Definitions and Guidelines to Support ALC Designation in Acute Inpatient 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 specifically 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 patient's stay must be at least 24 hours.

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 requirements 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)

[redacted]

Providence HEALTH CARE

PRESCRIBER'S ORDERS

NO DRUG WILL BE DISPENSED OR ADMINISTERED
WITHOUT A COMPLETED
CAUTION SHEET
ALLERGY/INTOLERANCE STATUS FORM (PHC-PH047)

DATE AND TIME

ALTERNATE LEVEL OF CARE (ALC) CATEGORY DESIGNATION ORDER

(Items with check boxes must be selected to be ordered)

Patient designated ALC – Effective date: _____ time: _____

ALC category entered into SCM (date) _____ (time) _____ by (UC initials) _____

ALC Code	Category of Care
☐ AL0	Awaiting Residential Care: Assessed & Ready To Go (ARTG) as confirmed by TST
☐ AL1	Awaiting Assisted Living / Supportive Housing
☐ AL2	Awaiting Transitional Care Unit / Convalescent Care
☐ AL3	Awaiting Hospice
☐ AL4	Awaiting Home Health
☐ AL5	Awaiting Specialized / Tertiary Mental Health & Addiction Services
☐ AL6	Awaiting Mental Health & Addiction Community Services
☐ AL7	Awaiting Adequate Housing
☐ AL8	Awaiting Family or Social Services
☐ AL9	Awaiting Specialized Rehabilitation Services

☐ AL10	Assessment in Progress-Residential Care
☐ AL11	Assessment in Progress-Other

☐ ALC Reverted to Acute

ALC designator

Printed Name _____ Signature _____ College ID _____ Contact Number _____

Alternative Level of Care
Categories and Definitions
Approved by SET October 2015

Alternative Level of Care (ALC) Categories

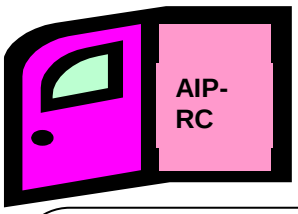
ALC Categories
Assessing - Assessments in progress
Assessment in Progress – RC
Assessment in Progress - Other
Waiting – for ALC destinations or services
Awaiting Residential Care
Awaiting Assisted Living or Supportive Housing
Awaiting Transitional Care Unit or Convalescent Care
Awaiting Hospice
Awaiting Home Health
Awaiting Specialized/Tertiary Mental Health & Addiction Services
Awaiting Mental Health & Addiction Community Services
Awaiting Adequate Housing
Awaiting Family or Social Services
Awaiting Specialized Rehabilitation Services

Note: It is also suggested that there be provision in future to track several categories of waits that are not considered Alternate Level of Care waits. Suggested categories are listed in Appendix A.

ALC Definition (Revised from 2012 definition)

When a patient is occupying a bed in a hospital and does not require the intensity of resources/ services provided in an acute care setting (Acute, Sub-acute, Acute Mental Health or Acute Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or VCH/PHC/CoC delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

Alternate Level of Care (ALC) Categories and Definitions



AL 10 - Assessment in Progress (AIP-RC)

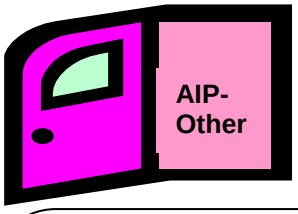
Definition

In order to determine the next most appropriate service an RAI-HC patient/client assessment has been ordered or is being conducted in hospital by the inter-professional team to determine whether the patient/client care needs indicate care in a Residential Care setting, and

- It is considered unsafe or inappropriate for the patient/client to have the assessment completed at home.

Inclusions/Potential subcategories (not exhaustive list)

- Includes patients/clients awaiting a RAI-HC Assessment to be completed in hospital
- Includes patients/clients for whom the RAI-HC assessment is in progress in hospital
- Includes patients waiting for assessment of eligibility



AL 11 - Assessment in Progress (AIP-Other)

Definition

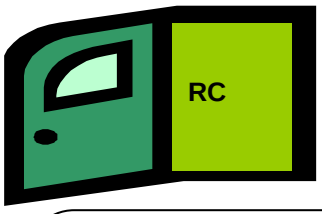
In order to determine the next most appropriate service a patient assessment has been ordered or is being conducted in hospital by the inter-professional team to determine whether the patient/client care needs indicate care in a specific setting or from a specific service. Examples of such settings and services include transitional or convalescent care, hospice, assisted living, subsidized housing, respite or private pay facility or home support, but this is not an exhaustive list. Furthermore

- It is considered unsafe or inappropriate for the patient/client to have the assessment completed at home.

Inclusions/Potential subcategories (examples, not an exhaustive list)

Includes patients/clients awaiting or undergoing:

- Assessment for transitional or convalescent care
- Assessment for hospice
- Assessment for assisted living
- Assessment for subsidized housing
- Assessment for respite
- Assessment for private pay facility or home support
- Assessment via family or case conference (e.g., “home first” conference, integrated care conference, discharge planning conference) - if wait is more than 48 hours)



AL 0 - Awaiting Residential Care

Definition

The inter-professional team has determined that the next, most appropriate care setting for the patient/client is residential facility care.

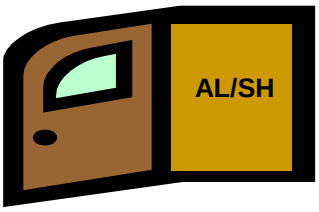
RAI-HC complete and any Home First Case conferences and approval processes for residential care have been completed. Referral is now with Priority Access.

Inclusions (special populations)

- Patients/clients with behavioral needs who require a special care environment.
- Patients with complex respiratory needs such as ventilator dependent clients.
- Patients/clients who require peritoneal dialysis
- Patients/clients who have bariatric needs
- The patient/client is awaiting a private pay Residential Care facility

Potential subcategories

- To be determined at a CoC/PHC level



AL 1 - Awaiting Assisted Living or Supportive Housing

Definition

The inter-professional team has determined that the next, most appropriate care setting/response for the patient/client is an Assisted Living facility or Supportive Housing.

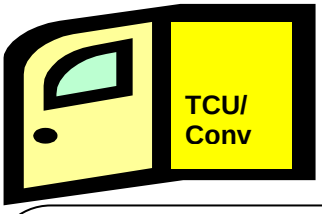
Note: In most circumstances it is most appropriate for the patient/client to be discharged home to await Assisted Living or Supportive Housing. Only in limited circumstances would it be appropriate for a patient/client to wait in an Acute Care setting for an Assisted Living or Supportive Housing vacancy.

Inclusions (special populations)

- The patient/client will be discharged to a private pay Assisted Living facility

Potential subcategories

- Awaiting Assisted Living
- Awaiting Supportive Housing
- Awaiting private pay Assisted Living



AL 2 - Awaiting Transitional Care Unit or Convalescent Care

Definition

The inter-professional team has determined that the next, most appropriate care setting/response for the patient/client is a Transitional Care Unit or Convalescent Care as the patient/client:

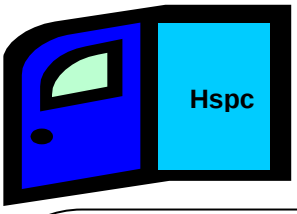
- Requires a period of time to improve functional abilities but cannot tolerate an acute level of rehabilitation and/or;
- Will be able to return home after a specified period of convalescence.

Inclusions (not exhaustive list)

- Patients/clients who are expected to return home after a period of reconditioning in order to meet their functional goal.

Potential subcategories

- Awaiting Transitional Care Unit
- Awaiting Convalescent Care Unit
- Receiving convalescent care in an acute care setting



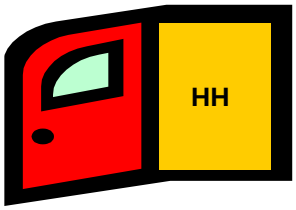
AL 3 - Awaiting Hospice

Definition

The patient/client has been assessed by the Palliative Access Line (PAL) Team as requiring hospice care in a Hospice Residence and it is unsafe or inappropriate for the patient/client to wait at home for these services to be arranged.

Note:

- Patients/clients who are waiting to receive palliative/end of life care in a **Residential Care facility** are classified as ALC-RC
- Patients/clients who require palliative services in **Acute Care** to stabilize or treat symptoms are classified as Acute
- Patients/clients who require palliative care or hospice-type services at **home** are classified as ALC-HH
- Patients/clients who require hospice care and there is no hospice care available in the community, are classified as ALC-Hspc while they remain in Acute Care



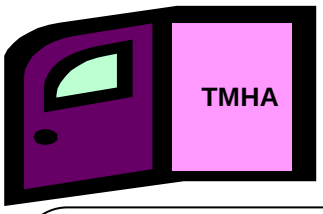
AL 4 - Awaiting Home Health

Definition

The inter-professional team has determined that the next**,** most appropriate care setting/ response for the patient/client is in the home environment with interventions from skilled health professionals/personnel and it is unsafe or inappropriate for the patient/client to be discharged home until services are arranged.

Inclusions/Potential subcategories (not exhaustive list)

- Home/environmental assessment
- Equipment or home modifications
- Home-based palliative care
- Other Home Health services:
  - Home Care Nursing
  - Occupational Therapist (OT), Physiotherapist (PT), Dietitian
  - Home support services
  - Home Intravenous (IV)
- Private arrangements in progress for care in the home



AL 5 - Awaiting Specialized/Tertiary Mental Health & Addictions Services

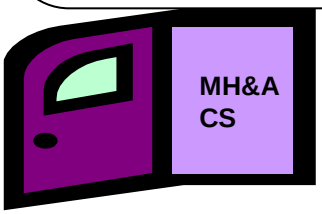
Definition

The inter-professional team has determined that the next, most appropriate care setting for the patient/client is a specialized/tertiary mental health & addictions setting and it is unsafe or inappropriate for the patient/client to wait at home for these services.
Note that the psychiatric ICU is an acute service, not included here.

Inclusions/Potential subcategories

Tertiary Mental Health Facility (e.g., not exhaustive list)**:**

- Willow Pavilion Unit
- BC Psychosis
- Trout Lake
- PHC Parkview or Alder/Langara Unit
- Gibsons Adult Rehab
- Burnaby Centre



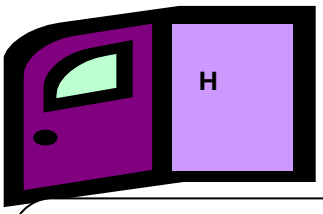
AL 6 - Awaiting Mental Health & Addiction Community Services

Definition

The inter-professional team has determined that the next, most appropriate care setting for the patient/client is community based mental health or addiction services and it is unsafe or inappropriate for the patient/client to wait at home for these services. Patients/clients requiring mental health or addiction services have agreed to participate in the recommended program.

Inclusions/Potential subcategories (not exhaustive list)

- MH Child & Youth
- MH Adult
- MH Older Adult
- MH Consumer
- MH Community
- MHA Child & Youth
- Alcohol & Addiction Services, including CTCT & Pennsylvania Suites
- MHA Ambulatory Clinics
- MHA Integrated Program
- MHA Housing
- MHA Community

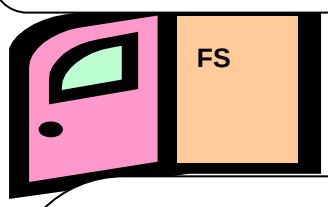


AL 7 - Awaiting Housing

Definition
The inter-professional team has determined that the next, most appropriate setting/response is discharge (and access to services is not the barrier), but the patient/client is unable to return to their previous living situation and arrangements are being made for housing.

Inclusions/Potential subcategories (not exhaustive list)

- Shelter
- Seniors housing
- Market housing



AL 8 - Awaiting Family or Social Services

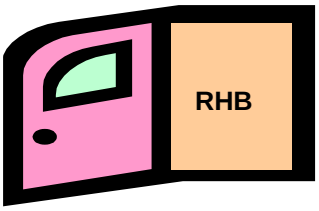
Definition
The inter-professional team has determined that the next, most appropriate setting/response is discharge (and access to services is not the barrier), but the patient/client is unable to return to their previous living situation due to an external or environmental reason which poses unacceptable risk, or the patient/client is unwilling to be discharged.

Discharge is imminent but is impeded by:

- Potential or evident risk/abuse issues
- Legal consent unable to be obtained
- Inability to pay for the following:
  - Prescribed medications
  - Transportation to receive prescribed treatments such as chemotherapy, radiation, dialysis etc.
- Caregiver is unavailable/unwilling to provide care or arrange for care provision

Inclusions (not exhaustive list)

- Child/youth issues:
  - Adoption when it is inappropriate or unsafe to be arranged from home
  - Emergent apprehension or foster care
- IV therapy, wound, or other treatments, that could be managed with a home-based level of care but there is an external or environmental reason which poses unacceptable risk
- Unwilling to be discharged



AL 9 - Awaiting Specialized Rehabilitation Services

Definition

The inter-professional team has determined that the next, most appropriate care setting for the patient/client is a specialized rehabilitation setting and it is unsafe or inappropriate for the patient/client to wait at home for these services.

Inclusions (not exhaustive list)

-awaiting a specialized rehab bed at GFS, HFH, LGH Acute Rehab
-awaiting a specialized rehab bed in FHA or other HA
-awaiting outpatient services while an inpatient at GFS (unable to go home to wait)

Appendix A
Non-ALC Categories

It is suggested that there also be provision for tracking of the following categories of waits that are not considered Alternate Level of Care waits

Non-Alternate Level of Care Categories
Waiting - for non-ALC transfer to acute facility destination or service
Awaiting transfer to Hospital-based Palliative Care
Awaiting transfer to Specialized Acute inpatient care
Awaiting Repatriation to Acute Care in another facility (whether same CoC, another CoC or another HA)
Awaiting transfer for Specialized Diagnostic or Intervention Procedure (e.g., MRI, CT, Cath Lab)
Awaiting transfer to Subacute unit