A provincial program led by the
Regional Geriatric Program of Toronto

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Supporting Ontario Health Teams to Influence Alternate Level of Care

Leading Practices in Community-Based Early Identification, Assessment and Transition

Ontario Health Teams (OHTs) have been advised that their collaborative Quality Improvement Plans (cQIP) are required to focus on improving overall access to care in the most appropriate setting (Ontario Health, August 2021). This includes an expectation that OHTs will implement services and supports for their attributed population to influence the indicator "Alternate Level of Care (ALC) Days".

OHTs have requested support to operationalize activities that can assist them in their efforts to help individuals at risk for protracted hospital stays (e.g. ALC designation). Many such individuals may be older adults living with multiple, complex health conditions. In concert with colleagues leading Senior Friendly Care initiatives across Ontario, Provincial Geriatrics Leadership Ontario is pleased to share the attached information to support OHTs.

The attached information builds on the work of the Provincial ALC Leading Practices Working Group and the newly revised **Alternate Level of Care Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults** and the companion **Self-Assessment Tool** .

With a focus on activities that can occur in community settings, the attached information can assist OHTs to pursue the following goals:

1. Facilitate proactive identification and promote practices in care and self-management that prevent, slow or reverse declines in the physical and mental capacities of older adults
2. Care Plan Development & Ongoing Re-Assessment
3. Delivery of Interventions/Senior Friendly Care
4. Proactive Transitions

Further assistance to support planning, design, implementation and evaluation of services and supports for older adults living with complex health conditions is available through Ontario's network of specialized geriatric services. Please contact your local regional specialized geriatric service or regional geriatric program at https://rgps.on.ca/regional-programs/ .

For more information, or to provide feedback on the attached material, which will be used to improve ALC related resources, please contact info@rgpo.ca .

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Leading Practices in Community Based Early Identification, Assessment & Transition: Preventing Alternate Level of Care

GOAL: Facilitate proactive identification and promote practices in care and self-management that prevent, slow or reverse declines in the physical and mental capacities of older adults

Early Identification & Assessment

Leading Practices	Tool(s)
1. All individuals, including health and social care workers, family, carers, emergency services, and voluntary sector workers, who could encounter people living with frailty recognize the signs of frailty (1). As people living with frailty will often live with or experience dementia and delirium, recognition of the signs of delirium and dementia is also key (19). **sf** 2. Active screening is undertaken in the community to identify older adults who are 'at-risk' for loss of independence and in need of care (2–4). **sf** 3. The approach to screening includes use of a process for early identification of older adults living with or at risk of frailty and functional decline. This includes identification and documentation of baseline functional status (e.g. two weeks prior to admission/onset of illness) (1,4–8). **sf** 4. The screening process is implemented across community settings including primary care, home and community care, community support services, and community paramedicine. (1,2,6,7). Implementation includes a standardized approach to frailty stratification (19). 5. Older adults identified as low-risk are directed to preventative programs and services in the community (e.g. exercise and falls prevention classes) to help them maintain and improve their strength and functional abilities (1,6). **sf** See INTERVENTION 6. Older adults identified as being 'at-risk' for loss of independence have prompt access to comprehensive assessment that accounts for physical, cognitive, functional, and psychosocial domains (1,2,4–7,9–11). **sf** 7. The comprehensive assessment is completed in partnership with the older adult and their care partner / SDM. It is essential that the older person and care partner are involved in decision-making and goal-setting from the outset – and that goals are set and prioritized according to the person's priorities, needs and preferences. (7,12). **sf** 8. The comprehensive assessment builds from and integrates screening and assessment information that has already been collected. (10,46,48,50,51): **sf** 9. The comprehensive assessment includes (12): **sf** a. A collateral history from a care partner / SDM, and/or primary care provider (13). b. Identification of baseline functional status (e.g. two weeks prior to presentation, illness onset, etc.). This is essential to determining the nature of the presenting complaint and timeline for any presenting change (11). c. Identification of goals of care, care needs, and what matters most to the older adult and care partner / SDM (e.g., what are they most concerned about in the short term and long-term? What is the change between baseline and current state across the physical, cognitive, functional, and psychosocial domains) (7,15–17). d. Determination of the older adult's functional goals and restorative potential to inform the plan of care. Mild to moderate symptoms of cognitive impairment, depression, or delirium and the presence of multiple chronic conditions or medical complexity should not be used as exclusion criteria in	Clinical Frailty Scale (CFS) (22) CFS Top Tips (23) C5-75 (24) NESGC Baseline Functional Status (25) Interprofessional Comprehensive Geriatric Assessment (26) PIECES of my Personhood (27)

decisions about whether an at-risk older adult has restorative potential (6,15,18–20). 10. A community-based interprofessional team who has skills and expertise in the assessment and management of older adults (I.e. frailty, dementia, and complexity) is available to support assessment and care (9–11,13,14). **sf** 11. Specialists with expertise in the care of older adults are included as essential collaborative partners on the care team. Roles of specialists can include direct care and training for practitioners without core expertise in geriatrics to ensure quality care for older persons living with complex and chronic health issues across the continuum of care (4,11,21). **sf**	

Goal: Care Plan Development & Ongoing Re-Assessment

Leading Practices	Tool(s)
12. A plan of care is developed with the older adult and their care partner / SDM and relevant partners to address the identified care needs with a focus on remaining in the community. Team membership is diverse and flexible based on the dynamic needs of the older adult (2,4,7,11,15,19,21,28). **sf** 13. A referral pathway is in place to enable timely navigation of older adults to the most-appropriate provider(s), setting(s), and type(s) of intervention(s) necessary to implement the plan of care. The referral pathway includes timely access to specialized geriatric care (2,7). **sf** 14. Frequent re-assessment of the older adult's' status is an essential part of the care process so that changes and resulting support needs are identified as early as possible, and the care plan and goals of care are adjusted accordingly (7,29). **sf**	Rehab Care Referral Decision Tree (15) RCA Direct Access Priority Process (DAPP) (30) RCA Primary Care Post-Fall Pathway (31) Rehab Framework for Older Adults Living With/At-Risk of Frailty (32)

Goal: Delivery of Interventions/Senior Friendly Care

Leading Practice	Tool(s)
15. Older adults have access to care that is delivered consistently according to best practice and evidence, and that is in alignment with individual preferences and cultural practices (33). **sf** 16. A minimum standard of care is in place for older adults (29). The standard of care includes domains of care and senior friendly processes of care that address (7,28,33,34): **sf** a. Cognition b. Delirium c. Mobility & Falls d. Function e. Pain f. Polypharmacy g. Social Engagement h. Mood & Mental Health i. Continence j. Nutrition & Hydration 17. Tailored interventions delivered in collaboration with system partners are available to address the spectrum of older adult care needs. This includes (4): **sf** a. Supporting older adults living with or at risk for mild frailty/less complexity by undertaking routine monitoring and referring them to programs or services to promote and optimize physical and mental health (1,5,6). b. Supporting older adults living with moderate or severe frailty/complexity through the management of geriatric syndromes by integrated interprofessional teams and specialized geriatric expertise, with an aim to prevent further progression of frailty (1,5,6,21).	sfCare Toolkit - RGP Toronto (35) Senior Friendly Care Learning Series (36) SF7 Toolkit - RGP of Toronto (33)

c. Supporting older adults living with severe frailty/complexity in developing and keeping up-to-date an advance care plan which is shared / readily available to the care team across the continuum of care, and by monitoring and managing arising symptoms (1,5,6,21).	
Goal: Proactive Transitions	
Leading Practices	**Tool(s)**
18. The older adult has a named health care professional who is responsible for coordination and management of care, communication, and timely transition planning across the continuum of care, and the older adult and their care partner will have their contact information in case they have questions (3,4,11). **sf** 19. Processes are in place that facilitate the timely communication of clinically relevant information to the older adult, their care partner, and the care team across the continuum of care (37). **sf**	HQO Dementia Quality Standard (11) Transitions into LTC for Older Adults with Responsive Behaviours (38) Various Transitions Resources (BSO) (39)

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