

Monday, April 20, 2009

Dear Colleagues:

I am very pleased to inform you that the Wait Time Information Program (WTIP), Cancer Care Ontario (CCO), working closely with our various sponsors and partners, has finalized an adoption strategy to support the use of a standardized **Provincial Alternate Level of Care Definition**. As the first step in the strategy, please find attached a copy of the standardized definition.

The official launch date for all acute and post-acute hospitals in Ontario to begin using the standardized definition to designate patients as ALC is **July 1st, 2009**. We encourage you to use this time to communicate the standardized definition within your organization and to use this opportunity to review your current process for designating ALC patients, to ensure the consistent application of the definition on July 1st, 2009.

The use of a standardized definition is a key step towards capturing high quality and near real-time data on all patients waiting in acute and post-acute hospitals for alternate levels of care. This data can help to inform resource allocation decisions, will ultimately lead to improved patient flow and reduced ER wait times, and will support patients in receiving the care that meets their specific needs.

WTIP has organized a variety of activities to support the adoption of the definition, the first of which are:

- May 11th, 2009 – Distribution of Clinician Adoption Toolkit to acute and post-acute hospitals
- May 20th, 2009 – Interactive Ontario Hospital Association (OHA) videoconference and live webcast

Details regarding additional activities will be communicated to you shortly. In the meantime, if you have any urgent questions, please do not hesitate to contact me at ALCdefinition@cancercare.on.ca.

Finally, we would like to inform you that the **Canadian Institute for Health Information (CIHI)** was involved in the development of the new definition and will continue to be engaged during the adoption phase of this initiative. In addition, CIHI has confirmed that the new Provincial ALC Definition is substantially similar to the CIHI definition for ALC used in the Discharge Abstract Database (DAD). CIHI is supportive of the efforts in Ontario to enhance the consistency and the quality of ALC data in the province.

Thank you for your continued support and collaboration. We look forward to working with all stakeholders as we take another important step towards reducing ER/ALC Wait Times and improving access to care for Ontarians. Please share this information accordingly.

Sincerely,



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Director, Wait Time Information Program
Cancer Care Ontario

cc: Ken Deane, Assistant Deputy Minister, Health System Accountability and Performance Division
Dr. Alan Hudson, Executive Lead, Wait Time Strategy and Access to Services
Sarah Kramer, President and CEO, eHealth Ontario
Sharon Pfaff, Deputy CIO, Cancer Care Ontario
Dr. Peter Nord, WTIP Physician Champion for ALC



Provincial ALC Definition

The healthcare system aspires to deliver care in a setting that is congruent with the clinical needs of a patient as defined by the patient's health status, treatment plan and goals.

The definition applies to all patient populations waiting in all patient care beds in an acute or post acute care hospital in Ontario.

Definition:

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC)¹ at that time by the physician or her/his delegate.

The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination² (or when the patient's needs or condition changes and the designation of ALC no longer applies).

Note 1

The patient's care goals have been met *or*

- progress has reached a plateau *or*
- the patient has reached her/his potential in that program/level of care *or*
- an admission occurs for supportive care because the services are not accessible in the community (e.g. "social admission").

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

Note 2

Discharge/transfer destinations may include, but are not limited to:

- home (with/without services/programs),
- rehabilitation (facility/bed, internal or external),
- complex continuing care (facility/bed, internal or external),
- transitional care bed (internal or external),
- long term care home,
- group home,
- convalescent care beds,
- palliative care beds,
- retirement home,
- shelter,
- supportive housing.

This will be determined by a physician/delegate, in collaboration with an interprofessional team, when available.

Final Note

The definition **does not** apply to patients:

- waiting at home,
- waiting in an acute care bed/service for another acute care bed/service (e.g., surgical bed to a medical bed),
- waiting in a tertiary acute care hospital bed for transfer to a non tertiary acute care hospital bed (e.g., repatriation to community hospital).

