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 (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

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 (English only)

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 (English only)
- 211 Ontario
- Rehabilitative Care in Ontario

Change concept 3: 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 4: 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 5: 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 6: 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 7: 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 8: 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 (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

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