North East **LHIN** | **RLISS** du Nord-Est

Rural Hospital ALC Leading Practices Guide

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Ontario

Overview

Patients who are waiting for an Alternate Level of Care (ALC) occupy a bed in a hospital but 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 older.

In 2015, the population of seniors 75+ represented 7.1% of the total population of the province. By 2041, that is projected to more than double from one million to over 2.5 million, or 15.5%. These patients are at risk of deconditioning, nosocomial infections and iatrogenic injury, affecting their future health status with increasing stays in hospital settings.

The 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 the fall of 2016, the Ministry of Health and Long-Term Care (MOHLTC) expanded the mandate of the Provincial ALC Advisory Committee to identify and support knowledge sharing of ALC leading practices. Members of the ALC Advisory Committee, representing a broad range of stakeholder groups, were selected to be part of three distinct working groups, with work commencing in January 2017.

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. In March 2017, Access to Care - Cancer Care Ontario (CCO) launched ALC Leading Practices User Guide, an ALC avoidance toolkit.

A Focus on Rural Hospitals:

While the ALC Leading Practices User Guide is proving valuable for large community and tertiary hospitals to use as a foundation for their ALC avoidance work, some of the strategies have not proved feasible for small, rural hospital sites to implement. Representatives from the North East LHIN have come together to develop a specific Rural Hospital ALC Leading Practices Guide. Built with the same philosophy and principles of the Provincial tool, the Rural Hospital ALC Leading Practices Guide has been developed with the realities of small, rural hospitals in mind. The Rural ALC Hospital Leading Practices Guide also includes much more emphasis on Senior Friendly Care, the principles of Activation & Restoration, and incorporates the learning of recent Ontario-based research on ALC client, family, and caregiver experience.

Rural Hospital 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	The strategy being assessed occurs less than 60% of the time in all units in the hospital.
	Almost There	The strategy occurs between 60-80% of the time on all units in the hospital.
	Met	The strategy occurs 80% of the time in all units of the hospital, and the strategy is clearly being **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. Or why the hospital team feel this strategy will not be value add for them

Rural Hospital ALC Leading Practices

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Goals of the Framework: To provide a framework for rural hospitals to support getting northerners to the right place of care, maximizing conservable days, and limiting the generation of ALC patients.

Purpose:

1. Avoid all unnecessary hospital admissions.
2. Identify & divert patients at risk of becoming ALC, and work to ensure all patients are in the right place to receive the level of care required.
3. Effective and timely management of patients designated ALC.
4. Meet benchmark length of stay (LOS) targets, HIG methodology (Hospital Inpatient Grouping weights - see CIHI) for 75% of all patients.

Selected References:

- Canadian Institute for Health Information (CIHI).
- Discharge From Hospital to Long-Term Care Issues in Ontario. Jane E. Meadus Barrister & Solicitor.
- Institutional Advocate Advocacy Centre for the Elderly. Updated February 2014 GTA Rehab Discharge Planning Guidelines, July 2009
- Long-Term Care Homes Act, 2007
- ALC Avoidance work from North Bay Regional Health Centre 2018 ALC related Templates from St Joseph's Hospital, Elliot Lake
- Change Foundation Care Giver Toolkit; sfCare Framework, RGP of Toronto, 2018; Rehabilitative Care Alliance (RCA) Definition of Restorative Potential & Referral Decision Tree; Caring For Our Aging Population and
- Addressing Alternate Level of Care, 2011; Assess & Restore Guideline, MOHLTC, 2014

LEADING PRACTICES AND IMPROVEMENT STRATEGIES

1. LEADING PRACTICE Senior team visibility and support is integral to the success of all policies and practices that support ALC avoidance and Right Place of Care. 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		
STRATEGIES	**Organizational Process**	**Self-Assessment**	**Supporting Documents**
1. Mechanisms are in place to ensure the senior team is aware of patients that are ALC, or deemed high risk to become ALC.		Choose an item.	
2. Members of the senior team lead, guide, and support all Right Place of Care/ ALC Avoidance work.		Choose an item.	
3.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.	

2. LEADING PRACTICE The organization focuses on trying to limit admissions for non- acute issues that do not require an acute care bed.	OVERALL ASSESSMENT OF THIS PRACTICE		
STRATEGIES	**Organizational Process**	**Self-Assessment**	**Documents**
1. Anyone being considered for a non- clinical/acute issue will be referred/assessed in person or by phone to Home and Community Care (HCC) to see if they can be managed in the community and a non-acute admission prevented.		Choose an item.	
2. If possible hold a non-acute client overnight in the ED, until you can connect with Home and Community/PATH (Priority Assistance to Transition Home) in the morning.			
3. The hospital audits the number of people made ALC within 24-48 hours of admission. To assess if they could have been supported in the community, and if the admission was avoidable.			

3. LEADING PRACTICE The organization sets expectations for LOS in alignment with industry benchmarks, and works to meet those targets for 75% of all patients (conservable/avoidable days).	OVERALL ASSESSMENT OF THIS PRACTICE		
STRATEGIES	**Organizational Process**	**Self-Assessment**	**Documents**
1. Hospitals review their top 20 CMGs (excluding obstetrics) and compare Length of Stay (LOS) data to industry benchmarks.		Choose an item.	
2. All clients/Substitute Decision Makers (SDMs) are provided with an Estimated Day of Discharge (EDD) within 24-48 hours of admission.		Choose an item.	
3. The medical/surgical/rehab units have bullet rounds at least 3 times a week to proactively plan for discharges that meet LOS benchmarks/targets.		Choose an item.	
4. There is a process in place for auditing what % of clients meet LOS stay benchmarks for the top 20 CMGs. For those CMGs where the hospital consistently does not meet benchmarks (less than 75% of the time) the hospital implements an improvement strategy to meet this target.		Choose an item.	

4. LEADING PRACTICE: An 'Assess and Restore' philosophy and function, and 'Senior Friendly' principles are central to the organization's delivery of patient care	OVERALL ASSESSMENT OF THIS PRACTICE		
STRATEGIES	**Organizational Process**	**Self-Assessment**	**Documents**
1. All patients are assessed for and have a documented baseline functional status/pre-admission status within 24 hours of admission. The baseline assessment could include tools such as a cognitive assessment, frailty index score, psycho-social assessment etc.		Choose an item.	
2. A patient's level of mobility is assessed within 24 hours of admission using a recognized best practice tool (e.g. The Simplified Mobility Assessment Algorithm, HABAM, etc.).		Choose an item.	
3.A patient's functional level is assessed on admission and discharge using a recommended best practice tool e.g. the Barthel Index, the Katz, etc.		Choose an item.	
4. There is a process in place to assess for and determine a patient's restorative potential. This determination is used to inform development of the most appropriate plan of care.		Choose an item.	
5. Interprofessional assessment and care is guided by evidence- informed practice to optimize the outcomes and abilities of older adults. The organization implements Senior Friendly Care Framework practices for screening, prevention, management, and monitoring of functional decline.		Choose an item.	
6. The organization implements Senior Friendly Care Framework practices for screening, prevention, management, and monitoring of delirium.		Choose an item.	

5. LEADING PRACTICE Right place of care & limiting the generation of ALC clients is a priority for the hospital.	OVERALL ASSESSMENT OF THIS PRACTICE		
STRATEGIES	**Organizational Process**	**Self-Assessment**	**Documents**
1. The hospital uses a screening process (based on known ALC predictors) for early identification of clients that present a high risk for being designated ALC (ALC risk stratification tool –examples include the Blaylock, ISAR, ALICE etc.) The client's barriers to discharge are aggressively case managed within available resources.		Choose an item.	
2. Any patient who is determined as being high risk to become ALC is discussed at weekly ALC rounds. The focus of the ALC rounds is an upstream approach of ALC prevention, not just management.		Choose an item.	
3. ALC rounds are attended by internal and external stakeholders. For example: VP/CNE, managers, Home and Community Care, PATH team, pastoral services, allied health, social work/discharge planners and other community support services e.g. March of Dimes, Red Cross etc.		Choose an item.	
4.Scripted ALC rounds focus on the following conversations: **1. Who is high risk to become ALC?** **2. What are the barriers to discharge?** **3. What would it take to be able to support this client in the community?**		Choose an item.	
5. Follow up is assigned to individuals (hospital and HCC), with a timeline for the follow up to occur. The hospital uses a template to track follow up.		Choose an item.	
6. The number of people made ALC every month is tracked. Determine if they were identified as high risk or not (a very high % should have been identified as high risk). ** Although some clients condition will change unexpectedly, and couldn't have been predicted**			

6. LEADING PRACTICE Incorporating feedback from patients designated ALC, families and caregivers	OVERALL ASSESSMENT OF THIS PRACTICE		
STRATEGIES	**Organizational Process**	**Self-Assessment**	**Documents**
1. Dedicated strategies in care plan "to see the person not the patient" for anyone who has an ALC designation.		Choose an item.	
2. Strategies to ensure the person designated ALC (includes family and caregivers) are continually informed and updated on transition or discharge plans, wait lists for LTC etc. For example: regular check-ins, ensure goals of care are aligned, someone identified for patient/caregiver to direct any questions/concerns.		Choose an item.	
3. There is a documented conversation with the SDM around the risks of being in hospital including that loss of mobility and incontinence are high. Also that 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.	
4. Hospital leaders and clinicians review the Change Foundation's Care Giver Experience Toolkit and consider strategies to improve caregiver experience. This may include strategies that make caregivers feel part of the care team, caregiver orientation to the hospital, ensuring a warm handover on discharge.		Choose an item.	

7. LEADING PRACTICE 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 6 months as related to key targets/benchmarks (e.g. average # of ALC patient days)			
STRATEGIES	**Organizational Process**	**Self-Assessment**	**Documents**
1. 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.	
2. The organization conducts a case review or tracer process monthly on a randomly chosen client that was designated ALC. The review assesses compliance with policies and procedures toenable organizational learning and opportunities to limit the generationof ALC clients.		Choose an item.	
3. ALC improvement targets and the impact of patients being in the wrong bed for the level of care they require is communicated to all everyone within the hospital.		Choose an item.	

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