Fall 2023
Provincial Common Orientation: Program Outline

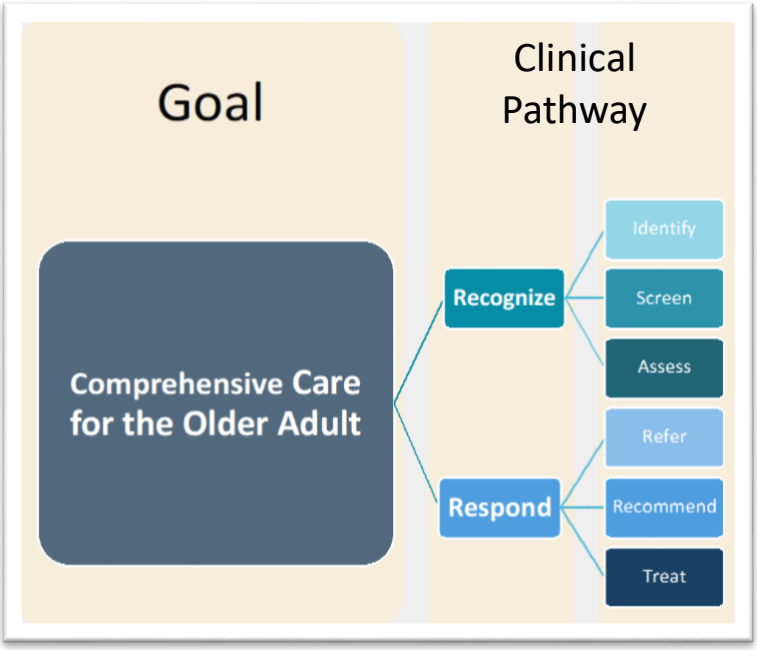
Building Awareness, Knowledge, Skills and Attitudes to Provide Care and Support for Older Adults Living with/at risk of Frailty

v September 8, 2023

Background

Older adults require a holistic approach to care and services that incorporates an individual's physical, mental and cognitive health to prevent disease, optimize health and enable function.

These requirements necessitate a comprehensive and integrated approach to health and social care founded on the ability of health and social care providers to **recognize** clinical conditions unique to the older adult and **respond** by integrating geriatric clinical evidence with contextual elements, senior friendly principles and individual goals and roles and your program mandate.



The **Provincial Common Orientation** is a tiered approach to learning that enables health and social care providers interested in the care of older adults living with frailty to engage in relevant and progressive professional development. The **Provincial Common Orientation** is intended to support a holistic approach to geriatric care through learning activities that integrate the complex physical, cognitive, social and mental health concerns frequently experienced among older adults.

Learners new to geriatrics build initial knowledge through foundational concepts appropriate for interprofessional teams (**Tier 1**). Learners then expand this foundational knowledge and develop additional skill by engaging in enhanced learning activities (**Tier 2**). **This course outline is specific to learning activities at the Tier 1 and Tier 2 level.**

For regulated health professionals working in specialized and focused geriatric services, additional continuing education is available through Ontario's Regional Specialized Geriatric Services Programs who provide advanced education that integrates new evidence and advanced clinical concepts (**Tier 3**). A final Tier (**Tier 4**), focused on the development of leadership and systems thinking in geriatric care enables the better integration of geriatric clinical expertise with health policy to support the design of integrated care systems for older adults in Ontario. Tier 4 content will be available through Provincial Geriatrics Leadership Ontario. Please see https://geriatricsontario.ca/resources/continuing-geriatric-education-links/ to access content related to Tier 3 and Tier 4.

The overall objectives of the Provincial Common Orientation are to support learners to increase awareness, improve attitudes, increase knowledge and increase skills in order to provide care that improves the older adult's care experience, achieves better health outcomes, improves staff experience and reduces health inequity and cost (Quintuple Aim[1]).

[1] Itchhaporia, D. (2021). The evolution of the quintuple aim: Health equity, health outcomes, and the economy. *Journal of the American College of Cardiology, 78* (22), p. 2262-2264, https://doi.org/10.1016/j.jacc.2021.10.018.

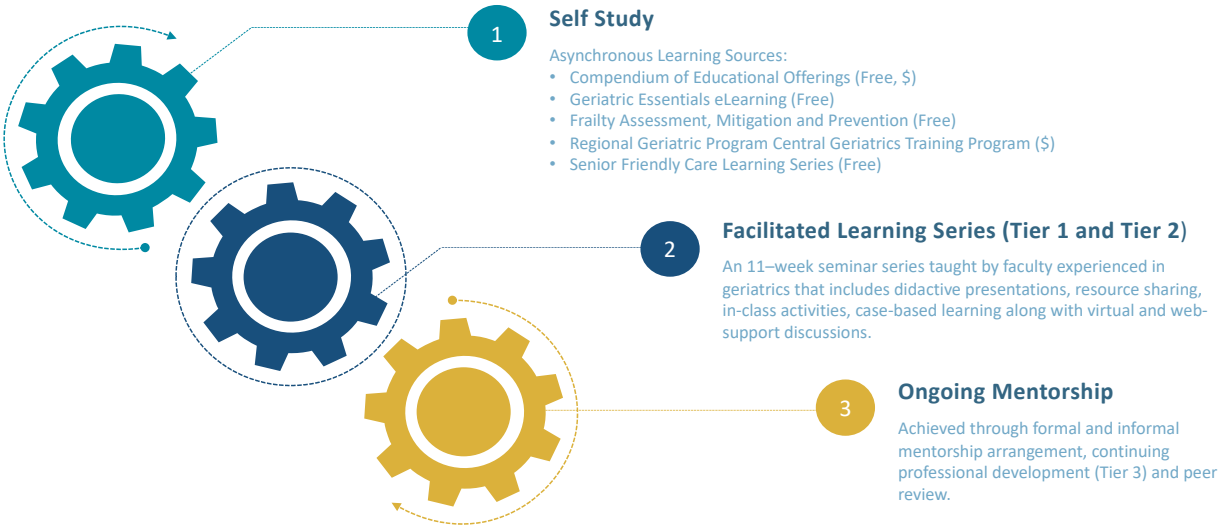
Overview of Tier 1 and Tier 2

Tier 1 and 2 of the Provincial Common Orientation are intended for:

- Staff of Ontario Health Teams (OHTs) that have prioritized a focus on older adults living with frailty
- Ministry of Health, Ministry of Long Term Care and Ontario Health funded programs focused on older adults waitlisted for Long Term Care (e.g. Community Paramedicine, High Intensity Supports at Home)
- Specialized Geriatric Services, who have been recently recruited or who require refresher or review

Format

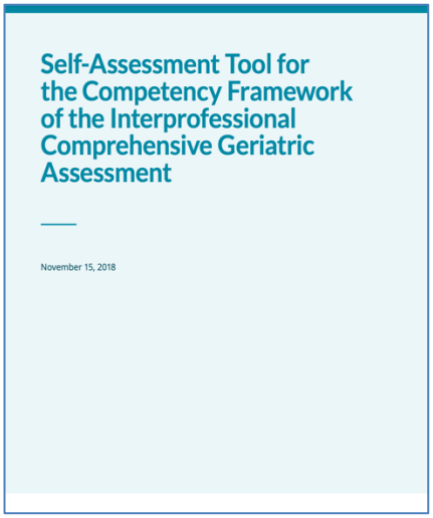
The format of Tier 1 and 2 presumes learners will be actively engaged in the development of their own competencies. This means that learners will participate in three main learning activities: self-study, a facilitated learning series and formal and informal mentorship.



1: Self-study

Learners begin their participation in the Provincial Common Orientation by completing a self-assessment to determine their learning needs in key geriatric topics. This may be completed informally (e.g. reflecting on current challenges, areas of uncertainty etc.), or for regulated health professionals may include the use of the *"Self-Assessment Tool for the Competency*

Framework of the Interprofessional Comprehensive Geriatric Assessment" which can be downloaded from https://geriatricsontario.ca/resources/self-assessment-tool-for-the-competency-framework-of-the-interprofessional-comprehensive-geriatric-assessment/ .



Following self-assessment and identification of learning needs, participants engaged in the Provincial Common Orientation commit to self-study to address identified knowledge gaps using resources such as

- The links referenced in the topical outline (pages 5 to 13)
- Compendium of Educational Offerings (Free, $)
- Geriatric Essentials eLearning (Free)
- Frailty Assessment, Mitigation and Prevention (Free)
- Regional Geriatric Program Central Geriatric Foundations eLearning ($)
- Senior Friendly Care Learning Series (Free)

Self-study is self-paced and asynchronous and is required prior to and during participation in the Facilitated Learning Series.

2: Facilitated Learning Series

To understand and apply the recognize and respond framework, learners engaged in the Provincial Common Orientation participate in a virtual series of synchronous **facilitated learning series** which provide the opportunity to integrate topics reviewed in self-study, discuss key concepts, ask questions and learn to apply new knowledge to their health and social care practice. These virtual Facilitated Learning Sessions will take place once weekly for eleven weeks and are led by expert facilitators.

Below are the learning outcomes and an outline of modules and objectives for Tier 1 (four weeks) and Tier 2 (seven weeks).

Tier 1: Foundations in Geriatrics for Interprofessional Teams Facilitated Learning Series

The primary goals of **Tier 1** facilitated sessions are to increase awareness, improve attitudes and increase knowledge. This level of training is appropriate for most health and social care professionals (e.g. 911 paramedics, home and community care professionals, social service professionals etc.). Depending on their role, not all participants in Tier 1 training will wish or need to continue on to Tier 2.

The learning outcomes of Tier 1 are as follows:

Tier 1: Foundations in Geriatrics for Interprofessional Teams
1.1. Identify the roles and responsibilities of different partners on the care team (including caregivers) 1.2. Recognize age related changes (normal aging, atypical presentations, delirium, falls, sensory changes) 1.3. Recognize and respond to ageism 1.4. Identify techniques for communicating with older adults 1.5. Define frailty (including prevention, screening, and early identification) 1.6. Describe what older adults want (goals of care)

Tier 1 is organized into four sessions that are typically offered once per week for 4 weeks. Below is the topical outline for the modules that comprise Tier 1.

Week	Tier 1 Modules & Learning Objectives	Recommended Readings and Resources
1	**Module 1: Welcome & Introductions**	
	By the end of this module, you will be able to: 1. Describe the background and expectations for the Provincial Common Orientation and Tier 1 Foundations in Geriatrics for Interprofessional Teams 2. Begin to set personal knowledge goals relevant to the care and support of older adults living with complex health conditions 3. Identify learning outcomes, learning tasks and pre-requisites required to achieve personal knowledge goals and training expectations	• Read the Program Outline • Complete the Self-Assessment Tool (if applicable) or create personal learning goals https://geriatricsontario.ca/resources/self-assessment-tool-for-the-competency-framework-of-the-interprofessional-comprehensive-geriatric-assessment/
	Module 2: Defining Frailty	

	By the end of this module, you will be able to: 1. Define frailty holistically, and consider the implications of caring for someone living with frailty to your own practice 2. Identify strategies to prevent frailty and plan patient messages to encourage uptake of preventive care activities	• Read the Consensus Statement: Care for the Older Adult with Complex Health Conditions – Reframing 'Frailty' in an Ontario Context • Read about the Canadian Frailty Network's AVOID Frailty Program and explore additional content on the website • Watch this Overview of Frailty presentation by Dr. Jo-Anne Clarke.
	Module 3: Roles and Responsibilities of the Interprofessional Team	
	By the end of this module, you will be able to: 1. Identify core competencies required for interprofessional teams 2. Describe roles and responsibilities of different health and social care professionals who might provide care to older adults living with frailty 3. Facilitate the inclusion of older adults and care partners on the team	• Read the National Interprofessional Competency Framework • Read the article: Graham, J., (2021, October 20). The treat me like I am old and stupid: Seniors decry health providers' age bias.
2	**Module 4: Age Related Changes**	
	By the end of this module, you will be able to: 1. Define normal aging 2. Identify age-related changes with a focus on delirium, falls, sensory changes 3. Link age-related changes with geriatric syndromes 4. Recognize atypical presentations of illness in the older adult 5. Identify "Red Flags" signaling unsafe or urgent medical concerns in the older adult 6. Identify common chronic illnesses seen in older adults (e.g. CHF, COPD pathways, diabetes pathways) 7. Discuss approaches to chronic disease management and self-management in Ontario 8. Discuss the implication of chronic disease care for geriatric patients	• Review this resource from Island Health about Age-Related Changes • Familiarize yourself with Aging and Chronic Diseases: A Profile of Canadian Seniors by the Public Health Agency of Canada. • For those working in specialized geriatric services, view the Heart Failure Pocket Guide (advanced clinical practice)

	(multi-focus versus traditional unidimensional)	
	Module 5: Overcoming Ageism and Its Effects	
	By the end of this module, you will be able to: 1. Identify myths and facts related to aging 2. Identify misconceptions of the aging population and ageism in healthcare.	• Download and read the Executive Summary of the Global report on ageism from the World Health Organization (2021). If you want to learn more, download the full report. • Watch these 4 Resilience Videos that showcase older adults through video messages of resilience, hope, and experience. • Review How to be anti-ageist: Top 5 Tips for Healthcare Providers from the RGP of Toronto
3	**Module 6: Communication with the Older Adult**	
	By the end of this module, you will be able to: 1. Demonstrate compassionate and patient-centered care 2. Identify core elements of Senior Friendly Care 3. Effectively communicate the unique needs of older adults 4. Recognize the significance of behavioural observations in dementia care 5. Collaboratively communicate and advocate for the unique needs of older adults with other care providers. 6. Apply communication strategies/skills for person centered communication.	• Watch the video: Communicating with Older Adults Gerontological Society of America • Read Tips for Improving Communication with Older Patients from the National Institute on Aging. • Review resources on communication strategies in persons living with dementia.
	Module 7: What Older Adults Want	
	By the end of this module, you will be able to: 1. Gain insight into the perspectives of older adults 2. Identify approaches to goal-based care planning and own role as advocate 3. Discuss “aging in place” as a concept and a motivation 4. Introduce Advance Care Planning	• Read about What Matters to Older Adults from the Institute for Healthcare Improvement • Read My Speak Up Plan to learn about Advance Care Planning • Review the resources on the Hospice Palliative Care Ontario site

4	**Module 8: Early Identification, Screening, and Assessment**	
	By the end of this module, you will be able to: 1. Discuss the basics of assessment in the older adult 2. Understand the importance of early identification and screening of frailty and other concerns 3. Perform and interpret an environmental safety scan at home 4. Perform and interpret the pictorial fit-frail scale and other frailty screeners 5. Consider next steps following screening, clarifying "responses" of different roles following screening	• Read about Holistic Approach to Frailty Screening in the Community • Learn about the Pictorial Fit Frail Scale and how to use it in practice
	Module 9: Tier 1 Wrap Up & Evaluation	
	Complete an evaluation of the education provided	

Tier 2: Core Geriatric Knowledge for Interprofessional Teams Facilitated Learning Series

The two main goals of the **Tier 2** facilitated sessions are to continue to increase knowledge by adding depth to the foundational knowledge obtained in Tier 1 and to increase skill by developing clinical skills to integrate into practice.

The learning outcomes of Tier 2 are as follows:

Tier 2: Core Geriatric Knowledge for Interprofessional Teams
2.1. Adapt processes of care (approaches to care for older adults) 2.2. Understand function and conduct a frailty screen and functional inquiry 2.3. Recognize and respond to geriatric syndromes (pain, continence, nutrition, polypharmacy, cognition, mental health, delirium, mobility, sleep, substance use) within professional role 2.4. Foster social connectivity 2.5. Recognize and respond to the unique needs of caregivers 2.6. Contribute to care plans, treatments, and interventions 2.7. Facilitate system navigation

Week	Tier 2 Modules & Learning Objectives	Recommended Readings and Resources
5	**Module 10: Introduction to Tier 2**	
	By the end of this module, you will be able to: 1. Understand the Tier 2 learning goals and objectives 2. Understand the approach to learning 3. Identify desired personal level of mastery in the recognize/respond approach to care appropriate for own role	
	Module 11: Process of Care	
	By the end of this module, you will be able to: 1. Understand the role and importance of inter-disciplinary nature of geriatrics. 2. Review the elements of the Senior Friendly Care Framework related to processes of care. 3. Complete a personal and organizational self-assessment of the current state of	• Read the Competency Framework for Interprofessional Comprehensive Geriatric Assessment • Familiarize yourself with the Senior Friendly Care Framework Senior Friendly Care Framework • Read about Caregiver ID and review other resources from the Ontario Caregiver Organization

	senior friendly processes of care related to one's own context	
6	**Module 12: Frailty, Function and Functional Inquiry**	
	By the end of this module, you will be able to: 1. Recap normal aging (from tier 1) 2. Recap holistic definition of frailty and strategies to prevent frailty (from tier 1) 3. Perform and interpret frailty screeners (i.e. the Clinical Frailty Scale) 4. Understand the meaning of baseline function and approaches to functional inquiry	• Read this Clinical Frailty Scale – Overview for Training and then Complete the Clinical Frailty Scale (CFS) Training Module
7	**Module 13: Geriatric Syndromes (Part 1): 3D's Dementia, Delirium, Depression**	
	By the end of this module, for each of the geriatric syndromes, you will be able to: 1. Define it (increase knowledge) 2. Apply new knowledge to your clinical interactions (applying knowledge) 3. Understand and apply the recognize and respond care pathway for appropriate for one's clinical setting (skills)	• Visit the IGeriCare website and complete, at minimum, the following lessons on dementia: ○ What is Dementia? ○ What is Mild Cognitive Impairment ○ The Different Types of Dementia ○ Stages of Dementia ○ How is Dementia Treated ○ Safety in Dementia • Access the sfCare E-Learning Series (self-enroll using the join code KYPFHJ) and complete the modules on Delirium and Delirium in Dementia • Read the article "One size does not fit all: Choosing practical cognitive screening tools for your practice". If you want to learn more, consider exploring the PGLO Cognitive Screening Toolkit.
8	**Module 14: Geriatric Syndromes (Part 2): Mobility, Falls, Pain, Polypharmacy**	
	By the end of this module, for each of the geriatric syndromes, you will be able to: 1. Define it (increase knowledge) 2. Apply new knowledge to your clinical interactions (applying knowledge)	• Return to the sfCare E-Learning Series and complete the modules on ○ Introduction to Mobility

	3. Understand and apply the recognize and respond care pathway for appropriate for one's clinical setting (skills)	○ Pain ○ Polypharmacy ○ Medication Adherence • Read the Comprehensive yet Practical Approach to Falls Prevention by Dr. Molnar from the Regional Geriatric Program of Eastern Ontario • If you want to learn more, explore additional Fall prevention resources
9	**Module 15: Geriatric Syndromes (Part 3): Continence, Nutrition, Sleep**	
	By the end of this module, for each of the geriatric syndromes, you will be able to: 1. Define it (increase knowledge) 2. Apply new knowledge to your clinical interactions (applying knowledge) 3. Understand and apply the recognize and respond care pathway for appropriate for one's clinical setting (skills)	• Return to the sfCare E-Learning Series and complete the modules on ○ Urinary Incontinence ○ Urinary Incontinence and Medications ○ Nutrition • Read about Sleep from the Canadian Frailty Network • Read this pamphlet on Managing Sleep in Older Adults by Sinai Health System
10	**Module 16: Social Connectivity**	
	By the end of this module, you will be able to: 1. Differentiate between social isolation, loneliness, and social support (knowledge) 2. Understand the impact of social isolation on older adults (e.g. Impact on function and safety)(applying knowledge)	• Consider the importance of social connectivity and review this Team of Eight resource from Thunder Bay District Health Unit
	Module 17: Caregivers	
	By the end of this module, you will be able to: 1. Recognize the importance/value of interacting with caregivers. 2. Understand the unique requirements of caregivers who support individuals living with frailty	• Learn about Caregiving Strategies, a collection of educational resources that have been developed and/or curated for family and friend caregivers

	3. Identify resources to support caregivers to meet their needs related to caring for the caregiver, pain, staying active, nutrition, bladder health, medication management, changes in thinking and behaviour and social engagement 4. Identify supports for caregivers to develop confidence in their approach and skills, personalize strategies related to specific aspects of care and access resources that meet your needs related to module topics	who provide care and support for seniors experiencing frailty. • Return to the Ontario Caregiver Organization and review Support For Caregivers
11	**Module 18: Care Planning and Intervention**	
	By the end of this module, you will be able to: 1. Recap compassionate and person-centered care 2. Identify reliable sources of information to inform the personal history 3. Identify techniques for communicating with people living with dementia or aphasia for the purposes of assessment and treatment. 4. Identify strategies to gather information about a patient's beliefs, concerns, expectations and illness experience 5. Use information about behavioural interventions to inform a person-centered goal-based care plan 6. Identify strategies to check for patient and caregiver understanding, ability and willingness to follow through with recommended interventions 7. Apply approaches to providing feedback to the interprofessional team on the evaluation of the care plan to inform refinement of plan	View resources about person-centred language at the Regional Geriatric Program of Toronto and Behavioural Supports Ontario Learn about Personhood from Behavioural Supports Ontario
	Module 19: System Navigation	
	By the end of this module, you will be able to: 1. Identify health, community, and social services in local area 2. Understand the importance and benefits of the 'warm hand off' the required individual and organization supports for enabling this	Explore system navigation resource at - Home and Community Care Support Services - Health811

3: Ongoing Mentorship

Formal and informal mentorship opportunities will be coordinated by the network of specialized geriatric services organizations and local SGS expert clinicians to continue building opportunities for professional development and peer review.

To explore mentorship opportunities, please contact your local Regional Geriatric Program or Specialized Geriatric Services by visiting https://geriatricsontario.ca/regional-programs/

Acknowledgements

This program's development was initiated by the PGLO Interprofessional Knowledge to Action Committee (iK2A).

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*denotes Committee Chair

PGLO gratefully acknowledges the many Regional Geriatric Programs and Specialized Geriatric Services partners whose content expertise, and previous orientation material has informed the development of this Common Orientation. Where possible we have referenced existing work and identified our Network's many already-developed, excellent resources for learners to explore.

Appendix 1 – Facilitator Biographies

Shaen Gingrich, PT, BHSc(Hon), MPT

Hello! It's an honour to have the opportunity to be a facilitator for this course. I have worked for the North East Specialized Geriatric Centre since 2009 as a geriatric assessor and physiotherapist and now as the regional geriatric knowledge translator. I am passionate about bringing clinicians together to build awareness, knowledge, skills, and attitudes to provide care and support for older adults living with/at risk of frailty. I am excited to be embarking on this learning journey with all of you!

Kelly Kay, MA-Leadership (Health Specialization), PhD(c)

Hello and welcome! I am looking forward to learning with you as part of this terrific facilitator team. I began working in health care as a registered practical nurse, and my interests and curiousity led to health leadership. I have been fortunate to work over the last 30 years in various roles such as health policy, health professional education, and health administration at the national, provincial and local levels. My work has included the development of the provincial competency framework for interprofessional comprehensive geriatric assessment, in collaboration with colleagues from Ontario's Specialized Geriatric Services. I am currently the Executive Director of Provincial Geriatrics Leadership Ontario, an entity funded by the Ontario Ministry of Health focused on providing province-wide system infrastructure for clinical geriatric services. My research interests include health and social service design and aging, and interprofessional team-based approaches to care.

Linda Rochon, SLP.D., Reg.CASLPO

Hello! I am honoured to have the opportunity to be a facilitator in this inaugural session of the Common Orientation. My 22-year career in healthcare has allowed me to support older adults, family and caregivers in both a clinical role and now a system transformation role. The foundation of my career has been built around patient and family centered approaches to communication which I feel strongly is a key component of supporting older adults, their family and caregivers. In 2019 I joined the North East Specialized Geriatric Centre as the Senior Friendly Care Lead for the Cochrane District working alongside my colleagues as part of the Regional Geriatric Program of the North East. My goal is to contribute to capacity building and practice changes with providers who care for older adults across our system. I am now a caregiver myself and will forever be an advocate for all older adults as well as the providers and caregivers to have the support and care they require when they need it most.

Laura Harrison, MSc OT Reg. (Ont.)

Welcome everyone! I am excited to be joining this fantastic team as a facilitator for this course. I have over 10 years working in specialized geriatrics – I started my career at the GAIN Geriatric Clinic at Scarborough Health Network as a geriatric assessor where I remained for 11 years, I now currently work at Baycrest as a Clinical Navigator in the Behavioural Supports Ontario coordinating office. Geriatrics is a wonderful field to work in and deserves knowledgeable and caring health professionals like yourselves! I am excited to be on this journey with you as you expand your geriatric knowledge. Be open, ask questions, actively participate and get as much out of this program as possible!

Mary-Lynn Peters, MScN, RN(EC) - NP

Hello everyone! My name is Mary-Lynn Peters and I am a nurse practitioner who is passionate about the care of older adults. This passion grew while I was working as a Quick Response Nurse in an Emergency Department in Mississauga, and spurred me to go back to school to complete a Master of Science degree in Nursing and a Post-Master's Nurse Practitioner diploma. I have been involved with geriatric-focused initiatives including the leadership of senior-friendly clinical service improvement projects, implementation of best practice guidelines, and participation on regional and provincial senior-friendly committees. I have presented at conferences on topics such as fall prevention, delirium, and person-centred language. I enjoy teaching and sharing my passion for excellence in the care of older adults. My clinical areas of interest include frailty, delirium, dementia, and fall prevention.

On a personal note, I recently moved out of the city and now live alongside a lake in the Kawartha region of the province. My husband and I have two adult children, an adorable grandson (I may be just a bit biased!) and a 'grand-puppy'. I am looking forward to working with you as you learn more about the care of older adults!

Erin Charnish, MScN, NP-PHC

Erin Charnish is a Primary Health Care Nurse Practitioner in Toronto with an active practice focus on the care of older adults. She is also a faculty instructor in the Primary Health Care Nurse Practitioner Program at the Daphne Cockwell School of Nursing at Toronto Metropolitan University.