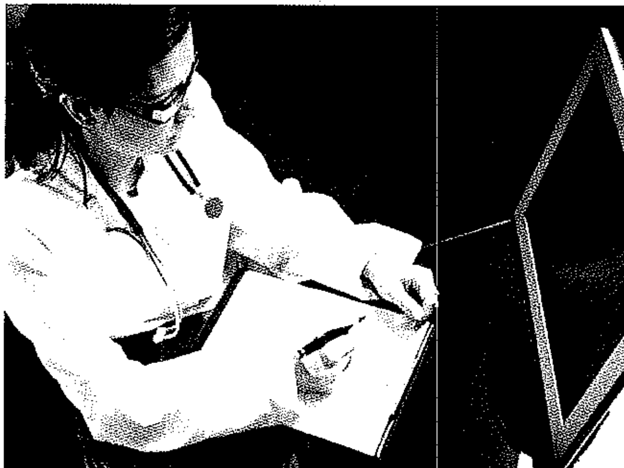
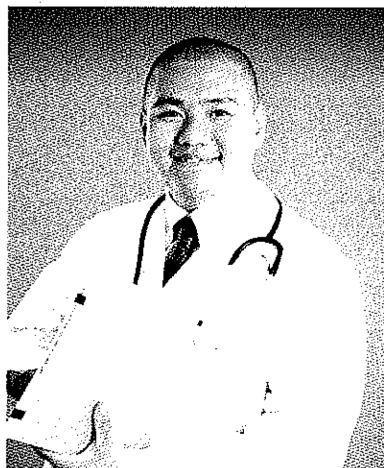
Provincial Alternate Level of Care (ALC) Definition

Practical Guide for Clinicians





Provincial ALC Definition and Case Studies

Background on the Provincial ALC Definition

On July 1st, 2009, all acute and post-acute hospitals in Ontario will begin using a standardized Provincial Alternate Level of Care (ALC) Definition to designate patients ALC. The use of a standardized definition is a key step towards capturing data on all patients waiting in hospitals for alternate levels of care. This data will help improve patient flow, reduce ER wait times and inform decisions regarding the allocation of resources to hospitals and communities.

For more information about the Provincial ALC Definition, please refer to our website at http://www.cancercare.on.ca/ocs/alc or contact us at ALCdefinition@cancercare.on.ca

Provincial ALC Definition

The definition applies to all patient populations waiting in all patient care beds in an acute or post-acute care hospital in Ontario. 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 Provincial ALC Definition is as follows:

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 destination[2] (or when the patient's needs or condition changes and the designation of ALC no longer applies).

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").

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.

Note: The definition does not apply to patients:
- waiting at home,
- waiting in an acute care beds/services 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).

Acute Care: ALC Case Studies

The following case studies are designed to illustrate common ALC scenarios to support clinicians in understanding the standardized Provincial ALC Definition. These case studies do not replace the clinical decision-making and judgment of the physician or interprofessional team.

Acute Care Case Study #1

Title	Patient is waiting in an acute care bed for an acquired brain injury rehabilitation bed
Patient Demographics	• 35 year-old man with anoxic brain injury due to a drug overdose • Had been living in shelters • Lack of social support system, but has an aunt identified as closest family
Scenario	• He requires constant redirection and supervision in the acute care setting to prevent him from falling and wandering • The acute care interprofessional team would like the patient to trial a period of rehabilitation to see if he is able to show some cognitive and behavioural improvement • Patient is designated ALC and a referral is made to a low intensity or slow stream acquired brain injury rehab program
ALC Designation	Yes
Rationale	As per the ALC definition, the patient no longer requires the intensity of the services provided in acute care. The interprofessional team feels that his ongoing rehabilitation goals and care needs could be met in another care setting. Therefore, he is designated ALC for the period of time that he awaits transfer to a rehab bed.

Acute Care Case Study #2

Title	Ventilator dependent patient in intensive care is waiting for vented complex continuing care bed
Patient Demographics	• 70 year-old man • Married with adult children and grandchildren • Medical History: High spinal cord injury (C1) sustained in a fall off a ladder in 2007
Scenario	• Patient has been in ICU since time of injury • He is unable to wean from the ventilator due to level of spinal cord injury • As such, there are no active rehabilitation goals • Otherwise, medically stable but requires complex continuing care bed that can care for a permanently ventilated patient • There are very few of these beds available in the province • He is designated ALC by the interprofessional team as he awaits complex continuing care • Consent is obtained and the paperwork completed for a complex continuing care facility that can care for ventilated patients
ALC Designation	Yes
Rationale	Once it is clear that weaning is not medically possible and he is stable on a home ventilator, the patient should be designated ALC since he no longer requires the intensity of resources provided in an intensive care setting. The availability of these services/ care settings is independent of the need to designate a patient ALC.

Complex Continuing Care: ALC Case Study

The following case studies are designed to illustrate common ALC scenarios to support clinicians in understanding the standardized Provincial ALC Definition. These case studies do not replace the clinical decision-making and judgment of the physician or interprofessional team.

Complex Continuing Care Case Study #1

Title	Patient is in a CCC bed and is not ALC
Patient Demographics	• 41 year-old man • Long distance runner • Medical history: Undiagnosed congenital heart condition
Scenario	• Patient suffered an unwitnessed cardiac arrest while training for a marathon • He was found shortly after by another runner • CPR was started at the scene however, the patient suffered an anoxic brain injury • He was eventually admitted to CCC • Patient is semi-conscious, has a cuffless tracheostomy and a PEG tube for feeding • Patient requires frequent suctioning and respiratory assessments on a daily basis by the healthcare team
ALC Designation	No
Rationale	Although some LTC homes can manage patients with a tracheostomy and a PEG tube, this patient requires daily assessment, treatment and evaluation of his respiratory status by the healthcare team. This level of care could not be provided in a LTC setting. The patient requires the intensity of resources/services provided in CCC. Therefore, he is by definition not ALC.

Rehabilitation: ALC Case Studies

The following case studies are designed to illustrate common ALC scenarios to support clinicians in understanding the standardized Provincial ALC Definition. These case studies do not replace the clinical decision-making and judgment of the physician or interprofessional team.

Rehabilitation Case Study #1

Title	Patient is in a rehab bed and has met care goals, but no appropriate services are available in the community.
Patient Demographics	• 20 year-old man • Severe traumatic brain injury • Limited support at home
Scenario	• Patient has completed rehab program and has reached a plateau • Patient continues to require 24 hour support with all his ADLs due to severe cognitive and physical impairment • No appropriate services are available in the community to meet the care needs of the patient
ALC Designation	Yes
Rationale	As per the interprofessional team decision, the patient's progress has plateaued. He is stable enough that he no longer requires the intensity of the care provided in the rehab unit. By definition, he should be designated ALC because his care needs could be managed in another care setting. The availability of these services/ care settings is independent of the need to designate a patient ALC. The purpose of this definition is to support the designation of ALC patients as a means of collecting data on ALC patients to identify needs in the system.

Mental Health: ALC Case Studies

The following case studies are designed to illustrate common ALC scenarios to support clinicians in understanding the standardized Provincial ALC Definition. These case studies do not replace the clinical decision-making and judgment of the physician or interprofessional team.

Mental Health Case Study #1

Title	Patient is in an inpatient mental health bed waiting for a LTC bed
Patient Demographics	• 85 year-old woman • Psychiatric history: Stage 6 Alzheimer's dementia • Lives in supportive housing • Has three adult children who live outside Ontario
Scenario	• Patient fell and is transferred to an acute care hospital • She is becoming progressively more confused, agitated and aggressive • Support staff at the home reports that she is unable to care for herself and is increasingly more dependent on staff • She is transferred to a specialized geriatric psychiatry unit for further assessment and treatment • Following the assessment, it is determined that the patient should be placed in a long-term care facility with a locked unit and constant supervision
ALC Designation	Yes
Rationale	As per the interprofessional team decision, the patient no longer requires the intensity of the mental health resources provided in the specialized geriatric psychiatry unit. By definition, she should be designated ALC because her care needs could be managed in another care setting. The availability of these services / care settings is independent of the need to designate a patient ALC. The purpose of this definition is to support the designation of ALC patients as a means of collecting data on ALC patients to identify needs in the system.