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)