Let’s Talk Informatics

Nova Scotia Health Alternate Level of Care Designation Project

- Audience audio and video options have been disabled.
- To interact in the Q & A portion of the presentation, select Q & A from the top menu bar, then type your question.
- Today’s session is being recorded and registered guests will be emailed a link to access.
- Want to stay informed about future sessions? Get on our mailing list here: **letstalkinformatics@nshealth.ca.**

Let’s Talk Informatics

Nova Scotia Health
Alternate **L**evel of **C**are
Designation Project

Phương Nguyễn
&
Danielle Pinkney-MacQuarrie

February 29th, 2024

Acknowledgement

We acknowledge that we are gathered today
in Mi’kma’ki (*Mig-***maw**-gee),
the traditional ancestral unceded
territory of the Mi’kmaq (*Mig-**maw**) people.

Alternate Level of Care

Informatics utilizes health information and health care technology to enable patients to receive best treatment and best outcome possible.

Let’s Talk Informatics Objectives

This series is designed to enable participants to:

- Identify knowledge and skills healthcare providers need in order to use information now, and in the future.
- Prepare health care providers through an introduction to concepts and experiences in Informatics.
- Acquire knowledge to remain current by becoming familiar with new trends, terminology, studies, data and news.
- Collaborate with a network of colleagues to establishing connections with leaders who can provide advice on business issues, best-practice and knowledge sharing.

Conflict of Interest Declaration

We do not have an affiliation (financial or otherwise) with a pharmaceutical, medical device, health care informatics organization, or other for-profit funder of this project.

Alternate Level of Care Learning Objectives

- At the conclusion of this activity, you will be able to:

✓ Gain a better understanding of why this project is needed and its purpose.

✓ Determine, based on the Alternate Level of Care definition and criteria, how to designate an ALC patient.

What is this project about?

Provincial **A**lternate **L**evel of **C**are Designation Project:

- Standardize ALC designation process across all acute care settings within Nova Scotia Health to promote a consistent approach when classifying ALC patients:
  - Definition & Criteria
  - Designation & documentation
  - Policy
  - Form

Why is this project required?

- High occupancy rates and volumes of long-stay patients across Nova Scotia Health (NSH)
  - to help understand and manage patient flow pressures.
- Inconsistencies in the ALC definition across the province.
- Inconsistencies in the ALC designation process across the province.
- Inconsistencies in the ALC documentation and reporting.

Others are doing it

- Several provinces across Canada have a process and means to measure ALC.
  - NSH has been measuring ALC with variations in interpretation; clarity is required in our processes
- Once the need for acute medical care no longer exists, services are coordinated in such a way to support transition to community.

Here at Nova Scotia Health

- The ALC project is one of the fundamental first steps.

What's in it for the organization?

- **Enhance the understanding and practice** for NSH physicians and staff.
- **Streamlined care processes** for more accurate and efficient service planning.
- **Ability to identify patients** who no longer require acute care improving patient flow and service planning.
- **Ability to identify supports required** to discharge ALC patients enabling executive leadership to advocate to the government for additional community resources to support the ALC population effectively.

Hospital Acquired Harms

- Delerium
- Nosocomial infection
- Deconditioning
- Falls
- Polypharmacy
- Incontinence
- Pressure injuries
- Treatment errors

What's in it for the patient / general public?

With improved patient flow planning, we hope to see:

- **Patient's time viewed as the most valuable currency.**
  - Give patients back their time by not being in the hospital longer than required!
- **Better alignment between care delivery and patient needs.**
- **Improved Access to Services:** streamlining patient flow and discharge planning processes through the ALC project improves access to acute care services for those who truly require them.
- **Continuity of Care:** facilitating smooth transitions between care settings, promoting continuity of care for patients as they move from acute care to home with support from community-based services.
- **Improved Outcomes:** ensuring that patients receive care in the most appropriate setting based on their clinical needs/ receive care in environments better suited to their level of acuity.

Project Roadmap

Jun – Oct 2023

1. Re-identified: Project Leads, Core Team members, Project Sponsors
2. Revised ALC Project Charter / Seek re-approval
3. Researched, benchmarked, developed, seek endorsement of NSH **Definition of ALC** at Network and Council

Oct – Nov 2023

4. Submission of NSH ALC definition to COC and received approval
5. Development and approval of ALC *Supports Required List*
6. Development and approval of **ALC Status Change Form**

Dec 2023 to Feb 2024

7. Development and approval of ALC data entry processes: STAR & Meditech.
8. Policy development (draft, seek partners/collaborators input, finalize, and submit for publication)
9. Develop ALC Communication Plan and Education Plan
10. Approve Education Plan /roll out

Mar – Jun 2024

11. Education to Zones- March to April ← We are here
12. Implementation (Go Live) to Zones- May to June
13. Evaluation of ALC Process (Summer 2024) – modify where necessary

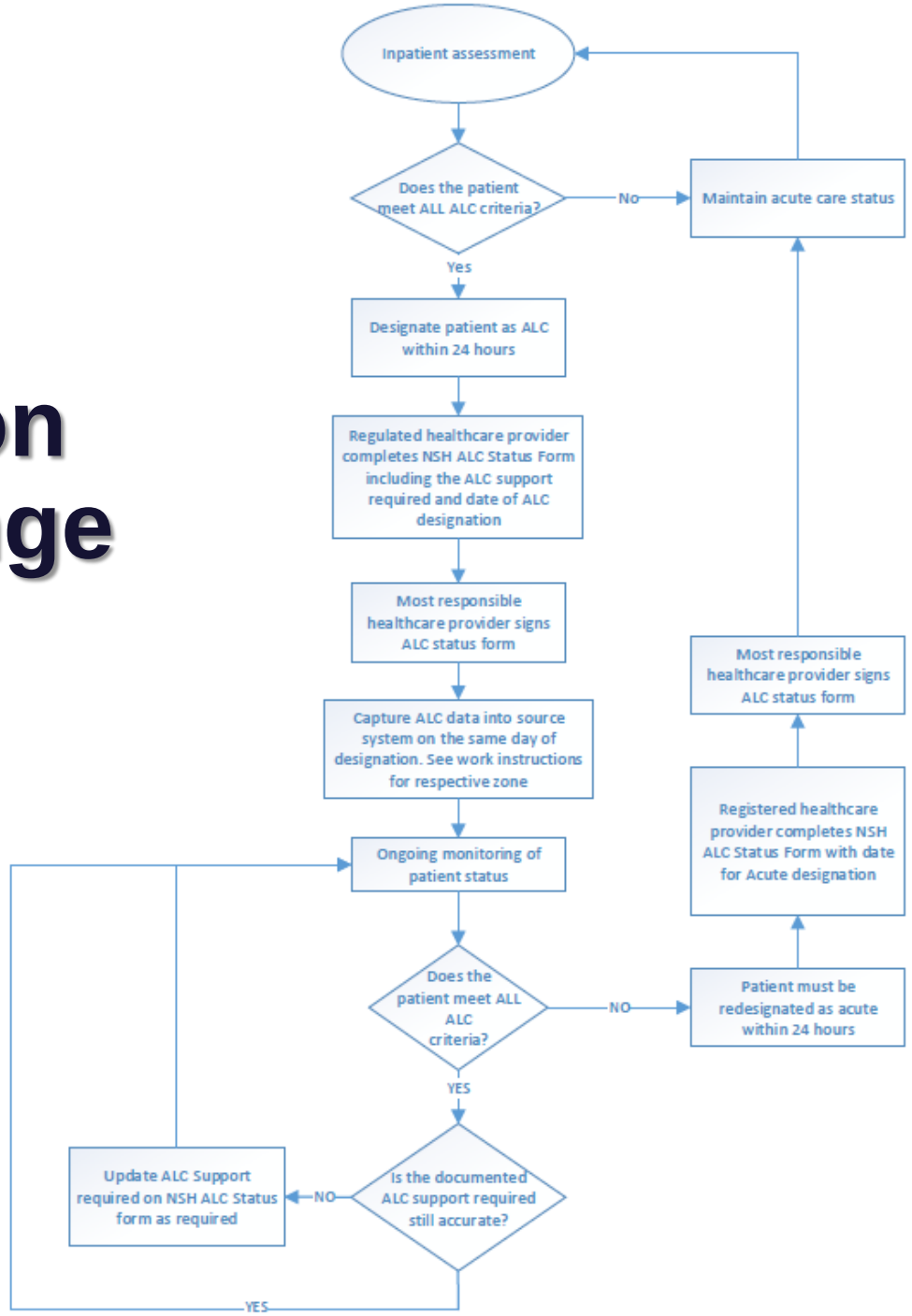
NSH ALC Definition

Alternate level of care (ALC) is used to identify patients who no longer require inpatient acute care services provided at their current facility, based on meeting all of the following ALC criteria:

- Clinical status is at baseline or new baseline supported by the patient's goals of care.
- Medical issues are at baseline or new baseline with stable treatment plan and care plan established.
- Mental Health is at baseline or could be managed effectively in community with supports.
- Medication titration and changes are largely complete or could be managed effectively in community with supports, and discharge scripts could be written if patient was being discharged.
- No additional medical diagnosis is being sought or investigated that would require acute care services.
- Palliative care treatments, if required could be provided in the community.
- Nursing assessments are stable.
- No test results are pending that could influence the discharge plan (to community or transfer to another hospital).
- All necessary inpatient physician consults are completed and arrangements are made for any non-urgent consults to be followed up in the community.

Once the patient fulfills above criteria, the patient must be designated as ALC by their care team within 24 hours.

ALC Designation and Status Change Process



ALC Status Policy

MASTHEAD INFORMATION

Policy Title:	Alternate Level of Care (ALC) Status
Applies to:	All Nova Scotia Health Team Members working in acute care units.
Sponsor:	Senior Director, Integrated Patient Access and Flow Network Senior Medical Director, Integrated Patient Access and Flow Network Chief Data Officer, Strategy, Performance & Analytics
Approval Authority:	Clinical Operations Council
Number:	AD-AO-110
Manual:	Administrative

TABLE OF CONTENTS

[Policy Office will populate]

PURPOSE

The policy standardizes the definition, criteria, and process for Alternate Level of Care (ALC) designation across all inpatient acute care services settings within Nova Scotia Health.

Note: This policy does not provide guidance on the billing aspect of ALC or any patient care/discharge processes for ALC patients.

PRINCIPLES AND VALUES

Nova Scotia Health is committed to:

- Prioritizing patient care in the most appropriate environment. The ALC designation process is designed to ensure that patients receive care aligned with their needs, promoting their well-being and recovery.
- Using data to drive decision-making. This commitment extends to leveraging data insights to inform strategic decisions, resource allocation, and process improvements across all zones.
- Upholding the principles of person-centered care and resource optimization with timely designation of patients as ALC once they fulfill all specified criteria, so that obstacles to discharge are promptly addressed, contributing to efficient patient flow and bed management across the organization.

By adhering to these principles and values, Nova Scotia Health aims to strengthen the effectiveness of the ALC designation process and continually improve the delivery of exceptional patient care.

POLICY STATEMENTS

Designation of ALC Status

Notes:

The terms ALC and Long-Term Care (LTC) are often and mistakenly used interchangeably throughout Nova Scotia Health. Not all ALC patients are LTC, and not all LTC patients are ALC.

A patient who still requires acute care services but whose needs are less complex than the services provided in their current unit should **NOT** be designated as ALC.

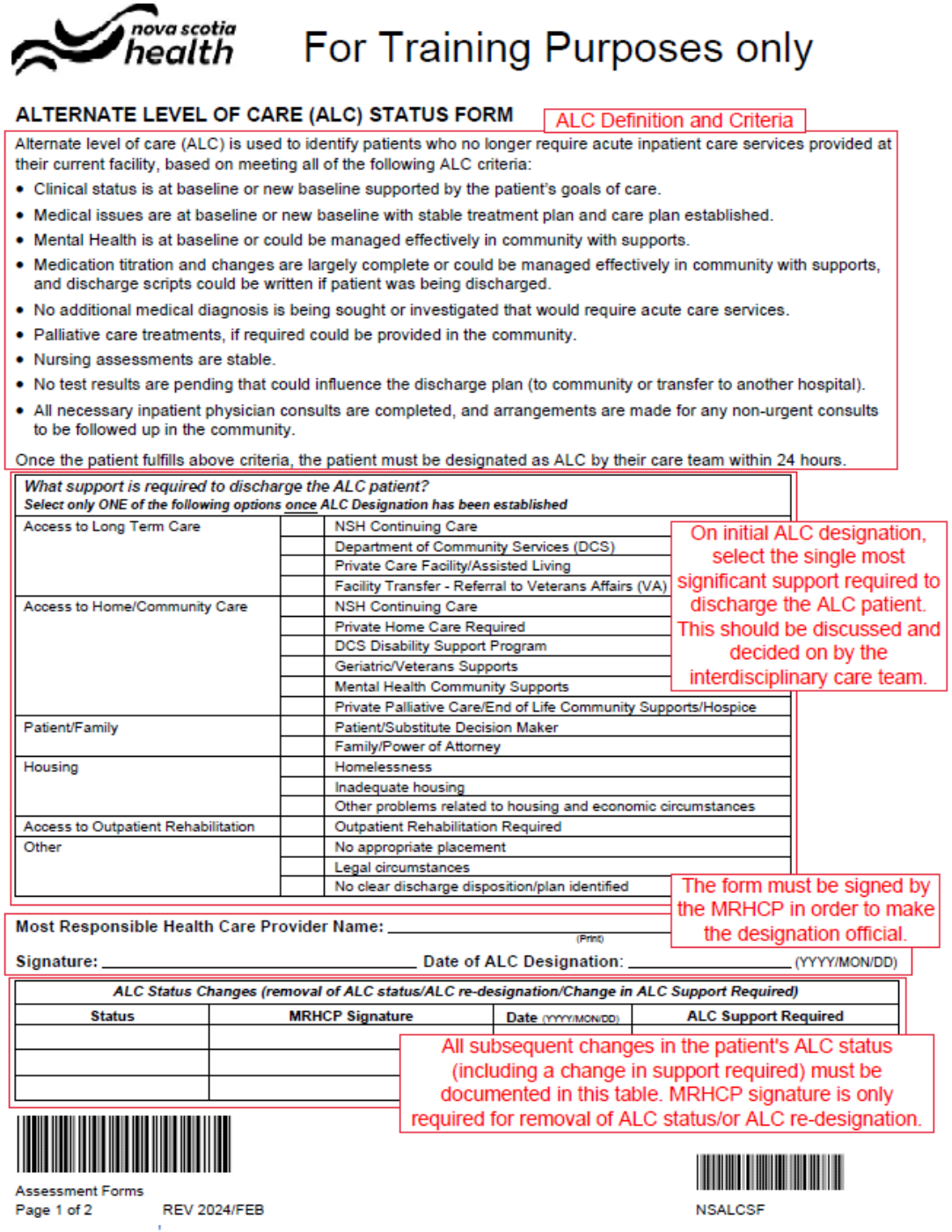
For example, a patient in an intensive care unit awaiting transfer to a medical/surgical inpatient bed for further acute care.

1. Nova Scotia Health uses ALC designation to identify patients who no longer require inpatient acute care services at their current facility.
2. For a patient to be designated as ALC, **ALL** of the following criteria must be met:
   - Clinical status is at baseline or new baseline supported by the patient's goals of care.
   - Medical issues are at baseline or new baseline with stable treatment plan and care plan established.
   - Mental Health is at baseline or could be managed effectively in community with supports.
   - Medication titration and changes are largely complete or could be managed effectively in community with supports and discharge scripts could be written if patient was being discharged.
   - No additional medical diagnosis is being sought or investigated that would require acute care services.
   - Palliative care treatments, if required could be provided in the community.
   - Nursing assessments are stable.
   - No test results are pending that could influence the discharge plan (to community or transfer to another hospital).
   - All necessary inpatient physician consults are completed, and arrangements are made for any non-urgent consults to be followed up in the community.
3. An ALC patient no longer meeting **ALL** of the above criteria and requiring inpatient acute care services must be re-designated to Acute Care.

ALC Status - Policy - NSHA AD-AO-110

Published on February 22, 2024

Effective March 8, 2024



For Training Purposes only

ALTERNATE LEVEL OF CARE (ALC) STATUS FORM

ALC Definition and Criteria

Alternate level of care (ALC) is used to identify patients who no longer require acute inpatient care services provided at their current facility, based on meeting all of the following ALC criteria:

- Clinical status is at baseline or new baseline supported by the patient's goals of care.
- Medical issues are at baseline or new baseline with stable treatment plan and care plan established.
- Mental Health is at baseline or could be managed effectively in community with supports.
- Medication titration and changes are largely complete or could be managed effectively in community with supports, and discharge scripts could be written if patient was being discharged.
- No additional medical diagnosis is being sought or investigated that would require acute care services.
- Palliative care treatments, if required could be provided in the community.
- Nursing assessments are stable.
- No test results are pending that could influence the discharge plan (to community or transfer to another hospital).
- All necessary inpatient physician consults are completed, and arrangements are made for any non-urgent consults to be followed up in the community.

Once the patient fulfills above criteria, the patient must be designated as ALC by their care team within 24 hours.

What support is required to discharge the ALC patient? ***Select only ONE of the following options once ALC Designation has been established***		
Access to Long Term Care		NSH Continuing Care
		Department of Community Services (DCS)
		Private Care Facility/Assisted Living
		Facility Transfer - Referral to Veterans Affairs (VA)
Access to Home/Community Care		NSH Continuing Care
		Private Home Care Required
		DCS Disability Support Program
		Geriatric/Veterans Supports
		Mental Health Community Supports
		Private Palliative Care/End of Life Community Supports/Hospice
Patient/Family		Patient/Substitute Decision Maker
		Family/Power of Attorney
Housing		Homelessness
		Inadequate housing
		Other problems related to housing and economic circumstances
Access to Outpatient Rehabilitation		Outpatient Rehabilitation Required
Other		No appropriate placement
		Legal circumstances
		No clear discharge disposition/plan identified

On initial ALC designation, select the single most significant support required to discharge the ALC patient. This should be discussed and decided on by the interdisciplinary care team.

Most Responsible Health Care Provider Name: _____ (Print)

Signature: _____ **Date of ALC Designation:** _____ (YYYY/MON/DD)

The form must be signed by the MRHCP in order to make the designation official.

ALC Status Changes (removal of ALC status/ALC re-designation/Change in ALC Support Required)			
Status	**MRHCP Signature**	**Date** (YYYY/MON/DD)	**ALC Support Required**

All subsequent changes in the patient's ALC status (including a change in support required) must be documented in this table. MRHCP signature is only required for removal of ALC status/or ALC re-designation.

Assessment Forms
Page 1 of 2 REV 2024/FEB

NSALCSF

ALC Status Form

The official record documenting ALC status

Takes precedence over any previously existing ALC designation form

excluding Mental Health and Addictions (MHA) ALC process- separate form in CZ

Includes:

ALC Support Required- what is preventing an ALC patient from being discharged

Date of Initial ALC Designation

MRHCP Signature

Changes in ALC status

ALC Supports Required

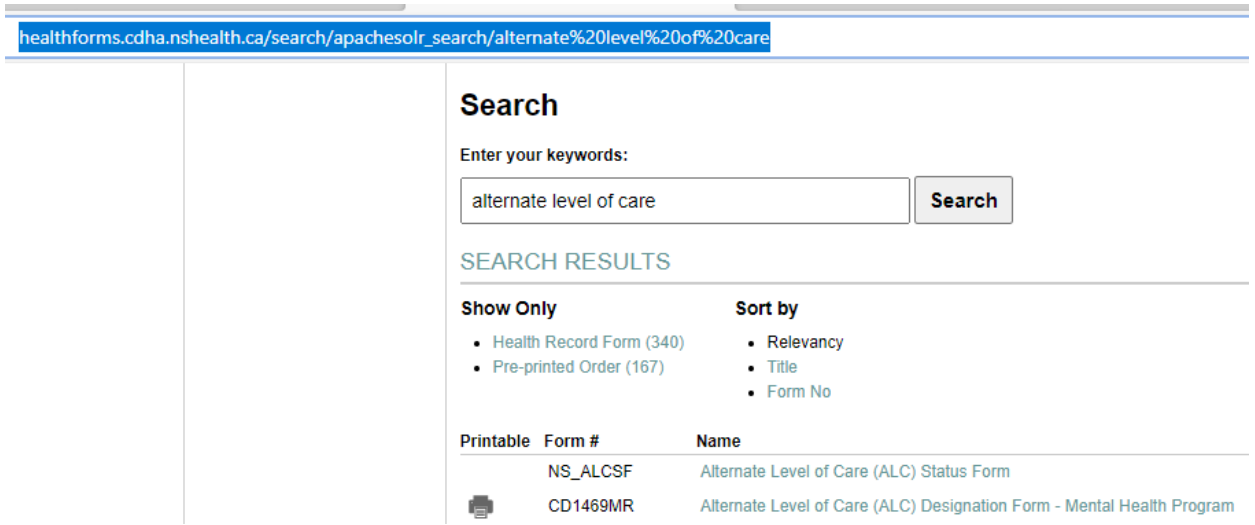
ALC Supports Required - Descriptions and Codes

The table below is intended to assist staff to identify the code based on selecting a support required to discharge an ALC patient from the inpatient acute care setting.

Category	Support Required	Description	STAR/ Meditech Code	STAR/Meditech Description
Access to Long Term Care	**NSH Continuing Care**	NSH Continuing Care (placement in progress, on waitlist, refused placement)	A20	LTC-CC FACILITY
Access to Long Term Care	**Dept. of Community Services (DCS)**	DCS (placement in progress, on waitlist, refused placement)	A21	LTC-DCS FACILITY
Access to Long Term Care	**Private Care Facility/Assisted Living**	Private Care Facility/Assisted Living (placement in progress, on waitlist, refused placement)	A22	LTC-PRIVATE FAC
Access to Long Term Care	**Facility Transfer - Referral to VA**	Referral to Veterans Affairs (VA)	A23	LTC-VETS AFFAIRS
Access to Home/Community Care	**NSH Continuing Care**	NSH Continuing Care (home support/home care nursing services, VON, equipment, assessment in progress)	A24	COMMUNITY CC
Access to Home/Community Care	**Private Home Care Required**	Requires home care services from private agencies not affiliated with NSH Continuing Care	A25	PRIVATE HOME NURS
Access to Home/Community Care	**DCS Disability Support Program**	DCS Disability Support Program (home support services, equipment, assessment in progress)	A26	DCS DISABILITY SUPP
Access to Home/Community Care	**Geriatric/Veterans Supports**	Requires geriatric/veterans supports	A27	COMMUNITY GERI/VETS
Access to Home/Community Care	**Mental Health Community Supports**	Waiting for community mental health program	A28	COMMUNITY MH
Access to Home/Community Care	**Private Palliative Care/End of Life Community Supports/Hospice**	Requires palliative care services/end of life community supports from private agencies not affiliated with NSH Continuing Care, waiting to access hospice	A29	PRIVATE PALL/HOSP
Patient/Family	**Patient/Substitute Decision Maker**	Patient (or substitute decision maker) non-compliance with discharge plan, competency/capacity issues, financial issues, challenging behaviours	A30	PATIENT/SDM
Patient/Family	**Family/Power of Attorney**	Public trustee, family (or power of attorney) non-compliance with discharge plan, family/guardian acceptance/availability (i.e. foreign visitor), caregiver burnout/respite, financial issues, family/relationship challenges	A31	FAMILY/POA
Housing	**Homelessness**	Homelessness	A32	HOMELESS
Housing	**Inadequate Housing**	Inadequate housing	A33	INADEQUATE HOUSING
Housing	**Other problems related to housing and economic circumstances**	Other problems related to housing and economic circumstances - includes required renovations	A34	OTHER HOUSING
Access to Outpatient Rehabilitation	**Outpatient Rehabilitation required**	Awaiting outpatient rehabilitation support due to reduced mobility	A35	OUTPATIENT REHAB
Other	**No appropriate placement**	Unavailability/inaccessibility of health care facilities	A36	NO APPROP PLACEMENT
Other	**Legal circumstances**	Unable to discharge due to legal circumstances	A37	LEGAL
Other	**No clear discharge disposition/plan identified**	No clear discharge disposition/plan identified	A38	UNKNOWN PLAN

ALC Status Form Continued

The following **new** form for use in **All Zones** has been uploaded effective February 2024 and can be accessed through:



- **Alternate Level of Care (ALC) Status Form**
  EFR: NS_ALCSF
  Meditech Chart Category: ASSESS – Assessment Forms

- **Central Zone:** NS_ALCSF - *available through DAL Printing and on the Intranet's Forms Web Page*
  Document Type: Assessment Forms

For coding, the form can be found under **Assessment Forms** on the Meditech Echart desktop and under Assessments in OneContent

Case Study #1

- Mrs. Lorenz, a 70 yr female.
- Admitted to the Halifax Infirmary: NSTEMI with CHF in CCU
- No longer needs CCU within 48 hrs, requires O2; qualifies to go to IMCU.
- IMCU bed not available, in CCU awaiting transfer to step down.

Is this an ALC scenario?

Is the case study #1 ALC?

No. The clinical team and MRHCP should not designate this patient as ALC.

Case Study # 2

- Mrs. Lorenz, a 70 yr female.
- Admitted to the Halifax Infirmary: Dx CHF exacerbation, SOB, fluid retention and ↑ fatigue.
- Responded well to the initial treatment with stable vital signs.
- Recovery was progressing more slowly than anticipated. New baseline.
- To be discharged home with the Support Required.
- VON on capacity alert for 72 hrs.

Is this an ALC scenario?

If so, what is the Support Required?

ALC Supports Required

What support is required to discharge the ALC patient? ***Select only ONE of the following options once ALC Designation has been established***		
Access to Long Term Care		NSH Continuing Care
		Department of Community Services (DCS)
		Private Care Facility/Assisted Living
		Facility Transfer - Referral to Veterans Affairs (VA)
Access to Home/Community Care		NSH Continuing Care
		Private Home Care Required
		DCS Disability Support Program
		Geriatric/Veterans Supports
		Mental Health Community Supports
		Private Palliative Care/End of Life Community Supports/Hospice
Patient/Family		Patient/Substitute Decision Maker
		Family/Power of Attorney
Housing		Homelessness
		Inadequate housing
		Other problems related to housing and economic circumstances
Access to Outpatient Rehabilitation		Outpatient Rehabilitation Required
Other		No appropriate placement
		Legal circumstances
		No clear discharge disposition/plan identified

Is the case study # 2 ALC?

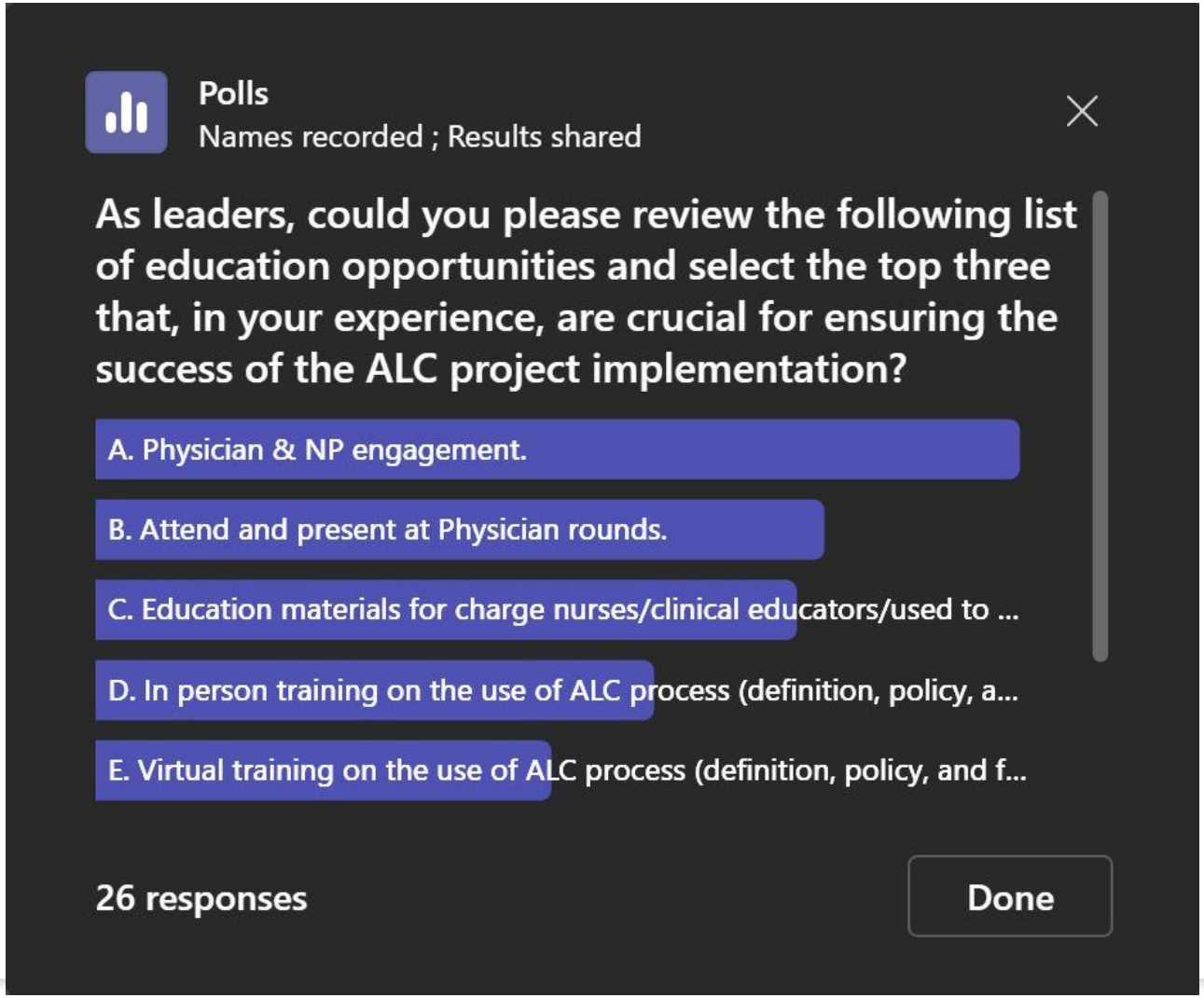
Yes

Support Required: **Continuing Care**

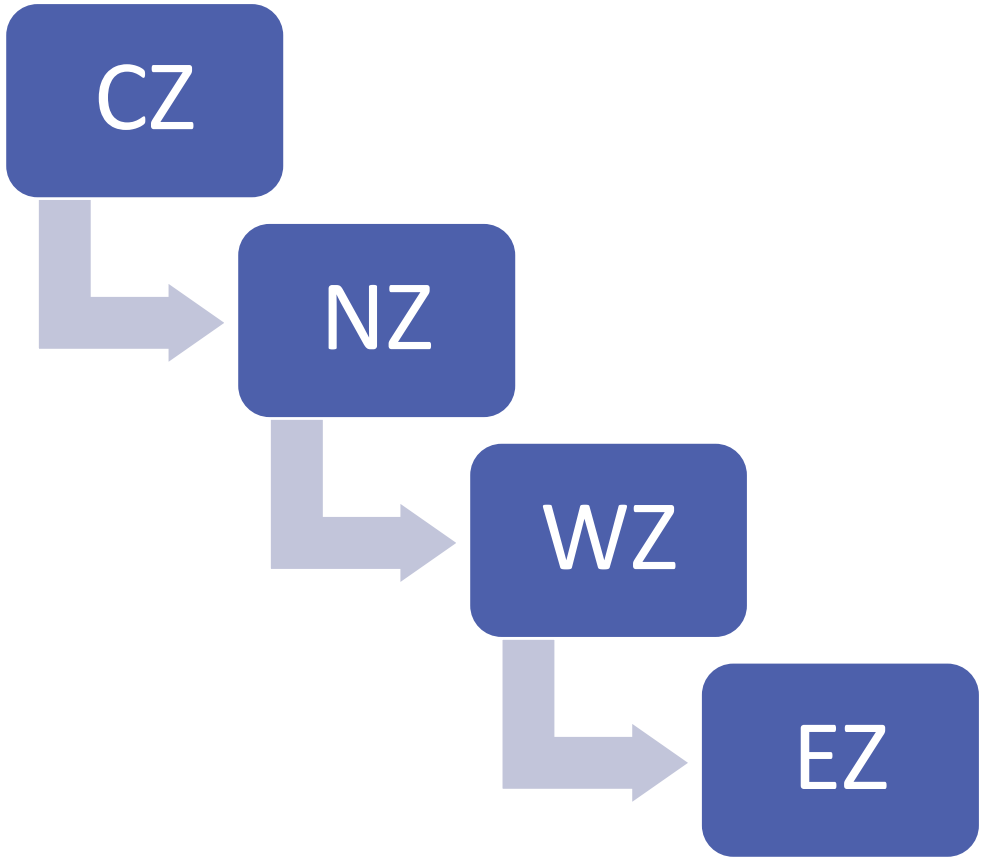
Education Phase

March and **April 2024**

Priority: Engagement & Support from Physicians



Education Rollout



Zone-based session for the following target audiences:

- Physicians
- Nurses, Allied Health (social workers, continuing care staff, etc.) and Data entry/ward clerks

Education / Training Methods

Formal	Informal
Factsheets / Case studies / Quick Reference Guides	Self-Guided Virtual Learning
Flowchart (ALC Designation Process)	Lunch and Learns
Library Guide (policy, form, working instructions, additional role specific materials)	Webinars (in-services, rounds, unit education opportunities)
Dynamic Health	
Virtual Project Leads led sessions	
Printed materials	
Project overview	

Key Information for Physicians

The provincial **A**lternate **L**evel of **C**are (ALC) designation project provides a new provincial definition for ALC. This includes a list of the supports required to enable discharge, such as home supports, community services or long term care.

Aim: To standardize the ALC designation process in all acute care settings within Nova Scotia Health.

Why?

- To promote consistency in designating ALC patients across NSH
- To ensure accurate reporting on ALC patients across NSH, which will help to better understand our patient population and patient flow pressures.
- To improve patient flow/service planning by making it easier to identify patients who no longer require acute care.
- To enable executive leadership to advocate to the government for additional community resources to support the ALC population effectively.

Library Services

nova scotia health

Alternative Levels of Care (ALC) Designation

Overview information, and clinical staff and physician tools, supporting ALC documentation across Nova Scotia Health (NS Health).

Purpose of ALC

> High occupancy rates and volumes of long-stay patients continue to be a challenge across NS Health. A standardized, organization-wide process for Alternate Level of Care (ALC) designation has been identified as a strategy to help understand and manage patient flow pressures.

The ALC Designation Project is designed to standardize the ALC designation process in all acute care settings within NS Health. Through the promotion of accurate and consistent ALC designation, documentation, and reporting the project aims to facilitate agile, operational decision-making by providing a better understanding our patient population and patient flow pressures.

A better understanding of our patient population and patient flow pressures will help improve patient flow and service

Implementation Phase- May and June

CZ – STAR Application

EZ, NZ, WZ – Meditech Application

- C3 alignment and future OPOR considerations

How you can support

- Support teams and conversations around patient status and ALC criteria.
- Start the conversation with care team when patient no longer requires medical acute care services and should be designated as ALC.
- In collaboration with the team, identify the most appropriate Support and start filling out the ***Nova Scotia Health ALC Status Form***
- Support discussions with patients, families/caregivers.
- Reassess ALC status as acute care needs change and update the ALC status form accordingly.

Our role in ALC

- Discharge planning begins with admission.
- Challenge the status quo.
- Home First philosophy.

Thank you!

phuong.Nguyen@nshealth.ca

danielle.pinkney-macquarrie@nshealth.ca

Let’s Talk Informatics Certifications

- **Digital Health Canada -** participants can claim 1CE hour for each presentation attended.
- **College of Family Physicians of Canada and Nova Scotia Chapter -** participants can earn one Mainpro+ credit by providing proof of content aimed at improving computer skills applied to learning and access to information.
- **Canadian College of Health Information Management -** approves 1 CPE credit per hour for this series for professional members of Canada’s Health Information Management Association (CHIMA).

Thank you

Need More Info?

letstalkinformatics@nshealth.ca