A NEW PARADIGM TO SOLVE THE ALTERNATIVE LEVEL OF CARE CRISIS:

A WAY FORWARD

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The Council on Aging of Ottawa
101-1247 Kilborn Place
Ottawa, Ontario
www.coaottawa.ca

II. Executive Summary

How do we support seniors to manage their own health in their own homes and to age successfully in the community? This persistent system-level problem will only intensify with a growing population of older persons. Individual programs and strategies have not proved adequate to support an aging population, and, consequently, frustration is building among health care managers, clients and their families. There are many reasons why seniors are admitted to hospital for appropriate procedures and treatments, and many pressures and programs to discharge them as quickly as possible. The net result is that seniors are regularly placed in long-term care (LTC) facilities when they could otherwise have more years of independent or assisted living in the community. This problem is not only reducing the quality of life of seniors and their families, but has considerable costs for the health care system. Although this problem has persisted over the last 30 years, the challenge of promoting seniors' independence and engagement is, if anything, more difficult today, in the face of escalating health care costs, heightened bureaucracy, the question of allocating scarce resources and, more important, the lack of sufficient community supports.

For over a decade, the Council on Aging of Ottawa (COA) has been championing seniors' issues covering the transition from hospital to home. With seniors representing about 12% of the total population, or almost 100, 000 people in Ottawa, concerns are mounting over the capacity of the health care system to meet the needs of this unique and complex group.[1] The senior population in Ottawa is expected to increase to just over 190, 000, or 16% of the total population, by 2021, and to triple to 230,922, or 20.3% of the total population, by 2031. When families and caregivers are taken into account, the number of people affected by this problem increases to between 500, 000 and 700, 000. The time to find and implement solutions is now.

In 2009, the Council on Aging of Ottawa hosted a forum to crystallize issues of critical concern to seniors, their families and health care providers. On October 1, 2010, the Council on Aging of Ottawa, in partnership with the Champlain Community Care Access Centre and the Regional Geriatric Assessment Program of Eastern Ontario, took the first step towards a new paradigm to solve the Alternative Level of Care (ALC) crisis in Ottawa. This report describes what was said by participants at the health care forum, and provides us with a way forward.

[1] Social Data Research & Flett Consulting Group. 2007. *Fact Book on Aging*; City of Ottawa.

III. Understanding the Alternative Level of Care Issue

"We need to start thinking of Alternative Levels of Care as system failure."

Narendra Shah, Chief Operating Officer, Mississauga Halton LHIN, Seniors Fall Forum 2010

Alternative **L**evel of **C**are, also known as **ALC**, is a designation applied to clients in acute care hospitals whose acute care phase is complete, and whose care needs could be better met in settings outside the acute care hospital. Clients are designated ALC when they require further treatment and intervention to complete their care, but are assessed as no longer needing to be in an acute care hospital. The significant impact of the ALC issue, in addition to that of previous acute care downsizing and planned reductions in projected lengths of stay, leads to lengthy wait times and hospital overcrowding, with clients placed in hallways or emergency departments for extended hours and days awaiting service. This 'hospital bed gridlock' contributes to the spread of multi-antibiotic resistant infections ('superbugs') which further risks the health of all hospital clients, creates unnecessary costs and perpetuates the stereotype of seniors as 'bed blockers' in our health care system.

We recognize that there are several factors behind the ALC crisis. These include the lack of appropriate services to support seniors in their homes; insufficient services for families to support their parents; challenges seniors face in accessing primary care; and the shortage of community, rehabilitation and long-term care resources for individuals who no longer need to remain in hospital. The ALC crisis is further aggravated by the need for more age-appropriate or senior friendly hospital care and the scarcity of rehabilitation and assessment beds, essential for seniors transitioning back into the community in a timely fashion.

A new way of thinking to address the Alternative Level of Care crisis is now warranted. This proposed paradigm shift would focus on rehabilitation and increased community supports as the realistic, preferred and logical alternative to acute care hospitals for seniors and their families. However, if this shift in thinking is to occur, community services must be properly resourced so as to make home and community a viable alternative to remaining in the hospital or being placed in long-term care.

The **CARL** Model was developed to increase understanding of the complementary parts of the health care system.[2]

CARL Model	
C	**C**ommunity Care (Primary Care, Clinics, CCAC)
A	**A**cute Care (Hospitals)
R	**R**ehabilitation Care
L	**L**ong-Term Care (Nursing Homes)

Community Care

Current approaches to resolving the ALC crisis have focused on 'downstream' approaches. While these address what to do after someone is designated ALC, little attention has been given to preventative approaches. ALC has been part of Ottawa's health care reality for decades, and it remains a persistent problem, even after considerable time, research and resources have been devoted to the issue. An 'upstream' philosophy, one that pinpoints those at highest risk of becoming ALC through early identification and intervention, is needed to prevent further escalation of the ALC crisis.

A salient example is dementia care. The 2009 Canadian Institute for Health Information (CIHI) document *Alternate Level of Care in Canada* clearly indicates that dementia is the primary diagnosis contributing to ALC rates. Various strategies are already in place, such as the Champlain Local Health Integration Network (LHIN)'s 'Aging at Home' strategy, and the Community Care Access Centre (CCAC)'s specialty teams that focus on complex seniors, with over 90% of those having a diagnosis of dementia.

However, development of community-based dementia care designed to keep persons with dementia out of hospital is not a significant part of ALC planning for the Champlain LHIN. Despite its role in driving up ALC rates, dementia is mentioned only once in the entire Champlain LHIN Strategic Plan, nor are plans apparent to improve community-based dementia care. This example illustrates the lack of long-term planning and upstream measures needed to avoid repeated ALC crises.

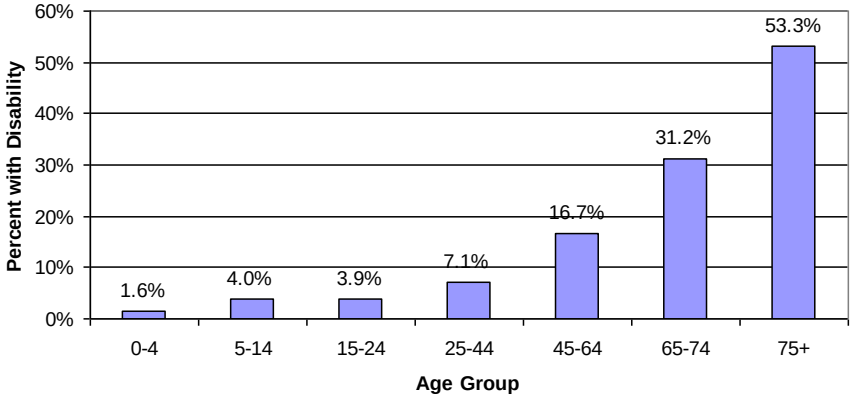
The reality is that seniors, not all of whom have the family support necessary to manage their health safely, are living longer and increasingly developing comorbid and chronic

[2] Molnar, Frank.

disorders. For example, the frail elderly are primary health care users who typically have the longest stays in hospital.[3] Frailty is generally associated with loss of mobility, falls, confusion, incontinence and polypharmacy.[4] Since seniors are at particular risk of functional decline with each day of hospitalization, longer hospital stays can have devastating effects, especially for at-risk seniors. Therefore, a senior-centred approach to health care would develop preventative practices in the community to reduce the number and length of seniors' stays in hospital.

Moreover, people over the age of 65 have an extremely high rate of disability, as the following table indicates in the relationship between age and disability across Canada.

Percentage of Persons with Disabilities by Age Group, Canada, 2001



Source: Statistics Canada, A Profile of Disability in Canada, 2001

Older adults with dementia, disabilities, the frail elderly, and isolated seniors are at high risk of health crises. To avoid reliance on costly and inappropriate utilization of the health care system, lengthy hospitalization and frequent ER visits, we must address the needs of the aging population appropriately, with an emphasis on prevention, community care, returning home and successful aging in the community as a complement to more senior friendly acute care.

Acute Care

The health care issues of seniors are ongoing and require attention on a 24/7 basis. Seniors are more likely to visit the ER for appropriate reasons; however, they may return more frequently as their care needs are not addressed appropriately either in the ER or

[3] Fisher, R. 2002. The Role of Specialized Geriatric Services in Acute Hospitals. *Geriatrics and Aging*, 5(5):48-51.
[4] Parker, S.G., Lee, S.D. and Fadayetavan, R. 2006. Acute hospital care for frail older people. *Age & Ageing* 2006, 35(6):551-552.

in the community. Acute care hospitals are designed to handle planned and unplanned admissions, some of which are immediate health crises, whereas community-based care is better suited to focus on prevention of health crises and completion of the care process. If community resources were available 24/7, they would have the potential to reduce the strain on ER departments. While serious health concerns would continue to be streamed to hospitals, patients with less serious health concerns could be re-routed to a community-based practitioner.

Rehabilitation Care

When older individuals become ill and are hospitalized, recovery often takes longer to reach the point where they can return home safely. It has been well documented that seniors experience rapid and dramatic functional decline during hospitalization, resulting in loss of independence and limiting their options for going home. In the current hospital system, seniors who do not improve rapidly, and who do not qualify for one of the limited number of rehabilitation beds, are designated ALC and dispatched to long-term care.[5] Further to the problem, there are only 94 'assessment and restorative' beds in Ottawa and the surrounding area, 54 of which are geriatric rehabilitation beds at Bruyère Continuing Care, the remainder being primarily for short-term rehabilitation. With little or no placement options, hospital staff has no choice but to house clients in hallways and ER overflow as they await a bed elsewhere. Stress has been proven to decrease healing time.
In order to prevent premature long-term care placement, seniors need appropriate numbers of 'assessment and restorative' beds. Here, they can recover in an environment that is conducive to healing. While in rehabilitative beds, older patients who were functioning safely at home before they became ill can spend 1 to 6 months recovering before deciding whether long-term care placement is needed.

In 2010, the Champlain CCAC conducted a comparative analysis of Convalescent Care Programs and Restore Programs in consultation with other regional LHINs. Their findings demonstrate that in Hamilton-Niagara-Haldimand-Brant (HNHB) and Mississauga-Halton (MH) regions, Restore Programs had an alleviating effect on ALC numbers. Presently, the Champlain LHIN and Bruyère Continuing Care are considering this option. The required number, location and funding of these new 'assess and restore' beds will have to be determined as soon as possible.

[5] Champlain LHIN. 2010. *ED/ALC Steering Committee 2010-11 Priorities.*

Long-term Care

Another factor exacerbating the ALC crisis is lack of income, which limits timely access for many seniors to both home and community care as well as to our publicly funded long-term care system. The majority of long-term care beds are designated preferred rate (60%) for private or semi-private rooms, which most seniors cannot afford. The longest waiting list in long-term care is for subsidized or ward beds, accounting for 40% of all long-term care beds. The basic or ward rate in long-term care in Ontario is $1619.08 per month as of January 2011.[6] A senior who cannot afford a semi-private room, which costs an additional $8.00 per day, or a private room, which costs an additional $18.00 per day, will be further down the waiting list and may remain unnecessarily in the hospital until a preferred bed in long-term care becomes available.

For seniors prematurely moved to long-term care because they cannot afford a private retirement home, efficiencies in cost would be greatly enhanced by developing affordable supportive housing rather than building more expensive long-term care facilities.[7] This would include providing low-income seniors with the option of a subsidized residence and increased low-cost community supports, thereby reducing the need for more long-term care beds.

Appropriate Level of Care

It is this intersection of community care, acute care, rehabilitation care and long-term care that is at the root of the ALC crisis. For solutions to be effective and enduring, they will have to include participation from a variety of sectors, ranging from palliative care, primary care and the Regional Geriatric Programs to community care, acute care and long-term care.

The 2010 Health Forum presented and confirmed the need to shift the focus of Alternative Level of Care (ALC) to Appropriate Level of Care, which entails providing the right care, at the right time, in the right setting, and at an affordable cost. As a caring community, we need to shift our focus from short-term, 'downstream' solutions that examine the options only *after* an individual is designated ALC. Instead, we need to promote long-term, 'upstream' solutions that will consider Appropriate Level of Care – solutions that help seniors age successfully in the community by increasing their independence, choice and quality of life.

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[6] Ontario Ministry of Health and Long-Term Care. 2011.
[7] Ontario Ministry of Health and Long-Term Care. 2010. *Seniors Care: Long-Term Care.*

IV. Purpose of the Forum

In 2009, the Council on Aging of Ottawa held a Fall Health Forum to identify gaps in the health care system and community services. Over 70 seniors shared their experiences as a foundation for the COA's mandate to move forward on the ALC issue. A second Fall Health Forum was held in 2010 as a follow-up to those areas highlighted in the previous year. Its purpose was to generate momentum and to implement a new philosophy governing the way in which acute care facilities, and their partners, approach the discharge process.

The 2010 forum convened seniors, key stakeholders and decision-makers to discuss the ALC crisis and then develop a new philosophy and create an action plan for implementation. The forum was designed to attract influential seniors from the community and senior managers from institutions at both the local and regional levels.

As part of the planning process, key decision-makers were interviewed in the agenda-building process. This approach raised awareness of the event and established "process and outcome ownership" with these upper-level decision-makers. The forum served to introduce, explain and discuss plans for a new philosophy of ALC, identifying the Champlain CCAC as the local champion and capacity-builder with the launch of its new "Home First" philosophy. Experts and supporters of a "Home First" philosophy from other areas in the province were invited to share their success stories, best practices and challenges.

The forum delivered three strategic messages: firstly, that it marked the first step in a transformative journey; secondly, that the forum was kept relatively small to ensure engaged discussions for leaders of the entire ALC system in Ottawa (or Champlain); and lastly, that leadership within each organization was challenged to consider, strategize and manage change in the best interests of their clients and organizations, while also engaging staff in discussions on the factors driving the change and implementation strategies.

V. Forum Process

Participant Selection Criteria

Forum participants were a key component in the development of tangible ideas and a focused approach. Therefore, participants were limited to forty to increase the opportunity for and exchange of ideas and solutions. This allowed for small-group presentations and a plenary discussion.

To ensure that participants were representative of the wider community, the following selection criteria were developed:

- Seniors who were community leaders
- Balanced representation from all stakeholders
- One representative per organization as determined by senior decision-makers within the organizations represented (CEO, VPs, Directors)
- Organizations representative of a stakeholder group, i.e. large enough to speak to most of the issues
- Organizations perceived as credible
- Organizations perceived as conservative or risk adverse
- Organizations that had previously introduced innovative programs or technologies

Guided by this selection process, participation in the forum included the CEO of the Champlain CCAC, accompanied by service providers; the CEO, Clinical VP and a Medical Chief from five hospitals in the Ottawa region; a representative from the *Réseau des services de santé de l'est de l'Ontario*; a representative from the LHIN; Community Health Centre representatives; and a selection of representatives and advocates for seniors. Forum participants formed a comprehensive representation of the institutions, service providers, policy makers and seniors either involved in, or affected by, the ALC issue.

Objectives and Performance Measures of Project

The objective of the forum was to identify and develop observable and measureable outcomes. These outcomes have been used to develop the foundation of a results-based framework that will quantify successes and establish the project's next steps. In order to move forward, energy from the forum must inspire a new way of thinking, reframing Alternative Level of Care as Appropriate Level of Care. This approach has the potential to reduce the number of seniors admitted to hospitals and sent to long-term care facilities, easing the strain on acute care hospitals and long-term care facilities. For

this ideological shift to take place, an instrument must be developed to support the adoption of this new philosophy. It will also require improvements in communication between institutions and community services involved in the provision of care for seniors.

Structural Process and Purpose

The forum was structured to include presentations from a panel of experts, small break-out groups and a large plenary discussion. The panel was representative of diverse opinions concerning the ALC issue and the best course(s) of action for resolution. A variety of viewpoints ensured a comprehensive foundation.

To further include various viewpoints, small groups of approximately 4-6 participants were pre-arranged. The main goal of the break-out groups was to encourage critical thinking on the benefits and barriers of the Appropriate Level of Care paradigm, as well as to consider how Appropriate Level of Care and 'senior-friendly hospitals' might be applied to participants' own situations or institutions. Each group reported its findings to the larger group, followed by a facilitated discussion around how best to incorporate the Appropriate Level of Care paradigm within the Champlain region.

Drawing on results from the small group discussions, participants formulated an action plan to harness the forum's momentum, move the Appropriate Level of Care paradigm forward in the Champlain region, and promote seniors' independence and engagement in the community.

VI. Key Findings and Analysis

Promote Recovery

Client recovery is a multifaceted process that may require multiple service providers and a supportive foundation of caregivers. In order to promote recovery, the health care system must shift its focus towards clients and their families, redefining the system around the needs of the client rather than making clients fit the system.

Senior-Friendly Hospitals

One of the best ways to support client recovery is with a Senior-Friendly Hospital strategy, a systematic approach that promotes evidence-based practices in geriatric care in acute care hospital settings.[8] As seniors typically suffer from chronic, and sometimes comorbid illnesses, the acute care approach can have negative consequences for hospitalized seniors. The Senior-Friendly Hospital framework was developed as a way for hospitals to address the unmet care needs of seniors. It addresses the areas of process of care; the emotional and behavioural environment; ethics in clinical care and research; organizational support; and the actual physical environment in which care takes place. If these targeted areas are modified appropriately, senior clients' treatment and recovery processes can be greatly improved.

Home First

The 'Home First' strategy highlights safety and quality of care, with a focus on clients' and families' needs first. Seniors account for approximately 75% of ALC clients in Ontario.[9] The majority of these clients, specifically those who are acutely ill, desire to return home. Most of them do not want or expect to enter into long-term care facilities. Progress made by other LHINs in addressing the ALC issue suggests that "Home First" is a key component in the Appropriate Level of Care paradigm that needs to be embraced and implemented by all hospitals.[10] Since the "Home First" program was launched, 591 seniors across the Champlain region have benefitted.

Whenever possible, giving clients the option to go "Home First" is the best solution, as it is a quality of life and care issue, as well as a safety issue. By going "Home First," clients have the opportunity to make functional gains prior to forming a decision about moving to long-term care. If long-term care is necessary, that decision can be made from home.

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[8] Martell, C. 2006. *The Senior Friendly Hospital Strategy.*
[9] Shah, N. 2010. *The New Philosophy Towards Solving the ALC Crisis (Home First)*.
[10] Love, C. (2010). Home First: A Strategy to Manage ALC.

In this way, clients are not waiting in hospitals for long-term care beds, thus reducing pressure on hospitals to place clients as quickly as possible. This means that clients can wait for the long-term care facility of their choice, while hospitals can have open acute care beds that would otherwise be occupied by ALC clients. However, this strategy will require a focused implementation plan to change the operational culture of hospitals. Furthermore, "Home First" is only available after hospital admission, at which point clients have already experienced a health crisis.

Transition to Home

The "Transition to Home" program was initiated at the Queensway Carleton Hospital in partnership with the Champlain CCAC and the Champlain LHIN.[11] A 24-bed unit with a small kitchen, its goal is to help seniors, especially frail seniors, remain independent after experiencing medical treatment. The program draws on a restorative-care focus to improve day-to-day functioning with resources such as specialized physiotherapy, occupational therapy, rehabilitative and geriatric nursing. To date, an average of 10 patients are being released home from the program per week with proper community care supports in place. The benefit of this program is that it reduces much of the in-hospital waiting senior clients typically experience. Consequently, it reduces the risk of functional decline resulting from hospitalization.

Active engagement in primary care means being able to make decisions concerning care; therefore, it is important to ensure that clients are making informed decisions about what is best for them. For clients to make appropriate and informed decisions, they must have realistic and timely options available to choose from which focuses on returning to their homes whenever possible.

System Coordination and Navigation

The health care system currently lacks cohesiveness between service provider organizations. This impedes the ability of service providers to provide comprehensive and continuous care for clients. A first step to address issues surrounding system coordination is to develop a 'collaboration charter' that could be used by all service providers as a guideline for treating clients across the spectrum of care. It would also strengthen the working relationship between the CCAC and the community support sector. It is also essential to develop a collaborative partnership between family doctors, the CCAC, the community support sector, acute care hospitals and the Regional Geriatric Program for better mapping of the processes and services involved in the care of clients, particularly seniors at risk.

[11] Champlain LHIN. June 9, 2011. *Champlin LHINfo Minute.*

Strengthen Community Care and Support

Studies have shown that a senior's quality of life is generally higher when he or she is at home and living in the community.[12] In order for seniors to retain their health and independence in the community, we must continue to develop affordable supportive housing for seniors; simplify access to services and resources by increasing the quality of information available to citizens; untangle the referral system and communication between service provider organizations; and increase support and assistance available to family members and informal caregivers.

Enhance Accountability

Lack of communication between health care agencies can lead to devastating consequences for a client. Communication between health care providers, the community support sector, hospitals and long-term care facilities should be a priority in the deliverance of care.

There is no single body accountable for the continuity of seniors care under the present fragmented health care system. Therefore, the proposed paradigm shift should be monitored closely by the LHIN to ensure successful implementation and client satisfaction. A scorecard should also evaluate the following areas: client satisfaction; clinical utilization and outcomes; system integration and navigation; sustained change; and financial performance. Each service is currently being evaluated separately, inhibiting a system-wide analysis of the impact of current Alternate Level of Care strategies. Seniors receive service across a spectrum of care that includes both community and acute care services, thus any scorecard evaluating the quality of their care should reflect the system-wide nature of care delivery.

Challenges and Solutions

To date, most modifications to the health care system have been in response to a crisis. Inevitably, this leads to short-term thinking and quick-stop solutions. Coupled with the fact that provincial elections regularly introduce new political priorities every four (4) years, this impedes a viable, system-wide vision and sustainable practice.

The reactionary atmosphere of the health care system has created a competitive environment in which agencies are left to compete for scarce resources. Rather than encouraging communication and cooperation, the system is fragmented, as each organization strives to prove its worth and provides reasons why it should be funded

[12] Williams, A.P. and Watkins, J. 2009. *The Balance of Care Project: Final Report.*

over others. The ensuing lack of trust between agencies must be ameliorated in order to transfer the focus back onto the client, reduce competition and increase sharing of resources and information.

In a system as complex as health care, change will not take place overnight. Clients will continue to use emergency services until there are other realistic and timely options in the community. However, by shifting the focus upstream to preventative care, and sharing responsibility between hospitals and the community, we can reduce the strain on the acute care system and improve the quality of care for the community at large, and more specifically, for the growing population of seniors.

VII. Recommendations

Note: The following recommendations are not ranked in order of priority. Rather, the recommendations listed are of equal importance to the proposed paradigm shift.

1. System-Wide Engagement

- Develop a system-wide agenda and policy which focus on the care of seniors; integrate this policy in the next Integrated Health Service Plan (IHSP) of the LHIN.

- Implement a LHIN-mandated ALC 'collaboration charter' aligned with the new seniors' agenda and policy, embedded in accountability agreements of organizations with the LHIN.

- Integrate a planning process for senior services, shifting from a fragmented project-based approach to an integrated system based approach (strategy development and implementation; budgeting; reporting).

2. System Coordination and Integration

- Map services and processes for seniors at risk, both those in the community and those who are hospitalized. From findings, address the need for a senior-friendly navigation system.

- Enhance the partnership between the CCAC and the community support sector, such as an integrated approach to needs assessment and care planning with standardized evidence-based tools.

- Build a partnership between the CCAC and the Regional Geriatric Program, developing and implementing a mechanism to identify seniors at risk in the community and in emergency departments.

3. Promotion of Health Recovery

- Implement the Senior-Friendly Hospital framework as per the priorities identified in the regional report expected this summer. Integrate implementation within the next LHIN IHSP and address resource needs for successful implementation.

- Review and reorganize various types of beds around client choice and need (convalescent, transitional, short term treatment, restorative, behavioural support…) developed to address ALC. Ensure clear mandates; optimal utilization; strong restorative focus; timely access through a streamlined referral and triage process with validated tools; and, where warranted, increase the number of rehabilitation and restorative beds.

4. Strengthen Community Care and Support

- Support the affordable housing framework and action plan for Ottawa. Lobby for the establishment of subsidized beds in the existing retirement homes.

- Ensure the sustainability of "Home First" and integrate this strategy within the Senior-Friendly Hospital framework.

- Ensure access to community care and support 24/7, shifting resources accordingly.

- Implement strategies to engage and support the primary care sector in senior care; consider the potential and benefits of a neighbourhood-based integrated approach to community care and support.

5. Senior Engagement and Independence

- Implement the Age Friendly Ottawa program under the leadership of the Council on Aging of Ottawa.

- Develop and implement communication and engagement strategies between all care sectors to support seniors at home.

- Develop the means to assist and support families and informal caregivers, providing care to seniors at home.

6. Enhance Accountability

- Develop a system-wide scorecard model, supported with age-sensitive indicators, to support ongoing monitoring of strategies, assist in a comprehensive research-based evaluation on the impact of the strategies, and assist in the development of future directions.

VIII. Plan of Action and Next Steps

Plan of Action

This report is meant to be used by seniors and their families, stakeholder organizations and individuals, policy makers and the media to help continue the discussion on the ALC issue with a focus on senior-centered solutions.

This report can be used as:

- ✓ A catalyst to guide the development and implementation of concrete strategies which supports a paradigm shift to solve the Alternative Level of Care Crisis.
- ✓ A reference tool for seniors, families and service providers.
- ✓ A policy framework on which to build a communication strategy.
- ✓ Supporting documentations for seniors and their families to advocate on their own behalf.

Next Steps

- Circulate the report widely to seniors and their families, forum attendees, other healthcare stakeholders and policy makers. Make the report available on the Council on Aging of Ottawa's website www.coaottawa.ca.
- Have a slide deck presentation available as a report summary.
- Convene and coordinate follow-up activities with seniors, their families, service providers and health care professionals to evaluate agreed upon priorities for the planning and implementation of senior-centered solutions.
- Monitor progress on the recommendations, through the Council on Aging of Ottawa and its committees.
- Develop a public communication strategy with key stakeholders focusing on promoting the independence and engagement of seniors in the community.

IX. Notes

This report addresses the ALC issue as highlighted by seniors and professionals alike, and was developed based on the ideas put forth at The Council on Aging of Ottawa's Health Forum 2010. Other sources used in the development of this report were as follows:

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