Appendix 3

Table of Quintuple Aim Framework domains with themes and additional illustrative supporting quotes

<table>
<tr><td rowspan="2">Domain: Patient Experience</td><td>Theme: Patient Description

Participants' descriptions of "social admissions" were inconsistent and included a wide range of health and social indicators from the patients experiencing financial troubles or unstable housing or psychological issues to being medically complex. In few cases, participants expressed that they (or their colleagues) believed "social admissions" had no immediate medical needs.</td><td>"Like you can't stereotype it as always the lower socioeconomic group because that's not the case. From my experience with the orphans, they've come from different levels of, you know, economic status. In my instance, mainly it has been there's been a physical barrier, that they don't have any supports, they're at home and just can't maintain the…or have the ability to do the daily activities of living." - HC103

"I know people here seem to think like, oh, they don't have a medical need, so they're an orphan. But I mean they obviously have some sort of need, whether it's their... unstable cognitive behaviours. They need some kind of stabilization to be able to be placed." - HC413

"So I think the way I would describe the population is just that - it's patients who are in an unfortunate social situation where their home…where they're living at the moment is not safe for them. So they're here until we find the safest place for them." - HC638

"So an orphan patient's usually a demented patient." - HC075

"Sometimes in most of these cases, I have to say 99% of them, are not medical-based. There's nothing acute to medically treat. Usually it's time and support, or they're waiting for home care, or waiting on this or that to come to fruition."- HC569</td></tr>
<tr><td>Theme: Provision of Care</td><td>"When a patient comes in as an orphan patient, it's hands-off. They're just there in a bed waiting and sleeping there until they go somewhere else. And I think that's absolutely heartbreaking. That's the reality, though, right, is there's no proactive." - HC375</td></tr>
</table>

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	Participants described the care provided to patients. The approach to care was passive and ”social admissions” were generally de-prioritized in a tertiary care setting. Further, participants shared that the hospital environment often does not meet the basic needs of patients and is not the ideal setting for anyone unless they are needing acute care. Others commented on the lack of dedicated allied health services available to these patients (e.g., physiotherapy, recreation therapy or occupational therapy) after admission.	“The approach to caring for the patient is passive. Which is in huge contrast to our approach to caring for medical and surgical acuity - which is very active. And then what's super interesting is when you have a patient that's getting a lot of active care but then is no longer active, right, then that same patient falls to the bottom of the barrel in terms of priority... They're no longer a priority by any members of the care team. And I think that can be very isolating and confusing for patients too.”- HC375 “So I think it's just like back to the basics of like actual just personal care for a patient, and like just their general well-being. Like we don't really… Like you know, simple things like putting the blinds up in the room so they have daylight during the day, like that is overlooked constantly here.” HC413 "I truly believe hospital is not a good place for anybody. It's really good when you have a truly acute need, but it's not necessarily the best for healing or convalescence or to meet the social needs.” - HC605 “I mean I think we've certainly advocated that we don't feel that this is the best placement for them.” - HC413 “We've known for years emergency is a horrible place to keep patients. It is loud. It is busy. It is no sunlight. Delirium sets in. Patients aren’t mobilized because we don't have PT, OT or the correct staffing ratios. There’s a lot of medication errors. Charts aren't solid. They’re on clipboards. There's all kinds of environmental factors that have been very well documented in the research that emergs are not the place to board patients.”- HC569 “As far as once they come to hospital, again these patients typically have multi-system disease. They're on polypharmacy. They may or may not have had a med review for a very long time. Medications may just get added. So these patients are not well served on services that can't actively participate in their care. Which is most of the services that these patients end up on. So even if they were stable when they presented to hospital, they become unstable because there isn't anyone with the ability to reassess them in an appropriate manner.” - HC156

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		“And I was trying to really remember the last time rec therapy was a staple on our unit. My experience with rec therapy, it had always been wonderful. We’d put in a request through our manager, and then we would have a coordinator send us a schedule with who was coming, which days. They would usually come for an hour to visit with specific patients, primarily long term care” -HC638
Domain: Care Team Wellbeing	**Theme:** Moral Distress Participants described the distress and tensions due to competing priorities and values experienced by many staff when providing care to “social admission” patients. This is a result of these patients having complex social and chronic health issues that they feel are outside of their clinical scope. Participants caring for these patients feel better care could be provided elsewhere and they themselves do not have the right training to care for them which can cause further distress.	"I think if you were to pull it back, sometimes that judgment is really ‘*I don't know how to care for this person. I'm not comfortable.*’ And so, you know, I think that's a challenge**.** So I think when tensions run high and bed pressures are as high as they are, and there are people for whom you know clearly are waiting to get in, and for whom you know what you could do, right, and you're skilled to do it, that creates I think an ethical tension for teams. And so, yeah, I think there can be a tendency to, you know, not fully understand all the needs or not feel able to address them because they're usually so complex that there isn't an easy fix.” - HC605 “So challenging ones would be the ones where, you know, that feeling of they are patients where you have…you know, huge amounts of patients waiting to see you. But then you see patients that you feel may not necessarily require your skill set, but they're kind of who is being admitted under you. So you have to take care of them.” - HC605 “There’s a gentleman that came in, he had his full head, but he had a condition where like he had the shakes so bad, and like he was… You know, he couldn't take care of himself. So we had him in, and we had him in for, you know, months. And we really had to fight and push for him to get placed. So what happens is, you know, he was at an age… And like we knew DSP couldn't place him. Because DSP, they usually place like in facilities that are not nursing homes. But this guy needed more nursing care because of his condition. So we really had a fight to get Continuing Care involved. And once they got involved, he was placed rather quickly because he was perfect for them. But it's just that initial hesitation.” - HC075 “So it's very challenging, and it creates a lot of moral distress, I would say, and injury in the care teams caring for the patient. So the other group that is challenging to care for, and from two different reasons - because of their complexity and because of the impact on patient flow in acute care - are our medically stable patients who no longer need to be in hospital. And that group of patients is growing.

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		And it's a complex problem. It's not as simple… Not everyone in that group are patients that are tied up and ready to go to long term care. Some of them, in fact, could probably go home with the right supports in place. But our system, in my experience, seems to be either under-resourced or we do not all collectively believe in home first. We do not as a system collectively believe in home first. So you may have pockets of bright spots that can focus on home first. But that's a difficult thing to do in the care of complex, frail and often geriatric patients, although not always. Because the supports they need are not available in the community. And although evidence tells us that patients don't receive good complex care in hospitals, in acute care, there seems to be a bit of a misconception that it's the safest place for them to be." HC375
	Theme: Hierarchy of Care Participants described a perceived order of importance of patients and their reasons for hospitalization. Participants described the hierarchy in acute care with "social admissions" being at the bottom of that hierarchy. Participants also described the "bed blocking" that exists and how these "social admissions" can make it much more difficult to provide the appropriate care to other patients.	"They're supposed to have a plan that follows through with like an allied profession, like PT, OT, social work, housing, waiting on placement, that type of thing. They're not supposed to be rounded by physicians every day, having new medication orders, treating active or new pain, changing doses, and things like that." HC569 "Like our CCAs are fantastic because they worked in nursing homes. So they've got such a good way with them. Like they know how to approach them, they know how to jolly them along. They know that if the patient says no, they go away for maybe 10 minutes and then they come back and ask them. Like do you know what I mean? Whereas like so if you're a busy nurse and all that, you don't have so much time" - HC075 "But when you're in a situation where you're running at one hundred percent capacity then all of a sudden, you're not doing routine things. people have expectations that they're going to get their cancers done on time. But we can't do your cancer operation because we don't have a bed. And then when we start looking around, why don't we have a bed, it's because you have somebody in a bed that not necessarily would fit the description of needing acute care surgical services." - HC307 "I think that those patients just do require a lot of time to really ensure they're getting a good look over and ensuring they're getting…or not mistakenly called an orphan patient. Because these are the patients that are…you know, can't give a reliable history or the collateral is not there right away in the middle of the night - things like that. So then you really do need to spend that time to be able to gather all that information. Which is not quick. You know, it's much less quick than seeing someone who, you know, is coming in with heart failure, right, and it's very easy. You know what to do with that" -HC840

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		"I'm sure they hear about things like, *'Oh, we don't know where you're going to go.'* And they see different services, and back and forth, and stuff like that. Which I'm sure some can read between the lines and to understand that, you know, maybe it's because no one wants to take care of the patient." -HC840
Domain: Health Equity	**Theme:** Stigma and Missing Opportunities The label comes with assumptions about the admitted patients' medical needs, cognitive abilities, and behaviors, which in turn affects the underlying assumptions held by healthcare providers and subsequently the care they receive. Participants described how patients being labelled as "social admission" early in the care chain led to an belief that they are medically stable when in fact they were not always.	"There's criteria within the orphan patient policy that they are assessed, that they are thoroughly assessed, and need to be determined orphan, that they don't require an acute care admission for a medical intervention, that they really don't need any medical treatment at all but they need to be housed in hospital. So what was happening is that was often being bypassed. So, you know, they were deemed by the paramedics not safe to go home. First of all, who should not be determining that. Then the charge nurse repeats that. So of course then they were labelled that way." -HC236 "Because people with social stressors and low social capital still get medically sick. And I think, again, once you're labeled in that way, I think we tend to miss that." -HC300 "I also think a challenge is that there is pressure to make the determination or the designation of orphan patient very early in the patient's presentation to the emergency department. And that sometimes we're making that designation with incomplete or inaccurate information. And as a result, are not providing the kinds of interventions that the person really needs. Or we're missing diagnoses or were making those diagnoses late." -HC300 "Those who do have some sort of cognitive impairment and can't really advocate for themselves very well, or who can't provide a reliable history ...because then lots of assumptions are made that something's wrong with…you know, that underlying diagnoses are the reason why they are presenting this way."- HC840 But even if… I'm just try to think of how they hand over report, and they say, "Oh, that's the orphan patient," or, "They don't need anything," because they don't maybe physically need anything at that time, they're not going for any testing or procedures, "Oh, that's my orphan." They just… They'd go over their usual like age, code status, and then say, "They shouldn't need anything because they're just awaiting long term care."- HC638

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		"You're particularly vulnerable coming in if you're an older adult too, because we may, by virtue of our bias or by not knowing any different, assume that someone had a cognitive impairment, assume what their baseline was, and what we're seeing. And then it may get worse in hospital... Without that collateral history, you may not know. So you may miss a diagnosis of delirium and an opportunity to treat." - HC605 "So it's a very quick way to try to push the patient somewhere else, not onto their service. And I think there's bed pressures. Yes, I agree they're a soft patient. But we don't take into factor like what is a couple of weeks of PT, OT going to do with them?"-HC569
	Theme: Prejudices Participants described underlying group assumptions about "social admissions". In particular, ageism that occurs when patients access acute care services for social issues was noted. For example, assuming all older patients have cognitive decline or lack capacity or assuming certain health services would not benefit older patients. Participants reflected on how race and gender implicitly affect care.	"Again, it sort of reminds me of, you know, how we may have negative attitudes in the emergency department with substance use disorders, right. And the orphan patient population to me is another kind of vulnerable group where I think the lens that we use to understand their health issues and think about how we respond is not the right lens to be using. And I also think that one of the challenges is that when someone presents to the emergency department because there is an issue with what we consider to be their social health, you know, again, housing or home care or whatever, I think we are slow to recognize and respond to the component of that that is medical instability. So, you know, I've seen these orphan patients on the consult service who have undiagnosed serious neurologic and medical health conditions that no one has recognized because they were admitted under the orphan patient policy, and there's a prevailing attitude that that means that, you know, they can't go home or they're there waiting for social supports, but that we don't need to do any further digging or evaluation from a medical lens." -HC300 "The biggest thing is, you know, the label – the label of that patient… I mean all my experience with orphan patients is they've all been elderly. And I just think it's a shame. I love the elderly... And I just feel that negative connotation, it's like, first impressions. They're hard to shake, the first, you know."-HC151 "I think sometimes with older adults, people can say they have dementia, and that would not be a health care need. I would argue dementia and strong dementia care is very much a health care need." -HC605

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		"But like it's very challenging in that way because we're really not set up, unfortunately, to handle like elderly and patients with dementia." - HC075 "First of all, I think their age. I believe that there's ageism within acute care. Especially if they were frequent flyers - which is a terrible term."- HC236 And therefore patients that need those really early complex discharge conversations, those conversations often don't happen until a decision has already been made that someone needs to go to long term care. **And an opportunity is then lost**, right, to sort of work with patients and families to come up with alternative solutions.
Domain: Cost of Care	**Theme:** Waitlists and Scarcity of Alternatives Participants commented on the inadequate supports available in the community which frequently lead to "social admissions". They described a system that is inefficient and ineffective at caring for this population because of severe resource constraints. Some of these patients have advocates or family caregivers who simply cannot do it anymore.	"Generally the patients that we see who end up being presented to the emergency department do have family members who are caregivers, but present with some degree of caregiver burnout" -HC156 "when I think of patients who are, to sort of say, quote-unquote, social admissions, I often think of people with complexity and frailty where their medical illness has led to a situation where the supports in the community, whether it's home care supports or social supports or mental health supports, are not adequate to meet their needs" -HC300 "And then like a lot of them don't have support people. So then you're like how do we help these people get the best care when they don't understand, they have nobody to turn to? We don't really have anywhere to send them when they're finished their procedures or what have you. And then like some of them can have like challenging behaviours, which makes it really hard of caring for them, or family dynamics. Like we have a lot of patients who the patient may be fine, but then you've got the families like that don't get along, and you're trying to appease everybody, and you never can. And you're like basically telling people to leave their baggage at home. So there's lots of factors that can contribute to challenging environments to care for these patients." - HC803 "In certain circumstances, yes, that we can. If someone needs PT, OT at home, the wait list is like 6+ months…They're waiting six months for anyone to come help them. They'll be so deconditioned by that time, they'll be bed sored into the bed. So there's the realities of the barriers of what's out there. It's out there. Can I get it? There's wait lists for everything. The system's backed up in home care. Wait lists have now increased. So today if I go send a referral with a two day turnaround, the coordinator

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		will call in two days. They'll probably go out to see them within a week. But you could be waiting a month plus for home care. And now, instead of giving you the full request, say if you're asking for two visits a day, there are now saying, when they slowly do start picking you up after a month, they'll say, "I can pick you up Monday mornings, Thursday evenings, maybe Friday. Sundays are not going to happen for a while." Like they started doing this partial service." - HC569 "Sometimes people in the community, from the day of making that phone call saying you need help, it could be a couple of weeks before…three or four weeks before you have someone knocking on your door helping you. That's evolved into about a month. Sometimes the coordinators have such big loads and there's low staffing levels that they're taking on double coordinator capacities, and they can't get out to see you." -HC569 "The money that they're providing for this Home First, it's just impossible to find workers. So we have people funneling into emerg, saying, "I have all this cash money that I can't find anybody. Like they can't give me care. They gave me cash. I can't find anybody to do it." - HC569 "we haven't responded enough to their cries for help in a different way. And they feel the only way they can get support, we heard, is to bring their loved one to emerg. And so I can't imagine the torture that must cause for the family member because I believe most don't want to do that, to ever get to that point. But I think caregiver burnout, caregiver stress is very, very real." - HC605 "And I would use a Home First lens. I would think, is there anything else that we can do to get them home? I think you do better at home. I think that that's the safest place for people, with the right amount of supports. But the problem is, is that usually once we've gone to that orphan patient policy, we've turned over every rock." - HC569 "How do you better support people to hold on and incentivize that rather than incentivize… And I mean that in the sense that, you know, right now people get into long term care almost exclusively from hospital." - HC605 "So it's very challenging, and it creates a lot of moral distress, I would say, and injury in the care teams caring for the patient. So the other group that is challenging to care for, and from two different reasons - because of their complexity and because of the impact on patient flow in acute care - are our

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		medically stable patients who no longer need to be in hospital. And that group of patients is growing. And it's a complex problem. It's not as simple… Not everyone in that group are patients that are tied up and ready to go to long term care. Some of them, in fact, could probably go home with the right supports in place. But our system, in my experience, seems to be either under-resourced or we do not all collectively believe in home first. We do not as a system collectively believe in home first. So you may have pockets of bright spots that can focus on home first. But that's a difficult thing to do in the care of complex, frail and often geriatric patients, although not always. Because the supports they need are not available in the community. And although evidence tells us that patients don't receive good complex care in hospitals, in acute care, there seems to be a bit of a misconception that it's the safest place for them to be." HC375
Domain: Population Health	**Theme:** Factors Leading to Vulnerability Participants commented on the multitude of social issues that increase the risk of a community dwelling adult becoming a "social admission", such as poverty, homelessness, social isolation, lack of primary care and substance use disorders. The inability to advocate for oneself was also a common observation.	"When you're experiencing any health issue, you're automatically vulnerable because you're dependent upon other people for support and care. So I think recognizing that inequity of power that exists, even for those who have robust social networks and ability to advocate for themselves, you're in a vulnerable spot just by virtue of needing health care. I think when you add someone who has cognitive impairment or a mental health issue or challenge, that may make it more difficult for them to articulate and advocate and process and reason all the different why they're experiencing what they are, and then be able to identify what they need." - HC605 "So bed-bound patients, psychiatric patients, dementia patients, extremely comorbid patients, substance abuse patients. Resistant patients. Resilient patients. Ones that are so proud that they won't take care until it gets them to the point that they crash and burn. You see this, "I'm fine. I'm going to be okay. I can't… No, I'm going to do on myself." And like, you know they're going home and breaking their hip. Like there's no way. And I can't force home care on you. You have the right to refuse." - HC569 "And I think the absence of having…of that subset of people, having an advocate for them, both in the community and when they interact with the acute care system, makes them particularly vulnerable to healthcare providers not understanding the full picture of their health issues and their social issues and stressor. And so if you don't have somebody in your corner that can help advocate for you with the healthcare team, I think it can be really challenging for all those reasons stated above." - HC300

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		“We always try to get the family docs to do it if possible. But so many people don’t have them or haven’t seen them for two years that often that’s not usually the way it gets done” – HC231
	Theme: System Changes for Addressing ”Social Admissions” Participants shared their visions for improvement to the current system to provide appropriate care to those accessing acute care with social needs.	“This is what the health system needs. Because increasingly we don't have people with single system issues anymore. And so the future of health care, in my opinion, is figuring out how to get from single system to holistic multi-system care. So I think the expertise that generalists or those who can look more broadly at the social determinants of health, as well as the multi-systems, and how it all interacts. For frail, for vulnerable people, it's often like a game changer, right? Like if you pull out one block, the whole thing's going to come crashing down.” - HC605 “I think more home care resources, faster. I see the system as for years we've been funneling cash money into an acute care system, band-aiding it. And really, if you step back and look at it, the acute care system is becoming the community system. We're becoming nursing homes, we're becoming this kind of mediation…this mediate pathway between community and long term care. Because long term care is failing at admitting people in a timely fashion. They destabilize and come into the hospital to be placed.” - HC506 “So we need a seniors care team in the emerg department, and we need senior-focused care. We need to geriatriatize care in the acute care. We need geriatricians attached to ortho, we need geriatricians attached to general surgery. I think that would decrease the mortality rate. Evidence shows that if you have a geriatrician providing post-care to orthopedic patients, especially the traumas, the hips and so on, the mortality rate decreases tenfold. So I would like to see more geriatrics in the hospital. I think we need to more prevention-based rather than reaction-based - which is what we are.” - HC236 “The biggest thing is like, you know, like looking at the bigger…like the picture as a whole. And like when you see that orphan term or, you know, somebody who's homeless, you can't just think…like don't think of the individual as that alone. Like they're a person just like anybody else. And like we all have needs that need to be met. So regardless if they're deemed orphan or not in the population, like we need to make sure that whatever needs they have are met as well. And, you know… And if there are medical concerns that arise, like we need to be the advocates for those patients because nobody else is.” - HC803 “I think there's still lots of opportunity to improve, you know, of identifying some of our biases and stigma that's associated with, you know, racism, with mental health issues. I think we're doing better

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		with that as a society, I think. So I think those things, it's so important and there's lots of work that needs to continue to happen." - HC605

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