CDA-AMC Health Technology Review Guidance

Alternate Level of Care in Canada

DRAFT

This report describes the guidance development process, The Health Technology Expert Review Panel's (HTERP) position on alternate level of care (ALC), and their guidance for decision-makers when considering evidence-informed strategies and initiatives to reduce the time patients spend with an ALC designation. The guidance was informed by Canada's Drug Agency Evidence Assessment report *Alternate level of care in Canada*, published separately.

The Issue: There is a need for support for patients with unmet needs to avoid or reduce the amount of time they spend in ALC within acute care settings across jurisdictions in Canada

- Alternate level of care (ALC) is a designation used and applied by clinical staff in Canada, defined by the Canadian Institute of Health Information (CIHI) as "*when the patient is occupying a bed in a facility but they no longer require the intensity of resources or services provided in that care setting*".[1] ALC can occur in acute care, mental health, rehabilitation, and chronic, intermediate, or complex continuing care settings. HTERP has adopted CIHI's definition of ALC. The guidance described in this report is limited to acute care inpatient populations.
- As outlined in the Canada's Drug Agency Evidence Assessment report, the proportion of hospitalizations with reported ALC days is continuously increasing in Canada, which significantly contributes to health system flow issues, including overcapacity, impacting emergency department and hospital overcrowding as well as wait times. Increasing ALC days also affect patients – both those in ALC beds and those awaiting acute care services – because these spaces in acute care remain unavailable to new patients and a greater proportion of patients are not in a facility and/or bed that is best suited to their needs. As a result, patients with an ALC designation are at a higher risk of adverse events such as hospital-acquired infections, mental and physical deterioration, and mortality.
- Patients of any age or health condition may remain in hospital after their acute care needs have been met; however, the most common group of patients with an ALC designation are older adults (aged 65 years and older[2]). Other sociodemographic factors associated with an ALC designation identified in the Evidence Assessment report include having low income or being unemployed, living alone, being unmarried, experiencing social isolation, having a care partner with stress or burnout, not having completed a high school degree, and being exposed to neglect or abuse.
- Inaccurate assessment of a patient's post-acute care and support needs, premature or delayed discharge planning, and decision-making processes that do not adequately involve patients and their care partners can lead to prolonged ALC stays or prevent successful, long-lasting discharges. Patients are often unaware of an ALC designation and its implications for their care (such as reduced frequency of contact with clinicians or intensity of care provided). A lack of transparency in the ALC designation process can result in confusion, frustration, and increased unmet needs for daily activities such as ambulation, dressing, and bathing. This, in turn, places greater reliance on informal care partners, creating emotional, financial, and time-related burdens.
- The variations in how ALC is designated and categorized across jurisdictions and healthcare settings, along with factors like patient demographics, availability of community resources, and degree of integration of care networks create challenges in accurately measuring and effectively addressing the issue. In addition, jurisdictional heterogeneity in the ALC definitions and application may confound comparisons across said jurisdictions.
- The designation of ALC may be influenced by factors beyond the assessment of a patient's clinical status. Organizations are incentivized by various pay for performance frameworks, accreditation standards, or workload constraints that influence when ALC designations are made, and as such staff may feel pressured to assign ALC designations earlier or later in a patient's stay to meet targets or to facilitate earlier discharge even though this may not be in the patient's best interests.

[1] Canadian Institute for Health Information. Definitions and guidelines to support ALC designation in acute inpatient care. Ottawa (ON): CIHI; 2016: https://www.cihi.ca/sites/default/files/document/acuteinpatientalc-definitionsandguidelines_en.pdf. Accessed 2024 May 15

[2] The literature and analyses of real-world data typically defines "older adults" as people aged 65 years and older. HTERP recognizes other definitions of older adults could include people aged 55 and older in recognition of the diversity of older adults, experiences of aging, and eligibility criteria for various programs and services in Canada.

- Capacity in both acute and community care has not evolved alongside changing population needs and shifting care preferences, contributing to increased ALC designations. For example, while the number of acute inpatient hospitalizations has increased over recent years, the total hospital beds per 1000 population and total long-term care beds per 1000 population have decreased.
- ALC bed days in acute care settings are often more costly and resource-intensive than appropriate care and support provided in non-acute settings. While it's not yet clear whether reducing ALC pressures would lower overall health system costs—since freed-up acute capacity would be used for other patients—evidence suggests that efforts to reduce ALC bed days may lead to improved outcomes both for ALC-designated patients as well as for other patients awaiting acute care.

The Response: Guidance From HTERP

The mandate of HTERP is advisory in nature and is to participate in the development of guidance or recommendations for Canada's Drug Agency projects on medical devices, diagnostic tests, and clinical interventions inclusive of models of care, programs of care, and health systems. To address the pan-Canadian challenges associated with ALC, HTERP convened to develop objective, impartial, and pan-Canadian guidance for health care decision-makers when considering evidence-informed strategies and initiatives to reduce the time patients spend with an ALC designation in jurisdictions across Canada. The guidance provided by HTERP is aimed at senior decision-makers responsible for developing and implementing federal, provincial, and territorial policies in Canada, as well as those leading health systems and decision-making teams tasked with advancing health system priorities. The intended audience includes federal, provincial, and territorial deputy ministers and assistant deputy ministers of health, other senior executives, and executives at provincial and territorial health authorities, cancer agencies, and other provincial health agencies, as well as hospitals and health service delivery organizations. The guidance may also be of relevance for senior decision-makers in departments of social services and development, and older adults and long-term care. This work also builds on previous health systems work undertaken by Canada's Drug Agency, including emergency department overcrowding and aging in place. It is recognized that these are interconnected contexts with similar underlying challenges.

HTERP's Guidance Development Process

HTERP comprises 7 core members who serve for all topics under consideration during their term of office: chair, ethicist, health economist, patient member, 2 health care practitioners, and a health technology assessment specialist. In addition to these core members, HTERP also includes up to 5 expert members appointed to provide their expertise on a specific topic. To develop guidance to support ALC in Canada, HTERP appointed 3 members with clinical and health care administration experience, and 1 member who was able to speak to the perspectives of patients and their care partners. The HTERP members are listed in Appendix 1.

To support HTERP deliberation and guidance development, Canada's Drug Agency prepared an Evidence Assessment report that assessed:

- ALC definitions in Canada and how they are applied across jurisdictions
- Reasons for ALC designation, including the reasons people with unmet needs receive ALC designation and remain in ALC in acute inpatient care settings, and the relevant, related ethical considerations
- Effectiveness and harms of published interventions to alleviate the ALC burden
- Other interventions implemented in Canada and internationally that exist to help alleviate the ALC burden
- Economic and resource considerations associated with ALC interventions, to health systems and patients
- Implementation considerations to identify facilitators of, and barriers to, implementation of ALC interventions

HTERP used the Alternate Level of Care Evidence Assessment report to inform their deliberations and to develop this guidance. HTERP members reviewed and discussed the evidence and information, considered public and expert input, and developed the guidance through a series of meetings between October and March 2025. A draft version of this guidance will be available for broad public feedback from April 24 to May 7, 2025. The feedback will be reflected in the final version.

HTERP's Position on Alternate Level of Care

- **ALC is about the appropriateness of the intensity of care for best meeting an individual's needs**. Patients should receive care in the most appropriate setting, provided by the right healthcare professional, at the right time, to meet their medical, social, and personal needs and values. There should be a focus on ensuring that the intensity of care aligns with an individual's needs. Ensuring the right level of care is essential for patient well-being and system efficiency. Patients who no longer require acute care should transition smoothly to environments best suited to their needs, whether that is rehabilitation, home care, or long-term care. Maintaining patients in inappropriate care settings can lead to increasingly negative health outcomes for those patients and create barriers for others who require acute care but cannot access it, contributing to inefficiencies within the healthcare system. Increases in ALC designations is not a problem caused by patients or the skills of acute care staff.
- **An ALC designation should not be a label applied to the patient themselves**; rather, it is an indication of the misalignment of services and patient needs.
- **Patients' needs and patient-centered care should guide all ALC designations, resourcing, and care decisions**, including the decision to apply an ALC designation, transparency in communicating the consequences of an ALC designation to patients and families (e.g., while they may remain in an acute care bed, they should expect a difference in their level of care that reflects their needs rather than their location), and the identification of interventions intended to reduce the risks and harmful outcomes associated with the ALC designation.
- **The likelihood of being designated ALC and the associated impacts of that designation may disproportionately affect individuals with unmet needs and members of equity-deserving groups** who experience multiple, and often intersecting barriers to care and support. These barriers may be historical, social, cultural, medical, structural, institutional, or environmental. Although older adults are one of the most common patient groups designated as ALC, individuals of all ages and health conditions with unmet needs can experience the impacts associated with ALC.
- **The increasing rate of ALC designations cannot be solved by a single intervention or sector alone; it requires a coordinated, system-wide effort.** Accountability for causes, impacts and solutions extends beyond the acute care setting. ALC is a complex health system issue that highlights broader challenges and emphasizes the need for coordinated solutions across multiple sectors.
- **Inefficiencies of processes and practices in non-acute care settings and fragmented coordination of care within and between care settings are main contributors to the receipt of an ALC designation and remaining in an ALC bed**. HTERP acknowledges the issue of social admissions contributing to ALC stays and the resulting tension in balancing the needs and risks to a patient who requires an acute care bed and a patient in the bed with no other place to go.
- **There is often an assumption that reducing ALC stays will reduce overall costs to the health care system, despite a lack of strong evidence to that effect.** Future work regarding cost savings to the health care system is necessary. However, while alleviating ALC rates and lengths of stay in hospitals may not result in short- or medium-term cost savings, it may improve overall patient health outcomes. Aligning services to patients' needs could improve outcomes both for patients who would otherwise be designated as ALC, as well as those in need of an acute hospital bed.
- **Evidence of effective interventions to reduce ALC rates, length of stay, and readmissions in Canada and internationally is limited and of low certainty** due to the challenges of randomized or controlled intervention studies to study complex interventions. There are many interventions without rigorous evidence that may hold unmeasured promise. HTERP also acknowledges the paucity of evidence and gaps in knowledge related to the impact ALC has on equity-deserving groups.

HTERP's Guidance to Inform Decision-Making to Support ALC

HTERP has developed the following guidance statements in response to the need to support patients with unmet needs to avoid or reduce the amount of time in ALC in acute care settings across jurisdictions in Canada.

- **Identify and implement solutions that**:
  - Are patient-centred in that they ensure the care setting provides the appropriate intensity of services to meet patients' needs and preferences
  - Align with the context in which ALC is occurring—whether at a provincial, zonal, or institutional level. This includes, but is not limited to, consideration of the demographics and clinical profiles of patients with an ALC designation, the primary drivers or reasons for ALC designation, and the availability, accessibility, and responsiveness of both acute and community-based care supports.
- **HTERP recommends that potential interventions be identified and evaluated with the support of**:
  - Canada's Drug Agency Evidence Assessment report
  - A repository of identified ALC strategies and interventions in Canada
  - An interactive dashboard that includes figures that describe ALC data for different provinces and territories in Canada, over time, and can be used to support decision-making. The dashboard is useful for understanding opportunities, aligning with existing initiatives, and networking with other facilities and jurisdictions to support the development and evaluation of interventions aimed at reducing ALC stays.

  HTERP recognizes that numerous interventions have been, and are being, implemented to reduce the amount of time individuals spend in ALC within acute care settings. Not all interventions were captured in the Canada's Drug Agency Evidence Assessment report, and some may not be found in the published literature. Despite low-certainty evidence for the effects of several of these interventions, some interventions identified in the Evidence Assessment report may show promise and are described in Appendix 3.
- **Develop and implement upstream, midstream, downstream, and system-level solutions that address the inequities disproportionately affecting members of equity-deserving groups.** This requires thorough and thoughtful engagement to ensure needs, lived experiences, cultures, and preferences are respected. HTERP recommends identifying and attending to those who might benefit from, be harmed by, excluded by, or experience discrimination or bias from the implementation of an intervention. Targeted approaches may be needed for specific equity-deserving groups.
- **Ensure ALC and early discharge policies include standardized pathways that identify patient goals and milestones to prioritize patient-centered care**, addressing both medical and social determinants of health by requiring individualized care and transition plans that consider housing, social supports, care partner availability, and mental health needs.
- **Ensure discharge planning is centered around patient dignity and respect for autonomy**, supporting patients to make informed choices about their care transitions. Patients have the right to autonomy and self-determination, consistent with the rights of non-patients, including when their decisions may involve some level of risk to themselves. Patients and their care partners (when appropriate) must be included in conversations early about discharge planning, particularly if likely to recommend a change to patient's living arrangements post-discharge.
- **Operationalize discharge planning at admission** to prevent, or reduce the time spent in, ALC status. A structured discharge planning process with appropriate and coordinated assessment tools should be established and should include consultation with patients and care partners with step-by-step considerations to ensure patients' needs are met.
- **Improve information and access to resources in the community and primary care settings to help educate and inform patients and their care partners about their options**.
- **Conduct proactive and needs-based planning at the patient and service level** to ensure timely decision-making that considers differing contextual factors. This approach should take into account various contextual factors, including the individual patient's circumstances, care setting, and specific needs. When determining an ALC designation, it is crucial to assess whether a patient's stay is appropriate, identify a more appropriate care setting, and determine the best provider to address their care needs. At the service level, the collection and analysis of patient and contextual information can help project future medical and social needs of populations.
- **Develop interventions and processes that engage patients and families early in their health journeys**—particularly within primary care—to support proactive health planning and help avoid unnecessary or prolonged acute care admissions due to limited access to appropriate alternatives.

- **Utilize technology and digital health solutions to facilitate care transitions and remote patient follow up and monitoring**, including virtual consultations, remote assessments, and telehealth interventions that may help reduce unnecessary hospital stays and time spent with an ALC designation. HTERP provides some examples of such interventions in Appendices 2 and 3. These include programs consisting of remote monitoring of vital signs, personalized alerts and timely responses to health changes, the availability of video, home and clinical-based assessments and advice, and digital software tools to help enhance discharge planning by matching patient's information to select residential aged care facilities.
- **Standardize ALC designations and the application of reason codes** to facilitate accurate tracking, equitable resource allocation, and appropriate care transitions. A clear, unified approach across healthcare settings should improve data reliability and enhance system-wide decision-making. Consider applying CIHI's guidelines to support ALC designation, which provides clinicians with prompting questions to consider for ALC designation. The Canada's Drug Agency Evidence Assessment Report provides a list of ALC definitions in Canada and how they are applied across jurisdictions.
- **Reduce health care budget silos as required** to alleviate the ALC burden. Savings observed for one budget holder as a result of decreasing time spent with an ALC designation may result in higher costs to another budget holder who provided resources or supported a transition to more appropriate care. In other words, efforts should be made to reduce budget silos.
- **Evaluate the process, outcomes, and cost effectiveness of implementing interventions to reduce ALC rates to ensure interventions are being adopted and having their intended effect**. Assess potential need for any adjustments in the approach and gather information that can be shared with others for learning. HTERP recommends supporting evaluation plans that are dynamic to ensure adoption of different strategies as the context changes. HTERP recommends planning for evaluation before interventions are implemented, evaluating outcomes of importance both to patients and decision-makers, and disseminating the results of evaluations through presentations and publications to build the Canadian evidence base.

Appendix 1: The Health Technology Review Panel

The mandate of HTERP is advisory in nature and is to participate in the development of guidance or recommendations for Canada's Drug Agency projects on medical devices, diagnostic tests, and clinical interventions (inclusive of models and programs of care)

HTERP comprises 7 core members who serve for all topics under consideration during their term of office: chair, ethicist, health economist, patient member, 2 health care practitioners, and a health technology assessment specialist. In addition to these core members, HTERP also includes up to 5 expert members appointed to provide their expertise on a specific topic. To develop guidance to support ALC in Canada, HTERP appointed 3 members with clinical and health care administration experience, and 1 member who was able to speak to the perspectives of patients and their care partners.

HTERP Core Members

Brian Chan – Health Economist, Ontario

Duncan Steele – Ethicist, Alberta

Lawrence Mbuagbaw – Health Technology Assessment Specialist, Ontario

Leslie Anne Campbell – Chair, Nova Scotia

Prachi Khanna– Patient member, British Columbia

Sandor Demeter – Health Care Practitioner, Manitoba

Tasleem Nimjee– Health Care Practitioner, Ontario

Expert Members

Adam Topp, President and CEO for the Chatham-Kent Health Alliance , Ontario

Deanna Clarke, Regional Director of Operational Flow, NL Health Services – Western Zone, Newfoundland

Doug Campbell, Executive Director, Provincial System Flow, Saskatchewan Health Authority, Saskatchewan

Jan Seely, President of the New Brunswick Special Care Home Association, New Brunswick

Conflict of Interest

None identified and reported.

Appendix 2: Promising ALC Interventions

Based on the identified evidence, information, and expert input, HTERP asserts that the following non-exhaustive list of interventions and strategies may show promise in alleviating the ALC burden in jurisdictions across Canada. These strategies would need to align with the main unmet need that resulted, or will result, in an ALC designation and in acute inpatient care settings.

Due to the complex nature of ALC, implementing interventions is context-dependent and typically requires coordination and cooperation across various levels of the health system (e.g., hospital, region, ministry) and potentially external and closely related systems (e.g., housing). It is possible that some interventions will lead to improved outcomes in some contexts, and not others.

The list of interventions and strategies includes those that have been assessed through Canada's Drug Agency Evidence Assessment Report as having a potentially favorable outcome effect (i.e., improvement in ALC rates, reduction in length of stay or delayed discharge) and otherwise identified by HTERP as showing promise, based on expert opinion and experience.

- Interventions are categorized by the outcomes they target. They are sub-categorized by: **Upstream**: interventions that aim to avoid ALC admissions (note: none were identified)
- **Midstream**: interventions that aim to improve ALC patient flow and efficiency and reduce the length of ALC stays
- **Downstream**: interventions that focus on facilitating effective, timely, and durable ALC discharges
- **System-level**: interventions that combine upstream, midstream, and/or downstream strategies.

Table 1: Interventions that may reduce ALC Rates

Intervention or strategy	Description
Midstream	
Assess and restore programs	
Humber River Health's Elderly Assess and Restore Team program [a]	An assess and restore program that offers both inpatient and outpatient short-term restorative care to hospitalized older adults with physiological and functional decline by a team of physiotherapists, occupational therapists, rehabilitation assistants, and registered practical nurses. Enrolled participants are assessed within 24 hours of hospital admission, given tailored therapy plans, and provided daily rehabilitative care. Upon discharge from the hospital, participants are connected to appropriate resources and contacted at home to ensure they have accessed these resources.
Downstream	
Transitional care	
Step-down intermediate care[a]	Short-term care environment in a care home for a maximum of 4 weeks for older people who would otherwise spend unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential care. The 72-hour discharge target (after being deemed fit for discharge) was a separate intervention implemented several months after the implementation of step-down intermediate care.
System-level	
Home-first strategy	

Home First	Philosophical and cultural shift within acute care to change the focus through partnerships to ensure seniors can age outside of acute care, to minimize the number of post-acute care transitioning to LTC from hospitals, and to develop a comprehensive integrated plan for appropriate inter-organizational care and placement.

[a] Includes comparative evidence described in the Canada Drug Agency evidence report

Table 2: Interventions that may reduce ALC Length of Stay

Intervention or strategy	Description
Midstream	
Enhance discharge planning	
Digital Matching Software Tool	Implementation of a digital software tool (DailyCare) that, in real-time, matches patient's information to select a residential aged care facility: geographical proximity, availability of specific services, vacancy and capability for clinical and personal requirements.
Multidisciplinary discharge coordination team	Team made up of hospitalists, case managers, social workers, hospital finance representatives, and patient representatives, that meets weekly to proactively address medical delays, disposition issues, discharge delays, and patient and family concerns.
Downstream	
Transitional Care	
Subacute Care for the Frail Elderly Unit [a]	Patients are transferred to a 20-bed transitional care program located within a large nursing home with a strong emphasis on a restorative, collaborative, and integrated approach. Early discharge planning and cognitive screening were conducted upon arrival to further enhance patients' transition back to the community by addressing cognitive impairments.
System-level - Overarching systemic factors	
Integrated Care	
Full vertical integration of health and social care organizations*	Creation of integration authorities to consolidate the planning, funding, and governance of adult social care, primary care, community health, and unscheduled hospital care across the country.
Urgent and Emergency Care Vanguards [a]	Local health and social care partnerships to improve integration of services with 5 different approaches: acute care collaboration, urgent and emergency care, enhanced health in care homes, multispecialty community providers, integrated primary and acute care systems.

[a] Includes comparative evidence described in the Canada Drug Agency Evidence report

Table 3: Interventions that may reduce Delayed Discharge

Intervention or strategy	Description
Midstream	
Increased intermediate beds	
More Step-Down Beds	Availability of additional step-down beds
Enhance discharge planning	
Nurse Led Discharge	Formal protocol for nurse led discharge based on specific criteria and pathway document to record the process within the patient notes and guide nursing staff.
Specialized acute care resources	
Diabetes Outreach Service	The service aimed to prevent admissions by developing rapid and open access services; to effectively manage diabetes of those admitted by addressing glycemic control, complication screening and risk factor management; to manage their other medical problems or support other teams providing specialist care; to reduce delayed discharge by early formulation of an effective discharge plan and to organize appropriate follow-up to ensure continuity of diabetes care.

Appendix 3: ALC Strategies, Programs and Policies in Canada

The following list of strategies, programs, and policies that address ALC across Canada were identified in the Canada's Drug Agency Evidence Assessment Report (Table 4). They were compiled from web-based searches, a review of the literature to identify interventions in Canada and internationally, and a survey that was conducted to identify existing strategies to alleviate the ALC burden that may not be available in the literature. Some of the interventions included in this section may not yet be evaluated as they have been implemented relatively recently, or they may have been evaluated and the associated data is not yet published.

Table 4: Descriptions of Interventions to Alleviate ALC in Canada Identified in the Canada's Drug Agency Scan

Intervention Name	Jurisdiction	Description
Upstream		
Complex Care Hub	Alberta	A program that provides hospital-at-home services to older adults, bridging acute care and the community.
Virtual LTC @ Home	Ontario	A proposed program that would provide LTC services at home via the creation of highly coordinated and integrated care teams.
Seniors' Housing Complex	Ontario	A multi-story building with residential units and onsite staff that will provide long term care services and general healthcare services to older adults.
Supporting OHTs to Influence ALC	Ontario	Information to assist OHTs pursue services in community settings, including early identification and assessment, care plan development and ongoing reassessment, deliver of interventions/senior friendly care, and proactive transitions.
Community Paramedicine for LTC	Ontario	A pilot program that increases the numbers of paramedics and expands the scope of their role, offering 24/7 access to health services and ongoing monitoring of the highest risk individuals.
Registered Nurse Navigator[a]	Saskatchewan	Pilot project to implement a Registered Nurse "navigator" in the emergency department. The purpose of this role is to create a discharge plan from the emergency department and avoid admitting consultant patients.
Midstream		
Harbour Light Integrated Transitional Care Program	Ontario	Transitional care program in a community setting intended to support acute hospital patients designated for LTC placement return to the community.
Pine Villa Reintegration Unit	Ontario	A site where patients designated as ALC can be transferred that provide specialized supportive care, therapeutic recreation, case management, and assistance with personal care.
Acute Care Dementia Strategy	All provinces	A resource that proposes elements for an in-hospital comprehensive acute care dementia strategy.
Personal Support Homes	Ontario	A resource that proposes a policy concept that allows people to leverage their empty bedrooms to temporarily house patients awaiting hospital discharge by renumerating homeowners.
ALC and Delayed Discharge: Lessons Learned from Abroad	Ontario	A resource that provides promising practices to address ALC, noting that they should be multicomponent, tailored to the local context, and employ high-level policy implementation.
Reactivation centres	Ontario	A collaborative and innovative approach that specializes in activation therapies. The intent of this approach is to deliver patient care in the most appropriate setting where patient privacy, dignity and safety are a top priority.
Reducing ALC Panel[a]	Manitoba	The implementation of a standard LTC paneling process, consultation, tracking, and ALC flagging. This intervention is currently in process.
Patient Flow Initiative[a]	New Brunswick	A review of patient lists to ensure each person is coded correctly. This is to allow for both proper reporting and finding alternatives to hospitalization.
Patient Flow Committee[a]	Northwest Territories	A monthly meeting to discuss the status of individuals who have been designated as ALC, including whether an LTC application has been completed, and subsequent steps.
Downstream		

Intervention Name	Jurisdiction	Description
DischargeHUB	Newfoundland and Labrador	Pilot project to develop and pilot a software and process solution which aims to streamline and coordinate the discharge of ALC patients.
Addressing Delayed Hospital Discharges for Patients with Intellectual and Developmental Disabilities and a Mental Illness	Ontario	Practice guidance consisting of 10 core components, intended to help facilitate the timely transition out of hospital for patients with intellectual and developmental disabilities and a mental illness.
Co-Designing an Integrated Transitional Care Model to Address Alternate Level of Care and Promote Aging in Place	Ontario	Researchers proposed a qualitative study that allows individuals from various groups to help co-design appropriate care pathways for older ALC patients to be discharged from hospital to home.
STEPS Program at Diamond House Personal Care Home[a]	Saskatchewan	In partnership with Saskatchewan Health Authority, Golden Healthcare Management Inc. is piloting the STEPS program within Diamond House in Warman, Saskatchewan. It offers 30 alternate-level-of-care (ALC) beds designed to support patients as they transition from acute care environments to more suitable, long-term living arrangements. STEPS provides a supportive, lower-intensity care setting that allows patients to recover, regain abilities, and plan their next steps. The program aims to improve transition outcomes, foster independence, enhance care partner engagement, and support cultural sensitivity.
System Level		
Implementing Alternative Levels of Care Leading Practices	Ontario	A report summarizing activities and discussions from 2024 workshop on roles in the system; inner and outer setting factors affecting change, and 7 recommendations to support the implementation of ALC leading practices.
Scenarios for Seniors' Care: Future Challenges, Current Gaps and Strategies to Address Them	All provinces	Proposed opportunities to reduce ALC patient days in the hospital setting, community and support services, seniors' care spaces, home care, primary care access; proposed policy changes, and key recommendations for provinces.
Confronting the ALC Crisis with a Multifaceted Policy Lens	Aberta; Ontario; Saskatchewan	Proposed upstream interventions, midstream interventions, and downstream interventions for alleviating ALC.
Essential Role of Caregivers in Improving Transitions and Addressing ALC	Ontario	Practical guide that provides information, tools, and resources for OHTs to help address ALC though integrating care partners and implementing care partner-focused strategies.
The Alternate Level of Care Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults	Ontario	Practice guide 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 setting.
Implementation Example of Ontario Health's ALC Leading Practice Guide[a]	Ontario	Adopting a home-first philosophy for discharge planning, which is focused on early intervention and an integrated Ontario Health at Home discharge planning model. There are also length of stay reduction strategies in hospital (i.e. MOVE, Senior-Friendly Care).
ALC Partnership Table[a]	British Columbia	NR
General ALC Strategy (NB)[a]	New Brunswick	A multicomponent strategy that includes discharge planners having access to patient charts as soon as admission is requested; early mobilization of patients who are identified as frail; and increasing available transition beds.

Intervention Name	Jurisdiction	Description
Patient Flow Rounds[a]	Newfoundland and Labrador	Conducting weekly patient flow rounds to review all patients designated as ALC as well as other patients who are at risk of becoming complex cases.
Collaborative Effort to Reduce ALC in Acute Care[a]	Northwest Territories	The Department of Health and Social Services in the Northwest Territories has increased LTC beds and hired more discharge planners to help move patients designated as LTC.
General ALC Strategy (SK)[a]	Saskatchewan	A strategy is to bring visibility to the individuals who are designated as ALC and the reason for their designation. This is followed by steps to move these individuals to a location that best suits their unique needs (e.g., home, transitional care, LTC, etc.).

ALC = alternate level of care; LTC = long-term care ; MOVE = mobilization of vulnerable elders; NB = New Brunswick; NR = not reported; OHT = Ontario Health Team; SK = Saskatchewan; STEPS = Short Term Enablement and Planning Suites.

[a]This intervention was reported in the survey, part of the Canada's Drug Agency Evidence Report.