Ontario Health

The Alternate Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults

September 2021

Document Version: V1

This guide was developed in 2021 by the Ontario Alternate Level of Care (ALC) Leading Practices Working Group as an update to the 2017 ALC Leading Practices User Guide,[8] and the 2019 Rural Hospital ALC Leading Practices Guide[30]. **V1 of this guide is applicable to hospitals**. **V2 is in development and will include community care.**

Ontario ALC Leading Practices Working Group (2021)

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A message from the Ontario ALC Leading Practices Working Group: September 2021

The COVID-19 pandemic has brought the issues of alternate level of care (ALC), patient flow, and the care provided to older adults to the forefront. Focus has shifted from decreasing ALC days to preventing the phenomenon of ALC altogether. With 80% of Ontario's ALC designations being attributed to older adults (65+), ensuring that older adults receive evidence-based care that meets their needs is a key factor in improving health outcomes and, in turn, improving flow by reducing length of stay (LOS) and ALC. These efforts are viewed as part of an approach to integrated patient care across the continuum where the right care is provided in the right place at the right time.

The causes of delayed transitions are often identified as capacity issues in other parts of the health care system, such as "not enough home care" and "not enough Long Term Care (LTC) beds". Beyond capacity however, it is equally important that hospitals examine how their own care processes may contribute to ALC rates and delayed transitions (1). This is particularly important for older adults living with frailty, where specific hazards of hospitalization, including falls and delirium, directly impact patient outcomes, safety and health system flow (2–4). Evidence and experience demonstrate that quality improvement efforts that prioritize senior friendly approaches to care, such as a focus on delirium prevention and early mobilization, can prevent hospital-acquired harm and delayed transitions. Not doing so directly contributes to ALC rates. (5–8).

Many new beds are now being added across the system to help address capacity. These beds will require intentional design to ensure that they support improved health outcomes for older adults by providing the right care in the right place at the right time.

This guide was developed as an update to the 2017 ALC Leading Practices User Guide (9). The updates include: a focus on assessing older adults for risks that may lead to delayed transitions in care; better engaging families and caregivers; embedding senior friendly care (sfCare) as essential, foundational care; and replacing the word "discharge" with "transition" to better reflect that older adults receive services across a continuum of care (10). Creation of leading practices for the Community sector is integral to a successful integrated care approach and is under development.

We gratefully acknowledge the valuable contributions to this guide from older adults, caregivers and frontline clinicians.

About this Guide

This guide identifies evidence-based leading practices for the care and proactive management of hospitalized older adults at risk of delayed transition to an appropriate setting that can be implemented in the emergency department, acute care and post-acute care settings. While the focus of this guide is on ALC prevention and management in hospitalized older adults, many of these leading practices can be applied to other patient populations.

The leading practices describe WHAT care should look like. Organizations determine HOW to implement these

practices by prioritizing change ideas and developing action plans. Users of this guide are encouraged to begin their reflection with the *Leading Practices Self-Assessment Tool.* It provides an approach to defining current state, where the results identify opportunities for quality improvement (QI) and can be used to inform the Quality Improvement Plan (QIP). While individual organizations can implement leading practices on their own, they are encouraged to ensure that integrated care is woven into improvement plans by co-developing their QI plans with organizations in other sectors. This can be achieved as part of an Ontario Health Team's (OHT) Collaborative QIP (cQIP) or for organizations who are not part of an OHT in collaboration with one or more of their care delivery partners.

Individual QI targets can simultaneously address multiple priority initiatives (ALC, sfCare, accreditation, etc.). This guide integrates many of the practices from the sfCare Framework (11), the Frail Seniors Guidance on Best Practice Rehabilitative Care in the Context of COVID-19 (12), the Transitions Between Hospital and Home - Care for People of All Ages Quality Standard (10) the Delirium Quality Standard (13) and insights from research conducted with patients designated as ALC, their designated caregiver / substitute decision maker (SDM) and providers (14,15). As a result, the ALC Leading Practices guide aligns directly with specific Required Organizational Practices (ROP) and High Priority criteria in the 2019 Accreditation Canada Standards (16–19) and with all ten recommendations that comprise the Regional Geriatric Program (RGP) of Toronto's sfCare Self-Assessment Tool (20).

Leading Practices that demonstrate alignment to Accreditation Canada (AC) Standards are identified by an * throughout this guide. A supplementary document is available that includes a full list of the aligned AC Standards.

Leading Practices that demonstrate alignment to the sfCare Self-Assessment tool are identified by sf throughout this guide. A supplementary document is available that demonstrates specific alignment to the sfCare Self-Assessment tool.

Who is "At Risk" of Delayed Transitions in Care

All older adults who receive care in the emergency department or in acute or post-acute care may be at risk of protracted stays (signalled by an ALC designation) unless leading practices for the prevention and management of ALC are in place. This risk increases when older adults live with multiple, complex and often interacting health and social conditions.

In the hospital setting (emergency department, acute care and post-acute care), common characteristics of individuals at risk of delayed transitions in care (hereinafter referred to as "at-risk") include:

- Over the age of 65, with increasing risk noted over the age of 75 (21–24);
- An admitting diagnosis that includes general medical illness (e.g. infections), falls, and dementia (21,25,26);
- Presence of functional or cognitive impairments, and multiple comorbidities (27–29);
- Experience of adverse events during admission – functional decline, delirium, falls, social isolation (14,21–23,25,27,30–33); and
- Caregiver stress (34)

Glossary

ALTERNATE LEVEL OF CARE (ALC) – is defined by the Canadian Institute for Health Information as a description used in hospitals to refer to patients who occupy a bed but do not require the intensity of services provided in that care setting (35).

ALC DISCHARGE DESTINATION (DD) - refers to the location determined by the physician or delegate in collaboration an interprofessional team (when available), as to where a patient is to be discharged or transferred to (36).

AT RISK – older adults at risk of delayed transitions in care.

DESIGNATED CAREGIVER – is defined in the context of the sfCare Framework. Caregivers are people who are involved in an older adult's care, but who are not paid, such as family or friends. Older adults are partners in care, as are their caregivers, when identified as such by the older adult. A "designated caregiver" is someone who the older adult identifies as their care partner.

GERIATRIC CARE – is provided by health care professionals who specialize in the care of older adults (e.g. Geriatricians, GEM nurses). Geriatric specialists use a comprehensive geriatric assessment to diagnose, treat and rehabilitate older adults with frailty (or those at risk of becoming frail) with complex and multiple medical, functional, and psychosocial issues.

NEXT BEST LEVEL OF CARE –is the location determined by the physician or delegate, in collaboration with an interprofessional team (when available), as to where a patient should be discharged or transferred to, based on the care needs of the patient, irrespective of whether or not the discharge destination is available, accessible and/or exists within the community (36). May also be known by clinicians as "most appropriate discharge destination" (MADD)).

OLDER ADULT – is defined in the context of the sfCare Framework as someone who is 65 years or older, with the understanding that adults with complex age-related conditions may be younger than this and also benefit from senior friendly care (11).

PERSON-CENTRED CARE – is a care approach that focuses on the needs of the person and their goals for care. These principles are part of sfCare.

REHABILITATIVE CARE – is a care approach that focuses on maintaining or restoring functionality or developing adaptive capacity. Rehabilitative Care for older adults aligns with Senior Friendly Care (sfCare) and is part of an interprofessional approach to care. It is delivered by geriatric specialists and health care providers who have the knowledge and skill in the provision of sfCare. *The Framework for Rehabilitative Care* (12) provides the foundation for what rehabilitation of older adults looks like in an organization.

SENIOR FRIENDLY CARE (sfCare) – is evidence-based, preventive and proactive care for the unique needs of older adults. It is not an add-on to care; it is essential care that should be provided at all times. Senior friendly processes of care include: delirium, mobilization, social engagement, nutrition, pain, polypharmacy, and urinary incontinence. *The sfCare Framework* (11) provides the foundation for what sfCare looks like in an organization, including the need for all care providers to have the knowledge and skill required to provide sfCare.

STAFF – is any individual who may provide care or interact with an older adult and their designated caregiver / Substitute Decision Maker (SDM).

The Leading Practices

The leading practices defined within this guide were developed based on the best available evidence and are organized around the older adult's journey in the hospital setting. The guide describes the leading practices that are required to achieve three key goals:

A. **Integrate sfCare as the foundation of care across the organization** – this goal is addressed by leading practices that focus on:

- Organizational Leadership & Support; and
- Older Adult & Caregiver Communication & Involvement

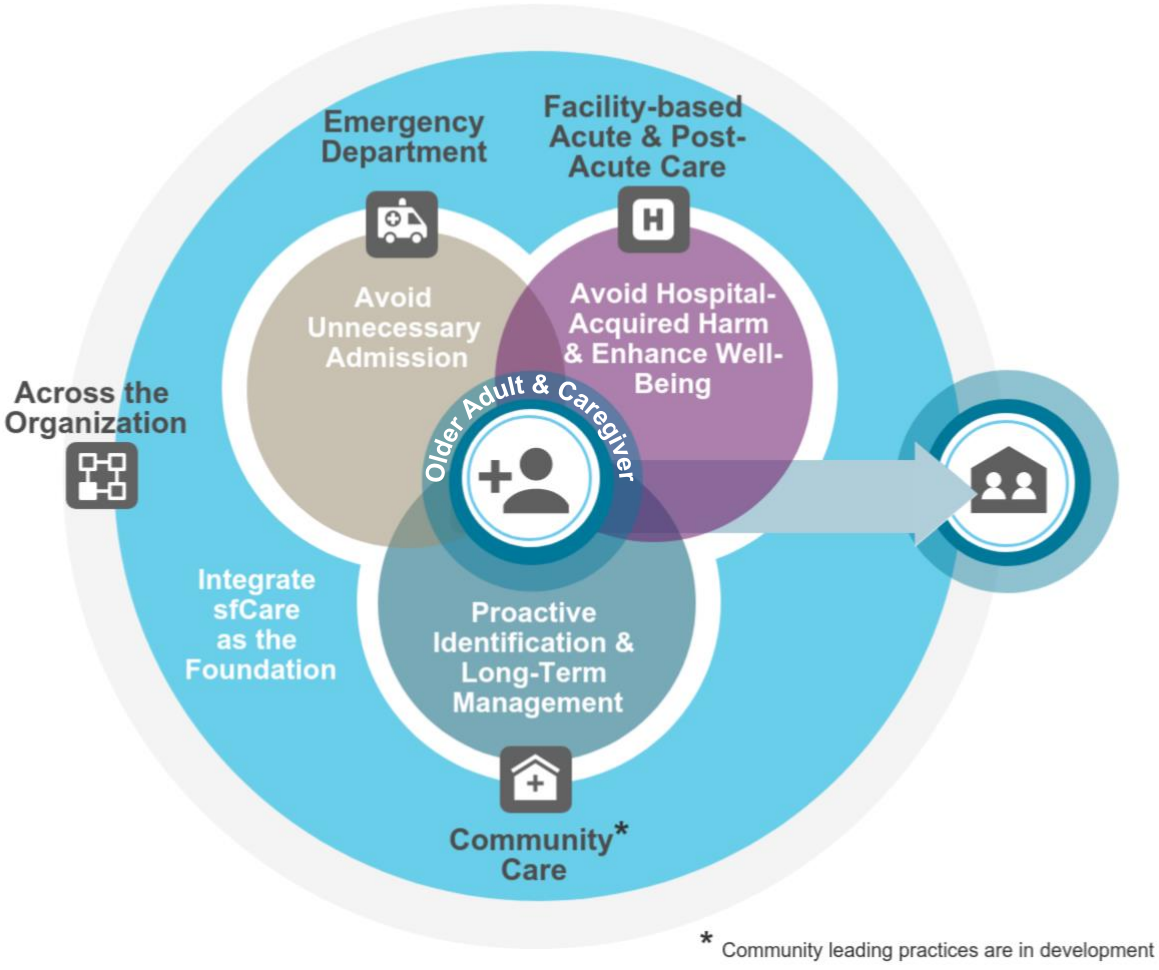
B. **Ensure practices and structures are in place in the Emergency Department (ED) to avoid unnecessary admission** - this goal is addressed by leading practices that focus on:

- Early Identification & Assessment;
- Care Plan Development & Ongoing Reassessment;
- Intervention/ Senior Friendly Care Processes; and
- Proactive Transitions

C. **Avoid hospital-acquired harm & enhance well-being in Facility-based Acute and Post-Acute Care areas** – consistent with the ED, this goal is addressed by leading practices that also focus on:

- Early Identification & Assessment;
- Care Plan Development & Ongoing Reassessment;
- Intervention/ Senior Friendly Care Processes; and
- Proactive Transitions

Leading Practices across the Older Adult & Caregiver Journey



A. Leading Practices across the organization

Embedding sfCare as the foundation of care requires an organization-wide approach and the commitment of senior leaders. sfCare approaches improve the quality of patient care, foster desired outcomes and contribute to reduced length of stay (LOS) and ALC.

GOAL: Integrate sfCare as the foundation of care

This goal aligns to the Accreditation Canada (AC) Standard "Services are co-designed to meet the needs of an aging population"(17) and is considered High Priority criteria.

Organizational Leadership & Support	
Leading Practices	**Tool(s)**
1. A member of the Senior Leadership team (such as a vice president) is designated as accountable for sfCare (8). **sf**	sfCare-Hospital-Policy-Brief (8)
2. Commitments to sfCare are included in the organization's strategic plan, operating plan, and/or corporate goals and objectives (11,37). **sf**	sfCare Self-Assessment

Organizational Leadership & Support	
Leading Practices	**Tool(s)**
3. A sfCare self-assessment is completed to understand the current state of senior friendly care delivery within the organization and opportunities for improvement. **sf** 4. A set of ALC-related process and outcome measures are collected, monitored and regularly reviewed by senior leaders, managers, physicians and staff.* **sf** 5. Functional decline and delirium are recognized as preventable harms and risk to the safety of older adults (8). **sf** 6. The structures, spaces, equipment, and furnishings provide an environment that minimizes the vulnerabilities of older adults and promotes safety, comfort, functional independence and well-being (37). **sf** 7. Clinicians who specialize in geriatric care are available 7 days a week to support a comprehensive assessment and care of older adults (38). **sf** 8. A training plan is in place for all staff, physicians, and volunteers so that they are proficient in the provision of sfCare, including (8,11,14,37): a. Seniors' sensitivity - i.e., communication, general awareness on aging and the special needs of older adults with frailty, and recognizing and addressing ageism; **sf** b. Delirium prevention and management* **sf**; and c. Mobilization* **sf** 9. Training is provided to hospital staff and physicians to ensure clarity about: a. How early transition planning is incorporated into the admission process and monitored (9); b. when to recommend an ALC designation (9). 10. Guiding documents (e.g., polices, standards, procedures, guidelines, care pathways etc.) reflect senior friendly values and principles; promote older adults' health, autonomy, dignity and participation in care; and ensure that an older adult will not be denied access to care or the opportunity to participate in research or quality improvement activities based solely on their age, as applicable (11,37). **sf** 11. Formal partnerships are in place with care delivery partners to support smooth and timely transitions from the ED, acute and post-acute care (e.g., pre-arrangements negotiated through Memoranda of Understanding and/or Purchase of Service Agreements) (10).* **sf** 12. Policies and procedures are in place to ensure ongoing reassessment occurs over the course of an older adult's admission. This includes intensive assessment of older adults who are long-stay ALC (22). 13. An escalation process is in place which provides clear direction about when and how to engage leadership in discussions around challenging barriers to transition for older adults at risk of an avoidable admission or potential ALC designation. (9). This	Tool (20) sfCare Toolkit - RGP Toronto (37) OHQ - Transitions in Care Quality Standard (10)

Organizational Leadership & Support	
Leading Practices	**Tool(s)**
includes non-punitive audit and feedback as part of an overall performance and quality improvement evaluation.	
Older Adult & Caregiver Communication & Involvement	
Leading Practices	**Tool(s)**
14. A process is in place to ensure that the older adult and their designated caregiver / Substitute Decision Maker (SDM) are included as part of the care team (11). * sf 15. The care plan, goals of care, and expected results of care are developed in collaboration with all members of the care team and the older adult and their designated caregiver / SDM, and are flexible and aligned with the older adult's preferences (what matters most) (11,14,37,39). * sf 16. The older adult and their designated caregiver are provided with information in their preferred format to let them know what to expect in their care, help them make decisions, and better self-manage their conditions (11,37). This includes being provided with: * sf a. Information on mobilization and delirium prevention to support the prevention of functional decline (8); b. The tools to support health literacy and language needs (an advocate, interpreter, etc.) so they can fully participate in their care; and c. Information on the role of the hospital, the SDM, co-payment costs, and a plan to participate in transition planning (9). 17. A system is in place to measure the experience and outcomes of older adults and their designated caregivers /SDMs and make improvements based on the results (9,11,37). sf	The Caregiver Identification (ID) Initiative (40) Communication Tool.pdf (14,41) Caregiving Strategies - RGPs of Ontario (42)

B. Leading Practices in the ED

The care provided in ED has the opportunity to 'set the stage' for subsequent care provided throughout the older adult's care trajectory (43). The older adult population accounts for a large, and ever increasing proportion of ED visits (43). The majority of "at-risk" older adults ultimately designated ALC are admitted through the emergency department (23).

GOAL: Avoid Unnecessary Admission

Early Identification & Assessment

Leading Practices	Tool(s)
1. A screening process/tool is used for early identification of "at risk" older adults presenting to the ED, regardless of presenting issue and inclusive of social factors, (24,43,44). The risk screen should tie directly into the comprehensive assessment (45).* sf 2. An interprofessional team who has skills and expertise in the assessment and management of older adults with frailty is available to support assessment and care of the older adult including (45):* sf a. Geriatric Emergency Management Nurse (GEM); b. Social Worker; c. Home and Community Care case manager; d. Physiotherapist, Occupational Therapist, Pharmacist, Behavioural Support clinicians, and other health professionals as needed; and e. Consultation with geriatric physician specialists (geriatric medicine, geriatric psychiatry, Care of the Elderly) as indicated. 3. A comprehensive assessment is initiated, which accounts for physical, cognitive, functional, and psychosocial domains, and includes:(45,46).* sf a. A collateral history from a designated caregiver / SDM, or primary care provider (47). b. Identification of baseline functional status (e.g. two weeks prior to illness onset). This is essential to determining the nature of the presenting complaint c. Identification of goals of care, outstanding care needs, and what matters most to the older adult and designated caregiver / SDM (e.g., what are they most concerned about in the short term and long-term?) (14,48,49).	CTAS Frailty Modifier (50) The Identification of Seniors at Risk (ISAR) (51) Blaylock (52) Clinical Frailty Scale (CFS)(53) Interprofessional Comprehensive Geriatric Assessment (54) Baseline Function_NESGC 202 (55) Geri-EM (45) Trial Tool (56) 'Information about me' (57)

Care Plan Development & Ongoing Reassessment

Leading Practices	Tool(s)
4. A plan of care is developed by all members of the care team with the older adult and their designated caregiver / SDM and relevant community partners to address care needs with a focus on transition to the pre-admission destination (11,22,48).* sf	

5. Frequent re-assessment of an older adult's status is an essential part of the care process so that changes and resulting support needs are identified as early as possible, and the care plan and goals of care are adjusted accordingly (23). **sf**	
Intervention/Senior Friendly Care	
Leading Practice	**Tool(s)**
6. A senior friendly care approach is implemented and includes: a. Processes for screening, prevention, management, and monitoring of functional decline (8). * **sf** b. Processes for screening, prevention, management, and monitoring of delirium (37,44). * **sf**	Senior Friendly Care Learning Series (58)
Proactive Transitions	
Leading Practices	**Tool(s)**
7. Transition protocols are in place that facilitate the timely communication of clinically relevant information to the older adult and their designated caregiver / SDM and primary care providers, including long term care homes (43). **sf** 8. Where appropriate, a clinical decision unit/short stay unit has been considered to support the development of a more comprehensive plan for their transition to the next best level of care or place for care. A protocol is developed and in-place (e.g. pre-printed order set) (24,43). 9. In partnership with the older adult and their designated caregiver / SDM, the medication reconciliation process is initiated for older adults with a decision to admit, and can be completed on the receiving unit (18).* **sf** 10. Processes are in place to transition individuals directly to the next best level of care to meet their presenting needs e.g., bedded rehabilitative care.* **sf**	Transitions into Long-Term Care for Older Adults with Responsive Behaviours (59) RCA Direct Access Priority Process (DAPP) (60) RCA ED Post Falls Pathway (61)

C. Leading Practices in Facility-based Acute and Post-Acute Care Areas

GOAL: Avoid Hospital-Acquired Harm & Enhance Well-Being

Processes are in place to prevent avoidable harm such as delirium and functional decline while treating and providing rehabilitation from acute illness, and to transition older adults to their next best level of care or place for care promptly.

Early Identification & Assessment	
Leading Practices	**Tool(s)**
1. Care delivery partners from all sectors who are already involved in the older adult's care are identified, contacted, and documented when the decision to admit is being made and collaborative information sharing is facilitated (10,37). **sf** 2. A designated caregiver / Substitute Decision Maker (SDM) or emergency contact is confirmed and documented (including contact details) within 48-hours of admission for all older adults.***** 3. The older adult has a medication review on admission. The review includes information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered and options are provided for those unable to afford these costs (10,17). *** sf** 4. Prior to ALC designation, a process is in place to ensure that the following occurs in partnership with older adults and their designated caregiver / SDM: **sf** a. Screening for early identification and risk-stratification as soon as possible upon admission (if not already completed in ED or if the older adult is a direct admission from the community) (9). This includes identification and documentation of baseline functional status (e.g. two weeks prior to admission/onset of illness) (25,32,48,49,62). b. An interprofessional team continues the comprehensive assessment (physical, cognitive, functional, and psychosocial domains), building from and integrating screening and assessment information that has already been collected (e.g., from care delivery partners, collateral history from the designated caregiver / SDM (10,45–47).***** c. A comprehensive geriatric assessment is completed when appropriate (e.g. when an increase in care for an extended length of time is anticipated), in partnership with the older adult and their designated caregiver / SDM (17).***** d. Determination of the older adult's functional goals and restorative potential to inform the plan of care (22,44,48,63). ***** e. Identification of barriers to transition (physical, social, financial, etc.). f. A referral, if appropriate, to relevant home and community care services or programs (9).	OH-Q Quality Standard: Transitions (10)  Baseline Function_NESGC 202 (55) Trial Tool (56) 'Information about me' (57) ISAR (51); CFS (53) Interprofessional Comprehensive Geriatric Assessment (54) RCA Referral Decision Tree (48)

Care Plan Development & Ongoing Reassessment	
Leading Practices	**Tool(s)**
5. Care needs are clearly identified and person-centred goals are developed to address these needs (e.g., what is the change between baseline and current state across the physical, cognitive, functional, and psychosocial domains) (14,48,49). **sf** 6. A plan of care is developed with the older adult and their designated caregiver / SDM and relevant community partners to address the identified care needs with a focus on transition to the community (11,22,48).* **sf** 7. There is a process for establishing the Estimated Discharge Date (EDD)(9). This process must be specific to each older adult and not dependent upon blanket EDD assumptions. **sf** 8. All older adults and their designated caregiver / SDMs are provided with an (EDD): within 48 hours of admission to acute care and within 4 days of admission to post-acute care. This also includes a conversation around the transition plan. EDD is reassessed frequently and adjusted to reflect changing clinical need and communicated with the older adult and designated caregiver/SDM (24,44).* **sf** 9. All older adults are assessed daily in acute care and post-acute care so that changes in medical/functional status and resulting support needs are identified as early as possible. The care plan and EDD, and any updates, are reviewed with the older adult and their designated caregiver/SDM and adjusted (23,49,64). **sf**	
Intervention/Senior Friendly Care	
Leading Practices	**Tool(s)**
10. A minimum standard of daily care (7days/week) delivered by an interprofessional team is in place for all older adults (regardless of ALC designation/discharge destination) to help them maintain and restore function while in hospital so that they are not prevented from returning home as a result of hospital-acquired deconditioning (23). The standard of care includes general hygiene, and senior friendly processes of care that address:* **sf** a. Mobilization: screening for functional decline; re-assessment of functional status at least weekly (8); and tailored mobilization interventions specific to their level of mobility and functional goals which supports participation in activities of daily living, physical activity, and self-care. b. Delirium: screening and monitoring for delirium(37,44); tailored intervention to prevent delirium; and older adults with delirium having a multicomponent interprofessional management plan (8). c. Social engagement d. Nutrition e. Pain	sfCare Toolkit - RGP Toronto (37) PIECES of my Personhood (65)

f. Polypharmacy g. Continence	

Proactive Transitions	
Leading Practices	**Tool(s)**
11. The older adult has a named health care professional who is responsible for timely transition planning, coordination, and communication, and the older adult and designated caregiver /SDM will have their contact information in case they have questions (10,14). Before the older adult leaves the hospital, this person ensures an effective transfer (early and timely) of transition plans and information related to the older adult's care (10,14). **sf** 12. A transition plan is developed with the older adult and their designated caregiver / SDM and relevant community partners early in the admission to address care needs, care preferences, and barriers to discharge, with a focus on transition to the community first (9).***** **sf** 13. An approach is in place to support the older adult, their designated caregiver / SDM, and staff in challenging ethical situations such as when there are differing perspectives around the EDD or transition plan. This could include holding a family meeting and/or consulting additional resources. **sf** 14. There is a scheduled opportunity for the interdisciplinary team to review all older adults identified as "at-risk"(e.g. "at-risk" (ALC) rounds) at least weekly (9). 15. "At-risk" (ALC) rounds include the following: a. Chaired and/or attended by a representative at a director/vice-president-level (9). b. Internal stakeholders (i.e., managers, front line staff etc.). The older adult and their designated caregiver / SDM, along with physicians, are also included in team rounds (14,24). c. Key external agencies are invited to participate as required (i.e., home care coordinator or community support services representatives) (9). d. Discussion includes a review of risks for each older adult (e.g. outstanding	Communication Tool.pdf (14,41) OH-Q Transitions Quality Standard (10)

care needs and impact on delayed discharge) (9). 16. An "at-risk" resolution table is developed, where challenging barriers to transition can be discussed and addressed. 17. The older adult has a final medication review before returning home. This review includes information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and options are provided for those unable to afford these costs (10,17).* **sf** 18. The older adult is assessed for the type, amount, and appropriate timing of home care and community support services they and their caregivers need. When these services are needed, they are arranged before the older adult leaves the hospital and are in place when they return home (10). **sf** 19. A written transition plan, developed by and agreed upon in partnership with the older adult and their designated caregiver / SDM, the hospital team, and primary care and home and community care providers is given to the older adult 2 days prior to leaving hospital. Transition plans are shared with the person's primary care and home and community care providers and any relevant specialist providers within 48 hours of discharge (10). **sf** 20. Transition plans incorporate referrals and consideration for programs, services or self-care activities to restore/maintain function recognizing the prevalence of functional decline after a hospital stay (49,66). **sf** 21. The health care team explains to the older adult what publicly-funded services are available to them and what services they will need to pay for. The older adult's ability to pay for any out-of-pocket health care costs is considered by the health care team. Options for those unable to afford these costs are included in transition plans. (10). **sf**	 June 2019 TCLHIN Final Service Resoluti OH-Q Transitions Quality Standard (10) Patient Oriented Discharge Summary (PODS) Toolkit (67) Transitions into Long-Term Care for Older Adults with Responsive Behaviours (59) OH-Q Transitions Quality Standard (10)

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