ACCOUNTABILITY AND COMMUNITY-BASED SOLUTIONS FOR ALTERNATE LEVEL OF CARE

June 2025

Improving Healthcare Together

Health Quality Alberta

Health Quality Alberta is a provincial agency that has a legislated mandate to promote and improve patient safety, person-centred care, and health service quality for Albertans. We engage with Albertans to gather information about their experiences and collaborate with government and our healthcare partners to identify and drive actionable improvements. Our responsibilities are set forth in the *Health Quality Council of Alberta Act.*

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INTRODUCTION

Hospital overcapacity is a persistent issue in Alberta. In 2025, alternate level of care (ALC) patients, on average, occupy 14.5 per cent of bed days in hospitals, above the 13.5 per cent provincial target. More than 6,300 patients a year spend between eight and 24 days in hospital unnecessarily rather than in environments more appropriate for their required level of care. In some very complex cases, ALC patients stay 300 days or longer in the hospital.

These vulnerable patients wait in hospital beds that were never intended to be their final destination. And many, including older adults, people with complex chronic conditions, and individuals managing cognitive decline, will leave with higher care needs than when they arrived.

These are the Albertans who no longer need acute care but cannot be safely discharged because the services and support they require in the community or in continuing care facilities across the province simply aren't available.

On October 10, 2024, the Minister of Health requested the organization to conduct an objective, in-depth review of ALC pressures and challenges across healthcare sectors.

In this report, Health Quality Alberta worked with government representatives and other healthcare system partners to take an evidence-informed look at the current state of ALC and identify opportunities to optimize patient flow and access to community-based solutions across the province.

The Health Quality Alberta review team conducted 51 interviews between February 25 and May 20, 2025, with relevant health partners and key individuals involved in and responsible for ALC transitions. In addition, the team reviewed policies and data to identify systemic issues, analyzed previously commissioned studies on ALC in Alberta, and completed a jurisdictional review to learn about promising programs, practices, and initiatives underway outside of Alberta.

Limitations

Further study is needed to appreciate Indigenous perspectives and experiences related to ALC. Engagement with Indigenous health directors and leaders is underway.

The perspectives of under-represented populations are missing from this report. Further study may also be required for other specific populations represented in ALC data. For example, the perspectives of populations with distinct needs that are not well served by current services and living options are not captured in this report. While some individual sites have developed culturally or age-appropriate programs in response to local needs, there has been limited system-level planning in this area.

There was limited engagement with primary care providers as part of the review. The recommended role of primary care providers in addressing ALC pressures (e.g., identifying patients at risk of becoming ALC, requesting community-based services and programs, etc.) remains to be validated.

Examples of programs, services, and interventions within Alberta were identified by individuals who are knowledgeable about efforts to address ALC in Alberta however, the review team was unable to fully explore all activities or programs implemented in response to ALC pressures.

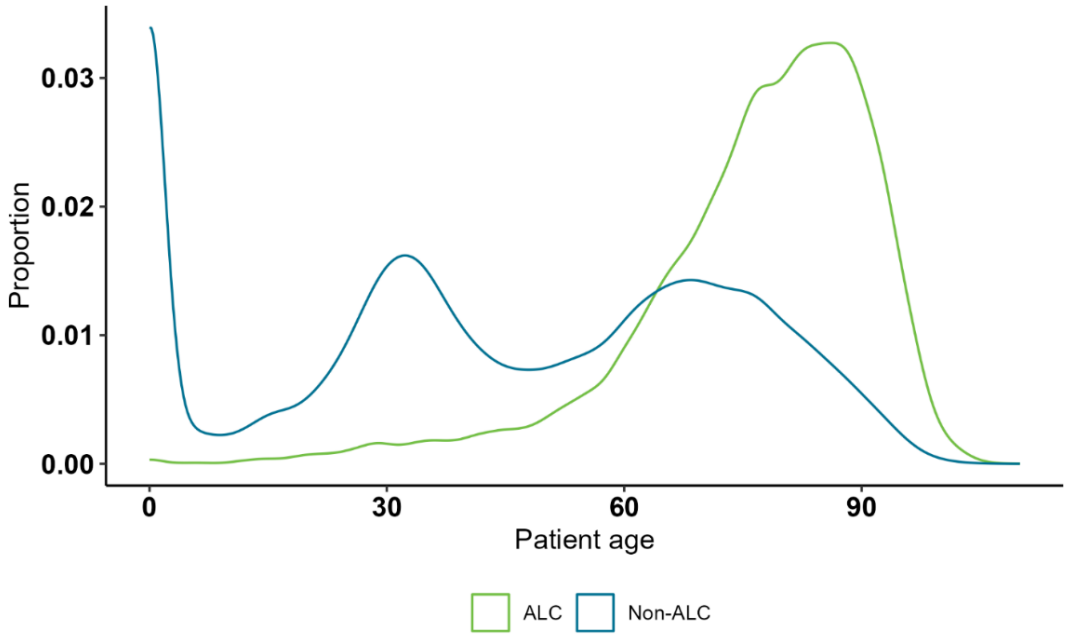
THE CURRENT STATE OF ALC IN ALBERTA

ALC is a designation used in Canada that is applied by clinical staff to the portion of a patient's hospital stay when the patient is occupying a bed and does not require the intensity of resources or services typically provided in that care setting. In other parts of the world, ALC is often referred to as delayed discharge.

ALC patients in Alberta

To fully understand the current state of ALC in Alberta, it's important to consider the following demographic and contextual factors of patients in this province. Only 4.7 per cent of hospital inpatients are classified as requiring ALC. However, these patients account for 14.6 per cent of hospital bed days (the number of days a patient spends in hospital). Most of the ALC patient population are seniors, with the average age of ALC patients being 76.6 years of age compared to 44.6 years of age for hospital patients without an ALC designation (Figure 1). Patients with an ALC designation tend to be female, live in urban settings, and have a lower social deprivation index (a tool that ranks communities based on how much disadvantage they face regarding social and economic resources) compared to patients without an ALC designation. ALC patients in Alberta have similar characteristics to ALC patients in the rest of Canada.

Figure 1: Age of hospital inpatients in 2024-25

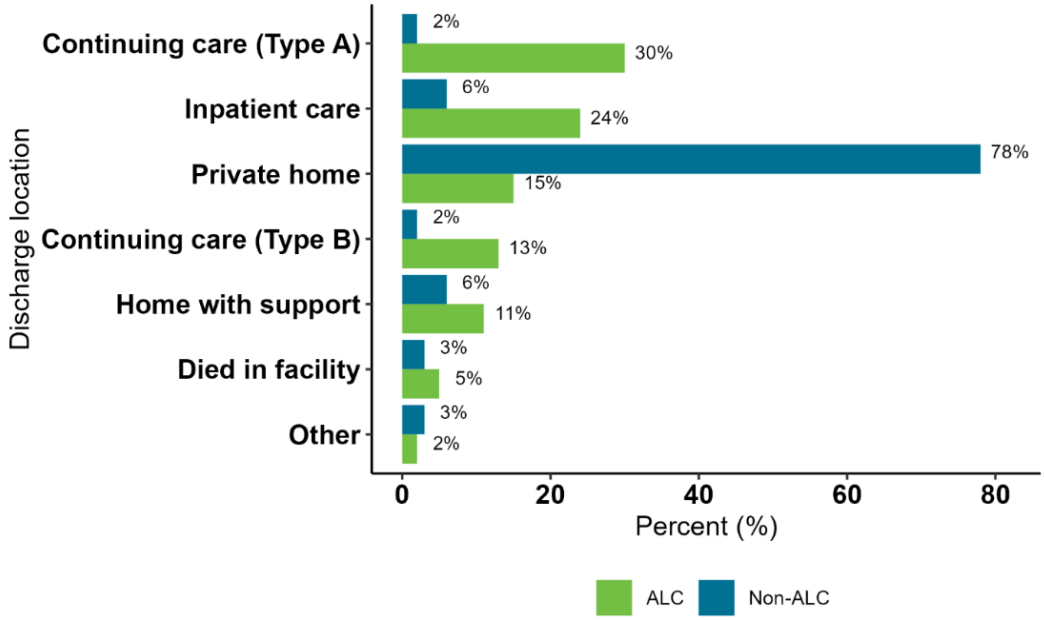


Source: Alberta Health Services, Data & Analytics (2025)

Most discharged to continuing care settings

Unlike most patients who transition to a private home after a hospital stay (78 per cent), the majority of ALC patients in Alberta transition to continuing care homes or other inpatient care settings (67 per cent). Some ALC patients (26 per cent) transition to a private home with or without support after their hospital stay.

Figure 2: Location an ALC patient is discharged to in 2024-25

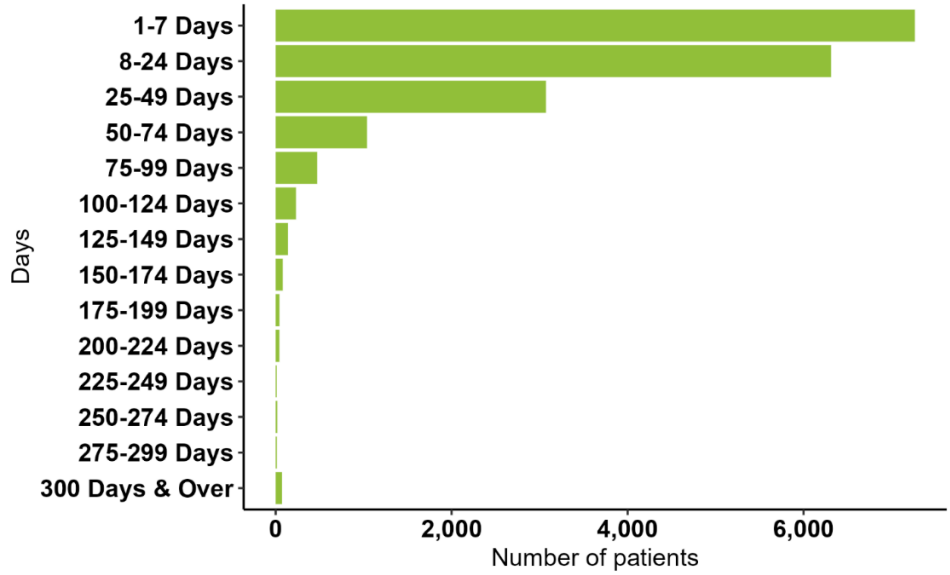


Source: Alberta Health Services, Data & Analytics (2025)

Time in hospital varies from less than a week to almost a month for most patients

Most of Alberta's ALC patients spend a week or less in hospital while post-acute care is arranged, with the next largest cohort spending up to 24 days of their hospital stay categorized as ALC. A small number of patients remain in hospital as ALC patients for an extended period. These clients tend to have complex issues that need to be addressed when arranging post-acute care (e.g., finding a community care setting that is equipped to manage significant behaviours that put the patient or others at risk of harm; or addressing legal or financial challenges).

Figure 3: Days spent in hospital with an ALC designation in 2024-25

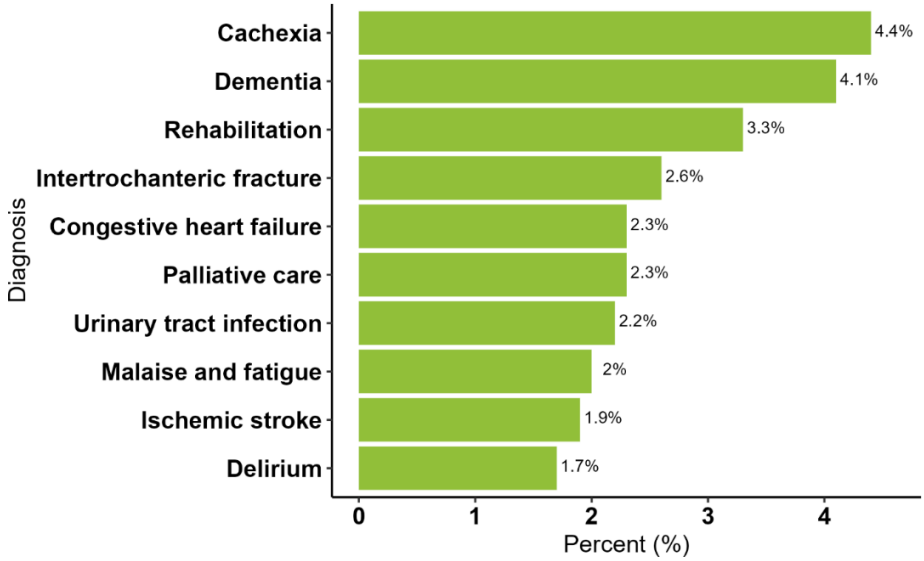


Source: Alberta Health Services, Data & Analytics (2025)

Supportive care frequently needed post-discharge

A review of the literature suggests that ALC patients tend to have diagnoses that require supportive care when they leave the hospital to help with managing behaviours (from dementia or a mental health condition) or activities of daily living such as bathing (e.g., muscle loss, called cachexia). Figure 4 shows the top 10 diagnosis' for ALC patients in Alberta.

Figure 4: Top 10 primary diagnosis' for ALC patients during their hospital stays in 2024-25



FINDINGS AND RECOMMENDATIONS

Health Quality Alberta's review of the ALC pressures and challenges revealed four key findings:

1. ALC issues are well known
2. Accountability for addressing ALC patient flow is unclear
3. Continuing care space capacity does not meet demand
4. Programs and services to address ALC pressures are not consistently implemented across Alberta.

1.0 ALC issues are well known

Over the years, ALC patient flow has undergone extensive study in Alberta. The Health Quality Alberta review team identified many of the same themes concerning challenges, risk factors, and proposed solutions to prevent ALC as was previously reported in other reviews of ALC issues in Alberta, the literature, and information from other jurisdictions.

Common challenges identified included:

- Lack of capacity in continuing care home living options, particularly specialized living environments to care for patients with complex needs.
- Limitations of home and community care resources and non-medical community support, and housing options.
- An increasing number of complex patients with specific challenges such as active addictions, behaviours related to mental health (particularly those requiring on-site security), individuals with developmental disabilities, people living with dementia or brain injury, smokers, bariatric clients, people with legal/financial issues, or other needs (e.g., people who are unhoused, those with little need for personal care but require 24/7 support and security).
- A siloed approach to care with barriers to information sharing between different health providers and social service organizations. Inflexible funding models and/or narrow admission criteria result in limited ability to support aging in place, and patient flow. Capacity planning for health infrastructure (e.g., hospital beds and continuing care homes Type A & B) is done in isolation with limited awareness of the impact of decisions on other parts of the system.

RECOMMENDATION 1.0

There is sufficient information to act: the data collected in previous studies provide sufficient direction to those accountable and responsible for ALC (see Recommendations 2.0 and 2.1) to develop an action plan for addressing current ALC pressures.

Further study for Indigenous perspectives is required. Further study may also be required for other specific populations represented in ALC data.

2.0 Accountability for addressing ALC is unclear

At the date of writing this report, there is not an effective governance structure for system-wide planning, decision-making, funding, and evaluation of a strategy and action plan to address ALC pressures. And this has led to unclear accountability (owning the outcome) and responsibility (completing the tasks) for implementing the recommendations in previous reports on ALC, resulting in limited progress being made on the issues identified.

Interviews with healthcare system partners responsible for community-based care reveal the current system is fragmented between sectors and across the Alberta Health Services (AHS) geographic zones. Preventing ALC requires coordinated and integrated efforts from a wide spectrum of healthcare service providers including primary care, community care, continuing care, emergency health services, acute care services, specialized geriatric services, allied health, mental health and addiction services, services for persons with developmental disabilities, and other specialty populations as well as those who require social services for housing, finance and other legal supports. Policymakers, capacity planners, and evaluators also have a role to play in supporting the changes needed to reduce ALC pressures.

RECOMMENDATION 2.0

Assign accountability for reducing ALC pressures to the Minister of Assisted Living and Social Services (ALSS). This ministry is best positioned to assign responsibility for implementing the many community-based programs deemed necessary to address ALC pressures. Collaboration with other ministries, provincial health agencies, and healthcare provider organizations is required.

RECOMMENDATION 2.1

Within six months, the Minister of ALSS should establish a coordinating committee to ensure ALC oversight from a system-wide perspective (ALC oversight committee).

Membership of this committee shall include: officials from all four provincial health agencies (Primary Care Alberta, Acute Care Alberta, Recovery Alberta, and Assisted Living Alberta); healthcare providers involved in care of people at risk of becoming ALC patients (including emergency and inpatient units); continuing care service providers (transitional services, home and community care, and continuing care homes); community rehabilitation programs, primary care service providers; addiction and mental health service providers; representatives from social services, housing; the Office of the Public Guardian and Trustee; Health Quality Alberta, and patient/family representatives. Indigenous representation on this committee and involvement in decision-making shall be discussed with Indigenous health leaders and addressed during the creation of this committee, as they may prefer to be engaged in a different way.

The ALC oversight committee should:

1. Develop a multi-faceted, integrated, system-wide action plan to address ALC pressures, including:
    a. prioritize actions to be implemented
    b. establish timelines for implementation
    c. assign responsibility to the appropriate provincial health agency and/or service delivery partners to implement specific activities
    d. develop an evaluation plan to monitor the impact of specific actions on ALC pressures
    e. Assign to Health Quality Alberta the responsibility of monitoring ALC at the system level, focusing on evidence of integration of activities within and between sectors (health and social services/housing).
2. Secure and allocate ongoing funds to implement the ALC action plan as a permanent program.
3. The ALC action plan will address recommendations in this Health Quality Alberta review (See Recommendations 3 and 4) and previously commissioned ALC reviews to improve:
    a. integration of activities across health and social services/housing
    b. early intervention and prevention of ALC
    c. enhanced care and support in community
    d. optimized resources and processes in acute care
    e. availability of continuing care homes and post-acute transition spaces
4. Establish a core bundle of community-based services to address ALC pressures and implement these services as standard across the province.
5. Monitor the impact of various activities across the province on ALC to identify learning opportunities across the system. Establish mechanisms for sharing evidence-based practices to scale and spread from one area to another using planned implementation approaches with adequate funding for these quality improvement initiatives.
6. Engage with social services and primary care sectors to validate promising practices (see Recommendation 4) and develop a coordinated effort to implement, scale, and spread these practices.
7. Direct Health Quality Alberta to create a system-wide ALC performance management dashboard and monitor the impact of the implementation of interventions on ALC key performance indicators. With input from the ALC oversight committee, establish performance standards for these measures (e.g., percentage meeting or exceeding performance standards). Revise the current provincial target for ALC from 13.5 per cent to five per cent to be achieved within five years, with regular assessment of the impact of ALC rates on other key indicators such as

Emergency Inpatient rates. Patient/family experience measures should also be developed in collaboration with Health Quality Alberta.

8. Assign the CEO of Health Quality Alberta to report to the provincial Integration Council quarterly on the progress to reducing ALC and provide an annual interim status update that summarizes the quarterly reports and provides details on successes and challenges to implementing the ALC action plan. Within three years, provide an evaluation of the ALC action plan addressing both process evaluation measures and outcome, or impact measures.

3.0 Continuing care space capacity does not meet demand

Interviewees consistently identified lack of capacity in continuing care homes as a challenge in all parts of the province. The majority of ALC patients represent those waiting for placement in a continuing care home.

RECOMMENDATIONS 3.0

In collaboration with the ALC oversight committee:

1. The Government of Alberta (GOA) ministries responsible for healthcare system capacity planning identify the highest priority locations for continuing care spaces to address ALC pressures in urban areas.
2. The GOA ministry responsible for capital grants for continuing care spaces make funds available on a regular (annual or every other year) basis and coordinate operating funds to be available to ensure a continuous stream of new capacity is added.
3. The GOA ministry responsible for continuing care capital grants re-issue a call for the Small Care Homes Stream to address the unique needs of the long-stay ALC clients (e.g., those who have behaviours not easily managed in regular continuing care spaces; those who smoke; bariatric patients, etc.).

The ALC oversight committee:

4. Will adopt common terminology for post-acute transitional care spaces; plan for transitional care spaces in capacity planning, move transitional care spaces out of acute care into community, evaluate the different service delivery models that have been operationalized in Alberta, establish a formal funding and staffing model for transitional care spaces. Establish standards for post-acute transitional care that includes:
    a. functional rehabilitation (e.g., physical therapists/occupational therapists)
    b. decision-making capacity assessments (e.g., occupational therapists and physicians)
    c. addressing legal and financial barriers (e.g., social workers).

5. Will determine which ministry is accountable for complex ALC clients whose needs cross ministerial mandates and establish agreements for responsibility and funding.
    a. For example: Assisted Living and Social Services could establish a formal accountability agreement between Assisted Living Alberta, Recovery Alberta, and Persons with Developmental Disabilities to develop community-based living options for patients with brain injury, developmental disabilities, and/or addiction and mental health issues that includes commitment for funding and ongoing support.
6. Encourage the establishment of complex client programs that leverage community partnerships and housing in collaboration with services from Recovery Alberta and the Office of the Public Guardian and Trustee. Examples of similar programs in Ontario include Harbour Lights, a Salvation Army community residential facility, and Pine Villa, a transitional care unit offered by SPRINT Senior Care, a not-for-profit community support service agency.

4.0 Programs and services to address ALC pressures are not consistently implemented across Alberta

Programs and services to address ALC pressures have been implemented independently across the province resulting in inequities in resources and access to services within and across zones as well as a mixture of service delivery models. A siloed approach to program implementation and funding has created barriers to information sharing, the ability to support aging in place, as well as impacting patient flow.

RECOMMENDATION 4.0

The ALC action plan will prioritize investment in a range of programs and services across the healthcare system promoting proactive assessment of individuals at risk of becoming ALC (older adults with cognitive impairments and/or requiring assistance) and implementation of services to help prevent unnecessary hospitalization, prevent decline during a hospital stay, and to support people to return home or to an appropriate living option.

RECOMMENDATION 4.1

The following reflect gaps in current programming and opportunities to spread current programs that have evidence of favourable impact. They do not reflect the full breadth of programs and services that could be implemented to address ALC. The program inventory (in Appendix A) includes information that should be considered in the development of the ALC action plan.

Whole system

- Expand navigation supports for individuals with identified risk factors associated with becoming ALC including designated staff with clear roles and responsibilities and improved access to information about community services.
- Explore opportunities to implement innovative programs identified in other jurisdictions that promote cross-sector collaboration such as RVH@Home, Nursing Home Without Walls, Frailty Ace, and GEDI.

ALC avoidance

- Reduce demand for acute care services and delay the need for continuing care home admissions through strategic investment in community-based preventative programs.
- Primary Care Alberta to engage with the social sector and primary care providers to validate available programs and services, identify promising practices, and ensure a coordinated effort for implementation, scale, and spread.
- Primary Care Alberta to develop and deliver targeted public education to reduce crisis-driven decisions, promote advance care planning, provide information about programs/services available in the community and clearly define the role of acute care within a broader continuum of health services.
- Assisted Living Alberta to establish a provincial planning process and funding methodology for home care that supports a growing aging population as well as expanding the scope and availability of home care services across the province.
- Assisted Living Alberta to explore flexible service delivery and funding models to support aging in place and to improve patient flow.
- Continue to expand and enhance community-based preventative programs that have demonstrated success in reducing demand for acute care services such as:
    - Mobile Integrated Health Programs
    - EMS Palliative and End of Life Assess Treat and Refer program
    - Nurse practitioner support for continuing care homes and in homeless shelters
    - CHOICE/C3
    - Assertive Community Treatment and outreach teams
- Assisted Living Alberta to ensure caregiver needs in the community are identified and addressed.
    - Proactively assess and address caregiver strain as part of client care planning.

- Expand the availability of flexible respite programs that accommodate the diverse needs of caregivers.

ALC patient flow

- Assign responsibility to Acute Care Alberta to:
  - Assess the effectiveness of resources embedded in the emergency department to support discharge home or referral to another service without the need for acute care admission to inform resource allocation, scale, and spread based on hospital characteristics.
  - Continue to build on existing initiatives including, but not limited to, discharge planning on admission, acute care bundle, and optimization of patient flow processes.
  - Continue to optimize use of Connect Care to support ALC reduction efforts.
  - Explore opportunities to introduce innovative programs from other jurisdictions that promote a more intentional connection between acute and community care, allowing for more seamless transitions and proactive follow-up care planning and reducing duplication. The teams begin service in acute care and either follow in community or have associated teams who continue to follow in the community. Examples include the RVH@home in Ontario, Mater at Home in Australia, D2A and Discharge to Assess programs in the U.K.
  - Finalize the information sharing agreement with Service Canada to allow two-way communication and improved discharge planning.

ALC patient discharge

- Expand discharge options for ALC patients through strategic investment in community-based programs to deliver short-term medical interventions, rehabilitation or other required supports in an individual's home or community.
  - Expand Destination Home across the province as a key action.
  - Clearly articulate Destination Home and the core programming that falls within it in the ALC action plan. Incorporate learnings from the Ontario Home First and UK D2A initiatives within the action plan.
  - Establish consistent evaluation measures for Destination Home programs.
  - Based on ongoing evaluation identify the most effective approaches for spread recognizing differences in population needs and resources across the province.
- Establish a provincial program to support individuals with complex responsive behaviours.
  - Confirm existing education, resources and services available across the province.
  - Identify gaps and opportunities to enhance services and coordination across the system.

- Identify core and optional education to build capacity from basic to expert level.

- Expand the Calgary Zone In-Home Restorative Care pilot project to Edmonton.
    - Explore opportunities to offer the program in other parts of the province recognizing the challenges in recruitment and retention of allied health professionals in rural areas.
- Request the Office of the Public Guardian and Trustee (OPGT) explore the potential to offer the Edmonton Zone e4c program in other parts of the province. Transfer the current budget for the program to the OPGT and request additional budget allocated from OPGT to expand the program.
- Replicate the Medical Respite Unit program in the Edmonton Zone in other cities based on need. Where need does not justify investment in a 24/7 program, expand South Zone Nurse Practitioner in shelter partnership model.

Rural

- Expand access to Mobile Integrated Health, EMS Palliative and End of Life Assess Treat and Refer, and the Client Directed Home Care Invoicing as programs that have been identified as helpful in addressing rural challenges.
- Explore the use of flexible spaces for transitional care in rural areas based on the experience of Community Support Beds in the South Zone.
- Continue to advance the priority actions identified in the Alberta Health Workforce Strategy and the Alberta Rural Health Action Plan.

CONCLUSION

The review of current efforts to address ALC pressures found examples of good work in all parts of Alberta. There are opportunities to build on that work to further enhance community-based solutions and address ALC pressures in this province.

Through Health Quality Alberta's interviews, analysis of previous reports, and jurisdictional scan, the review team identified four key findings:

1. ALC issues are well known
2. Accountability for addressing ALC patient flow is unclear
3. Continuing care space capacity does not meet demand
4. Programs and services to address ALC pressures are not consistently implemented across Alberta.

It was clear from what was learned in this review that ALC is a complex issue, and no single solution can address the challenges. To effectively reduce ALC and generate sustainable results, Alberta must approach the issue at a system level and through multiple interventions.

It's imperative that clear accountability and effective oversight of ALC is established in the province to guide this important work. Accountability and oversight will help address previous barriers to ALC progress, including continuing care space capacity, inconsistent funding and focus, lack of coordination in the implementation of community-based interventions, workforce challenges, as well as resources and geography in rural areas.

The recommendations in this report are aimed at supporting integration, collaboration, and innovation while reducing unnecessary hospitalization, the length of stay of ALC patients, and optimizing the outflow of ALC patients into the community.

APPENDIX A: PROGRAM INVENTORY

Table 1: Program inventory: Programs, services, and initiatives available provincially or in most zones

***Note**: Information in the program inventory was self-reported by zones. Further validation of programs and resources may be required in the development of the action plan and implementation of specific programs and services.*

Program Name	Program Elements	Details
Mobile Integrated Health (MIH)	Strategy	Emergency/urgent care in people's homes.
	Target population	Individuals who face barriers in accessing traditional healthcare facilities, such as the elderly, homebound individuals and those with mobility challenges.
	Brief description	The goal of Mobile Integrated Healthcare (MIH) is to provide access to hospital level care in the community, particularly for individuals who face barriers in accessing traditional healthcare facilities, such as the elderly, homebound individuals and those with mobility challenges. By providing care at the patient's location in community, this model seeks to reduce unnecessary 911 calls, ambulance responses, emergency department visits, hospital admissions, and healthcare costs while improving patient outcomes and overall health.
	Location	Provincial with limitations in rural. Areas within 50 kilometres of Edmonton and Calgary and within 80 kilometres of Medicine Hat, Lethbridge, Red Deer, Camrose, Grande Prairie and Peace River.
	Assessment of effectiveness	Evaluation report 2019
	Implementation considerations	Travel distances in rural areas.
Bridge to Income Supports	Strategy	Remove barriers for CCH to accept patients.
	Target population	Clients assessed as requiring a CCH and are eligible for financial assistance or have funds they are unable to access to qualify.
	Brief description	AHS Bridge to Income Support funding supports eligible clients to temporarily cover Continuing Care Home (CCH) accommodation charges, damage deposits and personal living expenses while the

Program Name	Program Elements	Details
Bridge to Income Supports		client and their team works to secure or access financial resources they are entitled to. Bridge to Income Support funding may also be used to cover expenses incurred in preparation for a transition to a CCH (Type A and Type B).
	Location	Provincial
	Assessment of effectiveness	Qualitative feedback in interviews.
	Implementation considerations	Variation in how each zone has operationalized the program. Administrative burden. Edmonton Zone has built in a mechanism to recover funds from OPGT when trusteeship is assumed.
Service Canada Escalations	Strategy	Cross-sectoral efforts to address discharge barriers.
	Target population	Patients eligible for benefits through Service Canada
	Brief description	An AHS Provincial Social Work initiative in partnership with Service Canada, since July 2021, functions to expedite Service Canada processes for patients via a secure online portal. Designated zone SW lead receives requests from frontline SWs to submit escalation requests to Service Canada. Without escalations, regular workflow can take 6+ months.
	Location	Provincial (highest use in Edmonton Zone)
	Assessment of effectiveness	Reduction in ALC days and LOS in acute care.
	Implementation considerations Implementation considerations	Limited resources at Service Canada to support process. Establishment of an information sharing agreement currently in process to support two-way communication.
Destination Home	Strategy	Enhanced in-home supports to reduce LOS.
	Target population	Patients identified as potentially requiring CCH placement who can be supported at home with enhanced services.
	Brief description	A philosophy of care that promotes discharge home with appropriate supports to determine if they require assessment for CCH placement. Various programs and services have been implemented across the

Program Name	Program Elements	Details
Destination Home		province – complex case management teams, collaborative discharge planning, and short-term enhanced home care services.
	Location	Calgary and Edmonton and limited implementation of formal programs in North and South Zones. Pilot projects in Central Zone (Rimbey and Red Deer).
	Assessment of effectiveness	Formal evaluation of specific initiatives implemented under the Destination Home program.
	Implementation considerations	Destination Home as a program is not well defined. Home Care resources in rural areas are limited by resource constraints and geography.
Equipment and Added Care Resources for CCH	Strategy	Remove barriers for CCH to accept patients.
	Target population	CCH
	Brief description	Provide access to specialized equipment and enhanced resources in Continuing Care Homes to facilitate transition of patients with complex needs. Bariatric equipment loan programs have been created.
	Location	All Zones
	Assessment of effectiveness	Informal evaluation and tracking of data in Zones indicate positive impact
	Implementation considerations	Each Zone has different process and resources to support. Staffing challenges limit ability to operationalize some added care. Funding to purchase, maintain, and replace equipment is required.
Nurse Practitioner Resources	Strategy	Emergency/urgent or enhanced care in people's homes.
	Target population	Home care, continuing care home, and homeless shelter clients
	Brief description	NP team are each assigned to specific Continuing Care Homes for day-to-day site clinical support, assist in returning residents from acute care by providing advanced acute interventions, end of life care, and ordering/following up on critical diagnostic results. NPs also play a vital role in ED avoidance by providing after hours on call support at a zone level. They also help to improve clinical skills of site nurses as needed.

Program Name	Program Elements	Details
Nurse Practitioner Resources		NPs are also utilized in the Home Living and Palliative Care programs as well as homeless shelters. They manage very complex clients in the community, many of whom may not have a primary care physician, to avoid admission to acute care.
	Location	Edmonton Zone, Calgary Zone, South Zone
	Assessment of effectiveness	Limited evaluation
	Implementation considerations	High demand for NPs in many areas
EMS Palliative and End of Life Assess Treat and Refer program	Strategy	Emergency/urgent care in people's homes.
	Target population	PEOLC patients in community
	Brief description	The program provides urgent care in the patient's home during a palliative emergency. Paramedics work with community clinicians to bring care to patients in their home or care facility instead of automatically transporting them to hospital.
	Location	Provincial
	Assessment of effectiveness	Evaluation completed in 2017 or 2018
	Implementation considerations	Limitations in other resources such as home care impacts PEOLC patients to remain at home in rural areas.
Complex Support Teams	Strategy	Support for complex needs
	Target population	Acute care clients who present challenges to placement in community
	Brief description	Specialized teams who support ALC patients in acute care, identified as requiring a specialty unit or clients who present challenges to placement to expedite discharge to the community. In community, the teams provide support for managing the most complex care needs clients in both specialized units and conventional spaces. Team supports initial transition planning and return from hospital for clients with complex care needs. **NOTE**: Variation in how teams are operationalized and resourced across zones
	Location	Edmonton Zone, Calgary Zone, North Zone, Central Zone

Program Name	Program Elements	Details
Complex Support Teams	Assessment of effectiveness	Indicators tracked – referral volumes, denials by providers, waitlist times and # of clients with no suitable option available
	Implementation considerations	Specialized living options for complex clients are required to improve effectiveness of these teams.
Ambulatory Home Care Clinics and Wound Care Clinics	Strategy	Enhanced care in home or closer to home
	Target population	Patients requiring short-term treatment and interventions following an acute care admission.
	Brief description	Clinics offer follow up nursing care (for example wound care, IV therapy) in a clinic environment to facilitate timely discharge home. In some cases, a short-term intensive care team will provide post-acute treatments and interventions in the home as needed.
	Location	All Zones with some limitations in rural
	Assessment of effectiveness	Volume of visits and other clinical outcomes tracked. No formal evaluation at a provincial level.
	Implementation considerations	Clinics can continue to be scaled and spread with additional resources.
ED2Home Program Transition Services Coordinators in ED Geriatric Emergency Management Program in ED Allied Health team in ED Mental Health team in ED	Strategy	Prevent acute care admission
	Target population	Patients presenting to ED who require care interventions that can be supported in community without an acute care admission
	Brief description	Resources are embedded in ED to proactively identify patients who can be discharged from ED to home with appropriate community supports.
	Location	All Zones but resources and service delivery models differ.
	Assessment of effectiveness	Informal and formal evaluation depending on program. Positive feedback about benefit of Transition Coordinators in ED.
	Implementation considerations	Different resources will be required based on local needs (patient volumes and demographics). Potential to use ED2Home as an overarching strategy with different service delivery models offered based on local needs. Further evaluation required to determine effectiveness of each approach implemented in AB.
Continuing Care Mental Health Consultation Support	Strategy	Support for patients with complex needs
	Target population	CCH and Home Care clients with responsive behaviours

Program Name	Program Elements	Details
Continuing Care Mental Health Consultation Support	Brief description	Mental Health clinicians respond to consult requests from CCH sites and Home Care to provide non-pharmacological recommendations to help manage resident behaviours and mental health needs to prevent ED visits and hospitalization. They also have access to consult with psychiatrists for medication management.
	Location	All Zones: resources and service delivery model varies.
	Assessment of effectiveness	Tracking of data
	Implementation considerations	Further exploration of resources and service delivery models required to identify gaps and opportunities for spread/scale.
Expanded supports for PEOLC clients (Edmonton) Hospice Access and Operations Hub HAOH (Calgary) Increased Rural In-Home Funding for PEOLC clients (North, Central, South)	Strategy	Enhanced care in or close to home, optimize processes
	Target population	Patients requiring PEOLC services
	Brief description	Edmonton Zone has expanded supports for Palliative Home Care (adults) and Hospice to facilitate seven day a week access to community palliative supports. Enables timely discharge from acute care back to community and clients to remain in community and avoid an acute care admission. Weekend worker role for adults introduced as part of Continuing Care Transformation funding (includes operational and grant funding). Children's Home Care: Case Manager RN position for suburban/rural area of the Edmonton Zone. **Partnership with Family Support for Children with Disabilities (FSCD)** - grant funding has enabled increased resourcing within Children's Palliative Home Care to support children in the suburban areas of the zone enabling them to remain in or return to community. Calgary Zone has established the HOAH a nurse-led coordinated system designed to ensure that patients requiring inpatient hospice care receive equitable, timely, and patient-centered access to services. The HAOH supports the transition of ~1200 patients per year. Rural In-Home funding - Program is designed to support end of life clients in their home communities.

Program Name	Program Elements	Details
Expanded supports for PEOLC clients (Edmonton) Hospice Access and Operations Hub HAOH (Calgary) Increased Rural In-Home Funding for PEOLC clients (North, Central, South)		Funding up to $10,000 per client is provided to support caregiving beyond the homecare program. Homecare services provided primary services to program maximum. PEOLC team & Homecare Case manager work with Client and Care plan to support around the clock care supports. Care can be provided by family or friends and refunded by invoicing.
	Location	Edmonton Zone and Calgary Zone; resources in rural Zones are more limited due to staffing constraints and geography
	Assessment of effectiveness	Edmonton Zone – new positions no evaluation to date Calgary Zone – tracking of key indicators Data tracked for rural in-home funding
	Implementation considerations	Processes and resources vary across Zones. Expanding PEOLC in community is part of the Provincial PEOLC Strategy.
NOTE: Other programs and services are in place to support individuals and their caregivers in community such as adult day support, respite, general home care services, and wellness programs. For the purposes of this inventory, only programs that had a more direct relationship to ALC and tracked data relevant to ALC have been included. *Routine practices such as daily capacity huddles and discharge rounds and regular operational resources to support transitions (transition coordinators, patient flow coordinators) are also not included but are important enablers to patient flow.*		

REFERENCES

Health Quality Alberta reviewed a number of articles and reports on ALC to help inform and interpret the data collected. A selection of those reports are referenced below:

1. Ahmed, Didi. (2019). The challenge of alternate level of care (ALC) facing older adults in Ontario: Implications for government and policy makers using a descriptive data analytics approach, McMaster University, (Thesis)
2. Alberta Health Services. (2021). Palliative and end of life care provincial framework addendum 2021. Palliative and End-of-Life Care Alberta Provincial Framework Addendum 2021
3. Arthur SA, Hirdes JP, Heckman G, et al (2021). Do premorbid characteristics of home care clients predict delayed discharges in acute care hospitals: a retrospective cohort study in Ontario and British Columbia, CanadaBMJ Open;11:e038484. doi: 10.1136/bmjopen-2020-038484
4. Barber BV, Gregg EE, Drake EK, Macdonald M, Hickey M, Flynn C, et al. (2024). Transitional care programs for older adults moving from hospital to home in Canada: A systematic review of text and opinion. PLoS ONE 19(7): e0307306. https://doi.org/10.1371/journal.pone.0307306
5. Benoit, R., Sun, M.P.H., Sinden, D., Spruin, S., Hsu, A.T. (2020). A case control study of the Sub-Acute Care for Frail Elderly (SAFE) Unit on hospital readmission, ED visits and continuity of post-discharge care. *JAMDA*. https://doi.org/10.1016/j.jamda.2020.07.020
6. Cadel, L., Guilcher, S.J.T., Kokorelias, K.M., et al. (2021). Initiatives for improving delayed discharge from a hospital setting: a scoping review. *BMJ Open*. www.https//doi:10.1136/bmjopen-2020-044291
7. Canadian Agency for Drugs and Technologies in Health (July 2024). Strategies to Reduce Alternate Level of Care, Canadian Journal of Health Technologies, July 2024, Vol 4, Issue 7
8. Canada's Drug Agency (2025). Alternate Level of Care in Canada, Health Technology Review,; https://www.cda-amc.ca/sites/default/files/ou-tr/OP0557-ALC_Combined_Report.pdf , Accessed May 2025
9. Carstairs S., Keon W.J. (2009). Canada's aging population: Seizing the opportunity. Special Senate Committee on Aging. Final report. Ottawa: Government of Canada
10. Chong N, Akobirshoev I, Caldwell J, Kaye HS, Mitra M (2022). The relationship between unmet need for home and community-based services and health and community living outcomes. Disabil Health J. 2022 Apr;15(2):101222. doi: 10.1016/j.dhjo.2021.101222.
11. Durante S, Fyie K, Zwicker J, & Carpenter T. (2023). Confronting the Alternate Level of Care (ALC) Crisis with a Multifaceted Policy Lens. *The School of Public Policy Publications,* Vol. 16 No.1. https://doi.org/10.11575/sppp.v16i1.76748
12. Lamarre M, Daignault M, Cheung VW, Forget MF, Nguyen QD. Factors Associated with Alternate Level of Care Status Designation: a Case-Control Study and Model to Optimize Care Trajectories. Can Geriatr J. 2024 Jun 3;27(2):152-158. doi: 10.5770/cgj.27.697. PMID: 38827424; PMCID: PMC11100979.
13. Maisonnave M, Rajabi E, Taghavi M, VanBerkel P (2024). Alternate Level of Care Patients in Canada: a Scoping Review. Can Geriatr J. Dec 1;27(4):519-530. doi: 10.5770/cgj.27.755.

14. McCloskey R, Jarrett P, Stewart C (2015). The untold story of being designated an alternate level of care patient. Health Policy. 2015 Aug;11(1):76-89.
15. MNP for AH (April 30, 2021). Improving quality of life for residents in facility-based continuing care. Alberta Facility-based continuing care review recommendations. Final report. webpage: health-improving-quality-life-residents-facility-based-continuing-care-2021-04-30.pdf
16. Mudge, A. M., McRae, P., Hubbard, R. E., Peel, N. M., Lim, W. K., Barnett, A. G., & Inouye, S. K. (2019). Hospital-Associated Complications of Older People: A Proposed Multicomponent Outcome for Acute Care. Journal of the American Geriatrics Society, 67(2), 352–356. https://doi.org/10.1111/jgs.15662
17. Newfoundland Health Services. (n.d.). A policy framework to reduce ALC rates in Newfoundland and Labrador. Unpublished document.
18. Ontario Health. (2021). The alternate level of care (ALC) leading practices guide: preventing hospitalization and extended stays for older Adults, V1
19. Schattner A. (2023). The spectrum of hospitalization-associated harm in the elderly. European journal of internal medicine, 115, 29–33. https://doi.org/10.1016/j.ejim.2023.05.025
20. Walker D. (2011) Caring for our aging population and addressing alternate level of care [unpublished manuscript}. Minister of Health and Long-Term Care.
21. Wang, Y. C., Chou, M. Y., Liang, C. K., Peng, L. N., Chen, L. K., & Loh, C. H. (2019). Post-Acute care as a key component in a healthcare system for older adults. *Annals of geriatric medicine and research*, *23*(2), 54–62. https://doi.org/10.4235/agmr.19.0009

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