Alternate Level of Care

ALC Success Story (Discharge Rounds)



A significant collaboration that threads the needle from the hospital to the community organization has led to the creation of the **Alternate Level of Care Action Team (ALC)**. This team is creating pathways for patients discharge from the hospital and designated to have Alternate Level of Care status because while they have completed the acute portion of their hospitalization, they are waiting for another level of service, whether that is in rehab, LTC, retirement home, home with supports, or other supports.



Complex Discharge Rounds at Quinte Health is a specific initiative supported by the HPE OHT ALC Action Team. The wall between the hospital and Community Support Service (CSS) agencies has crumbled to bring CSS into the fold of discharging patients with complex circumstances. The ALC Action Team cultivate relationships between these partners to collaboratively plan how to discharge complex patients and ensure identified community services can facilitate safe and supported transitions home.

Prior to a patient being discharged, the community support they require are in place, providing a seamless transition home that benefits the person and the health system. Relationships between these partners have strengthened and the trust from all those involved has created a pathway that helps clients return home safely and remain supported in the community.

Identifying an appropriate community solution does not always mean the service is immediately available. Limited funding, staffing and volunteer capacity, service eligibility requirements, and waitlists can affect the ability to put supports in place as quickly as the hospital and client might need them.

FOR MORE INFORMATION

Partners involved in ALC Action Team :

Community Care for North Hastings, Community Care for Center Hastings, Community Care for South Hastings, Prince Edward Community Care for Seniors, Community Paramedics, Quinte Health (ER, Medicine, Palliative, Mental Health, Patient Flow), Ontario Health at Home, Alzheimer's Society, CMHA-HPE, Got Care, Providence Care, VON, Heart of Hastings Hospice, Hospice Quinte, Hospice North Hastings, Hospice Prince Edward, Cheshire Supports to Independent Living, Stirling Manor, Hastings Manor, PCPC member

- Better identification of community support available to patients
  - CSS participation in Complex Rounds gives hospital staff insight of community-based services available. More consistent involved of CSS agencies can improve discharge planning, bolster reliable referral pathways, and promote early identification of clients who benefit from community supports.
- Building deeply-rooted relationships between hospital and community partners
  - A connection that improves communication across the system and develops more coordinated solutions for complex clients.
- Building a more connected system
  - Clients will transition safely from hospital and home with the right partners at the same table, working and planning together. By connecting the healthcare providers at the start, we are connecting the patients with the services to support ALC
- Bringing the patients, clients, and partners into the conversation early
  - Not only do those working in the healthcare system need to be in the conversation, but it is essential to have the voices of the community partners in early discharge planning. Initial involvement gives everyone more time to identify barriers explore available supports and develop a coordinated plan.

Integration doesn't not always require creating something new. Threading the needle to existing organizations and services, augmenting communication, and having the right voices supporting a client's care is all that is needed to contribute to a supported pathways in our healthcare system.

Hastings Prince Edward
Ontario Health Team