CAREDARA | WHITE PAPER

When Care Breaks Down

Two stabilization gaps in a fragmented care system

CENTRAL PROPOSITION

Gaps in client care and gaps in workforce coverage are distinct problems with a shared underlying challenge: care capacity is difficult to see, coordinate and activate at the moment it is needed.

A research-informed position paper

Caredara Inc. • November 2026

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Evidence synthesis and conceptual framework. This paper does not report findings from a controlled evaluation of Caredara.

01 / EXECUTIVE SUMMARY

The case for a stabilization layer

Health and community-care systems are designed to provide ongoing services, yet the moment between a breakdown in care and the restoration of reliable coverage can be difficult to navigate. That gap appears in two settings: an individual needing urgent, temporary support, and an organization needing short-term practitioner coverage. Both situations raise questions of timing, visibility, accountability and continuity.

Evidence of system pressure is substantial. Canadian Institute for Health Information (CIHI, 2026) data show that, among hospital patients designated alternate level of care (ALC) in 2024–2025, 20% were waiting for home care. Ontario reported a seven-day median wait from community referral to first home-care service as of March 2024 (Ontario Ministry of Health, 2025). At the same time, Canada's health-occupation job vacancy rate was 4.5% in 2025 (Masoud & Sayle, 2026). These are different measures, but together they illustrate unmet access and workforce demands.

FOUR SIGNALS FROM THE PUBLISHED EVIDENCE

20%

of ALC patients waited for home care

CIHI, 2026

7 days

Ontario median: community referral to first home care

Ontario MOH, 2025

4.5%

Canadian health-occupation vacancy rate in 2025

Masoud & Sayle, 2026

126 trials

in a 2023 transitional-care research synthesis

Tyler et al., 2023

Two different problems, one testable hypothesis

Client stabilization concerns the period when an individual has an immediate care need but dependable ongoing support is not yet available or has been interrupted. Workforce stabilization concerns brief, unexpected gaps in staffing coverage within care organizations. Caredara proposes that better coordination of appropriately qualified, available capacity may help address both gaps without replacing existing continuity providers.

EVIDENCE BOUNDARY

The literature supports the importance of timely care transitions and illustrates staffing pressures. It does not yet demonstrate that Caredara can reliably discover otherwise unused practitioner hours or improve outcomes at scale. Those are questions for formal field evaluation.

02 / PROBLEM ONE

The client stabilization gap

When immediate support is needed before continuity can be established or restored.

A change in a person's circumstances can expose a short but consequential interruption in care: discharge home before arranged services begin, a cancelled visit, a sudden deterioration in a caregiver's availability, or a new support need that cannot be accommodated promptly. The problem is not necessarily a lack of a long-term care plan; it may be the absence of a practical interim response.

What the evidence tells us

In 2024–2025, CIHI found that 8% of patients admitted to acute inpatient care through emergency departments were designated ALC. Their median hospital stay was 24 days, compared with four days for those not designated ALC; among ALC patients, 20% waited for home care (CIHI, 2026). These figures reflect hospital and downstream service constraints, not the prevalence of all community-based care interruptions.

Ontario's reported median wait of seven days from a community referral to a first home-care service (March 2024) points to another timing challenge (Ontario Ministry of Health, 2025). These community-referral waits should not be conflated with hospital discharge waits, which are measured differently.

In a separate CIHI home-care indicator, about 10% of hospital patients waited for home-care services or supports before discharge; among those who waited, half waited eight days or less (CIHI, 2025). These figures describe a specific patient group and should not be generalized to all transitions.

The literature also emphasizes that transition quality depends on continuity and information flow. Haggerty et al. (2003) distinguish informational, management and relational continuity. A Canadian review identified 119 transitional-care programs, illustrating both the attention devoted to the issue and the diversity of models in use (Barber et al., 2024).

Why a temporary response may matter

A 2023 systematic review and network meta-analysis of 126 randomized trials involving 97,408 participants found that various transitional-care interventions, particularly low- and medium-complexity approaches, were associated with lower hospital-readmission odds at certain follow-up intervals (Tyler et al., 2023). These findings support the broader importance of transitional support; they do not validate any particular Caredara service.

PROBLEM STATEMENT

The client stabilization gap is the interval between the emergence of a care need and the availability of an appropriate, reliable continuity response. Its significance depends on the person's risk, the duration of the gap and the feasibility of safe interim support.

03 / PROBLEM TWO

The workforce stabilization gap

When coverage is interrupted, even if an organization has an established workforce.

Long-term-care, retirement, home-care and other service organizations must continually align staffing with changing needs. A sick call, last-minute leave, partial shift or unexpected surge can create an urgent coverage requirement that conventional hiring and roster processes cannot always address quickly. The distinction is important: a short-term coverage gap is not the same as a structural shortage of permanent staff.

What the labour market reveals

Statistics Canada estimated 67,885 vacancies in health occupations in 2025, with a 4.5% vacancy rate, compared with 2.7% across all occupations. The rate for licensed practical nurses was 12.3%, while that for nurse aides, orderlies and patient service associates was 4.7% (Masoud & Sayle, 2026). The occupational categories are national and should not be treated as direct estimates of available personal support workers or Ontario registered practical nurses.

Ontario's long-term-care staffing study describes the 24-hour, seven-day nature of care and the need to backfill absences for vacations, holidays and training. It highlights balancing full-time, part-time and casual staffing while protecting care quality and worker well-being (Ontario Ministry of Long-Term Care, 2020).

The visibility question

Vacancy figures measure unfilled jobs, not unused worker availability. Likewise, being licensed or trained does not establish that a person is available, willing, eligible for a particular site, clinically suitable, or able to arrive in time. The existence, location and usability of what Caredara describes as latent capacity must therefore be measured—not assumed.

PROBLEM STATEMENT

The workforce stabilization gap is a time-sensitive mismatch between a care organization's immediate coverage requirement and the qualified, eligible practitioner capacity that can actually be mobilized for that requirement.

04 / SHARED DIAGNOSIS

Fragmented capacity is the connecting issue

Client-level care interruptions and organization-level coverage gaps share a structural feature: the service need is specific to a place, time, scope of practice and duration, while potential capacity is distributed across multiple organizations and practitioners. A system may have workforce resources in aggregate and still be unable to mobilize suitable capacity for a particular event.

CONCEPTUAL FRAMEWORK | NOT AN IMPLEMENTATION DIAGRAM

CLIENT PATHWAY



WORKFORCE PATHWAY



What stabilization would add—and what it would not

A stabilization layer is best understood as a limited-duration response that supports, rather than supplants, clinical judgment, established organizational responsibilities and long-term care relationships. For clients, the goal is a safe transition back to an existing provider or another appropriate continuity arrangement. For organizations, the goal is temporary coverage until normal staffing resumes.

Key boundaries are essential: practitioner qualifications and scope must be appropriate; receiving organizations retain their legal and clinical responsibilities; privacy and consent must be respected; and a requested activation should not be treated as guaranteed coverage. These conditions are part of the concept's feasibility, not matters that can be assumed away.

CORE RESEARCH PROPOSITION

Can time-limited care activation close selected gaps more reliably, transparently and safely than the current response pathway, while preserving continuity and the responsibilities of existing care providers?

05 / RESEARCH AGENDA

How the hypothesis should be tested

Measurement should separate process performance, experience and safety.

A prospective, multi-site demonstration could compare eligible stabilization requests with an agreed baseline or usual response pathway, while documenting the context and complexity of each event. Client and workforce pathways should be evaluated separately before any combined interpretation. Co-design with service users, families, practitioners and organizational partners is advisable (Barber et al., 2024; Tyler et al., 2023).

ILLUSTRATIVE EVALUATION QUESTIONS AND MEASURES

Evaluation question	Illustrative measures
Access and timeliness	Request-to-confirmation interval; request-to-care-start interval; time-of-day and geographic variation.
Reliability	Eligible-request coverage rate; cancellation rate; unfilled requests; partial-coverage frequency.
Continuity and handoff	Documented completion of handoff; receiving-provider acceptance; unresolved follow-up needs.
Workforce feasibility	Practitioner eligibility, willingness and available hours observed; reasons potential capacity could not be used.
Experience and equity	Patient/family, practitioner and partner-reported experience; variation by region and access barriers.
Safety and economics	Safety incidents and escalation; cost per completed episode; comparison with the current pathway.

Note. Measures are proposed, not published Caredara performance results. Eligibility definitions, denominators and safety review should be specified in advance.

What would count as credible evidence?

The most persuasive findings would include a pre-specified denominator of eligible requests, independently verified timestamps, transparent reporting of failed activations and cancellations, documented safety oversight, and comparison with a realistic alternative. Reporting favourable response times without unsuccessful cases would overstate system performance.

06 / IMPLICATIONS

From care interruption to dependable continuity

For health systems and care organizations

A stabilization lens directs attention to short, high-friction gaps that may be missed by conventional workforce and service planning. Health systems could assess where an interim response is appropriate, who remains accountable during the interval, and how continuity is documented. For LTC and home-care organizations, the priority is safe, practical coverage without confusing an emergency backfill mechanism with sustainable staffing policy (Ontario Ministry of Long-Term Care, 2020).

For practitioners and workforce development

Practitioners need visibility into opportunities that are appropriate to their capabilities and schedules, with clear expectations and safeguards. Any model must consider workload, rest, fair treatment, clinical competence and the risk of shifting labour-market burdens onto individuals. Workforce-development value should be evaluated through actual practitioner experience rather than inferred from participation alone.

For research and implementation partners

The next contribution is empirical: define the size and characteristics of the activation gap, determine whether previously unobserved capacity is usable, identify where temporary support improves process outcomes and document where it fails. Published research supports testing an approach that strengthens care transitions, but the effectiveness and economics of this particular model remain open questions (Tyler et al., 2023).

POSITION, NOT A CLAIM OF PROVEN IMPACT

Caredara's position is that rapid stabilization merits systematic study as a complement to existing care and staffing systems. The company has not established, through the published sources cited here, a causal reduction in readmissions, adverse events, staffing shortages or public expenditure.

Conclusion

A care system can be well supplied with organizations, programs and qualified professionals yet still fail to connect an urgent need with usable support at the right moment. Client stabilization and workforce stabilization are distinct manifestations of that coordination challenge. The opportunity is to examine whether a defined, time-limited stabilization layer can make appropriate capacity more responsive while protecting safety and continuity.

07 / SOURCE NOTES

References

APA 7th-edition author–date citations; alphabetical reference list with persistent source links.

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METHOD AND SCOPE

This narrative, non-systematic evidence synthesis draws on official Canadian health-system and labour-market reporting and peer-reviewed transitional-care research. Statistics describe their source populations and periods; they should not be generalized to all care interruptions or interpreted as Caredara outcomes. Links verified November 11, 2026.