Ontario Health

Collaborative Quality Improvement Plan Change Concepts and Change Ideas

Improving overall access to care in the most appropriate setting

Percentage of alternate level of care days.

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 (OH Access to Care). It is important to understand the population that is becoming ALC within the local OHT context.

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**

Change concept 1: 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**

Change concept 2: Conduct asset mapping to understand what services are available for the population and wait times

- Specialized and Focused Geriatric Services Asset Mapping Initiative
- 211 Ontario
- Rehabilitative Care in Ontario

Change concept 3: 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
- Senior Friendly Care implementation resources for mobilization (English only)

Change concept 4: Follow best-practice rehabilitation, community, and long-term care pathways

Implement evidence-based care pathways for rehabilitation

- Framework for Rehabilitative Care for Older Adults Living with or at Risk of Frailty

Change concept 5: 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

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 your Regional Palliative Care Network to get 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 6: 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 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
- There are more than 200 specialized geriatric services programs 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 to get information on supports and partners in your local area