Appendix A

Access to Care

Alternate Level of Care Leading Practices User Guide

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Ontario
Cancer Care Ontario

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Executive Summary

Patients who are waiting for an Alternate Level of Care (ALC) occupy a bed in a hospital that do not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation. Patients designated ALC are often seniors aged 75 and over. In 2015, the population of seniors 75+ represented 7.1% of the total population in the province and is projected to more than double from 1 million to over 2.5 million, or 15.5%, by 2041. These patients are at risk of deconditioning, nosocomial infections and iatrogenic injury, affecting their future health status with increasing stays in hospital settings.

Volume of patients designated ALC is influenced by both system capacity limitations and performance. While hospitals cannot control system capacity challenges, they are better able to control performance in ALC avoidance and management in an effort to have every patient in the most appropriate bed for their care needs.

In 2015, Toronto Central Local Health Integration Network's (TC-LHIN's) 17 hospitals had no standard approach to processes related to ALC avoidance. This was identified as an opportunity for TC-LHIN acute care hospitals and Toronto Central Community Care Access Centre (TC-CCAC) to come together to share knowledge, identify what strategies were most effective and work to adopt them.

ALC Leads from the acute care hospitals, along with TC-CCAC representation, formed a working group to discuss their ideas and experience supporting patients to avoid an ALC designation. They quickly recognized they had common patients and common challenges, and formed a consensus of what leading practices had been identified in their sector. These included early discharge planning, proactively case managing patients at high risk for being designated ALC, and communicating clear expectations with substitute decision makers (SDMs). The group also identified that ALC avoidance needs to be an organizational priority in order to consistently achieve consistently high standards.

Those leading practices were brought together in an ALC Avoidance Framework[1], which outlines the leading patient-centered practices and strategies hospitals can use to support limiting the generation of patients designated ALC, and allows for baseline self-assessment. The Framework is experiential, and at this point not research or evidence-based.

Other LHINs have also followed similar processes in looking to identify leading ALC strategies available, both locally and more broadly and have found similar challenges encountered in many regions. A variety of similar processes and recommendations incorporating hospital and community-based initiatives seen to enhance patient flow and support patient transitions to care, with the ultimate goal to minimize ALC generation can be seen. The ALC avoidance

[1] Developed by: Elaine Burr (Toronto Central CCAC), Sandra Dickau (Michael Garron Hospital), Ann Marie McLead (Sunnybrook Health Sciences Centre), Mary Ann Neary (Toronto General Hospital), Mary Kay McCarthy (Toronto Western Hospital), Melissa Morey-Hollis (St. Joseph's Health Centre), Carolyn Farqueson and Sharon Currie (Sinai Health System), Judy Shearer (St. Michael's Hospital)

framework has been trialed, and early results highlighting the ability to identify high-risk patients and to limit the generation of patients designated ALC is promising.

Purpose and Scope

Purpose

In Fall 2016, the Ministry of Health and Long-Term Care (MOHLTC) expanded the mandate of the ALC Advisory Committee to identify and support knowledge sharing of ALC leading practices. This mandate spurred the creation of three distinct working groups to;

1. Determine appropriate leading practices,
2. Disseminate leading practices and,
3. Evaluate the impact and effectiveness of selected leading practices.

Members of the ALC Advisory Committee, representing a broad range of stakeholder groups, were selected for each working group, with work commencing in January 2017. This document is a summary of findings for the first identified working group; determining appropriate leading practices.

Scope

The scope of leading practices includes all patients seeking access/those accessing inpatient hospital services in both acute and post-acute care settings across the hospital continuum.

Leading practices are targeted to address three areas known to ultimately impact ALC performance:

1. Avoid all unnecessary hospital admissions
2. Identify & divert patients at risk of becoming ALC
3. Effective and timely management of patients designated ALC

How to Use the ALC Leading Practices Tool

Goal

To provide a tool for hospitals and relevant stakeholders to; (1) review current practices for management of patients requiring an Alternate Level of Care (ALC) and, (2) identify opportunities for improvement with a focus on ALC avoidance/limiting the number of patients designated ALC.

Methodology

The ALC leading practices and improvement strategies outlined in this document reflect experiential learning and tactics that have proved effective in limiting the generation of patients designated ALC within the TC-LHIN.

This tool is an expansion on the TC LHIN ALC Avoidance Framework (2015). Final selection of leading practices for the ALC Leading Practices Tool was determined though expert-consensus, with cross-sectoral stakeholder representation.

An evidence-based review of literature from the United Kingdom, United States of America, Australia, and Canada was conducted to identify additional practices and strategies. (Please see ALC Leading Practices Tool Reference List).

Instructions

1. Review the 'Leading Practice' and 'Corresponding Strategies' of the leading practice.

2. Type free-text in the cell boxes under 'Organizational Process' to identify what your hospital has done to implement the strategy.

3. Click 'Choose an item' and select one of the (4) available options to indicate your stage of completion in implementing the strategy:
    a. *Not Chosen
    b. Unmet
    c. Almost There
    d. Met

4. If '*Not Chosen' was selected, under the '*Describe Reason(s) (Practice/Strategy) Not Chosen' section; type free-text to identify why the practice/strategy was/is not chosen.

5. For further information on each leading practice, click 'Leading Practices' in the tool to live-link to the corresponding practice in the 'Summary of Leading Practices and Rationale for Inclusion' section of this document.

ALC Leading Practices Tool: Section Labels and Definitions

Section Label		Definition
Leading Practice		
Corresponding Strategies		Identifies the key strategies/factors that support success in meeting the leading practice.
Overall Assessment of Leading Practice		
Organizational Process		Specific process that the organization has/is implementing to meet the identified strategies corresponding to a leading practice.
Self-Assessment		Hospitals determine their success in meeting the corresponding strategy. Note: In the tool, please use the available drop-down menu to select the appropriate self-assessment. Options available to be selected are the following:
	***Not Chosen**	Hospitals have made a choice to not choose the identified leading practice/corresponding strategy.
	Unmet	Hospitals have not taken any steps to implement the identified leading practice/corresponding strategy.
	Almost There	Hospitals have taken preliminary steps to begin implementing the identified leading practice/corresponding strategy.
	Met	Hospitals are able to clearly demonstrate that the leading practice/corresponding strategy has been implemented and **sustained**.
***Describe Reason(s) (Practice/Strategy) Not Chosen**		Detailed explanation completed by the hospital to identify possible barriers/risks/issues impacting implementation of an identified strategy.

ALC Leading Practices Tool

LEADING PRACTICE 1 **All alternatives are explored to ensure that anyone admitted could not otherwise be appropriately managed in a community care setting.**	OVERALL ASSESSMENT OF THIS PRACTICE		
CORRESPONDING STRATEGIES	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
If the hospital has over 30,000 Emergency Department (ED) visits annually, a fixed or virtual ED Clinical Decision Unit has been considered.		Choose an item.	
Implementing a short stay unit has been considered for the ED.		Choose an item.	
No patient is admitted without being assessed by a Geriatric Emergency Medicine (GEM) nurse, Community Care Access Centre (CCAC) Care Coordinator, or social worker (SW) to determine if the patient's presenting condition could be managed in the community. Note: This **includes** patients being held overnight in the ED to be assessed in the morning. It **excludes** patients that have an acute medical, surgical or psychiatric diagnosis.		Choose an item.	
The hospital has a process to identify patients that were designated ALC within 48-hours of admission and reviews each case to identify opportunities for improvement.		Choose an item.	
The hospital has a process to review whether patterns of ED visit volumes align with GEM nurse and SW staffing patterns.		Choose an item.	

LEADING PRACTICE 2 **All patients/Substitute Decision Makers (SDMs) are provided with an Estimated Day of Discharge (EDD) shortly following admission.**			
CORRESPONDING STRATEGIES	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
There is a process for establishing the EDD (i.e., Quality Based Procedures, Case Mix Index, etc.).		Choose an item.	
The EDD, discharge plan and discharge expectations are communicated to the patient/family/SDM within the first 2-7 days of admission and documented on the patient chart.		Choose an item.	
A process is in place to audit and evaluate how quickly the hospital determines and communicates an EDD to the patient/family/SDM.		Choose an item.	
LEADING PRACTICE 3 **Limiting the generation of patients designated ALC is a priority for the hospital. The hospital identifies patients at high risk for being designated ALC and focuses on ALC avoidance and limiting ALC days.**	**OVERALL ASSESSMENT OF THIS PRACTICE**		
CORRESPONDING STRATEGIES	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
The hospital uses a screening process (based on known ALC predictors) for early identification of patients that present as high risk for being designated ALC. The patient's barrier(s) to discharge are aggressively case managed.		Choose an item.	
The hospital has implemented strategies outlined in the 'Senior Friendly Hospitals Framework' to support optimal outcomes for seniors.		Choose an item.	

The hospital minimizes risk of 'longer than expected lengths of stay' by embedding evidence-based practices that actively mitigate the risk of avoidable deconditioning, falls and/or delirium etc.		Choose an item.	
Develop a forum to discuss ALC resolution where individual/challenging cases can be discussed. This should include participation from interprofessional health service providers, community providers, and others as appropriate. Note: Consider Circle of Care and Personal Health Information		Choose an item.	
There is a process in place for auditing the identification of patients at high risk for being designated ALC and compliance with the practices implemented to mitigate this risk.		Choose an item.	
LEADING PRACTICE 4 **Robust admission policies and procedures are in place to support ALC avoidance and management.** **Admission policies and procedures include:**	**OVERALL ASSESSMENT OF THIS PRACTICE**		
CORRESPONDING STRATEGIES	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
A philosophy that embraces discharge planning conversations with the patient/SDM beginning on admission. These initial discussions focus on getting the patient to the right place of care with appropriate resources.		Choose an item.	
The hospital communicates that it is the responsibility and requirement of the patient/SDM to identify Long-Term Care (LTC) choices. For patients requiring LTC, hospital identifies timeline for requiring a requested number of LTC choices and submission of a first choice.		Choose an item.	
The hospital communicates the responsibility and requirement of the patient/SDM to pay a co-payment, and to accept the first bed offered		Choose an item.	

from chosen facilities, if the patient needs to wait in acute or post-acute care for a LTC bed.			
The hospital communicates an escalation process that will be initiated if the patient/SDM refuses to engage/collaborate on a discharge plan. This includes triggers and timelines for enacting the escalation process.		Choose an item.	
Information is provided on admission to patients and SDMs. This may include information on the role of the SDM, co-payment costs, and an expectation to participate in discharge planning.		Choose an item.	
A process is in place to audit and evaluate compliance and effectiveness of these admission policies and procedures.		Choose an item.	

LEADING PRACTICE 5	**OVERALL ASSESSMENT OF THIS PRACTICE**		
The hospital has a well-defined escalation process to enable timely and effective management of potential discharge delays (ALC avoidance and escalation processes). **As part of the Escalation Policy, the hospital has considered strategies to respond to the following scenarios:**			
CORRESPONDING STRATEGIES TO RESPOND TO SCENARIOS	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
Patient/SDM declines to take steps to go home or explore the option of a discharge to the Community.		Choose an item.	
Patient/SDM declines to participate in the discharge planning process by delaying initiation of the process or delaying the submission of LTC choices.		Choose an item.	
Patient/SDM declines to consent to an application for another discharge destination (i.e., transitional bed, shelter)		Choose an item.	
Patient/SDM has made unreasonable choices regarding LTC placement (i.e., there is no likelihood of discharge from hospital based on the choice(s) that have been selected)		Choose an item.	

Patient/SDM declines to accept the first bed offered from their choice of facilities.		Choose an item.	
Patient/SDM refuses to comply with his/her discharge date or refuses the plan of care.		Choose an item.	
A process is in place to audit and evaluate compliance and effectiveness of the organization's escalation processes.		Choose an item.	

LEADING PRACTICE 6	**OVERALL ASSESSMENT OF THIS PRACTICE**		
Early discharge planning is embraced as part of the organization's culture and philosophy of care. Discharge planning commences on admission.			
CORRESPONDING STRATEGIES	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
Hospital staff and physicians have considered the use of tools and strategies used to identify and flag patients who are high risk for being designated ALC (e.g., Blaylock and/or ALICE tool).		Choose an item.	
Hospital staff and physicians are clear on how early discharge planning is incorporated into the admission process and monitored.		Choose an item.	
All patients identified as high risk for being designated ALC are referred, if appropriate, to CCAC before they are designated ALC.		Choose an item.	
A process is in place to audit and evaluate compliance and effectiveness of policies and practices related to early discharge planning.		Choose an item.	

LEADING PRACTICE 7 **Supports are in place that empower hospital staff and physicians to effectively avoid and manage patients designated ALC.**	OVERALL ASSESSMENT OF THIS PRACTICE		
CORRESPONDING STRATEGIES	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
Hospital staff and physicians receive support on how to have difficult conversations related to ALC avoidance with patients/SDMs/families, with internal colleagues and external partners (e.g., scripting)		Choose an item.	
To support conversations related to ALC avoidance, all staff have access to education and resources related to ethical decision making.		Choose an item.	
There is support to prevent staff feeling overwhelmed, unsuccessful and/or having low morale as a result of the number of patients designated ALC.		Choose an item.	
Internal communication reinforces that the number of patients designated ALC reflects performance and accountability as a system; both as a hospital and with health system partners.		Choose an item.	
A process is in place to evaluate the availability and effectiveness of supports for staff and physicians.		Choose an item.	

LEADING PRACTICE 8 **A process is in place to proactively and regularly case-manage patients at high risk for being designated ALC. Multiple internal/external stakeholders are engaged in limiting the generation of patients designated ALC.**	OVERALL ASSESSMENT OF THIS PRACTICE		
CORRESPONDING STRATEGIES	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
The hospital engages in ALC Rounds at least weekly.		Choose an item.	
ALC Rounds are chaired and/or attended at a director/vice-president-level.		Choose an item.	
In addition to patients who are already designated ALC, all patients at 'high-risk for ALC' are identified and discussed at ALC rounds.		Choose an item.	
There is a process for identifying whether those who were designated ALC were proactively identified as being high risk.		Choose an item.	
ALC Rounds include the involvement of internal stakeholders (i.e., vice-president, directors, managers)		Choose an item.	
Social work attends ALC rounds and comes prepared to participate in a discussion on the barriers to discharge for patients, and of potential discharge delays/issues.		Choose an item.	
Key external agencies are invited to participate in ALC Rounds, as required and/or are value-added (i.e., LHIN, CCAC or CSS representatives)		Choose an item.	
A process is in place to audit and evaluate compliance and effectiveness of the practices for proactively managing ALC.		Choose an item.	

LEADING PRACTICE 9 **The roles/responsibilities and expectations of an SDM are clearly explained in writing on admission.**	**OVERALL ASSESSMENT OF THIS PRACTICE**		
CORRESPONDING STRATEGIES	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
A SDM is confirmed within 48-hours of admission for all patients. This includes obtaining and documenting accurate contact details.		Choose an item.	
A process is in place to audit and evaluate compliance and effectiveness of the communication of patients and SDM roles and responsibilities.		Choose an item.	
A written admission document is provided within the first 48 hours of admission and outlines: A. The roles and responsibilities of the patient		Choose an item.	
B. The roles and responsibilities of a SDM		Choose an item.	
C. Information on acting in alignment with the patient's best interests.		Choose an item.	
D. There is a documented conversation with the patient/family/SDM around the risks of being in hospital including; (1) High risk of loss of mobility and incontinence. (2) Staying in hospital for prolonged periods of time increases the chance of contracting hospital borne infections, such as MRSA, VRE, and C. difficile.		Choose an item.	

LEADING PRACTICE 10 **Physicians are engaged in all ALC avoidance and management practices.**	OVERALL ASSESSMENT OF THIS PRACTICE		
CORRESPONDING STRATEGIES	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
There is visible and demonstrated commitment and physician engagement in ALC avoidance processes with a focus on getting the patient to the right place of care with appropriate resources.		Choose an item.	
There is clarity among physicians on when to recommend an ALC designation.		Choose an item.	
A process is in place to audit and evaluate compliance and effectiveness of physician engagement.		Choose an item.	

LEADING PRACTICE 11 **Senior team visibility and support is integral to the success of all policies and practices that support ALC avoidance and management. The senior team is aware of patients designated ALC and has a good understanding of the barriers to transitioning these patients out of the hospital.**	OVERALL ASSESSMENT OF THIS PRACTICE		
CORRESPONDING STRATEGIES	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
Mechanisms are in place to ensure the senior team is aware of patients who have been designated ALC and/or patients deemed at high risk for being designated ALC.		Choose an item.	
As part of the escalation process, there is a common understanding of the mechanisms and supports in place to engage the leadership team in discussion around challenging patient discharge issues.		Choose an item.	

A process is in place to audit and evaluate compliance and effectiveness of senior team visibility.		Choose an item.	

LEADING PRACTICE 12 **ALC avoidance and management is viewed as an integral part of the organizations' 'Continuous Quality Improvement' (CQI) efforts and priorities. There is demonstrated performance improvement over the last six months as related to key targets/benchmarks (e.g., average number of days patients are designated as ALC).**	**OVERALL ASSESSMENT OF THIS PRACTICE**		
CORRESPONDING STRATEGIES	**ORGANIZATIONAL PROCESS**	**SELF-ASSESSMENT**	***DESCRIBE REASON(S) NOT CHOSEN**
There is evidence of ALC avoidance being embraced as a corporate priority (e.g., reflected in the hospital's Quality Improvement Plan).		Choose an item.	
Practices are in place to ensure that the hospital conducts a case review at least quarterly on a randomly chosen patient that was designated ALC. The review assesses compliance with policies and procedures to enable organizational learning and opportunities to limit the generation of patients designated ALC.		Choose an item.	
ALC improvement targets and the impact of ALC is identified and communicated to all teams within the hospital. This information is communicated down to front-line staff.		Choose an item.	
Frontline staff and physicians on all teams have the information needed to be accountable for meeting improvement targets.		Choose an item.	
ALC improvement targets are monitored at regular intervals by all levels of the organization including the senior team. This information is communicated down to front-line staff.		Choose an item.	

Feedback from patients is obtained regarding their experience with admission, discharge planning and discharge. This feedback informs CQI efforts.		Choose an item.	
A process is in place to audit and evaluate compliance with these practices and the effectiveness of CQI related to ALC.		Choose an item.	

Summary of Leading Practices and Rationale for Inclusion

Leading Practice 1

All alternatives have been explored to ensure anyone admitted could not otherwise be appropriately managed in a community care setting.

Goal

- To engage all resources in the ED collaboratively, to ensure admission could not be managed in a community care setting and prevent admission for non-acute issues.

Rationale for Inclusion

- Process for early identification of patients with potential for high risk of becoming ALC is effective in ALC avoidance
- Many emergency departments have the majority of their non-medical/non-nursing resources (GEM, SW and CCAC) working in the morning to early afternoon while ED visit patterns show visits starting to build later in the day.

Factors to Achieve Success

- Admissions are limited to patients that require inpatient acute care for more than 48 hours.
- Successful strategies in the prevention of an inpatient admission can include a CDU or Medical Short Stay Unit.
- Availability of resources like GEM, SW or CCAC to assess and coordinate later in the afternoon or early evening can prevent admissions for patients with non-acute issues.

Leading Practice 2

All patients/Substitute Decision Makers (SDMs) are provided with an Estimated Day of Discharge (EDD) shortly following admission.

Goal

- To improve system-wide health service delivery there is a need to manage length of stay, and improve discharge/transitions to the community. Clearly communicating the EDD allows the hospital, home and community and patient and family to plan for and expect a discharge.

Rationale for Inclusion

- Clear communication and expectation setting with patients and families early in the admission around discharge dates is a critical factor to successfully transition the patient into the next place of care (i.e., post-acute, community).

Factors to Achieve Success

- Processes in place to audit and ensure this occurs with every patient, in a timely manner, based on the hospital's policy.
- A clearly articulate and understood policy.

Leading Practice 3

Limiting the generation of patients designated ALC is a priority for the hospital. The hospital identifies patients at high risk for being designated ALC and focuses on ALC avoidance and limiting ALC days.

Goal

- Creating a culture and having the policies and processes in place to support access and flow, right place of care, and ALC avoidance are identified as organizational priorities.

Rationale for Inclusion

- Patients are identified as high risk for ALC as early as possible to ensure that barriers can be identified and appropriate interventions and processes can be implemented to assist in smooth and timely transitions.

Factors to Achieve Success

- Senior team support and discharge oversight is a key factor in success of discharge planning process.

Leading Practice 4

Robust admission policies and procedures are in place to support ALC avoidance and management.

Goal

- Discharge planning starts on admission with the goal that 'everyone is being discharged to the community' is clearly and consistently communicated to patients and families by all healthcare providers.

Rationale for Inclusion

- Having policies in place allows for patients and families to be engaged early in discharge planning. They also support consistency in how and when hospital, home and community staff engage with patients and families, ultimately supporting appropriate care prior to returning home or moving to the next care destination.

Factors to Achieve Success

- Clear expectations, processes, timelines and communication within the discharge planning team to support transitions in a timely manner.
- Substitute Decision Makers who do not understand their role well, or the expectations of the hospital team (be accessible and participate in discharge planning) have been clearly identified as a barrier to the patient's discharge.

Leading Practice 5

The hospital has a well-defined escalation process to enable timely and effective management of potential discharge delays (ALC avoidance and escalation processes).

Goal

- Message/goal that all patients will be transitioned to the most appropriate place of care.
- The risks to patients who have extended stays in hospital are clearly articulated.

Rationale for Inclusion

- SDMs that are uninformed and unsupported as a barrier to discharge has provided an opportunity to change how/when/what is communicated with SDMs.
- Supporting them in their understanding of their role and clear communication around options the hospital may choose to pursue if functions of the SDM role are not met can facilitate more timely decision making.

Factors to Achieve Success

- Early and collaborative partnership in discharge planning with SDMs.
- Clear and consistent messaging to the SDMs around the expectations of someone who takes on this role for a patient.

Leading Practice 6

Early discharge planning is embraced as part of the organization's culture and philosophy of care. Discharge planning commences on admission.

Goal

- To set the expectation that for the majority of patients, a hospital is not an appropriate care setting for the long-term and that care will continue in an alternate setting if required (e.g. post-acute care, or community care).

Rationale for Inclusion

- There is a method to identify who is high risk for ALC, and these patients are managed differently in order to try and mitigate barriers to discharge.

Factors to Achieve Success

- CCAC, other members of the Home and Community Sector, and any other external stakeholders that could provide support/information are engaged early for patients identified as high risk to become ALC. (e.g., case resolution table for hard to move/hard to serve patients)

Leading Practice 7

Supports are in place that empower hospital staff and physicians to effectively avoid and manage patients designated ALC.

Goal

- To ensure the hospital has supports in place for staff who feel under pressure managing the impact of patients designated ALC.

Rationale for Inclusion

- Many patients that become ALC have very complex issues for hospital teams to manage, which can lead to ethical dilemmas. Using an ethical framework/toolkit will facilitate collaboration in delivering patient-centered care, improve worker satisfaction, and achieve greater consistency in practice.
- ALC Fatigue and burnout for staff are a reality. Implementing and maintaining the strategies in the framework take a consistent level of hard work. It is important to highlight success, and to acknowledge the ALC framework was created so we can 'do the best that we can do' but isn't a silver bullet that will solve the ALC challenges within the Province of care.

Factors to Achieve Success

- Staff to be supported and clear on what they can and cannot control and impact.
- Staff to be recognized for the work they do in trying to transition patients to the right place of care.

Leading Practice 8

A process is in place to proactively and regularly case-manage patients at high risk for being designated ALC. Multiple internal/external stakeholders are engaged in limiting the generation of patients designated ALC.

Goal

- To ensure patients at risk to become ALC are identified on admission, and an ALC designation is mitigated where possible.

Rationale for Inclusion

- The goal is not ALC management. It is identifying who is at risk to become ALC and wherever possible, avoidance of designation and being able to transition to the right place of care.

Factors to Achieve Success

- Screening tool to identify who is high risk to become ALC based on known predictors.
- Home and community sectors are engaged in working with the hospital team to try and prevent an ALC designation.

Leading Practice 9

The roles/responsibilities and expectations of an SDM are clearly explained in writing on admission.

Goal

- To ensure the SDM understands and appreciates what the expectations of the hospital team will be of them.

Rationale for Inclusion

- Many SDMs are not knowledgeable around what it means to take on this role, and what hospital staff will expect of them.
- It is invaluable to identify the SDM very early on in the admission process and articulate the SDM role in discharge planning.

Factors to Achieve Success

- The hospital team engages the SDM early on in the patient's admission to start to collaborate on discharge planning.

Leading Practice 10

Physicians are engaged in all ALC avoidance and management practices.

Goal

- To ensure physicians are engaged and committed to ALC avoidance and right place of care strategies.

Rationale for Inclusion

- Physicians are key stakeholders in messaging to patients and families around discharge planning.
- Having them engaged in getting patients to the right place of care, championing the idea of getting the patient to the right place of care with appropriate resources and not talking about the need for '24/7 care or LTC' is a key driver for success.
- While some patients will not be able to be discharged to the community, and others will need to wait in hospitals for LTC, it is critical to explore all options before CCAC assesses for LTC eligibility/entering into LTC discussions.

Factors to Achieve Success

- Accurate coding practices in ALC facilitates clarity of patient needs, barriers, and challenges while allowing for appropriate planning to occur.

Leading Practice 11

Senior team visibility and support is integral to the success of all policies and practices that support ALC avoidance and management. The senior team is aware of patients designated ALC and has a good understanding of the barriers to transitioning these patients out of the facility.

Goal

- To ensure the senior team drives ALC avoidance strategies by being visible and supportive to clinicians.

Rationale for Inclusion

- Front line clinicians and managers need the support of the senior team to help them through challenging conversations and discharges.
- Value of executive leadership in helping to drive initiative integral to success of implementing any/all ALC leading practices.

Factors to Achieve Success

- Clear communication and expectations within team, including senior administration, will support timely processes to occur.

Leading Practice 12

ALC avoidance and management is viewed as an integral part of the organizations' 'Continuous Quality Improvement' (CQI) efforts and priorities. There is demonstrated performance improvement over the last six months as related to key targets/benchmarks (e.g., average number of days patients are designated as ALC).

Goal

- To ensure the senior team supports and drives the rest of the hospital team to achieve implementing and maintaining all strategies in the ALC Avoidance Framework.

Rationale for Inclusion

- Without executive buy-in, support and championing, challenges will arise regarding implementation and maintenance of these strategies.

Factors to Achieve Success

- Visibility and accountability of senior leadership to implement the strategies.
- May require culture/process changes in some organizations.

Appendix 1: Feedback on the Application of the ALC Avoidance Framework

University Health Network

"University Health Network (UHN) has imbedded the Toronto Central Local Health Integration Network (TC LHIN) ALC Framework as a guide to plan ALC strategies within UHN at Toronto General Hospital (TGH) and Toronto Western Hospital (TWH). The acute care sites (TWH and TGH) use the ALC Framework as a blueprint for strategic ALC planning and has been a guide to highlight areas or best practices we should prioritize to implement at each hospital. The Self-Assessment is completed every 6 months and the results are used to monitor progress and we report the outcomes of the Self-Assessment at the UHN ALC Committee to determine what we are doing well and what areas still require attention. This ALC Framework is an excellent tool for ALC avoidance and management for UHN. We saw a significant improvement at TGH in total ALC reductions and in Long-Term Care Home (LTCH) reductions."

- Mary Kay McCarthy
Senior Clinical Director,
University Health Network

Michael Garron Hospital

"The ALC Avoidance Framework is the fruit of a collaborative effort between the Toronto Central (TC) Community Care Access Centre (CCAC) and the 17 hospitals of the Toronto Central Local Health Integration Network (TC-LHIN). The Framework outlines pockets of ALC leading practices gleaned from within the LHIN and throughout Ontario and brings them together in a self-assessment tool. It also provides a structured approach to developing and implementing ALC improvement plans.

Michael Garron Hospital (MGH) was an early adopter of the ALC Avoidance Framework. Upon completion of its self-assessment, MGH had approximately 50% of 54 ALC avoidance strategies in place. Following prioritization of improvements and a focus on three key tactics, MGH met 84% of the strategies - the highest of the 17 hospitals in the LHIN. Through its focused effort, MGH exceeded its annual ALC target by 15% and, in April 2016, achieved its best performance in over two years with an ALC rate of 8.4%, despite rising ALC rates LHIN-wide. In addition, MGH has decreased the number of patients designated ALC waiting in hospital for a long-term care bed by 50% and has ensured that 100% of long-term care bed offers are accepted. The framework is reviewed every 6 months and informs the next tactics we should embark on."

- Sandra Dickau
Director of Complex Continuing Care and Rehabilitation,
Family and Community Medicine,
Michael Garron Hospital

Humber River Hospital

"The Central Local Health Integration Network (CLHIN) ALC Collaborative, 6 hospital sites and CCAC applied the ALC avoidance framework to identify gaps in processes and worked together on identifying and prioritizing areas for improvement resulting in the development of the Discharge Planning Pathway, with Humber River Hospital taking the lead in roll-out. Some of the key areas we've focused on is the early identification of patients at a high risk for becoming ALC, having our social workers perform an initial assessment on those patients, and standardized escalations; all before an ALC designation. The pathway creates very clear expectations. All patients designated ALC are identified as high risk, a family meeting for complex discharges, and knowing what the ALC destination will be with referrals/applications processed – all completed pre-ALC. This helps us proactively prevent any delays, as well as ensure our standardized escalations occur to reduce the number of patients waiting in hospital for Long Term Care. We also use our interim Dashboard to capture high-risk patients/patients designated ALC to support these processes, and are working towards developing the automated Discharge Planning Dashboard that will give us real-time situational awareness, notifications and reporting.

We have seen a shift in our culture, where new patients designated ALC are mainly for convalescent care, rehab and complex continuing care, and patients that are complex discharges (potential long-term care) are communicated while still in the acute phase of their stay. We are able to ensure appropriate stakeholders are involved and escalations are performed to know we've exhausted all our options pre-ALC, and our conversations are becoming shorter but more meaningful. We are seeing a decrease in our ALC numbers and have prevented some avoidable ALC's to LTC and continuing to monitor for ongoing improvement."

- Mehdi Somji, Manager, Clinical Process Optimization and
- Carol Hatcher, Program Director
Humber River Hospital

Niagara Health

- "The ALC avoidance framework was instrumental for Niagara Health to conduct a comprehensive assessment of the obstacles to moving patients to the appropriate level of care.
- Conducting the assessment every year or 2 would be helpful for organizations to identify opportunities. More frequent use may become counterproductive due to the effort it takes to complete it.
- One of the gaps we identified with the framework is that it does not guide the discussion to identify system and capacity issues, so as a consequence a team may select opportunities that may lead to only minor improvements."

- Derek McNally
Executive Vice President Clinical Services & Chief Nursing Executive,
Niagara Health

Appendix 2: Acronyms

Acronym	Description
ACE	Advocacy Centre for The Elderly
ALC	Alternate Level of Care
ATC	Access to Care
CCAC	Community Care Access Centre
CCC	Complex Continuing Care
CCO	Cancer Care Ontario
CQI	Continuous Quality Improvement
CSS	Community Support Services
CDU	Clinical Decision Unit
ED	Emergency Department
EDD	Estimated Day of Discharge
FY	Fiscal Year
GEM	Geriatric Emergency Management
LHIN	Local Health Integration Network
LTC	Long-Term Care
LTCH	Long-Term Care Home
MOHLTC	Ministry of Health and Long-Term Care
MRSA	Methicillin-resistant Staphylococcus aureus
OACCAC	Ontario Association of Community Care Access Centres
OHA	Ontario Hospital Association
SDM	Substitute Decision Maker
SW	Social Work(er)
QIP	Quality Improvement Plan
VRE	Vancomycin-resistant enterococci

Appendix 3: ALC Leading Practices User Guide Reference List

1. Canadian Institute for Health Information (CIHI). (2014). *Rehabilitation Patient Group (RPG) Methodology and Weights*. https://www.cihi.ca/en

2. Regional Geriatric Program of Toronto. (2015) http://rgps.on.ca/

3. Ministry of Health and Long-Term Care. (2007). *Long-Term Care Homes Act*. Retrieved from

4. Jane E. Meadus Barrister & Solicitor. (2014). *Discharge from Hospital to Long-Term Care: Issues in Ontario*. http://www.acelaw.ca/appimages/file/Discharge_from_Hospital_to_LTC%2520February%25202014-1.pdf

5. Ontario Hospital Association. (2014). *Managing Transition: A Guidance Document*. http://mediasite.oha.com/2014/Nov.21,2014_-_Managing_Transitions/1%20-%20Katharine%20Byrick%20-%20Managing%20Transitions.pdf

6. Senior Friendly Hospitals. http://seniorfriendlyhospitals.ca/

Appendix 4: Additional Resources

1. Tools to Identify High-Risk Patients

a. ALICE Tool

b. Blaylock Tool

2. Managing Transitions: A Guidance Document Ontario Hospital Association

a. Link: https://www.oha.com/Documents/Managing%20Transitions%20-%20A%20Guidance%20Document.pdf