ALC Avoidance Leading Practices and Improvement Strategies for the Acute Care Sector

Developed by TC-CCAC in collaboration with representatives from each of the TC-LHINs acute care hospitals in 2015.

Toronto Central CCAC's ALC Avoidance Toolkit – An Overview

Health care providers across the system share the goal of providing the right care, in the right place, in a timely manner. Patients listed as ALC are in direct conflict with this goal, as they are in the wrong place to receive the type of care they need and, at the same time, it becomes more difficult for others to access their own care. Until now, no summary of leading practices in ALC avoidance existed.

The Toronto Central CCAC, working in a LHIN with 17 hospitals, had a unique opportunity to review the practices of a range of hospitals. By meeting with healthcare leaders and sharing information, it was recognized that hospitals have common clients and common issues and, from this consultation, the Toronto Central CCAC has developed this framework outlining client-centred leading practices and strategies for ALC avoidance in Ontario.

The **ALC Avoidance Framework** is a starting point for baseline self-assessment and action planning. Five variations of the framework have been created to suit acute care hospitals, post-acute care hospitals, cancer care centres, mental health facilities and home and community care. ALC patient volume can be influenced by both system capacity limitations and performance and while hospitals cannot control system capacity challenges, they can control performance in ALC avoidance and management. These tools, including the ALC Avoidance Framework and ALC Improvement Plan, will help achieve this.

How to Use this Framework

It is recommended that organizations who wish to use the Framework outlined herein, form a small team to complete the self-assessment and plan for future actions. Teams may include members of the interprofessional team, formal organizational healthcare leaders and home and community care partners.
To complete the self-assessment, identify where your organization is in regard to each practice and strategy: Met (green); Unmet (red); and Almost There (yellow).

Seeing Red

Don't panic if you see many red (unmet) areas after your self-assessment. Remember, the goal of this first step is simply to establish where your organization is right now: red areas represent opportunities for learning and continuous improvement.

Next Step: Action

Included in this package is a sample Improvement Plan that will help guide you in taking action. If there are many areas needing improvement, your team will need to triage which to work on first.
A second self-assessment should be performed one year later to assess progress and lead to a plan for further action.

Ongoing Success

ALC avoidance needs to be an organizational priority in order to consistently achieve the standards set out in this framework. Everyone needs to own the challenge of clients being in the wrong place of care, and therefore, others not having access to care. This Framework and Improvement Plan will help you meet this challenge with client-centred solutions.

Toronto Central CCAC Community Care Access Centre · CASC Centre d'accès aux soins communautaires du Centre-Toronto · Ontario Local Health Integration Network

Goals of the Framework:
To provide a tool for hospitals and Community Care Access Centres (CCACs) to review Alternate Level of Care (ALC) management practices and identify opportunities for improvement wth a focus on limiting the number of clients designated as ALC.

Methodology:
The ALC avoidance leading practices and improvement strategies outlined in this document reflect experiential learning and strategies that have proved effective in limiting the generation of ALC clients within the Toronto Central Local Health Integration Network (TC-LHIN). 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.This Framework was developed in 2015 by the Toronto Central Community Care Access Centre (TC-CCAC) in collaboration with representatives from each of the acute care hospitals in the TC-LHIN.

Selected References:

Canadian Institute for Health Information (CIHI). Rehabilitation Patient Group (RPG) Methodology and Weights, 2014
Regional Geriatric Program of Toronto, 2015.
Long-Term Care Homes Act, 2007.
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
Senior Friendly Hospitals. http://seniorfriendlyhospitals.ca/

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: Admissions are limited to clients that require inpatient acute care for more than 48 hours. All alternatives are explored to ensure anyone admitted could not be managed in a community care setting.	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
If the hospital has over 30,000 Emergency Department (ED) visits annually, the ED has considered a fixed or virtual Clinical Decision Unit.		
The ED has considered implementing a short stay unit.		
No client is admitted without being assessed first by a Geriatric Emergency Medicine (GEM) nurse, CCAC Care Coordinator, or Social Worker (SW) to determine if the client's presenting condition can be managed in the community. This includes clients being held overnight in the ED being assessed in the morning. It excludes clients that have an acute medical, surgical or psychiatric diagnosis.		
The hospital has a process to identify clients that were designated ALC within 48 hours of admission and reviews each case to identify opportunities for improvement.		
The hospital has a process to review whether patterns of ED visit volumes align with GEM nurse and SW staffing patterns.		

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: All clients/Substitute Decision Makers (SDMs) are provided with an Estimated Day of Discharge (EDD) shortly following admission.	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
There is an established process for establishing the EDD (i.e. Quality Based Procedures, Case Mix Index, etc.).		
The EDD, discharge plan and discharge expectations are communicated to the client/family within the first to 2-7 days of admission and documented on the patient chart.		
A process is in place to audit and evaluate how quickly the hospital determimes an EDD and how quickly its communicates to client/ SDM.		

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: Limiting the generation of ALC clients is a priority for the hospital. The hospital identifies clients at high risk for being designated ALC and focuses on ALC avoidance and on limiting ALC days.	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
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. The clients' barriers to discharge are agressively case managed.		
The hospital has implemented strategies outlined in the Senior Friendly Hospitals Framework to ensure optimal outcomes for seniors.		
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.		
There is a process in place for auditing the identification of clients at high risk for being designated ALC and compliance with the practices implemented to mitigate this risk.		

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: Robust admission policies and procedures are in place to support ALC avoidance and management.	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
Admission policies and procedures include: **A.** A clear time/timeframe for communicating, in writing, the expected EDD to the client or their SDM.		
B. A philosophy that embraces discharge planning conversations with the client/SDM beginning on admission. These initial discussions focus on the "Home First" philosophy and community discharge destinations.		
C. The responsibility and requirement of the client/SDM to identify LTC choices for clients requiring LTC. Including requested number of short LTC choices and the target timeline for submitting a first choice.		
D. The responsibility and requirement of the client/SDM to pay a co-payment, and to accept the first available bed, if the client needs to wait in acute care for a LTC bed.		
E. Reference to an Escalation Process that will be initiated if the client/SDM refuses to engage/collaborate on a discharge plan. This includes triggers and timelines for enacting the escalation process.		
F. An admission agreement signed by the client or SDM.		
A process is in place to audit and evaluate compliance and effectiveness of these admission policies and procedures.		

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: The hospital has a well defined, standard and aggressive escalation process to enable timely and effective management of ALC challenges.	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
As part of the Escalation Policy, the hospital has considered strategies to respond to the following scenarios: **A.** Client/SDM declines to be discharged home		
B. Client/SDM declines to participate in the discharge planning process by delaying initiation of the process or delaying the submission of LTC choices		
C. Patient/SDM declines to consent to an application for another discharge destination (e.g. transitional bed, shelter)		
E. Client/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)		
F. Client/SDM declines to accept the first bed offered from their choice facilities		
G. For clients/SDMs refusing to comply with his/her discharge date, refusing the plan of care or refusing to accept the first acceptable bed escalation to the appropriate Patient Care Manager and the Director/VP of Programs (in accordance with the Escalation Policy) occurs.		
A process is in place to audit and evaluate compliance and effectiveness of the organization's escalation processes.		

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: Early discharge planning is embraced as part of the organization's culture and philosophy of care. Discharge planning commences on admission.	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
Hospital staff and physicians have considered the use of tools and strategies used to identify and flag clients who are high risk for being designated ALC (e.g. Blaylock and/or ALICE tool).		
Hospital staff and physicians are clear on how early discharge planning is incorporated into the admission process and monitored.		

All clients identified as high risk for being designated ALC are referred, if appropriate, to CCAC before they are designated ALC.		
A process is in place to audit and evaluate compliance and effectiveness of policies and practices related to early discharge.		

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: Supports are in place that empower staff and physicians to effectively avoid and manage ALCs.	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
Hospital staff receive support on how to have difficult conversations related to ALC avoidance with clients/SDMs/families, with internal colleagues and with external partners (e.g scripting).		
To support conversations related to ALC avoidance staff have access to education and resources related to ethical decision making.		
There is support to prevent staff feeling overwhelmed or unsuccessful and/or low morale as a result of the number of clients designated ALC.		
Internal communication reinforces that the number of clients designated ALC reflects performance and accountability as a system, both as a hospital and with health system partners.		
A process is in place to evaluate the availability and effectiveness of supports for staff and physicians.		

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: A process is in place to proactively and regularly case manage clients at high-risk for being designated ALC. Multiple internal and external stakeholders are engaged in limiting the generation of ALC clients.	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
The organization engages in ALC Rounds at least weekly.		
ALC Rounds are chaired and/or attended at a Director/VP level.		
In addition to Clients who are already desgnated ALC, all 'High Risk for ALC' clients are identified and discussed at ALC rounds.		
There is a process for identifying whether those who were designated ALC were proactively identified as being high risk.		
ALC Rounds include the involvement of, and preparation for, the participation of internal stakeholders (i.e., VPs, Directors, managers).		
Social Work attends ALC rounds and comes prepared to participate in a discussion on the barriers to discharge for clients, and of potential discharge delays/issues. Key external agencies are invited to participate in ALC Rounds, as required and/or value-added (i.e., LHIN, CCAC or CSS representatives).		
Key external agencies are invited to participate in ALC Rounds, as required and/or value-added (i.e., LHIN, CCAC or CSS representatives).		
A process is in place to audit and evaluate compliance and effectiveness of the practices for proactively managing ALC.		

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: The roles/responsibilities and expectations of an SDM are clearly explained in writing on admission.	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
A written admission agreement is provided within the first 48 hours of admission and outlines: **A.** The roles and responsibilities of the client		
B. The roles and responsibilities of a SDM		

C. Information on acting in alignment with the client's best interests.		
D. 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. (ACE)		
A SDM is confirmed within 48 hours of admission for all clients. This includes obtaining and documenting accurate contact details.		
A process is in place to audit and evaluate compliance and effectiveness of the communication of client and SDM roles and responsibilities.		

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: Physicians are engaged in all ALC avoidance and management practices.	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
There is visible and demonstrated commitment of physician engagement in ALC avoidance processes and home first philosophy.		
There is clarity among physicians on when to apply - and when not to apply - the ALC designation.		
A process is in place to audit and evaluate compliance and effectiveness of physician engagement. This includes auditing whether clients are designated ALC at the appropriate time.		

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: 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 ALC clients and has a good understanding of the barriers to transition ALC clients out of the facility.	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
Mechanisms are in place to ensure the senior team is aware of clients who have been designated ALC and/or clients deemed at high risk for being designated ALC.		

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 client discharge issues.		
A process is in place to audit and evaluate compliance and effectiveness of senior team visibility.		

LEADING PRACTICES AND IMPROVEMENT STRATEGIES	
LEADING PRACTICE: ALC avoidance and management is viewed as an integral part of the organization's 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).	**OVERALL ASSESSMENT OF THIS PRACTICE**

STRATEGIES	Organizational Process	Self Assessment
There is evidence of ALC avoidance being embraced as a corporate priority (e.g. reflected in the hospital's Quality Improvement Plan).		
Practices in place to ensure that the organization conducts a Case Review at least quarterly on a randomly chosen client that was designated ALC . The review assesses compliance with policies and procedures to enable organizational learning and opportunities to limit the generation fo ALC clients.		
ALC improvement targets and the impact of ALC is identified and communicated to all teams within the hospital. ALC info to go up and down to point of care staff.		
Frontline staff and physicians, on all teams, have the information needed to be accountable for meeting improvement targets.		
ALC improvement targets monitored at regular intervals by all levels of the organization including the the Senior Team. ALC info to go up and down to point of care staff.		
Feedback from clients is obtained regarding their experience with admission, discharge planning and discharge. This feedback informs continuous quality improvement efforts.		
A process is in place to audit and evaluate compliance with these practices and the effectiveness of CQI related to ALC.		