Emergency Department Waits and Patient Flow Initiative
putting the Patient First

Patient Flow Toolkit

Module 2:

Alternate Level of Care

Reference guide for operational leaders, managers and point-of-care staff

Updated April 2016

SASKATCHEWAN HEALTH QUALITY COUNCIL

Government of Saskatchewan

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For more information about this toolkit, visit www.hqc.ca and select the Emergency Department Waits and Patient Flow Initiative in the Improving Quality of Health Care menu, or call 306-668-8810.

REVISIONS (April 2016)

- page 7, Definitions and Designation Guidelines
- pages 11-13, ALC Form v2.4 replaces previous version
- ALC Train the Trainer Manual

Module objectives

This module aims to provide operational leaders, managers, and point-of-care staff with background information about alternate level of care (ALC), increased awareness of and assistance in applying new ALC coding, and tools to promote a stronger understanding of the changes taking place in Saskatchewan's health care system.

The objectives of this module are to:

- create a common understanding throughout the province of the new provincial definition of ALC;
- provide teams and individuals who regularly care for ALC patients with the tools to capture data and information about this patient population; and,
- create a body of knowledge that will facilitate delivery of better health care and inform future investments of resources to reduce emergency department waits and improve patient flow.

What is Alternate Level of Care?

Acute care is the type of care delivered in a hospital. Alternate level of care (ALC) is the term used to describe all patients who have completed the acute care phase of treatment and are still in the hospital waiting to be transferred to a different care setting or discharged home.

ALC Provincial Definition

An ALC patient is a patient who is occupying a bed in a facility and does not require the intensity of resource and/or services provided in that care setting.

Why Do We Need a Provincial Definition?

Having a common ALC definition ensures that providers/care teams across the province are all designating patients in the same way.

As data is gathered, we will be able to identify when a patient no longer needs acute services. Information on demographics and clinical needs of the ALC patients will show us where there are currently gaps in service. Ultimately, a stronger understanding of the provincial ALC population will help inform targeted investments aimed at improving patient flow and patient care.

In the long term, identifying and classifying patients as ALC will help us provide better health care. It will inform the decisions we make regarding the allocation of resources. It will improve the flow of patients through the health care system. It will reduce wait times in the emergency department. But most importantly, it will support patients in receiving the care that meets their needs.

ALC patients may be waiting for transfer to long-term care (LTC), a personal care home (PCH), home with support, specialized rehabilitation, respite, or another non-acute setting.

The health care team has determined that these patients no longer require acute care. This means another setting, or community-based services, if available, would better meet the needs of the patient.

Why Capture ALC data?

The Emergency Department Waits and Patient Flow Initiative has identified understanding and managing ALC patients as a priority across the health system. Although we know ALC patients using acute care beds is one of the factors contributing to long waits in Emergency Departments, we don't have a complete understanding of the size of the ALC population, nor the demographic or clinical characteristics.

The goal of patient-centred care – putting the patient first – should be to prevent avoidable hospital admissions or, when admission is required, to successfully transition people back into their communities. The longer the hospital stay, the more likely a patient will worsen or get an infection. Long hospital stays can decrease general mobility and quality of life. Once medically stable, it is in a patient's best interest to be transferred as soon as possible to a more appropriate location.

The challenge is twofold: without the application of a provincial ALC definition we don't truly understand the size of the ALC population; and without accurate information about the ALC population, it's difficult to know where to invest resources to best support this population and improve patient flow.

Over the past year, representatives from across the health system – coordinated by the Emergency Department Waits and Patient Flow team – have developed a standard ALC definition and processes for data collection.

In order to think and act as one, all Saskatchewan health regions have agreed to identify and manage ALC patients in the same manner (see Memorandum of Understanding in appendices). Standardized processes throughout the province demonstrate our shared commitment to patient-centred care and the provision of care in the right place at the right time by the right provider.

This agreement also reminds us that the care provided to patients should be driven by the needs of that patient and not by their designation as ALC. In addition, the agreement also promotes the use of standardized education and support materials for patients and families, explaining what ALC is and what an ALC designation means.

Improvements and Supportive Changes

New Form

All regions must use the new common provincial ALC designation and data collection forms. Regions should continue to follow the current process for reporting ALC data to CIHI. Regional coders will utilize the ALC designation form to gather data for CIHI.

The use of a common form and one definition is necessary to more accurately identify and classify patients waiting in a hospital bed for alternate level of care.

A "Train the Trainer" manual has been developed to ensure region staff know how to use the ALC data capture form. It is included in this module as Appendix 2. Training sessions on using the new form are available.

The Role of the Patient

Standardized patient/family education materials have been developed for regions to use. These materials explain what ALC is and what an ALC designation means. Regions may need to add their own local information; a Microsoft Word template is available in the appendices.

The Role of Administration

Health region administrators have a critical role to play in ensuring the new ALC form gets used properly, with data coded correctly and entered into the health information system in an accurate and timely manner. The information that's collected will be used to make important decisions about how best to deliver patient care.

The Role of the Physician

Physicians have a crucial role to play in the designation of ALC patients.

Billing

Misunderstanding about the ALC definition has created confusion about how physicians should bill. With the exception of patients designated as awaiting long-term care placement, ALC designation should not impact billing practices nor affect care received. The focus of billing is related to the condition of the patient, the medically required services provided by the physician, and the requirements of the payment schedule fee code.

As care needs vary, so do the medical services provided by a physician. Eligible fee codes will vary depending on the patient's clinical needs and the physician services provided. As with the billing of all medical services, requirements of the payment schedule code being billed must be met, including appropriate documentation of medical necessity for the service. Some examples include:

- *Counselling on a third-party basis* may be appropriate when a family member is counselled because of the patient's serious and complex problem. It is not

payable for routine briefing or advice to relatives, which is considered part of the visit service fee. Third-party counselling must be provided at a booked separate appointment/time, is subject to a maximum of 30 minutes, and must be submitted in the counselled individual's name. This code can be billed by any physician (40B, 41B)

- *A case conference* may be appropriate in situations where the patient's care needs to be discussed with other allied health care professionals. These sessions must be a formal scheduled session, and may be billed by any physician (42B, 44B).
- If a patient has *acute needs that are being managed by a physician*, these services may support billing of hospital day care codes (25-28 B-T).
- *Services listed in the "A" section of the Payment Schedule.* These are billable by any physician. This includes patients designated as awaiting long-term care (626A).

Any general billing inquiries can be directed to the Medical Services Branch, Claims Analysis Unit, at 306-787-3454.

The Role of the Interdiscipinary Team

An ALC patient has many touchpoints within the health system and all members of his/her interdisciplinary team contribute to the patient's successful health care. Knowledge and awareness of the ALC designation process and of the importance of collecting ALC data are key to patient health.

Case Studies

The following case studies are designed to illustrate common ALC scenarios, to help health providers understand the standardized ALC provincial definition. These case studies are not intended to replace the clinical decision-making and judgment of the physician or interdisciplinary team.

Case Studies

Scenario	Rationale
A patient in an acute care bed no longer requires acute care and is waiting for a home care program, rehabilitation services, or a long-term care bed.	The patient whose discharge is delayed pending the availability of these services *would* be considered ALC.
A patient is admitted to a rehab program for therapy after a hip fracture. Once the therapy is completed, the patient must remain in the facility until home care can be provided.	The patient's course of rehab treatment has been completed but he/she is waiting in the rehab bed, so he/she *would* be considered ALC.
A patient in an acute, mental health, or rehabilitation bed is waiting to go home, but requires the installation of equipment within the home before he/she can be accommodated.	The patient *would* be considered ALC.
A patient is admitted for respite care to an acute, mental health, or rehabilitation bed.	When a respite care patient is admitted to an acute, mental health or rehabilitation care bed, the patient *would* be considered ALC for the entire episode of care.
A companion well baby (a baby who does not require acute, mental health, or rehabilitation care but who is admitted to a facility to stay with his/her ill mother) is admitted to a facility.	A companion well baby *would* be considered ALC.
A patient is documented by the physician or designate as ALC but is subsequently discharged later that same day.	Although the patient's status is designated ALC by the physician or authorized designate, the ALC transfer *cannot* be captured as the patient is subsequently discharged later the same day. The day of discharge is considered part of the total acute length of stay.

Case Studies

Scenario	Rationale
A patient on an acute care unit who still requires acute care services is waiting for another type of bed within the same hospital.	The patient is *not* considered ALC until they no longer require the services provided in the hospital.
A patient has been transferred to a sub-acute bed to convalesce post intervention while continuing to receive acute care services.	The patient would *not* be designated ALC.
A patient has been transferred from an acute care unit to a transition unit in an acute facility while waiting placement and no longer requires acute care services.	The patient *would* be designated ALC.
A patient is in an inpatient bed and no longer requires the intensity of inpatient resources/services, but cannot be discharged due to lack of available placement options attributed to complex illness-related and/or challenging behaviours.	This patient *would* be considered ALC waiting for available community placement to match patient care needs, including but not limited to: • complex residential care facility; • under-65 early aging facility; or, • other appropriate community based programs.
A patient is in an inpatient bed and no longer requires the intensity of inpatient resources/services, but cannot be discharged due to lack of available community programs/services that would support that patient's complex needs such as: • Home IV therapy; • Therapy services; or, • Complex dressing changes or wound management.	The patient *would* be considered ALC even though the services that match the needs of the patient are not available.

Commonly Asked Questions

Who is responsible for designating patients as ALC?

The physician or any health care team member can designate a patient as meeting the criteria for ALC. It will be the responsibility of each region to identify which team member(s) will complete the designation and be responsible for completing the required documentation.

Who qualifies as ALC?

A patient will be designated ALC if he/she:

- is occupying a bed in a facility and does not require the intensity of resource and/or services provided in that care setting;
- is awaiting placement for an alternate level of service; or,
- is admitted directly to a health care facility as ALC because alternate care is unavailable.

Who does not qualify as ALC?

A patient is not considered ALC if he/she:

- is convalescing post intervention and is being treated in a step down unit, designated as sub acute;
- continues to require acute care resources/ services while waiting to be transferred to another acute care bed/service within the facility or to a different facility; or
- is waiting in a tertiary acute care facility bed for transfer to a non-tertiary acute care facility bed.

Do you need to know the discharge destination when designating a patient ALC?

No. It is not necessary to know where a patient is being discharged to before making an ALC designation. It may take the health care team longer to identify the needs of some patients and determine what program/services may be required, but that delay doesn't need to affect the ALC designation.

Can a patient be designated ALC when the appropriate level of care is not available in the community to meet the care needs of the patient?

Yes. This type of information will be collected and used for planning.

Can a patient be designated ALC if he/she does not meet the eligibility criteria of the discharge destination?

Yes. Designation of a patient as ALC is not linked to eligibility for any beds/programs/ services.

Is there a specific timeframe for the patient's length of stay in order to be designated ALC?

Yes. Patients must meet the definition for ALC for a minimum of 24 hours before they can be designated ALC. The exception to this is

when a patient is admitted as ALC because an alternate level of care is not available (for example, admission for respite care).

Once a patient is designated ALC, can their ALC status be discontinued?

Yes. If the medical status of a patient changes and the patient again requires acute care, the ALC status would be removed. The patient may be re-designated ALC once their care needs are met and they no longer require the level of services provided in their current care setting.

Definitions and Designation Guidelines

The Western Patient Flow Collaborative has created a document called Definitions and Guidelines to Support ALC Designation in Acute Inpatient Care (see Appendix 3). This is intended to assist teams in the determination to designate a patient alternate level of care.

Appendices

ALTERNATE LEVEL OF CARE (ALC)

ALC – A patient occupying a bed in an acute care facility and does not require the **intensity** of resources/services provided in that acute care setting.

Note: The authorized designate may be a Physician, Long Term Care Assessor, Patient Care Manager, Care Team Member, Discharge Planner, etc.

Appendix 1 – ALC Form

1. Date of Admission: TIME: _____ DATE: _____ 20___

2. ALC Designation: TIME: _____ DATE: _____ 20___

3. Designate Initiating Form & Contact Information: _____

4. Communication to Patient / Next of Kin: ☐ No ☐ Yes DATE: _____ 20___

5. Reverted to Acute Status: TIME: _____DATE: _____ 20___ **Acute Diagnosis**: _____

*If patient **RETURNS** to **ALC** designation after acute episode a **NEW ALC Form is required***

Reasons for ALC Designation: ○ **Check ONE circle indicating the MAIN reason for ALC designation.**
☐ **Check MULTIPLE boxes for ALL contributory reasons that apply.**

Note: The one ALC reason is to identify the main reason why the patient is remaining in an acute care facility bed
Coders: Assign the applicable ICD-10-CA code for all ALC reasons indicated on this form and assign Prefix "A" to link all ALC related documentation on the DAD abstract. Note: Do not use prefix "A" for palliative care reason (Z51.5 if Prefix 8 applies to Z51.5). Prefix 8 takes precedence.

WAITING SERVICE	○ ☐ **Waiting for assessment to determine ALC care needs** (**Z75.2**) – ***complete backside of sheet***	
	○ ☐ **Approved and waiting for admission to facility/bed (waitlisted)** (**Z75.1**) – ***complete backside of sheet***	
	○ ☐ **Waiting for community service/helping agency/home services arrangement** (**Z75.2**) – ***complete backside of sheet***	
	☐ **Other waiting period for investigation and treatment** (**Specify)*:	
NEED FOR ASSISTANCE	○ ☐ **Assistance with personal care** (**Z74.1**)	○ ☐ **24 hour care/supervision** (**Z74.3**)
	○ ☐ **Reduced Mobility** (**Z74.0**) ☐ Supervision ☐ Assist x 1 ☐ Assist x 2 ☐ Sit/Stand Lift (Z99.8) ☐ Total Lift (Z99.8)	☐ **Cognitive Impairment** ☐ Mild (F06.7) *(*Specify if other than Mild)*:
	☐ **Behavioural Issue** *(*Specify)*:	**Incontinence:** ☐ **Urinary** (R32) ☐ **Fecal** (R15)
MEDs	☐ **Inability to manage medications** (Z73.8)	☐ **Adjusting medications/Patient Stable** (Z51.88)
	☐ **IV medications (longer than 1 week)** *(*Specify)*:	
SOCIAL ISSUES OR HOUSING	○ ☐ **Homeless** (**Z59.0**)	○ ☐ **Unfit Housing** (**Z59.1**)
	○ ☐ **Other Housing or Financial Issue** (**Z59.8**) (*Specify)**:**	○ ☐ **Legal problem** (**Z65.0**, **Z65.3**) (*Specify):
	○ ☐ **Inadequate family support** (**Z74.8**)	☐ **Lives Alone** (Z60.2)
	☐ **Absence of family member** (Z63.3)	○ ☐ **Caregiver fatigue/Respite** (**Z75.5**)
	○ ☐ **Need for assistance at home and no care provider to render care** (**Z74.2**)	○ ☐ **Patient/Family refusing proposed Discharge / Placement Option / Perception of Readiness** (**Z76.4**)
	☐ **Addiction Issue** *(*Specify)*:	
OTHER	○ ☐ **Boarder Caregiver/Baby** (No supervision required) (**Z76.3**)	○ ☐ **Boarder Baby/Child** (Medical/Nursing supervision required) (**Z76.2**)
	☐ **Bariatric needs** (E66) *(*Specify)*:	☐ **Palliative care** (Z51.5)
	☐ **Education/Counselling** *(*Specify)*:	☐ **Rehabilitation** *(*Specify)*:
	☐ **Other issues/care needs** *(*Specify)*:	

Document all services the patient requires that are NOT available, as applicable

○ ☐ **No facility available to meet ALC care needs** (**Z75.3**)
Specify type(s) of facility that does not exist _____

○ ☐ **No community service/helping agency/home service to meet ALC care needs** (**Z75.4**)
Specify type(s) of Community/Helping agency/Home service that does not exist _____

Patient designated ALC and waiting for …	CONSULT REQUESTED (DDMMMYYYY)	ACCEPTED TO PROGRAM and/or WAITLISTED ☐Yes ☐ No (DDMMMYYYY)	COMMENTS
Facility/Program/Service			
☐ **Rehabilitation** *(Specify)*:		☐Yes ☐ No Date:	
☐**Geriatrics**		☐Yes ☐ No Date:	
☐ **Restorative Care/Convalescent Care** *(Specify)*:		☐Yes ☐ No Date:	
☐ **Respite care**		☐Yes ☐ No Date:	
☐ **Transition Location** *(Specify)*:		☐Yes ☐ No Date:	
☐ **Repatriation** **Waiting for admission to facility/bed (waitlisted)** *(Specify)*:		☐Yes ☐ No Date:	
☐ **Long Term Care**		☐Yes ☐ No Date:	
Housing			
☐ **Assisted/enriched living**		☐Yes ☐ No Date:	
☐ **Personal Care Home**		☐Yes ☐ No Date:	
Community Services			
☐ **Home Care**		☐Yes ☐ No Date:	
☐ **Therapies**		☐Yes ☐ No Date:	
☐ **Home IV**		☐Yes ☐ No Date:	
Palliative Care			
☐ **Palliative Bed Admission** **Waiting for admission to facility/bed (waitlisted)**		☐Yes ☐ No Date:	
☐ **Palliative Home Care** **Waiting for services to be arranged**		☐Yes ☐ No Date:	
Mental Health			
☐ **Inpatient:** **Waiting for admission to facility/bed (waitlisted)**		☐Yes ☐ No Date:	
☐ **Detox** **Waiting for Community/helping agency/home services to be arranged**		☐Yes ☐ No Date:	
☐ **Community** **Waiting for Community/helping agency/home services to be arranged**		☐Yes ☐ No Date:	
☐ **Other (waiting for…)** *(Specify)*:		☐Yes ☐ No Date:	
☐ **Other (waiting for…)** *(Specify)*:		☐Yes ☐ No Date:	

Discharge status: Was patient discharged to service/program requested? ☐ No ☐ Yes

If No: ☐ Deceased ☐ Other _____

Discharge: TIME: _____ DATE: _____20_____

Appendix 2 – Revised training manual

ALC Train the Trainer

Collecting and Reporting on Alternate Level of Care Data - Training Manual

Version 1.3

April 1, 2016

eHealth Saskatchewan

Emergency Department Waits and Patient Flow Initiative
putting the Patient First

2016

eHealth Saskatchewan
3rd Floor 2130 11th Avenue Regina Saskatchewan S4P 0J5

Contents

Revisions, April 2016

Pages 2, 4-11, 16, 19-22

Introduction

Many patients stay in acute care beds, but no longer require that level of care, because there is a lack of options for them in sub-acute care or in the community. These patients would be considered Alternate Level of Care (ALC) patients. Another way to think of ALC is an unnecessary length of stay. These patients could be either at home or in a more appropriate unit or facility, if "X, Y or Z" existed. ALC data is key to understanding what the specific gaps are in sub-acute or community services.

Currently data captured in acute care facilities throughout the province about ALC patients is not only inadequate (usually only capturing those waiting for long-term care placement), but also does not provide any information on why a person is still in hospital and what their unmet needs are. Future development of programs to alleviate this issue requires this context specific information. Currently the number of ALC days is a significant driver for long wait times in the emergency department and poor patient flow.

In January of 2015, a Rapid Process Improvement Workshop (RPIW) was undertaken to:

- Identify what data should be captured about ALC patients to inform decision-making;
- Develop standard provincial definitions and work standards for the capture of the data; and
- Create a provincial template to be used by all Regional Health Authorities (RHAs) to capture and enable consistent reporting of ALC data to the Canadian Institute for Health Information (CIHI).

Subsequent to the RPIW two RHAs (Sunrise and Saskatoon) piloted the form and work standards. This allowed the province to undertake a number of Plan-Do-Check-Act (PDCA) cycles on the data capture form as well as supporting materials. After three months it was identified that inadequate training, monitoring, auditing and communications presented significant challenges to the adoption of the form and data capture process as well as uptake from an administrative and clinical perspective.

In June 2015, eHealth and HQC hosted a one-day intensive Kaizen event in Saskatoon to focus on the drafting of a Training Manual, Communications Plan, and Audit processes that could support a more timely roll-out, adoption and compliance with the new ALC data capture process, form and reporting. Out of this event also came the recommendation of offering a boot camp for all RHAs ready to implement the ALC data capture tool, training and reporting.

This training manual has been developed as a living document to support the standard training and implementation of ALC data capture and reporting throughout Saskatchewan.

Objective

The objective of the ALC data capture initiative is to have all Saskatchewan health regions collecting and reporting consistent and timely ALC data by March 31, 2017.

Definitions

Alternate Level of Care: When a patient is occupying a bed in a facility and does not require the intensity of resources/services provided in that care setting

Community Services - Therapies: When a patient requires therapies to be assessed or set up in the home/community setting to enable them to function in the home setting (i.e. Occupational Therapy and/or Physiotherapy).

Home Care: An array of services, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the informal (family) caregiver. *(Canadian Home Care Association)*

Long-term Care: A publicly subsidized long-term care system for individuals whose assessed needs cannot be met through community and home-based services or other housing options. *(Ref. Heather Murray, Community Care Branch)*

Mental Health: Refers to the broad range of services and supports available to individuals with mental illness. This also includes addiction services and supports aimed at preventing or reducing/treating substance abuse, substance use disorders and problematic gambling.

Palliative Care: Is active and/or supportive compassionate care of a terminally ill patient at the time when his or her disease is no longer responsive to traditional therapy aimed at a cure or prolonging life. Acute palliative care treatments may include pain control, symptom management, and intravenous therapy, feeding tubes, nerve blocks, radiation therapy and chemotherapy. A non-acute palliative care patient is one whose symptoms are well controlled and who could be cared for in a non-acute setting (for example, home care or hospice). Non-acute palliative patients should be designated as ALC patients if they are occupying an inpatient bed of an acute care facility. *(CIHI DAD)*

Personal Care Home: These are privately owned and operated facilities that provide another option to adults who generally do not require the services of a long-term care facility, but who need to receive assistance or supervision with personal care. *(Ref. Heather Murray, Community Care Branch)*

Rehabilitation: For patients requiring more intensive therapies in a time limited episode of service. Rehabilitation services are provided either in specialized facilities as well as hospital rehabilitation units, programs and designated rehabilitation beds. Admission criteria are specific to each rehabilitation program. *(Adapted from CIHI)*

Repatriation: The process of transferring the patient to his or her referring acute care hospital or to the acute care hospital that is the “closest” to his or her home address once the patient is deemed to be medically stable and/or suitable for transfer. The receiving acute care hospital is determined based on geography and the ability for the patient to receive the required ongoing care. *(Critical care services Ontario – Repatriation guide 2014)*

Respite: For clients who normally live at home but are dependent on family members for support. For example, it can be a planned period of relief for the usual caregiver or a crisis intervention when the patient's usual support system is unavailable due to illness of the usual caregiver. *(CIHI DAD)*

Restorative Care (formerly known as Convalescent Care): is the provision of a period of additional recuperative time following an intervention or serious illness. It is intended to provide clients with the opportunity to recover health/independence in order to return to the community setting. *(CIHI DAD)*

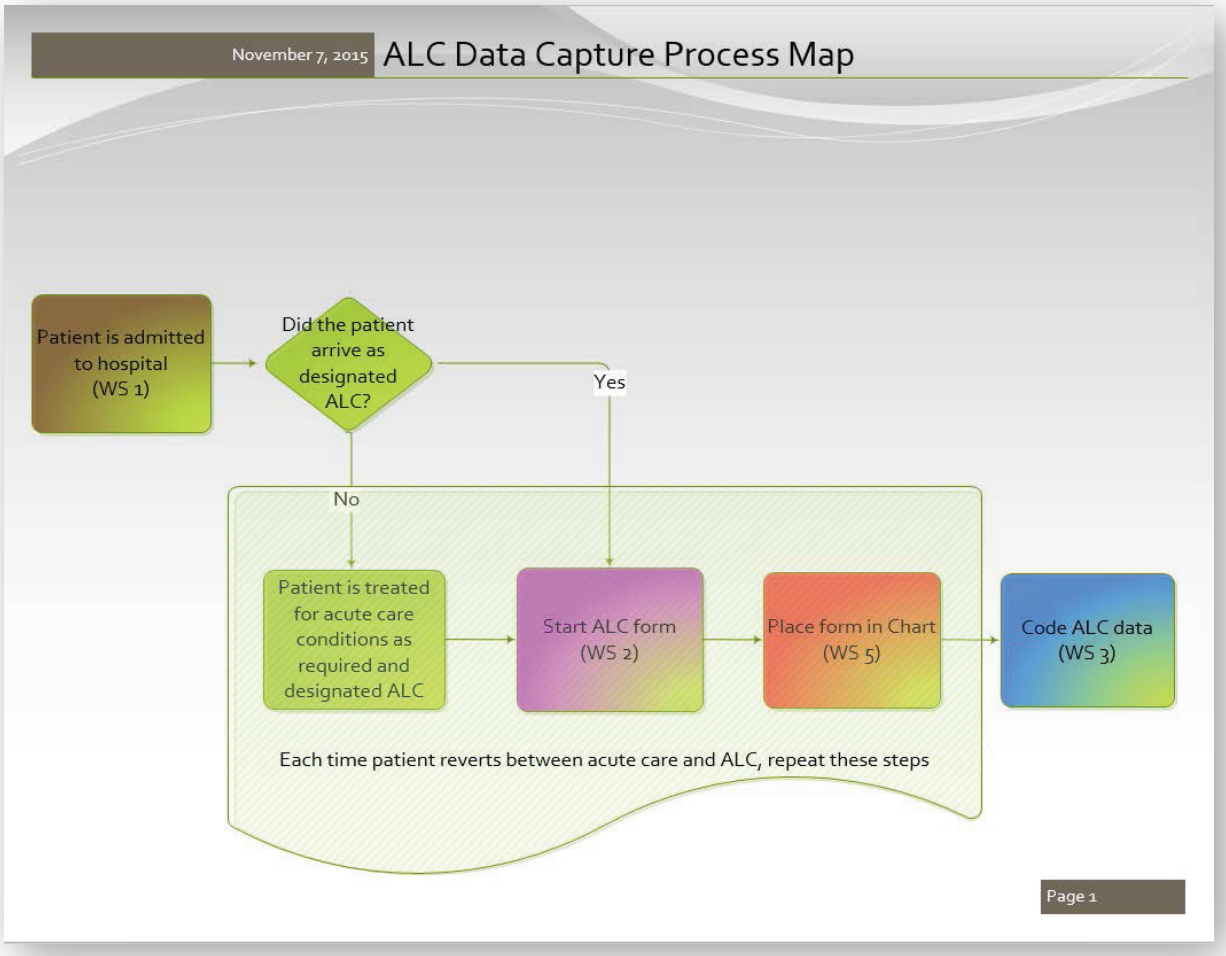
Transition Location: The patient has been transferred, but has not been discharged to their final destination. Transition locations could include an alternate level of care unit, a transition care unit, or an alternate acute care setting such as their home hospital.

Capturing the Data

*ALC designation does not **only** apply to patients waiting for Long-term Care.* When a patient is occupying a bed in an acute care facility but does not require the **intensity** of resources/services provided in that care setting the patient must be designated Alternate Level of Care (ALC) at that time by a member/members of the interdisciplinary team. There are many case examples described on page 5 of the toolkit.

For more details on when the ALC form needs to be filled out, please see **Work Standard 1: Criteria for Determining Alternate Level of Care (ALC)**

When a patient is determined to be ALC, a Provincial ALC data capture form must be initiated and placed on the patient chart. Along with the ALC data capture form, there are a number of Work Standards (WS) that were created to support care providers in understanding how and when information needs to flow during the ALC care process. The following process map shows the ALC Data Capture Process.

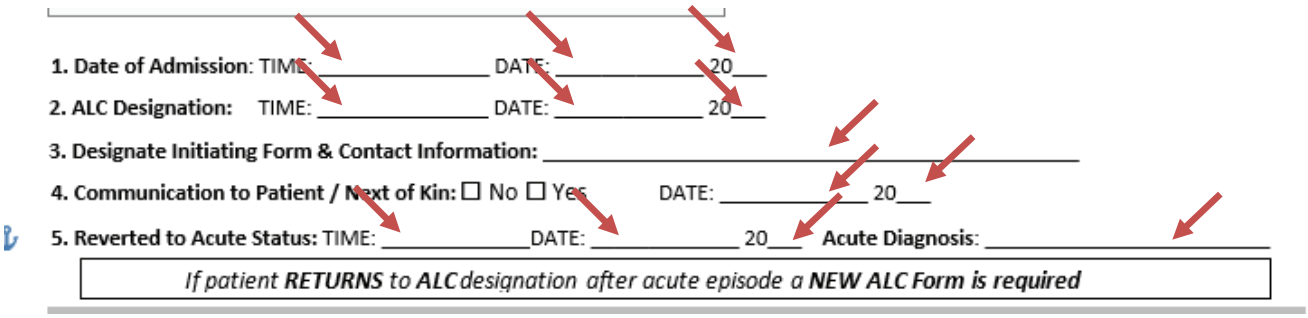


Filling Out the Form

For more detailed instructions on completing the form please refer to the **Work Standard 2: Completion of ALC Form**.

Numbered Section

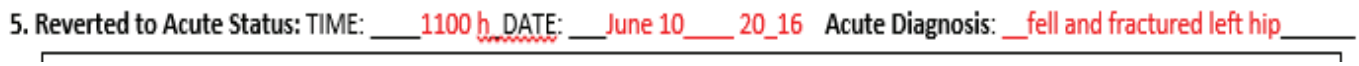
Ensure all numbered fields are completed in the first section, as applicable. Those marked with arrows are always required.



Note:

Documentation of reversion back to an acute status is mandatory.

If the patient deteriorates and requires acute care again, the time and date this occurs and the diagnosis should be recorded in the "Reverted to Acute Status" section of the form.

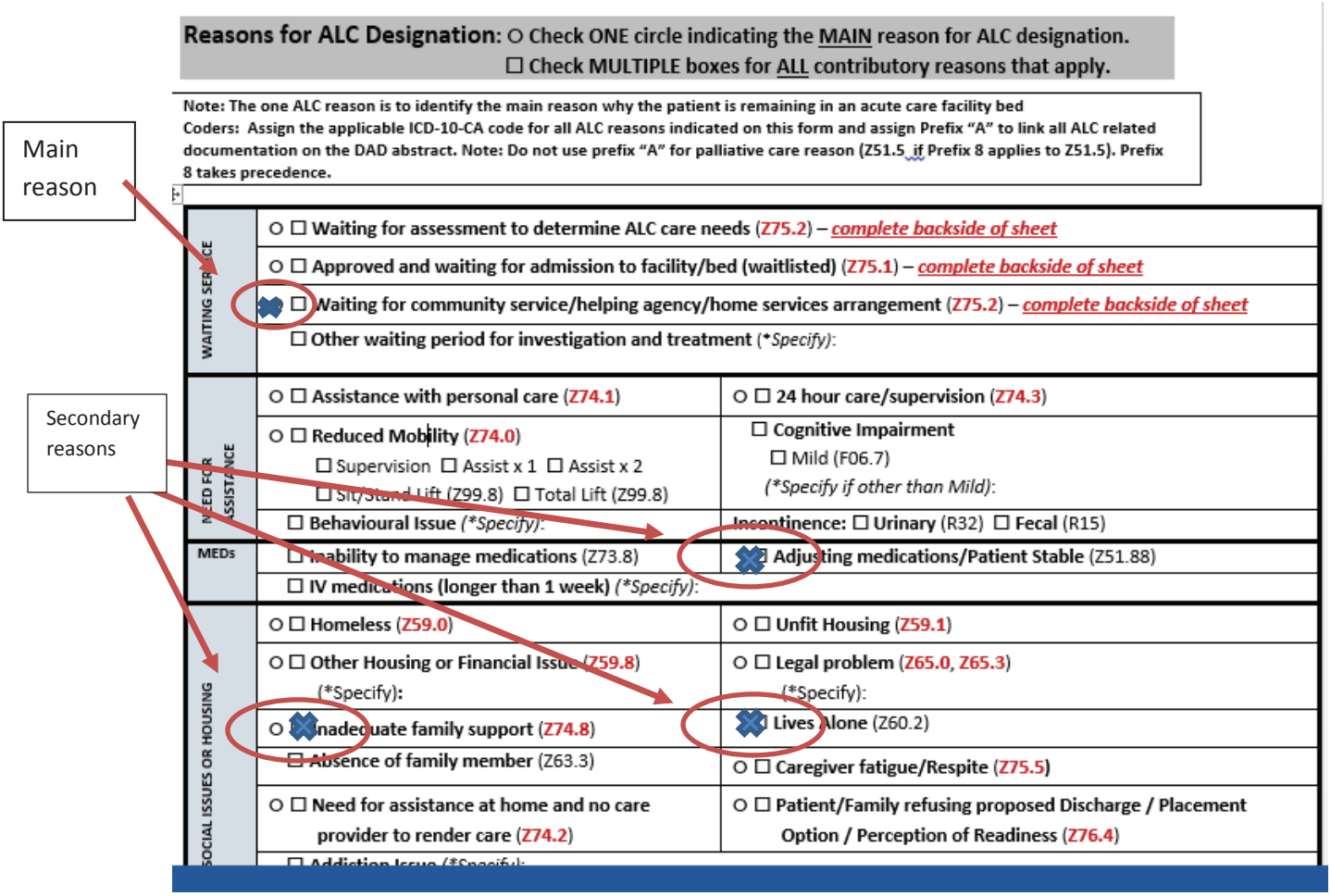


NOTE: If the patient returns to ALC designation after an acute episode, a new ALC form must be started.

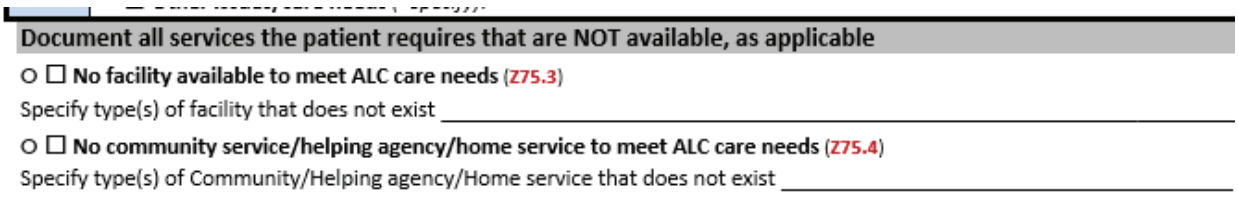
Reasons For Designation Section

There must be a main reason identified for why the patient is ALC. That reason must be chosen from the selections available on page 1 that are indicated with a **circle (○).** Only one main reason can be selected.

ALL contributory reasons can be indicated by marking the selections indicated with a **box (☐)**



It is important to identify services that aren't available, but would assist the patient in returning to the community or an alternate care setting if it was available. Note that this section can be identified as a main reason or contributory reasons. The Facility or Community service/Helping agency/Home service that is not available must be specified in the section provided for comments.



If required, the Interdisciplinary Team or responsible provider will determine necessary consults and/or assessments the patient needs to determine the most appropriate care setting for the patient to be transferred to. On the page 2 of the ALC form the following information should be completed:

- The date the consult/service was requested (recorded on the ALC Form under the Consult Requested column);
- The decision if the patient was accepted or waitlisted for the service/support/program or not and the date that decision was made (recorded on the ALC Form under the Accepted to Program/Waitlisted column); and
- Any comments that the team or provider may have in relation to the request or the decision.

Patient designated ALC and waiting for …	**CONSULT REQUESTED** (DDMMMYYYY)	**ACCEPTED TO PROGRAM and/or WAITLISTED** ☐Yes ☐ No (DDMMMYYYY)	**COMMENTS**
Facility/Program/Service			
☒ **Rehabilitation** *(Specify)*:	07/04/16	☐Yes ☒ No Date: 10/04/16	Patient cannot tolerate intensity of therapies.
☐ **Geriatrics**		☐Yes ☐ No Date:	
☒ **Restorative Care/Convalescent Care** *(Specify)*:	12/04/16	☒ Yes ☐ No Date: 15/04/16	
☐ **Respite care**		☐Yes ☐ No Date:	
☐ **Transition Location** *(Specify)*:		☐Yes ☐ No Date:	
☐ **Repatriation** Waiting for admission to facility/bed (waitlisted) *(Specify)*:		☐Yes ☐ No Date:	
☐ **Long Term Care**		☐Yes ☐ No Date:	
Housing			
☐ **Assisted/enriched living**		☐Yes ☐ No Date:	
☐ **Personal Care Home**		☐Yes ☐ No Date:	
Community Services			
☐ **Home Care**		☐Yes ☐ No Date:	
☐ **Therapies**		☐Yes ☐ No Date:	
☐ **Home IV**		☐Yes ☐ No Date:	
Palliative Care			
☐ **Palliative Bed Admission** Waiting for admission to facility/bed (waitlisted)		☐Yes ☐ No Date:	
☐ **Palliative Home Care**		☐Yes ☐ No	

The “Other” section at the bottom of page 2 may be used if the requested service is not listed. In the example shown, the patient did not meet the criteria for an inpatient Mental Health bed so the team is now investigating an out of province option. The specific program being investigated is noted on the form with additional information in the comments section.

Waiting for services to be arranged		Date:	
Mental Health			
☐ **Inpatient:** Waiting for admission to facility/bed (waitlisted)	14/05/16	☐Yes ☒No Date: 16/05/16	Does not meet admission criteria.
☐ **Detox** Waiting for Community/helping agency/home services to be arranged		☐Yes ☐ No Date:	
☐ **Community** Waiting for Community/helping agency/home services to be arranged		☐Yes ☐ No Date:	
☒ **Other (waiting for…)** *(Specify)*: Ponoka Brain Injury Program	18/05/16	☐Yes ☐ No Date:	Seeking source of funding for out of province program.
☐ **Other (waiting for…)** *(Specify)*:		☐Yes ☐ No Date:	

Discharge Information

When the patient leaves the acute care hospital, the date and time of discharge and discharge status must be recorded on the ALC form. It must be indicated if the discharge plans were followed and if not, what were the circumstances surrounding the change of plans.

Discharge status: Was patient discharged to service/program requested? ☐ No ☒ Yes
If No: ☐ Deceased ☐ Other _____

Discharge: TIME: _____ DATE: _____20_____

Discharge status: Was patient discharged to service/program requested? ☒ No ☐ Yes
If No: ☐ Deceased ☒ Other ___moved to Alberta to live with daughter_____

Discharge: TIME: __1400__ DATE: _June 15__2016__

Coding

Once initiated, the ALC form becomes part of the patient's chart and will remain on the chart when it is sent to Health Records for assembly/coding/filing. During assembly, place the ALC form directly after the discharge summary. For more detailed instructions on placing the form see the **Work Standard 5: Placement of Alternate Level of Care Form in Patient's Chart at Health Records**.

After the chart is assembled, Health Records staff are responsible for coding the chart. As part of your implementation and communications strategy, coding staff must be trained on **Work Standard 3: Coding of Alternate Level of Care Form**.

When to Code a Patient as ALC

The presence of the form is evidence this patient is no longer receiving acute care treatment and has been designated as ALC for a portion (24 hours or more) of his/her stay, record a Service Transfer of 99. Verify that the ALC length of stay is greater than 24 hours by referring to the ALC designation date and time and the discharge date and time and/or the date and time the patient reverted to acute status. If time is less than 24 hours do not code the ALC form. If there are multiple ALC forms for the stay, add up the days from all forms. Each ALC episode must be > 24 hours.

If the patient has been directly admitted as ALC, regardless if the total length of stay is less than 24 hours, capture the Main Patient Service as 99.

If the coder finds documentation in the chart to indicate that there were ALC days during the acute visit, but there is no ALC form present, the issue should be brought to the attention of the nursing unit manager or clinical coordinator of the nursing unit to which the patient was last admitted.

Calculating ALC Length of Stay

Calculate and enter the ALC length of stay by referring to the ALC designation date and discharge date and/or date reverted to acute status. If the patient has reverted between acute and ALC multiple times during the same admission, enter the ALC service transfer only once and capture the total length of ALC days by adding all ACL days (>24 hours) from all ALC forms.

Diagnosis Codes

In the Diagnosis Field for the "Service Transfer Diagnosis", code the appropriate Z code for the main reason for ALC designation. ALC Designated Z codes are listed in the *DAD Abstracting Manual – Section 3: Alternate Level of Care (ALC).* Refer to the marked reason indicated in a circle, on Page 1 of the ALC form to determine the designated Z code to capture. The Z codes on page 1 highlighted in red are the defined codes that have been assigned to capture main ALC reasons.

Capture this and all other contributory reasons indicated in the boxes for ALC designation with a Diagnosis Prefix of "A" so that contributory reasons for ALC can be identified on the DAD record. Reasons, listed with a diagnosis code in parentheses are the defined codes that have been assigned to capture those reasons. Where there is documentation provided in ***(Specify)**

code to the most specific ICD-10-CA code to capture the relevant additional information; these codes do not have to be Z codes. This allows more specificity than the main reason Z codes.

ALC diagnoses must be specified on the form or clearly indicated in the chart as an ALC reason. For example, coders cannot assume a behavioral issue mentioned in the chart is a contributing ALC reason unless this same diagnosis is also indicated on the ALC form.

Use the appropriate Diagnosis Type for each code, following the usual rules for diagnosis typing as set out in the DAD Abstracting Manual and the Canadian Coding Standards.

The mandatory Prefix 8 for patients known to be palliative prior to admission takes precedence over Prefix A if Prefix 8 applies to Z51.5. Be sure to follow the Canadian Coding Standards for coding of all other ALC reasons indicated on the form.

For more information

In the event of questionable information on the form, consult with the contact person indicated at the top of the form.

For questions or concerns with respect to coding the ALC Form contact dataquality@ehealthsask.ca.

AUDIT

An audit is used to assess success, failure and improvement possibilities. The deployment of the ALC form will be audited to identify where barriers exist with the use of the form. This audit will not be used to measure the data elements of ALC.

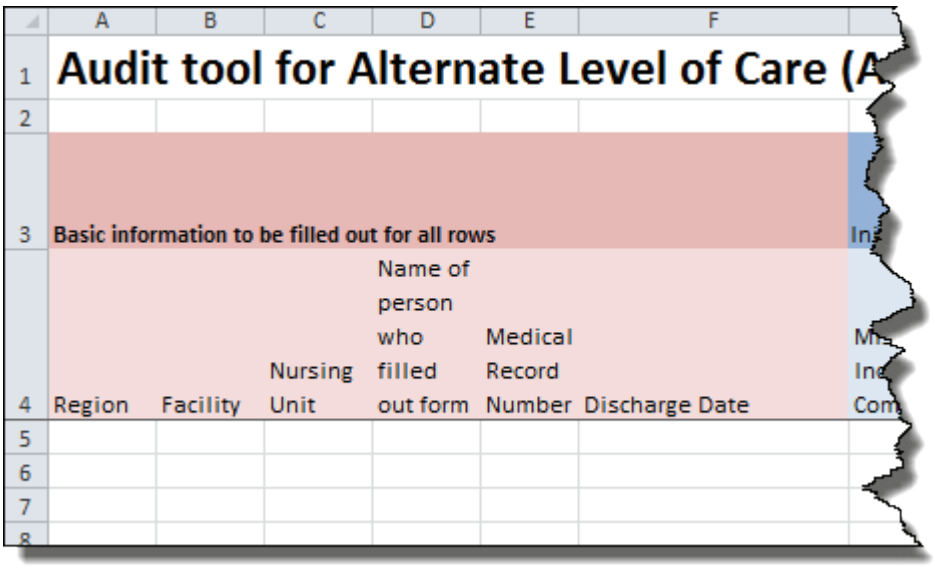
To aid in the audit of the ALC form an audit tool was created to assist in capturing the information to be used by the senior leaders. This information will determine the success of deployment or the need for corrective action. In addition, it will allow for managers responsible for reporting on ALC to know if the data captured is incomplete.

Regions are not expected to audit every completed ALC form, but may choose to audit a predetermined number of forms per week or on a schedule that fits local work flow processes.

How to use the Audit Tool

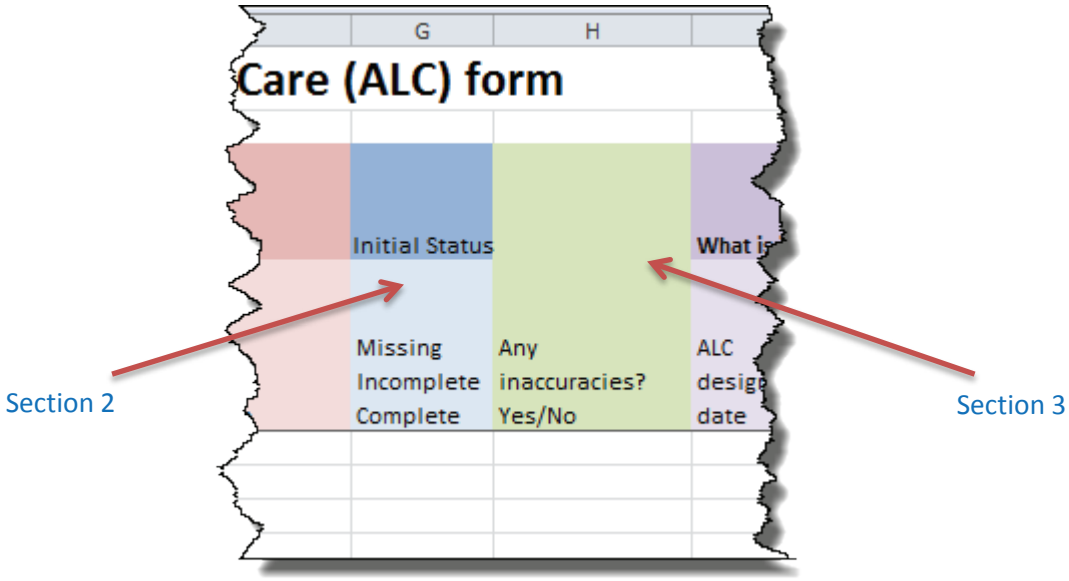
The Audit tool is a Microsoft Excel spreadsheet consisting of six sections. One line is to be used to record the status of each chart that is audited. It is not necessary to audit every form.

Section 1: Record the basic information for each entry.



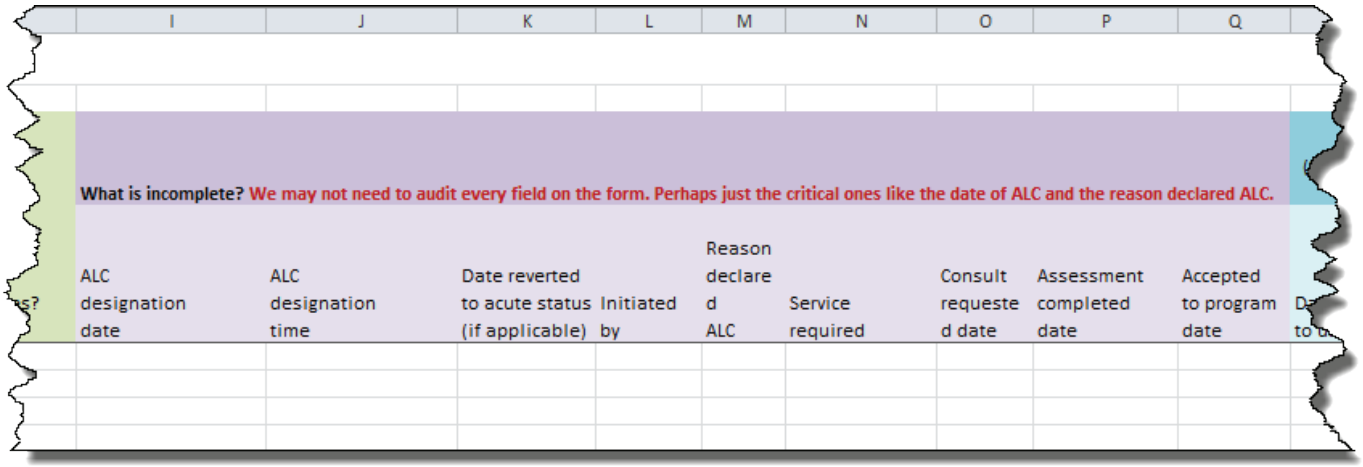
	A	B	C	D	E	F	
1	**Audit tool for Alternate Level of Care (A**						
2							
3	**Basic information to be filled out for all rows**						In
4	Region	Facility	Nursing Unit	Name of person who filled out form	Medical Record Number	Discharge Date	Mi Ine Com
5							
6							
7							
8							

Section 2: Record the *Initial Status* of the form. This section uses a drop down menu. Select Missing, Incomplete or Complete to identify how the original submission of the form was received.

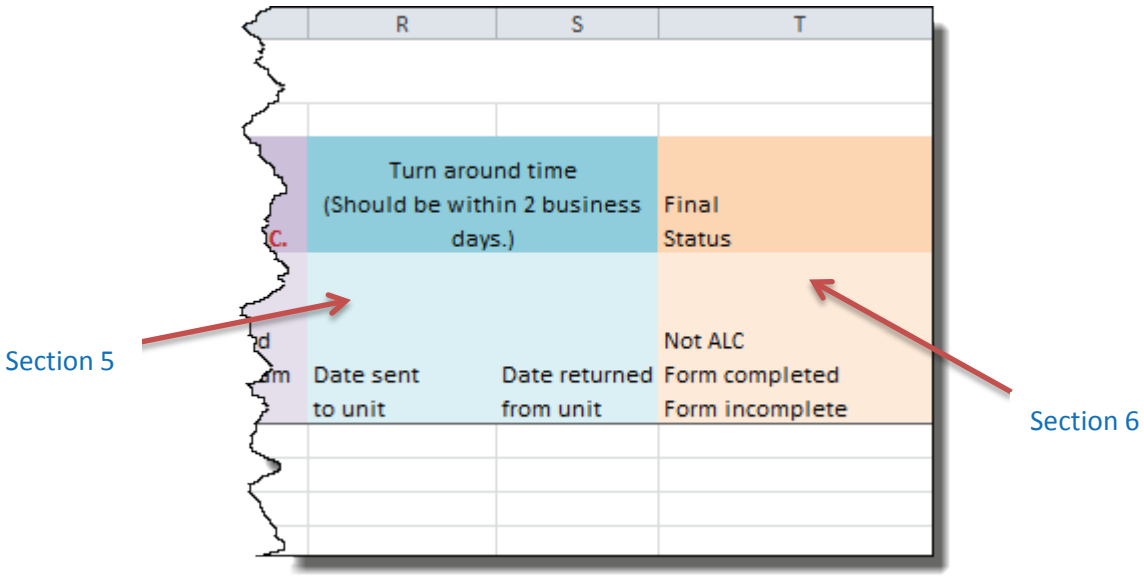


Section 3: Record if there are *Any Inaccuracies* on the form. This section uses a drop down menu. Select Yes or No. If yes, proceed to section 4; if no, proceed to Section 6.

Section 4: Record the specific information that is *Incomplete* on the form. This section uses a drop down menu. Select Missing or Inaccurate for all that apply.



Section 5: Record the turnaround time for the chart that has been sent to the unit for completion. This section requires text entry. Enter the date in the first column that the chart was sent to the unit for form completion. Turnaround time is expected to be within two business days. When the chart is returned from the unit, enter the date it was returned in the second column.



Section 6: Record the *Final Status* of the form. This section uses a drop down menu. Select Not ALC, Form Completed or Form Incomplete as appropriate.

Mentoring Teams and Continuous Improvement

A provincial ALC form is new for Saskatchewan. Training is required for all members of the clinical team and health records on how to use and enter information on the form and how to record this information in the Discharge Abstract Database.

The ALC boot camp on September 28, 2015 was the first such training session. Regional staff trained at this session may be able to help train others in their region.

There is a provincial implementation group who meet regularly to review the form and processes and provide further training and sharing of ideas. The Emergency Department Waits and Patient Flow Initiative also has an outreach support team available to provide coaching and support to regions as they implement this change. For assistance in accessing the outreach team contact edwaits@hqc.sk.ca.

The form and processes are not perfect and will be continuously improved as they are rolled out across the province. eHealth is committed to a quarterly review of the data collected to catch any data quality issues and get ideas for future improvements to the form. See **Work Standard 4: eHealth Review of ALC Form** for more details.

We are unable to record all information from the ALC form in the Discharge Abstract Database. For example, there is no place to record the dates that services/consults were requested. Although it may involve manual processes at first, units are encouraged to use the inform on the forms in real time to help coordinate the care of ALC patients and measure

improvements. eHealth is currently designing a provincial electronic data capture form that should be ready for all RHA's to use early in fiscal year 2016-17, allowing collection and analysis of all data field.

Appendices

Links to Job Aids from the Canadian Institute for Health Information

- Alternate Level of Care Diagnosis List: Clarification of Use: www.cihi.ca/en/alternate_level_of_care_diagnosis_list_en.pdf
- Changes to Z-Codes Allowable with ALC Service 99: https://www.cihi.ca/en/changes_to_z-codes.pdf
- Definitions and Guidelines to Support ALC Designation in Acute Inpatient Care: https://www.cihi.ca/en/acuteinpatientalc-definitionsandguidelines_en-web.pdf

ALC Form

See Appendix 1, Page 11 of the ALC Toolkit.

Document is also available at http://hqc.sk.ca/improve-health-care-quality/emergency-department-waits-and-patient-flow-initiative/

Work Standard 1: Criteria for Determining Alternate Level of Care (ALC)

<table>
<tr><td rowspan="2"> 
</td><td colspan="3">Name of Activity: Criteria for Determining Alternate Level of Care (ALC)

Role performing Activity: Physician or designate (typically Nurse Manager or Interdisciplinary/Multi-Disciplinary Team)</td></tr>
<tr><td rowspan="3">WORK STANDARD</td><td colspan="2">Location:
Hospital</td><td>Department:</td></tr>
<tr><td>Document Owner:</td><td colspan="2">Region/Organization where this Work Standard originated:

eHealth</td></tr>
<tr><td>Date Prepared:
28-Jan-2015</td><td>Last Revision:
5-Apr-2016</td><td>Date Approved:</td></tr>
</table>

Work Standard Summary:

Alternate Level of Care Definition: *ALC designation does **not** only apply to patients waiting for Long-term Care.* When a patient is occupying a bed in an acute care facility and does not require the **intensity** of resources/services provided in that care setting the patient must be designated Alternate Level of Care (ALC) at that time by a member/members of the interdisciplinary team. Other examples of ALC include respite care or days waiting in hospital for a home to be renovated to accommodate a patient with mobility issues.

	Essential Tasks:
1.	Patient is admitted to hospital. If a patient enters hospital already designated ALC but does not have an ALC form started, one is to be started.
2.	Patient is treated for acute care conditions as required.
3.	Member(s) of interdisciplinary team assess patient and may determine that the intensity of resources/services of acute care are no longer required but the patient cannot leave the facility without alternate services being made available for the patient in a more appropriate location.
4.	The "ALC Form" is initiated by designate of the interdisciplinary team.
5.	Follow Work Standard 2 for Completion of ALC Form.
6.	When a patient is discharged / transferred, ensure the ALC Form is kept with the patient chart to go to health records.
7.	If a patient reverts between acute care and ALC multiple times within the same admission, a new form must be started with each new episode of ALC.

Work Standard 2: Completion of ALC Form

Putting Patients First Transforming Health Care through Lean Jba-Consulting	**Name of Activity: Completion of ALC Form** **Role performing Activity: Interdisciplinary team member(s)**		
WORK STANDARD	**Location:** **Hospital**		**Department:**
	Document Owner:		**Region/Organization where this Work Standard originated:** **eHealth**
	Date Prepared: **28-Jan-2014**	**Last Revision:** **04-Apr-2016**	**Date Approved:**

Work Standard Summary:

ALC Form Definition: The ALC Data Capture Form should be used by the Interdisciplinary team to capture information related to the designation of a patient as Alternate level of care (ALC) as well as services required for discharge and rationale for ALC designation.

Essential Tasks:	
1.	Patient is determined to be ALC and an ALC Form is added to the chart.
2.	The designate initiating the ALC Form must put their name and contact information on the form.
3.	The date and time of ALC designation is recorded on the ALC Form.
4.	Using the reasons listed, **mark an X on one circle for the main reason** that the patient was designated ALC on the Form.
5.	Mark an X on all other boxes that apply for Reason for Designation. Specify the reason or further details when prompted by the form.
6.	If required, the Interdisciplinary team determines necessary consults and/or assessments. The date the consult/service is requested is recorded on the ALC Form under the Consult Requested column. If the service is not available, indicate that at the section at the bottom of page 1 and specify the type of service that does not exist.
7.	If the first assessment for a service/support does not meet the patient's needs and he/she requires a different type of service/support in order to be discharged from the acute care facility; these are also to be documented on page two of the ALC Form along with the date they are requested.
8.	The date the service/support/program accepts the patient is recorded on the ALC Form under the Accepted to Program/Waitlisted column. Note: This is not when the patient has been transferred from care but rather has been accepted and is waiting to be transferred.
9.	If the patient deteriorates or their condition changes and the patient needs to return to acute care status the Interdisciplinary team will record the time, date and diagnosis for return to acute care. If the patient returns to ALC designation a new ALC Form must be started.
10.	When patient is discharged from acute care and transferred to an appropriate level of care, the time and date of discharge must be recorded on the ALC Form. (bottom of second page). If the anticipated discharge destination changed or the patient was decreased, that should also be noted.

Work Standard 3: Coding of Alternate Level of Care Form

Putting Patients First Transforming Health Care through Lean Jba-Consulting	**Name of Activity:** **Coding of Alternate Level of Care Form** **Role performing Activity: Health Information Management Practitioner**		
WORK STANDARD	**Location:**		**Department:**
	Document Owner:		**Region/Organization where this Work Standard originated:** **eHealth**
	Date Prepared: **29-Jan-2015**	**Last Revision:** **04-Apr-2016**	**Date Approved:**

Work Standard Summary:

	Essential Tasks:
1.	The Alternate Level of Care Form will be placed directly after the Discharge Summary in the patient chart.
2.	When the patient is designated as ALC for a portion (24 hours or more) of his/her stay, record the Service Transfer as 99. Verify that ALC length of stay is greater than 24 hours by referring to the ALC designation date and time, the reverted to acute status date and time (if applicable), and the discharge date and time. If the total time is less than 24 hours do not code the ALC form.
3.	If the patient was directly admitted as ALC, regardless if the total length of stay is less than 24 hours, capture the Main Patient Service as 99 and code as ALC.
4.	Calculate and enter the ALC length of stay by referring to the ALC designation date, the date reverted to acute status (if present), and discharge disposition date. If the patient has reverted between acute and ALC multiple times during the same admission, capture the total length of ALC days by adding all ALC days from the multiple forms. Each episode of ALC must be greater than 24 hours.
5.	Refer to the main reason on the ALC form indicated by an X in a circle – found on page 1. Use this designated Z code, in parentheses, to correspond to Main Patient Service 99. If the "primary reason" is documented in a "Specify*" area, code to the most descriptive code listed in the allowable ALC Diagnoses Codes List – see DAD Abstracting Manual, Section 3: Alternate Level of Care.
6.	Boxes with an X identifies the additional issues/needs that are contributing to the main ALC reason. For reasons listed with a diagnosis code in parentheses, capture this code on the abstract. Where there is documentation provided in *(Specify) code to the most specific code to capture the relevant additional information; these codes do not have to be Z codes.
7.	Assign Prefix "A" to ALC Designation code and all additional codes to link all ALC related documentation on the abstract. Do not use Prefix "A" for palliative care reason (Z51.5) if Prefix 8 (palliative care documented as a known component of the patient's care prior to arrival at the facility) applies.

8.	All assigned codes will adhere to the Canadian Coding Standards – "Diagnosis Typing Definitions for DAD"
9.	In the event of questionable information on the form, clarify with the contact person indicated at the top of the form - **Designate Initiating Form**.
10.	If the coder finds documentation in the chart to indicate that there were ALC days during the acute visit, but there is no ALC form present, the issue should be brought to the attention of the nursing unit manager or clinical coordinator of the nursing unit to which the patient was last admitted.

Work Standard 4: eHealth Review of ALC Form

Putting Patients First Transforming Health Care through Lean Jba-Consulting	**Name of Activity: eHealth Review of ALC Form** **Role performing Activity: eHealth Data Quality Team**		
WORK STANDARD	**Location:** **eHealth**		**Department:** **Information Gov**
	Document Owner: **Director of Info Gov**	**Region/Organization where this Work Standard originated:** **eHealth**	
	Date Prepared: **28-Jan-2015**	**Last Revision:** **05-Apr-2016**	**Date Approved:**

Work Standard Summary:

Review of ALC Data and Reporting: eHealth will be responsible for conducting various quality reviews of both submitted data as well as use of the ALC Form, Work Standards and Definitions. Any updates or changes will be discussed and communicated out provincially.

	Essential Tasks:
1.	**Quarterly Review of Form:** eHealth will conduct a quarterly review of the entire form. The primary focus of the review will be with regards to formatting and usage changes as a result of feedback from users, as well as results of the other quarterly and monthly reviews as described in steps 2-4.
2.	**Quarterly Review of ALC Reasons:** eHealth will conduct a quarterly review of the reasons specified on the form. The primary review will focus on the use of "Other issues/care needs as a reason. If there is increased utilization of the "other" categories in a particular facility/region, eHealth will initiate a detailed root cause analysis to help determine why the "other" reason is being used and whether an adjustment to the provincial ALC Form, definitions or Work Standard is required. This may potentially be determined by an increase in use of other codes not available on the ALC Form.
3.	**Quarterly Review of Services Required**: eHealth will conduct a review of the ALC Form specific to "Services Required". The use of "other" services/consultations will be monitored. If there is increased utilization the "other" section in a particular facility/region eHealth will initiate a detailed root cause analysis to help determine why the code is being used and whether an adjustment to the provincial ALC Form, definitions or Work Standard is required. This may potentially be determined by an increase in the use of other codes not available on the ALC Form.
4.	**Monthly ALC Data Quality Dashboard:** eHealth will monitor ALC under reporting and on a monthly basis provide an ALC Data Quality Report back to each Region that will identify charts that could potentially be an ALC patient but were not coded as such.

Supplies:

Work Standard 5: Placement of Alternate Level of Care Form in Patient's Chart at Health Records

<table>
<tr><td rowspan="2"> 
</td><td colspan="3">Name of Activity:
Placement of Alternate Level of Care Form in Patient's Chart at Health Records

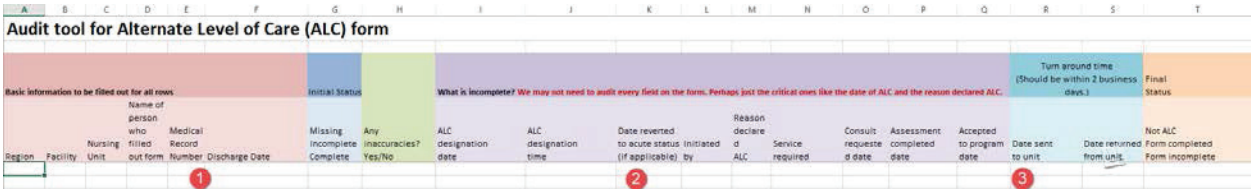
Role performing Activity:
Chart Assembly</td></tr>
<tr><td rowspan="3">WORK STANDARD</td><td colspan="2">Location:</td><td>Department:</td></tr>
<tr><td colspan="2">Document Owner:</td><td>Region/Organization where this Work Standard originated:

eHealth</td></tr>
<tr><td>Date Prepared:
29-Jan-2015</td><td>Last Revision:</td><td>Date Approved:</td></tr>
</table>

Work Standard Summary:

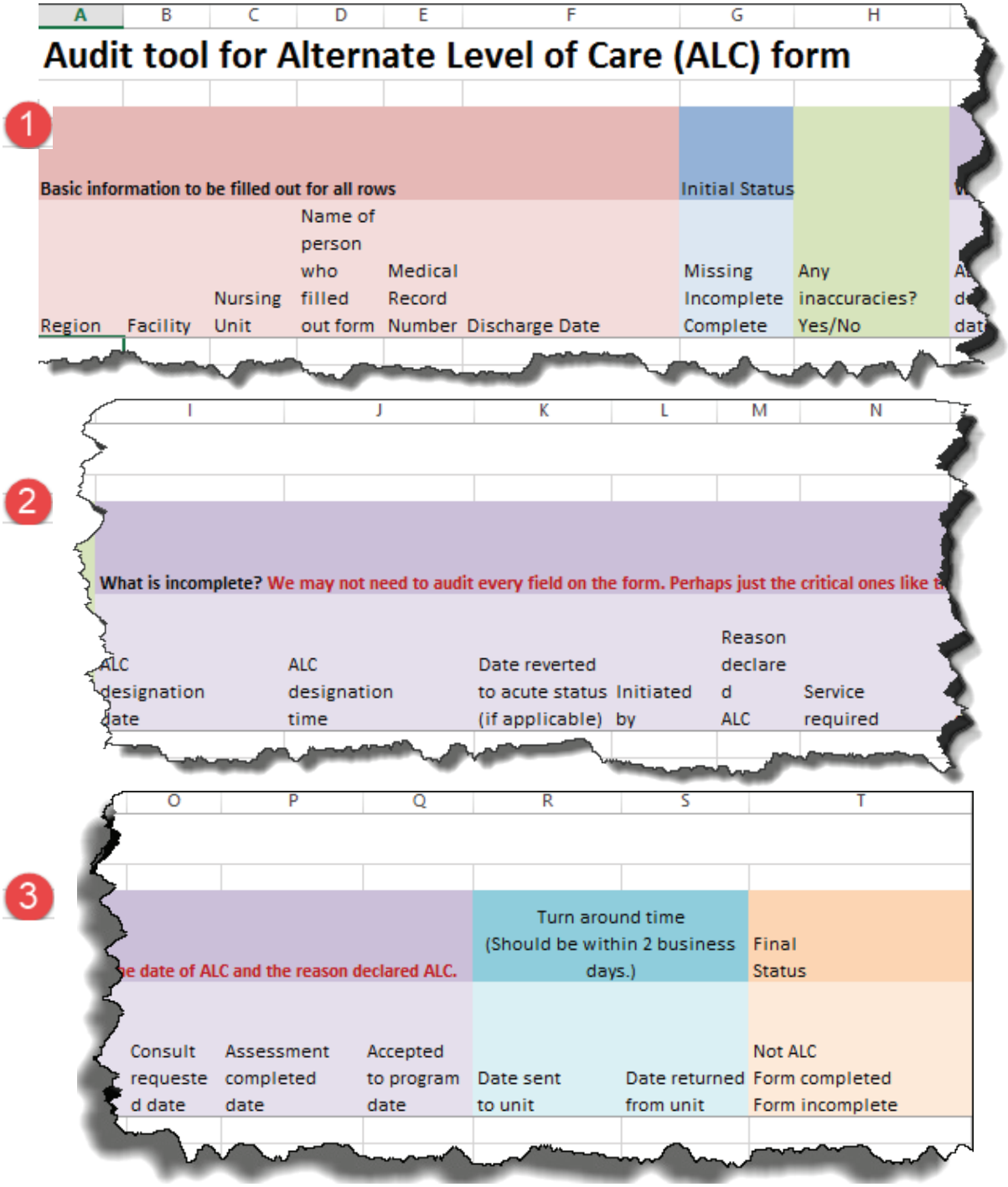
	Essential Tasks:
1.	When the ALC form is triggered it will be sent to Health Records Department upon discharge with patient's chart.
2.	During assembly, place ALC form directly after the discharge summary.

Audit Tool for Alternate Level of Care Form


Audit tool for Alternate Level of Care (ALC) form

Basic information to be filled out for all rows | Initial Status | What is incomplete? We may not need to audit every field on the form. Perhaps just the critical ones like the date of ALC and the reason declared ALC. | Turn around time (Should be within 2 business days.) | Final Status

Region | Facility | Nursing Unit | Name of person who filled out form | Medical Record Number | Discharge Date | Missing Incomplete Complete | Any inaccuracies? Yes/No | ALC designation date | ALC designation time | Date reverted to acute status (if applicable) | Initiated by | Reason declared ALC | Service required | Consult requested date | Assessment completed date | Accepted to program date | Date sent to unit | Date returned from unit | Not ALC Form completed Form incomplete


Audit tool for Alternate Level of Care (ALC) form

Basic information to be filled out for all rows | Initial Status

Region | Facility | Nursing Unit | Name of person who filled out form | Medical Record Number | Discharge Date | Missing Incomplete Complete | Any inaccuracies? Yes/No

What is incomplete? We may not need to audit every field on the form. Perhaps just the critical ones like t

ALC designation date | ALC designation time | Date reverted to acute status (if applicable) | Initiated by | Reason declared ALC | Service required

e date of ALC and the reason declared ALC. | Turn around time (Should be within 2 business days.) | Final Status

Consult requested date | Assessment completed date | Accepted to program date | Date sent to unit | Date returned from unit | Not ALC Form completed Form incomplete

Note: The Audit Tool is an Excel document included in the toolkit.

Appendix 3 – Definitions and Guidelines to Support ALC Designation in Acute Care

Introduction

Alternate Level of Care (ALC) is a system classification used in Canada that is applied when there is a mismatch between the intensity of care needs in relationship to the intensity of services/resources in that setting. This can occur in acute inpatient, mental health, rehabilitation, and chronic, or complex continuing care. It has been recognized that there is a need for a standardized approach in considering patient status in ALC designation.

Definitions

Alternate Level of Care (ALC): When a patient is occupying a bed in a facility and does not require the intensity of resources/services provided in that care setting.

Contextual information

Why: The consistent use of ALC designation facilitates measurement of the access gap from one care setting to another. These gaps, once defined, inform system level planning to improve access.

Where: This guideline applies specificially to acute inpatient care.

Who designates: The patient must be designated ALC by the most appropriate care team member, which may be a physician, long-term care assessor, patient care manager, discharge planner or other care team member. The decision to assign ALC status is a clinical responsibility.

When: The ALC time frame starts on the date and at the time of designation as documented in the patient chart or record. The ALC time frame ends (1) on the date and at the time of departure from the ALC setting or (2) on the date and at the time the individual's care needs change such that the ALC designation no longer applies. For a patient who is ALC and reverts to acute status and then becomes ALC again, the patient's total count of ALC days should resume and not start again from 0. **Note: The discharge or transfer destination need not be known at the time of ALC designation.**

How: The ALC status is clearly documented in the patient record by clinical staff, preferably on an approved ALC Designation form. **Acute care patients require daily assessment; therefore, the assessment for ALC designation takes place daily.** The Health Information Management Professional will record the pertinent ALC information in the Discharge Abstract Database (DAD) abstract. In order to enter the ALC service in the abstract, the duration of the ALC portion of the

Acute inpatient care: An active, short-term care episode including facility-based overnight stay and the presence of 1 of the following:

- The need for active treatment of serious injury or illness, urgent medical or mental health condition or during initial recovery from surgery
- Care/monitoring provided 24/7 by a multidisciplinary team, which may include physicians, nurses (registered or practical), nurse practitioners, and other allied health professionals (pharmacist, physiotherapist, occupational therapist, registered dietitian, social worker, etc)
- Services provided at a minimum level of certain frequencies and intensity levels:
  - Attendance and charting by a physician or delegate at least once per day
  - Close clinical monitoring at least 3 times daily based on delegated functions by the physician
- Access to diagnostic tests required to stabilize plan of care

Acute inpatient care encompasses a range of clinical health care functions and treatments, including emergency medicine, trauma care, acute medicine, acute care surgery, critical care, obstetrics, gynecology, acute pediatric care, acute mental health, acute rehabilitation, acute palliative care and inpatient stabilization.

Guidelines to support ALC designation by clinicians

The following table is intended to support clinical decision-making to determine whether an individual's inpatient status should be designated ALC. **The guidelines are intended to prompt questions for clinicians to consider for ALC designation. In all cases, application of clinical judgment and adherence to best practice is expected judgment for final designation decisions.**

	Acute inpatient care (if any 1 of the following criteria is met)	ALC
Patient characteristic		
Clinical status	• Unstable and/or deteriorating • Anticipated risk for rapid decline • Actively under investigation and diagnoses under revision	• Stable and/or patient's status has plateaued • Low risk for rapid decline • No longer searching for new additional diagnoses
Safety risk: Self and others	• Progressive acute behavioural or neurological difficulties requiring acute inpatient care • Evidence of actual or potential danger to self or others • Requires protection for self and/or others from aggression/self-injurious behaviour • Requires 1:1 observation	• Cognitive impairment including dementia, with stable treatment plan, not requiring acute care services • Behavioural or neurological difficulties that can be managed with interventions in the community as specified in the care plan
Team requirements		
Activity tolerance	• Activity level markedly below baseline or new baseline; requires assistance • Anticipated to require access to the full range of professional therapies to achieve client goal • Altered cognition or physical symptoms impair rehabilitation services • If dominant treatment plan is rehabilitation, can tolerate intensity of 2 professional therapeutic services (e.g., nursing, occupational therapy [OT], physical therapy [PT])	• Baseline independence recovered or new baseline established • Can receive activity support in a different setting • Assisting patients in returning home or moving to another level of care (e.g., waiting for specialized rehabilitation care beds)
Clinical practice and process	• ≥2 professional therapeutic services are required daily (e.g. any combination of nursing, OT, PT, etc.) • Close monitoring at least 3 times daily (e.g., vital signs) • Plan actively changing • Clinical status or need requires ≥1 daily doctor visit	• Required professional therapeutic services and monitoring can be provided in a different setting (e.g., in specialized rehabilitation care beds/facilities) • Stable treatment plan • Requires <1 daily doctor visit
Clinical interventions		
Medication and fluid administration	• Requires multiple assessments and/or titrations • Requires special routes of administration that must be performed in hospital (e.g., IV, epidural, intrathecal)	• Frequency of assessment and/or titration per administration can be accomplished in another setting • Route of administration could be done on an outpatient basis (e.g., IV medication) regardless of service availability in the community
Diagnostics and therapeutics	• Requires access to diagnostics/procedures and results or pre-/post-testing care	• Service as well as pre-/post-care available in a setting other than hospital • No immediate results requirement

	Acute inpatient care (if any 1 of the following criteria is met)	ALC
Specialized care or scenarios		
Palliative care	• Medically unstable with potentially reversible conditions requiring diagnostics and treatments not available outside the hospital setting. The goal is life prolongation. • Complex symptom control issues and required support for imminent death within the acute care environment (e.g., a patient on a medical ward, palliating without a plan to move to another level of service) • End-of-life care focused on comfort only, with unstable complex symptoms that require the support of the interdisciplinary team and specialist palliative care services	• Medically stable with gradual progression of non-reversible illness; stable treatment plan may be supported outside of acute inpatient care • Care requriements may be delivered in another setting (e.g., chronic or complex continuing care, home with home care, hospice care) • Comfort care can be supported within the community setting • Patient-centred care can be creatively planned to support dying at home
Mental health	• Suffers from sudden and severe psychiatric symptoms; can include patients who are suicidal, or who have hallucinations, extreme feelings of anxiety, paranoia or depression • Progressive acute behavioural or neurological difficulties requiring acute clinical or psychiatric care • Therapeutic pass to inform clinical readiness for discharge	• Can be managed with individual or group therapy, or relapse prevention services • Clinically stable or has plateaued and is able to participate in recovery plan in the community, including in designated non-acute- mental health treatment facilities • Overnight or >24-hour trial discharge where treatment plan supports care in an alternate setting
Respiratory care	• On a ventilator with a new tracheostomy (cuffed), requiring ≥3 assessments/day	• On a ventilator, chronic respiratory care
Companion		• Companion — well baby/adult (if registered)

Appendix 4 – Patient Brochure Text for RHAs

Patient Information on Alternate Level of Care

What is Alternate Level of Care (ALC)?

When you're in hospital, a health care team of professionals are involved in your care and recovery. As you know, recovering from an illness or surgery takes time. Recovery is different for every one of us. How you recover also affects the kind of ongoing care you require. Most patients are sent home – or discharged – to recover.

Many people still need to receive some kind of care, just not the same kind of care a hospital offers. This type of care is called Alternative Level of Care, or ALC for short.

Your health care team has recognized that you no longer require the care that comes from an acute care hospital setting. They will discuss your specific care requirements with you, but this pamphlet provides a quick overview of what ALC means.

An ALC patient is a patient who is occupying a bed in a health facility or hospital and does not require the intensity of resources/services provided in that care setting. This does not mean you don't need care. It just means the care you need could be provided outside the hospital setting.

What does ALC mean for you?

ALC options are different for each patient. They may also change over time as you recover. Every attempt will be made to let you recover where you are most comfortable – your home. Your health care team will want to know important information about you or your family situation to help them plan your discharge:

- Will your family be available to help?
- Do you live with someone who can help with things like going to the bathroom and making meals?
- Are you or your family willing to having community services help you at home?
- Are home care services available where you live?
- What services or programs are available in your community?

The answers to these questions will help determine how your care needs could be met at home.

Sometimes, your recovery may make it difficult to be discharged home right away. Perhaps a chronic illness becomes worse, complications after surgery occur, or you have a sudden onset of another illness. These changes can be even more challenging for someone who is very elderly. If it's been determined that you no longer need to be in a hospital setting, then your health care team will help determine options in planning your discharge from hospital.

How is ALC determined?

When you entered the hospital, your health care team already started to plan for your discharge. This is normal. We know that no one likes to stay in hospital longer than required. It takes time and preparation to plan for discharge. The health care team continually assesses your condition. At some point, they may identify you are now "alternate level of care." Many factors go into this, for example:

- Do you need further medical testing?
- Do your medical treatments still have to be carried out in hospital?
- Do you require full-time nursing care?
- Do you need to see a doctor every day?
- Do you require close monitoring of your medications?
- Do you require the intensive therapy services that are offered in the hospital?

These are a few examples of questions that will be asked, and if the answers are "no," it's possible you may be considered ALC.

What happens after you are designated ALC?

Your health care team has assessed you as being ALC. So now what?

The first thing that will happen is your health care team will discuss with you what options are available to you. The goal is to continue providing the right care in the right setting. Options may include, but are not limited to:

- home (with or without any additional services);
- a non-acute type of setting such as a convalescence unit or transition unit. The availability of these programs varies across the province; or
- care homes. The availability and variety of care homes also varies from region to region.

You may have heard of some of the following facilities: [each RHA to regionalize with examples and language appropriate for your area – not an exhaustive list, just one that makes sense to the community/ies of the patient]

It is not necessary to determine where your care is going to take place before being assessed as ALC.

How will transfer occur?

xxxx

What do I need to do?

xxxx

Appendix 5 – Family Brochure Text for RHAs

Family Information on Alternate Level of Care

What is Alternate Level of Care (ALC)?

When a patient is in the hospital, a health care team of professionals is involved in their care and recovery. As you know, recovering from an illness or surgery takes time and each person's recovery is different. Families play a key role. How a patient recovers affects the kind of ongoing care he/she requires. Most patients are sent home – or discharged – to recover. Many people still need to receive some kind of care, just not the same kind of care a hospital offers.

The health care team looking after your family member has recognized that he/she no longer requires the type of care provided in an acute care hospital. Instead your family member needs what's called alternative level of care, or ALC for short. The health care team will discuss specific care requirements with the patient, but this pamphlet provides a quick overview of what ALC means. We encourage you to discuss this information together, provided your family member is willing to do so.

An ALC patient is a patient who is occupying a bed in a health facility or hospital but does not require the intensity of resources/services provided in that care setting. This does not mean the patient no longer needs care. It just means the care he/she needs could be provided outside the hospital setting.

What does ALC mean for the patient?

ALC options are different for each patient. They may also change over time as the patient recovers. Every attempt will be made to allow patients to recover where they are most comfortable – their home. A patient's health care team will want to know important information about him/her, or their family, to help plan the patient's discharge:

- Will you or other family members be available to help?
- Does the patient live with someone who can help with things like going to the bathroom and making meals?
- Are you or other family members willing to having community services help the patient at home?
- Are home care services available where the patient lives?
- What services or programs are available in the patient's community?

The answers to these questions will help determine how a patient's continuing care needs could be met at home.

Sometimes, the speed at which a patient is recovering makes it difficult for him/her to be discharged home right away. Perhaps a chronic illness becomes worse, complications after surgery occur, or he/she has a sudden onset of another illness. These changes can be even more challenging for an elderly patient. However, if it's been determined the patient no longer needs to be in hospital, then that patient's health care team will help determine the best options for meeting their care needs after discharge.

How is ALC determined?

Shortly after a patient enters the hospital, his/her health care team is already starting to think about discharge to home. This is normal. We know that no one likes to stay in hospital longer than required. It takes time and preparation to plan for discharge. The health care team continually assesses a patient's condition, even before the patient has completed his or her recovery. At some point, they may determine the patient is now "alternate level of care." Many factors go into this, such as:

- Does the patient need further medical testing?
- Does the patient's medical treatment still have to be carried out in the hospital?
- Does the patient require full-time nursing care?
- Does the patient need to see a doctor every day?
- Does the patient require close monitoring of their medications?
- Does the patient require the intensive therapy services that are offered in the hospital?

These are a few examples of questions that will be asked, and if the answers are "no," then the patient may be considered ALC.

What happens after a patient is designated ALC?

After a patient is designated ALC, his/her health care team will discuss what options are available. The goal is to continue providing the right care in the right setting. Options may include, but are not limited to:

- Home (with or without any additional services);
- A non-acute setting such as a convalescence unit or transition unit. The availability of these programs varies across the province; or,
- Care homes. The availability and variety of care homes also varies from region to region.

You may have heard of some of the following facilities: [each RHA to regionalize with examples and appropriate wording – not an exhaustive list, just one that makes sense to the community/ies of the patient]

It is not necessary to determine where the patient's care is going to take place before he/she is assessed as ALC.

How will transfer occur?

xxxx

What do I need to do as a family member?

xxxx

Appendix 6 – Alternate Level of Care Patients – Designation, Measurement and Management

Memorandum of Understanding

Of

All Saskatchewan Regional Health Authorities

This Memorandum of Understanding (MOU) sets forth the terms and understanding between all Saskatchewan Regional Health Authorities (RHAs) related to the designation, measurement and management of Alternate Level of Care (ALC) patients.

Purpose

In the spirit of a health system that thinks and acts as one, this MOU will outline agreed upon principles related to identification and management of ALC patients. Agreement on these principles will reflect a shared commitment to patient centered care and the provision of the care in the right place at the right time by the right provider.

Standardized processes based on agreed upon principles will also ensure that the resources and capacity of the provincial health system are efficiently and maximally utilized.

Background

The Emergency Department (ED) Waits and Patient Flow Initiative (the Initiative) has identified understanding and managing the ALC population as a system level priority. ALC patients utilizing acute care beds are one of the contributing factors to long waits within the ED. The prolonged presence of this population within acute care is reflective of the system's inability to meet their care needs within the community. A goal of patient centered care should be to prevent avoidable hospital admissions for this vulnerable population and if an admission is required, successfully transition those individuals back into the community after acute care is no longer required.

Currently a common definition is not used provincially to identify and manage this patient population. Regions have primarily been capturing ALC data on patients waiting for a long-term care (LTC) bed while in hospital. As a result, ALC patient days are underreported provincially.

For 2013-14, 7.8% of total patient days were reported as ALC by all the regions. By using the additional CIHI discharge destinations of General Rehabilitation Facility; Chronic Care Facility; Nursing Home; Special Rehabilitation Facility; or Home for the Aged; CIHI estimated the actual percentage for 2013-14 at 8.9%.

This historic practice of only reporting patients waiting for LTC placement has also contributed to the practice of requesting LTC assessment before community options are explored. This may result in patients being discharged to an inappropriate setting and receiving an inappropriate level of care.

By using this provincial definition for ALC, the goal of the system to have the right patient in the right place at the right time receiving the right care in a cost effective and safe environment will occur. In addition, the system will begin to see that this group of patients is not just waiting for LTC placement.

Early results from recent improvement work on ALC designation, using the new provincial definition in two regions, (Sunrise and Saskatoon) has demonstrated that the actual ALC patient days may be significantly higher than 8.9%. Accurate data on the ALC population is essential to inform the system on potential investments in community based care that will provide safe, accessible, cost effective options for this population. This will also decrease the utilization of acute care beds; thereby positively impacting patient flow and reducing ED wait times.

Regional stakeholders want to standardize and improve the processes on designation, measurement, and management of ALC patients. This has included identifying and addressing the barriers affecting this work.

The Initiative's ALC working group has found that the current designation of ALC results in several misunderstandings in the management of these patients. Examples of these care breakdowns include:

- Reduced or withdrawn professional services, even though the patient's care may be negatively impacted;
- Implementation of bed charges for patients after the ALC designation, even though there is no other care option available for that patient; and,
- Confusion over allowable provider billing policies.

These situations may provide a disincentive to identifying patients as ALC and further compromise the ability to collect accurate data necessary to drive future planning. Education regarding this provincial ALC process is required for administrators, care providers, patients and families.

Principles

When designing policy; procedures; processes; guidelines or work standards related to ALC patients, the following principles will be incorporated by the parties that are signatory to this MOU:

1. The following definition of ALC will be used provincially: ***An ALC patient is a patient who is occupying a bed in a facility and does not require the intensity of resources/ services provided in that care setting***.
2. Common provincial ALC designation and data collection forms, which have been tested and validated through a provincial replication process, will be used by all regions.
3. ALC data will be reported to CIHI by individual regions as per normal processes.
4. The care provided to patients should be driven by the needs of that patient, not their designation as ALC. Appropriate services for that patient will be determined by the potential for improvement, care goals and the impact on the patient's health status if service is reduced.
5. A level of care assessment (the Minimum Data Set tool) will be utilized to determine an appropriate service/program/location to meet the needs of the ALC patient.
6. Community based options should be considered first; a LTC assessment should be completed, if appropriate, only when all other care options have been explored.
7. Parties of this agreement will use standardized maximum bed charge guidelines as developed by the Joint Committee on Acute and Emergency Services (JCAES).
8. Standardized provincial education material for patients and families on what ALC is and what an ALC designation means will be developed and utilized by all regions. Regional context may be required in the materials developed.

Duration

This MOU is at-will and may be modified by mutual consent of authorized officials from (CEOs). This MOU shall become effective upon signature by the authorized officials from the (CEOs) and will remain in effect until modified or terminated by any one of the partners by mutual consent. In the absence of mutual agreement by the authorized officials from (CEOs) this MOU shall endure.

Contact Information

Jennifer Conley, CEO, Athabasca Health Authority — September 29/15 Date

Beth Vachon, CEO, Cypress Health Region — 10 Sept 2015 Date

Cheryl Craig, CEO, Five Hills Health Region — September 1, 2015 Date

Greg Cummings, CEO, Heartland Health Region — 29.9.15 Date

Jean-Marc Desmeules, CEO, Keewatin Yatthé Health Region — September 28 2015 Date

Shane Merriman, CEO, Kelsey Trail Health Region — SEPT. 2/2015 Date

Andrew McLetchie, CEO, Mamawetan Churchill River Health Region — Aug 31/15 Date

David Fan, CEO, Prairie North Health Region — September 23, 2015 Date

Cecile Hunt, CEO, Prince Albert Parkland Health Region — Sept 23 2015 Date

Dan Florizone, CEO, Saskatoon Health Region — Sept. 3, 2015 Date

Keith Dewar, CEO, Regina Qu'Appelle Health Region — Sept 3/15 Date

Marga Cughet, CEO, Sun Country Health Region — September 2, 2015 Date

Suann Laurent, CEO, Sunrise Health Region — August 31, 2015 Date