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## 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.<sup>1</sup> 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.<sup>2</sup> 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 reappoints 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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<sup>1</sup> 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>.

<sup>2</sup> 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).<sup>3</sup> 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.

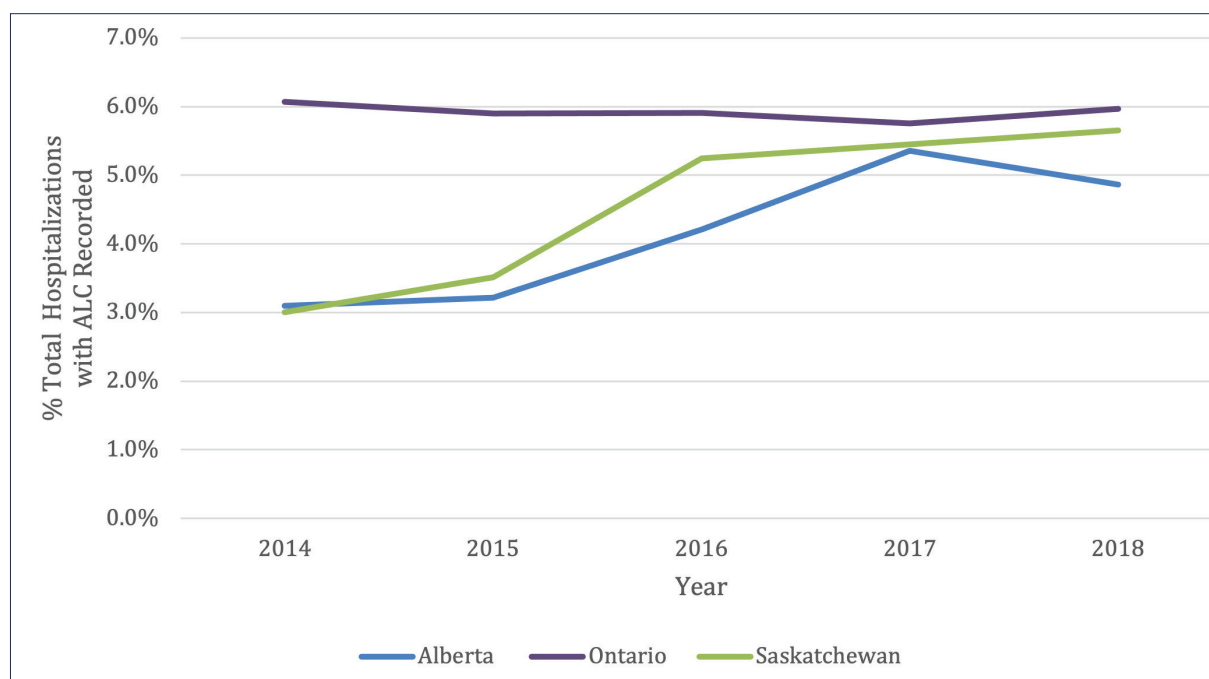
With this in mind, working with data that are as consistent, accurate and adequately granular as possible is important to provide the insights to inform the design and implementation of policy reform. For example, in comparing Alberta and Saskatchewan with Ontario between 2014 and 2018 (using data available 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

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<sup>3</sup> 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**

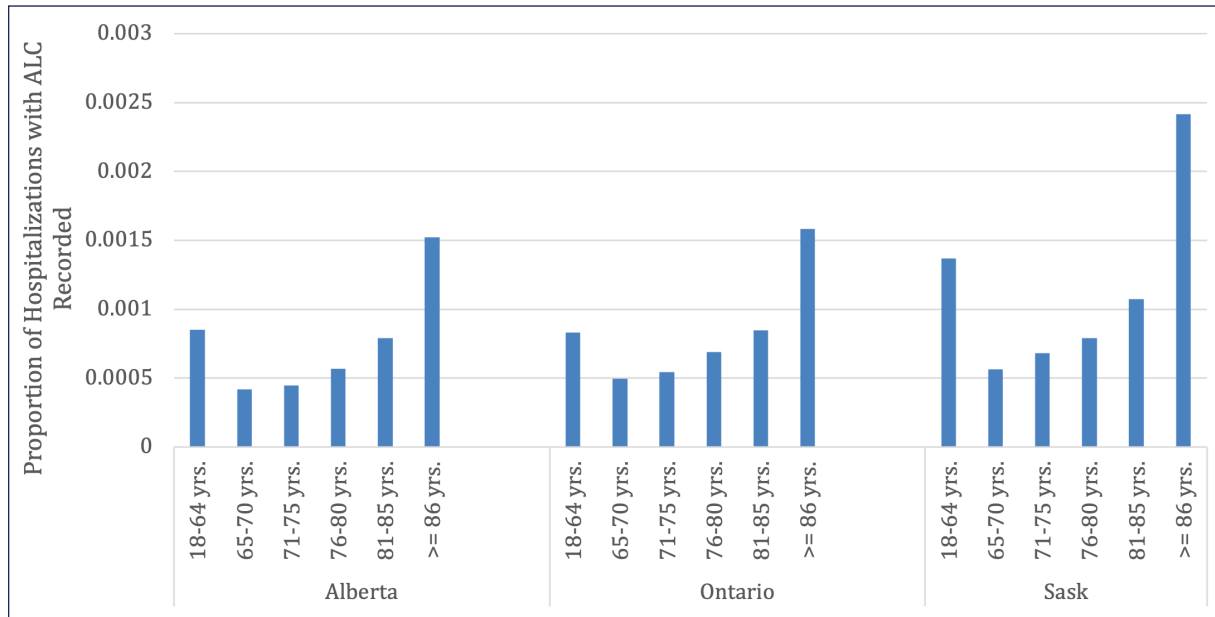


Source: CIHI

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

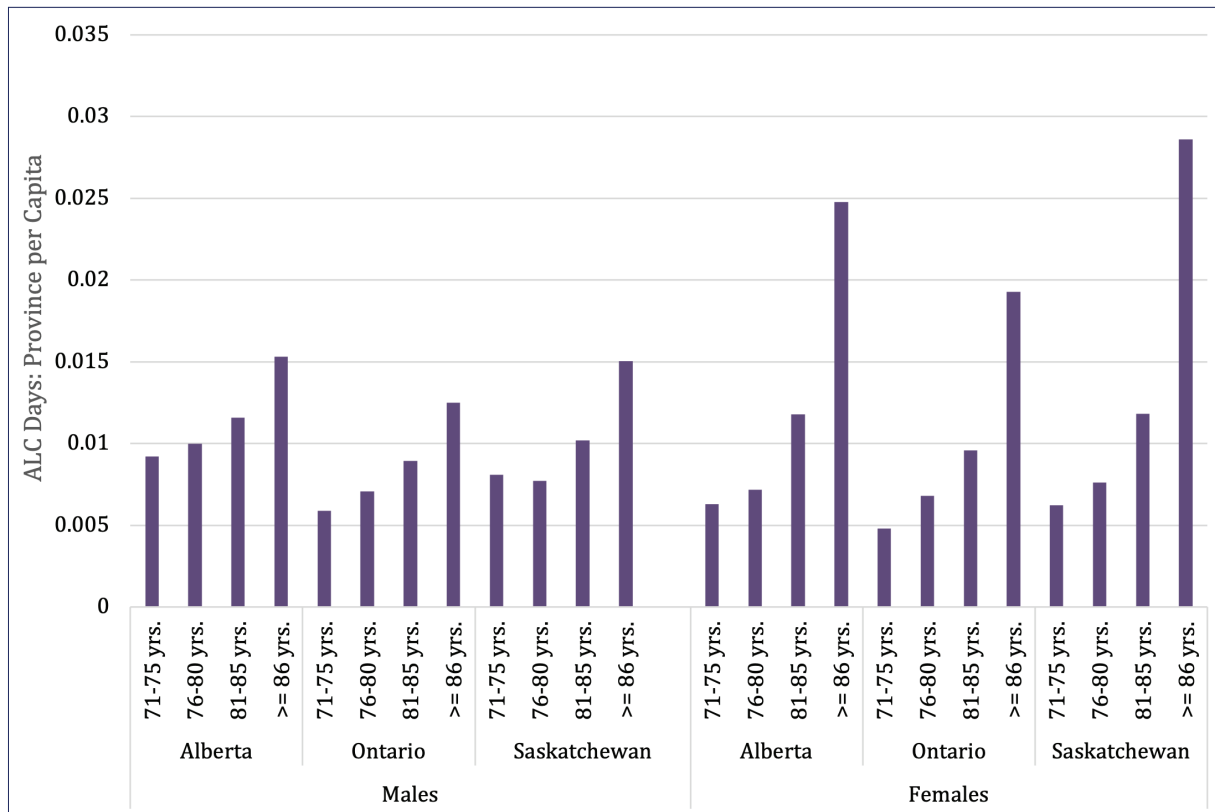
Demographic Variable	Effect on/Relationship to ALC Rates
<b>Age</b>	ALC rates rise dramatically in those over 80 and even more significantly in those 86 or older. This reflects the combination of increasing frailty with natural aging, accumulation of specific age-related medical diagnoses and social factors like decreasing availability of caregivers (who may become aged or unwell themselves) or dwindling financial resources late in life.
<b>Gender</b>	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).
<b>Major Clinical Category (MCC)</b>	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.
<b>ALC Discharge Disposition</b>	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.

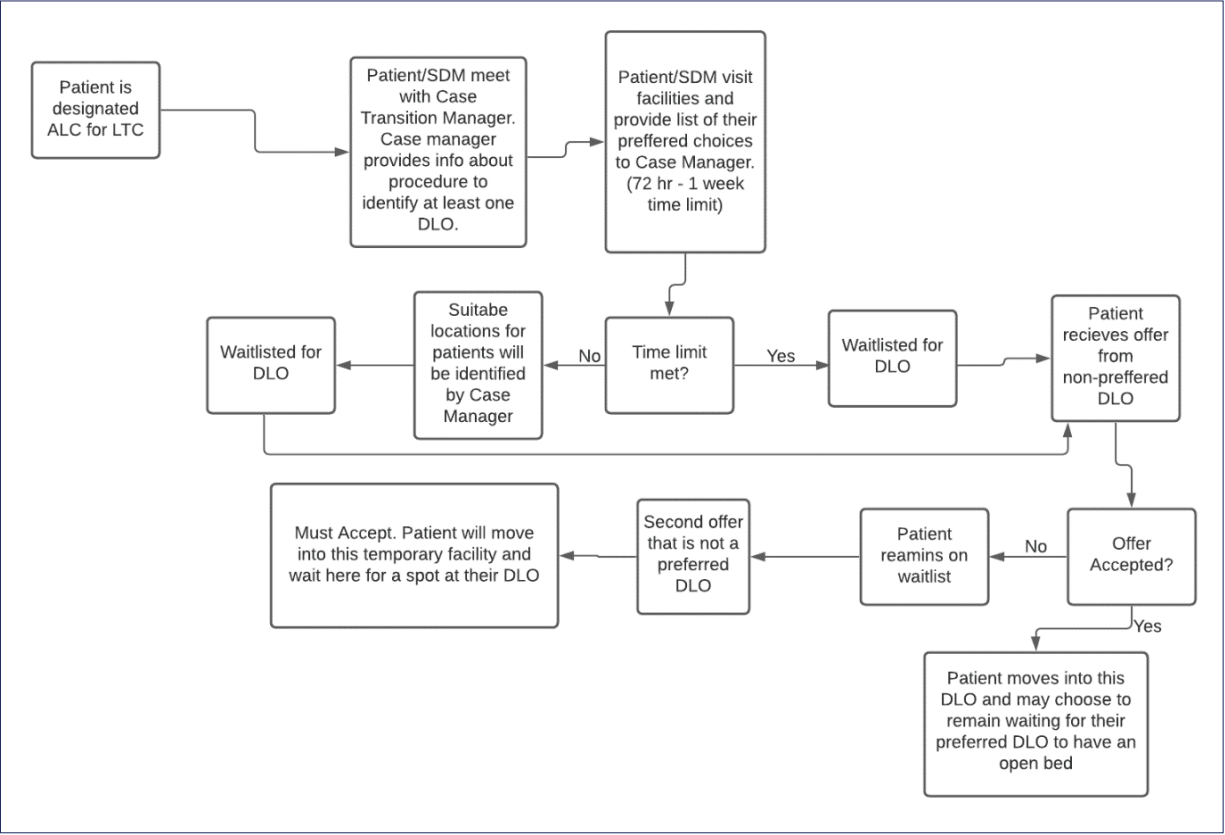
**Additional fees** are a politically volatile but likely necessary policy intervention. Health systems across Canada have long used daily bed charges to recoup some of the sunk resource costs resulting from ALC hospitalizations (McCloskey et al. 2015). Legal authority to do so has been permitted under 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),<sup>4</sup> 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

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<sup>4</sup> 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)**

<b>Saskatchewan</b>				
<b>Fiscal Year</b>	<b>Gender</b>	<b># of Hospitalizations with ALC recorded (total)</b>	<b>Total Length of Stay in Days</b>	<b>ALC Length of Stay in Days</b>
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)
<p>Strategies to reduce ALC admissions and/or avoid unnecessary admissions</p> <ul style="list-style-type: none"> <li>• 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.).</li> <li>• Improving community care and supports to avoid unnecessary acute-care hospitalizations.</li> <li>• Improving outpatient supports and medical management for frail patients.</li> <li>• Early recognition of patients who will need institutional care and improved pathways from community to institutional care.</li> </ul>	<p>Strategies that target improving patient flow and efficiency and reducing the length of ALC stays</p> <ul style="list-style-type: none"> <li>• Paradigm shifting to change perceptions of risk and increase tolerance of risk.</li> <li>• Early and enhanced discharge planning.</li> <li>• Reformed/increased bed charges.</li> <li>• Stricter policies for choosing discharge destinations and improved long-term care wait-list management.</li> <li>• Increased use of activity-based funding models.</li> <li>• Increased provision of ALC-specific inpatient units.</li> </ul>	<p>Practices that focus on facilitating effective, timely and durable discharges</p> <ul style="list-style-type: none"> <li>• Increased provision of transitional care settings.</li> <li>• Increased provisions of supports, financial incentives and home-care services to allow patients to avoid institutional care.</li> <li>• Increased provision of long-term care.</li> <li>• Increased provision of palliative care services and advanced care planning to avoid low utility care usage at end of life.</li> </ul>

## 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	18.00	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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