MUSKOKA ALGONQUIN HEALTHCARE		**Policy/Procedure Name:**	**Alternate Level of Care and Discharge Policy**
Manual:	Administration	**Number:**	
Section:	Risk Management	**Effective Date:**	18 MAR 2021
Pages:	1 of 28	**Revision Date:**	12 MAY 2021

Scope:

This policy and procedure applies to all employees of the Muskoka Algonquin Healthcare (MAHC), Home and Community Care, as well as, credentialed staff with MAHC privileges (i.e., medical, dental, midwifery, and extended class nurses) and students that are involved in the discharge process. These individuals shall be referred to collectively as Workers herein.

Policy Statement

All health care providers at MAHC believe that it is in the best interest of the patient to safely return home (being the venue from which they have been admitted) and will work collaboratively towards this goal. To maintain access to care MAHC has an ethical responsibility to ensure hospital resources, including acute care beds, are utilized as intended.

The inpatient acute care episode is usually intense, but brief. Once patients complete their acute care treatment, they are ready for discharge home or to the most appropriate level of care that meets their health care needs. This discharge must occur in a timely and effective manner to ensure capacity to provide safe, high quality patient-centered care.

Discharge planning is a complex process requiring an inter-disciplinary approach with patients and families at the center in order to facilitate a discharge from hospital. MAHC has a discharge planning pathway, with key activities developed from leading practices, to ensure a continuous process with clear, standardized communication letters provided to the patient/Substitute Decision Maker (SDM), when necessary.

This policy and supporting documents are intended to be a resource for healthcare providers who are assisting patients and families to plan discharge. Information regarding definitions, co-payment and processes to guide the Interprofessional Team through complex discharge situations are included in supporting materials.

Definitions

Alternate Level of Care (ALC) - When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting, the patient must be designated ALC at that time by the Most Responsible Provider (MRP) or 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).

Co-Payment – A co-payment may be charged when the patient has been designated as ALC-Long-Term Care or Complex Continuing Care and an application has been made to a discharge destination where a co-payment will be charged. The maximum co-payment rate is set by the Ministry of Health and is the same for all patients and all hospitals, subject only to an ability to apply for reduction based on specific circumstances. If the patient condition changes, and they require acute care again, then co-payment charges would not apply during the acute period.

Insured In-Patient Services – on admission to a hospital, a patient with the Ontario Health Insurance Plan (OHIP) coverage will be entitled to insured services which generally includes services of all hospitals.

Interprofessional Team — MAHC employees including Professional Staff, Nursing, Home and Community Care Support Services Care Coordinators, Allied Health, and others as appropriate.

Most Responsible Provider (MRP) — credentialed staff who is primarily responsible for the medical care and management of the patient.

Per Diem – per diem or daily rate is a charge which reflects the actual cost of providing care. This rate is determined by the hospital, and is based on the intra-provincial OHIP rate. A hospital may charge a per diem after the effective date of discharge order, when a patient has refused to leave and/or has declined to accept a long-term care bed that has been offered by one of the homes to which they applied.

Substitute Decision Maker (SDM) — a person who is authorized under section 20 [Health Care Consent Act (1996)] are to give or refuse consent to a treatment on behalf of a person who is incapable with respect to the treatment.

Procedure

Discharge Planning**:**

Discharge planning will begin upon admission to the hospital and is a collaborative process that includes open and early communication with patients, family members of patients, the health care team, and, if applicable, substitute decision makers (SDMs). The expected and preferred discharge destination is home with appropriate resources and supports in place. Discharge readiness is determined by the MRP or designate in collaboration with the Interprofessional Team when the patient no longer requires the intensity of resources/services in acute care.

The Interprofessional Team works with the patient/SDM to plan for discharge home and will collaborate with Home and Community Care Coordinators to arrange for any required

community supports prior to discharge. Due diligence of Home and Community Care coordinators, will ensure all discharge destination options have been exhausted before a patient is designated ALC. Patients requiring the next level of care (i.e. Complex Continuing Care, Convalescent Care, Group Home, Palliative Care, Rehabilitation, Retirement Home, Supportive Housing, or Long Term Care) may wait in hospital for a short period of time. During their stay they will be reassessed to determine if they are eligible for discharge home.

Refusal of Discharge:

If an acute patient has a written discharge order, from their MRP or delegate and the patient/SDM refuses to leave, and a period of 24 hours has passed with the patient not having left the hospital, then the patient is no longer entitled to "insured in-patient services" at the hospital, as per Ontario's Health Insurance Act (HIA). The patient will be charged directly for their continued stay at the hospital at MAHC's Per Diem Rate. Once notified of the patient/SDM's refusal to leave, the patient/SDM will be provided with the MAHC Refusal of Discharge Letter and Per Diem notice.

Alternate Level of Care Designation:

When a patient's condition meets the criteria in accordance with the provincial definition of ALC, the MRP or designate shall enter an ALC order in the patient's record.

When a patient is designated ALC for Long Term Care (LTC) or Complex Continuing Care the Co-Payment will be applied if/when appropriate, as determined by the Ministry of Health. The patient/SDM (when appropriate) will be provided with the MAHC Co-Payment Letter, explaining ALC, ALC co-payment, discharge planning, and the hospital policy that the patient will be discharged as of the date that a bed becomes available at any one of their facility choices, and that they will be charged the per diem from that date forward should they refuse the bed offer.

Patients who are assessed as eligible and who have been accepted by an ALC facility will be transferred to that facility once a bed offer is made. The MRP or designate will write a discharge order and communicate the order to the patient/SDM and Interprofessional Team.

Refusal of Bed Offer:

If a patient/SDM refuses a bed offer from one of the Long-Term Care homes to which they have applied, has a written discharge order, from their MRP or delegate, and a period of 24 hours has passed with the patient not having left the hospital, then the patient is no longer entitled to "insured in-patient services" as per Ontario's HIA. The patient will be charged directly for their continued stay at the hospital at MAHC's Per Diem Rate. Once notified of the patient/SDM's

refusal of bed offer, the patient/SDM will be provided with the MAHC Refusal of Bed Offer Letter and Per Diem notice.

Note- should a patient refuse any planned discharge, the per diem rate will apply as the patient could leave hospital.

N.B. LTC applications may be initiated in hospital by request (e.g. to await crisis placement from home). This does not mean that the patient is approved to wait for placement from hospital (remains ALC for Home). Discharge planning will continue to facilitate the patient's return to the community to wait for placement.

References / Relevant Legislation

Government of Canada, "Canada Health Act" (09 November 2017) at
https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canadahealth-act.html

Health Care Consent Act (1996) at
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm#BK11

Health Insurance Act, RSO 1990, c H.6 [HIA] at
https://www.ontario.ca/laws/statute/90h06

Ontario Hospital Association. 2018. Managing Transitions: A Guidance Document – Second Edition at
https://www.oha.com/health-system-transformation/alternate-level-of-care-and-emergency-room/managing-transitions

Public Hospitals Act, RSO 1990, c. P.40 at
https://www.ontario.ca/laws/statute/90p40

Notes

Appendices

Original versions of all appendices are housed on SharePoint at https://mahc.sharepoint.com/sites/nursing/Discharge Tools and Letters

Appendix 1 - Discharge Planning Pathway

Appendix 2 - SDM/POA Not Participating in Discharge Letter

Appendix 3 - Per Diem Notice (Refusal of Discharge) Capable Patient Letter

Appendix 4 - Per Diem Notice (Refusal of Discharge) Substitute Decision Maker Letter

Appendix 5 - Co-Payment Letter

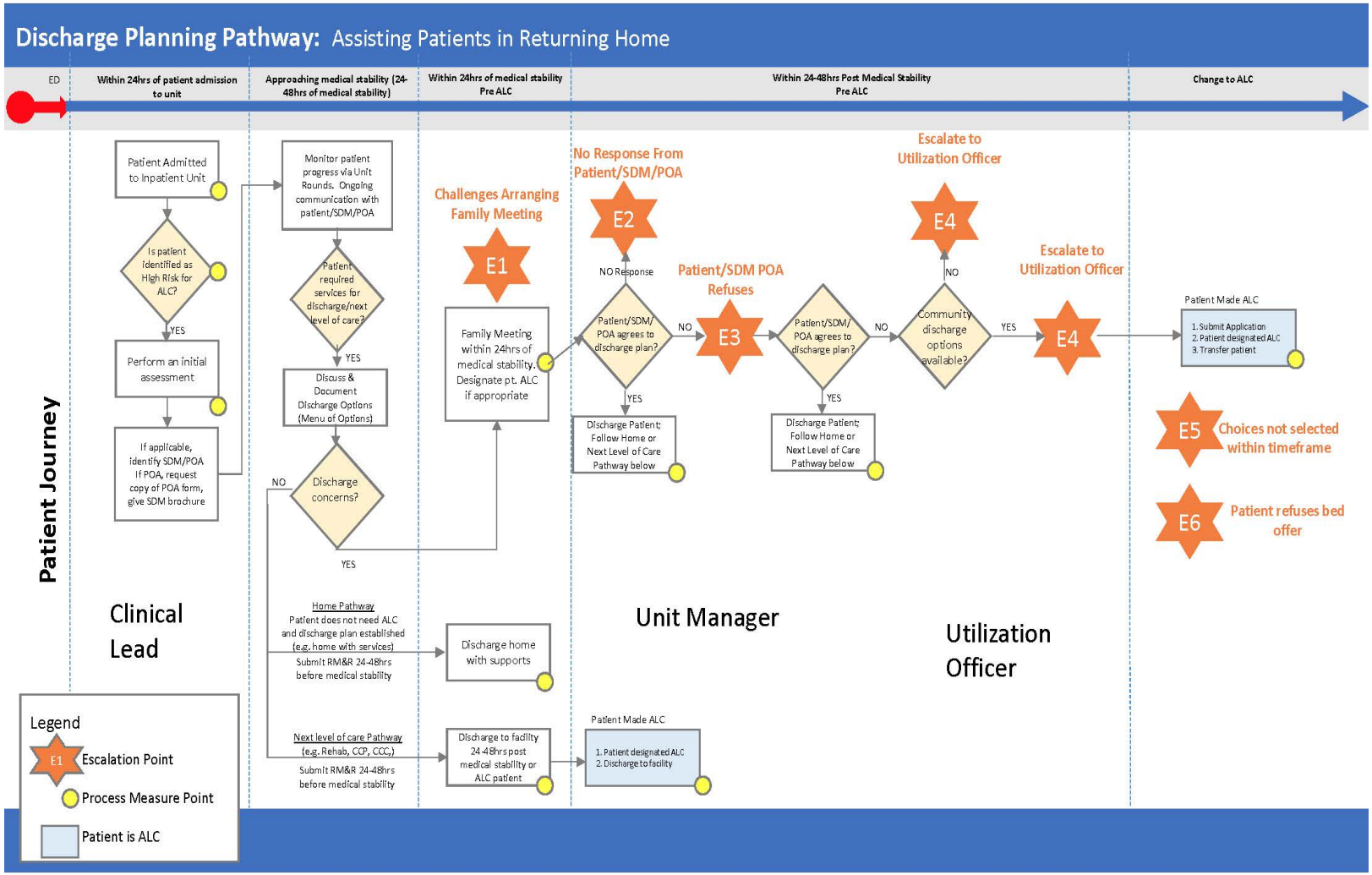
Appendix 6 - Refusal of Bed Offer Capable Patient Letter

Appendix 7 - Refusal of Bed Offer Substitute Decision Maker Letter

Appendix 1 - Discharge Planning Pathway

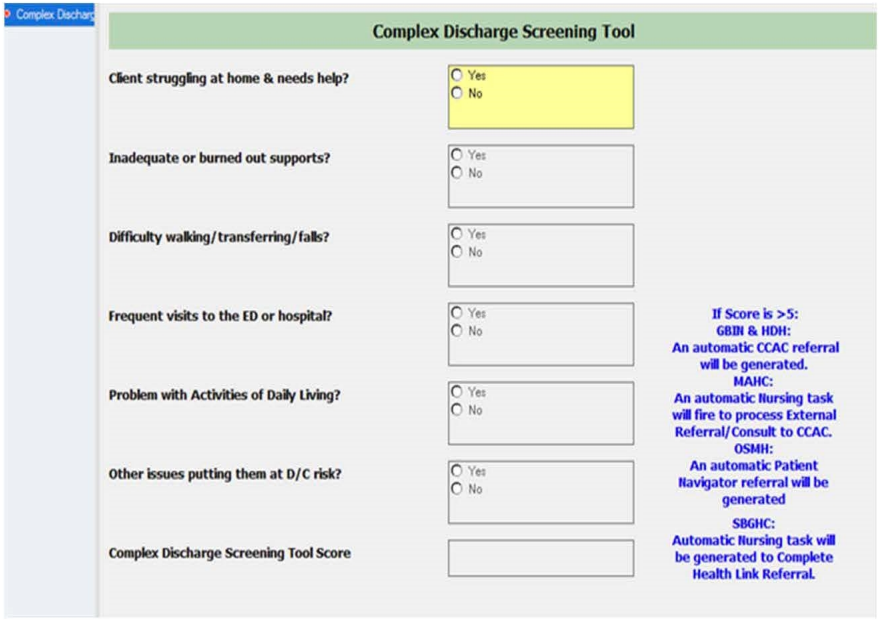
Discharge Planning Activity

- Within 24 hrs. of admission- nurse completes assessment determines if patient is high risk for ALC
- Monitor progress of patient towards discharge via rounds (referral to HCC required?
- Discharge concerns? Arrange discharge planning meeting. If no response- send letter
- Discharge date written by physician and patient refuses to leave? Provide letter which explains per diem that will be charged
- Patients made ALC? provide ALC brochure which explains requirements and co-payment
- No acceptance of bed offer- provide letter


Discharge Planning Pathway: Assisting Patients in Returning Home
ED
Within 24hrs of patient admission to unit
Approaching medical stability (24-48hrs of medical stability)
Within 24hrs of medical stability Pre ALC
Within 24-48hrs Post Medical Stability Pre ALC
Change to ALC
Patient Journey
Patient Admitted to Inpatient Unit
Is patient identified as High Risk for ALC?
YES
Perform an initial assessment
If applicable, identify SDM/POA If POA, request copy of POA form, give SDM brochure
Monitor patient progress via Unit Rounds. Ongoing communication with patient/SDM/POA
Patient required services for discharge/next level of care?
YES
Discuss & Document Discharge Options (Menu of Options)
Discharge concerns?
NO
YES
Challenges Arranging Family Meeting
E1
Family Meeting within 24hrs of medical stability. Designate pt. ALC if appropriate
No Response From Patient/SDM/POA
E2
NO Response
Patient/SDM/ POA agrees to discharge plan?
YES
Discharge Patient; Follow Home or Next Level of Care Pathway below
NO
Patient/SDM POA Refuses
E3
Patient/SDM/ POA agrees to discharge plan?
YES
Discharge Patient; Follow Home or Next Level of Care Pathway below
NO
Escalate to Utilization Officer
E4
NO
Community discharge options available?
YES
Escalate to Utilization Officer
E4
Patient Made ALC
1. Submit Application
2. Patient designated ALC
3. Transfer patient
E5
Choices not selected within timeframe
E6
Patient refuses bed offer
Home Pathway
Patient does not need ALC and discharge plan established (e.g. home with services)
Submit RM&R 24-48hrs before medical stability
Discharge home with supports
Next level of care Pathway
(e.g. Rehab, CCP, CCC,)
Submit RM&R 24-48hrs before medical stability
Discharge to facility 24-48hrs post medical stability or ALC patient
Patient Made ALC
1. Patient designated ALC
2. Discharge to facility
Clinical Lead
Unit Manager
Utilization Officer
Legend
E1 Escalation Point
Process Measure Point
Patient is ALC

Discharge Planning Risk Assessment

- Completed by the primary nurse within 24 hours of admission
- Automatically generates a referral to the discharge Officer identifying patients that may require services on discharge or an alternate level of care
- Risk Assessment Tool: Cerner- Complex Discharge Screening Tool



Discharge Planner Initial Assessment

Engaging patients early to streamline their discharge plan and reduce avoidable delays

Multi-disciplinary Team and Home and Community Care Officer (HCC) @ Bed Rounds will:

- Review patient's life before hospital admission
- Current living situation/condition
- Patient's wish (i.e. where they would like to go)
- Language preferences

For patients that are both capable and not capable

- Capacity (if applicable and known)
- Patient's consent to speak with family
- SDM/POA (obtain POA form if applicable)
- Provide The Role of the Substitute Decision Maker (SDM) Brochure (if applicable)

Family Meeting, team approach

Discharge Planning Meeting with Physician, Home and Community Hospital Care Officer (HCC) and appropriate team members, with patient/family to plan a supportive discharge, answer questions, and minimize delays and gaps in communication. Family meeting to be arranged while patient is medical, at least 24 hours before medical stability.

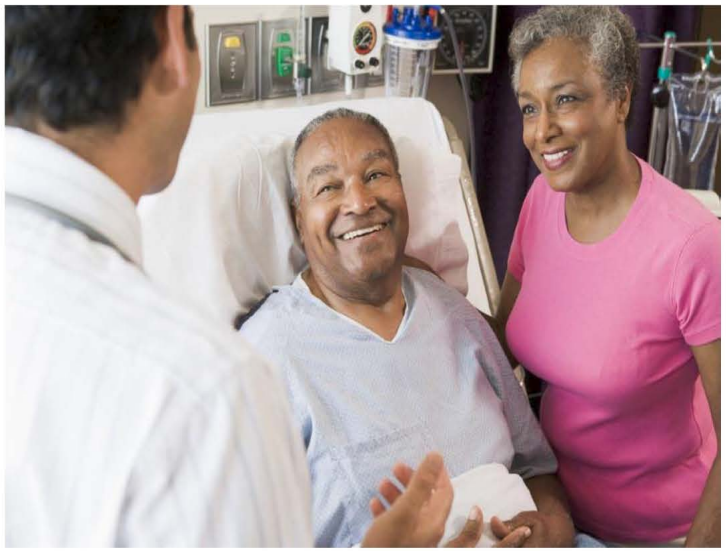
Assumptions:

- Initial Assessment has been performed by the team
- Discussion regarding discharge discussions has occurred

Guidelines:

Family Meeting with Discharge Planner, HCC and relevant disciplines

- **Team Approach:** discharge planning meeting with Discharge Planner, HCC, and appropriate members of the patient's health care team, to provide patient/family with opportunity to discuss options and ask questions.
- **Consistent messaging**
- **Upfront understanding** to ensure discharge plan and services offered are aligned with patients needs
- Safely transition patients to community



If the patient agrees

Discharge patient from active care and designate ALC if appropriate

If the patient disagrees

Reinforce discharge plan. If patient still refuses provide formal letter outlining per diem charges and designate ALC if appropriate

Plan for discharge home not viable at this time and patient currently needs to wait in Hospital for Long Term Care- ALC brochure and co-payment information

Long-Term Care Process

Some patients may be permitted to wait in hospital for a short period of time for Long Term Care
During their stay they will be reassessed to determine if they are eligible for discharge home

Assumptions:

- Family Meeting has occurred; multi-disciplinary are team, HCC and clinical lead have met with patient and family together
- Escalation E3 has occurred
- Escalation E4 has occurred; patient has been presented at ALC Discharge Rounds, Utilization Officer to temporarily allow patient to wait in hospital

LTC Process:

Manager, Clinical Lead and HCC meet with patient/SDM/POA

1. **Clinical Lead/Manager:** Provide co-payment letter, discuss hospital policy regarding refusal of bed offer. Document letter was given and Patient/SDM/POA signed or refused to sign. Scan letter into patients chart
2. **HCC:** Proceed with placement application; discuss benefits of selecting short wait-listed homes
3. **Change to ALC:** Clinical Lead to notify physician to change patients status to ALC (co-payment begins)

Choices not selected within 5 days – refer to E5

LTC Home Acceptance/Rejection (within 5 days):

If LTC Homes do not provide acceptance/rejection within 10 days, they will be escalated by Home & Community Care to Discharge Planning

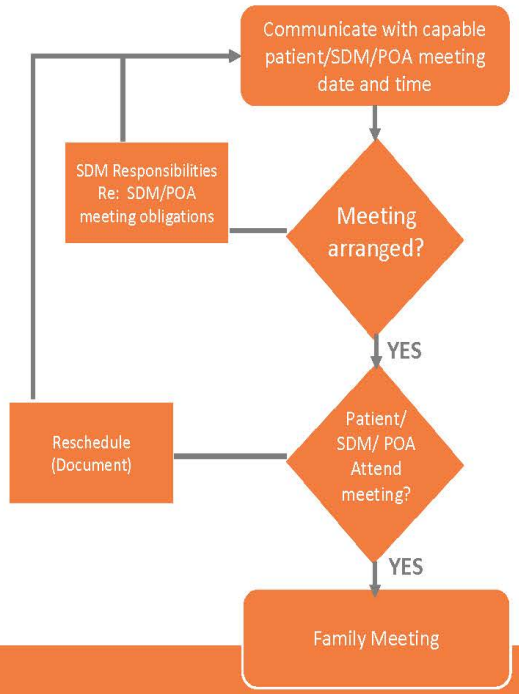
Patient Reassessment:

HCC to reassess patient to determine if their condition has improved and are eligible to return to community

Patient refuses bed offer – refer to E6

Escalation E1

Escalation	Resources	Summary	Timeframe
E1	1. Multidisciplinary Team, HCC 2. Unit Manager	Challenges arranging Family Meeting with SDM/POA	24-48hrs



- Follow Process Diagram
- Ensure SDM/POA has received The Role of the Substitute Decision Maker (SDM) brochure
- Inform SDM/POA of their responsibility - they must be willing, capable, and available (including meetings) to be a SDM/POA.

Refer to next slides for scenario's below

1. No reply from SDM/POA
2. SDM/POA schedules meetings but does not attend

Escalation E1

Escalation	Resources	Summary	Timeframe
E1	1. Multidisciplinary Care Team, HCC 2. Unit Manager	Challenges arranging Family Meeting with SDM/POA	24-48hrs

1. <u>No reply from SDM/POA</u>

- Make 3 attempts to contact SDM/POA; document each attempt
- 3 attempts are necessary before moving to the next SDM/POA or PG&T
- Refer to The Role of the Substitute Decision Maker (SDM) brochure for more information on the role and rank of SDMs

Process

- Day 1 –Attempt 1 (leave voicemail and document)
- Day 2 –Attempt 2 (leave voicemail and document)
  - Inform SDM/POA that one more attempt will be made tomorrow, if they do not reply and co-operate in the discharge plan, we will move onto the next SDM/POA or PG&T as per Section 20 of the Health Care Consent Act
  - Inform Unit Manager
- Day 3 –Final Attempt (leave voicemail and document)
  - Inform SDM/POA that this was the final attempt, we will be moving onto the next SDM/POA or PG&T as per Section 20 of the Health Care Consent Act
  - Inform Unit Manager, **Send Letter # 1 through registered mail**

Escalation E1

Escalation	Resources	Summary	Timeframe
E1	1. Multidisciplinary Team, HCC 2. Unit Manager	Challenges arranging Family Meeting with SDM/POA	24-48hrs

2. <u>SDM/POA Schedules Meeting but does not attend</u>

- Make 3 attempts to meet with SDM/POA; document each attempt
- 3 attempts are necessary before moving to the next SDM/POA or PG&T
- Refer to The Role of the Substitute Decision Maker (SDM) brochure for more information on the role and rank of SDMs

Process

- Day 1 –Meeting 1 (call to arrange meeting next day and document)
- Day 2 –Meeting 2 (call to arrange meeting next day and document)
  - Inform SDM/POA that one more attempt will be made tomorrow, if they do not attend and co-operate in the discharge plan, we will move onto the next SDM/POA or PG&T as per Section 20 of the Health Care Consent Act
  - Inform Unit Manager
- Day 3 –Final Meeting (call to arrange meeting next day and document)
  - Inform SDM/POA that this was the final attempt to meet and we will be moving onto the next SDM/POA or PG&T as per Section 20 of the Health Care Consent Act
  - Inform Unit Manager, **Send Letter # 1 through registered mail**

Escalation E2

Escalation	Resources	Summary	Timeframe
E2	1. Multidisciplinary Team, HCC 2. Unit Manager 3. Utilization Coordinator	No response from patient/SDM/POA for consent/refusal of discharge plan	24-48hrs

No Response from Capable Patient

- Discharge Planner to obtain consent/refusal to discharge plan from patient within 24hrs
- Escalate to Unit Manager if patient does not provide a response
- Unit Manager to escalate to the Utlization Officer if patient does not provide a response within 24hrs

No Response from SDM/POA

- Make 3 attempts, document. **Send Letter #1 through registered mail**
- If no response move to next SDM

Escalation E3

Escalation	Resources	Summary	Timeframe
E3	1. Multidisciplinary Team, HCC 2. Unit Manager 3. HCC Manager	1. Patient/SDM/POA refuses discharge plan 2. Plan for discharge home not viable at this time and patient currently needs to wait in Hospital for Long-Term Care	24-48hrs

1. **Patient/SDM/POA refuses discharge plan**
   - Discharge Planner and HCC meet with patient to accept discharge plan (within 24hrs)
   - Discharge Planner escalate to Unit Manager. Unit Manager, Multidisciplinary Team, HCC meet with patient to accept discharge plan (within 24hrs)
   - Unit Manager may escalate to HCC Manager to inquire about additional HCC services to facilitate discharge
   - If patient refuses, escalate to Utilization Officer (E4)

2. **Plan for discharge home not viable at this time and patient currently needs to wait in Hospital for Long Term Care**
   - Escalate to HCC Manager & Inform Unit Manager
   - HCC : Escalate to HCC Manager to determine if additional services can be implemented; if patient cannot be supported in community with HCC services
   - Discharge Planner escalate to E4 (instructions below)
   - Inform Unit Manager

Patients escalated to E4 will be discussed during ALC Discharge Rounds

Escalation E4

Escalation	Resources	Summary	Timeframe
E4	1. Utilization Officer and VP, Patient Services, Quality & Chief Nursing Executive,	• Following E3, if patient **(A)** refuses discharge plan, or **(B)** plan for discharge is not viable at this time and patient needs to wait in hospital for Long Term Care • Utilization Officer to explore options below	24hrs

Unit Manager, or, Utilization Officer determines patient does not require LTC from hospital

- Give refusal of discharge letter (**Send Letter #2**) to patient/SDM/POA or send through registered mail

Unit Manager discharge home is not viable at this time and patient needs to wait in hospital for Long Term Care

- Approve patient to temporarily wait in hospital for Long Term Care with the expectation that they will be reassessed to revisit their discharge home if their condition improves
- Start co-payment and give co-payment letter (**Send Letter #3**), discuss hospital policy regarding refusal of bed offer
- Document and scan letter into chart

Escalation E5

Escalation	Resources	Summary	Timeframe
E5	1. HCC 2. Multidisciplinary Team 3. Unit Manager	• Choices not selected within timeframe	5 Days

Choices not selected within 5 Days

- HCC explains urgency of touring and submitting a minimum of 1 choice (but 4 or 5 is preferable) within 5 days to secure waitlist date.
- Day 6 –HCC reminds Patient/SDM/POA of deadline and consequences
- Day 7 –Clinical Lead reminds Patient/SDM/POA of deadline and consequences
- Day 8 –Unit Manager reminds Patient/SDM/POA of deadline and consequences

If no response from SDM/POA

- Make 3 attempts, document, **Send Letter #1 through registered mail**
- If no response move to next SDM/POA

If SDM/POA refuses to make choices

- Request 3 times, document, move to next SDM/POA

Escalation E6

Escalation	Resources	Summary	Timeframe
E6	1. HCC 2. Multidisciplinary Team 3. Unit Manager 4. Chief of Patient Flow or Operations Director BM9	• Patient refuses bed offer	24hrs

No Response from Patient

1. HCC informs patient that the facility will be removed and hospital will follow-up regarding discharge plan
2. HCC to inform Multidisciplinary Team/Unit Manager
3. Clinical Lead and/or Unit Manager to inform patient of consequences of declining LTC bed offer
4. Unit Manager – request letter from Utilization Officer (BM10), Patient Services, Quality & Chief Nursing Executive

- If patient refuses bed offer, give discharge/per diem letter (provide **Letter #4** or send through registered mail)

Appendix 2 – SDM/POA Not Participating in Discharge Letter

<Date>

<Receiver Name and Address>

RE: <Patient's Name>

Dear <SDM>:

There have been three attempts by Muskoka Algonquin Healthcare (MAHC) and/or Home and Community Care (HCC) staff to contact you as the Substitute Decision Maker (SDM) for <patient's name> to arrange a meeting to work with you to discuss and implement further discharge arrangements.

As we have not been able to reach you through other methods, this letter is a written request that you contact the <discharge planner> either by phone no later than <date> to participate in the planning of <Patient's Name> discharge back to the community with support from our community partners.

Being a substitute decision maker is an important role that comes with obligations of considering needs, wishes and best interests and includes being available and willing to assume the responsibilities of giving or refusing consent. If you do not wish to take on the role of substitute decision maker, or you find yourself unable to continue as a substitute decision maker, please let us know by contacting us at the numbers provided below upon receipt of this letter. If we do not hear from you by <Date>, we will conclude that you are no longer willing and available to act as a SDM for <Patient's Name> and will look to the *Health Care Consent Act* to determine who may be an alternate person to fulfill the role.

We appreciate your attention to this matter and than you in advance for you cooperation.

_____ _____

Manager Phone

cc: Home and Community Care

Appendix 3 – Per Diem Notice (Refusal of Discharge) Capable Patient Letter

<Date>

<Receiver Name & Address>

RE: <Patient's Name>

Dear <Patient>:

This letter is to confirm that your discharge from Muskoka Algonquin Healthcare has been planned for <Discharge Date>. In accordance with the order written by Dr. <Physician's Name> on <Date of Discharge Order>. Your healthcare team remains available to continue to work with you to plan for your discharge from Muskoka Algonquin Healthcare.

Please note that following your discharge date of <Discharge Date>, it is expected that you will leave the hospital within 24 hours by <date and time>.

If you choose not to leave the hospital by this date and time, you be required to pay the daily uninsured rate of $1,227.00 per day.

We appreciate your attention to this matter and look forward to your cooperation

_____ _____

Manager Phone

cc: Business Office
Utilization Coordinator
Home and Community Care

Appendix 4 – Per Diem Notice (Refusal of Discharge) Substitute Decision Maker Letter

<Date>

<Receiver Name & Address>

RE: <Patient's Name>

Dear <SDM/POA>:

This letter is to confirm that <patient name> discharge from Muskoka Algonquin Healthcare has been planned for <Discharge Date>. In accordance with the order written by Dr. <Physician's Name> on <Date of Discharge Order>. Your healthcare team remains available to continue to work with you to plan for your discharge from Muskoka Algonquin Healthcare.

Please note that following your discharge date of <Discharge Date>, it is expected that you will leave the hospital within 24 hours by <date and time>.

If you choose not to leave the hospital by this date and time, you be required to pay the daily uninsured rate of $1,227.00 per day.

We appreciate your attention to this matter and look forward to your cooperation

_____ _____

Manager Phone

cc: Business Office
Utilization Coordinator
Home and Community Care

Appendix 5 – Co-Payment Letter

Date:

RE: **Alternate Level of Care (ALC), ALC Co-Payment and Discharge Planning**

Dear <Patient/Substitute Decision Maker> and Family,

Muskoka Algonquin Healthcare (MAHC) is committed to working with you and your family to develop and support your plan of care and health goals. This includes the plan and preparation for your move to another care service or setting outside of the hospital, after your immediate medical care needs have been met.

As any change is difficult, we will start discussing discharge plans soon after your admission to the hospital. We know that your wishes and understanding of these plans are important to the success of the transition.

This letter provides you with information regarding what "alternate level of care" is and how it affects planning for your transition to other care services or settings outside of the hospital

Understanding Alternate Level of Care (ALC)

What is Alternate Level of Care (ALC)?
As an acute care hospital, our services, doctors and staff are here to meet the healthcare needs of patients with immediate and urgent needs. In Ontario, once a patient no longer needs these acute care services, the patient is designated an Alternate Level of Care (ALC). This means that the patient is ready to move on to an 'alternate' setting, different from the hospital, which is better suited to meet their ongoing healthcare needs.

There are many different care settings, or 'destinations' for ALC patients. Some discharge options include home with services, complex continuing care, retirement home or a long-term care home. Your team will work with you to determine the clinically appropriate options for your transition from acute care.

Who identifies a patient as ALC?
Your doctor, in collaboration with your healthcare team, decides when your status in the hospital changes from acute care to ALC. Your doctor will write the change form acute care to ALC in your health records to communicate it to your healthcare team. We will inform you of this change in your status.

Understanding ALC Co-Payment

What is the ALC co-payment?
When you are an acute care patient in the hospital, the services you receive are paid for by the provincial insurance.

As of < insert date >, you will be charged the ALC co-payment fee.

Once you are designated as an ALC patient and your discharge destination is long-term care, a daily fee is charged to cover the costs of some of the services you are receiving while you wait in the hospital. This daily fee is called a co-payment.

This fee applies to the cost of your room and meals at the hospital and is set by the Ministries of Health and Long-Term care. The current rate for the co-payment fee is ^62.18 per day. There are situations in which this rate may be reduced and you will be able to review this option as part of the co-payment initiation process. If you have questions about co-payments before this time, please contact our Finance Clerk at 705- 789.0022 ext. <?>

When does the ALC co-payment fee start and how do I make my payment?
When it is determined that you no longer need acute care and are designated as an ALC patient waiting for a long-term care bed, we will inform you of your change in status and ask that you contact the Finance Clerk at 705.789.0022 ext <?> to arrange an appointment to discuss your co-payment, including any reductions to the set rate. The Finance Clerk will require a copy of your last income tax return.

A copy of your last income tax return can be emailed to <finance email address> faxed to 705.789…… or dropped off at the cashier office located in the main entrance. If you would like to speak or meet in person, we can arrange a meeting time with you. The Finance Clerk will help you and/or your family complete the co-payment calculation form. This will determine your co-payment fee.

Please note that if you do not make arrangements with 2 weeks after you are determined to be an ALC patient, the full co-payment fee will be charged. You may, of course, follow up with the Finance Department at a later date to request a review of your co-payment calculation.

Will I be charged the ALC co-payment if my condition changes?
If your condition changes and you need acute care again, your doctor will document this in your health record. We will change your status from ALC back to acute care. You will not be charged a co-payment during any period of acute care.

ALC Status and Discharge Planning

How does being designated ALC affect discharge planning?

You may start applying to care settings outside of the hospital any time before your status changes to ALC. However, once your doctor has designated ALC, discharge planning will become a priority and you will have to complete application forms within five (5) business days. Your discharge planner, along with the healthcare team and community partners, will guide you through the application process for long-term care placements, as well as work with you to explore other options that may be appropriate to meet your care needs.

How many long-term care applications should I make?
It is strongly recommended that you apply to the maximum allowable number of facilities to increase your options for your transition from acute care. You may apply to a maximum of five (5) long-term care facilities. When applying to long-term care facilities, it is strongly recommended that you consider at least two (2) facilities with shorter waiting lists.

Important: By transitioning to a facility with a shorter wait list, you will be able to move into a setting that better meets your care needs faster. You can move into this facility temporarily, and stay on the waitlist until a bed becomes available at your first choice.

What happens when a bed I have chosen becomes available at one of my chosen facilities?
When you are accepted at any of the facilities to which you have applied, it is expected that you will transition from acute care and that your plans, including discharge from the hospital, will be confirmed within 24 hours.

If you decide not to transition to one of your chosen options when it is available, you will still be discharged from the hospital. At this time you are no longer eligible to receive services at the co-payment amount, or other insured services, Please note that the daily uninsured rate to stay in hospital more than 24 hours after discharges is $1,227.00 per day as these services ae not covered by OHIP.
Where can I get more information?

Your discharge planner is available to answer any questions you may have about this information, and to guide you in this process. Please feel free to contact your discharge planner at the contact information below.

For financial information, please contact the Finance Clerk at 705.789.0022 ext. <?>. You can also visit the Ministries of Health and Long-Term Care website at www.health.gov.on.ca and search for 'hospital chronic care co-payment."

_____ _____
Manager Phone

cc: Utilization Coordinator
Home and Community Care Coordinator
Business Office

Appendix 6 – Refusal of Bed Offer Capable Patient Letter

<Date:>

<Receiver Name & Address>

RE: Bed Offer

Dear <Patient's Name>:

We would like to continue to work with you to support your transition to a clinically appropriate care setting. You have been designated as Alternate Level of Care (ALC) since <ALC Date> and have been waiting for a bed offer from one of the Long-Term cCare homes to which you have applied. It is our understanding that a bed offer to a Long-Term Care home that you have chosen was made to you by Home and Community Care (HCC) at <time> on <date>.

Your continued admission to Muskoka Algonquin Healthcare (MAHC) has been specifically for the purpose of waiting for such a bed offer. As you were advised on <Date of ALC Co-Payment Letter>, you will be discharged from the hospital 24 hours after this bed offer is made, subject to any extension for the purpose of making the necessary arrangements for your transition to Long-Term Care. Accordingly, your discharge is planned for <date>.

You advised on <Date> that you are not planning to accept the bed being offered. We are asking you to reconsider, and confirm that you will be discharged from the hospital as planned. This means that if you do not leave the hospital by <Date>, you will no longer be entitled to insured services and will be charged the daily rate of $1,227.00 per day for any continuing stay at Muskoka Algonquin Healthcare as long as you do not require the services offered her.

Please contact the Home and Community Care (HCC) Coordinator at <phone number> or the Discharge Planner by <next business day> to confirm your plans for your discharge from Muskoka Algonquin Healthcare.

We appreciate your cooperation in this matter. Please let us know if you have any questions, or require any further assistance with your plans.

_____ _____

Manager Phone

cc: Business Office
Home and Community Care
Utilization Coordinator

Appendix 7 – Refusal of Bed Offer Substitute Decision Maker Letter

<Date:>

<Receiver's SDM's Name & Address>

RE: Bed Offer

Dear <Name>:

We would like to continue to work with you, as the Substitute Decision Maker (SDM), to support <Patient's name> transition to a clinically appropriate care setting. <Patient's Name> has have been designated as Alternate Level of Care (ALC) since <ALC Date> and have been waiting for a bed offer from one of the Long-Term Care homes to which you have applied. It is our understanding that a bed offer to a Long-Term Care home that you have chosen was made to you by Home and Community Care (HCC) at <time> on <date>.

<Patient's Name> continued admission to Muskoka Algonquin Healthcare (MAHC) has been specifically for the purpose of waiting for such a bed offer. As you were advised on <Date of ALC Co-Payment Letter>, <Patient's Name> will be discharged from the hospital 24 hours after this bed offer is made, subject to any extension for the purpose of making the necessary arrangements for your transition to Long-Term Care. Accordingly, Patient's Name> discharge is planned for <date>.

You advised on <Date> that you are not planning to accept the bed being offered. We are asking you to reconsider, and confirm that you will be discharged from the hospital as planned. This means that if you do not leave the hospital by <Date>, you will no longer be entitled to insured services and will be charged the daily rate of $1,227.00 per day for any continuing stay at Muskoka Algonquin Healthcare as long as you do not require the services offered her.

Please contact the Home and Community Care (HCC) Coordinator at <phone number> or the Discharge Planner by <next business day> to confirm your plans for your discharge from Muskoka Algonquin Healthcare.

We appreciate your cooperation in this matter. Please let us know if you have any questions, or require any further assistance with your plans.

_____ Phone _____

Manager

cc: Business Office
Utilization Coordinator
Home and Community Care