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 April 2024

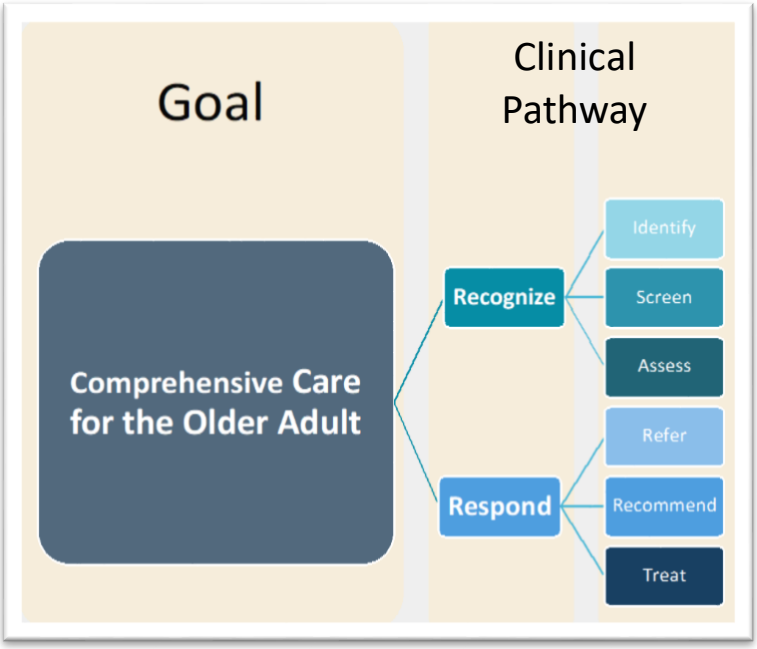
Introduction

The **Provincial Common Orientation to the Care of Older Adults (Provincial Common Orientation)** is a workforce training series for health and social care professionals. Combining on-line content (self-paced) and 11 weekly 90-minute sessions to discuss and apply content, facilitation is led by expert interprofessional geriatric assessors. Topics are addressed through 20 interactive modules covering content ranging from normal aging, ageism and communication to screening, assessment, care planning and intervention across geriatric syndromes.

Program Rationale

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.

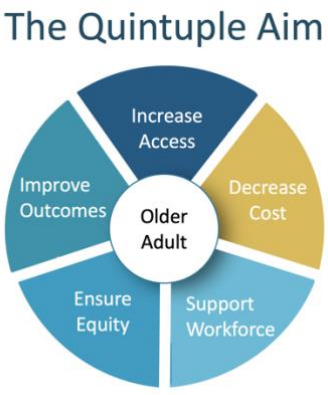


The **Provincial Common Orientation** is a tiered approach to learning that enables health and social care providers interested in the care of older adults living with frailty to engage in relevant and progressive professional development. The **Provincial Common Orientation** is intended to support 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]).

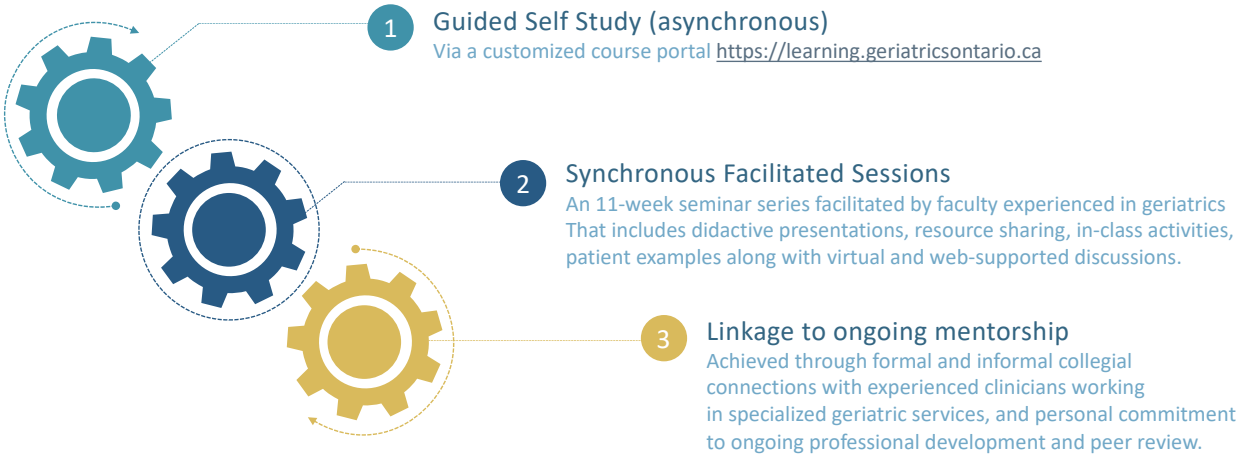
Intended Audiences

Tier 1 and 2 of the Provincial Common Orientation are intended for health and social care professionals in all roles from:

- Ontario Health Teams (OHTs) or primary care settings that have prioritized a focus on older adults living with complex health conditions (e.g. frailty, dementia)
- Ministry of Health, Ministry of Long-Term Care and Ontario Health funded programs focused on older adults (e.g. Community Paramedicine, High Intensity Supports at Home, Alternative Level of Care related initiatives, etc.);
- Specialized Geriatric Services, who have been recently recruited or who require refresher or review;
- Other health and social care professionals new to the care of older adults living with complex health conditions (e.g. frailty, dementia)

Format

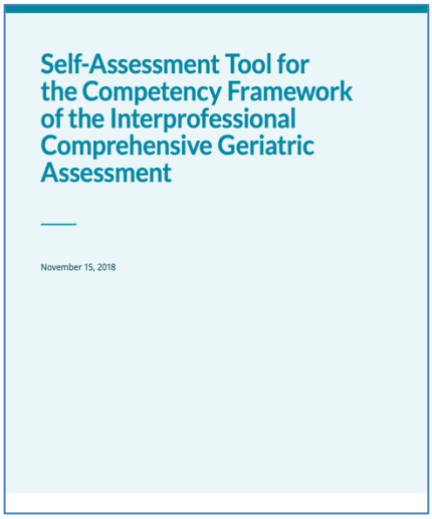
The format of Tier 1 and 2 actively engages learners in the development of their own competencies. This means that learners will participate in three main learning activities: self-study, a facilitated learning series and formal and informal mentorship.



[1] 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.

1: Guided Self-study (Asynchronous)

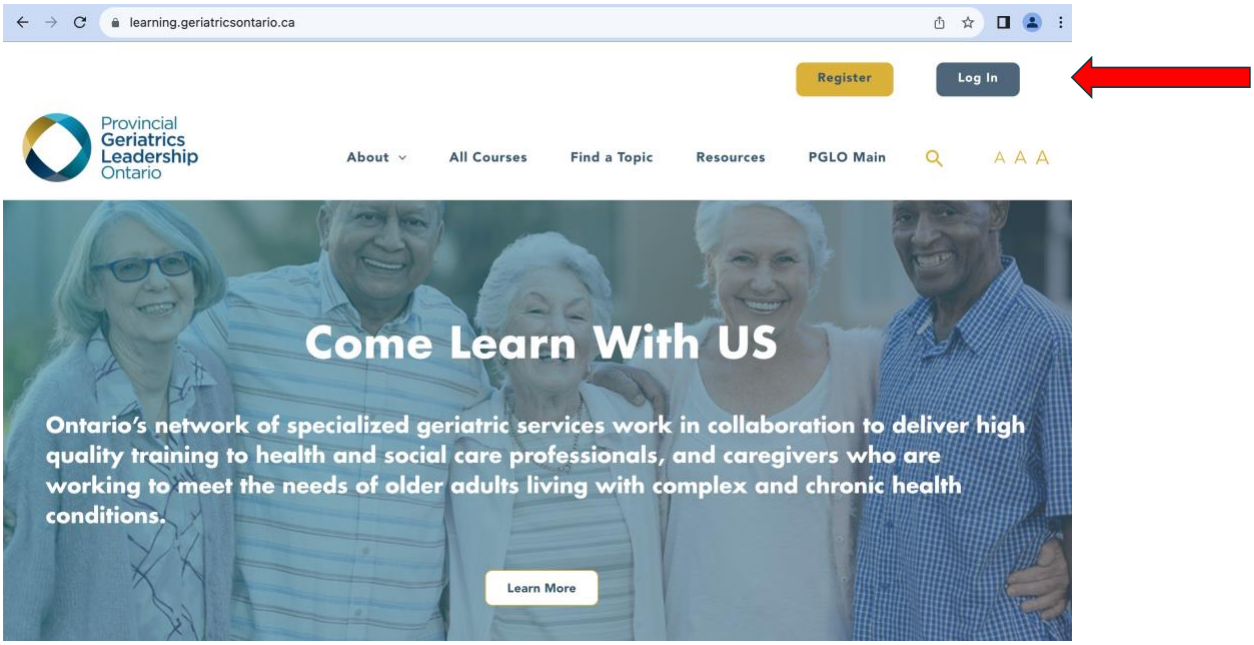
Learners begin their participation in the Provincial Common Orientation by completing a self-assessment to determine their learning needs in key geriatric topics. This may be completed informally (e.g. reflecting on current challenges, areas of uncertainty etc.), or for regulated health professionals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

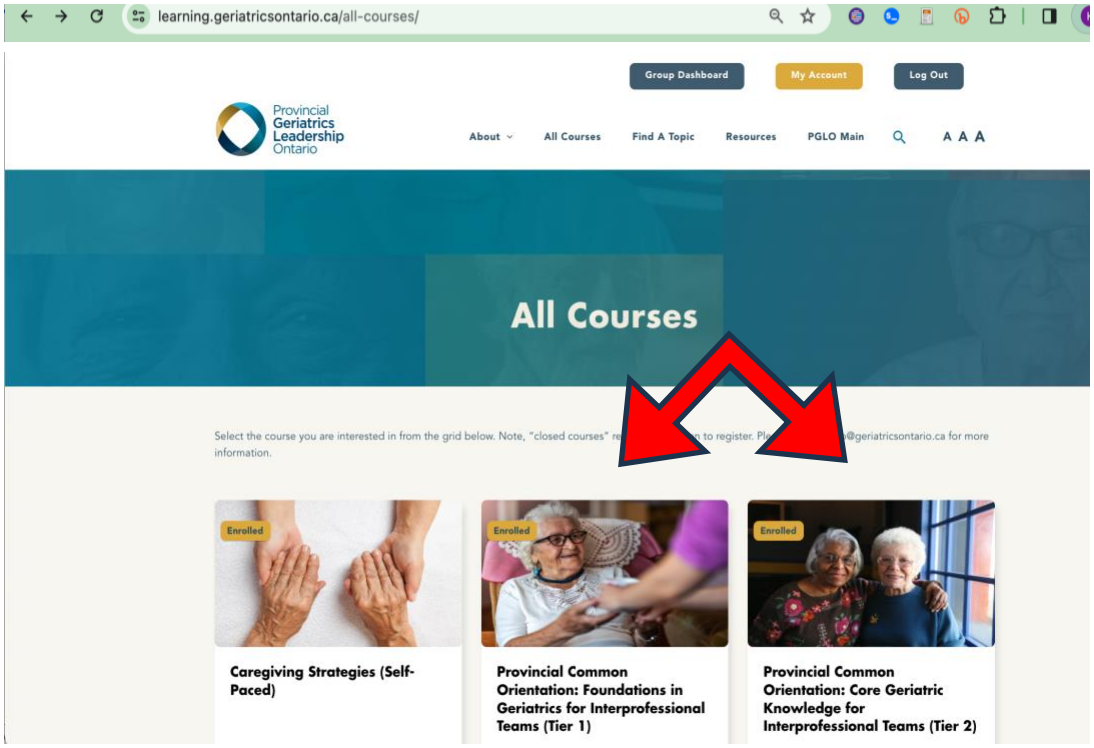


Online Course Portal

Following self-assessment and identification of learning needs, participants engaged in the Provincial Common Orientation commit to participating in weekly activities and readings found in customized course portal at https://learning.geriatricsontario.ca/

Participants enrolled in the facilitated series will receive a user account to access the course(s) they have registered for (e.g. Tier 1: Foundations in Geriatrics for Interprofessional Teams, Tier 2: Core Geriatric Knowledge for Interprofessional Teams, or both). Participants then log-in, navigate to the course and get started.





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

Participants may also wish to engage in independent self-study on topic of interest or to address personal knowledge gaps. Many links and resources are included in the on-line course portal for further exploration. Additionally, the following links may be of interest:

- 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)

2: Facilitated Learning Series (Synchronous)

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 sessions** 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
1	**Module 1: Welcome & Introductions**
	By the end of this module, you will be able to: • Describe the background and expectations for the Provincial Common Orientation and Tier 1 Foundations in Geriatrics for Interprofessional Teams • Begin to set personal knowledge goals relevant to the care and support of older adults living with complex health conditions • Identify learning outcomes, learning tasks and pre-requisites required to achieve personal knowledge goals and training expectations
	Module 2: Defining Frailty
	By the end of this module, you will be able to: • Define frailty holistically, and consider the implications of caring for someone living with frailty to your own practice

	• Identify strategies to prevent frailty and plan patient messages to encourage uptake of preventive care activities
	Module 3: Roles and Responsibilities of the Interprofessional Team
	By the end of this module, you will be able to: • Identify core competencies required for interprofessional teams • Describe roles and responsibilities of different health and social care professionals who might provide care to older adults living with frailty • Facilitate the inclusion of older adults and care partners on the team
2	**Module 4: Age Related Changes**
	By the end of this module, you will be able to: • Define normal aging • Identify age-related changes with a focus on delirium, falls, sensory changes • Link age-related changes with geriatric syndromes • Recognize atypical presentations of Illness in the older adult • Identify "Red Flags" signaling unsafe or urgent medical concerns in the older adult • Identify common chronic illnesses seen in older adults (e.g. CHF, COPD pathways, diabetes pathways) • Discuss approaches to chronic disease management and self-management in Ontario • Discuss the implication of chronic disease care for the geriatric patients (multi-focus versus traditional unidimensional)
	Module 5: Overcoming Ageism and Its Effects
	By the end of this module, you will be able to: • Identify myths and facts related to aging • Identify misconceptions of the aging population and ageism in healthcare.
3	**Module 6: Communication with the Older Adult**
	By the end of this module, you will be able to: • Demonstrate compassionate and patient-centered care • Identify core elements of Senior Friendly Care • Effectively communicate the unique needs of older adults • Recognize the significance of behavioural observations in dementia care • Collaboratively communicate and advocate for the unique needs of older adults with other care providers. • Apply communication strategies/skills for person centered communication.
	Module 7: What Older Adults Want
	By the end of this module, you will be able to: • Understand the perspective of older adults • Identify approaches to goal-based care planning and own role as advocate • Discuss "aging in place" as a concept and a motivation • Introduce Advance Care Planning
4	**Module 8: Early Identification, Screening, and Assessment**

	By the end of this module, you will be able to: • Discuss the basics of assessment in the older adult • Understand the importance of early identification and screening of frailty and other concerns • Perform and interpret an environmental safety scan at home • Perform and interpret the pictorial fit-frail scale and other frailty screeners • Consider next steps following screening, clarifying “responses” of different roles following screening
	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
5	**Module 10: Introduction to Tier 2**
	By the end of this module, you will be able to: • Introducing Tier 2 learning goals and objectives • Introducing approach to learning • 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: • Understand the role and importance of inter-disciplinary nature of geriatrics. • Review the elements of the Senior Friendly Care Framework related to processes of care • Complete a personal and organizational self-assessment of the current state of senior friendly processes of care related to one's own context
	Module 12: System Navigation
	By the end of this module, you will be able to: • Identify health, community, and social services in local area • Understand the importance and benefits of the 'warm hand off' the required individual and organization supports for enabling this
6	**Module 13: Frailty, Function and Functional Inquiry**

	By the end of this module, you will be able to: • Recap normal aging (from tier 1) • Recap holistic definition of frailty and strategies to prevent frailty (from tier 1) • Perform and interpret frailty screeners (i.e. the Clinical Frailty Scale) • Understand the meaning of baseline function and approaches to functional inquiry
7	**Module 14: 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: • Define it (increase knowledge) • Apply new knowledge to their clinical interactions (ie. Impact on function and safety)(applying knowledge) • Understand and apply the recognize and respond care pathway for appropriate for one's clinical setting (skills)
8	**Module 15: 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: • Define it (increase knowledge) • Apply new knowledge to their clinical interactions (ie. Impact on function and safety)(applying knowledge) • Understand and apply the recognize and respond care pathway for appropriate for one's clinical setting (skills)
9	**Module 16: Geriatric Syndromes (Part 3): Continence, Nutrition & Sleep**
	By the end of this module, for each of the geriatric syndromes, you will be able to: • Define it (increase knowledge) • Apply new knowledge to their clinical interactions (ie. Impact on function and safety)(applying knowledge) • Understand and apply the recognize and respond care pathway for appropriate for one's clinical setting (skills)
10	**Module 17 Sexuality**
	By the end of this module, you will be able to: • Recognize the need to support sexuality & intimacy in all older adults • Dispel myths and misconceptions about older adults and sexuality • Respond appropriately with practical supports for sexuality & Intimacy
	Module 18: Social Connectivity
	By the end of this module, you will be able to: • Differentiate between social isolation, loneliness, and social support (knowledge) • Understand the impact of social isolation on older adults (e.g. Impact on function and safety)(applying knowledge)
11	**Module 19: Caregivers**
	By the end of this module, you will be able to: • Recognize the importance/value of interacting with caregivers.

	• Understand the unique requirements of caregivers who support individuals living with frailty • 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 • 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 their needs
	Module 20: Care Planning and Intervention
	By the end of this module, you will be able to: • Recap compassionate and person-centered care • Identify reliable sources of information to inform the personal history • Identify techniques for communicating with people living with dementia or aphasia for the purposes of assessment and treatment. • Identify strategies to gather information about a patient's beliefs, concerns, expectations and illness experience • Use information about behavioural interventions to inform a person-centered goal-based care plan • Identify strategies to check for patient and caregiver understanding, ability and willingness to follow through with recommended interventions • Apply approaches to providing feedback to the interprofessional team on the evaluation of the care plan to inform refinement of plan

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).

Name		Title	Organization
Miriah	Botsford	Nurse Practitioner	North West Specialized Geriatrics Services
Carla	Brittos	Advanced Practice Nurse	North Simcoe Muskoka SGS
Alison	Denton	Program Manager	North West Regional Seniors' Care
Michelle	Doherty	Education Coordinator	Regional Geriatric Program Central
Sabeen	Ehsan	Director of Quality	Seniors Care Network
Chris	Gabor	Education Coordinator	Regional Geriatric Program Central
Shaen	Gingrich*	Geriatric Knowledge Translator	North East Specialized Geriatrics Centre
Alekhya	Johnson	Knowledge-to-Practice Project Manager	Regional Geriatric Program of Toronto
Kelly	Kay	Executive Director	Provincial Geriatrics Leadership Ontario
Heather	MacLeod*	Knowledge Translation Specialist	Regional Geriatric Program of Eastern Ontario
Tamara	Nowak-Lennard	Clinical Manager	North Simcoe Muskoka SGS
Danielle	Petruccelli	Clinical Manager	Hamilton Health Sciences
Jenny	Siemon	Director	Regional Geriatric Program Central
Marion	Tabanor	Psychogeriatric Resource Consultant	Peterborough Regional Health Centre

*denotes Committee Chair

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

PGLO also acknowledges the significant contribution of our facilitators to the development of the program learning materials. With gratitude to Shaen Gingrich, Heather MacLeod, Kelly Kay, Mary-Lynn Peters, Laura Harrison, Erin Charnish, Nicole Gallagher and Angie Lepine.