# ALC Leading Practices – Community Current State Assessment Tool

# HOW TO USE THIS TOOL

This implementation tool is intended to be used in conjunction with the[Alternate Level of Care (ALC) Leading Practices to Prevent Hospitalization and Extended Stays for Older Adults (2021)](https://rgps.on.ca/wp-content/uploads/2022/02/ALC-Leading-Practices-Guide-v1-2021.pdf) andthe [Leading Practices in Community Based Early Identification, Assessment & Transition: Preventing Alternate Level of Care (2022)](https://rgps.on.ca/wp-content/uploads/2022/04/2022-April-1-ALC-Community-_-FINAL.pdf).

**For each leading practice:** Under “Status”, click “Select”, then click the arrow beside “Select”. A drop-down menu appears. Click one of the three drop-down choices to indicate your organizations’/OHT’s status in implementing the leading practice (Note - N/A is available as an option for select leading practices):

|  |  |
| --- | --- |
| Met | Your organization or OHT can clearly demonstrate that the leading practice has been implemented and **sustained**. The leading practice occurs 80% of the time. |
| Partial | Your organization or OHT has taken SOME steps towards implementing the leading practice. The leading practice occurs between 60-80% of the time. |
| Unmet | Your organization or OHT has taken NO steps towards implementing the leading practice. The leading practice being assessed occurs less than 60% of the time. |

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| **NOTE**: ***For the community***, all applicable programs/services must have implemented and sustained the leading practice in order to select the status of “Met”. If some units have not implemented and sustained the leading practice, select “Partial” instead. **For OHT’s**, all applicable organizations must have implemented and sustained the leading practice in order to select the status of “Met”. If some organizations have not implemented and sustained the leading practice, select “Partial” instead.  |

Use the “Notes & Validation” section to add details about how your organization/OHT has met the leading practice, plans to meet it, or any identified challenges in meeting the practice. Refer to the *Alternate Level of Care (ALC) Leading Practices Guide* (2021) for suggested implementation tools.

**Designate an implementation team**- ideally, an interdisciplinary team (which may include clinical leaders with geriatric expertise, quality improvement staff and individuals focusing on transitions and flow as part of their core portfolios) would take the lead in championing the leading practices by working across the community to review and complete the self-assessment and set priorities moving forward for ongoing implementation, monitoring and assessment.

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# CURRENT STATE ASSESSMENT TOOL

## Leading Practices across the Organization / System

GOAL: Senior friendly care (sfCare) as the foundation of care

| Organizational Leadership & Support | Overall Assessment of this Practice | Supporting Information |
| --- | --- | --- |
| Leading Practices | Status | Implementation Notes | Validation (Data, Forms, etc.) |
| 1. A member of the Senior Leadership team (such as a vice president) is designated as accountable for sfCare. **sf**
 | Select |  |  |
| 1. Commitments to sfCare are included in the OHT’s/organization's strategic plan, operating plan, and/or corporate goals and objectives. **sf**
 | Select |  |  |
| 1. A sfCare self-assessment is completed to understand the current state of senior friendly care delivery within the OHT/organization and opportunities for improvement. **sf**
 | Select |  |  |
| 1. A set of ALC-related process and outcome measures are collected, monitored and regularly reviewed by senior leaders, managers, physicians and staff.**\*****sf**
 | Select |  |  |
| 1. Functional decline and delirium are recognized as preventable harms and risk to patient safety. **sf**
 | Select |  |  |
| 1. The structures, spaces, equipment, and furnishings provide an environment that minimizes the vulnerabilities of older adults and promotes safety, comfort, functional independence and well-being. **sf**
 | Select |  |  |
| 1. Clinicians who specialize in geriatric care are available 7 days a week to support a comprehensive assessment and care of older adults. **sf**
 | Select |  |  |
| 1. A training plan is in place for all staff, physicians, and volunteers so that they are proficient in the provision of sfCare, including:
2. Seniors' sensitivity - i.e. communication, general awareness on aging and special needs of older adults with frailty, and recognizing and addressing ageism; **sf**
 | Select |  |  |
| 1. delirium prevention and management**\*****sf**
 | Select |  |  |
| 1. mobilization**\*****sf**
 | Select |  |  |
| 1. In the hospital setting, training is provided to staff and physicians to ensure clarity about:
	1. How early transition planning is incorporated into the admission process and monitored.
 | Select |  |  |
| 1. When to recommend an ALC designation
 | Select |  |  |
| 1. Guiding documents (e.g. polices, standards, procedures, guidelines, care pathways etc.) reflect senior friendly values and principles; promote older adult's health, autonomy, dignity and participation in care; and ensure that an older adult will not be denied access to care or the opportunity to participate in research or quality improvement activities based solely on their age, as applicable. **sf**
 | Select |  |  |
| 1. Formal partnerships are in place with care delivery partners to support smooth and timely transitions to/from the Community, ED, acute and post-acute care, Long-Term Care, etc. (e.g., pre-arrangements negotiated through Memoranda of Understanding and/or Purchase of Service Agreements).**\*****sf**
 | Select |  |  |
| 1. Policies and procedures are in place to ensure ongoing reassessment occurs over the course of an older adult’s receipt of care.
 | Select |  |  |
| 1. An escalation process is in place which provides clear direction about when and how to engage leadership in discussions around challenging barriers to transition for older adults at risk of an avoidable admission. This includes non-punitive audit and feedback as part of an overall performance and quality improvement evaluation.
 | Select |  |  |

| Patient & Caregiver Experience & Communication | Overall Assessment of this Practice | Supporting Information |
| --- | --- | --- |
| Leading Practices | Status | Implementation Notes | Validation (Data, Forms, etc.) |
| 1. A process is in place to ensure that the older adult and their care partner / Substitute Decision Maker (SDM) are included as part of the care team.**\* sf**
 | Select |  |  |
| 1. The care plan, goals of care, and expected results of care are developed in collaboration with all members of the care team and the older adult and their care partner / SDM, and are flexible and aligned with the older adult’s preferences (what matters most). **\* sf**
 | Select |  |  |
| 1. The older adult and their care partner are provided with information in their preferred format to let them know what to expect in their care, help them make decisions, and better self-manage their conditions.This includes being provided with: **\* sf**
2. Information on mobilization and delirium prevention to support the prevention of functional decline;
 | Select |  |  |
| 1. The tools to support health literacy and language needs (an advocate, interpreter, etc.) so they can fully participate in their care; and
 | Select |  |  |
| 1. Information on the role of the hospital, the SDM, co-payment costs, and a plan to participate in transition planning.
 | Select |  |  |
| 1. A system is in place to measure the experience and outcomes of older adults and their care partners /SDMs and make improvements based on the results. **sf**
 | Select |  |  |

## Leading Practices in Community 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 | Overall Assessment of this Practice | Supporting Information |
| --- | --- | --- |
| Leading Practices | Status | Implementation notes | Validation (Data, Forms, etc.) |
| 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. 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. **sf**
 | Select |  |  |
| 1. Active screening is undertaken in the community to identify older adults who are ‘at-risk’ for loss of independence and in need of care. **Sf**
 | Select |  |  |
| 1. 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). **Sf**
 | Select |  |  |
| 1. The screening process is implemented across community settings including primary care, home and community care, community support services, and community paramedicine. Implementation includes a standardized approach to frailty stratification.
 | Select |  |  |
| 1. 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. **Sf**
 | Select |  |  |
| 1. 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.**Sf**
 | Select |  |  |
| 1. 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. **Sf**
 | Select |  |  |
| 1. The comprehensive assessment builds from and integrates screening and assessment information that has already been collected. **Sf**
 | Select |  |  |
| 1. The comprehensive assessment includes: **sf**
 | Select |  |  |
| * 1. A collateral history from a care partner / SDM, and/or primary care provider.
 | Select |  |  |
| * 1. 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.
 | Select |  |  |
| * 1. 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).
 | Select |  |  |
| * 1. 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 decisions about whether an at-risk older adult has restorative potential.
 | Select |  |  |
| 1. 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 (9–13). **Sf**
 | Select |  |  |
| 1. 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**. sf**
 | Select |  |  |

| Care Plan Development & Ongoing Reassessment | Overall Assessment of this Practice | Supporting Information |
| --- | --- | --- |
| Leading Practices | Status | Implementation notes | Validation (Data, Forms, etc.) |
| 1. 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. **sf**
 | Select |  |  |
| 1. 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. **Sf**
 | Select |  |  |
| 1. Frequent re-assessment of the older adults’ 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. **Sf**
 | Select |  |  |

| Intervention/sfCare | Overall Assessment of this Practice | Supporting Information |
| --- | --- | --- |
| Leading Practices | Status | Implementation notes | Validation (Data, Forms, etc.) |
| 1. 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. **sf**
 | Select |  |  |
| 1. A minimum standard of care is in place for older adults. The standard of care includes domains of care and senior friendly processes of care that address: **sf**
 | Select |  |  |
| 1. Cognition
 | Select |  |  |
| 1. Delirium
 | Select |  |  |
| 1. Mobility & Falls
 | Select |  |  |
| 1. Function
 | Select |  |  |
| 1. Pain
 | Select |  |  |
| 1. Polypharmacy
 | Select |  |  |
| 1. Social Engagement
 | Select |  |  |
| 1. Mood & Mental Health
 | Select |  |  |
| 1. Continence
 | Select |  |  |
| 1. Nutrition & Hydration
 | Select |  |  |
| 1. Tailored interventions delivered in collaboration with system partners are available to address the spectrum of older adult care needs. This includes: **sf**
 | Select |  |  |
| 1. 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.
 | Select |  |  |
| 1. 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.
 | Select |  |  |
| 1. 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.
 | Select |  |  |

| Proactive Transitions | Overall Assessment of this Practice | Supporting Information |
| --- | --- | --- |
| Leading Practices | Status | Implementation notes | Validation (Data, Forms, etc.) |
| 1. 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. **sf**
 | Select |  |  |
| 1. 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. **sf**
 | Select |  |  |