ORIGINAL RESEARCH

An Environmental Scan of Alternate Level of Care (ALC) Policies in Ontario, Canada

Diya Ahmad, MD[1,a], Andrea Pace, BSc[1,a], Laura Jamieson, MSc[2,a], Kristina M. Kokorelias, PhD[3,4,5], and Guillaume Lim Fat, MD, FRCPC[3]

[1]Temerty Faculty of Medicine, University of Toronto, Toronto, ON; [2]School of Medicine, University of Limerick, Limerick, Republic of Ireland; [3]Division of Geriatric Medicine, Department of Medicine, Sinai Health System and University Health Network, Toronto, ON; [4]Department of Occupational Science & Occupational Therapy, Temerty Faculty of Medicine, University of Toronto, Toronto, ON; [5]Rehabilitation Sciences Institute, Temerty Faculty of Medicine, University of Toronto, Toronto, ON

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ABSTRACT

Background

Alternate level of care (ALC) patients occupy hospital beds despite no longer requiring acute services, impacting patient flow and contributing to overcrowding. Ontario hospitals have updated legislation and policies to address this issue, yet protocols vary across centres. This study conducted an environmental scan of ALC policies to examine differences in patient identification, management, and support.

Methods

The research employed a multi-phase approach, beginning with a review of ALC policies obtained through direct inquiry from relevant institutions and publicly available documents. Policies were analyzed using content analysis to systematically identify common practices and differences across key areas, including risk identification, clinical criteria, leadership roles, early discharge planning, and patient engagement. A coding framework was developed based on Ontario Health guidelines and used as a comprehensive guiding document for comparison. Two researchers independently coded the documents to ensure consistency, and discrepancies were resolved through discussion to reach consensus. Key patterns and themes were then synthesized to highlight areas of convergence and divergence across the policies.

Results

Qualitative content analysis of 10 policy documents revealed consistency in the core definition of ALC patients but variability among clinical criteria, substitute decision-maker roles, caregiver supports, discharge-planning protocols, and language. Variability existed in the application of senior-friendly care principles, with emphasis on discharge rather than successful transitions, suggesting opportunities for improvement in person-centred care.

Conclusions

ALC policies vary greatly and exhibit both strengths and gaps in addressing patient flow and care coordination. Comprehensive discharge-planning models, which maintain a person-centred approach, could help mitigate patient flow challenges without loss of senior-friendly care principles by strengthening caregiver engagement and standardizing ALC patient identification and management practices. These findings identify the need for a more cohesive and formalized ALC management strategy in Ontario, with implications for the development of national policies and protocols worldwide.

Key words: delayed discharge, care transitions, policy analysis, quality improvement

INTRODUCTION

Globally, healthcare systems are facing immense challenges in ensuring timely access to care and managing patient flow for an aging population. Older adults, particularly those with complex health and social needs, are at risk of delayed discharge from acute care settings due to the limited availability of health and social support services such as home care, long-term care (LTC), and transitional care facilities.(1) Different terms have been used by varying jurisdictions to describe these patients, including "delayed discharge," "medically fit for discharge," "clinically optimized," "prolonged

[a]Indicates co-first author; these authors contributed equally to this study.

hospitalization," and even, historically, "bed-blockers" throughout the United Kingdom, United States, and Sweden.[2–5] While terminology may differ, the consequences of delayed discharges are consistently described across the literature and include decreased patient satisfaction, adverse outcomes, caregiver burden, increased costs, bed shortages, prolonged emergency department (ED) wait times, and elective surgery cancellations.[6–9]

In Canada, alternate level of care (ALC) is the term used to describe patients who occupy a bed in an acute inpatient setting but no longer require the intensity of services provided in that care setting.[10] ALC patients in Canada occupy between 10% and 20% of beds in acute care centres, costing the system $5–9 million every day.[7] In 2021, 80% of all ALC designations in Canada's most populous province, Ontario, were older adults (65+ years).[11] As documented in a recent scoping review,[12] ALC patients are, on average, of advanced age and with characteristics such as dementia and multiple comorbidities which prolong their length of stay (LOS).[12] Described as "a far-reaching crisis," the ALC problem negatively impacts patients and families, while more broadly contributing to prolonged waiting times, service disruptions, and additional strain on finite resources in acute care.[12] Tailored interventions and policies are required to improve patient outcomes and mitigate pressures on our healthcare systems.

To reduce ALC days and optimize resource utilization across the care continuum, provincial legislation and guidelines have been developed. In 2021, Ontario Health (OH) released *The Alternate Level of Care (ALC) Leading Practices Guide*: *Preventing Hospitalization and Extended Stays for Older Adults*.[11] This document describes actionable items to meet three main goals: integration of senior-friendly care (sfCare), avoidance of unnecessary hospital admissions, and minimization of hospital-acquired harm. sfCare is an evidence-based paradigm involving preventive care for the unique needs of older adults that is described as essential care rather than additive.[11] OH also formalized an operational direction called *Home First*,[13] whereby every effort is made to ensure adequate resources are provided to prioritize patients' return home upon discharge, rather than remaining hospitalized until transfer to LTC. More recently, the Ontario government passed *Bill 7, More Beds, Better Care Act, 2022*, an amendment to the *Fixing Long-Term Care Act, 2021*, specifically pertaining to ALC patients. Bill 7 gives discharge coordinators the authority to apply to LTC home(s) on patients' behalf (located up to 70–150 kilometers away from the patient's preferred location depending on the area) and authorizes transfers without consent when "reasonable efforts" to obtain consent have been unsuccessful.[14] Patients who decline these transfers can be charged a co-payment of $400 per day in hospital.[15] The extent of Bill 7's implementation across sites and the frequency of co-payment enforcement remain unclear.

Despite existence of wider provincial legislation and directives, gaps remain in understanding policy frameworks guiding ALC management at the local institutional level. Current literature provides a foundation for development of policies by examining delays in transition through the lens of patient and caregiver experiences[16–20] and offering critical insights into national trends to emphasize the need for integrated approaches.[12] However, these studies primarily focus on operational challenges and patient-level factors. Instead, this paper adopts a policy-oriented perspective and evaluates existing ALC policies.

By conducting an environmental scan and current-state analysis of ALC policies in Ontario hospitals, we aim to establish a more nuanced understanding of how current local policies compare to the OH ALC Leading Practices Guide. The findings will contribute to ongoing quality improvement pertaining to ALC at the authors' home institution by informing future policy development. Ultimately, we hope to improve both the quality of care provided and timely access to the right level of care while aligning with sfCare practices.

METHODS

This environmental scan involved collecting and analyzing ALC policies from Ontario healthcare institutions for comparative content analysis. The search process was conducted over approximately 2 months, from June to July of 2024 and employed direct institutional inquiry due to lack of public access to policy documents.

Two publicly available documents from regulatory bodies, namely the OH ALC Leading Practices Guide[11] and the Canadian Institute for Health Information (CIHI)'s document to support ALC designation in acute care settings,[10] were used as guiding frameworks. Academic and community hospitals were directly contacted to gain access to current ALC policies. Twenty hospitals were purposively sampled to ensure representation across academic versus community hospitals and bed size, balancing feasibility and diversity of policy approaches. The research team principal investigator e-mailed individuals in geriatrics, hospital leadership, and/or patient flow roles at both academic and community institutions. Institutions who did not respond initially were contacted again approximately 2 weeks later.

Inclusion Criteria

The scope of this scan was limited to policies that are readily accessible to front-line staff involved in care of ALC patients and ALC-specific rather than broader discharge or patient flow policies. Policies from both community and academic hospitals were included. The decision to focus solely on Ontario policies was driven by the province's unique policy landscape and guidelines within variability in ALC management nationwide, and for applicability to quality improvement at our local sites. Drafts and in-development policies were excluded from our analysis. There were no restrictions on policy publication dates; however, institutions were asked to provide the most recently updated documents available.

Content Review

A comprehensive guiding document for comparison of the policies was created based on the OH guideline. This selection was based on OH's role in overseeing the administration of Ontario's healthcare facilities and the document's stated mission to "describe what care [of older adults] should look like,"[11] given the high proportion of ALC patients who are older adults. Initial categories for comparison were based on the headings of the OH guidelines and aimed to represent key contents and messaging.

Two reviewers independently extracted policy information using a standardized form capturing definitions, clinical criteria, roles, discharge planning, and patient/caregiver engagement. The research team collaborated to establish standardized definitions for tone descriptors, such as formal, collaborative, authoritative, informative, and procedural. Discrepancies were resolved through discussion; unresolved disagreements were adjudicated by a third reviewer. Inductive coding allowed categories to emerge directly from policy content. Codes were grouped into overarching themes through iterative discussions among the research team. Microsoft Excel (Microsoft Corporation, Redmond, WA, USA) was used to organize and manage codes, and inter-rater reliability measures were not calculated.

RESULTS

A response rate of 75% was achieved with 15 institutions replying to our inquiry (Figure 1). Of the 15, 5 reported using the OH guidelines, 1 reported using the CIHI document, and 9 reported having their own ALC policy. Of these nine, eight agreed to share their policies with us, while one declined. Our sample includes multiple large academic centres, a community health network, and a smaller rehabilitation centre, providing a broad perspective on ALC policy variations. In the Public Hospitals Act, Ontario's hospitals are categorized by the provincial government based on size and types of care provided including general/teaching hospitals (group A, n = 16); >100 beds (group B, n = 43); and <100 beds (group C, n = 82).[21,22] Our sample includes four group A and three group B hospitals. One of the institutions included was a rehabilitation centre that was not captured in these groups and is classified in group E: general rehabilitation hospitals. To maintain confidentiality and adhere to institutional agreements, the specific hospital names are not disclosed but characteristics are summarized in Table 1.

As shown in Table 2, an overarching similarity between the OH and CIHI guidelines with the institution-specific ALC policies was the establishment of an ALC definition. Numerous institutions referenced the provincial definition of ALC: "When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting, the patient must be designated alternate level of care (ALC) at that time by the physician or delegate." Four key discrepancies were identified between institutional policies and guiding documents: (i) priority objectives, (ii) clinical criteria, (iii) key principles of ALC patient care, and (iv) tone and language.

Priority Objectives

As shown in Table 3, there was significant variability in the stated priorities of the institution-specific and guiding policy documents. Notably, despite OH's emphasis on sfCare, none of the institution-specific policy documents included this term or placed significance on this philosophy. Additionally, the CIHI document focused on the clinical definitions of ALC, which none of the institutional policies did. However, like CIHI, two of eight institutional policies emphasized standardizing ALC designation. The Home First philosophy is also described in two of the eight institution-specific guidelines. Many institutions prioritized early intervention, though approaches varied, with some focusing on early ALC designation itself and others on expedited discharge/transition planning. In contrast, the OH guidelines highlight early intervention at multiple care points, including screening in the ED, involvement of an interdisciplinary team, and proactive transition planning.

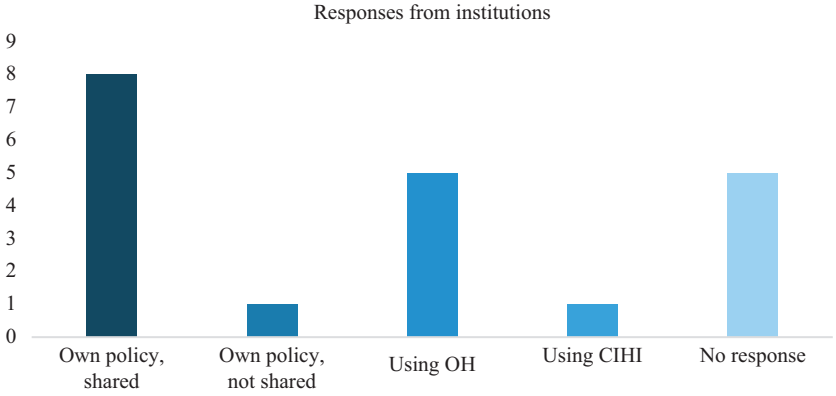

FIGURE 1. Responses from Healthcare Institutions

TABLE 1.
Comparison of institutional context and policy adoption

Institution/Guideline	*Context*	*Public Hospitals Act Classification*	*ALC Policy Creation (Y/N)*	*Date Created/ Last Reviewed*
CIHI	Federal guideline	Not applicable – National organization	No	2016
OH	Provincial guideline	Not applicable – Provincial organization	No	2022
Large academic 1	Academic/large centre	Group A	Yes	2023
Large academic 2	Academic/large centre	Group A	Yes	2018
Large academic 3	Academic/large centre	Group B	Yes	2024
Large academic 4	Academic/large centre	Group A	Yes	2022
Large academic 5	Academic/large centre	Group B	Yes	2022
Large academic 6	Academic/large centre	Group A	Yes	2015
Small rehab centre	Smaller/rehabilitation	Group E	Yes	2022
Community health network	Urban/community hospital	Group B	Yes	2020

ALC = alternate level of care; CIHI = Canadian Institute for Health Information; OH = Ontario Health; Y/N = yes/no.

TABLE 2.
ALC definitions

Institution/Guideline	*ALC Definition*
CIHI	"When a patient is occupying a bed but no longer in need of acute services."
OH	"Patients occupying a bed but no longer requiring acute care."
Large academic 1	"Patients who no longer require acute care services but continue to occupy a hospital bed."
Large academic 2	References provincial ALC definition.
Large academic 3	"Patients meeting criteria for discharge but occupying a hospital bed."
Large academic 4	"Patients ready for discharge; determined by attending physicians."
Large academic 5	"Patients ready for discharge; determined by attending physicians."
Small rehab centre	References provincial ALC definition.
Large academic 6	References provincial ALC definition.
Community health network	References provincial ALC definition.

ALC = alternate level of care; CIHI = Canadian Institute for Health Information; OH = Ontario Health.

Clinical Criteria

As shown in Table 4, none of the institutional policies explicitly defined specific clinical criteria when designating patients as ALC, despite several emphasizing standardization of ALC designation. Conversely, the CIHI document outlines criteria for distinguishing between acute care and ALC designation, including patients' current clinical status and safety risks. The OH guidelines outline a team-based process for ALC assessment, involving comprehensive geriatric assessment and collateral history from the substitute decision-maker (SDM). Conversely, the institutional policies do not outline such criteria, with three documents deferring to the judgment of the attending physician or healthcare team, potentially leading to inconsistent ALC designations. One academic health network references criteria established by the former Ontario Ministry of Health and Long-Term Care.

Key Principles of ALC Patient Care

Key principles of ALC patient care, as described in the OH guidelines, are summarized in Table 5. The OH guidelines extensively detail the role of a comprehensive geriatric assessment consisting of physical, cognitive, and functional assessments performed by interprofessional teams with expertise in the care of older adults. Conversely, only one large academic health network made mention of such assessments.

The OH guidelines describe common characteristics for early identification of individuals at risk for delayed discharge, including age over 65 years, functional or cognitive impairments, and caregiver stress. Two policies partially reflect this approach by emphasizing early identification of patients who cannot return home without community resources, may require a different level of care, or may face

TABLE 3.
Priority objectives

Priority Objectives	*Institution/Guideline*									
	CIHI	OH	LA1	LA2	LA3	LA4	LA5	LA6	Rehab	Comm
Senior-friendly care		✓								
Standardizing ALC designation	✓							✓	✓	
Home First philosophy			✓	✓						
Early discharge planning						✓	✓			
Early transition planning					✓					
Early ALC identification										✓
Collaboration with SDM and families						✓	✓			
Escalation procedure			✓		✓					

ALC = alternate level of care; CIHI = Canadian Institute for Health Information; Comm = community health network; LA = large academic centre; OH = Ontario Health; Rehab = small rehab centre; SDM = substitute decision-maker.

TABLE 4.
Clinical criteria for ALC designation

Institution/Guideline	*Clinical Criteria for ALC Designation*
CIHI	Clinical criteria provided to distinguish acute care and ALC.
OH	"A comprehensive assessment is initiated, which accounts for physical, cognitive, functional, and psychosocial domains."
Large academic 1	No explicit clinical criteria.
Large academic 2	No explicit clinical criteria.
Large academic 3	References criteria established by the former Ministry of Health and Long-Term Care to designate patients as ALC.
Large academic 4	No formal criteria; relies on attending physicians' judgment.
Large academic 5	No formal criteria; relies on attending physicians' judgment.
Small rehab centre	No explicit clinical criteria.
Large academic 6	No explicit clinical criteria.
Community health network	No formal criteria; relies on the healthcare team's judgment.

ALC = alternate level of care; CIHI = Canadian Institute for Health Information; OH = Ontario Health.

TABLE 5.
Key principles of ALC patient care

Key Principles	*Institution/Guideline*									
	CIHI	OH	LA1	LA2	LA3	LA4	LA5	LA6	Rehab	Comm
Comprehensive assessment		✓	✓							
Early risk identification		✓[a]	✓[a]	✓[a]						
Ongoing reassessment	✓	✓	✓	✓				✓		✓
Involvement of SDM		✓	✓	✓	✓	✓	✓		✓	
Involvement of PCP		✓				✓	✓			
Escalation process		✓	✓	✓	✓	✓	✓			

ALC = alternate level of care; CIHI = Canadian Institute for Health Information; Comm = community health network; LA = large academic centre; OH = Ontario Health; PCP = primary care provider; Rehab = small rehab centre; SDM = substitute decision-maker.
[a]Principle was described with specific criteria.

barriers to accessing services. The remaining institutional policies do not outline early risk identification, though one community hospital network notes its importance without specifying criteria.

Fifty percent of institutions and both guiding documents outline processes for ongoing ALC reassessment; however, there is limited consensus on appropriate reassessment intervals. The OH and CIHI's guidelines recommend daily reassessment of ALC status, including monitoring changes in medical and functional domains, estimated discharge date, and support needs. In contrast, only one academic network includes daily reassessment, two community hospital networks assess every 2 days, and one academic institution does so weekly. Four institutions do not mention reassessment.

Overall, we noted emphasis on procedural enforcement of Bill 7, with five of eight institution-specific policies detailing escalation processes for when the first LTC bed offer is refused, which is not detailed in the OH guidelines. Notably, while all policies mention collaboration with caregivers and SDM, it is often only in the context of escalation processes. Finally, only two policies mention communicating with the patient's primary care provider.

Tone and Language

The OH guidelines emphasize the integration of sfCare. However, none of the institution-specific documents explicitly reference sfCare principles, as shown in Table 6. OH's guidelines recommend replacing the term "discharge" with "transition" to more accurately reflect continuum of care. However, this approach is not mirrored in institutional policies, as all eight policies used the word "discharge" more frequently than "transition." Additionally, institutional policies incorporated terms like "escalation" and "refusal" more than the guiding documents. While the concept of "collaboration" appeared in two of the eight policies, its use was not as prevalent as in the OH guidelines.

The OH guidelines were characterized by a formal, informative, and collaborative tone, whereas the CIHI guide adopted a formal, informative, and instructional tone. Many institutional policies employ a formal and authoritative tone, particularly when describing escalation processes. For example, one large academic health network states "If a bed offer to a program within or outside [our health network] is refused, the social worker escalates to the clinic manager immediately." In general, institutional policies were often procedural and directive in tone and structure.

DISCUSSION

The purpose of this study was to examine existing institutional ALC policies, assess their alignment with OH best practices, and make recommendations for future work. Overall, content analysis of eight ALC policies from urban communities (n = 2) and academic hospitals (n = 6) in Ontario revealed inconsistencies with OH, particularly around ALC designation and reassessment, caregiver involvement, and language choice, as shown in Table 7. We note that many institutional policies pre-date the OH guidelines; however, to our knowledge, these documents represent the most current versions of ALC policies and have not been revised to incorporate the sfCare philosophy.

A key finding was the absence of standardized clinical criteria for ALC designation across institutional policies with no distinction regarding who should be involved in assigning, reassessing, and, if necessary, reversing ALC status. This omission creates room for subjective interpretation by healthcare providers and increases the risk of inconsistent ALC designations, potentially leading to inequities in patient care and resource allocation. For example, without clear processes outlining if and when ALC designations should be discontinued during long admissions, co-payment fees may be charged to patients unjustly, or care transitions could be

TABLE 6.
Variability in tone and language

Institution/Guideline	*Frequent (n > 2) Terminology*[a]	*Tone*
CIHI	"Discharge"	Formal, informative, and instructional
OH	"Transition," "discharge," "collaboration"	Formal, informative, and collaborative
Large academic 1	"Discharge," "escalation," "transition," "refusal"	Formal, authoritative, and operational
Large academic 2	"Discharge," "transition," "collaboration," "refusal"	Formal, authoritative, and directive
Large academic 3	"Discharge," "escalation," "refusal"	Formal, authoritative, and procedural
Large academic 4	"Discharge," "refusal"	Formal, directive, and collaborative
Large academic 5	"Discharge," "refusal"	Formal, directive, and collaborative
Small rehab centre	"Discharge"	Formal, authoritative, and procedural
Large academic 6	"Discharge," "transition," "collaboration"	Formal and technical
Community health network	"Discharge"	Formal, authoritative, and procedural

CIHI = Canadian Institute for Health Information; OH = Ontario Health.
[a]In order of frequency.

TABLE 7.
Summary of key differences

Guiding Documents—OH and CIHI	*Institutional Polices*
Senior-friendly care principles emphasized; "evidence-based, preventive, and proactive care for the unique needs of older adults"	Emphasis on procedures for early ALC identification, facilitating discharge and escalation processes
Emphasized "partnership" with patient and their designated SDMs	Identifies SDM only in the context of the escalation process
Advocates for comprehensive geriatric assessments when appropriate	No specified role for comprehensive geriatric assessment
Frequent reassessment of ALC status and care needs "is an essential part of the care process"	Majority do not mention ongoing reassessment and/or frequency of reassessing ALC status nor have defined ALC clinical criteria
Emphasis on the usage of person-centred language, e.g., replacing "discharge" with "transition" to reflect a continuum of care	Directive or procedural language, e.g., "discharge," "escalation," and "refusal"

ALC = alternate level of care; CIHI = Canadian Institute for Health Information; OH = Ontario Health; SDM = substitute decision-maker.

made inappropriately, resulting in readmissions and negatively affecting patient outcomes.

Collaboration with SDMs as it relates to patient preferences and discharge planning is also not included in institutional policies. Most policies mention caregivers and SDMs only in the context of escalation processes following a LTC placement refusal, thereby minimizing their role in decision-making and continuity of care while framing them as barriers to patient flow. This undermines family-centred approaches and potentially negatively impacts quality of care. Engaging in shared decision-making via formal caregiver inclusion has been shown to significantly reduce readmissions and LOS while lowering healthcare costs[23–25] and improving quality of life.[26] Kuluski et al.[26] also notes that without standardized procedures for engaging with caregivers, those who advocate more for their loved ones may secure better care, raising issues of equity. Moreover, the absence of clear caregiver collaboration protocols may further minimize family voices, particularly for older adults with cognitive impairments or limited self-advocacy capacity. The integral role of caregivers must be universally acknowledged and explicitly mandated within ALC policies.

Finally, our analysis revealed fundamental differences in language choice. Institutional policies favour operational terms such as discharge, escalation, and refusal, while the OH uses terms like transition, in alignment with sfCare. Notably, none of the institutional policies explicitly include sfCare philosophies, despite provincial guiding documents emphasizing its importance. The language used by institutions are likely rational reflections of the system-level pressures hospitals are facing but may be undermining patient care. The literature shows that negative and stigmatizing language used in documented medical records can transmit bias between providers and influence physicians' attitudes and decision-making.[27,28] For example, in the context of diabetes documents, there is clear evidence that the use of inappropriate language by healthcare providers (e.g., labelling patients as "non-compliant" or "failing" to control their diabetes) diminishes patient self-efficacy and well-being.[29] It is therefore likely that the language used in ALC policies can shape how ALC patients and caregivers are being perceived and treated, contributing to ALC patients' feelings of guilt, powerlessness, and abandonment.[30] Standardizing patient-centred and non-stigmatizing language across policies is a concrete step toward mitigating bias and promoting dignified care.

This study has several limitations. First, the sampling method used may have created selection bias which limits the generalizability of the findings and potentially underestimates the prevalence of institution-specific ALC policies across other regions or healthcare settings. Since participation was voluntary, institutions with a strong interest in the topic or familiarity with our principal investigator may have been more likely to participate. Additionally, as the analysis was restricted to written policy documents, the study could not capture the nuances of policy implementation or associated training processes that influence staff adherence and interpretation in clinical practice. Policies may also have been updated since our initial inquiry. Finally, the lack of a formal reporting guideline limits the reproducibility of our results.

CONCLUSIONS

Our review underscores that a lack of clear and consistent ALC policies is not merely an administrative issue; it is a patient care issue. Inconsistencies in the criteria for ALC designation and reassessment protocols may exacerbate disparities in access to timely and appropriate care, particularly among older adults in rural areas or in settings with limited availability of geriatric specialists, underscoring the need for standardized, equity-driven policies. To ensure equitable ALC management, clinical criteria and reassessment practices should be standardized across all institutions. To achieve this, investments in primary care, geriatric medicine, and home and community care services are urgently needed to address regional disparities. While system-wide reforms are essential, they require time, funding, and political support. Immediate quality improvement efforts, including policy work at the local and institutional levels, can serve as a key

lever. Comprehensive, consistent, and patient-centred policies are a necessary addition to the expanding toolkit of measures available to hospitals for approaching the ALC challenge. Further research should incorporate chart audits and healthcare provider interviews to better understand how ALC policies, including Bill 7, are operationalized in practice.

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Not applicable.

CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal's* policy on conflicts of interest disclosure and declare that we have none.

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Correspondence to: Guillaume Lim Fat, MD, FRCPC, Mount Sinai Hospital, 600 University Ave, Toronto, ON M5G 1X5
E-mail: guillaume.limfat@mail.utoronto.ca