MUSKOKA ALGONQUIN HEALTHCARE	**Policy/Procedure Name:**	**Alternate Level of Care (ALC) Destination**
Manual:	**Number:**	
Section:	**Effective Date:**	03 Oct 2013
Pages: 1 of 12	**Revision Date:**	01 May 2018

Purpose

The purpose of this policy is to define the application and process of Alternate Level of Care (ALC) destination for patients in hospital who no longer require acute care services.

Scope

The policy pertains to all staff members and physicians at Muskoka Algonquin Healthcare (MAHC), as well as LHIN Home and Community Care staff.

Policy Statement

The policy is a clearly and concisely stated course of action to assist in decision making to achieve a desired patient outcome for the ALC patient at MAHC.

Definitions

- Alternate Level of Care:

The Ontario Provincial ALC definition as of July 1, 2009 is *"when a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies"*

General Principles:

Muskoka Algonquin Healthcare (MAHC) has a responsibility to ensure appropriate access to its inpatient acute care beds, complex continuing care beds and to ambulatory and emergency services so that all hospital services benefit the patients that require them. In order to ensure that hospital beds are available for patients who need them, MAHC will work with patients and their families to develop plans for appropriate and timely care, transfer and discharge to home other appropriate locations, following a 'home first' approach. This requires effectively managing the care of alternate level of care (ALC) patients who no longer require acute care, but remain in acute hospital beds awaiting placement in an alternative care setting; as well as those in non-acute beds where discharge planning/placement issues affect timely discharge from hospital

Strategies For Efficient Bed Utilization Include:

- Early development of appropriate discharge and/or service transfer plans with the participation of all members of the interdisciplinary care team, the patient, and patient's family members and Substitute Decision Maker (SDM's) and LHIN Home and Community Care (HCC) Care Coordinators. Generally, LHIN Care Coordinators and/or Patient-Flow Navigators (PFN) assume the co-ordinating role, compiling the necessary assessments, determining the appropriate level of care and educating and supporting the patient/family throughout the process. HCC takes the lead for HCC patients, and PFN takes lead on non-HCC patients for d/c planning. The Most

Responsible Physician (MRP) will ensure that appropriate discharge and/or transfer orders are written, charted, and communicated to the patient care team and to the patient or to their substitute decision-maker in an appropriate and timely manner. Discharge destinations will be determined by a physician/delegate, in collaboration with an inter-professional team, when available. Discharge /transfer destinations may include, but are not limited to:

- *Home (with/without services/programs)*
- *Rehabilitation (facility/bed, internal or external)*
- *Long Term Care Home*
- *Complex Continuing Care (Slow Stream Rehab/Palliative/Medically Complex)*
- *Group Home*
- *Convalescent Care Bed*
- *Retirement Home*
- *Shelter*
- *Supportive Housing*

- Prompt designation of the patient by the MRP or designate as Alternate Level of Care (ALC), when patient no longer requires acute level of care with appropriate criteria charted. Prompt designation of those patients in Complex Continuing Care who similarly no longer require that level of care, should be designated ALC.

- Early identification of patients who could be safely maintained in the community with support, for a period of time, while awaiting other appropriate placements. The LHIN HCC Care Coordinators/ Patient Flow Navigators will develop and co-ordinate the discharge plans in collaboration with the patient/family and other community-based or private resources. The MRP, in collaboration with the team, will ensure that the appropriate ALC, discharge and/or transfer orders are written and communicated to the patient or patient's substitute decision maker (SDM) in a timely manner.

- On-going identification of patients who may be transferred to a more appropriate bed within MAHC, including transfer to the other site if a bed becomes available that better suits the patient's physical, social and emotional needs; with appropriate order for transfer including physician to physician transfer with appropriate MRP designation at the receiving site.

- When placement in a Long Term Care Home (LTCH) is appropriate, the LHIN HCC Care Coordinators who are mandated to determine eligibility and the LHIN Placement ~~Services~~ Coordinator who authorizes admissions to LTC Homes will manage the process, as per the LTC Act.

- Complex Continuing Care (CCC) (Slow Stream Rehab, Medically Complex, Palliative) OR Convalescent Care Program (CCP) eligibility is determined by LHIN HCC Coordinators, in collaboration with the interdisciplinary team, and is based on the assessment of the patient's current abilities, goals and discharge destination plans. CCP eligibility is based on LTC legislation as well. Bed offers for these services are managed by LHIN HCC Coordinators.

POLICY:

Muskoka Algonquin Healthcare strives to ensure that patient care needs always match the particular bed and service which the patient occupies. Planning for discharge begins at the time of admission to hospital and is an on-going process throughout the patient's stay. The purpose of the policy is to standardize the identification and designation of patients as ALC, to define roles and escalation mechanisms, and support the goal of team consensus.

Patients who no longer require care in the acute care setting will be designated as requiring an alternative level of care (ALC) in a timely manner by their MRP/ Team leader, or designate. This decision will be made in a collaborative manner with the patient's care team. The patient will be discharged and/or transferred to an appropriate level of care based on their needs, in a timely manner. The team will support the patient, their substitute decision maker (SDM) and their family in making discharge plans to ensure transitions are made as smoothly and sensitively as possible, in order to support improved patient safety, satisfaction and experiences.

ALC, SERVICE CHANGE, AND DISCHARGE PROCEDURES:

1. Once a patient is no longer in need of treatment in the acute care setting, an ALC order shall be written by the MRP or designate and communicated to the patient or the incapable patient's SDM. Completion of the documentation of ALC status and destination in Cerner is done electronically and interfaced to the ATC/CCO ALC Wait Time System. See "Appendix C" for process. The interdisciplinary care team will identify the appropriate level of care and notify the appropriate stakeholders. The physician, LHIN HCC or /and Patient ~~Experience~~ Flow Navigator (P~~E~~FN) will meet with the patient/family member to inform them the acute care portion of the patient's stay is completed and to discuss and determine an appropriate discharge destination. During this meeting they will be advised that remaining in a bed in the acute care setting is not an option, as it is imperative that we have the right patient, in the right bed and will be given a letter from MAHC's CEO as outlined in "Appendix A" on the date the patient is designated ALC. If designated ALC- Long Term Care (LTC), the letter of co-payment will be issued the same day they are found eligible for LTC as outlined in "Appendix B".

2. In anticipation of, or when a discharge and/or transfer order has been written, MAHC/LHIN HCC Coordinator will assist the patient, family and SDM in assessing appropriate discharge options. It is expected the patient, the incapable patient's SDM and/or involved family members or support persons will cooperate fully in this process so that discharge options are maximized and the discharge may occur immediately upon a suitable discharge/transfer environment being available.

3. For patients who are awaiting placement to a LTCH - the patient, family and/or the patient's SDM will be encouraged to apply to a maximum of five (5) LTCH locations, and up to five (5) Short Stay Interim Facilities. Patients and/or SDM are obligated to apply to at least 1 LTCH location. The patient, family or SDM will be counselled by the HCC Coordinator regarding LTC facilities that have interim, idle beds and short waiting lists. Every effort will be made to ~~have~~ encourage patients/families to choose locations which have either available beds or short waiting lists. If a patient requires more specialized LTCH care (e.g. exit-seeking, behavioural issues, smoker, etc.) their preferred choice must be a LTC facility that can appropriately meet those needs.

   3.a)Once a LTC bed becomes available in either the preferred location or at an alternative location while awaiting the preferred location, the patient/SDM must accept the bed within 24 hours. It is expected that discharge/transfer plans will be developed early in the patient's admission and will be revised as needed during the patient's stay. A longer time frame may be required for complex patient care requirements if there are issues surrounding the identification of the appropriate SDM of an incapable patient, if a hearing before the Consent and Capacity Board is required and/or there is a need to involve the Office of the Public Guardian and Trustee.

3. b)The LHIN HCC Coordinators will work with the care team and others as appropriate throughout the process to collect medical and functional data; to intervene with individuals/families for which this represents a particularly difficult process; and to ensure compliance with policy. These efforts and the responses from the patient, and/or incapable patient's SDM will be recorded in the patient's health record.

3. c) If the patient is ALC-LTC, the LHIN HCC Coordinators will discuss with the patient/family/SDM the co-payment process and/or the uninsured hospital billing process. Their discussions with patient/family/SDM will include other available and appropriate members of the inter-professional care team.

4. Where, in the opinion of the care team, all reasonable efforts have been employed to engage the patient, SDM and/or family in this discharge process and where further supportive measures are not likely to create change, the case will be immediately forwarded to the attention of the Manager of the Inpatient area and highlighted during daily bullet rounds for further discussion/negotiation and resolution. Care conferences will be arranged with the patient/SDM and inter professional team when required. An in depth discussion of the patient's plan of care will occur at weekly rounds.

5. If there is no resolution through the Manager's intervention, the Chief Nursing Executive and Clinical Services will be notified to intervene if the patient/SDM or family delay the process, or reject an appropriate alternative care location. Details surrounding the discussions will be documented in the patient's health record. See "Appendix D" for escalation process.

6. Although the combined efforts of staff, Manager and Chief Nursing Executive and Clinical Services will be directed to achieve a positive outcome, if the patient/SDM fails to comply with discharge/transfer planning as set out above, or if the patient fails to leave the hospital upon being discharged and transfer dates set, the patient will be subject to paying the uninsured hospital rate as of the date of discharge.

7. The Chief Nursing Executive and Clinical Services will notify the Chief Executive Officer (CEO) and the patient's physician of the recommendation to charge the uninsured hospital rate. The CEO will notify the Manager of Finance and the patient's physician, once a decision has been reached to charge the patient.

NON-COMPLIANCE WITH DISCHARGE PLANNING:

It is expected that patients, families and SDM's will actively and constructively collaborate, in a timely fashion, with the care team, with HCC, and with others as appropriate, in planning and executing patient discharge from one MAHC service, including from one MAHC site to another, and from the various MAHC services back to the community, whether that be their own home, LTCH, or other arrangement. The written, dated and documented most responsible physician (MRP) order, which indicates the next MAHC service or external placement the patient requires, will provide the appropriate authority for such moves.

Staff members are to follow the algorithm "Appendix D" with regard to discharge planning and escalation process. Where a patient or incapable patient's SDM refuses to comply with discharge planning (i.e. refuses to apply for appropriate alternative care placement, unduly delays the application process, fails to comply with this policy, etc.) where a discharge order has been written, the patient may be required to pay the per diem uninsured rate for occupying the hospital bed. This rate is currently $725 per day.

Refusal of an offered bed or unwillingness to leave the hospital within 24 hours of an alternative location becoming available may result in MAHC charging the patient the uninsured daily rate.

ALTERNATE LEVEL OF CARE SERVICE DESIGNATION AND CO-PAYMENT CHARGES:

Patients who have been designated as Alternate Level of Care (ALC) – LTC and who remain in an acute hospital bed awaiting placement to an alternative care location, as well as those in certain other hospital services, are subject to a co-payment for accommodation in accordance with the Public Hospitals Act, Health Insurance Act and MAHC's Co-Payment Policy. This charge is unrelated to the charges for non-compliance.

The following are the alternative care locations and the grace periods prior to co-pay commencement from the day the person has been designated as requiring an alternative level of care/transferred to the following designations:

Co-payment begins immediately if the patient is in an acute bed and is designated as requiring a Long Term Care Home. The LHIN HCC Coordinator will take the notification form (Appendix "E") to Business Office. Business Office will communicate with patient/family or SDM to facilitate co-payment process, and will provide letter of understanding and authorization (appendix "B")

PROCESS

1. Patient becomes ALC-LTC (or medically complex in CCC)
2. Clinical lead advises LHIN CC of date that patient is ALC-LTC
3. Family is advised that copayment will apply to their situation, via family meeting, and/or LHIN CC will advise. Patient/family will be advised of the need to provide the patient's most recent Notice of Assessment (NOA) to the business office, to be eligible for rate adjustment.
4. Family can be given Ministry website information for reference about the Copayment http://www.health.gov.on.ca/en/public/publications/chronic/chronic.aspx and/or provided a standard package with printed copies
5. LHIN CC will submit the copayment notification form to the business office to advise of a billable patient.
6. LHIN CC will include family contact information on the notification form.
7. Business office will complete the copayment letter with the family.
8. LHIN CC will discuss involuntary separation with families if applicable.

- Home or senior's residence/retirement home – there is no grace period or co-payment charge. Those refusing to leave a hospital bed to go to or return to these locations, once plans are in place; will be charged the uninsured per diem rate of $725/day.

References / Relevant Legislation

1. Ministry of Health and Long-Term Care. Alternative Level of Care (ALC) Patient Definition; http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/alc_definition.aspx
2. Cancer Care Ontario Manual Version, May 2016 https://archive.cancercare.on.ca/ext/databook/db1819/documents/Appendix/ALC_Reference_Manual_v2.pdf
3. Wait Time Strategy: Better Access To Care. ALC Definition Practical Guide for Clinicians; Frequently Asked Questions; ALC Information for Patients and Families. https://www.cihi.ca/en/hcic2012_conclu_en.pdf

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4. Ontario Regulation 79/10, Long-Term Care Homes Act, 2007, Part III.
5. Public Hospitals Act, R.S.O. 1990, s.16 of Regulation 965,
6. Health Insurance Act, R.R.O, 1990, s. 10 of Regulation 552
7. Ministry of Health and Long-Term Care. Complex Continuing Care Co-payment 2010 http://www.acelaw.ca/appimages/file/Hospital%20Complex%20Continuing%20Care%20(CCC)%20Co-Payment0001.pdf
8. MAHC Co-Payment Policy & Procedure
9. Hospital Management R.R.O. 1990, Reg. 965: *Public Hospitals Act, R.S.O. 1990, c. P.40* https://www.ontario.ca/laws/regulation/900965
10. Hospital Chronic Care Co-Payment/Questions and Answers, Sept. 2017 http://www.health.gov.on.ca/en/public/publications/chronic/chronic.aspx

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Appendices

APPENDIX 'A'

Dear Patient and Family:

Making Plans for Your Discharge

Your health care team at Muskoka Algonquin Healthcare is here to attend to your care needs. We are committed to ensuring that every patient receives the care and services they require and that every hospital bed is used for the benefit of the community.

From the time of your admission, your health care team will work with you and your family to make plans for your discharge from hospital. When you no longer require the level of care provided in the hospital, you will be discharged to one of the following options:

1. Return home with your previous level of support.

2. Return home with additional support, which could include support from family and friends, NSM LHIN Home and Community Care (HCC) and/or privately paid-for caregivers from an agency.

3. Relocation to a retirement facility. If required, additional services may be available through the NSM LHIN Home and Community Care (HCC) or privately purchased.

4. In extenuating circumstances only, move directly from the hospital to a Long Term Care Home.

If returning to your residence while waiting for a long term care home is an option, we will make every effort to assist you or your loved one in doing so, as we know that;

- People recover more quickly in their own homes
- People are at risk of picking up infections in hospital and often become weaker and deconditioned because there is limited socialization and activity.
- Deciding to live in a long-term care home is a big decision and best made in the comfort of your home with support from your loved ones.
- LHIN HCC can provide support for you to return home

In extenuating circumstances only, you may be deemed to need LTCH directly from hospital. Although current regulations only require you to select one (1) long term care facility, we are asking that you select as many as five (5) long term care facilities of your choice, which may include Long Term Care Homes with shorter wait lists or empty beds within the surrounding area. Every effort will be made to move you to your preferred location but should one of your other choices become available, you will be transferred there to wait for your preferred location. The LTCH will review your application and will inform you of their ability to meet your needs. If declined by a chosen facility, you will be asked to make another selection. Your position on the waiting list for the facilities you choose is maintained by NSM LHIN HCC. Any time after you leave the hospital, you may review and alter your facility choices with LHIN Placement Services.

If no bed is available in one of your choices and we are able to coordinate appropriate services to accommodate you at home or another setting, you will be asked to wait elsewhere for your preferred LTCH accommodation, as the hospital is unable to accommodate patients who no longer require acute care. You may be asking, "Why can't I, or my family member remain in hospital to wait for my first choice?" The answer is one of bed availability. When people wait in hospital for LTCH beds, fewer beds are available for acutely ill patients. We are committed to ensuring that the right bed is used by the right patient and at the right time.

If, for any reason, you must wait within the hospital for a long term care home, you will be required to pay a co-payment charge as per the Canada Health Act. There is financial assistance available if your income does not cover the cost of this co-payment. A Care Coordinator will meet with you to discuss these co-payment charges.

Please be advised the hospital may charge you a full daily rate of $725.00/day as per the Public Hospitals Act if you no longer require the services of the acute care hospital, yet remain in an acute care bed and:

- do not agree to complete the Long Term Care application within the time-frame discussed
- do not agree to choose at least one (1) long term care home but we encourage up to five (5) choices.
- do not accept the bed offer for a long-term care home that you have chosen
- refuse to leave the hospital on the scheduled date of discharge
- refuse discharge to a suitable, planned community setting

We do understand that applying and waiting for a long-term care bed is a difficult time for you and your family. The health care team is here to help you. If you have questions or concerns about your discharge plans, please speak with a member of your healthcare team. Your understanding is appreciated.

Appendix "B"

MUSKOKA ALGONQUIN HEALTHCARE

Dear: _____ Patient Name and MRN #:_____

Acute Care hospitals have been directed by the Ministry of Health and Long Term Care to charge a monthly co-payment to all patients who have been designated by the Attending Physician, as requiring *Alternate Level Care*, in a long term care facility. This designation is given to patients who no longer require acute hospital care and are better serviced in another setting, such as a nursing home. Your doctor assigned this designation on _____, 2018. The Co-payment is the responsibility of the patient, guarantor or sponsor. (As per Ministry guidelines, once the co-payment charge commences, it continues throughout the entire period you are requiring an alternative level of care while in the hospital.)

You will be required to pay a monthly co-payment charge from the designation date above, until the date of your discharge from Muskoka Algonquin Healthcare. The "maximum" charge for co-payment is set by the Ministry of Health and Long Term Care annually and is currently $1819.53 per month or $59.82 per day. This fee is for meals and ward accommodation only. Individual co-payment charges are calculated by the Accounting Clerk at MAHC based on the patient's monthly income using your latest Notice of Assessment Form from Revenue Canada. There are exemptions from the fee in exceptional circumstances. These can only be determined by completing a co-payment calculation form. There is an additional charge for preferred accommodations, if requested, which is $30.00/day for semi-private or $60.00/day for private accommodations.

We kindly ask that you please see the Accounting Clerk located in the Business Office at MAHC regarding arrangements for payment. A copy of the patient's most current Notice of Income Tax Assessment from Revenue Canada and Power of Attorney for Property (if necessary) is required. If we do not receive this information within one month from the date of this letter, we will assume that your charge will be the maximum co-payment. Receipts for Income Tax purposes will be issued when payment is received.

Thank you for your cooperation in this matter. If you have any further questions please speak to the Accounting Clerk as indicated below:

- Huntsville District Memorial Hospital 705-789-2311 ext.2230.
- South Muskoka Memorial Hospital 705-645-4404 ext. 3212.

Patient Name: _____ Signature: _____

or Substitute Decision Maker Name: _____ Signature: _____

Mailing Address: _____

_____

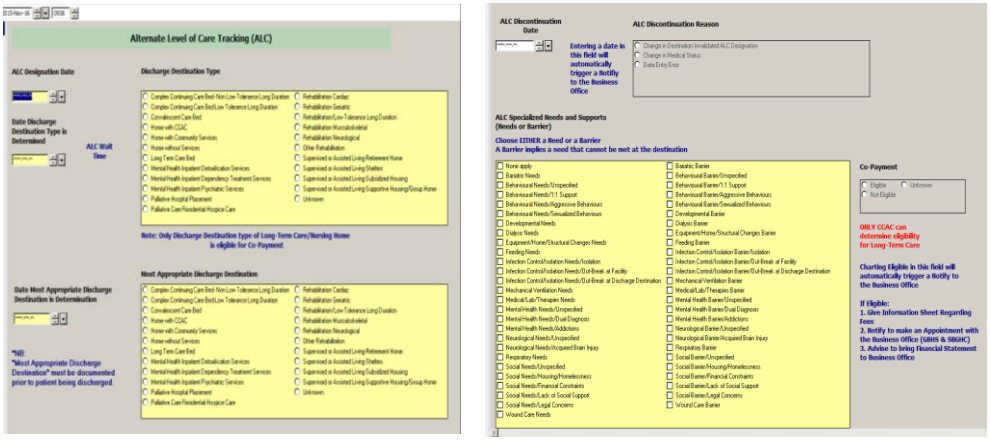
Date Signed: _____

Appendix 'C"

Documentation of ALC Status & Destination in Cerner

1. In PowerChart, select Access Management Office at the top right, open the correct unit. Right click on the patient to be designated ALC and select put patient on ALC from the menu. Enter date and time of the ALC designation. Exit Access Management Office screen when complete.
2. Open the patient's PowerChart. Select PowerOrder, and then select **ALC orderset** and order as a therapeutic intervention. In this orderset, change vital signs to once weekly, weight to once per month, and select ALC daily assessment. Choose another PowerOrder for **ALC Patient.** Refresh screen. The ALC tracking form will now be found on the task list (greyed out).
3. Re-sign into PowerChart with manager log in (can be completed by Clinical Leads or Manager). The task list will show the **ALC tracking form**, which is no longer greyed out. Choose the form and complete it, entering the designation date, discharge designation type, date most appropriate discharge determination is determined, and most appropriate discharge destination. See **Figure 1** below. Discontinuation of ALC status due to change in status, is done on the same form that was used to create the original designation, by modifying it, and resaving. The form can be printed from Clinical notes once completed.

Figure 1



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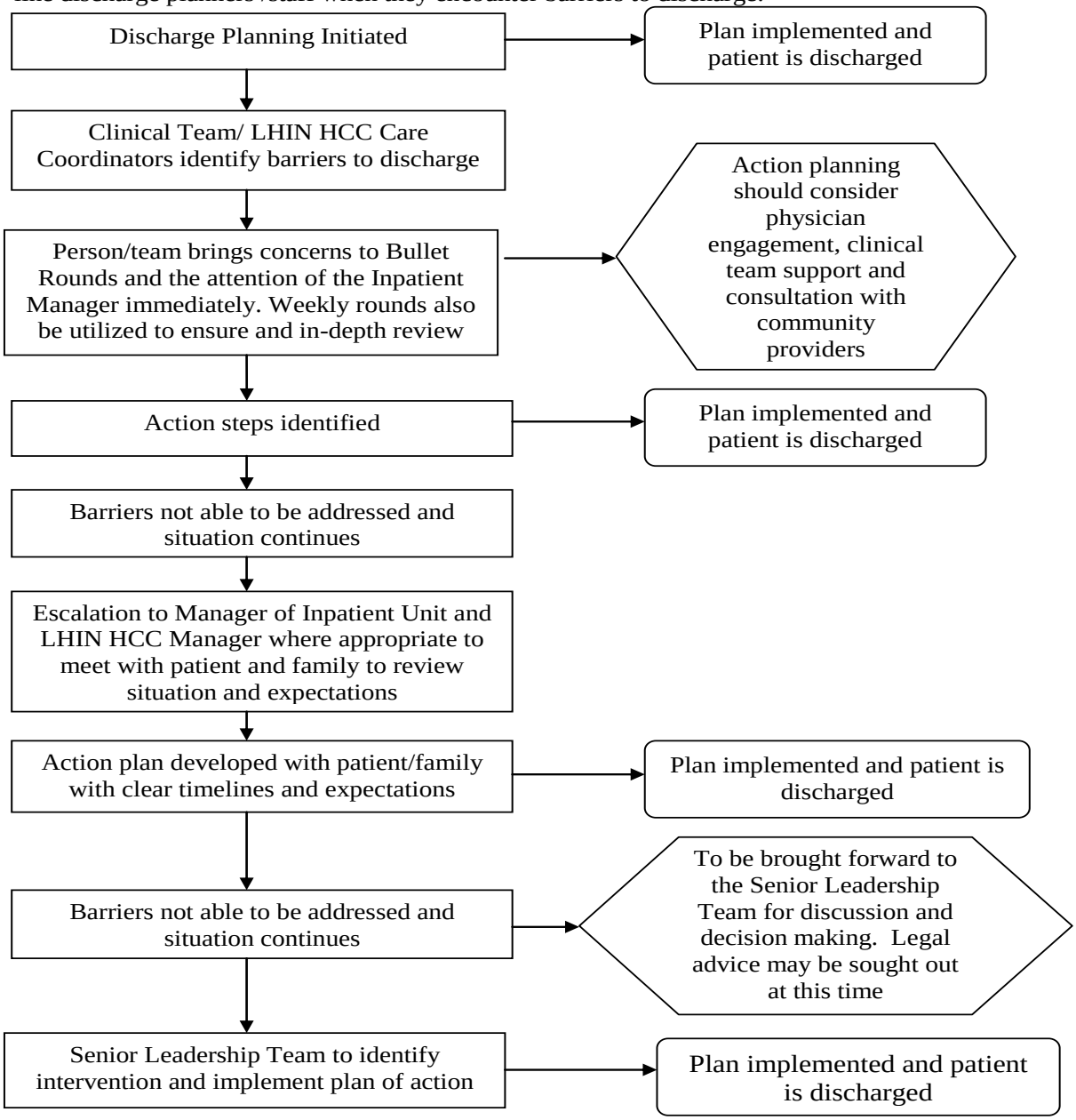
APPENDIX 'D'

Development of an Escalation Protocol to Address Barriers to Discharge Planning:

As we endeavor to work with patients and families on discharge options from acute care there are situations which arise that require support and intervention from management and possibly senior leadership of the hospital and CCAC. Below is a general outline of an escalation process to support front line discharge planners /staff when they encounter barriers to discharge:



Appendix "E"

CCCP Notification Form
(Complex Continuing Care Co-payment)

Date form completed	
Completed by	
Signature	
Patient Name	
Patient BH#	
Patient HU#	

ALC-Not eligible for CCCP

ALC-Eligible for CCCP **Effective date to START CCCP:_____**

-waiting for LTCH

-waiting for CCC Regional Program

Patient discharged **Effective date to STOP CCCP:_____**

POA/SDM Information:

Name: _____

Address: _____

_____

Phone: _____