

Collaborative Quality Improvement Plan Change Concepts and Change Ideas

Improve transitions and access to integrated team-based care, including home and community care

- Alternate level of care (ALC)

About the Indicator

Alternate level of care (ALC) refers to a patient who is occupying a bed in hospital and waiting to receive care elsewhere. A designation of ALC can have negative effects on both the patient (for example, through risk of hospital-acquired harms such as infections, delirium, and functional decline while in hospital) and the health care system (for example, through high costs and decreased access to acute services for patients who truly require them). In Ontario, greater than 80% of ALC designations in acute care are attributed to older adults 65 years of age and over, with the largest cohort, 64%, over the age of 75 (Ontario Health Access to Care). It is important to understand the population that is most at risk of becoming ALC and how they access care across the continuum within the local Ontario Health Team (OHT) context.

In 2023/24, hospitals across the province took an important next step toward identifying the root causes of delayed transitions in care through completion of the ALC Leading Practices Self-Assessment. Many OHTs and community health service providers have also engaged in similar processes to assess themselves against leading practices in community-based early identification, assessment, and transition. Collectively, this work helps to define the current state across the continuum and establishes a baseline for improvement from which OHTs can plan and integrate change initiatives that support overall access to care in the most appropriate setting.

Key Resources

- [ALC Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults \(2021 V1\)](#); and [self-assessment tool](#) (English only)
- [Supporting Ontario Health Teams to Influence Alternate Level of Care: Leading Practices in Community-Based Early Identification, Assessment and Transition](#) (English only)
- [Palliative Care quality standard](#)
- [Delirium quality standard](#)
- [Behavioural Symptoms of Dementia quality standard](#)
- [Operational Direction: Fall/Winter 2024/25 Readiness and Response](#) (English only)

Getting Started: Review and analyze data to identify, understand, and explore variation within the patient population

Use data to understand the population that is most at risk for being designated ALC. Access your OHT Data Dashboard or email OHTanalytics@OntarioHealth.ca to request access.

- [Frailty Estimates by Census Division and Ontario Health Region](#) (English only)



Change concept 1: Conduct asset mapping to understand what services are available for the population and wait times

- [Specialized and Focused Geriatric Services Asset Mapping Initiative](#) (English only)
- [211 Ontario](#)
- [Rehabilitative Care in Ontario](#)



Change concept 2: Include patients and care partners as part of the care team

- Develop care plans and goals of care collaboratively with patients and care partners
- Implement an approach to measuring patient and care partner experiences and outcomes



Change concept 3: Optimize processes for early identification, assessment, and care plan development in the community and prior to ALC designation

- Use a screening process or tool to identify patients at risk for loss of independence and in need of care
- Identify and document patients' baseline functional status
- Complete comprehensive assessment that addresses physical, cognitive, functional, and psychosocial domains
- Determine patients' functional goals and restorative potential to inform the care plan
- Develop care plans to address identified care needs with a focus on remaining in the community



Change concept 4: Across sectors, support patients with behaviours and those at risk of deconditioning

- Embed evidence-based practices that prevent avoidable harm
 - [Behavioural Supports Ontario](#)
 - [Senior Friendly Care implementation resources for delirium prevention](#) (English only)
 - [Senior Friendly Care implementation resources for mobilization](#) (English only)



Change concept 5: Follow best-practice rehabilitation, community, and long-term care pathways

- Implement evidence-based care pathways for rehabilitation
 - [RCA & PGLO Framework for Rehabilitative Care for Older Adults Living with or at Risk of Frailty](#) (English only)

- [RCA Post-Fall Pathway: Primary Care](#) (English only)
- [RCA Direct Access Priority Process](#) (English only)



Change concept 6: Transition patients requiring palliative support back to the community

- Use evidence-based tools to identify individuals who would benefit from palliative care
 - The [Ontario Palliative Care Network’s Tools to Support Earlier Identification for Palliative Care](#) outlines recommended tools that can be integrated into various settings of care
- Implement an evidence-based model of care for providing palliative care in community settings
 - The [Ontario Palliative Care Network’s Palliative Care Health Services Delivery Framework](#) outlines recommendations to guide organization and delivery of palliative care and includes a [patient pathway](#) (see page 16)
- Foster collaboration and communication internally and across care settings to support discharge to home or to other dedicated end-of-life settings
 - Explore virtual platforms for connecting with specialists or with patients, especially in remote areas (e.g., Ontario Telemedicine Network’s [eConsult](#), [eVisits](#), and [Virtual Palliative Care](#) programs)
 - Reach out to ProvincialPalliativeCareProgram@OntarioHealth.ca for information on supports and partners in your local area
 - Share resources (staff, technology, or training opportunities) among partners in your region (e.g., sharing and co-funding a nurse practitioner among partners within a region, holding regional educational events)



Change concept 7: Transition patients requiring support to age in place back to the community

- Use evidence-based tools to identify individuals living with or at risk of frailty
 - [Provincial Geriatrics Leadership Ontario](#) and the [Ontario Collaborative for Aging Well](#) have identified recommended frailty screening tools for [primary care](#) and [community care](#) (English only) that can be integrated into various settings of care
- Implement models of interprofessional team-based care designed around principles of integrated care for older adults
 - [Provincial Geriatrics Leadership Ontario](#) has identified [design elements of integrated care](#) to inform the creation of robust community supports for older adults living with complex health conditions, including [an implementation rubric](#) (English only)
 - There are [more than 200 specialized geriatric services programs](#) (English only) that can be linked to efforts to support older adults to age in place in the community
- Co-design the future of older adult care in Ontario
 - Reach out to your [Regional Geriatric Program or Regional Specialized Geriatric Services office](#) (English only) to get information on supports and partners in your local area