review of the existing records, but a physical exam would likely have already been completed for any patient under the physician's care. Patients can also refuse examination for assessment and treatment of other conditions, so it is not unheard of to 'treat' a patient without being able to complete a physical exam.

37. Dr. Arya states that under Bill 7 the "only recourse for a physician facing the prospect of having their ethical obligation to ensure a patient's care seriously compromised, will be to not designate a patient ALC in the first place, or to remove the ALC designation when the

outcome presents the patient with options which are potentially harmful."[22] In such a scenario, the hospital could consider employing other (typically rarely used) measures outside of Bill 7, such as considering charging 'per diem' rates for patients no longer entitled to receive insured services. These are generally more than the $400/day charge allowed under the changes made by Bill 7 and are typically prohibited from being charged to patients with an active ALC designation.[23] From an ethical perspective, removing an ALC designation for a patient who remains medically stable (i.e. not medically active) is at best dishonest, or worse, could open a physician to allegations of professional misconduct.

38. I highly respect Dr. Sinha as a knowledgeable clinician and academic, and while I do not wish to single him out, I comment on his evidence specifically because his affidavit speaks to the issues most relevant to my areas of practice and to the impact of Bill 7.

39. Dr. Sinha comments that Bill 7 would not be required if we had a "right-sized" healthcare system.[24] It is true that our system has a comparatively low number of hospital beds per capita and therefore the magnitude of the problem could be expected to be somewhat different if we had more beds overall. However, this oversimplifies and implies that these issues are a more uniquely Canadian problem than they are. If, for example, we were somehow able to dramatically increase beds per capita by approximately 25% (likely a physical and practical impossibility in the near-term) and achieve a level similar to the Netherlands, many of the same problems would still exist[25] and require similar solutions:

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[22] Dr. Arya's affidavit at para. 31.
[23] See Ontario Hospital Association "Managing Transitions – A Guidance Document", Second Edition at Section 9 "Unregulated Charges or 'Per Diems'": online: <https://www.oha.com/Documents/Managing%20Transitions%2c%20Second%20Edition.pdf>.
[24] Dr. Sinha's affidavit at para. 63.
[25] Nienke van Dijk, "Tackling the bed blocking problem at the Medical Spectrum of Twente" (2012), online:

specifically additional measures to promote efficiency and prioritize appropriate use of scarce resources.

40. Dr. Sinha suggests that many patients with active medical needs are inappropriately and over-aggressively designated as ALC "to reflect hospital management priorities" and that "ALC designations [are] being made earlier and earlier during the hospital stay of many patients to facilitate their earlier discharge from hospital."[26] I disagree. Most evidence suggests that ALC designation is almost universally underestimated and under-coded rather than over-coded. Patients in hospital are considered "medically active" by default and will only be designated as ALC after a clinician has taken specific action to change the patient's status. For example, Saskatchewan's unification into one health system and the introduction of better standardized coding across the province in 2016 are likely responsible for the significantly increased documented ALC rates between 2015 and 2017.[27]

41. My view that ALC designations are likely under-coded rather than over-coded is supported by my own experience in clinical practice. Due to high clinical workloads and more time sensitive tasks taking priority, physicians and other medical staff often only complete an ALC designation well after the patient has achieved clinical stability. For the same reasons, there is some truth in Dr. Sinha's statements that physicians or medical staff may be slow to reverse an ALC designation if a previously stable patient becomes "medically active" once again.[28] However, I disagree that a truly "medically active" patient would be discharged from hospital in such circumstances. As I have already noted, there are strong incentives to avoid this,

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<essay.utwente.nl/61916/1/Tackling_the_bed_blocking_problem_at_the_MST_Nienke_van_Dijk.pdf>.

[26] Dr. Sinha's affidavit at paras. 4-10.

[27] See Exhibit "B".

[28] See Dr. Sinha's affidavit at para. 7.

predominantly the professional desire to provide appropriate care and extremely strong incentives to avoid adverse events and preventable readmissions that could result in patients or caregivers filing a formal complaint with the regulatory body or considering civil legal action.

42. Finally, there are circumstances where discontinuing an ALC designation may run contrary to patient or family wishes. The most critical and common example of this would be where a minor (and temporary) medical issue in hospital could jeopardize transfer to a rehabilitation hospital or preferred long-term care home the patient has been waiting for if the accepting facility is provided with information that "medical stability" has been lost and the patient would no longer be appropriate for admission to that facility. Patients that are not discharge-ready should not be discharged, but there are circumstances where the MRP, in consultation with the patient and family, may wish to avoid cancelling an ALC designation.

43. From a health equity standpoint, Dr. Sinha describes how many patients are "terrified" about a $400 per day charge under Bill 7.[29] He goes on to indicate that many patients are unable to afford the $63 a day co-payment that pre-dates Bill 7. In my opinion, these statements confirm that the financial measures in Bill 7 are not an entirely new threat to the most marginalized and vulnerable patients - including many of the patients at my own hospital for whom recovery of any funds in any circumstances is simply not possible due to financial destitution. Rather, the financial component of Bill 7 is generally only of concern to patients that are financially well off enough so that recovery of such funds is feasible.

[29] Dr. Sinha's affidavit at para. 55.

44. While the physician affidavits point to differences in health outcomes between "desirable" and "undesirable" long-term care homes, they fail to acknowledge the pre-Bill 7 reality. In most circumstances, marginalized patients, especially those without strong family supports to advocate on their behalf, are more likely to end up in "undesirable" facilities. In a publicly subsidized long-term care system where most Canadians would have the expectation that patients receive roughly equivalent care, it is hard to see how erecting barriers that benefit the well-off and well-resourced serve the cause of health equity or the population overall. Given LTC home demand will dramatically exceed supply in coming years, multiple reports have indicated that closing underperforming homes is generally not an option.[30] Instead, making the entire long-term care system available to all patients is more likely to focus attention and advocacy to improve underperforming homes compared to the current state.

45. Similarly, the contention that more preferred or desirable long-term care homes can be made available simply with increased government resources is likely a false argument. Especially with respect to ethnocultural long-term care facilities, this argument neglects consideration of what makes many of these homes special beyond the human and financial resources they employ. Critical resources like volunteers, community supports, and language skills are often in short supply and not easily replicable or able to be provided at larger scale, even with greater financial resources.

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[30] Robyn Gibbard, "Sizing up the Challenge: Meeting the Demand for Long-Term Care in Canada" Ottawa: The Conference Board of Canada, 2017, online: <https://www.cma.ca/sites/default/files/2018-11/9228_Meeting%20the%20Demand%20for%20Long-Term%20Care%20Beds_RPT.pdf>; see also *Ontario*'s *Long-Term Care COVID-19 Commission: Final Report*: https://files.ontario.ca/mltc-ltcc-final-report-en-2021-04-30.pdf

46. I must also disagree with Dr. Sinha's emphatic statements that the provisions in Bill 7 are inappropriate or ethically unsound.[31] The established consensus in other provinces has been that acute care hospital beds are a valuable public resource which should be appropriately allocated to serve the most serious health needs of all citizens. Dr. Sinha suggests a longer hospital stay for ALC patients may be appropriate given the importance of a period of considered dialogue and negotiation regarding long-term care placement. However, he also references the large proportion of patients who are already awaiting long-term care prior to even being admitted to hospital. Given the critical importance of appropriate use of acute care beds, and the fact that many patients will have already applied to LTC, in my view it is unethical and inappropriate to use limited acute care resources for the purpose of allowing patients without acute care needs to wait at length for their preferred long-term care option to become available. For this reason, for example, the Alberta Access and Waitlist Management policies leave only a 48-hour time window for patients and families to consider offers for Temporary Designated Living options.[32]

47. Finally, Dr. Sinha asserts that, under Bill 7, people "will live their last days" in a home they did not choose.[33] Patient choice should remain a paramount consideration in disposition planning for patients. However, given that the significant waitlists for preferred homes will often dramatically exceed the life expectancy for many patients, these homes will simply not be realistic discharge options in many circumstances. As Dr. Sinha and his colleagues

[31] Dr. Sinha's affidavit at paras. 58-62.
[32] Online: <https://extranet.ahsnet.ca/teams/policydocuments/1/clp-designated-living-option-access-waitlist-mgmt-continuing-care-hcs-117-01-procedure.pdf>.
[33] See Dr. Sinha's affidavit at para. 56.

highlight, many of these patients will die in the hospital with an ALC-for-LTC designation, which is also not in keeping with their wishes.

48. Similarly, while there is truth to Dr. Sinha's arguments that there clearly are some patients whose clinical needs go unmet in our current system, the reality in Canada is that acute hospital care (and even attempted rehabilitative care) for frail patients near the end of life is almost certainly overprovisioned compared to our international peers, resulting in acute care costs and usage in the last six of months of life that exceed even the United States.[34] I would agree that there is clearly a need for broader use and cultural acceptance of high-quality palliative care.[35] In my view, however, such efforts should be pursued, not instead of the measures in Bill 7, but in addition to them.

49. To conclude, I believe public health care in Ontario, including acute care hospitals, are an essential public service where good management and appropriate use of resources are critical to ensuring maximal health and social benefits for all Ontarians. Healthcare access is a central tenet of quality care and the ALC crisis is significantly and immediately impairing accessibility and compromising the care available to Ontarians. Multi-faceted interventions are required to immediately address all aspects of this situation. The solutions suggested by the physicians relied on by the Applicants are obviously critical to consider and potentially to implement; however, these measures should be pursued in parallel with the measures in Bill 7 rather than as distinct alternatives.

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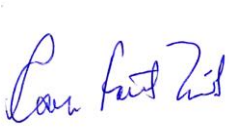
[34] *Ontario*'s *Long-Term Care COVID-19 Commission: Final Report*: <https://files.ontario.ca/mltc-ltcc-final-report-en-2021-04-30.pdf>.

[35] Lucas Vivas & Travis Carpenter, "Meaningful futility: requests for resuscitation against medical recommendation" (2021) 47(10) J Med Ethics 654, online: <https://pubmed.ncbi.nlm.nih.gov/32332150/>, DOI: <10.1136/medethics-2020-106232>.

50. I do not think it is hyperbole to state that a failure to immediately and effectively address the ALC problem could have deadly implications for some patients. Access concerns have already resulted in some high-profile deaths in patients awaiting care in emergency departments. In my view, the measures implemented by Bill 7 are part of the response necessary to address this challenging issue.

SWORN BEFORE ME in the City of Toronto by Travis Carpenter at the City of Toronto before me on February 21, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.



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Commissioner for the Taking of Affidavits

.....

DR. TRAVIS CARPENTER

This is **Exhibit "A"** referred to in the Affidavit of **Dr. Travis Carpenter,** sworn this 21st 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)

TRAVIS CARPENTER MD MPH FRCPC

Education

2018 **Master of Public Health** (2018)
- TH Chan School of Public Health, Harvard University – Boston, MA

2017 **Fellowship in General Internal Medicine** (PGY4-5)
- Department of Medicine, University of Toronto – Toronto, ON

2015 **Residency in Internal Medicine** (PGY1-3)
- Department of Medicine, University of Toronto – Toronto, ON

2012 **Doctor of Medicine**
- Faculty of Medicine and Dentistry, University of Alberta – Edmonton, AB
- Top graduate 2012 MD class, Moshier Memorial Gold Medal and Alberta Premier's Silver Medal recipient

2008 **Bachelor of Science**, Major in Microbiology & Immunology
- Faculty of Science, Dalhousie University - Halifax, NS
- Top baccalaureate graduate, Governor General's Silver Academic Medal recipient

Citizenship

Canadian / Canada
Manitoba Métis Federation / Red River Métis

Employment Experience and Academic Appointments

2020-Present	Assistant Professor, Temerty Faculty of Medicine, University of Toronto (Toronto, ON)
2023-Present	Research Fellow, School of Public Policy, University of Calgary (Calgary, AB)
2016-Present	Staff Physician, St. Joseph's Health Centre and Unity Health Toronto (Toronto, ON)
2016-Present	Associate Staff Physician, Trillium Health Partners (Mississauga, ON)
2017-2020	Lecturer and Clinician Teacher, Department of Medicine, University of Toronto (Toronto, ON)
2017-2018	Clinical Associate Physician, Sunnybrook Health Sciences Centre (Toronto, ON)

Leadership Positions

2021-Present **Health Policy Committee - Ontario Medical Association**
- Chair (2023-present), Committee member (2021-2023)
- Committee provides member oversight and input into OMA's health policy activities on behalf of Ontario's 43,000 physicians, medical students and retired physicians

2020-2023 **Council on Anti-racism, Equity and Social Accountability (CARESA) - Unity Health Toronto**
- Representative and council member
- Committee provides input and evaluation of institutional efforts to advance anti-racism, equity and social accountability in patient care, research and human resources policy

2019-Present **Site Director, General Internal Medicine Quality Improvement Network (GeMQIN) - Health Quality Ontario + Unity Health Toronto + GEMINI Research Collaborative**
- St Joseph's Health Centre lead for analysis, evaluation and quality improvement activity within Department of Medicine

- Local manager of GEMINI database for care patterns and patient outcomes

2017-2022 **Family Medicine Trainee Lead, Department of Medicine Education Council, Department of Medical Education, Research & Scholarship - SJHC, Unity Health Toronto**

- Appointed as clinical education director for family medicine residents

2017-2021 **Undergraduate Program Trainee Lead, Department of Medicine Education Council, Department of Medical Education, Research & Scholarship - SJHC, Unity Health Toronto**

- Appointed as clinical education director for medical (MD) students and physician-assistant (PA) students

2019-2020 **Challenging Behavior Project: Medicine Steering Committee – SJHC, Unity Health Toronto**

- Committee representative for improving clinical identification, documentation, and management of delirium and cognitive impairment, specifically challenging and physically violent behaviors

2016-2018 **QI Consultant, ED Return Visit Quality Program Working Group - Health Quality Ontario**

- Committee representative charged with planning and organizing a qualitative program-wide evaluation of the ED RVQP and its effect on promoting continuous quality improvement in Ontario emergency departments (see Research Section below)

Recent Publications, Periodicals and Posters

2023 **Confronting the Alternate Level of Care (ALC) Crisis with a Multifaceted Policy Lens**
School of Public Policy Publications (University of Calgary)
https://www.policyschool.ca/wp-content/uploads/2023/06/HSP112-Brief.ConfrontCareCrisis.pdf

2023 **A Systematic Review of Models of Follow-up Care for Survivors of Childhood Cancer: The Role of Policies and Guidelines in Guiding Future Care in Canada (Poster)**
CAPO Conference – Co-designing Psychosocial Oncology: Optimizing Outcomes for All
June 2023, Montreal QC

2022 **Incrementalism likely an enemy of our health system this winter**
Toronto Star
https://www.thestar.com/opinion/contributors/incrementalism-likely-an-enemy-of-our-health-system-this-winter/article_4d8f91dd-7fd6-501b-b4bf-011a4b1c3ad7.html

2022 **Understanding how deferred consent affects patient characteristics and outcome: an exploratory analysis of a clinical trial of prone positioning for COVID-19**
Journal of Clinical Epidemiology
https://pubmed.ncbi.nlm.nih.gov/36273771/

2022 **Prone positioning of patients with moderate hypoxaemia due to covid-19: multicentre pragmatic randomised trial (COVID-PRONE)**
BMJ
https://www.bmj.com/content/376/bmj-2021-068585

2021 **Advocate or Allocate (or both)? What are the ethical responsibilities of the medical profession during and after the COVID-19 pandemic?**
Canadian Family Physician
https://www.cfp.ca/news/2020/10/30/10-30

2021 **Convalescent plasma for hospitalized patients with COVID-19: an open-label, randomized controlled trial**
Nature Medicine
https://www.nature.com/articles/s41591-021-01488-2

2021 **Value-Based Mental Health Services for Youth and Families: The Role of Patient-Reported Outcome Measures in Youth Mental Health Services**
School of Public Policy Publications (University of Calgary)
https://www.policyschool.ca/authors/travis-carpenter/

2021 **Patient-Reported Outcome Measures for Youth Mental Health Services: A Scoping and Qualitative Review**
Quality of Life Research
https://rdcu.be/dl9He

2020 **Exploring clinician experience with virtual care for pediatric concussion during the COVID pandemic (Poster)**
2020 Children's Healthcare Canada Conference
https://www.ucalgary.ca/labs/brain-injury-research-children/about/conference-presentations

2020 **Meaningful Futility: Requests for Resuscitation Against Medical Recommendation**
Journal of Medical Ethics
https://jme.bmj.com/content/early/2020/04/24/medethics-2020-106232

2020 **Ethical Arguments Against Coercing Provider Participation in MAiD (Medical Assistance in Dying) in Ontario, Canada**
BMC Medical Ethics
https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-020-00486-2

2020 **Primary Care Physician Compensation Reform: A Path for Implementation**
School of Public Policy Publications (University of Calgary)
https://www.policyschool.ca/authors/travis-carpenter/

2020 **Military help lays bare how misplaced health care priorities have harmed our seniors**
Toronto Star
https://www.thestar.com/opinion/contributors/2020/05/28/military-help-lays-bare-how-misplaced-health-care-priorities-have-harmed-our-seniors.html

2020 **Lack of leadership to limit "futile" end-of-life care leaves Canada hamstrung in COVID-19 pandemic**
Journal of Medical Ethics Blog
https://blogs.bmj.com/medical-ethics/2020/04/29/lack-of-leadership-to-limit-futile-end-of-life-care-leaves-canada-hamstrung-in-covid-19-pandemic/

2019 **Should the United States Create a Human Right to Health Care?**
The Regulatory Review
https://www.theregreview.org/2019/07/02/carpenter-should-united-states-create-human-right-health-care/

Recent Research and Quality Improvement Experience

2023-Present **Evaluating the effect of a peer-comparison feedback letter on antimicrobial use in hospital-based physicians** *(Co-investigator)*
- Grant Funding: $300,000 CAD – *CIHR Priority Announcement (Early Career Researcher Antimicrobial Resistance Multi-Year Grant Priority Announcement)*
- Pragmatic, parallel arm cluster randomized controlled trial to determine whether peer comparison audit and feedback on antimicrobial use is effective in safely reducing the volume of antimicrobials prescribed

2023-Present **Patient & Caregiver Priorities for Quality Improvement on General Medical Wards** *(Co-principal investigator)*
- Qualitative research project using group concept mapping to explore the patient and caregiver experience on general medical wards and create a map of key concepts to identify top priorities for quality improvement

2023-Present **Antibiotics for Delirium in Older adults with No clear Urinary Tract infection [A-DONUT]** *(Co-investigator)*
- Randomized controlled trial to examine if adults (aged 60 or older) with delirium and suspected urinary tract infection benefit from taking antibiotics

2023-Present **paxloviD For the prEvention of LoNg coviD (DEFEND)** *(Co-investigator)*
- Randomized controlled trial to study the effectiveness of Paxlovid as a preventative therapy related to serious long-term cardiovascular conditions

2022 – Present **Investigating variation in the inpatient allocation of scarce COVID-19 therapeutics: Equity and Clinical Outcomes** (*Co-investigator*)
- Grant Funding: $400,000 CAD – *CIHR Pandemic Preparedness and Health Emergencies Research Priority Announcement*
- Health services study to investigate whether medication use varied across Ontario geographic regions or hospitals or whether treatment allocation was influenced by patient sociodemographic characteristics, such as age, sex, disability, homelessness, or neighbourhood marginalization measures
- Study will also analyze whether inequities in medication allocation can help explain the large sociodemographic disparities in clinical outcomes associated with COVID-19

2022 - Present **Understanding the effects of hospital capacity strain on quality of hospital care for patients admitted to medical and ICU wards during the pandemic and evaluating interventions to mitigate hospital capacity strain** (*Co-investigator*)
- Grant Funding: $500,000 CAD – *CIHR Health Services and Policy Research*
- Health services study of acute care institutions in Ontario to investigate how hospital strain and two major capacity-mitigating interventions (large-scale inter-facility transfers and extended ICU care onto medical wards) affected quality of care for hospitalized ICU and medical patients with and without COVID-19

2022 - Present **Understanding how COVID-19 has Affected Hospital Performance** (*Co-investigator*)
- Grant Funding: $500,000 CAD – *CIHR Health Services and Policy Research*
- Health services study of acute care institutions in Ontario to investigate how the COVID-19 pandemic caused additional operational and financial stress on hospitals and will be focused on analyzing the effect of COVID-19 on the administrative and clinical capabilities of hospitals across Ontario

2022 - Present **Improving the recognition and care of patients with long-term health complications of COVID-19** (*Co-principal investigator*)

- Grant Funding: $500,000 CAD – *CIHR Project Grant*
- Population study of Ontario COVID-19 patients to develop prediction models for development of clinical conditions, types and quality of care patients receive in hospital, their long-term patterns of health care needs including end-of-life care, and their risk of death following discharge from hospital with COVID-19 infection

2022 - Present **Prospective evaluation of artificial intelligence tools that predict and identify delirium in the setting of the COVID-19 pandemic** (*Co-principal investigator*)

- Grant Funding: $100,000 CAD – *CIHR Priority Announcement Funding*
- Large database study to prospectively validate and investigate socioeconomic and demographic bias in artificial intelligence (AI)-based delirium identification and prediction tools

2020-Present **The GEMINI Hospital Cohort Study** (*Co-principal investigator*)

- Grant Funding: $18,000 CAD – *Unity Health Toronto and GEMINI*
- Large database study to address research areas for medical and intensive care patients in hospital including: standardizing and assessing quality of data for research across multiple hospitals, characterizing populations of hospitalized patients and examining variation, predicting and modeling clinical outcomes and resource use for patients, and quantifying the association between organizational aspects of hospital care (e.g. staff scheduling, ward organization, infection control practices, etc.) and resource use and clinical outcomes

2022-Present **Effect of a Government Emergency Order on ALC Demographics in Ontario Hospitals** (*Principal investigator*)

- Grant Funding: $25,000 CAD – *Unity Health Toronto*
- Large database study to analyze the changes in demographics of hospital patients in Ontario in response to emergency order *Ontario regulation 272/21* during the COVID-19 pandemic, estimate the overall impact on province-wide hospital operations as a result of the order, and to discuss implications from a policy perspective

2021-Present **Diabetic ketoacidosis from New SGLT2i: Can Genomics Estimate Risk - the DaNGER study** (*Co-principal investigator*)

- Multi-centre case-control clinical study to identify genetic variants associated with SGLT2 inhibitor-associated diabetic ketoacidosis

2021-Present **Aligning Alberta's GP to Specialist Referral Pathways with Best Practices for Patient Empowerment** (*Co-principal investigator*)

- Qualitative evaluation of how to improve patient-centeredness and effectiveness of GP-to-specialist referral pathways / gatekeeping in Alberta

2020-2022 **The Demography and Policies of Alternate Levels of Care** (*Co-principal investigator*)

- Population study of demographics of ALC patients in Canadian hospitals and policy review of ALC mitigation strategies in Canada and abroad

2020-2022 **Healing Healthcare Inequities in Chronic Pain: Key Considerations for the Implementation of the Alberta Pain Strategy** (*Co-principal investigator*)

- Qualitative study to identify existing inequities in chronic pain treatment and opportunities for the promotion policy considerations to address challenges in accessing care due to systemic, organizational, and cultural barriers

2019-2021 **Exploring Clinical Decision-Making in Pediatric Concussion and the Impact of the COVID-19 Pandemic** (*Co-principal investigator*)

- Qualitative project focusing on evaluating provision of pediatric concussion services in Ontario, Alberta and British Columbia
- Project completed qualitative interviews (of physicians, occupational therapists and physiotherapists in the three provinces) to explore factors that guide how healthcare professionals manage pediatric concussion, understand perspectives on recent clinical practice guidelines and resulting changes in practice, and to explore the impact of the COVID-19 pandemic on healthcare practices, including the provision of remote telehealth/telerehab services.

2019-2021 **Value-Based Mental Health Services for Youth and Families: the Role of Patient-Reported Outcome Measures in Youth Mental Health Services** (*Co-principal investigator*)

- Research study to map literature on PROMs and PROMIS measures being used in YMH services, describe youth perspectives on three of these measures (using qualitative interviews), and advance the policy discussion on the importance of PROM utilization to evaluate and guide provision of YMH services in Alberta

2020-2021 **CONCOR-1: A Randomized, Open-Label Trial of CON valescent Plasma for Hospitalized Adults With Acute CO VID-19 R espiratory Illness** (*Co-investigator*)

- Multi-centre randomized controlled trial to assess efficacy of convalescent plasma in treatment of acute COVID-19 infection

2020-2021 **COVID-PRONE** (*Co-principal investigator*)

- Multi-centre randomized controlled trial to assess efficacy prone positioning in treatment of acute COVID-19 infection in non-intubated patients

2019-2020 **Primary Care Physician Compensation Reform: A Path for Implementation** (*Co-principal investigator*)

- Conducted research review and analysis of attempts at primary care payment reform in the Canadian context, specifically transitions to Alternative Payment Plans as replacements for Fee-For-Service billing
- Project provided policy recommendations and framework for Alberta government pursuing APP reform with its primary care physicians

2019-2020 **Nurse Practitioner Integration into Primary Care: Policy Challenges for Alberta's Primary Healthcare Transformation** (*Co-investigator*)

- Qualitative project to describe the policy environment surrounding and supporting NPs in Alberta's primary care environment
- A policy analysis and interviews were conducted with primary care physicians, NPs, and PCN Executive Directors to understand the challenges and benefits in having more NPs in primary care in the context of recent government policy changes

2018-2020 **How does context shape the process of discharging homeless patients from hospitals in Toronto, Canada?** (*Co-investigator*)

- Multi-centre qualitative research study to delineate the underlying mechanisms and structures that shape and influence the process of hospital discharge for homeless patients, aiming to provide information to create more effective discharge plans for homeless patients leaving acute inpatient care

2016-2018 **ED Return Visit Quality Program, Health Quality Ontario**

- Involved in design and planning of program-level evaluation of effectiveness of province-wide ED Return Visit Quality Program. The ED-RVQP is designed to support institutional and regional-level quality improvement

initiatives to improve emergency department quality-of-care with the aim of reducing repeat ER visits, especially for sentinel diagnoses of interest
- Evaluation program was designed to leverage both qualitative and quantitative data from interviews with staff from participating institutions
- Summary report delivered to HQO in November 2018

2016-2017 **Reducing Readmissions with a Post-Discharge Follow-up Clinic**
(*Principal investigator*)
- PGY-5 quality improvement project and leadership role in reorganization of outpatient GIM clinics at University Health Network / Toronto General Hospital with goal of increasing utilization of outpatient clinic, improving patient safety, improving patient satisfaction, and reducing readmission rate
- Maintained and analyzed activity metrics to develop strategies to target patients likely to benefit from outpatient reassessment after discharge
- During first 6 months of patient encounters, our group successfully reduced department-wide readmission rate from pre-intervention average of 15.4% to 11.8% (3.6% absolute reduction, 23% relative reduction); likely minimum annual cost savings of estimated $1.8 million

Resident Teaching Evaluation Summaries:

Full teaching effectiveness reports available on request for indicated academic years. Median scores for all teaching effectiveness subcategories have been 5 out of 5 for the past six academic years.

2022-2023 Overall Teacher/Faculty Rating:
- Mean 4.78 / 5
- Median 5 / 5
- Selected Comments:
  "Discussed other aspects of medicine such as interpersonal relationships and professionalism, great reminder for how to conduct myself as a resident and physician"
  "Great teacher, very easy to approach as a learner, passionate about topics being taught, allows for independence as an R1"
  "Excellent teacher who challenges you around your specific learning goals!"

2021-2022 Overall Teacher/Faculty Rating:
- Mean 4.75 / 5
- Median 5 / 5
- Selected Comments:
  "Dr Carpenter was an excellent teacher - he is kind, approachable, invested in teaching and tailors resident learning to their areas of interest which I really appreciated. It was wonderful having him as a preceptor!"
  "Creates a very safe comfortable learning environment where learning and patient care is the top priority Always a pleasure to work with! Makes coming to work exciting and something to really look forward to! Thank you very much!"
  "What a fantastic clinical teacher. Travis was a joy to work with, so enthusiastic, learner-centred, interested in teaching, SKILLED at teaching. He made working on the weekend fun and rewarding!"

2020-2021 Overall Teacher/Faculty Rating:
- Mean 4.89 / 5
- Median 5 / 5
- Selected Comments:
  "Fantastic advocate for patients. Great role mode. great leadership. Amazing mentor."

"Excellent teacher. Gives pragmatic advice."
"Very respectful and tailors to learner's own goals. Friendly and makes learning environment very positive. Really enjoyed the overall mentorship as well."

2019-2020 Overall Teacher/Faculty Rating:

- Mean 4.75 / 5
- Median 5 / 5
- Selected Comments:
  "Dr. Carpenter is exceptionally friendly, supportive, accommodating. He is an excellent teacher, a skilled clinician and truly a great mentor and role model. I hope that I can maintain such positive, kind demeanour when I am working independently. He is a complete pleasure to work with!"
  "Extremely enjoyable to work with. Appreciate him taking time to teach. Excellent preceptor; supportive of resident learning"

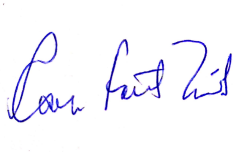
2018-2019 Overall Teacher/Faculty Rating:

- Mean 4.67 / 5
- Median 5 / 5
- Selected Comments:
  "Enthusiastic and truly excellent teacher and clinician, very supportive and encouraging, great role model"
  "Dr. Carpenter is an exceptional role-model. He practices GOOD medicine, and encourages residents to do the same, without cutting corners. He is always able to highlight key learning points from cases seen and expands with teaching around the topic. He is very validating and that is appreciated by residents. He builds our self-confidence in this way. He stimulates learning with provocative questions."

2017-2018 Overall Teacher/Faculty Rating:

- Mean 4.5 / 5
- Median 4.5 / 5
- Selected Comments:
  "Dr. Carpenter is an exceptional role model, educator, clinician and collaborator. Dr. Carpenter takes numerous opportunities to teach. When on call he comes in early, reviews cases and asks if there is anything you would like to learn. He takes this opportunity to give individualized teaching. He also does daily teaching during rounds both around cases as well as eliciting student learning goals. He encourages students to take a broad perspective, which is a great strength and shows great flexibility. Acknowledges his own perspective on management but encourages students to recognize that there is more than one valid way to approach a problem. As such he encourages students to state their perspectives and manage according to their style within appropriate limits."
  "Dr. Carpenter creates a supportive work environment. He shows collegiality towards his fellow physicians and interdisciplinary staff. Through building these relationships he is able to collaborate well with others and advocate for patient care. He ensures that students are comfortable and is mindful of encouraging learners to have work-life balance. He is extremely accessible and approachable, which as an off service student made me feel much more comfortable managing patient issues as they arose. Overall, Dr. Carpenter was an excellent preceptor, who showed passion for the profession, patients and learners. Was such a pleasure working with him and I learned a great deal. Thank you for a wonderful rotation!"

This is **Exhibit "B"** referred to in the Affidavit of **Dr. Travis Carpenter,** sworn this 21st 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)

Briefing Paper
Volume 16:21
June 2023

UNIVERSITY OF CALGARY | THE SCHOOL OF PUBLIC POLICY

CONFRONTING THE ALTERNATE LEVEL OF CARE (ALC) CRISIS WITH A MULTIFACETED POLICY LENS

Stephanie Durante, Ken Fyie,
Jennifer Zwicker and Travis Carpenter

http://dx.doi.org/10.11575/sppp.v16i1.76748

CONFRONTING THE ALTERNATE LEVEL OF CARE (ALC) CRISIS WITH A MULTIFACETED POLICY LENS

**Stephanie Durante, Ken Fyie,
Jennifer Zwicker and Travis Carpenter**

EXECUTIVE SUMMARY

Dual demands for increased provision of acute episodic care in hospital and chronic care in the community have contributed to an ALC crisis in Canadian hospitals, where large numbers of patients are boarded in acute-care beds rather than in environments more appropriate for their required level of care. Addressing this crisis will be one of the most profound challenges facing provincial health systems in Canada over the coming decades.

This paper outlines the magnitude and complexity of confronting this growing crisis as well as defining a paradigm through which to explore and implement policy solutions along the entire continuum of challenges.

ALC as an administrative designation aggregates diverse groups of patients covering a wide spectrum of demographic variables, medical diagnoses, social circumstances, discharge destinations and other characteristics, all of which can affect how and when ALC is coded. It is itself a significant challenge to collect consistent, accurate and adequately granular data to inform the design and implementation of policy reforms. With this in mind, a dominant association between advanced age and markedly higher ALC rates needs to be acknowledged and highlights that solutions to the ALC crisis will be significantly interwoven with addressing previously described challenges for the overall health system with an aging population.

Clinically and operationally, ALC is a complex health-system issue that reflects and presents challenges from admission, throughout a patient's hospital stay and after discharge. This paper outlines a holistic approach to categorizing policy interventions that address obstacles along this continuum, describing potential interventions in each phase. To achieve success, policy approaches must incorporate multi-faceted interventions into the overall context and systematize them to prevent, mitigate the burdens of, and improve the management of ALC.

INTRODUCTION

Alternate level of care [ALC] is used in Canada to define patients who occupy a bed in an inpatient setting but no longer need acute-level inpatient care.[1] At any given time, ALC patients in Canada occupy between 10 and 20 per cent of beds in acute-care centres, overall representing 17 per cent of all acute-care bed-days in Canada in 2020-2021 (Canadian Institute of Health Information 2022). Such patients are most often treated in acute care for illness or injury but are subsequently unable to be discharged home as their clinical condition mandates a need for some alternate form of care such as transfer to a long-term care (LTC) facility, discharge home with support (home care) or transfer to a specialized care facility (such as a rehabilitation, psychiatric or complex care facility), etc. In other cases, ALC patients may have been admitted predominantly for social reasons, when an acute medical condition may not have been present per se, but certain circumstances force patients and caregivers to turn to an emergency department due to a real or perceived failing of social services or lack of adequate community supports.

Sadly, mismanagement of ALC care has resulted in intentional and unintentional de-prioritization of this cohort of patients (McCloskey et al. 2015). This suboptimal care leads to crippling inefficiency in patient flow through the health system, an ineffective use of finite acute-care resources and further backlogging of the system overall.[2] Financially, estimates suggest ALC issues cost Canada's health-care systems $5 million to $9 million a day, totalling billions of dollars a year in staffing and resources (Whatley 2020).

Tackling the ALC crisis in Canada requires multi-faceted policies and interventions that address the entire complex continuum of challenges. It is not an issue of strictly optimizing hospital stays and discharges, but rather differentiating and articulating the role of acute care while simultaneously improving integration with and the resourcing of complementary parts of the health-care system. Effectively tackling the ALC crisis requires policy changes that adequately support and improve management of acute-care resources, but also reapportions resources appropriately to necessary programs and providers outside acute care.

In many ways, Canada is uniquely over-reliant on costly acute-care providers (Roberge et al. 2010). Public, media and political fixation on acute care (and cultural touchstones like hallway medicine) results in persistent and intense pressure to fix acute care by directing ever more resources to this sector of the health-care system, while paradoxically (and counterintuitively) reducing pressure on acute care may in fact require the more effective redistribution of resources to other areas (Carpenter 2019). This reality, as well as the necessity of comprehensiveness in managing the ALC crisis, creates significant complexities and difficulties that are barriers to reform.

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[1] Around the world, terms such as delayed discharge, delayed transfer patient and bed-blocker are used to describe this type of patient (Manzano-Santaella 2010). While ALC designations can and often do exist in post-acute-care settings such as rehabilitation hospitals and complex continuing care centres, this briefing will focus on ALC-designated patients in Canadian acute-care hospitals. Guidelines for ALC designation in this setting can be found at https://www.cihi.ca/en/guidelines-to-support-alc-designation.

[2] This includes clinically detrimental outcomes such as delays and suboptimal care in overcrowded emergency departments when inpatient transfers are delayed, longer wait times for surgeries when fewer inpatient beds are available for recovery and suboptimal care when there are delays in accessing specific medical units (e.g., stroke care), etc.

Policies directing regulatory changes or resource prioritization activities are required to reduce the number of ALC patients. A comprehensive strategy with standards and policies is the ideal; however, there are many stakeholders with diverse perspectives and special interests, making policy change particularly challenging. Therefore, while the most thoughtful, broad-based and potentially effective packages of policies should always be sought and proposed, political realism may sometimes mandate a more incremental approach.

The purpose of this communication is to first describe some key considerations and challenges for policy reform and then discuss a paradigm of policy options to address the continuum of ALC challenges. Policy options should prevent, mitigate the burdens of and improve the management of ALC. Concurrently, we will highlight that ALC is a phased process, requiring multi-faceted policies and intervention in each phase.

LITERATURE

For this analysis, information regarding Canadian ALC challenges, policy development and implementation (with a primary focus on Alberta, Ontario and Saskatchewan) was obtained through a structured custom internet search of traditional and grey literature produced by government, NGOs, health authorities and health providers. Relevant literature was identified using free text and thesaurus search terms for the concepts of "alternate levels of care" and "continuing care policy" in Canada (see Appendix D). Documents were deemed relevant upon review of abstracts and/or executive summaries. The reference lists of relevant documents were used to further aid in finding literature pertaining to the scope of this piece and were reviewed for relevancy. Sources from blogs and other unestablished organizations were generally excluded, with relevant literature from government and health-care organizations retained.

KEY CONSIDERATIONS AND CHALLENGES IN ANALYSIS OF DATA FOR POLICY REFORM

When considering quantitative data or literature discussing policy reforms, it is important to acknowledge significant challenges for contextualizing this information. Patients occupying a bed in an acute-care setting who no longer need acute-level inpatient care is simple in concept; however, ALC is a complex issue to analyze and manage in large part due to the diversity in patients and circumstances. Still, population-level data analysis is an important tool to evaluate and inform policy reform. There are a number of important considerations when looking at data related to ALC policy reform, including recognition of this diversity and complexity of the population, the need for accurate and standardized coding procedures for ALC and recognition that distinguishing acute from ALC is not clear cut.

Policies must be nuanced to address that ALC aggregates groups of patients covering (with varying frequencies) a wide spectrum of demographic variables, medical diagnoses, social circumstances, discharge destinations and the like (Table 1), all of which can affect how and when ALC is coded. While all demographic nuances must be adequately addressed, the paramount association of age with increasing ALC rates represents the greatest challenge all provinces will continue to face in coming years. Over 861,000 people aged 85 and older

were counted in the 2021 Census, more than twice the number observed in the 2001 Census. By 2046, the population aged 85 and older could triple to almost 2.5 million people (Statistics Canada 2022). Of particular note is that markedly higher ALC rates exist in this cohort of patients even compared to other advanced-age cohorts (see Figures 2 and 3), highlighting the centrality of ALC issues for overall health-system management in coming years. Also, given the rapidity of change associated with these aging demographics, it may be difficult to clearly mark the goalposts for success. It can be anticipated that sometimes, simply holding the line or preventing more rapid deterioration in certain indicators may paradoxically represent significant accomplishments when taken into context.

Furthermore, while ALC designation is an important system-level distinction, at the patient level distinguishing acute from ALC is not clear cut. The concept of coding an ALC designation on a particular day during hospitalization potentially inaccurately signals a more discrete change in clinical status for patients than exists in reality. While likely necessary statistically and operationally, there is significant potential folly in sharply delineating the proportion of a patient's stay that is acute vs ALC. While this simplification may be useful as a measurement tool or operational signal, the eminent importance of actions and circumstances occurring before the designation must be kept in mind.

Introducing accurate and standardized coding procedures for ALC designations is critical for guiding policy development and directing operational management (Cancer Care Ontario 2017).[3] Comparing ALC management within and between provincial health systems must be done in the context of the stringency of which ALC is identified and designated as much as the underlying ALC rates themselves. For example, Saskatchewan's unification into one health system and introduction of standardized coding across the province in 2016 likely on its own significantly increased documented ALC rates between 2015 and 2017 (Figure 1).

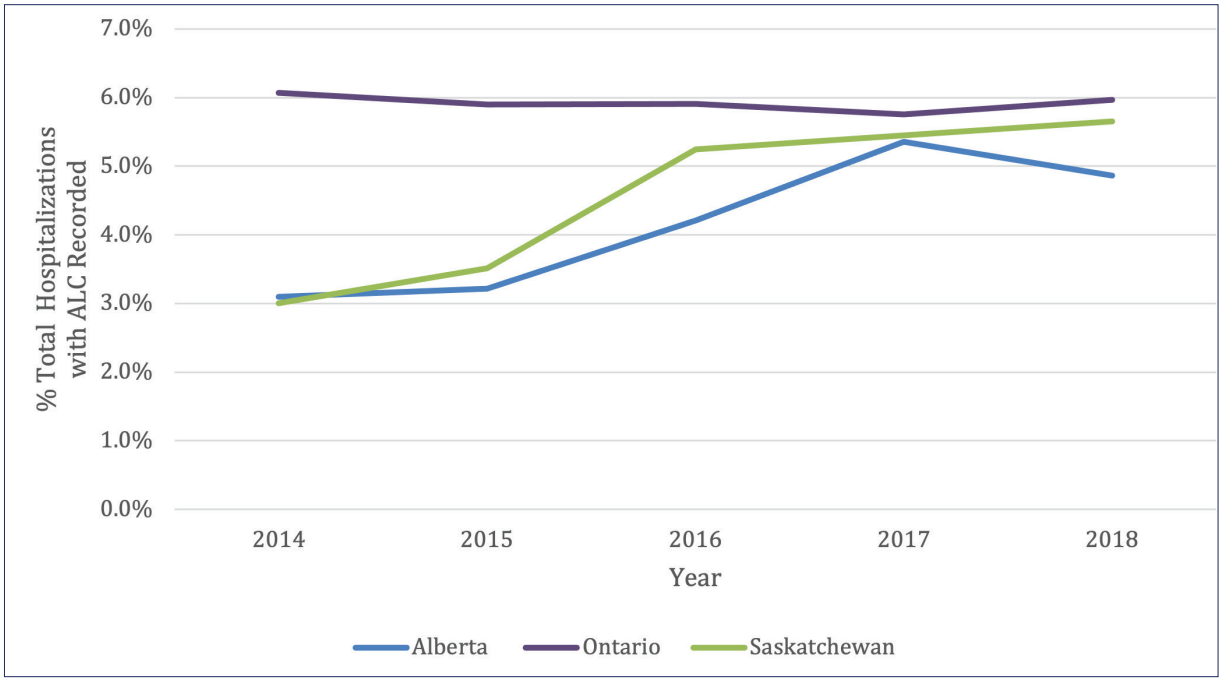
Hospitalizations with ALC recorded jumped from 3,924 in 2015 to 6,011 in 2017 (a greater than 50 per cent increase) while the overall number of hospitalizations remained roughly constant (see Figure 1 and Table 4 (in Appendix A)). These dramatic potential effects of improved recognition and coding could create an uncomfortable paradox: hospital units, institutions, health regions or even provinces with enhanced identification of patients appropriate for ALC designation may unfortunately encounter negative stigma or attention as low performers with proportionally high ALC rates. Thus, while data analysis is a critical component, analyzing overall rates of ALC in populations and the efficacy of interventions in the health-care system is fraught with difficulty.

With this in mind, working with data that are as consistent, accurate and adequately granular as possible is important to provide the insights to inform the design and implementation of policy reform. For example, in comparing Alberta and Saskatchewan with Ontario between 2014 and 2018 (using data available before the disruption of the COVID-19 pandemic), it is striking to note the relative stability of overall ALC hospitalizations in Ontario compared with the dramatic increases noted in the other provinces. Taken contextually, this discrepancy may predominantly reflect Ontario (with the lowest number of hospital beds per capita) (Ontario Hospital Association [OHA] 2019) being forced to better characterize and

[3] For more information regarding specific considerations on how hospitals are expected to code ALC accurately, please see "Guidelines to Support ALC Designation" (Canadian Institute for Health Information 2016) and "Alternate Level of Care (ALC) Reference Manual" (Cancer Care Ontario 2017).

comparatively improve management of its ALC issues earlier than other provinces. While Ontario has arguably had some verifiable success in mitigating the effects of its growing and aging population over this time period (OHA 2019) with reduced lengths of stay and hospitalization rates, the number of ALC cases and ALC bed-days overall was still noted to be rising (OHA 2019).

Figure 1: Percentage of Hospitalizations with ALC Recorded by Province

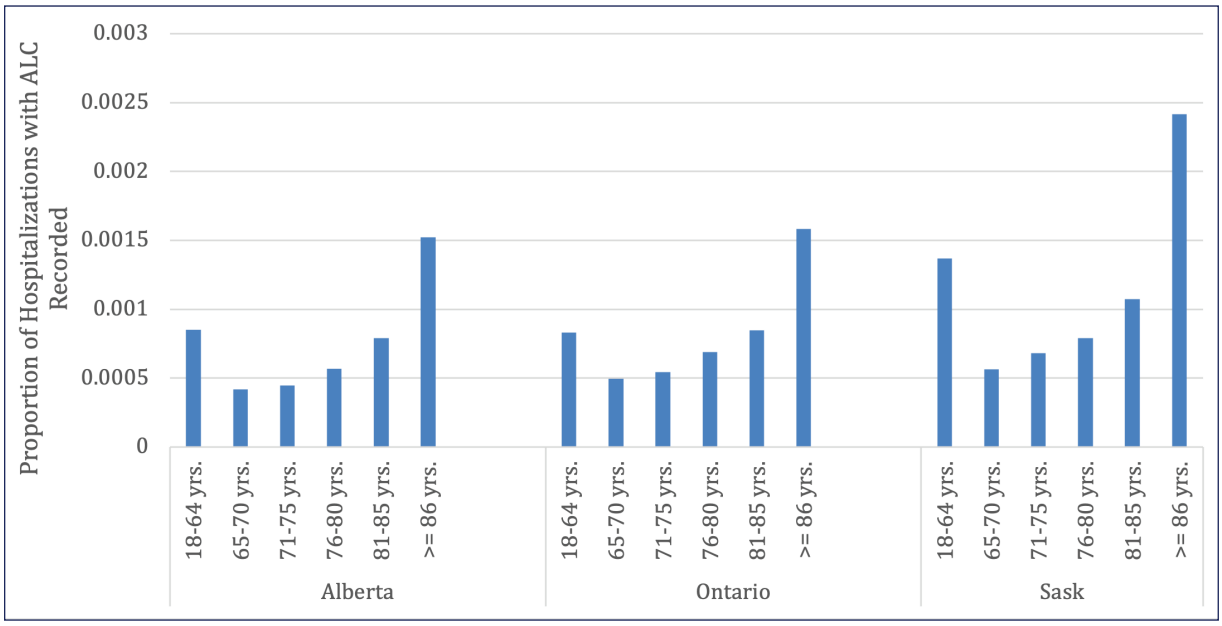


Source: CIHI

Table 1: Examples of Major Demographic Variables and their General Associations with ALC Rates

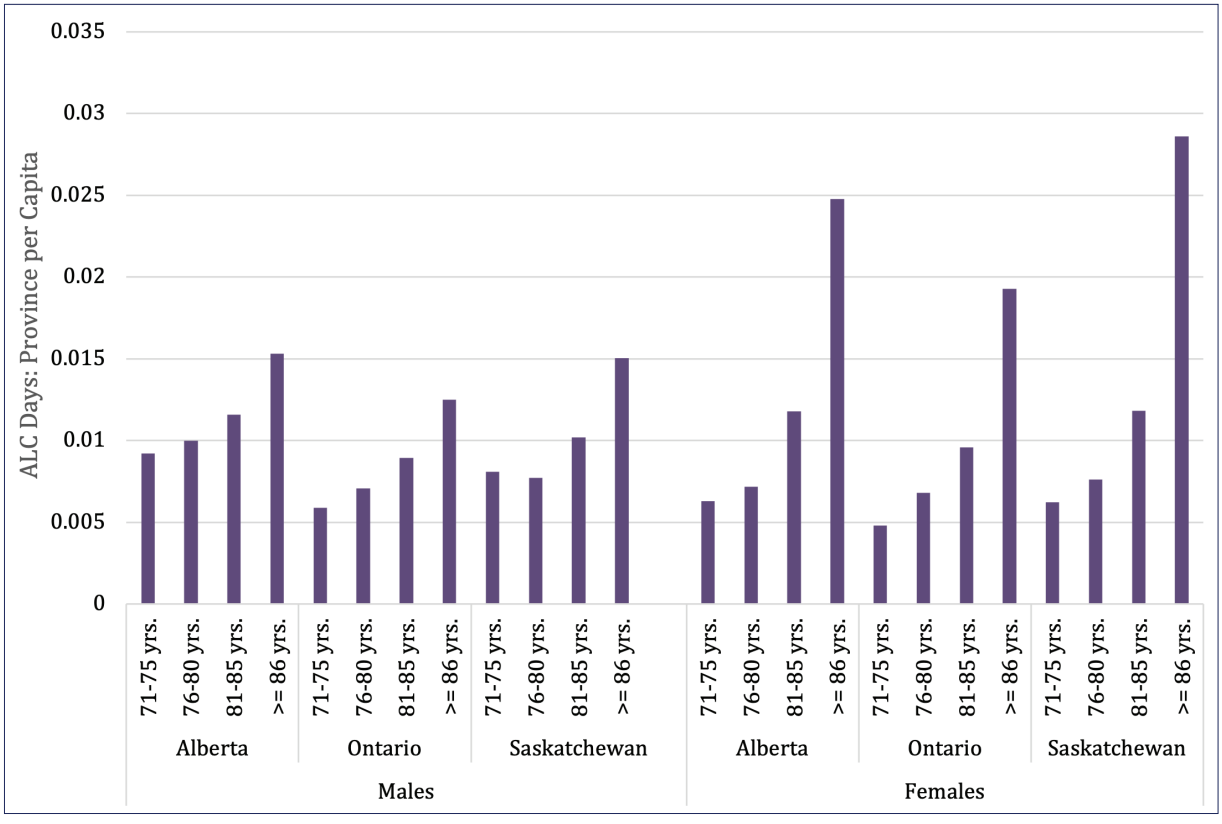
Demographic Variable	Effect on/Relationship to ALC Rates
Age	ALC rates rise dramatically in those over 80 and even more significantly in those 86 or older. This reflects the combination of increasing frailty with natural aging, accumulation of specific age-related medical diagnoses and social factors like decreasing availability of caregivers (who may become aged or unwell themselves) or dwindling financial resources late in life.
Gender	Longer lifespans in females result in a proportionally larger population of female patients in older age brackets. Also, gender-specific medical, social and behavioural needs may differentially impact ALC length of stay (Scommegna 2019).
Major Clinical Category (MCC)	ALC includes all manner of possible diagnoses; however, conditions resulting in significant long-term functional impairments including trauma, psychiatric disease and neurological disorders are consistently predominant players in driving higher ALC rates.
ALC Discharge Disposition	Patients waiting for permanent transfer into institutional care (i.e., LTC, CCC) may have long waits in hospital until an appropriate bed is available at a care facility or extremely robust home care assistance can be set up. In contrast, those whose eventual disposition is home often require less robust and less complicated or less resource-intensive supports or may even improve over their time in acute care.

Figure 2: The Proportion of Hospitalizations with ALC Recorded by Age Group (2018)



Source: CIHI

Figure 3: Comparison of ALC Days for Patients Greater than 70 y of Age by Gender and Province (2018) Standardized for Population Greater than 18 y of Age



Source: CIHI

OPPORTUNITIES AND CHALLENGES IN POLICY TO REFORM ALC MANAGEMENT

ALC is a complex issue that reflects and presents challenges from admission, throughout a patient's hospital stay and after discharge. Policies must address the flow of a patient's stay holistically rather than primarily targeting specific discrete events or being reliant on one-size-fits-all approaches. This section describes some opportunities for ALC reduction and optimization from the literature, categorized by the point of interaction in the system including ALC avoidance (upstream interventions), ALC patient flow (midstream interventions) and ALC patient discharge (downstream interventions).

1. **ALC Avoidance** includes upstream strategies to reduce ALC admissions and/or avoid unnecessary admissions. This component of ALC mitigation can be described as encompassing all strategies to overtly reduce ALC admissions and ALC inpatient days directly and/or avoid unnecessary admissions likely to result in ALC inpatient days:

    - Early recognition and intervention for patients likely to require ALC days in hospitals (including ALC avoidance frameworks; initiatives to prevent deconditioning/inpatient complications in frail patients, etc.);
    - Improving community care and supports to avoid unnecessary acute-care hospitalizations;
    - Improving outpatient supports and medical management for frail patients; and
    - Early recognition of patients who will need institutional care and improved pathways from community to institutional care.

2. **ALC Patient Flow** includes strategies that target improving patient flow, improving efficiency and reducing the length of ALC stays:

    - Paradigm shifting to change perceptions of risk and increase tolerance of risk;
    - Early and enhanced discharge planning;
    - Reformed/increased bed charges;
    - Stricter policies for choosing discharge destinations and improved long-term care wait-list management;
    - Increased use of activity-based funding models; and
    - Increased provision of ALC-specific inpatient units and reactivation centres.

3. **ALC Patient Discharge** includes practices that focus on facilitating effective, timely and durable discharges:

    - Increased provision of transitional care settings;
    - Increased provisions of supports, financial incentives and home-care services to allow patients to avoid institutional care;

- Increased provision of long-term care; and
- Increased provision of palliative care services and advanced care planning to avoid low utility care usage at end of life.

To effectively reduce ALC stays will require policies optimizing ALC avoidance, ALC patient flow and ALC patient discharge interventions. In the section below, we discuss some promising practices from the literature to guide policy reform.

ALC AVOIDANCE (UPSTREAM INTERVENTIONS)

Health systems have increasingly shifted to implement operational interventions and frameworks aimed at decreasing length of stay and directly or indirectly avoiding ALC. Such strategies generally affect reducing ALC stays by expediting discharge timing and processes and early identification of patients requiring increased supports, as well as prompt discharge home of patients presenting for predominantly social reasons (National Health Services [NHS] England n.d.a; Siddique et al. 2021). Such strategies can be devised and implemented either locally or at the system level.

Local adaptation allows organizations to build their ALC avoidance plan accounting for their own quality challenges, strategic goals and values, which supports a more effective alignment with operations. For example, in 2014 the former Toronto Community Care Access Centre [CCAC] and subsequent Local Health Integration Network [LHIN] introduced a process to allow local providers to develop tailored initiatives (structured ALC avoidance frameworks) aimed at ALC reductions. This included enhanced transition planning during the acute phase of illness, proactively supporting patients at high risk of an ALC designation and ensuring expectations were clearly communicated to substitute decision-makers [SDMs]. As a result, ALC avoidance frameworks were developed for acute care, post-acute care, regional cancer centres, mental health and addiction facilities (Burr and Dickau 2017). In a similar vein, NHS England implemented a national strategy and campaign (the Reducing Length of Stay Programme), establishing a directorate to provide strategic direction and support local delivery (NHS England n.d.a). This included system-level enhancements in clinical leadership, evaluation and communication to drive engagement and move the program forward, as well as mandating specific actions for local providers, including planning for discharge from the start of admissions, involving patients and SDMs in discharge decisions, establishing systems for accommodating frail patients and embedding multidisciplinary team patient reviews (NHS England n.d.b).

ALC reduction can also significantly benefit from broader clinical initiatives to improve the quality of specific areas of inpatient care with differential impacts on ALC rates. For example, immobility and deconditioning during hospital stays frequently result in rapid and potentially irreversible functional declines in frail patients, with activity and exercise shown to help in recovery and contributing to reduced length of stay in hospitals (Arora 2019). Given that ALC designation predominantly reflects functional impairment in the context of medical stability, the importance of leveraging concurrent initiatives to improve inpatient care quality and minimize preventable harm and complications that result in new or prolonged functional impairments cannot be understated in the management of ALC issues overall.

More comprehensive and effective community care can also aid in avoiding ALC stays. Patients requiring home care and lacking appropriate social supports (especially when combined with high levels of frailty), who subsequently present to hospital, are at high risk of poor outcomes (Andrew 2016) including potentially long lengths of stay and ALC designation (Muratov 2019). In this setting, increased ALC burdens resulting from inadequate social support or home-care provision are a consequence both of an increase in admissions for social reasons overall and increased acute-care usage due to complications incurred because of these unnecessary admissions. The necessity of caring for dramatically increasing populations of sicker, frailer individuals at home requires resource re-alignment to allow community service providers to enhance the services they provide and strengthen their role in the continuum of care, hopefully reducing pressures on acute care in the process (Walker 2011).

Such measures must be suitably designed to account for reducing (not increasing) stresses on overburdened caregivers and on home-care providers (who may be more vulnerable to human resource shortages than acute care and may struggle to deliver more complex services required by sicker, more complex patients). This includes the need to introduce new models of care to address patients whose care needs exceed current service maximums but who cannot or should not yet be placed in long-term care. Examples may include expanded assisted living/supportive housing capacity, homemaking services, caregiver support and respite programs, day programs for seniors with dementia and other behavioural issues, outreach teams and similar services. Significant benefit could also likely be realized by supporting informal caregivers who may already provide 80 per cent of all care given to seniors in the community and 30 per cent of services to seniors in institutions, potentially saving the health system billions annually (CARP 2016). Again, however, leveraging informal caregivers further in this regard may be difficult to do effectively given that many are already under heavy psychosocial stresses and may be limited in their capacity to contribute further without significant additional outside resources and support (Health Quality Ontario 2016).

Targeting unnecessary admissions resulting from inadequate provision of outpatient medical care is also highly desirable from an ALC management perspective. Historically, access to both primary care (Mangin 2022) and specialty care (Liddy 2020) has been comparatively poor in Canada, making Canadians uniquely dependent on emergency departments and acute care (Roberge et al. 2010). Given the inverse association between accessibility and quality of primary health care with preventable hospitalizations (Rosano 2013), especially for frail patients with high health-care usage (Muratov 2019), all Canadian jurisdictions face considerable risk with an accelerating capacity crisis in primary care coupled with increased frail and elderly populations. In Ontario, 1.8 million patients have lost their family physicians since the start of 2020 and 1.7 million patients are attached to a family physician 65 or older, threatening dramatic and crippling losses of access in coming years (Mangin 2022). In this setting, patients and caregivers will be forced to seek less appropriate and more expensive health-care services in emergency rooms and hospitals (Donner 2015).

From an ALC management perspective, making imminent reforms to the primary care system is imperative to reduce hospitalizations overall and the negative consequences of unnecessary hospitalization (which both result in increased ALC burdens). It is important to note that Canadians' notorious difficulty accessing specialty care (Liddy 2020), coupled with

the common gatekeeping function of (increasingly less available) family physicians with respect to specialty care, implies that outpatient specialty care is poorly positioned to step in and make up for deficiencies in primary care delivery for management of chronic conditions and preventing avoidable deterioration and hospitalization. Critically, Canada spends substantially less on primary health-care services than most comparable countries as a proportion of total health expenditure (Mangin 2022) and therefore it is imperative to preferentially redirect resources to this sector. At a strategic level, primary care should be better aligned and integrated with other sectors including community service providers and acute care (Donner 2015). This includes timely and meaningful communication between providers, and ideally, broad deployment of new team-based models of care (Mangin 2022; Purbhoo et al. 2017).

Streamlined pathways to institutional care for frail patients that are accessible and communicated to patients and families in advance can aid in appropriate decision-making and accessing required services in a timely and effective manner. For frail patients experiencing expected, protracted and unavoidable declines in function and independence (i.e., those expected to require long-term institutional care in the near future), avoidable visits to the emergency department and admissions for social reasons (Andrew 2016) are not only undesirable but in some ways inexcusable. Adequate care provision in this regard should include structured care co-ordination, including formalized triggers to reassess the patient's condition when their clinical status or circumstances change (Purbhoo et al. 2017). More proactive patient and family education about the value of discussing future care options before a patient's health fails has been highlighted as an important recommendation for many years (Burton et al. 2006). However, most formalized reassessment for LTC eligibility remains reactive to changes in health status like hospitalizations or other health crises (British Columbia Ministry of Health 2016; Purbhoo et al. 2017).

ALC PATIENT FLOW (MIDSTREAM INTERVENTIONS)

Risk management is likely one of the broadest and most difficult interventions to implement in the health-care system but is arguably one of the most important overall for ALC mitigation. Specifically, frail patients traditionally have been kept in acute care for relatively prolonged periods until many perceived risks of discharge are eliminated (Chidwick et al. 2017). Significant benefits in reducing length of inpatient ALC stays are likely to be realized by adopting the perception that living with some risk is natural and even desirable. Patients may be discharged faster when the significant risks of ongoing acute-care hospitalization (including functionality loss, nosocomial infection, decreased mental health and quality of life, etc.) are adequately considered and outweigh the perceived risks of discharge (Department of Health & Social Services 2022). Clinicians, administrators, patients and families may all weigh risks differently; therefore, establishing transparent and consistent standards of care is critical when operationalizing these concepts.

One approach to improving risk management is to implement strategies to minimize or remove decision-making processes from front-line clinical staff. In its revised *Six Change Ideas* to minimize ALC days in hospital, the William Osler Health System placed an emphasis on minimizing or removing decision-making processes from front-line clinical staff

(especially physicians) who have strong incentives to avoid conflict and risks resulting from acute-care discharges (Chidwick et al. 2017). WOHS recognized that any degree of risk after discharge made clinical staff uncomfortable and their unstated goal was often to ensure everyone felt comfortable, creating barriers to discharge by inferring to patients and families that discharge was "both negotiable and many times, ill-advised."

Unfortunately, individual institutions have limited ability to change risk management; broader governmental and regulatory reform is required. Government policies to delineate expectations and standards around discharge policies and procedures are critical to inform clinical staff and allow appropriate decision-making. In the U.K., this has included significant directives to explicitly shift assessment and monitoring responsibilities away from acute care and onto outpatient service providers, focusing on distributing and optimizing risk management across the health system (Department of Health & Social Services 2022). Crucially, regulatory colleges and organizations handling complaints must be directed to provide increased protections for inpatient providers against non-meritorious claims. Meaningful adoption of this paradigm to optimize acceptance of traditional risks will require regulators to significantly improve processes for handling complaints and legal claims, specifically requiring increased efficiency, transparency, enhanced early dispute resolution and meaningful support for practitioners that extends beyond hollow reassurances of fair processes (Ries 2021).

Early and enhanced discharge planning is an intervention already in widespread use and with wide acceptance. Prioritization of effective discharge planning for admitted patients can work to prevent discharge delays, potentially avoid an ALC designation (as discussed with respect to ALC avoidance frameworks) and create smoother patient flow (NHS England 2012; Ontario Hospital Association [OHA] 2013; Sturgess n.d). Current standards in the U.K. indicate that discharge planning should begin immediately once a patient is admitted (Department of Health & Social Care 2022). To facilitate progress thereafter, NHS England introduced red and green bed days to document and track movement towards discharge (NHS Improvement n.d.; Sturgess n.d.).

A day is designated green if interactions with health services or teams moved the patient closer to discharge and red if not. Overt visual tracking of status for patients and an impetus to see more green days were used as further motivators that contributed to some success in improving patient flow, along with concurrent use of the SAFER patient flow bundle emphasizing frequent and timely senior staff review of patient statuses (NHS Improvement n.d.; NHS England 2019; Sturgess n.d.). Similarly, the University Health Network in Toronto made early social work involvement in the emergency department for admitted patients a key plank to its local ALC avoidance framework (Burr and Dickau 2017), operationalizing longer standing provincial recommendations (Walker 2011). The effectiveness of early discharge planning typically leverages earlier determinations of what an individual needs and wants after discharge, thereby helping minimize delays directing the patient onto the discharge pathway that best meets their needs. Efficacy in this regard requires recruitment and use of specialized staff (often social workers or dedicated transition planners) with appropriate skill sets required to engage patients and families, facilitate appropriate decision-making and access community resources (Department of Health & Social Care 2022; Walker 2011). Current Ontario best-practice guidelines emphasize that outcomes are

optimized when processes ensure that patients and caregivers are included as part of the care team (Corsi et al. 2021). This may require significant resources and support to operationalize productively, including interventions to enhance health literacy, promote self-efficacy, define the hospital's role and preserve flexibility to adequately incorporate personal preferences into discharge planning.

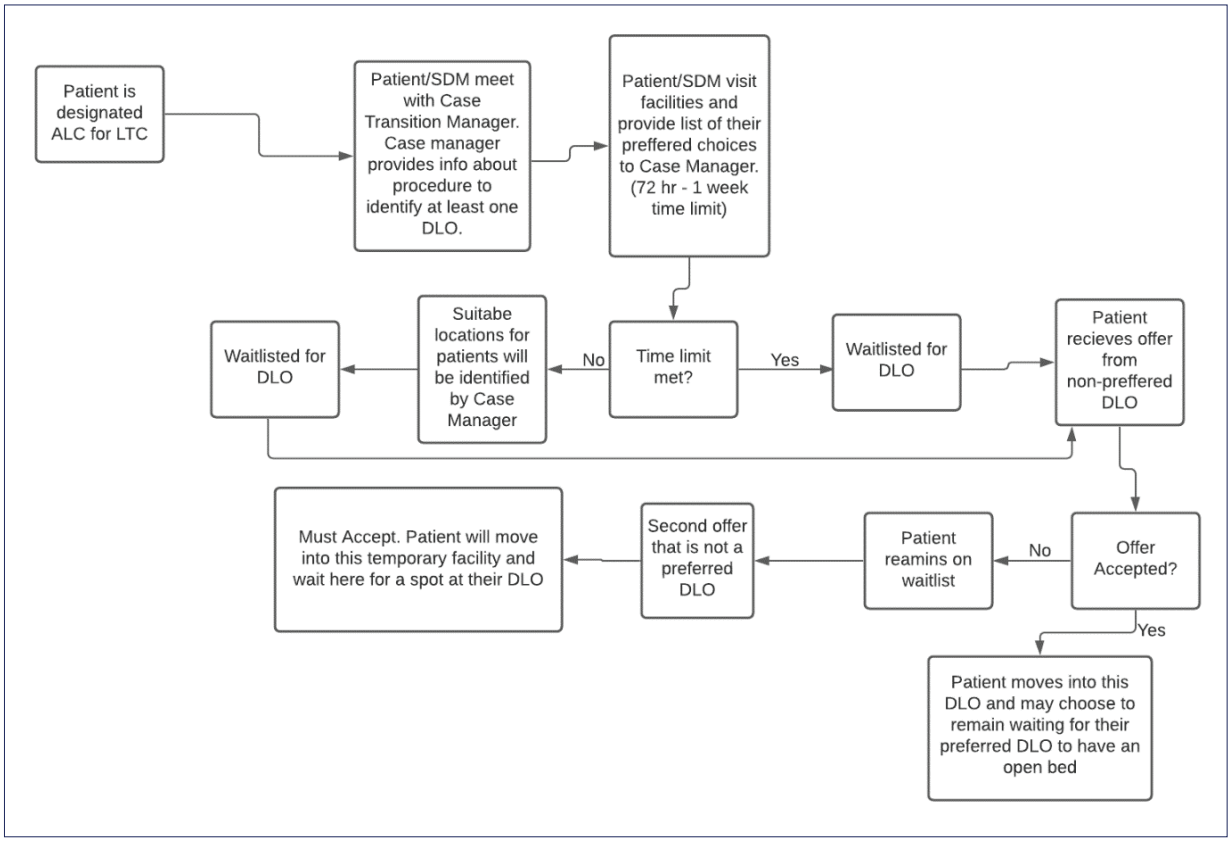
Additional fees are a politically volatile but likely necessary policy intervention. Health systems across Canada have long used daily bed charges to recoup some of the sunk resource costs resulting from ALC hospitalizations (McCloskey et al. 2015). Legal authority to do so has been permitted under the proviso that if patients are classified as no longer needing acute care, the care is deemed unnecessary under the *Canada Health Act* and is thus potentially an uninsured service (Canada 1985; OHA n.d.). However, rates are typically set equivalent to daily charges for a standard long-term care room rather than full uninsured rates for acute-care hospitalization (McCloskey et al. 2015; OHA n.d.; OHA 2012.). Using this lesser charge does potentially incentivize patient/SDM activity to search for a preferred living destination or attempting a home-first discharge compared to a scenario where hospital care remains entirely free in perpetuity. However, many patients/SDMs often make no serious objection to this charge if their desired goal is to (potentially inappropriately) remain in hospital longer term or in perpetuity as they would pay the same rate regardless of being in hospital or a LTC facility (McCloskey et al. 2015). Thus, current policies often unintentionally incentivize patients to delay decision-making, enable unrealistic discharge plans and timelines, or even (in rare circumstances) enable selection of facilities with the longest wait lists in order to remain in hospital and maintain a desired higher level of care (with, for example, higher nursing/staff to patient ratios in hospital vs LTC, increased access to specialized services and physicians, etc.).

While close collaboration with patients and SDMs is obviously a cornerstone of effective discharge planning, this work must also be supported by appropriate policy levers, including stricter policies for choosing discharge destinations and reformed or increased bed charges. These issues in particular have recently featured prominently in Canadian media with political controversy around passage of Ontario's Bill 7*, More Beds, Better Care Act, 2022* (CBC News 2022; Legislative Assembly of Ontario 2022). In the context of increased ALC patient numbers placing critical and urgent strain on the hospital system, the bill aimed to force ALC patients in hospital awaiting long-term care into nursing homes not of their choosing on a temporary basis (given that prior Ontario legislation required explicit consent from the patient or their family to do this). Patients who refused such transfers would be required to pay substantial fees for ongoing hospitalization, fees far beyond those typically charged under similar circumstances in the past in the province. Prior to Bill 7, it was very rare to charge inpatients full uninsured or per diem rates that reflected the actual cost of providing care, with the provisions of the *Public Hospitals Act* generally making this unlawful or impossible for most ALC patients in Ontario (OHA n.d.).

Since ALC care results in unfair (or unjust) and inefficient use of resources, the controversy around Bill 7 seems misplaced (Carpenter 2022). In the U.K. (with a strong cultural and practical tradition of universally accessible, publicly funded and publicly administered health care similar to Canada), current government policy explicitly states that no right exists to remain in acute care without clear medical need (Department of Health & Social Care 2022).

This contrasts with contentions made by critics of Bill 7 that financially coercive measures to incentivize appropriate discharge planning somehow violated seniors' fundamental rights (CBC News 2022). In Canada, longstanding policy in Alberta with regard to preferred long-term care homes (with potentially long wait lists) has generally pursued a "wait in long-term care for (a preferred) long-term care" strategy rather than a "wait in hospital for long-term care" one like Ontario. To better manage LTC wait lists and eliminate a proportion of long ALC stays, Alberta Health Services [AHS] policies require a cap on how much time (one week) patients/SDMs have to select and rank a list of preferred facilities and, after two non-preferred homes have made admission offers, the client must move temporarily to the non-preferred home while awaiting an open bed at their preferred facility (Alberta Health Services 2015). This process is illustrated in Figure 4. This wait-list procedure likely has had some significant success in its goals of making decisions and transfers more timely; however, it is important to note that such a provincial strategy will only be efficacious so long as open beds exist somewhere in the long-term care system. From an equity perspective, such policies also have potential advantages in focusing public attention and political pressure on maintaining quality of care in all care homes rather than desirable homes that have likely selected over time for patients and families with stronger abilities to advocate.

Figure 4. Alberta Health Services, ALC to Long-Term Care Wait List Management Policy (2015)



Increased activity-based funding provisions and reforms for Canadian hospitals are another way to incentivize timely decision-making and discharges. Global hospital budgets (encompassing the total cost of operations) were frequently the historic norm for acute-care funding in Canada, and this (along with exclusively public administration of the health system and shielding patients from sharing in the costs of treatment) has likely been a powerful determinant of Canadian hospital systems having higher costs than comparable peers with universal health-care systems in the OECD (Liddy et al. 2020; Sutherland and Crump 2013). While Canadian governments have made some strides in recent years implementing activity-based funding programs (Ontario Ministry of Health and Long-Term Care 2022),[4] these activities have been harder to implement for the care of frail patients with multimorbid illness compared to things like surgeries and singular acute medical diagnoses (like stroke or myocardial infarction). However, there are strong rationales for pushing further forward, including potentially facilitating a more efficient allocation of resources by allowing local providers more autonomy to re-allocate funds (compared to central planning) and avoid disincentivizing cost-saving decisions that could result in losses of funding if programs run surpluses or have unspent funds at year-end (Sutherland and Crump 2013). Providers can also avoid the cash crunch that occurs when increases in patient volumes rub up against fixed global budgets. However, caution must be exercised to avoid poorly designed remuneration mechanisms that penalize hospitals for factors outside their control such as disproportionately sick or socially frail patient populations or the lack of community services not under their direct administrative or financial control. The U.K. went a step further in addressing the latter problem in particular with the *Community Care (Delayed Discharges) Act (2003)* that actually allowed hospitals to potentially charge community organizations financial penalties if patient discharges were delayed because appropriate services were not available (Godden 2009).

Finally, co-locating ALC patients in specific units of an acute-care centre rather than dispersed across different wards or units in the facility may enhance patient flow. Consolidating ALC patients into singular dedicated units is not a new initiative, having been implemented in countries such as the Netherlands and Australia under a variety of different terms, including after-care units, geriatric assessment units, extended care units, etc. (Ahmed 2019). While this method technically does not immediately reduce the number of ALC patients occupying beds in acute care (St. Joseph's Healthcare Hamilton 2013), it does have a number of advantages. It helps avoid the de-prioritization problem that occurs when chronic (and comparatively stable) patients share a unit with acutely unwell patients or those newly admitted or imminently to be discharged. By ensuring adequate prioritization and staff attention, decision-making can be more timely. This particular benefit is accentuated by ALC-specific unit staff being more effective if they are better trained and more experienced in the management of ALC-specific patients, issues and care processes. Finally, patient comfort and safety can be further specialized and optimized, potentially improving care and reducing complications that can lead to longer lengths of stay (Arora 2019). While this strategy can be effective when operationalized well, the temptation

[4] In this context, activity-based funding refers to paying hospitals for individual services provided or individual patients cared for, with the aim of incentivizing provision of a higher volume of services or treatment of superior quality compared to traditional block grants (Esmail 2021). Activity-based funding is thought to potentially generate increased efficiency, improved transparency and accountability, improved access to care and increased equity among health-care organizations. For further information, see https://www.cihi.ca/en/activity-based-funding.

to use ALC units as a cost-saving measure (as is often the case) must be avoided given that decreasing staffing ratios and other resources almost certainly attenuates any potential gains. Also, specific attention must be paid to consistently maintain an active discharge-focused culture on these units to avoid the risk of paradoxically longer lengths of stay if a decrease of overall medical acuity is falsely equated with a decreased impetus for discharge compared to other more acute units. Finally, capacity constraints will obviously always limit the effectiveness of these units, with the Dutch experience highlighting significant reductions in delayed discharge days followed by the development of queues for admission to these transitional units (Ahmed 2019).

ALC PATIENT DISCHARGE (DOWNSTREAM INTERVENTIONS)

Alternate facilities for ALC patients may represent more appropriate or useful options to reduce the number occupying acute-care beds. Certain facilities, such as repurposed older or under-used facilities, facilities typically designated for other use, retirement residences or even private homes could be used to house ALC patients while they either convalesce or await their alternate level of care (Whatley 2020; Nauenberg 2021). Depending on the context, such facilities can be referred to as transitional care, reactivation centres, step-down beds, etc. (Local Government Association 2022). If there are adequate resources, specialization in ALC-related issues can maximize patient safety and comfort while allowing time for recovery, promoting increased independence and facilitating timely transitions to other settings. With respect to effectively offloading acute-care resources, the potential usefulness of this strategy was demonstrated in the COVID-19 pandemic when such measures were used out of necessity across most provinces (King 2021; Saskatchewan Health Authority 2020; Whatley 2020).

While transitional care settings can provide an effective bridge to settings other than long-term care, the burden of ALC patients requiring LTC can often be a majority (Costa et al. 2012), making calls for simply expanding long-term care capacity inevitable and powerful. While undoubtably necessary in some form, many things will limit the effectiveness of this policy item alone to relieve pressures on acute care. Relative long-term neglect of the LTC sector has left system capacity woefully short of expected demands. Even with other resources in place, there is an anticipated need in Canada for 200,000 new LTC beds (compared with the current stock of 250,000), with this degree of capacity expansion therefore posing a monumental challenge. With an annual cost of operating each bed of $75,000 and a building cost of $320,000 for each bed, the required financial resources alone are extreme, perhaps $64 billion to build and $130 billion to operate through 2035 (The Royal Society of Canada 2020; Gibbard 2017).

A building and expansion program at the scale required for LTC is difficult to effectively realize, but is also limited by the lack of available resources like skilled labour. For example, RN vacancies in Ontario have more than quadrupled since the beginning of 2016 and more than doubled since the start of the COVID-19 pandemic. Similarly, vacancies that have remained unfilled for 90 days or more have increased by nearly 50 per cent since the start of the pandemic (Registered Nurses' Association of Ontario [RNAO] 2021). Leaving aside the massive increase in staffing required for expansion, this even brings into question the

feasibility or sustainability of adequate staffing in existing LTC homes, especially when public demands and political pressure are resulting in more regulations and standards to increase care provision in old and new facilities alike (Marrocco et al. 2021; The Royal Society of Canada 2020). Despite its desirability, building our way out of the ALC crisis to a significant degree simply may not be possible.

Both operationally and culturally there is a pressing need to re-evaluate the existence of LTC as a desirable default for many patients. When publicly funded health insurance (*Canada Health Act 1984*) was established, LTC did not substantively exist in the format we think of now. The average age of death was 76 years, and much of the end-of-life nursing care was provided at home, or if necessary, in an extended-care hospital setting (Watts 2020). With the creation of our modern LTC system, placement in these facilities has often inadvertently become an expected and/or recommended course of action, with the concurrent atrophy of the ability and/or willingness to facilitate this type of care in the community. With current pressures, Ontario has long indicated a need to break with the discharge pathways for seniors focused on Admit → ALC → LTC placement that will likely no longer be an available or predominant care pathway for many patients (Walker 2011).

Home-first strategies represent an early and limited (but useful) step in this direction. Similar to best managing demand for limited acute-care resources, such reforms will help ensure limited LTC resources are available to those who need it most and for whom no other options exist. Overall, this requires multi-faceted interventions, including increased provisions of supports, financial incentives and home-care services to allow patients to avoid institutional care. In the United States, the Program of All-inclusive Care for the Elderly (PACE) was designed to provide flexible but comprehensive medical and social care to maximize seniors' ability to remain in their own homes rather than seek institutional care (Centre for Medicare & Medicaid Services 2023). In the U.K., the Discharge to Assess, Home First program mandates that the vast majority of patients are expected to go home following discharge, with LTC assessments only happening once they have reached a point of recovery where their longer term needs can be accurately assessed (Department of Health & Social Services 2022).

In Canada, home-first strategies have been widely used with attempts to facilitate cultural change, accept some risk, emphasize home as a default destination and pivot the safety net to provide adequate care at home (Purbhoo et al. 2017). In addition to these broader strategies, effective policies must emphasize specific interventions likely to contribute to realizing these goals. Patients and caregivers consistently prioritize insufficient public coverage for home-care services as a gap; the health system is required to improve the transition from hospital to home (Kiran 2020). While specific provision of formal supports is clearly required, these supports and financial incentives should be designed to leverage the considerable support informal caregivers provide. Currently, informal caregivers likely provide a substantial majority of care for seniors in the community and were previously estimated to save the health-care system between $24 billion to $31 billion annually (CARP 2016). Interventions like expansion of tax credits (including the Canada Caregiver Credit) are comparatively easy ways for governments to support this kind of care (Canada Revenue Agency 2022; De Rosa 2020). More complex measures would include administrative

interventions to allow family caregivers to self-direct funding provided by various government ministries into the services which that individual needs most (Donner 2015). Such flexibility is desirable but also likely requires co-provision of significant care co-ordination that may extend to managing the purchasing of these services.

Finally, appropriate use of palliative care must be provisioned and prioritized to complement and enhance most other policy measures discussed, with the justification for this being a combination of practical, ethical and clinical considerations. With increasing demand for health-care services being driven in large part by patients at the extreme of age or otherwise nearing end of life, Canadians would be well-served to address structural factors and inefficiencies in our health-care system that facilitate expensive, unhelpful, potentially harmful or even unwanted medical interventions at the end of life. Canadians spend more on end-of-life care than other high-income countries, including the U.S., yet we achieve poor results compared to most (Quinn et al. 2021).

Planning one's wishes in the event of illness or medical intervention prior to such a need or deterioration reduces time spent waiting for decisions, optimizes resource use and improves patient outcomes and comfort (National Institute on Aging [NIA] 2018). This can also serve as a major avenue to cost saving and decreased acute-care use through greater provision of high-quality palliative care, care focusing primarily on improving comfort and quality of life, often being delivered in patients' own homes or sometimes dedicated hospices. Inadequate provision of these services has been described as a predominant driver of Canada's uniquely high costs of health-care delivery at end of life by driving inappropriate acute-care usage (Quinn et al. 2021). While this phenomenon partially results from the lack of appropriate allocation of financial or other resources to this type of care, our health-care system's unique overdependence on acute care for treatment in the setting of medical deterioration likely contributes to an environment where triggers for transitioning to a palliative approach are inappropriately delayed, resulting in increased end-of-life visits to the emergency room, hospital and the intensive care unit (Quinn et al. 2021). While not a problem limited specifically to ALC patients, missing appropriate transitions to palliative care is a particularly acute issue for frail patients in this population as demonstrated by the large numbers of patients designated ALC who subsequently die in hospital or within 90 days. In fiscal 2017/18 in Ontario, almost 190,000 ALC patient-days (nearly 40 per cent of all ALC patient-days in Ontario) were accounted for by patients who were in the final 90 days of life (Quinn et al. 2021).

From a policy perspective, there are excellent examples of successful initiatives to shift away from acute-care use. The former Toronto Central LHIN's Integrated Palliative Care Plan created a single integrated care team around each client and family, facilitating an increase in the number of palliative patients who achieved their wish of dying outside of a hospital, and reducing risks of emergency room visits and hospitalizations by 30 per cent (Donner 2015). The U.K. has a very robust palliative medicine system overall, with NHS England also establishing the End-of-Life Care Programme to increase the identification of people in their last year of life and personalize care to people's needs and preferences, secure strong clinical engagement and leverage regional end-of-life networks (NHS England 2021). Emulating some of these initiatives is likely to be effective in the broader Canadian context; however, there is likely also significant need to amend the relevant regulatory and legal frameworks in Canada (Vivas and Carpenter 2021).

The Canadian status quo has tended to prioritize patient autonomy over other considerations, including patients' best interests and distributive justice, allowing patient-perceived benefits of acute-care interventions to dominate decision-making and contribute to a significant expansion of expensive and potentially inappropriate end-of-life care in Canada. To reverse this trend, laws and regulations likely will need to change to appropriately balance patient-perceived benefits with objective personal and societal burdens. In potentially establishing limits to unhelpful, futile or even harmful end-of-life care, legislation and policies will, by necessity, have to be much more explicit about how we value things like cultural and spiritual expectations, and how much financial cost our health-care system and society at large can practically or morally sustain (Vivas and Carpenter 2021; Carpenter and Vivas 2020). This task may be uniquely and exceptionally difficult in Canada compared with other countries (where limits have previously been set) because Canadians generally view access to health-care services as an absolute and inviolable right (Carpenter 2019).

CLOSING COMMENTS

While the problem of increasingly overwhelming numbers of ALC patients in our acute-care system is daunting, it is also increasingly urgent to mitigate. While the solutions discussed above are interconnected and complex, there is also fortunately much we can do to address the issue. As we have discussed, different providers, hospitals and provinces will be at varying stages along the continuum of reform. Provinces must therefore comprehensively and carefully consider the complexities of their status quo, the success and failure of interventions in other contexts, codify their desired state and work towards reforms and implementation to accomplish these goals. Too often, approaches and interventions by governments and health-care providers are piecemeal and may unnecessarily result in insufficient benefit or outright failure in their aims. With this report, we have communicated the importance of considering ALC mitigation as a phased process, requiring multi-faceted policies and intervention in each phase. Use of any such paradigm must consider the diversity and complexity of the ALC population and the data and coding that measure service use. Policy approaches that incorporate ALC avoidance, patient flow and discharge will be essential to integrate interventions into overall context and systematize them to prevent, mitigate the burdens of and improve the management of ALC.

APPENDIX A: ALTERNATE LEVEL OF CARE DATA 2014-2018 – ALBERTA, ONTARIO, SASKATCHEWAN

Table 2: Alberta Alternate Level of Care Hospitalizations & Lengths of Stay (Total and ALC)

Alberta				
Fiscal Year	Gender	# of Hospitalizations with ALC recorded (total)	Total Length of Stay in Days	ALC Length of Stay in Days
2014	F	5,349	310,650	172,536
2014	M	4,301	301,372	168,656
2015	F	5,510	327,097	194,982
2015	M	4,596	309,339	181,191
2016	F	7,312	368,610	221,732
2016	M	5,944	353,984	209,215
2017	F	9,153	415,355	254,982
2017	M	7,682	396,285	238,970
2018	F	8,359	368,054	221,990
2018	M	6,983	389,675	241,448

Source: CIHI

Table 3: Ontario Alternate Level of Care Hospitalizations & Lengths of Stay (Total and ALC)

Ontario				
Fiscal Year	Gender	# of Hospitalizations with ALC recorded (total)	Total Length of Stay in Days	ALC Length of Stay in Days
2014	F	31,485	873,731	473,440
2014	M	24,791	810,895	440,356
2015	F	30,492	849,027	468,886
2015	M	24,746	808,270	447,160
2016	F	30,853	915,328	516,131
2016	M	25,069	881,839	502,499
2017	F	30,422	934,219	535,082
2017	M	24,764	907,188	517,512
2018	F	31,397	1,002,703	584,663
2018	M	26,316	983,357	571,007

Source: CIHI

Table 4: Saskatchewan Alternate Levels of Care Hospitalizations & Lengths of Stay (Total & ALC)

Saskatchewan				
Fiscal Year	Gender	# of Hospitalizations with ALC recorded (total)	Total Length of Stay in Days	ALC Length of Stay in Days
2014	**F**	1,972	67,947	35,146
2014	**M**	1,391	56,588	29,300
2015	**F**	2,244	70,329	39,107
2015	**M**	1,680	57,045	30,624
2016	**F**	3,377	96,206	55,054
2016	**M**	2,513	85,736	49,260
2017	**F**	3,372	98,893	59,493
2017	**M**	2,639	81,944	49,103
2018	**F**	3,372	104,233	64,042
2018	**M**	2,745	93,872	57,886

Source: CIHI

APPENDIX B: ALTERNATE LEVEL OF CARE REDUCTION AND OPTIMIZATION POLICY CATEGORIES

Table 5: Policy Categories and the Multi-faceted Management of the Continuum of ALC Challenges

Alternate Level of Care Reduction and Optimization: Policy Categories		
ALC Avoidance (Upstream Interventions)	**ALC Patient Flow (Midstream Interventions**	**ALC Patient Discharge (Downstream Interventions)**
Strategies to reduce ALC admissions and/or avoid unnecessary admissions • Early recognition and intervention for patients likely to require ALC days in hospitals (including ALC avoidance frameworks; initiatives to prevent deconditioning/ inpatient complications in frail patients, etc.). • Improving community care and supports to avoid unnecessary acute-care hospitalizations. • Improving outpatient supports and medical management for frail patients. • Early recognition of patients who will need institutional care and improved pathways from community to institutional care.	Strategies that target improving patient flow and efficiency and reducing the length of ALC stays • Paradigm shifting to change perceptions of risk and increase tolerance of risk. • Early and enhanced discharge planning. • Reformed/increased bed charges. • Stricter policies for choosing discharge destinations and improved long-term care wait-list management. • Increased use of activity-based funding models. • Increased provision of ALC-specific inpatient units.	Practices that focus on facilitating effective, timely and durable discharges • Increased provision of transitional care settings. • Increased provisions of supports, financial incentives and home-care services to allow patients to avoid institutional care. • Increased provision of long-term care. • Increased provision of palliative care services and advanced care planning to avoid low utility care usage at end of life.

APPENDIX C: ALTERNATE LEVEL OF CARE DATA (2018)

Table 6: Comparison of Alternate Level of Care (2018)
Length of Stay Data for Patients >70 y of Age by Gender and Province.

Gender	Province	Age Group (Years of Age)	ALC Length of Stay (Days)	Total Length of Stay (Days)	Proportion ALC Days of Total LOS Days	Median ALC LOS (Days)	Median Total LOS (Days)	Proportion ALC Median LOS to Median Total LOS
Males	**Alberta**	71-75	30,794	46,631	0.6604	13.00	33.00	0.3939
		76-80	33.58	51,905	0.6427	12.00	30.00	0.4000
		81-85	38,623	60,537	0.6380	14.00	33.00	0.4242
		>= 86	51,100	81,283	0.6287	14.00	30.50	0.4590
	Ontario	71-75	68,008	118,159	0.5756	7.00	20.00	0.3500
		76-80	81,949	137,099	0.5977	7.00	20.00	0.3500
		81-85	103,497	166,274	0.6224	7.00	20.00	0.3500
		>= 86	144,647	234,979	0.6156	8.00	20.00	0.4000
	Saskatchewan	71-75	7,181	11,331	0.6337	12.00	26.00	0.4615
		76-80	6,849	10,885	0.6292	11.00	24.00	0.4583
		81-85	9,058	14,491	0.6251	12.00	25.00	0.4800
		>= 86	13,360	21,557	0.6198	11.00	22.00	0.5000
Females	**Alberta**	71-75	21,038	34,293	0.6135	10.00	28.00	0.3571
		76-80	23,978	40,567	0.5911	10.00	25.00	0.4000
		81-85	39,338	63,519	0.6193	11.00	27.00	0.4074
		>= 86	82,695	132,590	0.6237	13.00	27.00	0.4815
	Ontario	71-75	55,476	100,669	0.5511	6.00	18.00	0.3333
		76-80	78,769	135,505	0.5813	6.00	18.00	0.3333
		81-85	110,886	181,298	0.6116	7.00	1800	0.3889
		>= 86	223,083	355,309	0.6279	7.00	18.00	0.3889
	Saskatchewan	71-75	5,526	9,432	0.5859	10.00	22.50	0.4444
		76-80	6,765	11,583	0.5840	9.00	22.00	0.4091
		81-85	10,501	16,050	0.6543	10.00	21.00	0.4762
		>= 86	23,379	39,741	0.6386	10.00	22.00	0.4545

Source: CIHI

APPENDIX D: SEARCH TERMS

KEYWORDS INCLUDED

"Alternate Level of Care" or "ALC" and "Canada" or "Alberta" or "Saskatchewan" or "Ontario"

"Delayed Discharge Patient"

"Hospital Gridlock" or "Hospital Delays" and "ALC" and "Costs"

"Alternate Level of Care" or "ALC" and "Policy" or "Methods" and "Reduce"

"Continuing Care" and "Delays"

"Acute Care" and "Inefficiency"

"Policies" and "International Methods" and "Delayed Discharge"

"Long-Term Care" and "Access" or "Wait List"

"Alberta Health Services" and "Policy" and "ALC"

"Ontario" and "LHIN" or "CCAC" and "ALC" or "Alternate Level of Care" and "Policy"

"Saskatchewan Health Authority" and "ALC" or "Alternate Level of Care" and "Policy"

"Community Care" and "Supports" and "Delays" or "Insufficient"

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This is **Exhibit "C"** referred to in the Affidavit of **Dr. Travis Carpenter,** sworn this 21st 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

---

1. My name is Dr. Travis Carpenter. 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

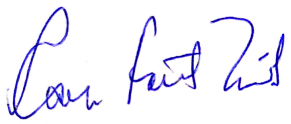
DR. TRAVIS CARPENTER

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

of **Dr. Travis Carpenter,** sworn this 21st 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)

Guidelines to Support ALC Designation

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

Clinical Status

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

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

Alternate Level of Care

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

Safety Risk: Self and others

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

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

Alternate Level of Care

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

Activity Tolerance

Acute Inpatient Care

If any one of the following criteria is met:

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

Alternate Level of Care

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

Clinical Practice & Process

Acute Inpatient Care

If any one of the following criteria is met:

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

Alternate Level of Care

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

Medication and Fluid Administration

Acute Inpatient Care

If any one of the following criteria is met:

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

Alternate Level of Care

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

Diagnostics and Therapeutics

Acute Inpatient Care

If any one of the following criteria is met:

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

Alternate Level of Care

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

Palliative Care

Acute Inpatient Care

If any one of the following criteria is met:

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

Alternate Level of Care

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

Mental Health

Acute Inpatient Care

If any one of the following criteria is met:

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

Alternate Level of Care

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

Respiratory Care

Acute Inpatient Care

If any one of the following criteria is met:

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

Alternate Level of Care

- On a ventilator, chronic respiratory care

Companion

Alternate Level of Care

- Companion - well baby/adult (if registered)

Featured resource

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

This is **Exhibit "E"** referred to in the Affidavit of **Dr. Travis Carpenter,** sworn this 21st 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)

Emergency department overcrowding and access block

Andrew Affleck, MD*; Paul Parks, MD†; Alan Drummond, MD‡; Brian H. Rowe, MD, MSc§; Howard J. Ovens, MD‖

EXECUTIVE SUMMARY

Emergency department overcrowding (EDOC) is defined as a situation where the demand for emergency services exceeds the ability of an emergency department (ED) to provide quality care within appropriate time frames.[1,2] ED overcrowding has been a key issue in Emergency Medicine in Canada for more than 20 years. Despite increased political, administrative, and public awareness, EDOC situations continue to rise in frequency and severity.[3] Patient suffering, prolonged wait times, deteriorating levels of service, adverse patient outcomes and the ability to retain experienced staff in an ED are all ill effects of this ongoing problem.

Contrary to popular perceptions, ED overcrowding is not caused by inappropriate use of ED's, or by high numbers of lower acuity patients presenting to the ED; the inability of admitted patients to access in-patient beds from the ED is the most significant factor causing EDOC in Canadian hospitals.

Despite its importance, there currently are no national benchmarks in place to determine severity (and thus identify the factors causing poor performance). Through this position statement, CAEP will put forth recommended national benchmarks (targets) for ED performance to help address the issue. The suggested targets are as follows:

i. ***Time to physician initial assessment (PIA):***

- Median of 1 hour, 90th percentile of 3 hours.

ii. ***Time (to transfer) to in-patient bed:***

- Median of 2 hours, 90th percentile of 8 hours

iii. ***ED LOS:***

- **CTAS IV/V discharged patients** – median of 2 hours, 90th percentile of 4 hours;
- **CTAS I-III discharged patients** – median of 4 hours, 90th percentile of 8 hours;
- **Admitted patients (all CTAS levels)** – median of 8 hours, 90th percentile of 12 hours.

It is CAEP's belief that adoption of national benchmarks *(see recommendations for further details)* will provide goals for each province or territory to strive to achieve, and a mechanism for comparing their progress to their peers. We understand that depending on their circumstances and current situation, individual hospitals may find these targets difficult to reach while others may be performing at or above these targets, but we believe all will benefit from a set of common metrics and benchmarks.

EDOC is a public health concern whose root causes extend beyond the walls of Canada's ED's. It reflects a need for solutions and interventions at multiple levels within the health care system. Solutions outlined within this position statement will reflect this need while not minimizing the most important factor causing EDOC – delays in securing beds for patients admitted through the ED.

CAEP POSITION

1. The primary problem arising from EDOC is a block in the provision of health care required by patients presenting to the ED within an appropriate time and

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in an appropriate place. This results in a diminished access to health care or "Access Block" (AB).* Access Block often results from system capacity and efficiency issues that lie outside of the ED.

EDOC is associated with increased mortality and worse outcomes for patients assessed in a crowded ED whether admitted or discharged.[5,6] It has been studied extensively and can be conceptualized using the ***input-throughput-output*** model where a comprehensive, jurisdictional approach is required to address factors impacting flow outside the ED; in the community, in the rest of the acute care hospital, and in the post-acute continuing care sector. A summary of the evidence on interventions and strategies to reduce overcrowding has been published.[7,8] Comprehensive approaches to EDOC from a system perspective should include:

a. Transparent and easy access to valid and reliable data to measure performance[9] using nationally standardized definitions as per the Canadian Triage and Acuity Scale (CTAS), Canadian Emergency Department Information System (EDIS) National Working Groups, and the National Ambulatory Care Records System (NACRS) database;
b. Establishment of performance targets and benchmarks for key ED and in-patient intervals;
c. Timely public reporting of performance targets along with success on achieving the benchmarks;
d. Financial incentives (pay-for-performance initiatives) should be explored for hospitals and providers to improve performance;
e. Coaching and education for hospitals on best practices to improve processes related to flow within the ED along with overall hospital flow, using evidence based repositories;
f. Attention to community access to long-term care must become a local, provincial and national priority;
g. Attention to:
    i. Acute care capacity (target maximum below 95% occupancy rates);
    ii. Alternative Level of Care (ALC) levels in acute care settings (target maximum 5% occupancy rates);
    iii. Adequate capacity in the Long-term Care (LTC) and post-acute care sector;
    iv. Community and home care supports for vulnerable groups such as the frail elderly.

2. Use of standard intervals for performance monitoring and public reporting is important to allow cross-jurisdictional comparisons of performance. With the starting time being the time of registration or triage, intervals or performance metrics should include:
    a. "**Waiting Times**" – Intervals that are strictly waiting:
        i. Time to physician initial assessment (PIA) – is the total time from initial registration/triage to first being seen by an MD;
        ii. Time for transfer of care for Emergency Medical Services (EMS) arrivals: "ambulance offload time" – time from arrival until care accepted by ED;
        iii. Time to consultation: ideally, time elapsed between the consult request to arrival of consulting physician;
        iv. Time to transfer to in-patient bed for admitted patients: time from admit decision to actual transfer/departure to the ward.
    b. "**Care Times**" – Intervals that include care and waiting combined:
        i. Total Length of Stay in the ED (ED Length of Stay, or ED LOS);
        ii. Time from arrival to consult request (for patients receiving consults this includes the emergency physician's process time and often the time for diagnostic imaging to be performed (and reported) and lab turnaround times);
        iii. Consult request to disposition decision (for patients receiving consultation this is the consultant's process time).
3. The format for public reporting is crucial. Key principles include:
    a. **Segregate populations**: Differentiate between patients requiring admission to hospital and

*For consistency, the term EDOC is utilized within this paper to specifically refer to the ED manifestations of Access Block. The transition to the use of Access Block has been recently encouraged, to reinforce the concept and understanding that EDOC is a form of Access Block with roots and causes that frequently lie outside of the ED. To remain consistent we have chosen to continue to utilize the abbreviation EDOC to describe Access Block that manifests within the ED.[4]

those who can be safely discharged from the ED.

b. **Report Non-aggregated Data**: EDOC is primarily a problem of academic centres and high volume urban centres. Aggregating regional or provincial data will obscure significant local problems. Performance of individual facilities must be reported separately.

c. **Format of metrics**: For internal performance monitoring, reporting of metrics at the 90th percentiles has advantages and is recommended for health care professionals and system administrators. On the other hand, public reporting requires the use of medians which are better understood by the public and patients. Averages have problems in skewed data sets and should be avoided.

4. Targets are an important component of performance improvement. Very little evidence exists to guide the setting of targets for ED wait times, but targets should be determined using best existing evidence in conjunction with expert consensus. Ideally the targets should be aligned across jurisdictions to allow performance comparisons. Without objective measures and system access benchmarks it can be difficult to quantify the level of Access Block within a hospital, region or province. Worse, without gauging success at achieving targets over time, it can be very difficult to assess whether system adjustments designed to improve flow are accomplishing their intended effect. At a minimum it is recommended that targets be established for the following parameters, and, based on existing provincial goals and expert consensus, the suggested targets are as follows:

   i. **Time to physician initial assessment (PIA)**:

   - Median of 1 hour, 90th percentile of 3 hours.

   ii. **Time (to transfer) to in-patient bed**:

   - Median of 2 hours, 90th percentile of 8 hours.

   iii. **ED LOS:**

   - **CTAS IV/V discharged patients**
     - median of 2 hours, 90th percentile of 4 hours;
   - **CTAS I-III discharged patients**
     - median of 4 hours, 90th percentile of 8 hours;
   - **Admitted patients (all CTAS levels)**
     - median of 8 hours, 90th percentile of 12 hours.

5. It is important to keep in mind that "wait times" are different than "length of stay." The wait times are the intervals where a patient is waiting for something (i.e., care from a health care provider or assignment to a bed). Length of stay markers measure the time it takes for a patient to receive care, including assessment and treatment. While the experience of waiting and receiving care can be intimately intertwined in an ED visit, they are frequently confused. It is important to provide clarity when publishing and discussing these numbers, as spending a total of 8 hours in an ED including assessment, complex diagnostics and treatment (ED LOS) is considerably different from waiting 8 hours in an ED waiting room awaiting assessment by a physician (time to PIA).

INTRODUCTION

ED overcrowding is a complex, multi-dimensional health services problem which is conceptualized using the input-throughput-output model.[4,10,11] While media attention has highlighted input factors and inappropriate use of the ED across Canada, the primary and definitive cause of ED overcrowding is hospital overcrowding (also known as "Access Block").[4] Hospital overcrowding can also be conceptually organized with the same model: input (e.g., elective and ED admissions); throughput (in-patient services and flow), and output (e.g., discharge, community care resources, access to LTC).

BACKGROUND

CAEP published its first position paper on ED Overcrowding (EDOC) in 1994 with a revision in 2009. The first paper identified and defined the issue of EDOC which helped to propel Emergency Department Wait Times onto provincial forums as well as causing ED wait times to be included on the national Wait Time List supported by the Canadian Medical Association (CMA). Having identified EDOC as a growing health care concern, the second position paper stressed the system-wide origins of EDOC and recommended wait time targets to improve patient care as well as stressing the fact that Access Block solutions must occur on a system wide basis. Since the

last position paper in 2009, change has rapidly occurred in Canada and internationally. At a provincial level, several provinces have taken steps to look at and address ED wait times. Over time, there has been a growing appreciation of the multi-factorial causes of EDOC, and a system-wide approach to addressing Access Block has now been generally accepted.

The main factors causing long ED wait times and EDOC penetrate almost every level of the Canadian health care system. Consequently, there has been a shift away from focusing solely on overcrowding alone and processes within the ED to adopting language that better describes the true causative factors of EDOC and the Access Block that patients are experiencing at multiple levels.

On the input side, changes occurring in primary care have also resulted in Access Block that can contribute to EDOC. Patients without a primary care provider (PCP) may turn to the ED as their only access to health care, while other patients may have a PCP that cannot accommodate semi-urgent bookings, so they often turn to the ED for urgent attention. This creates a situation where more patients utilize the EDs, and worse, a larger proportion of these patients have missed opportunities for preventative care and thus present with illnesses that are further advanced. In addition, the age of patients presenting to the ED and the complexity of their problems has increased. Consequently, in many EDs, there is an increased need for investigations, advanced imaging and consultation, further extending the length of stay and contributing to overcrowding. Finally, utilization of ED's for episodic care and chronic conditions also creates a need for better communication between EDs and PCPs to help coordinate the overall care of patients.

On the output side, ALC patients can have a significant impact on EDOC by occupying acute care spaces that could be utilized by newly admitted ED patients. In addition to the reduced bed capacity that results from high ALC levels, the patients waiting ALC placement are not receiving the appropriate ALC care in the optimal place which can impact on their outcomes and experience - and thus their needs have to be addressed as part of the solution.

This position paper will serve to update the previous position papers to reflect these changes. The goal of this update is to add recent experience and scientific literature to the discussion in the hopes of creating a document that can be used when trying to address the multi-layer causes of EDOC.

PROBLEM DEFINITION

Delays in emergency care can occur at a variety of levels. As outlined in the Executive Summary, the inability for admitted patients to access in-patient beds from the ED is the most significant factor causing EDOC in most busy Canadian hospitals. Although ED input pressures can contribute to EDOC in some communities, specifically where a lack of timely access to a PCP is a significant factor for patients, the vast majority of the time the system bottlenecks are located "down-stream" from the ED and occur on the output side of patient flow. Problems associated with flow of admitted patients out of the ED and into the hospital, and then ultimately back out into the community, can arise from several factors. At different times in different hospitals/communities the problems can be based on numerous capacity and efficiency limitations and may include:

- Suboptimal utilization of acute care beds including access to diagnostics;
- A shortage of acute care bed capacity - actual bed numbers may be inadequate and/or beds may be blocked for budget or other reasons including presence of ALC patients;
- ED staffing shortages (including physicians);
- Staffing shortages and other inefficiencies affecting physicians/consultants and programs providing inpatient services;
- Limited community care resources - both home care and post-acute care resources such as long term care or rehabilitation services;
- Lack of integration of community and hospital-based resources;
- Poor communication between acute care facilities and PCPs when patients are ready for discharge but require timely follow-up;
- Confusion on who is accountable for the patient at different times in the patient's care.

With the shortage of hospital beds and recurring issues with acute care capacity, hospitals increasingly face a situation where more patients require admission than there are beds to accommodate them. The current approach to dealing with Access Block due to hospital crowding involves delaying the outflow of admitted patients into appropriate inpatient areas; resulting in an excessive and unsafe use of EDs to inappropriately "warehouse" admitted patients, both stable and unstable, for long periods of time. This "boarding" of admitted

patients within the ED results in EDOC and thus creates delays in seeing new patients presenting to the ED.

Surveys have shown that patients attempt multiple other options prior to accessing the ED.[12] Moreover, patients of lower acuity and urgency do not occupy acute care stretchers, require little nursing care, and typically have brief treatment times. The myth of "inappropriate use" should be permanently dispelled, and administrators and politicians should be encouraged to avoid attributing EDOC to ambulatory patient ED health services access. While patients discharged home are not the cause of ED overcrowding, process improvements for this group can decrease their waiting, and improve their experience. All Canadian ED's should commit to continuous quality improvement to ensure they are keeping up with best practices and optimizing ED resource use and patient experience. Improving and optimizing care delivery within every ED should be an ongoing priority for all hospitals, but this optimization process will not be able to address the down-stream output bottlenecks that are the root causes of EDOC.

Given the near universal and recurrent issue in Canada of in-patient bed limitations, EDOC is a direct consequence of hospital overcrowding, which in turn is a major contributor to Access Block.[13] In Canada, the problem of EDOC is most critical at trauma, tertiary care, teaching, and high-volume hospital EDs.[3] The consequences of EDOC are, however, similar across the emergency care system; referring hospitals and ambulances are unable to access secondary and tertiary care ED facilities in a timely fashion. For instance; despite having adequate acute care capacity locally, peripheral hospitals often experience Access Block in the form of delayed transfer to definitive care for their patients. This form of Access Block is an important issue for rural physicians and their patients, when physicians are unable to transfer patients requiring a higher level of care to urban receiving facilities which are frequently overwhelmed.

Pressures on ambulance services can occur when EDs are gridlocked with admitted patients and paramedics are unable to transfer patient care to ED staff in a timely fashion. Ambulance offload delays or, in uncommon cases, ambulance diversion are both examples of Access Block where EDOC impacts and delays access to pre-hospital care. While EDOC can compromise care for the EMS patient waiting to be off-loaded to an ED care space, it can also lead to staffing pressures for EMS services and result in longer response times for new calls. This in turn compromises the safety of patients experiencing emergencies in the community as the Access Block moves upstream.

Access Block can also occur within hospitals on multiple levels. Within the ED when inpatients occupy ED stretchers for prolonged periods of time they block access to these care spaces by ill and injured patients in the waiting room and increase waiting times for newly arriving patients. For the inpatients housed in the ED, the care provided is not equivalent to that on a ward and thus there is Access Block to appropriate inpatient care. Within many Canadian hospitals, elective surgery cases have been delayed or cancelled in an effort to deal with hospital and ED overcrowding, and in doing so patients awaiting scheduled surgery experience Access Block. On the inpatient wards, as hospital overcrowding increases, nursing workloads that are often perceived as dangerous result and provider/patient satisfaction decreases when over capacity protocols (OCP) are initiated.

In 2009, Canada had only 1.7 acute care beds per 1,000 Canadians, ranking 33rd out of 34 Organisation for Economic Co-Operation and Development (OECD) countries (OECD average was 3.4/1,000).[14] The lack of acute care beds in Canada means that most hospitals frequently operate at unsustainable occupancy rates of higher than 95%, a level at which regular bed shortages, periodic bed crises, and hospital overcrowding are inevitable.[15–17] Functioning at capacities above 95% occupancy does not allow for flexibility in the system to accommodate the natural peaks in patient volumes and admissions that will periodically occur.

Acute care bed capacity can also be significantly affected by patients who occupy acute care beds but who actually require an "alternate level of care" (e.g., long term care, rehabilitation etc.) and yet cannot access this care because of shortages in community resources and post-acute bed capacity. These patients account for the occupancy of up to 20% of acute care hospital beds, and thereby contribute to ED overcrowding and Access Block by preventing the admission of emergency patients to hospital beds.[18] The majority of patients in ALC status are elderly; with life expectancy increasing and the population aging this bottleneck will escalate if the problems are not addressed.

As can be seen, the problem of Access Block in general, and more specifically the growing concern of EDOC, is a multifaceted issue and no one single intervention will be effective. Any attempts to address EDOC will require a system-wide approach that will need to take into account input factors (improved

primary care access and improved ongoing care for patients with chronic conditions), throughput issues and ED optimization, along with addressing output bottlenecks and the flow of admitted patients (from acute care capacity and efficiency improvements all the way back out to the community and to post-acute care capacity).

RECOMMENDATIONS

The following recommendations have been generated from evidence-based documents with input from CAEP experts' opinions and consensus.

i **Establish national benchmarks for key intervals in the ED experience and report them publicly:** CAEP recommends the establishment of national benchmarks for key intervals in the experience of patients receiving care within the ED. In order to encourage transparency, and to ensure this issue remains in the forefront of the public's attention, these targets and individual non-aggregated hospital performance measures should be publicly reported. All benchmarks must be measurable and be linked to an accountability framework in order to adequately assess performance. Reliable, complete, and accurate data must also be collected in every ED so that progress can be measured and interventions evaluated.

For public reporting the median is best understood by lay people and reflects the typical patient experience. The 90th percentile targets should also be measured and reported as they better reflect majority experience and are a better tool for identifying existing delays and for judging process improvement, and can be used for incentives such as pay for results programs.

It is predicted that hospitals across the country will be at varying levels of performance initially, but patients can expect us to work towards a common standard of service. In general, expecting improvements of 5-10% per year towards these targets are reasonable.

Currently, there are many different targets in place across Canada – see Table 1 – CAEP urges provinces to meet and agree on common targets and reporting standards so Canadians can know how their community compares to others across the country.

1. **Time to PIA:** This is the interval from triage or registration until the patient is seen by an MD. This is the interval that most patients would intuitively think of as their "wait time" on an emergency visit, and correlates to "left without being seen" rates, overall patient satisfaction and total ED length of stay.
   CAEP recommends a target of one hour at the median and 3 hours at the 90th percentile.

2. **Time to In-patient Bed**: This is the interval from admission decision until a patient departs to the ward. It is the other key waiting interval and reflects bed availability at the time of admission, as well as hospital administrative efficiencies in assigning beds and arranging transfer of care and transportation. Admitted patients wait in uncomfortable circumstances in the ED for long periods of time, and this should be avoided in an optimally resourced and well-functioning health care system.
   CAEP recommends a target of 2 hours at the median and 8 hours at the 90th percentile.

3. **Overall length of stay in the ED (EDLOS)**: This is the time from arrival at triage or registration until departure home or transfer

Table 1. Variation in Emergency Department wait-time targets (as of November 2011)

	Admits	High Acuity Discharges	Low acuity discharges
Nova Scotia	8 hours 90th %-ile	8 hours 90th %-ile	4 hours 90 th %-ile
Quebec	12 hour (mean)	8 hours (mean)* * applies only to stretcher patients.	
Ontario	8 hours 90th %-ile	8 hours 90th %-ile	4 hours 90th %-ile
Manitoba		N/A	
Saskatchewan		N/A	
Alberta	8 hours 90th %-ile	4 hours 90th %-ile	
British Columbia	10 hours 75th %-ile	4 hours 75th %-ile	2 hours 75th %-ile

Courtesy of the Health Quality Council of Alberta.

to the ward. It reflects total patient experience, including care and waiting. In some cases, better care will require a longer stay, which is partly reflected in the varying target times by acuity/disposition.

a. **Low acuity discharged patients (CTAS IV or V on arrival): CAEP recommends a target of 2 hours at the median and 4 hours at the 90th percentile;**
b. **High acuity discharges (CTAS I-III on arrival): CAEP recommends a target of 4 hours at the median and 8 hours at the 90th percentile;**
c. **Admitted patients: CAEP recommends a target of 8 hours at the median and 12 hours at the90th percentile**.

ii **Link ED length of stay (ED LOS) benchmarks to incentives and infrastructure investment:** ED LOS benchmarks must be linked with incentives and infrastructure investment for meaningful change to be achieved. The UK and Ontario have achieved significant reductions in ED wait times following the adoption of jurisdiction-wide targets for ED LOS.[19] This was coupled with financial incentives, accountability measures, and tackling delays in access to inpatient beds, specialist doctors, and diagnostic investigations.

iii **Mandate a national ED repository of visit data:** It is a national conundrum that ED visit data are not all held and reported from one central resource. Only Alberta and Ontario contribute all ED visit data to the National Ambulatory Care Records System (NACRS) database maintained by the Canadian Institute of Health Information (CIHI). Transparent and easy access to valid and reliable data to measure performance, using nationally standardized definitions as per the CAEP CTAS and CEDIS National Working Groups, should be a provincial and federal priority.

iv **Optimize bed management and proactively plan bed capacity:** In addition to increasing the absolute number of acute care beds, inpatient bed capacity can also be improved by optimizing bed management. Effective bed management strategies should smooth the degree of variability in the numbers of admissions and discharges. Areas of focus for better management include; discharge planning, surgical smoothing, admission procedures, capacity planning, operational planning, and hospital policies for bed availability priorities and bed use. Hospital overcapacity protocols, along with expedited discharges and formalized discharge processes, will improve overall hospital flow and mitigate EDOC.

OTHER POTENTIAL SOLUTIONS

Several strategies have been used to address Access Block/EDOC including:

i. **INPUT Solutions:**

1. **Improve Primary Care Access**: Investing in a robust primary care system ensuring all Canadians have reasonable access to a PCP with a focus on prevention and healthy living. Improved and extended access to a PCP, with increased after-hours access and semi-urgent appointments, would possibly prevent patients from becoming ill and thus requiring hospital care.
2. **Improve EMS Coordination:** Consideration should be given to improve EMS offload processes. Utilization of Ambulance Offload Nurses in Ontario has shown some impressive success in addressing Access Block for pre-hospital patients. Ontario provided funding for nurses specifically to take over care of patients arriving by ambulance from paramedics at peak periods of the day – even if no stretcher is available (suitable areas for this to take place are found in the ED waiting/arrivals area or adjacent to the ED). Paramedics are then able to get back on the road. Alberta has also used EMS consolidation processes to address EMS Access Block. In some hospitals multiple EMS patients are consolidated together and cared for by one EMS provider to facilitate the rapid return of ambulance crews back out into the community.

ii. **THROUGHPUT Solutions**

1. **Engage in process improvement:** Management techniques such as "LEAN" have shown that many hospital and ED processes can be simplified and improved.[20]
2. **Invest in improving staffing of our EDs:** Most ED's are staffed to average patient flow demands. Queuing at specific times of the day,

days of the week, and during specific seasons is surprisingly predictable. Volume-based staffing that ensures adequate physicians, nurses, allied health workers, and alternate care providers (e.g., NP's, PA's, GEM nurses, Social Workers, PT's and OT's, Discharge Planners etc.) are present when required, should be part of the staffing plan. Note that a critical volume of ED visits, likely above 30,000 is needed to ensure efficient use of extra resources.

3. **Match staffing to patient demand:** Many ED's can do a better job of scheduling their existing resources by analyzing patient arrival patterns**.** Recent randomized controlled trial evidence also suggests that altering shifts can be studied using both quantitative and qualitative results.[21] Alternatively, employing staff on administrative functions has been shown to increase overall ED efficiency.[22]
4. **ED Information Systems (EDIS) are basic ED infrastructure:** EDIS or patient tracking systems, can assist with moment to moment management of patient flow and resource use, and can also provide data capture to inform management decisions and assist with compliance with obligations regarding reporting of data.[9] EDIS systems that are aligned with our strategies and incorporate our definitions and targets can allow for real time collection and distribution of performance measures to support transparency on local performance perturbations and support better management of performance at all levels – from unit to hospital to regional to system wide.
5. **Utilize medical directives:** When combined with an appropriate approval process, education and implementation program and ongoing monitoring, medical directives can speed care for selected patients on arrival to the ED.
6. **Utilize Fast Track Areas:** Many alternatives such as dissuading ED use through media campaigns and diversion of patients to walk-in clinics have been proposed; however, most evidence suggests these are ineffective strategies.[23,24] Overall, while the evidence is poorly coordinated, there appears to be support for the role of fast-track areas in most high-volume, urban EDs. These data likely don't apply to smaller, rural hospitals. Several reports conclude that the operation of an ED fast-track system appears to be efficient, operationally cost-effective, safe, and improves patient satisfaction with care[8,25] The author of the most comprehensive report concluded that: 1) fast-tracks were safe and did not appear to provide lower quality of care; 2) because they require less resources, fast-track areas are cost-effective; and 3) the quality of the literature in this area would be considered "weak".[25]
7. **Utilize "Rapid Assessment Zones (RAZ)":** Many EDs have had success with organizing and staffing specific areas to meet specific patient population needs. "Fast Tracks", or ambulatory or minor treatment areas, service patients with low risk of admission who have no need for a stretcher. They can be cared for in non-traditional care spaces, frequently only needing to be in a stretcher for a very brief examination period followed by treatment and wait periods in comfortable chairs that take up less ED space and resources. Rapid assessment zones or RAZ's can be utilized for the initial assessment of intermediate acuity patients who are stable enough to wait in a chair, but require a stretcher for assessment and/or intimate examinations/procedures.[26]
8. **Establish formalized "Intake" Policies and Processes**: Intake is a formalized process where patients who have complaints that cannot be evaluated within a short triage process, can be moved to a rapid assessment area where a physician can do a more formal assessment and streamline the patient to the appropriate care space within the ED. Typically patients with CTAS level 3 complaints, undifferentiated abdominal pain as an example, can be assessed in an intake area of the ED, investigations can be initiated rapidly, and the patient can then be more streamlined into the appropriate acute care space, or to the Fast Track/minor treatment environment to complete their care.
9. **Establish SSU's, CDU's and/or Observation Units, and or MAU's:** In some settings, carefully designed and monitored Short Stay Units, Clinical Decision Units and/or ED Observation Units, or Medical Assessment

Units decrease EDOC and improve overall patient flow and care. In general the higher the ED volume and admissions the greater the positive effect of these types of units. Recent evidence from implementation of CDUs in Ontario suggest the benefit may be less than previously reported.[27]

10. **Dedicated ED Satellite labs:** Given the delays associated with ordering laboratory testing in the ED that have been identified in the medical literature,[28] it might be reasonable to expect that improvements in laboratory times would have dramatic influence on overall LOS. Based on the available evidence summarized in the HQCA Report, the effect of point-of-care testing on turn-around times is supported by relatively strong evidence, whereas its positive effect on LOS is supported by limited evidence. Overall, the best evidence would suggest a 60 minute reduction in length of stay using a dedicated satellite ED lab, although actual results will vary locally depending on baseline turn-around times and the tests available.[7]
11. **Utilize Better Teaching Practices:** The traditional approach to teaching- often with initial assessment by a junior and consequent delayed decision making - can be an impediment to flow. We need to find ways to preserve the teaching experience while remaining patient centred and preserving access and quality.

iii. Output Solutions**:**

1. **Implement overcapacity protocols:** Access block and EDOC are symptomatic of demand exceeding capacity in hospitals and requires system-wide solutions. Access Block and EDOC can be addressed immediately, with existing resources, through mechanisms to improve patient flow. CAEP recommends the rapid implementation of overcapacity protocols as part of comprehensive surge strategies so that all hospitals have an organized approach to deal, in the best manner possible, with situations of demand exceeding capacity. While the evidence for this intervention is weak,[29] implementing overcapacity protocols effectively shares the responsibility for already stabilized and admitted patients with all wards in the hospital, instead of just 'warehousing' them in the emergency department. Overcapacity protocols should be implemented at times of peak inpatient pressures where ED patient care is compromised. While these are not a permanent solution for Access Block or EDOC, they represent a mechanism to temporarily "decompress" the ED. As other strategies lead to better baseline performance the frequency with which these protocols would be required will diminish.
2. **Formalized Hospital Wide Flow Policies and Processes:** One approach to improving flow is to create a Hospital LOS committee to continually monitor and optimize patient flow and to appropriately minimize LOS. These committees would need to be led by senior administrators with local decision making authority. The goal of these committees would be to aggressively addresses factors directly associated with hospital LOS such as:

   - Most Responsible Physician (MRP) designation – which is particularly important in complicated patients with multiple services involved in their care;
   - Designated discharge planners;
   - Inpatient lab and radiology priorities;
   - Monitoring and improving consultant times;
   - Improved discharge planning through formalized Evidence Based Guidelines and benchmarks;
   - Improving communication with primary care providers;
   - Facilitating specialist follow-up;
   - Assessment of readmission rates and addressing areas of concern for continuing quality improvement;
   - Creation of outpatient/ambulatory care clinics to promote early discharge;
   - Earlier involvement of CCAC (home care).

Measures designed to help hospitals achieve ED length of stay benchmarks must be appropriate to the local context. There will not be a "one size fits all" solution. Access Block and EDOC must be dealt with urgently through collaborative action between the provincial governments, health authorities, hospital administrators, community care access organizations, front-line emergency physicians, and all hospital staff in order to effect the necessary changes needed for safe access to emergency care and improved patient flow.

CONCLUSIONS

Access Block and EDOC represent a public health emergency. Crowded EDs are associated with poorer outcomes including increased mortality for patients seen during crowded periods. Access Block and EDOC is the result of complex multi-layer problems requiring engagement at all levels of the health care system. The accountability for patient care extends well beyond the walls of the ED and the hospital with an increased emphasis on both primary care access and meeting the needs of ALC patients. Incentives need to be aligned with desired behaviours, performance needs to be tracked and reported, and senior executives need to demonstrate leadership and be held accountable. There are now domestic and international examples of jurisdictions that have successfully mitigated this problem. The time to act is now; there is no longer any excuse for delay.

Further information on ED overcrowding and local/provincial progress and successes can be obtained from the Canadian Association of Emergency Physicians at www.caep.ca.

GLOSSARY OF TERMS

Access Block - refers to the situation where patients in the emergency department (ED) requiring inpatient care are unable to gain access to appropriate hospital beds within a reasonable time frame, or anywhere else patients needing care are unable to obtain it in a timely fashion appropriate to their need.

ALC: Alternative Level of Care - are patients who no longer require hospital care but cannot be discharged due to a lack of beds and/or resources in the community. In short, ALC patients are not receiving the right care in the right place. They are often referred to as "Bed Blockers" as they prevent more acute patients from receiving a required bed, but we should remember they are also not having their needs met either.

CAEP: The Canadian Association of Emergency Physicians - CAEP is the meeting place for emergency physicians! CAEP's mission is to promote the interests of emergency physicians and the specialty of emergency medicine in Canada by advocating for emergency physicians and their patients, connecting emergency physicians, providing leading emergency medicine education and a forum for research in emergency medicine.

CDU: Clinical Decision Units - is an observation unit in or adjacent to the emergency department. It is designed to provide appropriate physician and nurse staffing and diagnostic/treatment capabilities to allow extended care for select patients, usually up to 24 hours, in a safe, effective and comfortable environment.

CEDIS: Canadian Emergency Department Information Systems - is a working group that develops resources, tools and definitions to promote improved data gathering and reporting in ED's.

CTAS: Canadian Triage And Acuity Scale - is a tool that enables Emergency Departments (ED) to prioritize patient care requirements at arrival in a standardized fashion. CTAS levels correlate with resource requirements including admission rate but are not designed for this purpose and should be used with caution for anything other than triaging of patients.

ED: Emergency Department - an area within the hospital designed to respond immediately to patients suffering from serious medical problems.

EDIS: Emergency Department Information System - A computer program for tracking patients arriving and departing to ED's and assist in ED management.

EDOC: Emergency Department Overcrowding - defined as "a situation where the demand for emergency services exceeds the ability to provide care in a reasonable amount of time."

EMS: Emergency Medical Services - ambulance services; a mobile medical service dedicated to providing out-of-hospital acute medical care, transport to definitive care, and other medical transport to patients with illnesses and injuries which prevent the patient from transporting themselves.

GEM nurse: Geriatric Emergency Management Nurse - provides advanced gerontological expertise in the care of the frail elderly seen in the ED who are at risk of suffering adverse events, loss of independence and admission to hospital or long-term care.

LTC: Long Term Care - a facility able to provide a variety of services which help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for an indefinite periods of time (eg a "nursing home").

MAU: Medical Assessment Unit - provides a service for the rapid assessment and treatment of a wide range of medical conditions. It improves the

efficiency in the admission process for unplanned patients by providing assessment, care and treatment for a designated period (usually 48 hours) prior to transfer to a medical ward or home where appropriate. The patients stay on an inpatient ward is eliminated or drastically reduced for appropriate patients when this model of care is used.

NACRS: National Ambulatory Care Records System - contains data for hospital-based and community-based emergency and ambulatory care (for example, day surgery and outpatient clinics).

NP: Nurse Practitioner - A nurse practitioner (NP) is a nurse with a graduate degree in advanced practice nursing.

OLD: Off Load Delay - is a state when an ambulance transports a patient to a hospital and paramedics must wait with the patient until hospital staff assumes responsibility for care of the patient.

PA: Physician's Assistant - is a healthcare professional who is trained to practice medicine as part of a team with a physician.

PCP: Primary Care Provider - is a health care practitioner who sees patients at their own request for preventative care or for common medical problems. In Canada, this person is usually a family doctor; however, increasingly in North America. this person may also be a nurse practitioner, a Pediatrician, or an Internist.

PIA: Physician Initial Assessment - The first contact with a physician after arrival at an ED.

RAZ: Rapid Assessment Zones - An area in an ED to facilitate efficient care of patients with moderate acuity. These patients typically are well enough to wait in a chair in an internal waiting area adjacent to the exam areas, but require a stretcher for assessment or intimate examinations. These zones allow privacy while increasing stretcher productivity.

SSU: Short Stay Units - provide an alternative to traditional inpatient services for patients with short anticipated hospital stays. See MAU, there is overlap in these concepts.

Target - refers to a designated benchmark for key performance metrics.

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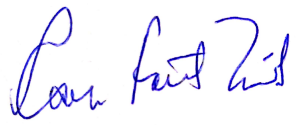
This is **Exhibit "F"** referred to in the Affidavit

of **Dr. Travis Carpenter,** sworn this 21st 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)

CONTINUING CARE *Living well in a place you call home.*

Entering Long-Term Care

For those who can no longer live in their home or community alone, or with relatives/friends with Home Care supports, long-term care may be the answer. Long-term care provides meals and accommodation, supervision, personal care, and nursing services for those who need it.

The Department of Health and Wellness licenses and approves two types of long-term care facilities; residential care facilities and nursing homes. Residential care facilities are designed for people who need minimal supervision, but may require help with personal care and reminders about routine tasks and activities, such as taking medication. Nursing homes are designed for people who require personal care, nursing services and medication administration.

How do I know if I need to go to a long-term care home?

Everyone's situation is different. Some people enter long-term care because:

- Their care needs may exceed what Home Care can provide.
- The family member(s) who usually provide their care, can no longer do so.
- Their health care status may change, requiring a higher level of care, such as ongoing nursing services.

How do I apply for long-term care?

If you or a family member needs long-term care, call Continuing Care, toll free, at **1-800-225-7225**.

If you are in the hospital, you can also call the toll-free line or have the hospital staff make the referral on your behalf.

How do I know the level of care I need?

After you contact Continuing Care, a Care Coordinator will meet with you to assess your care needs. Other professionals may also need to meet with you and your family to better understand your personal situation.

I may need a nursing home in a couple of years…should I apply now?

No, only those who are ready to move into a home now should apply.

Can I choose where I want to live?

Yes, you can choose the home you prefer and is able to meet your care needs. Your Care Coordinator will discuss your options with you and your family. You may choose as many long-term care homes as you wish. Your name will be placed on a wait list according to the date you were approved for long-term care.

What should I keep in mind when selecting these homes?

It is important you put your name only on wait lists of homes where you are sure you want to live. You or a family member should consider visiting some homes when making selections. When choosing a nursing home or residential care facility, keep the following points in mind:

- Is the home in a community where you would like to live?
- Is the location of the home convenient for friends and family to visit?
- Does the home offer activities and services you enjoy?

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How long are the wait lists?

The length of home wait lists varies and depends on a number of factors. Wait times can range from several weeks to several months, or longer. Wait times depend on the number of people who are waiting to get into a specific home, as well as how quickly suitable vacancies become available.

If you live at home and your situation worsens while you are on the wait list, you should contact your Care Coordinator. The Care Coordinator may be able to arrange for other services, such as additional Home Care or respite care. If you feel you need hospital care, please call your family doctor.

When I get a bed offer, can I defer placement if I'm not ready to go?

As of March 2, 2015, clients waiting in the community for placement in a long term care facility will no longer have the option to defer placement until a later date. When the client receives a bed offer, they must either accept or refuse the bed.

What happens if I turn down a bed that is offered to me?

If you choose to refuse a bed offer, regardless of whether you are waiting at home in your community or in hospital and subject to First Available Bed provision, you will be removed from the wait list. Individuals who refuse a bed offer and wish to reapply will have to wait 12 weeks, unless there has been a significant change to their health status.

How long will I have to wait for a long-term care placement if I want to live in the same home as my family member?

When you meet with your Care Coordinator, he/she will determine whether you require long-term care and if your care needs can be met in the same facility as your family member. Efforts are made to place certain family members in the same facility as soon as possible.

What do I need to know if I am in the hospital waiting for long-term care placement?

Every effort will be made to place you in the home of your choice. However, when a suitable bed is not available in your chosen home, you will be asked to move to the first available bed within 100 kilometers of the community of your choice. When a suitable bed becomes available in one of your selected home(s), you will have the option to transfer there. If you decline a placement, the hospital may discharge you or charge you a daily fee to stay in the hospital.

What if I'm not eligible for long-term care?

There is a Service Decision Review Process that you can discuss with your Care Coordinator.

Do I pay for my own long-term care?

Long-term care costs are shared by you, the resident, and the provincial government. You pay your accommodation costs and personal expenses and the Department of Health and Wellness pays your health care costs.

The Department of Health and Wellness sets standard accommodation charges annually. Those who can pay the standard accommodation charge are not required to complete a financial assessment. Those who cannot pay the standard accommodation charge can apply to have their rate reduced through an income based financial assessment. Please refer to the Paying for Long Term Care fact sheet for more detail.

To learn more about Long Term Care, please call Continuing Care toll-free line at **1-800-225-7225,** or visit the Department of Health and Wellness website at **novascotia.ca/dhw/ccs.**

This is **Exhibit "G"** referred to in the Affidavit of **Dr. Travis Carpenter,** sworn this 21st 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)

Long-Term Care Services

Last updated on January 4, 2024

Long-term care services provide 24-hour professional supervision and care in a protective, supportive environment for people who have complex care needs and can no longer be cared for in their own homes or in an assisted living residence. Long-term care services include:

- standard accommodation;
- development and maintenance of a care plan;
- clinical support services (e.g., rehabilitation and social work services) as identified in the care plan;
- ongoing, planned physical, social and recreational activities (e.g., exercise, music programs, crafts, games);
- meals, including therapeutic diets prescribed by a physician, and tube feeding;
- meal replacements and nutrition supplements as specified in the care plan or by a physician;
- routine laundry service for bed linens, towels, washcloths and all articles of clothing that can be washed without special attention to the laundering process;
- general hygiene supplies, including but not limited to soap, shampoo, toilet tissue, and special products required for use with facility bathing equipment;
- routine medical supplies;
- incontinence management;
- basic wheelchairs for personal exclusive use;
- basic cleaning and basic maintenance of wheelchairs; and
- any other specialized service (e.g., specialized dementia or palliative care) as nee by the client that the long-term care home has been contracted to provide.

For more information on wheelchairs, see Client FAQs (below).

If you require long-term care services, supportive and compassionate care is provided in long-term care homes with the goal of preserving an individual's comfort, dignity and quality of life as their needs change, and to offer ongoing support for family and friends. For more information about hospice care and end-of-life care services provided in long-term care homes, go to:

- Hospice, Palliative and End-of-Life Care

For more information about long-term care services, go to:

- Home and Community Care Policy Manual (Chapter 6)

Is this care right for me?

Long-term care services are for people who can no longer be cared for in their own homes or in an assisted living residence and:

- have severe behavioural problems on a continuous basis;
- are cognitively impaired, ranging from moderate to severe;
- are physically dependent, with medical needs that require professional nursing care, and a planned program to retain or improve functional ability; or
- are clinically complex, with multiple disabilities and/or complex medical conditions that require professional nursing care, monitoring and/or specialized skilled care.

What are the long-term care eligibility criteria?

In addition to the general eligibility criteria for home and community care services, to be eligible for long-term care services you:

- have been assessed as having 24-hour professional nursing supervision and care needs that cannot be adequately met in your home or by housing and health services;
- are at significant risk by remaining in your current living environment, and the degree of risk is not manageable using available community resources and services;
- have an urgent need for long-term care services;

- have been investigated and treated for medical causes of disability and dependency that may have been remedial;
- have a caregiver living with unacceptable risk to their well-being, have a caregiver who is no longer able to provide care and support, or do not have a caregiver; and
- have agreed to pay your assessed rate (see Home and Community Care Policy Manual, Policy 7.B, Income Based Clients) and charges for any optional services, programs or supplies that you choose, that are not included as a benefit but are offered by the long-term care home.

To read the general eligibility criteria for all home and community care services, go to:

- Are You Eligible?

How do I arrange for long-term care services?

If you are interested in receiving long-term care services or know of someone who might need these services, you can contact your health authority's home and community care office, or you can have a health care professional make a referral on your behalf.

For contact information and a detailed description of how to arrange for long-term care services, please see:

- How to Arrange for Care

Veterans please note:

If you are a veteran and you are eligible for home and community care services, your health authority is required to contact Veterans Affairs Canada for an assessment of eligibility for federal benefits and arrange your placement on their veterans' priority access bed waitlist for those long-term care homes with veterans' priority access beds.

Access to Long-Term Care Services

If you and the health authority professionals working with you determine that you qualify for publicly subsidized long-term care services, your health authority will provide you with detailed information on the long-term care homes that meet your care needs and are located in your chosen geographic area, including average wait times for admission. You will have the ability to choose up to three preferred care homes and your name will be

placed on the waitlist for those homes. If you can wait safely at home, you will be offered support services until a bed is available. If you cannot wait safely at home, you will be offered a bed in an interim care home until a bed is available in your preferred care home. Your waitlist date will be the date you choose your preferred care homes and you will maintain your position on the waitlist regardless of where you are waiting. The primary criteria for choosing which client is offered care and accommodation in a long-term care home is wait time (i.e., those who have been waiting longest get highest priority), with consideration for situations where a client is at an intolerable risk or for the reunification of spouses residing in different long-term care homes. Wait times vary for each care home and fluctuate over the course of time.

Exceptional situations that may result in a higher ranking for a client include: repatriating a client who was temporarily admitted to a care home outside of their community or to a hospital; closure of a client's care home; temporary pressures, such as a natural disaster and/or a need to relieve pressure on a hospital on a short-term, time-limited basis.

How do I decide which long-term care home is best for me?

Your health care professional will provide you with detailed information regarding the long-term care homes that meet your individual care needs, including average wait times. It is advisable that you visit the long-term care homes on the list.

There are many things to consider as you plan for your future care needs. In B.C., long-term care services and support options are available from both publicly subsidized and private pay long-term care homes. The following booklet contains information about eligibility, cost, services, oversight, and practical examples of things to consider when selecting a long-term care home:

- Help in Selecting a Long-Term Care Home (PDF, 386KB)

In addition to the information provided to you regarding specific long-term care homes, many care homes have an information brochure or package that provides an overview of their philosophy and services, and answers many of your questions.

You can also ask for the admissions agreement or similar documentation. An admission agreement will clarify what services are provided, what services are not available, and any extra charges that may apply for a given long-term care home. Many long-term care homes also have their own websites.

To learn more about long-term care homes in your region, visit the long-term care pages on your health authority's website using the links below:

- Fraser Health
- Interior Health
- Island Health
- Northern Health
- Vancouver Coastal Health

Offer of Care and Accommodation

Once you are offered care and accommodation in a preferred care home, you have 48 hours to accept an offer and move into your preferred care home. If you are offered care and accommodation in an interim care home, you have 72 hours to accept an offer and move into the interim care home. If you decline an offer of care and accommodation in an interim care home, you will remain eligible for access to long-term care services and remain on the waitlist for your preferred care homes. The health authority will advise you of your options while waiting for your preferred care home.

If you believe you will not be able to move within the 48-hour period or have concerns about managing the cost of the move, speak with your health authority.

How do I transfer from an interim care home to my preferred care home?

While every effort is made to offer you care and accommodation in your preferred care home, if there is no vacancy in your preferred care home(s), you may first be offered care and accommodation in an interim care home. If you accept care and accommodation in an interim care home, you will retain your position on the waitlist for your preferred care home. At any time while in an interim care home, you can decide to remain there.

The amount of time you wait before you are offered the opportunity to transfer to your preferred care home will depend on several factors, including the number of people who are waiting to transfer to that long-term care home. Average wait times for specific long-term care homes are available through the health authority.

If you are paying privately for long-term care services while waiting for access to publicly-subsidized care, you cannot be guaranteed your subsidized bed will be in the same long-term care home. If the long-term care home that you are living in has publicly-subsidized beds, you can identify that long-term care home as one of your preferred care homes. If there is no availability in one of your preferred care homes, you may be offered a publicly-subsidized bed in an interim care home. If this is the case, you will retain your original wait time for your preferred care home.

Choosing to pay privately for residential care should not impact the length of time you wait for an offer of care and accommodation in a publicly-subsidized long-term care home. If you have concerns with the length of time that you have been waiting, you should raise your concerns with your health care professional.

Changing Selection of Preferred Care Homes

You may change your selection of preferred care homes until you are offered care and accommodation in one of them and, upon making the change, will maintain your original waitlist date. If you change your selection at the time of or after being offered care and accommodation in one of your preferred care homes, your waitlist date for admission will be changed to the date at which you amended your choice of preferred care homes.

Client Transfers Between Health Authorities

If you are eligible for or receiving long-term care services, you may at any time, request admission to a long-term care home in another health authority. The health authority where you reside will provide you with options for long-term care homes appropriate to meet your care needs in your selected health authority.

If you are in hospital and cannot safely go home, and you want to transfer to another health authority, but there is no availability in a long-term care home in the receiving health authority, the health authority where you currently reside must offer care and accommodation to you in an interim care home until a there is availability in the receiving health authority.

For further information on transferring long-term care services between health authorities, please refer to the Home and Community Care Policy Manual, Policy 6.D.

Couples in Long-Term Care

When both spouses are eligible for long-term care services, the health authority makes every effort to place couples in a long-term care home together.

When only one member of a couple is eligible, and the couple wishes to stay together, the health authority will explore, with the couple, those options that may help to maintain and support their relationship.

For more information, refer to:

- Home and Community Care Policy Manual (Policy 6.D.1)

Community Care Facility Reports

Health authorities post summary inspection reports on their websites for routine and follow-up inspections of community care facilities licensed under the *Community Care and Assisted Living Act* or licensed or designated under the *Hospital Act.* The reports include information relating to substantiated complaints and inspections.

- Community Care Facility and Residence Reports

Family and Resident Councils

A family and/or resident council is a group of persons who either live in a long-term care home or are the contact persons, representatives or relatives of long-term care home residents, and who meet regularly to identify opportunities to maintain and enhance the quality of life for the care home clients, and to engage with staff to contribute a voice in decisions which affect the clients. A resident/family council is self-led, self-determining and democratic.

- Family and Resident Councils

Is there a cost for long-term care services?

If you receive publicly subsidized long-term care services, you will pay a monthly rate of up to 80 per cent of your after tax income towards the cost of secure, supervised housing and care services, subject to a minimum and maximum monthly rate. Your monthly rate is calculated based on your “after tax income” (as defined in the Continuing Care Fees Regulation) in one of two ways:

If your after tax income is less than $19,500 per year, your monthly rate is calculated as your after tax income less $3,900 and divided by 12 (Formula A).

Note: The $3,900 deduction ($325 per month X 12 months) is set to ensure that most clients have at least $325 of income remaining per month after paying their monthly rate.

If your after tax income is equal to or greater than $19,500 per year, your monthly rate is calculated as your after tax income multiplied by 80 per cent and divided by 12 (Formula B).

For more information on how your after tax income is calculated, please see:

- Continuing Care Fees Regulation
- Hospital Insurance Act Regulations (Division 8)

The minimum monthly rate is adjusted each year based on changes to the Old Age Security/Guaranteed Income Supplement (OAS/GIS) rate as of July 1 of the previous year. For 2024, the minimum monthly rate for a client receiving long-term care services is $1,417.00 per month.

If you and your spouse are sharing a room in a long-term care home and are both in receipt of the Guaranteed Income Supplement (GIS) benefit at the married rate, your monthly rate will be calculated based on your after tax income, subject to a minimum and maximum monthly rate. For 2024, the minimum monthly rate for a couple sharing a room and both in receipt of the GIS benefit at the married rate is $1,001.69 per month per person.

The maximum client rate is adjusted each year based on changes to the Consumer Price Index over the previous year. For 2024, the maximum monthly rate for a client receiving long-term care services is $3,974.10 per month.

If you receive support and/or shelter allowance under the *Employment and Assistance Act* or the *Employment and Assistance for Persons with Disabilities Act*, you will pay a fixed monthly rate for your long-term care services. For more information on these fixed monthly rates, please contact your health authority.

For more general information on the costs of publicly subsidized home and community care services in B.C., please see:

- Who Pays for Care?

If payment of your assessed monthly rate would cause you or your family serious financial hardship, you may apply to your health authority for a temporary reduction. For more information, please see below, **"What if I cannot afford my assessed monthly rate?"**.

What if I cannot afford my assessed monthly rate?

If you are receiving long-term care services and payment of your assessed monthly rate would cause you or your family serious financial hardship, you may be eligible for a reduced rate.

Serious financial hardship means that payment of your assessed monthly rate would result in you (or your spouse, if applicable) being unable to pay for:

- adequate food;
- monthly mortgage/rent;
- sufficient home heat;
- prescribed medication; or
- other required prescribed health care services.

For more information on eligibility and how to apply for a temporary rate reduction of your monthly rate, please see:

- Temporary Reduction of Your Client Rate

What optional services can I choose to pay for in addition to my monthly rate?

Long-term care homes may also offer you optional equipment, products, and services in addition to those that are included as part of your long-term care services. If you choose to receive any of these optional services, you may be required to pay an additional fee over and above your monthly rate. These optional services may include:

- personal cable connection and monthly fee;
- personal telephone connection and basic services;
- nutrition supplements, where the client requests a specific commercial brand rather than the brand provided by the long-term care home;
- personal newspaper, magazines and periodicals;

- hearing aids and batteries, including replacement batteries;
- personal transportation;
- extra or optional craft supplies, entertainment and recreational activities that are additional to activities and supplies provided as benefits above, and are chosen by the client;
- an administration or handling fee associated with the service, where reasonable, to perform a task or service that would normally be the client's responsibility;
- purchase or rental of equipment that is for the exclusive use of the client (e.g., walker, crutches, canes or other devices, and maintenance as required);
- modifications to basic wheelchairs/ modified wheelchairs, specialized wheelchairs, as per Policy 6.F.1;
- therapist fees for assessment and determination of modified wheelchair and specialized wheelchairs;
- miscellaneous charges associated with wheelchair cleaning and maintenance such as non-basic maintenance services, emergency cleaning, and damage;
- companion services;
- personal dry cleaning or laundry services for items requiring special attention; and
- personal hygiene and grooming supplies that the client chooses in preference to general supplies provided by the long-term care home including:

    - facial tissue
    - hand lotion
    - denture cleaner
    - brush and comb
    - toothpaste
    - hair shampoo and conditioner
    - talcum powder
    - shaving cream
    - special soap
    - preferred incontinence supplies.

Frequently Asked Questions about Wheelchairs for Long-Term Care (including short-stay) Clients

1. What is the policy on basic wheelchairs in long-term care homes?

   Long-term care clients who reside in publicly-subsidized long-term care homes have access to a free basic wheelchair for personal exclusive use, if required. Basic maintenance and basic cleaning of the basic wheelchairs will also be provided as a free benefit. For additional information, please speak with your long-term care home.

2. What qualifies as a basic wheelchair?

   A basic wheelchair is a manual, self-propelled, safe and durable wheelchair that enhances personal mobility; has a basic contoured seat cushion; and which is reasonable to obtain and maintain. A basic wheelchair is a wheelchair without modification, upgrade, customization or specialization. A custom-made wheelchair is not a basic wheelchair. Bariatric wheelchairs and wheelchairs with super-low seating are not basic wheelchairs. For additional information, please speak with your long-term care home.

3. I am eligible/ have access to wheelchair benefits from another organization, can I utilize both sets of benefits?

   No. If you are eligible for wheelchair benefits from other organizations (such as Veteran's Affairs Canada, Worker's Compensation, etc.), you do not qualify for the wheelchair benefit provided through the Ministry of Health, Home and Community Care Program.

   If you have extended health benefits, which provide assistance with wheelchairs, discuss your options with your long-term care home.

Licensing and Residential Care

For information about licensed residential care facilities, see:

- Community Care Licensing

Residents' Bill of Rights

The Residents' Bill of Rights is a comprehensive set of rights grouped into four main themes: commitment to care; rights to health, safety and dignity; rights to participation and freedom of expression; and rights to transparency and accountability. For more information, see:

- Residents' Bill of Rights

Other Home and Community Care Services

For a full list of the types of care that are publicly subsidized in B.C., see:

- Care Options and Costs

Did you find what you were looking for?

Yes No

The B.C. Public Service acknowledges the territories of First Nations around B.C. and is grateful to carry out our work on these lands. We acknowledge the rights, interests, priorities, and concerns of all Indigenous Peoples - First Nations, Métis, and Inuit - respecting and acknowledging their distinct cultures, histories, rights, laws, and governments.

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6.A
SECTION:	A	GENERAL DESCRIPTION AND DEFINITIONS	**PAGE:**	1 OF 4
SUBSECTION:			**EFFECTIVE:**	NOVEMBER 4, 2019

Intent
To describe health authorities' responsibilities in planning and delivering publicly subsidized long-term care services.

Policy
Health authorities must plan and deliver publicly subsidized long-term care services to clients as part of their established care plans, which can include short-stay services provided as:

- convalescent care;
- hospice care;
- respite care; or
- services for other purposes determined appropriate by a health authority to meet the unique needs of the client.

Health authorities must:

- ensure that long-term care services are delivered in compliance with the Residential Care Regulation;
- establish local service delivery models that will provide clients with access to long-term care services within their community or within accessible distance to their community;
- authorize and manage access to long-term care services, including short-stay services, by:
    - determining the client's needs using assessment criteria (Long-Term Care Access Guidelines), clinical judgment and best evidence, identifying the appropriate service for the identified needs, and facilitating access to long-term care services where appropriate;
    - informing clients, substitutes and their caregivers of the process for managing the waitlist and admission;
    - establishing a plan with clients and their families/caregivers to assist them to remain safely at home with support services where required until they are admitted to a long-term care service;
    - providing information to the client, substitute and their caregivers about the relevant long-term care services available at the long-term care homes appropriate for the client's care needs, as set out in the Long-Term Care Access Guidelines; and

- ensuring that consent for admission to a long-term care home is obtained as per the *Health Care (Consent) and Care Facility (Admission)* (see 6.D.2, Consent to Long-Term Care Home Admission)

Definitions

care and accommodation refers to the long-term care services that are being offered to the client when a vacancy becomes available in either an interim care home or a preferred care home.

Community Care Licensing provides licensing, inspection and monitoring of the health and safety of individuals living in community care facilities licensed under the *Community Care and Assisted Living Act* and Residential Care Regulation as delegated by the Medical Health Officer.

convalescent care is a short-stay service provided to clients with defined and stable care needs who require a supervised environment for reactivation or recuperation usually prior to discharge home, most commonly following an acute episode of care.

hospice care is a short-stay service provided in a hospice bed to clients who require support with comfort, dignity and quality of life in the final days or weeks of their lives, and is distinct from the end-of-life care provided to clients residing in a long-term care home.

interim care home is specific to each client and is a long-term care home that is not one of the client's preferred care homes.

long-term care home is a facility designated by the health authority to provide long-term care services, including short-stay services, and includes licensed community care facilities, private hospitals and extended care hospitals.

long-term care services provide a secure supervised physical environment, with accommodation and care, to clients who:

a. cannot have their care needs met in their own home or in an assisted living residence on a permanent basis; or
b. require convalescent care, hospice care or respite care on a short-term basis.

Patient Care Quality Office is the central complaints office within each health authority that receives, investigates and responds to complaints regarding the quality of care that a client received, and derives its authority from the *Patient Care Quality Review Board Act*.

preferred care home is specific to each client and is a long-term care home selected by the client or substitute as a care home where they prefer to be admitted.

RAI MDS 2.0 is a comprehensive, standardized instrument for evaluating the needs, strengths and preferences of people in long-term care settings.

resident/family council is a group of people who are either clients living in a long-term care home, or are their family members or close friends, who meet regularly to identify opportunities to maintain and enhance the quality of life for clients of the care home, and to engage with staff to contribute a voice in decisions which affect the clients of the care home.

respite care is a short-stay service provided for the purpose of allowing the client's principal caregiver a period of relief, or to provide the client with a period of supported care to increase independence.

short-stay services are facility-based services provided on a short-term basis (usually less than three months) and include a safe, supervised physical environment, with accommodation and care to those who need convalescent care, hospice care or respite care.

substitute means:

- the client's committee of person, or
- if there is no committee of person, the person chosen by the manager, under section 22 of the *Health Care (Consent) and Care Facility (Admission) Act,* to give or refuse consent to admission to, or continued residence, in a long-term care home, on behalf of a client who has been determined to be incapable of giving or refusing this consent.

References

Community Care and Assisted Living Act
Director of Licensing Standard of Practice Number: 01/08/2006
Health Care (Consent) and Care Facility (Admission) Act
Hospital Act
Patient Care Quality Review Board Act
Long-Term Care Access Guidelines
Residential Care Regulation

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6.B
SECTION:	B	SHORT-STAY SERVICE NEEDS DETERMINATION	**PAGE:**	1 OF 1
SUBSECTION:			**EFFECTIVE:**	NOVEMBER 4, 2019

Intent

To describe health authorities' responsibilities in determining the appropriate short-stay services to meet the client's needs.

Policy

Health authorities are responsible for determining the appropriate short-stay services to meet the client's needs.

Short-Stay Services

Short-stay services may include:

- convalescent care;
- hospice care;
- respite care; or
- services for other purposes determined appropriate by a health authority to meet the unique needs of the client.

Service Needs Determination

Health authorities can approve short-stay services for a client who:

- has been assessed as requiring short-stay services (see Policy 2.D, Assessment);
- has agreed to pay the applicable daily rate (see Policy 7.C.1, Short-Stay Services Rates);
- has given consent to admission to the care home or consent has been given by the client's substitute; and
- has agreed to vacate the care setting at the end of the agreed upon period of short-stay care.

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6.C
SECTION:	C	LONG-TERM SERVICE NEEDS DETERMINATION	**PAGE:**	1 OF 2
SUBSECTION:			**EFFECTIVE:**	NOVEMBER 4, 2019

Intent

To describe health authorities' responsibilities in determining the appropriate publicly subsidized long-term care services to meet the client's needs.

Policy

Health authorities are responsible for determining the appropriate long-term care services to meet the client's needs.

Service Needs Determination

Health authorities can approve long-term care services for a client who:

- has been assessed as having 24-hour professional nursing supervision and care needs that cannot be adequately met in the client's home or by housing and health services;
- is at significant risk by remaining in their current living environment, and the degree of risk is not manageable within available community resources and services;
- has an urgent need for long-term care services;
- has been investigated and treated for medical causes of disability and dependency that may have been remedial;
- has a caregiver living with unacceptable risk to their well-being, no longer able to provide care and support, or there is no caregiver available to the client;
- has given consent to admission to the care home or consent has been given by the client's substitute; and
- has agreed to pay the assessed client rate (see Policy 7.B, Income-Based Client Rates) and any additional charges (see Policy 6.F, Benefits and Allowable Charges) after being fully informed about those costs.

Client Characteristics for Long-Term Care Services Options

Clients eligible for long-term care services, not including short-stay services, refers to those who:

- have severe behavioural problems on a continuous basis;
- are cognitively impaired, ranging from moderate to severe;
- are physically dependent, with medical needs that require professional nursing care, and a planned program to retain or improve functional ability; or
- are clinically complex, with multiple disabilities and/or complex medical conditions that require professional nursing care, monitoring and/or specialized skilled care.

Reference

Health Care (Consent) and Care Facility (Admission) Act

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6.D
SECTION:	D	ACCESS TO SERVICES	**PAGE:**	1 OF 6
SUBSECTION:			**EFFECTIVE:**	NOVEMBER 4, 2019

Intent

To describe health authorities' responsibilities in managing timely access to long-term care services, including short-stay services, using a consistent, principle-based and transparent approach with the objective of achieving the best match between the client and the service.

Policy

Health authorities must coordinate access to all long-term care services, including short-stay services, consistent with the following:

- give priority for service to clients who have been assessed as having the highest care needs and/or the highest levels of risk; and
- determine which clients will have priority for admission or transfer for care and accommodation in a long-term care home, where more than one client's assessment of need and risk are equal.

Health authorities must facilitate access to long-term care services, other than short-stay services, consistent with the following requirements:

- manage access to long-term care services and transfer of clients between long-term care homes, based on the preference of the client or substitute and the available resources in the community;
- ensure clients and/or substitutes are fully informed of the long-term care access policy and processes at the earliest opportunity;
- ensure that the client or substitute has up to 72 hours to identify up to 3 preferred care homes, in no ranked order;
- where circumstances permit, allow the client or substitute to choose more than 3 preferred care homes;
- allow the client or substitute to change their choices of preferred care homes up until they are offered care and accommodation in one of their preferred care homes with no impact to their original waitlist date;
- ensure a client maintains their place on the waitlist for their preferred care homes while waiting for admission, even if they move into an interim care home;
- obtain consent to admission to the client's preferred care homes, as per the Policy 6.D.2, Consent to Long-Term Care Home Admission;
- monitor all clients waiting for admission to one of their preferred care homes to ensure they continue to meet eligibility requirements for access, as per Policy 6.C, Long-Term Service Needs Determination;
- determine the relative priority of all clients who have been assessed as eligible for publicly subsidized long-term care services for admission or transfers using criteria set out in the Long-Term Care Access Guidelines;

- manage, in an equitable manner, a client's transfer to a preferred care home where a client's request for a preferred care home cannot be met on admission;
- admit couples to the same care home where both members of a couple meet the eligibility criteria for long-term care services, and when desired by the couple;
- develop a consultation process with a service provider to determine whether a long-term care home is appropriate for the needs of the client, and/or how the care home can address the needs of the client, where the service provider has requested that the referral decision be reviewed. This does not constitute an authority for a service provider to accept or reject specific clients. A client's specific diagnosis or a client's history of colonization or infection with a multiple antibiotic resistant organism is not, in itself, grounds to request a review of a referral decision; and
- monitor continuously the status of clients approved and waiting for admission to long-term care services, including:
  - an increase in the availability and flexibility of community health supports and home support services;
  - a care plan that meets the needs of the client while waiting for placement; and
  - preparation and information regarding placement in long-term care services.

Access Prioritization Criteria

The prioritization process begins immediately after:

- the client or substitute has been provided with a list of long-term care homes that align with the client's geographical and cultural preferences, and can meet the client's care needs;
- the clinician and client or substitute have had a comprehensive conversation about admission/transfer options and processes including what happens when a client or substitute declines an offer of care and accommodation in a preferred or interim care home; and
- the client or substitute has identified the client's preferred care homes or identified that the client or substitute is willing to accept an admission into any long-term care home that can meet the client's needs.

Offer of Care and Accommodation

An offer will be made to the client when care and accommodation becomes available in one of the client's preferred care homes.

The client or substitute has up to 48 hours to make a decision on whether to accept the offer, and, if accepted, move into the preferred care home.

If there are no vacancies in any of the client's preferred care homes, the client may be offered care and accommodation in an interim care home when one becomes available, if the client or substitute has agreed to consider interim care homes. The client or substitute has up to 72 hours to make a decision on whether to accept the offer, and, if accepted, move into the interim care home.

A client is eligible for transfer from an interim care home to one of their preferred care homes upon being admitted to the interim care home.

While residing in the interim care home, unless the client or substitute decides the client will remain there, the client will retain their priority position on the waitlist for transfer to one of their preferred care homes.

Changing Selection of Preferred Care Homes

Clients and substitutes can change their selected preferred care home(s) up until they are offered care and accommodation in one of their preferred care homes and, upon making the change, will maintain their original waitlist date.

If the client or substitute changes their selection at the time of or after being offered care and accommodation in one of their preferred care homes, their waitlist date for admission will be changed to the date at which the client or substitute amended their list of preferred care homes.

Declining an Offer of Care and Accommodation

If the client or substitute declines an offer of care and accommodation in an interim care home or in one of their preferred care homes, they will be advised of options for publicly-subsidized and/or private pay services, and support from family/friend caregivers.

If the client is in hospital and remains there, they will be subject to client charges based on provincial acute care policy.

If the client or substitute declines an offer of care and accommodation in one of their preferred care homes, they may still be offered care and accommodation in that particular long-term care home as an interim care home. The policy regarding changing choice of preferred care homes will apply in these situations.

Complaints Resolution
Clients or persons acting on behalf of the client may, at any time, initiate a complaint regarding the access process for publicly subsidized long-term care services. See HCC Chapter 2.E Complaint Process for details on how to submit a complaint.

Veterans Priority Access Beds
Veterans Affairs Canada priority access beds are beds designated by the Ministry and Veterans Affairs Canada for veterans who are eligible for a long-term care home as set out in this manual and under the *Department of Veterans Affairs Act*.

Health authorities must:
- refer a veteran who is eligible for home and community care services to Veterans Affairs Canada for an assessment of eligibility for federal benefits; and
- manage and maintain a veterans' priority access bed waitlist in those long-term care homes with veterans' priority access beds.

Eligibility for Federal Benefits
Veterans Affairs Canada will:
- advise the health authority if a veteran is eligible for federal benefits and, upon admission, will advise the service provider of the costs of health care payable by the veteran; and
- determine the Veteran Admission Priority Category (A, B or C).

Veterans' Priority Access Bed Waitlist
The name of a veteran who is eligible and agrees to admission to a veterans' priority access bed is to be placed on the regular health authority priority access list, as well as the veterans' priority access bed waitlist at those long-term care homes with veterans' priority access beds. This ensures veterans are not penalized if a suitable regular bed becomes vacant before a veterans' priority access bed becomes available. Veterans occupying regular beds will be transferred to veterans' priority access beds when their names reach the top of the veterans' priority access bed waitlist for a long-term care home.

The veteran's position on a priority access bed waitlist is first determined by the veteran's need for placement and the veteran's admission priority category. Those in category A are the highest priority for admission, followed by B, and then C, provided that the need for placement is equal. The only exception is that a veteran hospitalized from a priority access bed and awaiting placement in the originating

long-term care home is to be admitted to the next priority access bed available, regardless of the veteran's service priority category.

If there is no veteran on the waitlist for a veterans' priority access bed, vacant beds may be offered to non-veterans. When a veteran's name is subsequently placed on the veterans' priority access bed waitlist, the next vacant bed in the long-term care home is to be designated a veterans' priority access bed.

Non Resident Admissions

A veteran who is not a client may be admitted to George Derby Centre (Burnaby), Brock Fahrni Pavilion (Vancouver) or The Lodge at Broadmead (Victoria) if the veteran:

- would be eligible as a client but for the required residency period; and
- is eligible for a veterans' priority access bed.

Veterans Affairs Canada will pay the full cost of care (less a portion for which the veteran is responsible as determined by Veterans Affairs Canada) for the veteran until the veteran is eligible to receive publicly subsidized home and community care services.

Client Transfers between Health Authorities

Clients eligible for or receiving a long-term care service may, at any time, request admission to a long-term care home in another health region that is appropriate to meet the client's care needs.

The health authority where the client currently resides must contact the receiving health authority responsible for the long-term care home or location requested and must:

- determine whether the client meets the access criteria for the long-term care service requested; and
- provide the receiving health authority with the most recent assessment and full documentation to support the request; and
- provide information to the client or substitute about the relevant long-term care services available at the long-term care homes appropriate for the client's care needs, in the receiving health authority, as set out in the Long-Term Care Access Guidelines.

Where the client is in hospital and wants to transfer to another health authority, and where there is no availability in either a preferred or interim care home in the receiving health authority, the health authority where the client currently resides must offer care

and accommodation to the client in an interim care home until something becomes available in the receiving health authority.

The receiving health authority is required to:

- manage access to the long-term care home in their region for out of region clients in the same manner as for clients currently living in that region;
- ensure that the client or substitute is personally aware of, and consents to, any plans for transfer that have been initiated by family members or responsible health care professionals.

Temporary Absences

A client may be temporarily absent from a long-term care home:

- due to hospitalization or admission to specialized services; or
- if a reasonable period of absence is in the best clinical or personal interests of the client.

The cumulative client absences due to hospitalization or admission to specialized services are not limited during a calendar year.

The cumulative client absences for personal reasons are limited to 30 days in a calendar year unless the health authority approves otherwise.

The client is required to continue to pay their client rate during a temporary absence from the long-term care home unless arrangements have been made for another person to temporarily use the client's bed. In this case, the temporary client is responsible for paying the client rate.

Reference

Hospital Policy Manual: Eligibility, Benefits, and Reporting
Long-Term Care Access Guidelines
Veterans Affairs Canada/Ministry of Health Services Transfer Agreement, 1974

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6.D.1
SECTION:	D	ACCESS TO SERVICES	**PAGE:**	1 OF 3
SUBSECTION:	1	SUPPORTING SPOUSES WITH DIFFERING CARE NEEDS	**EFFECTIVE:**	JULY 15, 2019

Intent

To ensure that health authorities involve spouses, families and their caregivers in exploring a range of options available to support and maintain the continuity of spousal relationships when only one spouse requires long-term care services.

Policy

When only one spouse meets the eligibility criteria for long-term care services, and the spouses have requested to continue living together, health authorities will work with spouses and their families or primary caregivers to identify options that support the continuity of an ongoing spousal relationship. A planning meeting will be held and information provided on:

- implications and potential challenges for both spouses;
- options that could provide reasonable arrangements; and
- practical considerations like costs and processes.

Definitions

campus of care is a situation where more than one level of housing, services and care is provided in a residence or group of buildings, e.g., assisted living services in one building and long-term care services in an adjacent building.

non-eligible spouse is a spouse that does not meet the eligibility criteria for admission to long-term care services.

reasonable arrangements are alternatives determined by making an assessment of available resources while using diligence and good faith.

Reasonable Arrangements

Health authorities are not required to admit individuals into publicly subsidized long-term care homes who do not meet the criteria for long-term care services (see Policy 6.C. Long-Term Care Services, Service Needs Determination). In those rare instances, where spouses feel that separation as a result of long-term care placement is a significant hardship to their health and well-being, health authorities will engage in a collaborative approach to explore reasonable arrangements that would enable spouses to maintain and support their relationship.

Reasonable arrangements may include:

- facilitation of the spouses to spend time together in the long-term care home on a regular basis including shared meals;

- identifying transportation options that may assist a non-driving spouse to visit the long-term care home;
- identifying opportunities for accommodation for the non-eligible spouse in a nearby independent housing unit, apartment block, or other housing accommodation;
- considering any opportunities for co-location in a campus of care setting;
- considering any opportunities for co-location in an assisted living unit (see Policy 5.B, Service Needs Determination).

Co-locating in a Long-term Care Home

In exceptional circumstances where no other reasonable arrangement or appropriate and available community resources exist to meet the combined care needs of both spouses, health authorities may consider the non-eligible spouse for residency within the same long-term care home as the eligible spouse.

Exceptions will be guided by an assessment of the following criteria:

- capacity of the long-term care home to accommodate an individual who does not need care services;
- need to support the language, cultural customs, values and beliefs of the spouses;
- impacts of separation on the health and well-being of both spouses;
- impacts of admission to long-term care on the non-eligible spouse; and
- impacts for other individuals eligible for long-term care, should their admission be delayed in order to accommodate a non-eligible spouse.

Planning Meeting

Health authorities must coordinate a planning meeting that involves the spouses, family members and caregivers (if requested by the spouses), their primary health care provider and the health authority care manager, prior to approving an exception for joint residency of a couple with a non-eligible spouse. Areas to be discussed include:

- a review of reasonable arrangements for accommodating the spousal relationship;
- expectation of family responsibility for supporting reasonable arrangements;
- financial costs to both spouses of all publicly subsidized options;
- description of services, programs and benefits within the long-term care home for the non-eligible spouse;

- conditions in which the exit of the non-eligible spouse may be required; and
- considerations for the non-eligible spouse including:
  - potential loss of privacy and choice in routines, activities and meals;
  - potential for increasing dependence;
  - potential impact of changing care needs on the spousal relationship;
  - their changing care-giver role in relation to the care that will be provided to the spouse in the long-term care home; and
  - adjustment to the new environment and risks that may be associated with the complex care provided in long-term care homes.

Admission Agreement

When a non-eligible spouse is admitted to a long-term care home with the sole or primary purpose of accompanying an eligible partner, health authorities must ensure that there is a signed written agreement prior to admission that includes:

- costs to the non-eligible spouse including access to programs, benefits and services while residing in the long-term care home;
- a waiver of any care services normally provided in the long-term care home, yet not required by the non-eligible spouse at admission; and
- an exit plan (should the eligible spouse pre-decease the non-eligible spouse) that includes the health authority's responsibility for assisting the non-eligible spouse to relocate to an appropriate housing environment within 6 months.

The conditions of an existing admission agreement for the non-eligible spouse may be removed in the event that the non-eligible spouse is assessed to require long-term care services. When this occurs, the spouse becomes a permanent resident of the long-term care home.

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6.D.2
SECTION:	D	ACCESS TO SERVICES	**PAGE:**	1 OF 7
SUBSECTION:	2	CONSENT TO LONG-TERM CARE HOME ADMISSION	**EFFECTIVE:**	NOVEMBER 4, 2019

Intent

To ensure that health authorities comply with Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* including the requirements to seek and obtain consent from a client or their substitute prior to admission into a long-term care home and to assess a client when there is reason to believe a client may be incapable of giving or refusing consent.

Policy

Health authorities must ensure that:

- consent is obtained prior to a client's admission to a long-term care home (including short-stay services);
- the consent is voluntary, informed, given by a capable adult of giving or refusing consent to care facility admission, and specific to the facility to which they are admitted;
- if the client seems unable to understand and appreciate the information provided about long-term care homes, they are assessed to determine if they are incapable of giving or refusing consent to care facility admission;
- if the client is determined to be incapable of giving or refusing consent to a care facility, consent to care facility admission is sought from a substitute as set out in section 22 of the *Health Care (Consent) and Care Facility (Admission) Act*; and
- when a client expresses the desire to no longer remain residing at a long-term care home, the requirements in the *Health Care (Consent) and Care Facility (Admission) Act* and Residential Care Regulation for continued residence are followed.

Health authorities are expected to follow the Practice Guidelines for Seeking Consent to Care Facility Admission in its admission processes and when assessing if a client is incapable of giving or refusing consent to care facility admission.

Definitions

assessor refers to the person who is responsible for assessing whether a client is incapable of giving or refusing consent to admission to, or continued residence in, a care home, and who is qualified to make a determination of incapability according to the *Health Care (Consent) and Care Facility (Admission) Act*.

capable means capable of giving or refusing consent to admission to, or continued residence in, a care home.

capable client means a client who has not been determined to incapable of giving or refusing consent to admission to, or continued residence in, a care home.

committee of person is the person (or Public Guardian and Trustee) appointed by the court according to the *Patients Property Act* to make personal and health care decisions for a person who is declared by the Court to be incapable of managing themself.

designated person means the persons designated by the health authority to receive reports of a substitute who is acting in a manner that may be abusive or harmful to the client for whom they are making decisions.

incapability assessment means an assessment made according to section 26 of the *Health Care (Consent) and Care Facility (Admission) Act,* to determine if a client is incapable of giving or refusing consent to admission to, or continued residence in, a care facility.

incapable means incapable of giving or refusing consent to admission to, or continued residence in, a care home.

incapable client means a client who has been determined through an incapability assessment of being incapable of giving or refusing consent to admission to, or continued residence in, a care home.

manager means the person responsible for coordinating the admission process, and seeking and obtaining consent for care facility admission.

Manager Responsible for Seeking Consent to Admission
Before a client is admitted into a long-term care home, consent for the admission must be obtained from the manager. For an admission to a care home, the manager will be the health authority employee who is responsible for coordinating the admission process, unless the health authority does not coordinate admissions for the care home (in which case the person responsible for this process at the care home will be the manager).

Health authorities must ensure managers fulfill this responsibility in accordance with the Practice Guidelines for Seeking Consent to Care Facility Admission. It is also expected that managers successfully complete the course, Consent to Care Facility Admission in British Columbia: A Course for Managers and Assessors.

When Consent to Admission is Obtained
Consent to admission must be obtained prior to the client moving into the long-term care home. For long-term care services, other than short-stay services, consent for admission will be sought and obtained at the time when preferred care homes are identified, as per policy 6.D, Access to Services. Prior consent to admission to a preferred care home or interim care home does not prevent a client or substitute from revoking their consent before or when care and accommodation becomes available.

Informed Consent
The requirements for providing information to a client or substitute when seeking consent to care facility admission are set out in section 21 (1) (d) of the *Health Care (Consent) and Care Facility (Admission) Act* and described in the Practice Guidelines for Seeking Consent to Care Facility Admission. The Long-Term Care Access Guidelines specify the requirements for providing information about the care provided and services available in long-term care homes. In addition to this information, health authorities are required to provide information about the circumstances under which the adult may leave the care facility (see Continued Residence, below).

Documenting Consent
Health authorities are required to document consent to care facility admission, whether it is provided orally, in writing or inferred from conduct. Health authorities can use the Care Facility Admission Consent form (HLTH 3909) to document consent. An adapted or different form can be used to document consent if the form:

- clearly identifies the adult to be admitted;
- clearly identifies the facility or facilities for which consent to admission has been given;
- identifies if consent has was given by a substitute;
- identifies if consent has been given in orally, in writing or inferred from conduct;
- can be signed by the client to indicate their consent;
- can be signed by the substitute to indicate their consent, if substitute consent is given;
- is signed by the manager if consent from the client or substitute has been given orally or is inferred from conduct;
- indicates specific consent for any specific care home for which consent has been given (as opposed to a single consent provided for multiple facilities)

The completed form must be provided to the long-term care home where the adult is admitted, prior to admission.

When an Incapability Assessment is Conducted

And incapability assessment is only required when the manager has reason to believe the client may be incapable of giving or refusing consent to care facility admission. While the indicators of the need to conduct an incapability assessment may emerge during to process of seeking consent, if an incapability assessment is required, it must occur before preferred care homes are selected and consent for admission to these care homes obtained.

Assessor Responsible for Conducting Incapability Assessments

A determination of incapability must be made by an incapability assessment conducted by a:

- medical practitioner,
- registered nurse,
- nurse practitioner,
- registered psychiatric nurse,
- occupational therapist,
- psychologist, or
- social worker.

Health authorities must ensure assessors fulfill this responsibility in accordance with the Practice Guidelines for Seeking Consent to Care Facility Admission. It is also expected that assessors successfully complete the course, Consent to Care Facility Admission in British Columbia: A Course for Managers and Assessors.

The manager is responsible for determining what assessor will conduct the incapability assessment when one is required.

Second Assessment

The Health Care Consent Regulation requires that a client is informed of the assessor's determination when an incapability assessment has been conducted. If the client has been determined to be incapable and the adult disagrees with this determination, they may request a second assessment. In these circumstances a second assessment must be conducted by a different assessor. The second assessment is determinative. A second assessment is not required if an adult is confirmed to be capable and a person disagrees with this determination.

When a second assessment is required it must be conducted by a medical practitioner or nurse practitioner, unless the initial assessment was conducted by a medical practitioner or nurse practitioner. If the initial assessment was conducted by a medical or nurse practitioner, the second assessment can be conducted by any qualified assessor.

Documenting the Assessment

The Health Care Consent Regulation requires that upon completing an assessment the assessor complete an assessment report. Health authorities can use the Incapability Assessment Report form (HLTH 3910) to detail the assessment. An adapted or different form can be used to detail the assessment if the form includes:

- information identifying the client who was assessed;
- the name, professional designation of the assessor, the assessor's regulatory college and registration number;
- confirmation that medical information was reviewed, including the client's relevant diagnoses and prognoses;
- the factors that were considered in making the determination of the client's capability or incapability;
- the conclusions that were reached on the basis of those factors; and

- a summary of information gathered from consulting with, or collecting information from, others (including information relied upon if the client refused or was unable to participate in the assessment).

Manager for Continued Residence
Health authorities must determine whether the manager responsible for fulfilling the continued residence responsibilities will be a health authority or care home employee.

Continued Residence
For clients residing in a long-term care home:

- if a client who has not been determined to be incapable expresses a desire to leave the care home, they cannot be prevented from doing so; and
- if the substitute for a client who has been determined to be incapable expresses a desire for the client to leave the care home, the client cannot be prevented from leaving the care home.

If a client is expressing a desire to leave a care home, they must be assessed for incapability if:

- the client has not been determined to be incapable and the manager doubts that the client is capable; or,
- the client has been determined to be incapable and the manager doubts that the client remains incapable.

If an incapable client expresses a desire to leave a care home, the manager must seek consent to continued residence in the care home from the client's substitute, unless:

- the client was admitted to the care home within the last 30 days; or
- consent for continued residence has been obtained from the substitute within the last 90 day.

Documenting Substitute Consent to Continued Residence
Substitute consent to continued residence must be documented whether it is provided orally or in writing. The Consent For Continued Residence form (HLTH 3911) can be use to document substitute consent. An adapted or different form can be used to document consent if the form:

- identifies the name of the client and the care home where they reside;

- identifies whether the substitute consent was obtained in writing, orally or by email;
- can be signed by the substitute to indicate their consent; and,
- is signed by the manager to confirm substitute consent is obtained.

Protection from Abuse or Harm

Health authorities must designate persons to receive reports that a client's substitute may be acting in a manner that may be abusive or harmful to the client.

If a manager believes a client's substitute is acting in a manner that may be abusive or harmful to the adult, including removing the client from a care home into harmful circumstances, the manager must:

- immediately notify a person designated to receive such reports; and
- take steps that the manager believes are necessary to protect the client, including preventing the client form being removed from the care home, until the designated person instructs otherwise.

Reference

Health Care (Consent) and Care Facility (Admission) Act
Health Care Consent Regulation
Community Care and Assisted Living Act
Hospital Act
Adult Guardianship Act
Representation Agreement Act
Patients Property Act
Power of Attorney Act
Public Guardian and Trustee Act
Practice Guidelines for Seeking Consent to Care Facility

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6.E
SECTION:	E	ASSESSMENT	**PAGE:**	1 OF 1
SUBSECTION:			**EFFECTIVE:**	JULY 15, 2019

Intent

To describe health authorities' responsibilities to ensure that all clients receiving publicly subsidized long-term care services receive an assessment using the RAI MDS 2.0 assessment tool and have a current care plan.

Policy

Health authorities must ensure that all clients receive an assessment using the RAI MDS 2.0 assessment tool and have a current care plan compliant with the Residential Care Regulation Section 80 and 81, as set out below:

- complete an assessment for all long-term care clients admitted to the care home on a permanent basis and develop a care plan for each client within 21 days of admission to the service;
- complete subsequent assessments on a quarterly and annual basis, or as needed, for each long-term care client and make appropriate changes to the client's care plan.

Reference

Residential Care Regulation

Intent

To clarify the benefits and chargeable items for clients receiving publicly subsidized long-term care services.

Policy

Health authorities must ensure that service providers:

- provide long-term care benefits to clients at no additional charge over and above the client rate;
- do not charge administrative fees for services or supplies required by the client's care plan;
- that offer chargeable items, do so at a reasonable cost at or below market rates and on an optional basis (purchase of chargeable items is at the discretion of the client);
- explain fees for chargeable items to the client, and ensure the client has agreed in advance of any billing for chargeable items; and
- provide a written statement of the refund policy when an individual pays in advance for services.

Definitions

benefits are the services, programs and supplies provided to clients at no additional cost over and above the client rate pursuant to applicable regulations, this policy manual, or the contract between the service provider and health authority.

chargeable items are services, programs or supplies that are not included as a benefit and are offered by the service provider.

companion service is any non-care social support or activity service provided to clients that is beyond the services a service provider is expected to provide. Companion service is a voluntary arrangement initiated by clients, their families, or individuals acting on behalf of the clients, and is the financial responsibility of the clients.

meal replacement is a commercially formulated product that, by itself, can replace one or more daily meals. It does not include vitamin or mineral preparations.

nutrition supplement is a food that supplements a diet inadequate in energy and essential nutrients, and typically takes the form of a drink but may also be a pudding, bar or other form. It does not include vitamin or mineral preparations. Homemade milkshakes or house brand supplements may be used where the care plan or the client's physician do not specifically require a named commercial brand for medical reasons.

therapeutic diet is any medically prescribed diet that is under the supervision of the client's attending physician (e.g., diabetic and low sodium diets).

Benefits Include:

- standard accommodation as outlined in Part 3 of the Residential Care Regulation;
- development and maintenance of care plans for each client, as set out in the Residential Care Regulation Section 81, that includes:
  - skilled care, with professional supervision consistent with the needs of the client;
  - a falls prevention plan;
  - a bathing and skin care plan; and
  - other routines to meet the unique needs of the client.
- clinical support services such as rehabilitation and social work services consistent with the client’s care plan;
- ongoing, planned physical, social and recreational activities, such as exercise or music programs, crafts, games;
- meals, including therapeutic diets if prescribed by the client's physician, and tube feeding;
- meal replacements and nutrition supplements specified in the care plan or by a physician:
  - homemade milkshakes or house brand supplements may be used where the care plan or the client's physician do not specifically require a named commercial brand for medical reasons;
- routine client laundry service for bed linens, towels, washcloths, and all articles of clothing that can be washed without special attention to the laundering process;
- general hygiene supplies for all clients, including but not limited to soap, shampoo, toilet tissue, and special products required for use with the bathing equipment in the long-term care home;
- routine medical supplies, including but not limited to:

- sterile dressing supplies
- glucose strips
- disposable under pads for bed and chair use
- equipment for general use of all clients, such as lifts, bed alarms, specialized mattresses, surveillance system devices
- surveillance systems to support client safety
- bandages (elastic or adhesive)
- syringes
- equipment physically attached to the long-term care home
- shared equipment for short-term general use, such as shared wheelchairs and walkers
- disposable gloves: sterile or non-sterile
- wound care supplies and dressings

- incontinence management including but not limited to:
  - toileting program, including individualized scheduled toileting plan to assist in maintaining continence and, where necessary, an incontinence plan;
  - single use, disposable under pads, briefs and inserts;
  - catheters – indwelling, straight, catheterization tray, drainage tubing, drainage bag, irrigation set, irrigation solution, leg bag drainage set; and
  - condom drainage sets;
- basic wheelchairs for personal exclusive use, as per Policy 6.F.1;
- basic cleaning and basic maintenance of wheelchairs, as per Policy 6.F.1;
- any other specialized service (such as specialized dementia or palliative care) that the service provider has been contracted to provide.

Chargeable Items May Include:

- personal cable connection and monthly fee;
- personal telephone connection and basic services;
- nutrition supplements, where the client requests a specific commercial brand rather than the brand provided by the service provider;
- personal newspaper, magazines and periodicals;
- hearing aids and batteries, including replacement batteries;
- personal transportation;
- extra or optional craft supplies, entertainment and recreational activities that are additional to activities and supplies provided as benefits above, and are chosen by the client;
- an administration or handling fee associated with the service, where reasonable, to perform a task or service that would normally be the client's responsibility;
- purchase or rental of equipment that is for the exclusive use of the client, such as walker, crutches, canes or other devices, and maintenance as required;

- modifications to basic wheelchairs/ modified wheelchairs, specialized wheelchairs, as per Policy 6.F.1;
- therapist fees for assessment and determination of modified wheelchair and specialized wheelchairs;
- miscellaneous charges associated with wheelchair cleaning and maintenance such as non-basic maintenance services, emergency cleaning, and damage;
- companion services;
- personal dry cleaning, or laundry services for items requiring special attention; and
- personal hygiene and grooming supplies that the client chooses in preference to general supplies provided by the service provider including:
  - facial tissue
  - hand lotion
  - denture cleaner
  - brush and comb
  - toothpaste
  - hair shampoo and conditioner
  - talcum powder
  - shaving cream
  - special soap
  - preferred incontinence supplies

Medications and Devices
Eligible prescription drugs, ostomy supplies and pre-approved prosthetic devices are provided under PharmaCare/Plan B.

Some non-prescription medications in community care facilities licensed under the *Community Care and Assisted Living Act* are considered a Chargeable Item.

Special Services
Health authorities must ensure that service providers do not request a client or a family to enter into a private arrangement to obtain staff assistance to which the client is entitled under the Residential Care Regulation and Ministry policy.

In some circumstances clients, families or friends may wish to obtain extra direct care or complementary services. Arrangements for such special services are permitted, subject to the following:

- the health authority and service provider are informed of the provision of the special service in the long-term care home;
- services provided are the responsibility of clients, in cooperation with the service provider;
- payment is the responsibility of clients; and
- if requested, the service provider is provided with regular detailed information on the service provided and outcomes for inclusion in the client's health record.

References

Community Care and Assisted Living Act
Continuing Care Act
Hospital Insurance Act
Residential Care Regulation
Wheelchair Policy Interpretation Guide, Ministry of Health, 2016

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6.F.1
SECTION:	F	BENEFITS AND ALLOWABLE CHARGES	**PAGE:**	1 OF 2
SUBSECTION:	1	BASIC WHEELCHAIR BENEFIT	**EFFECTIVE:**	JULY 15, 2019

Intent

To clarify, the benefits and chargeable extras for clients receiving wheelchairs for personal exclusive use.

Policy

Health authorities must ensure that service providers:

- provide a basic wheelchair for personal exclusive use to the client at no additional charge to the client over and above the client rate;
- provide basic maintenance and basic cleaning of the basic wheelchair at no additional charge to the client over and above the client rate;
- do not provide a basic wheelchair benefit to any client who is eligible for similar or better wheelchair benefits from another source such as the Ministry of Social Development and Poverty Reduction, Veteran's Affairs Canada, WorkSafeBC, or any other provincial or federal government Ministry, agency, program or crown corporation;
- do not provide a basic wheelchair to any client for whom a basic wheelchair would not be safe and clinically appropriate;
- inform and receive client consent before charging fees for chargeable items associated with modifications to basic wheelchairs, modified wheelchairs and specialized wheelchairs, including assessments, maintenance, cleaning services, and damages; and
- advise clients that the basic wheelchair must be returned to the service provider in its original condition when no longer required.

Definitions

Basic cleaning and basic maintenance is regular cleaning, disinfection, and minor adjustments of a wheelchair at regular intervals to address wear and tear to preserve clinical effectiveness and client dignity and safety.

Basic wheelchair is a manual, self-propelled, safe and durable wheelchair that enhances personal mobility; has a basic contoured seat cushion; and which is reasonable to obtain and maintain.

Customized/ Specialized wheelchair is a wheelchair with significant manual/ technical upgrades and modifications and includes custom made wheelchairs to meet an individual's unique needs and/ or lifestyle.

Modified basic wheelchair is a basic wheelchair with appropriate adjustments, modifications and upgrades to cushion, armrests, and/or back, and excludes all physical (frame) and permanent alterations to the basic wheelchair. Modifications must be non-permanent so that the attributes of the basic wheelchair remain available for the next client who uses the wheelchair.

Personal exclusive use is exclusive non-restricted use by a single client.

Wheelchair is a device providing wheeled mobility and seating support for a person with mobility issues.

Wheelchair Benefits Include:

- provision of a basic wheelchair for personal exclusive use;
- basic cleaning and basic maintenance of the basic wheelchair.

Chargeable Wheelchair Items May Include:

- modifications to the basic wheelchair;
- specialized wheelchairs;
- therapist and other fees related to modifications and specialized wheelchairs;
- non- basic cleaning and maintenance; and
- damages and related expenses.

References

Wheelchair Policy Interpretation Guide, Ministry of Health, 2016

Intent

To describe health authorities' responsibilities to safeguard personal funds and belongings of clients receiving publicly subsidized long-term care services.

Policy

Health authorities must ensure service providers establish reasonable accounting and security measures to receive and control funds for the personal comfort of the client, and make adequate provision for the custody and safekeeping of the client's personal funds and belongings.

Client Personal Needs Funds

Health authorities must ensure that, for all transactions undertaken on behalf of a client, service providers:

- maintain a separate personal needs account in a non-interest bearing account within the province of British Columbia for funds used to pay for personal items and charges on behalf of the client;
- maintain simple books that must clearly show additions, withdrawals, and a balance for each client; and
- keep the personal needs account up to date at all times, supported by receipts.

A client's personal needs account shall be maintained at a level that is consistent with the monthly discretionary spending of the client, and must not exceed $500.00 at any one time unless approved by the client.

Client Belongings

Health authorities must ensure service providers:

- are requested to assist the client in safekeeping only those personal effects and jewellery that are for everyday use of the client; and
- take immediate steps to request that the client arrange for safekeeping of the article in another location where the client has personal effects or jewellery exceeding this definition.

Conflict of Interest

Health authorities must ensure that no service provider or employee, or spouse or relative of either, may accept any benefit from clients by gift or will, or influence a client in the conduct of their financial affairs for the benefit of the service provider or employee, or spouse, relative or friend.

Where an employee of a service provider has a family or personal relationship with a client, the employee must provide notice of this relationship in writing to the service provider, to be retained on the client's health record.

The service provider must ensure that a client's funds or belongings are not handled by the specific employee without management supervision.

References

Community Care and Assisted Living Act (Part 2, section 18)
Hospital Act (Part 1, section 41)
Residential Care Regulation Section Part 6

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6.H
SECTION:	H	RESIDENT AND FAMILY COUNCILS	**PAGE:**	1 OF 1
SUBSECTION:			**EFFECTIVE:**	JULY 15, 2019

Intent
To describe health authorities' responsibilities to ensure that resident/family councils are encouraged and supported.

Policy
Health authorities must support the development of resident/family councils to promote the interests of clients and support the on-going role of family caregivers in long-term care homes by:

- providing meeting space, staff liaison and access to common information on the roles of councils and tools to develop or operate a council;
- identifying communication channels and encouraging collaborative relationships between staff, families and volunteers;
- providing information to assist the resident/family councils in functioning effectively and supporting a respectful and encouraging environment; and
- encouraging opportunities for resident/family councils to participate in regional education and networking opportunities.

Reference
Residential Care Regulation

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6. I
SECTION:	I	RESIDENTS' BILL OF RIGHTS / PATIENTS' BILL OF RIGHTS	**PAGE:**	1 OF 1
SUBSECTION:			**EFFECTIVE:**	JULY 15, 2019

Intent

To define health authorities' responsibilities to inform clients and families about the Residents' Bill of Rights for adults who live in community care facilities licensed under the *Community Care and Assisted Living Act,* or the Patients' Bill of Rights which applies to persons in care who live in private hospitals and extended care facilities regulated by the *Hospital Act*, and to ensure that clients and families know how to raise concerns.

Policy

Health authorities must ensure that:

- the resident or patient rights are fully incorporated into the delivery of long-term care services;
- the Residents' Bill of Rights or the Patients' Bill of Rights is posted in a prominent place in all long-term care homes;
- staff receive training about the meaning and intent of the Residents' Bill of Rights and/or the Patients' Bill of Rights;
- information on the Residents' Bill of Rights or the Patients' Bill of Rights, how to resolve a concern and contacts for Community Care Licensing and the Patient Care Quality Office are provided to both clients and family members upon admission to a long-term care home;
- decisions to limit a client's rights are clearly documented and supported by appropriate background information in the client's record; and
- no action will be taken to evict, discharge or intimidate an individual who makes a complaint regarding their care or the application of resident / patient rights.

References

Community Care and Assisted Living Act
Patient Care Quality Review Board Act
Patients' Bill of Rights Regulation
Residential Care Regulation
Residents' Bill of Rights

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6.J
SECTION:	J	MOVEMENT OF CLIENTS – CLOSURES OR RENOVATIONS	**PAGE:**	1 OF 2
SUBSECTION:			**EFFECTIVE:**	NOVEMBER 4, 2019

Intent

To outline health authorities' responsibilities in managing the change process for clients as a result of an operational decision by a health authority or service provider to close a long-term care home, close beds in a long-term care home or renovate a long-term care home that results in the movement of clients.

Policy

Health authorities must plan and manage the change process for clients where a long-term care home is being closed, beds in an existing long-term care home are being closed or the long-term care home is being renovated, consistent with the following requirements:

- ensure that maintenance of the quality and safety of the client's care is the priority throughout the process;
- ensure that a client will not be required to move more than once unless requested by the client;
- provide the client or substitute with information on the long-term care homes in the health service area that are appropriate to the client's needs, and the options for choosing other long-term care homes;
- offer each client an opportunity to meet with health authority and long-term care home staff through a care conference to identify the key concerns in making the move to a new long-term care home and develop an individual placement plan for the client;
- ensure that a client is not moved until the care conference has occurred and an individual placement plan has been developed;
- offer placement options that take into consideration the distance, time and terrain that the client's caregivers will need to travel in order to visit the client;
- ensure couples are relocated together in the new long-term care home, even if their care needs differ, when the couple is currently residing in the long-term care home and they have requested to stay together; and
- facilitate the move to another health region if a client, substitute or couple requests such a move.

Health Authority Process

Health authorities must develop operational policy and procedures that include the following:

- a process for working with clients to provide opportunities for a care conference with health authority and long-term care home staff, and to develop an individual placement plan;
- timely communication with the client, and an opportunity for follow up discussion of questions and concerns;
- a reasonable time frame for the client to plan for the relocation;
- a process to assess the client's needs and evaluate the suitability of their long-term care homes preferences;
- a process to ensure consent is obtained for admission into the receiving long-term care home, as per Policy 6.D.2, Consent to Long-Term Care Home Admission; and
- a process to communicate the client's current clinical and special clinical needs to staff in the receiving long-term care home.

Moving Costs

Health authorities are responsible for the costs associated with a client move, including transportation, address notification, medication transfer and one-time reconnection costs for personal phone and cable television, with the following exceptions:

- where the client or substitute chooses to move to a long-term care home in another health region, the costs related to the move are the responsibility of the client; and
- the client is responsible for any new costs they initiate, such as upgrading their telephone or cable services, or hooking-up a new appliance.

Retention of Benefits

Clients receiving publicly subsidized long-term care services who move to an assisted living residence because their long-term care home is being closed will retain their PharmaCare Plan B benefits.

Reference

Provincial Guidelines for Closure of Residential Care Facilities, Ministry of Health Services, June 2009

CHAPTER:	6	LONG-TERM CARE SERVICES	**NUMBER:**	6.K
SECTION:	K	LARGE-SCALE STAFF REPLACEMENTS	**PAGE:**	1 OF 1
SUBSECTION:			**EFFECTIVE:**	JULY 15, 2019

Intent

To ensure that the quality and safety of client care is maintained during a large-scale staff replacement, meaning mass staff turnover through the change from one contracted service provider to another or through a change in ownership.

Policy

Health authorities must ensure service providers plan and manage the change process for clients where a service provider is planning a large scale staff replacement, consistent with the following requirements:

- ensure that maintenance of the quality and safety of the client's care is the priority throughout the process;
- provide the client with information about the upcoming change;
- offer clients and families an opportunity to meet with service provider staff to identify the key concerns in the changeover in staff; and
- ensure that the staff replacement does not happen until all clients are informed and have had an opportunity to have their concerns heard.

Health Authority Process

Health authorities must ensure service providers develop operational policy and procedures that include the following:

- timely communication with the client, and an opportunity for follow up discussion of questions and concerns;
- timely communication to the community care licensing office;
- measures to assist clients with loss of continuity in their care;
- a process to communicate the client's current clinical and special clinical needs to new staff; and,
- a process to monitor and mitigate impacts from the change.

This is **Exhibit "H"** referred to in the Affidavit of **Dr. Travis Carpenter,** sworn this 21st 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)

Alberta Health Services

PROCEDURE

TITLE
DESIGNATED LIVING OPTION: ACCESS AND WAITLIST MANAGEMENT

SCOPE
Provincial

DOCUMENT #
HCS-117-01

APPROVAL AUTHORITY
Clinical Operations Executive Committee

INITIAL EFFECTIVE DATE
May 27, 2015

SPONSOR
Vice-President, System Innovations & Programs

REVISION EFFECTIVE DATE
July 4, 2019

PARENT DOCUMENT TITLE, TYPE AND NUMBER
Access to a Designated Living Option in Continuing Care

SCHEDULED REVIEW DATE
July 4, 2022

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

If you have any questions or comments regarding the information in this document, please contact the Policy & Forms Department at policy@ahs.ca. The Policy & Forms website is the official source of current approved policies, procedures, directives, standards, protocols and guidelines.

OBJECTIVES

- To provide direction to **health care providers** on the transparent process for assessing wait listing and transitioning **patients** to an appropriate **Designated Living Option (DLO)**.
- To provide direction for patient transitions to DLO(s) and **temporary Community Option(s)**.
- To recognize the importance of **family** supporting the patient in the transition to DLO and welcome their involvement based on the wishes of the patient.
- To recognize the need to expedite transitions from **Acute Care** into **community** settings for the safety of patients as well as to ensure hospital beds are made available as quickly as possible for those with acute conditions.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

1. Accountability and Responsibility

1.1 Refer to Alberta Health Services (AHS) *Access to Designated Living Option* Policy for detailed information on accountability and responsibilities of AHS and contracted operators.

2. Assessment and Service Needs Determination For Designated Living Option(s)

2.1 Patients can request an assessment for Continuing Care health services (including **Home Care**) through self-referral or referral made through family, friends, health care providers or other community agencies acting on their behalf.

2.2 AHS shall support the patient throughout the entire process, including referral, intake, assessment, needs determination, waitlist prioritization and transition by:

a) assigning a contact person(s) who will actively support the patient and stay in regular contact throughout the access to a DLO process (this shall be the **AHS case manager**);

b) involving patients in all discussions and assessments including providing clear information about the access to a DLO process;

c) providing opportunities for the patient to participate in and ask questions about the DLO process;

d) encouraging the patient who has been assessed and approved for a DLO to contact individual **sites**, explore the services provided, and if at all possible tour potential sites (including using virtual tours); and

e) facilitating communication among all care providers and the patient.

2.3 AHS **health care professional(s)** shall use the following resources, as applicable, to guide all assessments for unmet needs; for service needs determination, and the need for a DLO:

a) the *Coordinated Access* process outlined in the *Framework for Coordinated Access to Publicly Funded Continuing Care Health Services*;

b) the *Resident Assessment Instrument* – Home Care (RAI-HC) as the standardized assessment tool;

c) secondary assessments as appropriate;

d) the *Provincial Continuing Care Assessment Guide for AHS Case Managers;* and

e) the *Continuing Care Service Needs Determination Guide.*

2.4 Home and/or community is the optimal environment for assessment, patient recovery, and making life changing decisions related to Continuing Care health services.

2.5 Patients no longer requiring Acute Care services should transition to the most appropriate community location prior to assessment. Depending on needs and available services and support, locations may include:

a) Location of origin;

b) Post-acute Unit (e.g., Transition Unit, Restorative Care Unit); or

c) Community living (e.g., private residence, Lodge, congregate living settings).

2.6 The AHS case manager shall coordinate with the patient, AHS Home Care, and informal supports as available to facilitate return to an appropriate community location, when safe to do so, in order to support optimal assessment and decision-making.

a) If returning to a congregate living site, or the patient's current Designated Living site, the AHS case manager, the patient, and where appropriate, the housing operator or provider shall collaborate to identify and remediate any gaps in ability to provide appropriate, safe care.

b) For all patients returning to a community location, the AHS case manager shall ensure a plan for supporting the patient's transition is in place and has been communicated to the patient.

2.7 When the patient's **assessed unmet needs** indicate the need for transition into a DLO, the following shall occur:

a) AHS case manager shall engage the patient in discussions to assess and identify the appropriate DLO level using the *Admission Guidelines for Publicly Funded Continuing Care Living Options*;

b) AHS case manager shall ensure that the patient has been provided with the following information both verbally and in writing:

(i) information about the process of selecting preferred DLOs;

(ii) information about the waitlist, concerns resolution and transition processes, including temporary DLOs and temporary Community Options;

(iii) what to expect if the patient's preferred DLO(s) are not available or if a DLO is declined;

(iv) a list of all appropriate DLOs that best match the patient's preferences and assessed unmet needs; and

(v) information about the sites, if available, or shall direct patients to available information (e.g. online).

2.8 Once the initial assessment is complete and the level of care has been identified the AHS case manager shall:

a) approve the patient to be waitlisted for a DLO (the approval date is the waitlist date used in prioritization and waitlist management),

b) document the approval date on the patient's **health record**; and

c) place the patient's name on the waitlist(s) using the approval date.

2.9 The patient may be considered for, and/or offered any appropriate temporary DLO or temporary Community Option available while waiting for their most preferred DLO(s).

3. Identifying Preferred Designated Living Options

3.1 The patient shall be requested to specify at least one (1) most preferred Designated Living site and should be provided the option of indicating additional preferred Designated Living sites based on options that meet the patient's assessed unmet needs, if available.

3.2 The following factors are waitlist considerations that may be identified by the patient in collaboration with the AHS case manager when specifying their preferred Designated Living site(s):

a) reunification of relationships where both require a DLO;

b) geographical distance and/or location;

c) cultural, linguistic, and/or religious preferences;

d) availability of social support(s); and

e) wait times, services available, and costs for specific sites.

3.3 waitlist considerations (Section 3.2) identified in collaboration between the patient and the AHS case manager may:

a) facilitate the patient transitioning to a preferred DLO; and

b) enable the most appropriate match to facilitate patients moving to their most preferred DLO.

3.4 After assessment, including discussions with the patient, the patient shall be requested to specify their preferred Designated Living site(s) to their AHS case manager within:

a) 72 hours for patients in Acute Care; or

b) seven (7) days for patients who are assessed in Community.

3.5 In the event a patient does not specify any preferred Designated Living sites(s) within the specified time frame, the most appropriate DLO(s) as determined by

the patient's assessed unmet needs shall be identified by the AHS case manager and the patient shall be informed of the selection.

3.6 The patient may request to change their preferred Designated Living site(s) at any time; in this situation their original waitlist date shall remain in effect.

3.7 Where a patient's assessed unmet needs can only be safely met at one (1) Designated Living site, that site shall be identified as the most preferred. The AHS case manager shall inform the patient of the reasons for the selection.

4. Waitlist Management

4.1 The patient shall be offered an available DLO, in accordance with the *Waitlist Prioritization Criteria* as outlined in *Appendix A*, and review of waitlist considerations.

4.2 The patient shall remain active on the waitlist until:

a) the patient is admitted to one of their most preferred Designated Living site(s);

b) the patient requests to remove themselves from the waitlist; or

c) the patient, upon reassessment, is removed from the waitlist by AHS.

4.3 The AHS *Continuing Care Waitlist Management Guide* (*Waitlist Management Guide)* outlines the standardized process to be used for waitlist management within Continuing Care, based on the following:

a) Acute Care and the community shall be considered together and prioritized daily if required;

b) Patients in each rank shall be considered for available spaces according to the *Waitlist Prioritization Criteria*. The match most appropriately reflecting waitlist considerations may be given priority to facilitate patients moving to their most preferred DLO;

c) Patients awaiting transition may be prioritized for an available space ahead of others if care needs are becoming urgent or if identified waitlist considerations can be met;

d) Site specifications at the time the space becomes available may also influence matches and offers;

e) If there are two (2) patients waiting for transfer who also have the same waitlist date, the space shall be offered to the individual who has waited the longest in a temporary space.

4.4 If an AHS case manager assesses that the needs of a patient waiting in community cannot be safely managed in their current environment for more than 48 hours and are at risk of Acute Care admission, the patient shall be:

a) designated as **Immediate in the Community**;

b) prioritized and offered a temporary or preferred DLO according to the assessed urgency of their condition and circumstances, regardless of their waitlist date; and

c) reviewed on a daily basis to ensure their condition and circumstances are being safely managed.

4.5 If a patient designated as Immediate in Community refuses to transfer to an available DLO or temporary Community Option, AHS shall determine through review whether or not the patient requires Immediate in Community status (refer to Section 8).

a) The patient shall continue to be supported and shall remain on the waitlist (refer to Section 4.1).

b) The patient may choose a temporary DLO (refer to Section 6).

4.6 The waitlist date shall not be impacted:

a) if a patient's assessed unmet needs change while on the waitlist and a reassessment indicates the need for a different DLO level;

b) if the patient updates their list of preferred DLO(s) for any reason;

c) by transfer to temporary DLO or temporary Community Option;

d) by AHS initiated transfer or discharge;

e) by concerns resolution proceedings; and/or

f) by rejection of offers for temporary DLOs.

4.7 Once the patient transitions to one of their most preferred Designated Living site(s), any further transfers shall be pursued under a new waitlist date corresponding to the date the new transfer request is approved. This includes anyone requiring a different DLO level.

5. Most Preferred Designated Living Option Offer

5.1 If the patient's most preferred Designated Living site has availability and the patient is appropriate based on *Waitlist Prioritization Criteria* and identified waitlist considerations the patient shall be offered a space at that site.

a) The patient and family shall be given up to 48 hours in order to respond to the offer and communicate with the AHS case manager.

5.2 When a most preferred Designated Living site has been accepted, a date of admission shall be mutually agreed upon between the patient and the site representative.

a) A transition care plan shall be developed by the AHS case manager involving the patient and all care partners to ensure a seamless transition of care between care teams and care providers.

6. Temporary Designated Living Option or Temporary Community Option Offer

6.1 If the patient's most preferred Designated Living site(s) is not available, the patient should be offered a choice of:

a) a preferred DLO where available; or

b) another temporary DLO where available; or

c) a temporary Community Option, when appropriate (refer to *Appendix B*). Offers shall be based on *Waitlist Prioritization Criteria* and waitlist considerations.

6.2 The temporary DLO offer shall be from the most appropriate options available, taking into consideration where possible, the preferred Designated Living site(s) specified by the patient.

6.3 The patient shall be given up to 48 hours to respond to the offer in order to:

a) reflect on and clarify the information provided;

b) ask and receive answers to any questions;

c) seek additional information;

d) consult with those close to them; and

e) inform the AHS case manager of their decision.

6.4 Patients waiting in Acute Care or community who wish to avoid an additional move to a temporary DLO may choose to wait in their home through an arrangement where they purchase private care or provide **extensive family contribution** on a temporary basis. This temporary Community Option (refer to *Appendix B*) is a specific arrangement negotiated to address care needs while waiting and makes them eligible for Rank 1 Temporary to Most Preferred (refer to AHS *Waitlist Management Guide*).

6.5 When a temporary DLO offer has been accepted, a date of admission is mutually agreed upon between the patient and the site representative.

a) A transition care plan is developed by the AHS case manager involving the patient and all care partners to help ensure a safe and effective transition of care between care teams and care providers.

b) The patient shall remain on the waitlist for their most preferred and preferred DLO(s) as per the *Waitlist Prioritization Criteria*.

c) The patient shall remain on the waitlist for multiple preferred DLOs and multiple most preferred DLOs, where waitlist management functionality (manual and/or electronic) allows.

7. Refusal of a Designated Living Option Offer

7.1 When any DLO offer has been refused, the AHS case manager shall actively engage the patient in a process of exploration and negotiation to identify alternate options where available, including temporary Community Options.

a) If the patient does not respond to any DLO offers this shall be treated as a refusal.

7.2 Using a **patient and family centred care / person centred care** approach, and with the goal of identifying the most acceptable solution from the range of options, the AHS case manager shall:

a) explore with the patient the issue(s) that resulted in refusing the temporary DLO;

b) engage in problem solving to find a solution to the issue(s);

c) identify one (1) or more potential alternate options, if available; and

d) negotiate an alternate Designate Living Option or temporary Community Option that is acceptable to the patient

7.3 Following this process of exploration and negotiation, one (1) further offer of a DLO may be made if available.

a) If there is only one (1) appropriate Designated Living site that meets the patients' assessed unmet needs, the care team may proceed with transfer (refer to Section 8).

7.4 If the patient declines the second DLO offer (Section 7.3) or refuses to respond, the AHS case manager shall consult with the Program Manager who shall:

a) review the specific patient circumstances to ensure all appropriate options have been fully explored with the patient in compliance with this Procedure and the *AHS Continuing Care: Access to a Designated Living Option Policy;*

b) consult with other identified stakeholders including but not limited to, Acute Care, Home Care, housing operators and/or physicians to look for unique person-specific options; and

c) support and advise the AHS case manager in the ongoing exploration/ negotiation process with the patient.

7.5 If the patient is in Acute Care and no temporary Community Option and/or DLO is agreed upon, the need for DLO is reviewed and the care team may proceed to transfer to the next available appropriate DLO, or discharge (refer to Section 8).

7.6 If AHS and the patient jointly identify extenuating circumstances that prevented the acceptance of the DLO offer at the time it was made, the offer shall not be considered as part of the two (2) alternate DLO offers (Section 7.1 and 7.3). Extenuating circumstances may include, but are not limited to: family crisis, death in immediate family, or natural disasters.

8. Discharge/Transfer

8.1 For a patient in Acute Care, where all option(s) have been explored, negotiated and exhausted with no resolution, the accountable leaders shall refer to the appropriate Zone leadership to consider whether to proceed to discharge the patient or transfer the patient to the most appropriate available Designated Living Option as a temporary measure. The process pursuant to the *Hospitals Act* may be used by AHS to transfer or discharge a patient from Acute Care.

8.2 Following discharge or transfer the patient shall continue to be supported by their assigned AHS case manager and shall remain on the waitlist prioritized for transfer to their preferred DLO(s). If the patient's health status or needs change they shall be reassessed as per the process in Section 2.

9. Concerns Resolution

9.1 Patients shall be provided with information about the *Concerns Resolution Process* (refer to AHS *Appeals Panel Process* Procedure) on initiation and throughout the *Access to Designated Living Option Process* including referral, intake, assessment, needs determination, waitlist prioritization and transition.

DEFINITIONS

Accountable leader means the individual who has ultimate accountability to ensure consideration and completion of the listed steps in the management of the Access to a Designated Living Option Policy. This means the individuals for Acute Care and Continuing Care who have been designated to provide approval for a Designated Living Option Assessment to occur in Acute Care.

Acute Care means all urban and rural hospitals, psychiatric facilities, urgent care facilities, and sub-acute settings that are co-located with Acute Care, where care is provided for patients with acute illnesses or injuries, or who are recovering from surgery.

AHS case manager means a regulated health care professional(s) accountable for case management services for an assigned caseload. A case manager comprehensively assesses all factors contributing to the patient's care needs for transitioning through the care stream, while working with the patient, family and multidisciplinary team to mitigate any risks.

Alternate Decision-Maker means a person who is authorized to make decisions with or on behalf of the patient. These may include, **Specific Decision-Maker**, a minor's Legal Representative, a **Guardian**, a 'nearest relative' in accordance with the *Mental Health Act* or an **Agent** in accordance with a Personal Directive or a person designated in accordance with the *Human Tissue and Organ Donation Act*. This also includes what was previously known as the substitute decision-maker.

Assessed unmet need means the care requirements that remain after the strengths and resources of the patient and family and of the community have been considered in relation to the functional deficits and needs identified on assessment. The assessment includes the patient's ability to learn the skills necessary for self-care and the willingness, ability and availability of the family and community to participate or learn.

Community / community living means a permanent living arrangement where an individual resides alone or with others in a setting that can vary from independent living in a private residence to a variety of communal settings where health and personal support services may or may not be provided. These settings may include:

- Private homes, apartments,
- Congregate living settings that provide housing and hospitality services (e.g., lodges, group homes etc.)
- Designated Supportive Living levels 3, 4 and 4D.

Concern means a written or verbal expression of dissatisfaction that may be related to: the provision of goods and services to a patient, a failure or refusal to provide goods and services to a patient, terms and conditions under which goods and services are provided to the patient, by Alberta Health Services or by a service provider under the direction, control or authority of Alberta Health Services. It may also include dissatisfaction with professional practice and/or an allegation of unprofessional conduct. The concern may be clinical or non-clinical and may be directed at any member of the organization or the organization as a whole. The concern may also include the dissatisfaction with an Alberta Health Services owned or operated facility.

Continuing Care means an integrated range of services supporting the health and wellbeing of individuals living in their own home, a supportive living or long-term care setting. Continuing care clients are not defined by age, diagnosis or the length of time they may require service, but by their need for care.

Designated Living Option means residential accommodation in the Continuing Care system that provides publicly funded health and support services appropriate to meet the patient's Assessed Unmet Needs. The level of care is accessed through a standardized assessment and single point of entry process and consists of Designated Supportive Living Level 3 (DSL3), Designated Supportive Living Level 4 (DSL4) and Designated Supportive Living Level 4 Dementia (DSL4D) and Long Term Care (LTC).

Extensive Family Contribution means strategies to supplement current AHS continuing care program resources, with care provided by a family member or designate who is available, willing and able to contribute on a temporary basis that is unsustainable (with or without added home care). Refer to temporary Community Option.

Family(ies) means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers. This may or may not be legally identified as the patient's legal co-decision maker or an alternate decision-maker.

Home Care means publicly funded personal and healthcare services to help people remain well, safe and independent in their home or congregated living setting (i.e. a lodge) for as long as possible.

Immediate in the community means patients waiting in community whose needs cannot be safely managed in their current environment for more than 48 hours. Immediate admission to an appropriate Designated Living Option is required due to a crisis arising from a change in condition or circumstances.

Most preferred designated living option(s) means the patient has specified one or more Designated Living sites as where they would prefer to live over all other Designated Living sites.

Patient means all persons; inclusive of residents and clients who receive or have requested health care or services from Alberta Health Services and its health care providers. Patient also means, where applicable:

a) a co-decision-maker with the person; or
b) an alternate decision-maker on behalf of the person.

Patient and family centred care means care provided working in partnership with patients and families by encouraging active participation of patients and families in all aspects of care as integral members of the patient's care and support team, and as partners in planning and improving facilities and services. Patient and family centred care applies to patients of all ages and to all areas of health care.

Person centred care means care that considers the individual's cultural traditions, their personal preferences, values and goals, their family and community, and their lifestyles. Individuals and their caregivers are an integral part of the care team who collaborate in care planning and decision making. Person-centred care recognizes the individual's strengths and expertise and supports building their self-management skills by ensuring unbiased information and tools are provided. Person-centred care ensures that transitions between providers, departments, health care settings and other supports are respectful, coordinated, and efficient.

Preferred designated living option(s) means one or more Designated Living Option site(s) that the patient identifies in order of preference. At least one of these sites should be identified as their most preferred Designated Living Option(s).

Private living option means any residential care setting that provides non-publicly funded health and personal care services on site. Accommodation, hospitality, health and personal care services are included in the monthly rent, paid under a private accommodation agreement negotiated by the operator with the patient and/or family.

Purchased care means professional health or personal support care services which the patient chooses to purchase in order to address some or all of the patient's assessed unmet needs which may be beyond the scope of care available in the patient's current living setting.

Reunification means reuniting close relationships through transfer when both patients require a Designated Living Option. Close relationships are determined by the patient.

Site means, for the purposes of this policy suite only, a specific Designated Living Option building and services.

Temporary community option means a specific strategy intended to temporarily provide care while the patient waits in the community for their most preferred Designated Living Option to become available. This option is negotiated with the AHS case manager and may include private living option, purchased care and/or extensive family contribution.

Temporary designated living option means a Designated Living Option that is not one of the patient's specified most preferred Designated Living Option (s).

Waiting in community means patients who are waiting in a community residence for access to a Designated Living Option where assessed unmet needs can no longer be met in their current living setting. These individuals should be ready to accept a Designated Living Option when offered.

Waitlist means, for the purposes of this policy suite only, a prioritized list of patients waiting for admission to a continuing care Designated Living Option who have been assessed and approved for a Designated Living Option.

REFERENCES

- Appendix A: *Waitlist Prioritization Criteria*
- Appendix B: *Temporary Community Options*
- Alberta Health Services Governance Documents:
  - *Alternate Level of Care Accommodation Charges - Patients Waiting for Continuing Care* Policy (#FS-01)
  - *Appeal Panel Process* Procedure (#HCS-146-01)
  - *Designated Living Option: Access and Waitlist Management* Policy *(#HCS-117-01)*
  - *Patient Concerns Resolution Process Policy suite*
- Alberta Health Services Resources:
  - *Admission Guidelines to Publicly Funded Continuing Care Living Options*
  - *Continuing Care Referral Guide*
  - *Continuing Care Service Needs Determination Guide*
  - *Continuing Care Waitlist Management Guide* (*Waitlist Management Guide)*
  - *Framework For Coordinated Access to Publicly Funded Continuing Care Health Services*

- Non-Alberta Health Services Documents:
  - *Hospitals Act* (Alberta)

VERSION HISTORY

Date	Action Taken
June 23, 2015	Revised: Housekeeping changes only
October 14, 2015	Revised: Housekeeping changes only
July 4, 2019	Revised; includes change in Title from "Designated Living Option: Access and Waitlist Management in Continuing Care"

APPENDIX A

Waitlist Prioritization Criteria

Rank	Transition Type

Rank 1	**Temporary to Most Preferred**
	Driver: honour patient choice
	
	Patients waiting in a temporary DLO for transfer to one of their most preferred DLOs and their remaining chosen preferred DLOs. This includes*:*
	• Patients who accepted a **temporary DLO**
	• Patients who refused a temporary DLO but accepted a **temporary Community Option** which may include:
	  ○ a **private living option**
	  ○ **purchased care**, and/or
	  ○ **extensive family contribution**
	• Patients who are pursuing further transfer under a new waitlist date.

	Community with Extensive Family Contribution and/or Private Care *Drivers: preserve patient/family resources; preserve health care resources, patient safety* Patients waiting in community who wish to avoid a move to a temporary DLO and agree to purchase private care or provide extensive family contribution as a temporary community option while remaining in their current residence become eligible for Rank 1 Temporary to Most Preferred.
	Requesting a Transfer or Updating Choice Patients already in their most preferred site can request a new transfer to another DLO site at the same level of care. Waitlist date will be assigned as of the date of the new request.
Rank 2	**Acute Care** *Driver: preserve health care resources, patient safety* Patients waiting in Acute Care for access to a DLO who are ready for discharge. Patients originating from Acute Care who agree to accept a temporary DLO, a temporary private living option, purchase private care or provide extensive family contribution as a temporary option and are discharged to one of these options become eligible for Rank 1 Temporary to Most Preferred.
	Community *Drivers: preserve patient/family resources; preserve health care resources, patient safety* Patients who are **waiting in community** for access to a DLO where assessed unmet needs can no longer be met in their current living setting. They require the care and are ready to move to a DLO. Patients originating from community who agree to accept a temporary DLO, a temporary private living option, purchase private care or provide extensive family contribution as a temporary option become eligible for Rank 1 Temporary to Most Preferred.

Also see AHS *Continuing Care Waitlist Management Guide* for more examples.

APPENDIX B

Temporary Community Options

For the purposes of this policy suite only, a temporary Community Option is a specific strategy implemented while the patient waits in the community for their preferred DLO(s). A temporary Community Option is intended to temporarily provide the assessed unmet care needs that resulted in the patient being waitlisted for a DLO. The temporary Community Option could be one of the following temporary alternatives provided for in the Procedure:

1. Private Living Option.
2. Purchased Care.
3. Extensive Family Contribution.

In the context of the Access to Continuing Care DLO policy suite a temporary Community Option (refer to Section 6.4) may be agreed upon where:

- The patient has been as assessed by an AHS Case manager as requiring a Continuing Care DLO (DSL3, DSL4, DSL4D, or LTC);
- The patient's name has been added to the AHS Continuing Care waitlist;
- The patient or alternate decision-maker wishes to avoid a move to a temporary DLO or no appropriate temporary DLO exists in their community of choice;
- The patient and/or alternate decision-maker indicate that they or other family members are willing, able and if necessary, available to carry out the agreed upon terms of the temporary Community Option while awaiting for their most preferred DLO(s);
- The temporary Community Option has been specifically negotiated by an AHS case manager with the patient or alternate decision-maker (in some situations, where appropriate, the housing operator where the patient currently resides) as an alternative to accepting a temporary DLO while awaiting their most preferred living option.

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

of **Dr. Travis Carpenter,** sworn this 21st 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)

Nursing Homes

Department of Social Development
Last updated on: June 22, 2023

Housing Options

On this page

About

Are you or a loved one no longer able to live at home because of the need for nursing care and the support of a care provider around-the-clock?

If you do, a Nursing Home may be a place you can live where nursing care is available any time of the day. Licensed Practical Nurses and Registered Nurses are there to support your health needs. Other care providers, such as Dietitians may be available to help as well.

your supervision and personal care needs. Meals, medications and housekeeping services are provided by the Nursing Home. They also provide access to rehabilitative care, social and recreational programming.

Social Development is responsible for licensing and inspecting the homes annually. The inspection reports for Nursing Homes are posted online and can be viewed by **clicking here.**

Nursing Homes are required to follow:

- **The Nursing Home Act**
- **Regulations under the Nursing Home Act**
- **Standards Manual for Nursing Home Services**
- **Management Directives for Nursing Home Services**

Nursing Homes are specially designed to ensure your environment can meet your needs. For example:

- Sprinkler system
- Handrails in the corridors
- Grab bars in bathing and toileting areas
- Door security code to exit the building

Who qualifies?

Seniors aged 65 and older that do not need to be in a hospital, but need regular nursing care to manage their health with support from providers may benefit from living in a nursing home.

People who benefit from living in a Nursing Home meet the following criteria:

- You are eligible for services through the Long Term Care program
- Your health status is stable. This means you are currently not receiving care and treatments that could significantly improve your condition;
- You will need the service for a long period of time;
- You may need assistance or supervision with walking or using a wheelchair;
- You need the assistance from one or two care providers to carry out your daily activities safely such as getting dressed, bathing, grooming and managing medications;
- You may have responsive behaviours related to dementia such as agitation, wandering, repetitive actions or verbalization that requires specialized supervision and intervention; and
- You may require regular nursing care which is provided by a Registered Nurse or a Licensed Practical Nurse

In some situations, people under the age of 65 enrolled in the **Disability Support Program** may qualify. Talk to your Social Worker to learn more.

How do I apply?

You will need to apply through the Long Term Care program at Social Development. A Social Worker will help you find out if your personal goals and care needs can be safely met in a Nursing Home or if other services that are available through this program can meet your needs.

The Long Term Care Program is for seniors, 65 years of age or older. To learn how you may qualify and apply to the Long Term Care Program, **click here**.

Eligible clients may receive financial help to go towards the cost of living in a Nursing Home. The most you will have to pay to live in a nursing home is $113 per day. A monthly allowance of $108 per month provides residents the ability to purchase personal items such as clothes, shoes, etc.

Once you qualify for Nursing Home services through the Long Term Care Program, these are some of the steps that will help you move into a facility:

1 **Social Worker will provide this form to you.**

2 You must select two nursing homes as your preferred nursing homes for placement. These two selections are treated as equal preferences. For a complete list of Nursing Homes, **click here**, or visit **the New Brunswick Nursing Home Association website**.

3 It is recommended, if possible, that you visit the homes to help with your decision. Some questions to ask might be:

- What type or social and recreational programming is available?
- Do you provide transportation to and from medical appointments? What is the cost?
- Are there any additional fees? (For example, cable, phone, internet, etc.)
- Will I have to share a bedroom?
- What personal belongings can I bring with me? (For example, chair, dresser, décor, etc.)

4 Once you have decided on what Nursing Homes you prefer to live in, you need to let your Social Worker and those Nursing Homes know your decision. Your name and your choices of Nursing Homes will be added to the Nursing Home Waiting List that Social Development manages and shares.

5 If there's no vacancy in the nursing homes you prefer, you may be offered an interim placement. An interim placement is a non-preferred placement which is 100kms or less from your residence and offers services in your official language of choice. When you accept an offer of interim placement your name will remain registered on the waitlists of the nursing homes you selected. When a bed is available you will be offered the choice to transfer to a preferred home or you may choose to remain a resident of the nursing home you currently reside in.

6 When a bed becomes available, the Nursing Home will call the people from the Nursing Home Wait List (following chronological order) to offer you placement.

7 If you decline a bed offer at either a preferred or interim placement, your name will be placed at the bottom of all waitlists (if you reside in the community). If you are awaiting placement in hospital and have been medically discharged, you will retain your place on the waitlist. If you are in the hospital awaiting placement, be sure to ask about hospital policies. The hospital may start to charge you for your room if you refuse a vacancy.

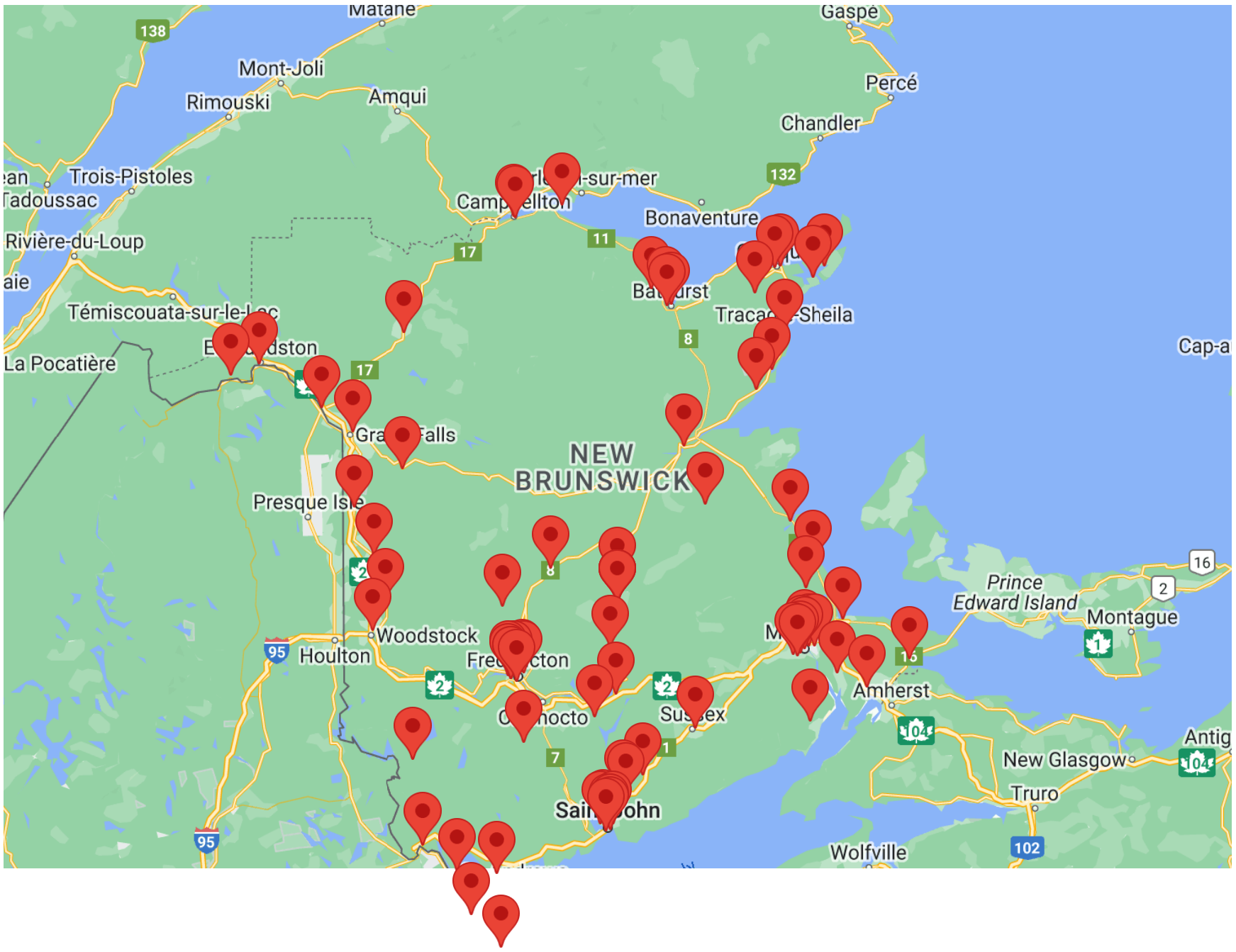
What do I need?

If you are going to move into a Nursing Home, you will need to have a Physical Examination and History form completed by a physician or a nurse practitioner. Physician or nurse practitioner offices can charge a fee to complete the form.

For more information about going to a nursing home please refer to the ***Going to a Nursing Home*** *booklet* available through the **Public Legal Education and Information Service of New Brunswick**.

You can now search for nursing homes in your area using the map provided by **211 NB**. Use your postal code to find the nursing homes closest to you. Nursing homes will appear on the map as red dots. Click on individual nursing homes to see their contact information.

TELL US WHAT YOU THINK



Google

Map data ©2024 Google

More Information

Long Term Care Program Brochure

Learn more about the Long Term Care Program and how to apply.

Download PDF

Aging in New Brunswick

A helpful resource for older adults on navigating information, services, forms, and resources in New Brunswick. To request a printed copy, call 2-1-1.

Download PDF

TELL US WHAT YOU THINK

Contact

For more information, please contact your local office of the Department of Social Development

1-833-733-7835

Can’t find the program or service you are looking for?

211

Do you need to know what supports exist in your community? 211 can help. Connect by phone, chat, email, or browse the website. Available in 150+ languages, 24 hours a day, 7 days a week.

Learn More

Help Accessing Government Benefits

It can be hard to know where to start when searching for government benefits throughout the country. Prosper Canada’s Benefits Wayfinder tool can help you find and track benefits that you may be eligible for.

Learn More

Need Help?

TELL US WHAT YOU THINK

TO REPORT ABUSE OR NEGLECT OR IF YOU NEED TO APPLY FOR SOCIAL DEVELOPMENT SERVICES CALL 1-833-733-7835.

Social Supports NB

We're helping New Brunswickers navigate and explore government programs and services.

I want to learn about:

Help for Seniors

Help for Disability

Help for Housing

Help with Finances

Help with Abuse and Neglect

Help for Families and Youth

Help with Your Health

New Nouveau Brunswick CANADA

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

of **Dr. Travis Carpenter,** sworn this 21st 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)

Long-term Care

Long-term care provides specialized nursing and personal care services to individuals who can no longer live on their own, with family or home care supports. These services are provided while respecting each resident's dignity and personal choices.

Services are provided in both public and private long-term care nursing homes and include:

- 24-hour nursing care;
- room and board;
- personal care; and
- medical services.

I may need a nursing home in a couple of years ... should I apply now?

No, only those who are ready to move into a home now should apply.

How do I know the level of care I need?

After you contact Home Care, a Care Coordinator will meet with you to assess your care needs. Other professionals may also need to meet with you and your family to better understand your personal situation.

How do I know if I need to go to a long-term care home?

Everyone's situation is different. Some people enter long-term care because:

- they may require more care than what Home Care can provide;
- family member(s) can no longer meet their care needs; or
- their health care needs have increased, requiring additional services such as daily nursing care.

How do I apply for long-term care?

If you or a family member believes you need long-term care, your care needs will be evaluated through a standard health assessment review. The assessment will be used to determine if you need nursing care to continue to meet your basic daily health care requirements. Once you have been assessed as needing nursing home care, you may be eligible for admission if you:

- are a resident of PEI;
- have a valid PEI Health Card;
- have Canadian citizenship or are a landed immigrant (a non-Canadian who has established residence in Canada and who holds a visa entitling permanent residence in Canada); and
- are present in PEI for six months or more.

Note: An individual who does *not* meet the above eligibility criteria, may apply for admission to a nursing home and request consideration for admission on an *exceptional status* basis from the Director of Long-term Care.

Can I choose where I want to live?

Yes, you can choose the home you prefer as long as it is able to meet your specific care needs. Your Care Coordinator will discuss nursing home options with you and your family. You may request to be on the wait list of up to three different facilities. Your choices are given equal priority when we offer you a chance to move into a nursing home, so it is important that you choose only those nursing homes you wish to move into. Once you provide us with your list of facilities, your name will be placed on the wait list according to the date you were approved for long-term care.

What should I keep in mind when selecting these homes?

It is important you put your name only on wait lists for homes where you are sure you want to live. You or a family member should consider visiting some homes when making selections. When choosing a nursing home keep the following points in mind:

- Is the location of the home convenient for friends and family to visit?
- Does the home offer activities and services you enjoy?
- Does the home offer the type of accommodation you prefer at a price you can afford?

How long are the wait lists?

Wait times can range from several weeks to several months, or longer, and depend on the number of people on the wait list and how quickly a suitable vacancy becomes available. If you live at home and your situation worsens while you are on the wait list, you should contact your Care Coordinator. The Care Coordinator may be able to arrange for other services, such as additional Home Care or respite care. If you feel you need hospital care, please call your family doctor.

How long will I have to wait for a long-term care admission if I want to live in the same home as my family member?

When you meet with your Care Coordinator, he/she will determine whether you require long-term care and if your care needs can be met in the same facility as your family member. Efforts are made to place close family members in the same facility as soon as possible.

What do I need to know if I am in the hospital waiting to move into a long-term care home?

Every effort will be made to place you in the home of your choice. However, when a suitable bed is not available in your chosen home, you will be asked to move to the **first available bed**. When a suitable bed becomes available in one of your selected home(s), you will have the option to transfer there. If you decline the offer to move to a nursing home, the hospital may discharge you.

Is there an age requirement for eligibility?

You are eligible to move into a nursing home if you are **60 years of age or older and have been assessed as needing nursing level of care**.

If you are **under 60 years of age**, you may be considered for eligibility **if you have been assessed as needing nursing level of care and no other reasonable alternative exists**.

Do I pay for my own long-term care?

Long-term care costs are shared by you, the resident, and the provincial government. You pay your accommodation costs and personal expenses and Health PEI pays your health care costs. The Department of Health and Wellness sets standard accommodation charges annually. Those who can pay the standard accommodation charge are not required to complete a financial assessment. Those who cannot pay the standard accommodation charge can apply to have their rate reduced through an income based financial assessment.

How much will it cost?

The daily cost for accommodations in public manors and for subsidized residents in private care homes is **$105.78 per day**. Other rates may also apply in private homes, depending on the type of room you requested and ability to pay.

If you have a net annual income of **less than $41,000**, you may qualify for a government subsidy to help pay for your accommodations at the nursing home. For more information, contact the Long-term Care Subsidization Program at **1-888-365-5313.**

Private nursing homes have various rates for their accommodation charges, unless a resident has qualified for a government accommodation subsidy.

How do I contact a specific long-term nursing home?

Long-term care nursing homes include both public and licensed private nursing homes, as well as, licensed nursing beds in private combined nursing facilities.

There are nine public nursing facilities and ten private nursing homes located across the province:

Souris

- Colville Manor
  20 MacPhee Avenue

Montague

- Riverview Manor
  14 Rosedale Road

Charlottetown

- Prince Edward Home
  75 Maypoint Road
- Beach Grove Home
  200 Beach Grove Road

Summerside

- Summerset Manor
  15 Frank Mellish Street
- Wedgewood Manor
  310 Brophy Avenue

Tyne Valley

- Stewart Memorial
  6926 Rte 12

O'Leary

- Margaret Stewart Ellis Home
  14 MacKinnon Drive

Alberton

- Maplewood Manor
  405 Church Street

How do I contact Long-term Care?

Long-term Care
16 Garfield Street
PO Box 2000
Charlottetown, PE C1A 7N8

Telephone: (902) 368-5313
Fax: (902) 569-0579

Published date: February 9, 2024

General Inquiries

Health PEI
PO Box 2000
Charlottetown, PE C1A 7N8

Phone: 902-368-6130
Fax: 902-368-6136

healthpei@gov.pe.ca

Your Health Privacy

Media Inquiries
Phone: 902-368-6135

Health PEI Board of Directors

If you are experiencing a medical emergency, call 9-1-1 or go to the nearest emergency department.

If you are unsure what to do about a health issue or if you need health information, call 8-1-1.

This is **Exhibit "K"** referred to in the Affidavit of **Dr. Travis Carpenter,** sworn this 21st 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)

geriatrics

MDPI

Article

Healthcare-Associated Adverse Events in Alternate Level of Care Patients Awaiting Long-Term Care in Hospital

Guillaume J. Lim Fat [1,2,*], Aquila Gopaul [1], A. Demetri Pananos [3] and Mary-Margaret Taabazuing [1]

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Abstract: Introduction: A growing number of Canadian older adults are designated alternate level of care (ALC) and await placement into long-term care (LTC) while admitted to hospital. This creates infrastructural challenges by using resources allocated for acute care during disproportionately long hospital stays. For ALC patients, hospital environments maladapted to their needs impart risk of healthcare-associated adverse events. Methods: In this retrospective descriptive study, we examined healthcare-associated adverse events in 156 ALC patients, 65 years old and older, awaiting long-term care while admitted to two hospitals in London, Ontario in 2015–2018. We recorded incidence of infections and antimicrobial days prescribed. We recorded incidence of non-infectious adverse events including delirium, falls, venothrombotic events, and pressure ulcers. We used a restricted cubic spline model to characterize adverse events as a function of length of stay. Results: Patients waited an average of 56 ALC days (ranging from 6 to 333 days) before LTC placement, with seven deaths occurring prior to placement. We recorded 362 total adverse events accrued over 8668 ALC days: 94 infections and 268 non-infectious adverse events. The most common hospital-acquired infections were urinary-tract infections and respiratory infections. The most common non-infectious adverse events were delirium and falls. A total of 620 antimicrobial days were prescribed for infections. Conclusions: ALC patients incur a meaningful and predictable number of adverse events during their stay in acute care. The incidence of these adverse events should be used to educate stakeholders on risks of ALC stay and to advocate for strategies to minimize ALC days.

Keywords: delayed discharge; waiting for long-term care (LTC); healthcare-associated adverse events; hospital-acquired infections; healthcare-associated infections; delirium; falls; antimicrobial stewardship

Citation: Lim Fat, G.J.; Gopaul, A.; Pananos, A.D.; Taabazuing, M.-M. Healthcare-Associated Adverse Events in Alternate Level of Care Patients Awaiting Long-Term Care in Hospital. *Geriatrics* **2022**, *7*, 81. https://doi.org/10.3390/geriatrics7040081

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1. Introduction

With the rising care needs of Canada's aging population, there is corresponding demand for placement of older adults into long-term care centres (LTC). Given limited availability of LTC beds with limited economic investment in opening and staffing new centres, patients often await LTC placement for an extended period following the initial application process, with an average wait time of 159 days for a community application and 90 days for an application from hospital in Ontario [1]. Although the ideal pathway for this transition is for the patient to await placement at home, the need for higher level of care often arises after deterioration of health in hospital. Following an acute illness, older adults often attain a lower functional baseline [2], and when service needs exceed available homecare services, the multimorbid patient is unable to safely return home [3]. Finding themselves with no alternative disposition where they can await placement, a growing number of patients remain in hospital awaiting LTC [4,5].

In Canada, this population of patients are designated "Alternate Level of Care" (ALC) to emphasize their lack of acute medical issues in contrast to the usual hospital patient [4].

In other countries, including the United States and England, these patients are often classified under the "delayed-discharge" designation. In 2008, 5% of all hospitalizations and 14% of all hospital days in Canada were accounted for by ALC-designated patients, and this has continued to grow [4,5]. With particularly long lengths of stay, ALC patients awaiting LTC contribute to a large proportion of non-medical days at acute hospitals [6], creating infrastructural challenges within already strained hospital systems by occupying beds and using resources allocated for acute care. Patient characteristics that have been associated with greater ALC lengths of stay include psychiatric diagnoses such as dementia, behavioral symptoms, cerebrovascular disease, and morbid obesity [6]. This suggests a particular profile of frail, multimorbid, and often cognitively impaired Canadians with challenging care needs making up a disproportionate number of hospital days.

Furthermore, at the patient level, ALC patients are at high risk for individual adverse outcomes. The acute care hospital setting is not designed to meet a patient's rehabilitative needs but has conversely been shown to advance functional deterioration and place patients at significant risk of hospital-related adverse events including infections and falls [7]. Compared to non-ALC patients, ALC patients have been observed to have longer length of stay, higher median hospital costs, and greater number of complications in hospital, particularly nosocomial infections [7]. At one Canadian academic medical centre, ALC patients were observed to have a median length of stay of 30.85 days, versus 3.95 days in non-ALC patients, and a median hospital cost of $22,459, versus $5003 in non-ALC patients [7]. ALC patients and their families also consistently describe poor care in qualitative studies, with anxiety regarding the uncertainty of the patient disposition and a perception of inconsistent care delivery [8,9].

Our study aims to examine the burden of healthcare-associated adverse events including nosocomial infections, delirium, and falls, in the ALC population and characterize the relationship between these outcomes and length of stay. A secondary aim is to use incidence of these adverse events to educate stakeholders on risks of ALC stay and to advocate for strategies to minimize ALC days

2. Methods

In this descriptive retrospective study, we examined the rates of healthcare-associated adverse events in 156 of the 2386 ALC patients who were awaiting long-term care placement while admitted to two acute care hospitals in London, Ontario. The study was approved by the Western University and Lawson Research Institute ethic boards.

2.1. Inclusion/Exclusion Criteria

Patients were eligible for inclusion if they were 65 years of age or older, admitted as an inpatient at one of the two hospital sites, did not originally come from a LTC centre, and had been given ALC designation specifically to await LTC placement while all acute presenting issues were resolve.

Patients were excluded if they were younger than 65, came from a LTC centre, or were given ALC designation to await a destination other than LTC (i.e., rehabilitation centre, complex continuing care, or psychiatric facility). We only recorded adverse events during ALC days, thus if a patient became medically active and lost ALC designation, we did not record events until and unless they were designated ALC once more.

Patients were not excluded if they died while waiting for LTC in hospital.

2.2. Sample Selection

We reviewed patient data from University Hospital and Victoria Hospital, two tertiary care centres in London, Ontario, and identified 2386 ALC-designated patients who awaited LTC placement in hospital during 2015–2018. Using a random number generator, a sample of 165 charts were selected.

The sample size was based on a simulated test of proportions comparing adverse events in ALC patients to patients already placed in LTC, to power detection of a minimum

meaningful difference between the two groups of 0.5. While this direct comparative analysis was not performed in this study, ongoing data collection on LTC patients is underway for this secondary study. The simulation recommended 330 patients in total with 165 in each group. We therefore began with a random sample of 165 ALC patient charts, of which 9 were excluded due to being ALC but not awaiting LTC, leaving us with our final sample of 156. Common geriatric syndromes and comorbidities were collected for baseline characteristics.

2.3. Data Collection

Charts were individually reviewed by three reviewers using a data extraction tool specifically designed for this study to record the number and types of healthcare-associated adverse events during the entire study period. Active medical issues prior to the date of ALC designation were not included in the recorded adverse events. Healthcare-associated adverse events were classified into two main categories: infectious or non-infectious.

Infectious adverse events were defined as per the McGeer's Criteria Surveillance Definitions of Infections in Long-Term Care Facilities [10]. These are divided into five groups: respiratory tract infections, urinary tract infections, skin/soft tissue infections, gastrointestinal infections, and bloodstream infections. Each of these groups were further categorized into specific infections, such as pneumonia under respiratory tract infections and *C. difficile* colitis under gastrointestinal infections, as fully outlined in the results. In addition to the different infectious events, we also recorded the number of days of antimicrobial treatment that were prescribed to treat these infections.

We recorded four main non-infectious adverse events of interest: delirium, falls, venothrombotic events (VTE), and pressure ulcers. As above, non-infectious adverse events were only recorded if they were newly developed during the ALC period while awaiting LTC placement. A fifth miscellaneous category of "Other" non-infectious adverse event was also included with a defined selective criterion—such events must be deemed reasonably partially attributable to the hospital environment and/or its associated care and required consensus between two or more of the researchers to be included. Examples included hypervolemia from excessive intravenous fluids, adverse medication reactions, new or worsening depression requiring initiation of antidepressants, worsening anemia in the context of frequent blood draws, and injury from use of physical restraints.

To enhance consistency between chart reviewers, practice charts were chosen at random from the study population and all three reviewers appraised the same chart independently. Reviewers then compared their individual chart review tools and ensured the same events were recognized as adverse events. This was repeated with three charts. Any discrepancies were discussed until consensus criteria were reached. Formal chart reviewing only commenced following this exercise.

2.4. Statistical Modelling

After the data were collected, we use a restricted cubic spline to model the expected number of adverse events as a function of length of stay in ALC. The spline used four knots placed at the 5th, 35th, 65th, and 95th percentiles of length of ALC stay (7.7 days, 21.9 days, 47.2 days, and 189.1 days respectively). All models were fit using R [11] and the *rms* package [12]. As our model's primary objective is descriptive, we forgo measures of statistical significance (e.g., p values).

3. Results

Our study population was a sample of 156 patients of 2386 ALC-designated patients who were awaiting LTC at LHSC between 2015 and 2018. The average age was 84 years. Males made up 51.9% and 46.2% of patients were from home with partner and/or family prior to admission to hospital. The most common comorbidity was dementia, with 46.8% of ALC patients having a documented diagnosis at the time of admission. Table 1 summarizes baseline characteristic of our study population.

Table 1. Baseline Characteristics.

	All(%)	Females	Males	Dementia	No Dementia
Age					
65–74	26 (16.7%)	12 (16.0%)	14 (17.5%)	6 (8.2%)	20 (24.1%)
75–84	46 (29.5%)	20 (26.7%)	26 (32.5%)	28 (38.4%)	18 (21.7%)
85–94	72 (46.2%)	37 (49.3%)	34 (42.5%)	34 (46.6%)	37 (44.6%)
95 or older	12 (7.7%)	6 (8.0%)	6 (7.5%)	5 (6.8%)	8 (9.6%)
Sex					
Male	81 (51.9%)	–	81 (100%)	30 (41.1%)	45 (54.2%)
Female	75 (48.1%)	75 (100%)	–	43 (58.9%)	38 (44.6%)
Living situation					
Retirement home	31 (19.9%)	14 (18.7%)	17 (21.0%)	15 (20.5%)	16 (19.3%)
Home alone	48 (30.7%)	29 (38.7%)	19 (23.5%)	15 (20.5%)	33 (39.8%)
Home with partner or family	72 (46.2%)	30 (40.0%)	42 (51.8%)	41 (56.2%)	31 (37.3%)
Other	5 (3.2%)	2 (2.7%)	3 (3.7%)	2 (2.7%)	3 (3.6%)
Comorbidities					
Dementia	73 (46.8%)	30 (40.0%)	43 (53.1%)	73 (100%)	–
with BPSD	16 (10.3%)	6 (8.0%)	10 (13.3%)	16 (21.9%)	–
Falls	49 (31.4%)	26 (34.7%)	23 (28.4%)		
Polypharmacy (>10 medications)	46 (29.5%)	21 (28%)	25 (30.9%)	26 (35.6%)	20 (24.1%)
Osteoarthritis	46 (29.5%)	23 (30.7%)	23 (28.4%)	18 (24.66%)	28 (38.4%)
Atrial fibrillation	38 (24.4%)	22 (29.3%)	16 (19.7%)	16 (21.9%)	22 (26.5%)
Diabetes	37 (23.7%)	13 (17.3%)	24 (29.6%)		
Coronary artery disease	26 (16.7%)	8 (10.7%)	18 (22.2%)	13 (17.8%)	13 (15.7%)
Depression	23 (14.7%)	14 (18.7%)	9 (11.1%)	10 (13.7%(	13 (15.7%)
Congestive heart failure	23 (14.7%)	9 (12.0%)	14 (27.4%)	6 (8.2%)	17 (20.5%)
Chronic kidney disease	20 (12.8 %)	8 (10.7%)	12 (14.8%)	12 (16.4%)	8 (11.0%)
Chronic pain	16 (10.3%)	10 (13.3%)	6 (7.4%)	5 (6.8%)	11 (13.2%)
Urinary incontinence	11 (7.1%)	6 (8%)	5 (6.2%)	4 (5.4%)	7 (8.4%)
Parkinson's disease	9 (5.8%)	4 (5.3%)	5 (6.2%)	4 (5.4%)	5 (6.0%)
Bowel incontinence	8 (5.1%)	5(6.7%)	3 (3.7%)	4 (5.4%)	4 (4.8%)
COPD	8 (5.1%)	5 (6.7%)	3 (3.7%)	3 (4.1%)	5 (6.0%)
Delirium	5 (3.2%)	4 (5.3%)	1 (1.2%)	3 (4.1%)	2 (2.4%)

Patients waited an average of 56 ALC days before LTC placement, ranging from a minimum of 6 to a maximum of 333 days, with 7 deaths occurring prior to placement. Table 2 shows the different lengths of stay.

Table 2. ALC lengths of stay.

	All (%)	Females	Males	Dementia	No Dementia
<15 days	34 (21.7)	16 (21.3%)	18 (22.5%)	15 (20.5%)	19 (22.9%)
15–30 days	41 (26.2)	22 (29.3%)	16 (20.0%)	9 (12.3%)	29 (34.9%)
31–60 days	37 (23.7)	21 (28.0%)	18 (22.5%)	22 (30.1%)	18 (21.7%)
61–100 days	18 (11.5)	9 (12.0%)	9 (11.3%)	7 (9.6%)	11 (13.3%)
101–200 days	20 (12.8)	7 (9.3%)	13 (16.3%)	15 (20.5%)	5 (6.0%)
201–300 days	4 (2.5)	0 (0%)	4 (5.0%)	3 (4.1%)	1 (1.2%)
>300 days	2 (1.2)	0 (0%)	2 (2.5%)	2 (2.7%)	0 (0%)

For our primary outcome, we recorded 362 total adverse events accrued over the combined 8668 ALC days. Of those, 94 adverse events were infections and 268 were non-infectious adverse events. Table 3 shows all adverse events recorded.

Table 3. Adverse events during ALC stay.

	All	Females	Males	Dementia	No Dementia
Total adverse events	362	156	206	206	156
Infections	94	37	57	58	36
Urinary tract infections	50	22	28	31	19
Respiratory infections	26	6	20	18	8
Skin/soft tissue infections	14	7	7	8	6
Gastrointestinal infections	3	1	2	0	3
Bacteremia	1	1	0	1	0
Non-infectious adverse events	268	119	149	148	120
Delirium	76	35	41	44	32
Falls	39	18	21	20	19
Venothrombotic events	2	2	0	1	1
Pressure ulcers	22	10	12	8	14
Other	129	54	75	75	54
Antimicrobial days	620	247	373	387	233
For urinary infections	299	133	166	200	99
For respiratory infections	147	39	108	79	68
For skin/soft tissue infections	136	51	85	94	42
For gastrointestinal infections	24	10	14	0	24
For bacteremia	14	14	0	14	0

The most common infectious adverse events were urinary tract infections (50 events, 13.81%) and respiratory infections (26 events, 7.18%). The most common non-infectious adverse events were delirium (76 events, 21.0%) and falls (39 events, 10.77%). Non-infectious adverse events included a large proportion of "Other" adverse events which met the aforementioned criteria without fitting into an alternative category, with a total of 129 such events.

The restricted cubic spline model we utilize allows us to non-linearly model expected number of adverse events in our population as a function of the length of stay in ALC.

Table 4 shows model estimates for the average number of adverse events as a function of length of stay, using examples of lengths of stay at 14, 30, 60, and 100 days.

Table 4. Estimated adverse events over length of ALC stay.

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ALC Days	Adverse Events	Infections	Delirium	Falls
14	1.08	0.25	0.23	0.18
30	1.81	0.49	0.35	0.23
60	2.93	0.71	0.62	0.20
100	3.93	0.99	0.85	0.25

Figure 1 shows the plots of model predictions (red) along with data used to fit the model (black circles). To avoid overlapping of data points, we add noise to the vertical component of the scatter plot.

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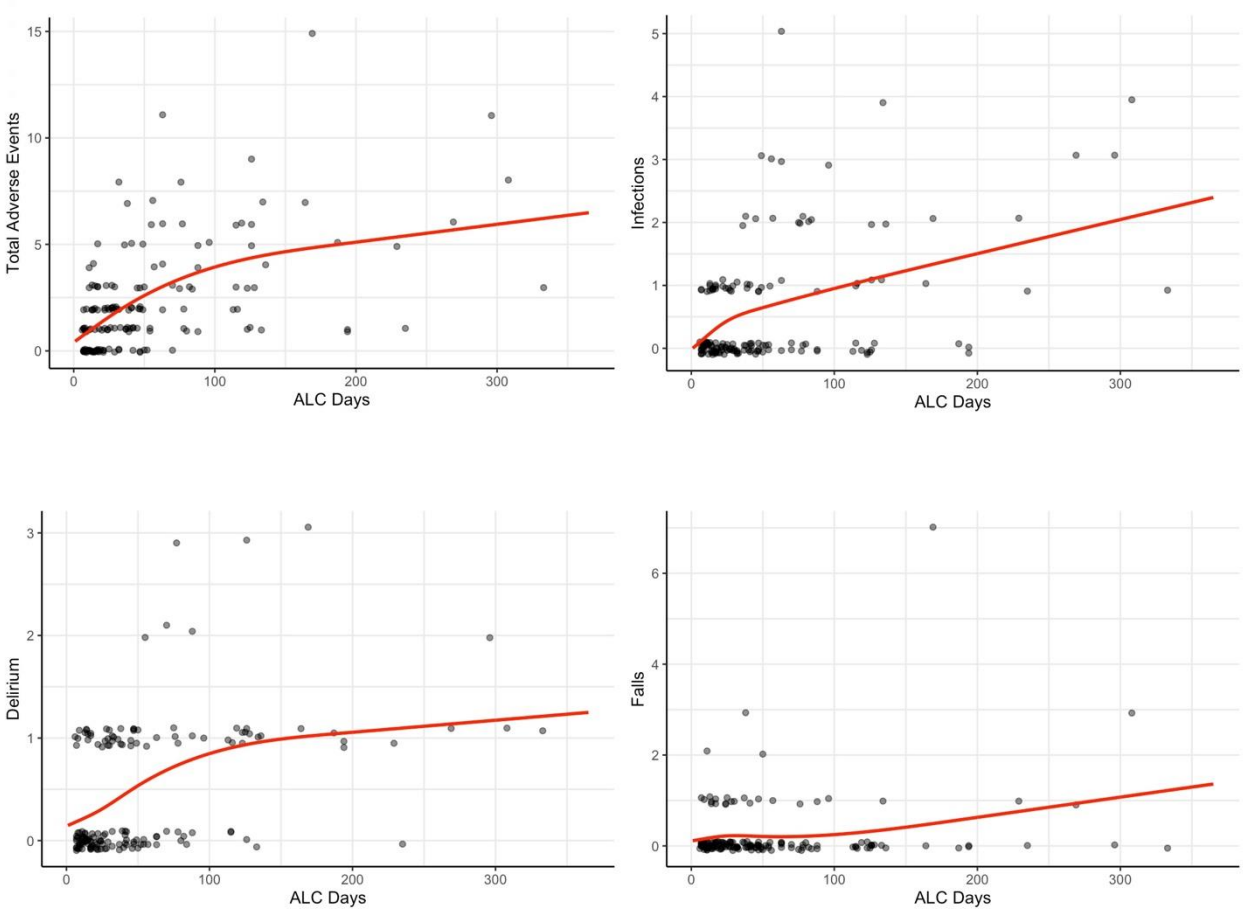

Figure 1. Descriptive modelling of expected healthcare-associated adverse events in study population as a function of ALC days using restricted cubic spline.

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4. Discussion

4. Discussion

Our results demonstrate that ALC patients incur a significant burden of both infectious and non-infectious adverse events while waiting for LTC, leading to worse patient outcomes, poor antimicrobial stewardship, and further delayed discharges. Our modelling suggests there is a predictability of adverse events in relation to length of ALC stay, which could be used to educate patients and families regarding risks associated with waiting for LTC in hospital. At a systems level, this can also be used to advocate to stakeholders of healthcare administration and hospital leadership to further strategies for reduction of ALC days, appropriate resource allocation, and policy reform.

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Our sample reflected the older age of ALC patients, with an average of 84 years, and minimal gender difference with 81 males and 75 females. Previous population-level data obtained using Ontario's RAI-HC database described a similar average age of 83 years, but slight female predominance at 61.5% female to 39.45% males [3], which we did not re-demonstrate. Unsurprisingly, dementia was our most prevalent co-morbidity at 46.8%. Cognitive impairment has a well-described association with ALC designation, increased care needs, delayed discharge [13–15], particularly in Ontario where up to 68.4% of ALC patients have some level of clinical memory impairment [3]. Our random sample was therefore largely representative of previously described characteristics of ALC patients in Ontario.

Hospital-acquired infections (HAIs) are well-described contributors to increased length of stay, morbidity, and mortality at the patient level [16–18], while producing a large economic burden at the population level [19,20]. The most prevalent HAIs we observed were urinary tract infections and respiratory infections, and these have been identified as the most common HAIs in older adults [21]. Hospital acquired UTIs are on the rise in Canadian hospitals [22], and a probable contributor is the overdiagnosis and overtreatment of UTIs in hospitalized older adults [23,24]. Hospital-acquired respiratory infections have also interestingly been observed to be over-diagnosed in older adults [25]. A total 620 days of antimicrobial treatment was prescribed for HAIs in our population. While inevitable when treatment is required, increasing overuse of antimicrobials is widely recognized as contributing to growing antimicrobial resistance, particularly in the hospital environment [26,27].

Falls and delirium were our leading non-infectious adverse events, in keeping with their known prevalence and overlap in hospitalized older adults [28]. The fluctuating and often prolonged nature of delirium made recording incidence of delirium distinct, in that we rarely identified multiple convincingly discrete occurrences over the same hospitalization. Delirium was therefore largely binary, either present or absent throughout the hospitalization. The predominance of delirium was reflective of dementia, widely recognized as a strong predisposing risk factor for delirium, being the most common comorbidity in our ALC population at 46.8% of the study population [29].

The ALC designation has several implications that transcends the often-emphasized impact on patient flow across the acute care health system. As defined by the Institute of Medicine, a high-quality health system is safe, effective, patient centered, timely, efficient, and equitable [30]. ALC designation disproportionately impacts older adults with functional impairment and multiple comorbidities including cognitive impairment [8]. We therefore argue that ALC status is an indication of system failure in care quality and equity, placing vulnerable older adults at further risk of functional decline delirium, falls, and infections, while incurring disproportionate healthcare costs [3,31,32]. Our findings reinforce the negative health outcomes detrimental to the individual ALC patient, with an incremental effect with length of stay [32]. Although we did not examine cost, a retrospective cohort study of patients admitted to a tertiary setting similar to our sites confirmed increased adjusted healthcare cost among ALC patients compared to non-ALC patients [7].

Qualitative studies have highlighted the dehumanizing aspect of being an ALC patient, including depersonalization and the notion of "patient over person" while in hospital [8]. ALC patients and their families eagerly await transition into LTC, where they foresee experiencing enhanced autonomy and daily structure [8,9]. We hypothesize that these perceptions and the adverse events we observed stem in part from ALC patients having needs overlooked in favour of patients with acute issues. Furthermore, ALC patients experience multiple relocations as they move through the hospital system. Lack of stability and myriad of unfamiliar environments sensibly increase delirium risk. Given the multiple adverse outcomes described, it is important to advocate for measures and policy reforms which address the overgrowing ALC population and its effect on our strained healthcare system.

4.1. Limitations

Our study has a number of limitations. Our data rely on the documentation of these adverse outcomes during admission, and the accuracy and reliability of this charting inherently varies based on physician and allied worker's practices. Our population is also limited to two specific tertiary hospitals within the same catchment area in the Middlesex–London area, reducing generalizability to other institutions that may have different LTC availability. Our models of adverse events are also descriptive in nature and are limited to predictions within our own study population. While we present our findings stratified within clinically relevant subgroups of interest, namely male/female and dementia/no dementia, our study is not powered to directly compare prevalence of adverse events between these groups or inference of statistical significance, but rather shows descriptive observational data.

4.2. Future Directions

Direct comparison to a LTC cohort should be explored to examine if they experience similar rates of adverse events. We are currently pursuing this with data collection at a LTC centre in London, Ontario, with similar catchment area to the hospitals examined.

In recent years, health systems have developed transitional care units (TCU) with the purpose of transferring ALC patients out of acute care beds and into dedicated space more suitable to their level of care. This has been demonstrated to result in improved outcomes for ALC patients at reduced cost [33]. TCU access remains limited, however, and while these can offload a number of ALC patients from hospitals, many remain in acute care settings despite this strategy. Comparing adverse events in a similar TCU population to our cohort would provide further insight into their efficacy.

While operational changes and policy reform are expected, it is yet unclear exactly how the COVID-19 pandemic has affected wait times for LTC and the ALC population [34]. With the disproportionate number of LTC cases and death in Canada [35], it is expected that LTC accessibility has shifted by virtue of both direct resident deaths and changing public perception of safety in LTC. While we expect some degree of risk of adverse events to be specific to the hospital environment, shortcomings in infection control in LTC highlighted by the pandemic raises the question of whether LTC residents truly incur fewer adverse events compared to ALC patients.

5. Conclusions

ALC patients incur adverse events while waiting for LTC in an acute care environment maladapted for their needs. This results in a number of downstream effects in an already vulnerable population, disfavored by the limitations of our healthcare system and unfairly perceived as a burden due to associated care costs and bed strain. The predictability of adverse events in relation to length of ALC stay should be used to educate patients and families regarding risk of waiting for LTC in hospital. At a systems level, prevalence of adverse events in ALC patients should be used to advocate for improved homecare resources to support patients at home and solutions to improve access to LTC to minimize waiting in hospital, such as the use of TCUs. Direct comparison to adverse events in LTC and TCUs are avenues for further research.

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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
SUPERIOR COURT OF JUSTICE

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