A photograph of two elderly women, one with dark hair and one with white hair and glasses, both smiling warmly. The image is overlaid with a semi-transparent purple filter.

The Essential Role of Caregivers in Improving Transitions and Addressing Alternate Level of Care: Insights, Leading Practices & Resources for Ontario Health Teams

The Ontario Caregiver Organization

Land Acknowledgement





OUR PURPOSE

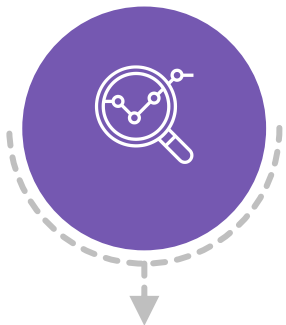
The Ontario Caregiver Organization (OCO) exists to improve the lives of Ontario caregivers; ordinary people who provide physical and emotional support to a family member, partner, friend or neighbour

Our work with OHTs

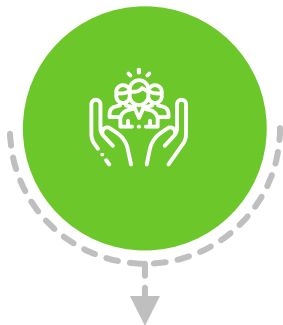
INCLUDE CAREGIVERS
AS PART OF THE
PATIENT CARE TEAM

CONNECT CAREGIVERS
TO SUPPORT

ENGAGE CAREGIVERS



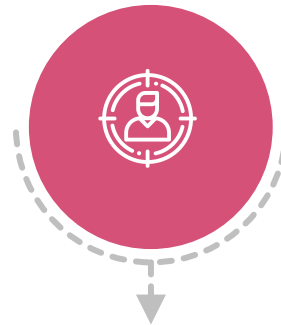
Learning Events and
Webinars



Collaboration,
Guidance and
Support



Connection to
Resources and Tools



Programs and
Services for
Caregivers

Today's Presenters



Ida McLaughlin

Former Caregiver, and
Chair of Alternate Level
of Care Patient and
Caregiver Advisory
Council



Dana Corsi

Chair of the Ontario ALC
Leading Practices Working
Group (2021), Regional
Geriatric Rehab Lead,
North East Specialized
Geriatric Centre (NESGC)



Dr. Kerry Kuluski

Dr. Mathias Gysler
Research Chair in Patient
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Professor, Institute of
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Management and
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Lisa Salapatek

Executive Lead,
Strategic
Partnerships and
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The Ontario
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Organization



Bianca Feitelberg

Project Lead,
Strategic
Partnerships and
Innovation
The Ontario
Caregiver
Organization

Focus of Today's Webinar

01

Setting the context – Why Caregivers are Essential to Improved Transitions and ALC Avoidance

02

Insights and Leading Practices to Include Caregivers

03

Key Take Aways for OHTs

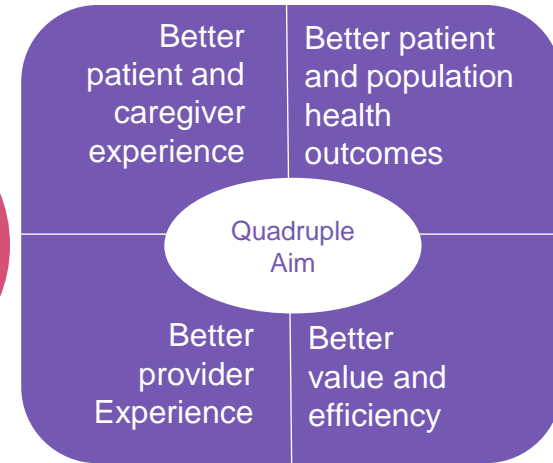
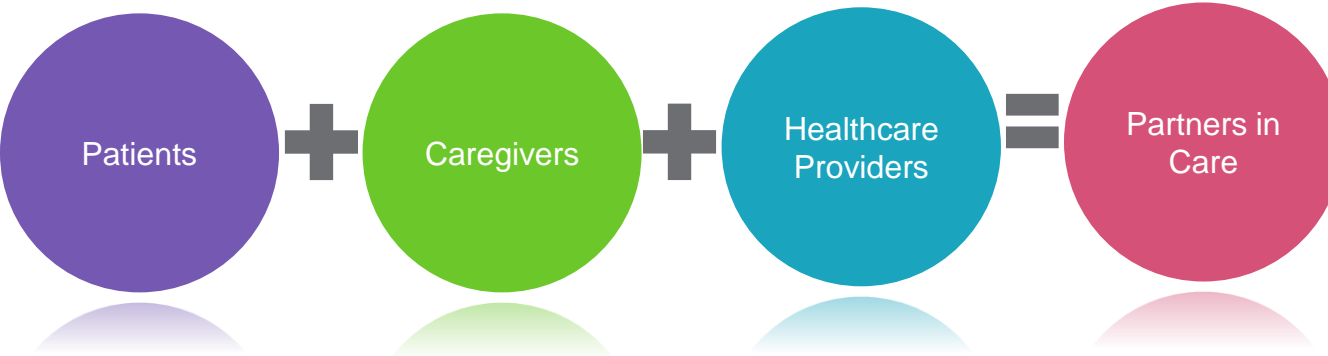




Poll

Caregivers are Critical to our Health Care System

4 million caregivers across Ontario provide an estimated 75% of the care in the system



Caregivers are Essential to the Healthcare System

If caregivers are not included as essential care partners

Risk and harm to Patients

Risk to Healthcare System

- Health outcomes and quality of care
 - Cognitive, mental and physical health decline
 - Increased risk of depression
 - Medication adherence may decrease
 - Missed opportunities for patient history
 - Missed opportunities for preventative care
 - Understanding of discharge instructions may be compromised
 - Greater risk for those with linguistic/ethno-cultural care needs or complex conditions
 - Risk to culturally-safe care
- Increased hospital usage:
 - Less successful transitions and risk of readmission
 - Greater risk of ALC designation
 - Missed opportunities for ALC avoidance
 - Increased demands on health care workers
 - Higher system costs

Pro-active and early inclusion of caregivers can help avoid ALC

- ✓ **Caregivers know the patient**
- ✓ **Caregivers are key to successful transitions and increased patient safety**
- ✓ **Caregiver burnout is a risk factor for ALC**



Inclusion of Caregivers is critical to an ALC prevention strategy

“Strengthening relationships with patients and caregivers as members of the team to create shared understanding of goals and priorities is required to better address [delayed discharge].”

Kerry Kuluski, Lauren Cadel, Michelle Marcinow, Jane Sandercock, Sara JT Guilcher, Expanding our understanding of factors impacting delayed hospital discharge: Insights from patients, caregivers, providers and organizational leaders in Ontario, Canada, Health Policy, Volume 126, Issue 4, 2022, Pages 310-317, ISSN 0168-8510,



Poll

A photograph showing a close-up of two hands being held together. The hands appear to be of different ages, with one being significantly older and wrinkled. The image is overlaid with a semi-transparent green filter. A white rectangular frame is centered on the image, containing the text "PANEL DISCUSSION" in white, uppercase, sans-serif font.

PANEL DISCUSSION

ALC Leading Practices



North East Specialized
Geriatric Centre
Centre gériatrique
spécialisé du Nord-Est

| How It Started...

2017 – Original ALC Leading Practices

Goal

- Standardize ALC practices across the province
- **Administrative and operational processes**

Lessons Learned

- Need for:
 - ✓ Better engagement of families and caregivers
 - ✓ Enhanced focus on Senior Friendly Care and rehabilitative care principles.
- Need to Integrate **care processes** across the continuum

Population Focus

ALC
Population

80% Age 65+

64% Age 75+

Common
Characteristics

- An admitting diagnosis that includes general medical illness (e.g. infections), falls and dementia;
- Presence of functional or cognitive impairments, & multiple comorbidities;
- Experience of adverse events during admission – functional decline, delirium, falls, social isolation;
- Caregiver stress

GOAL:

Meet the
needs of the
population
at-risk for ALC

| ...How It's Going



| The Evidence

bettercarejourney.com



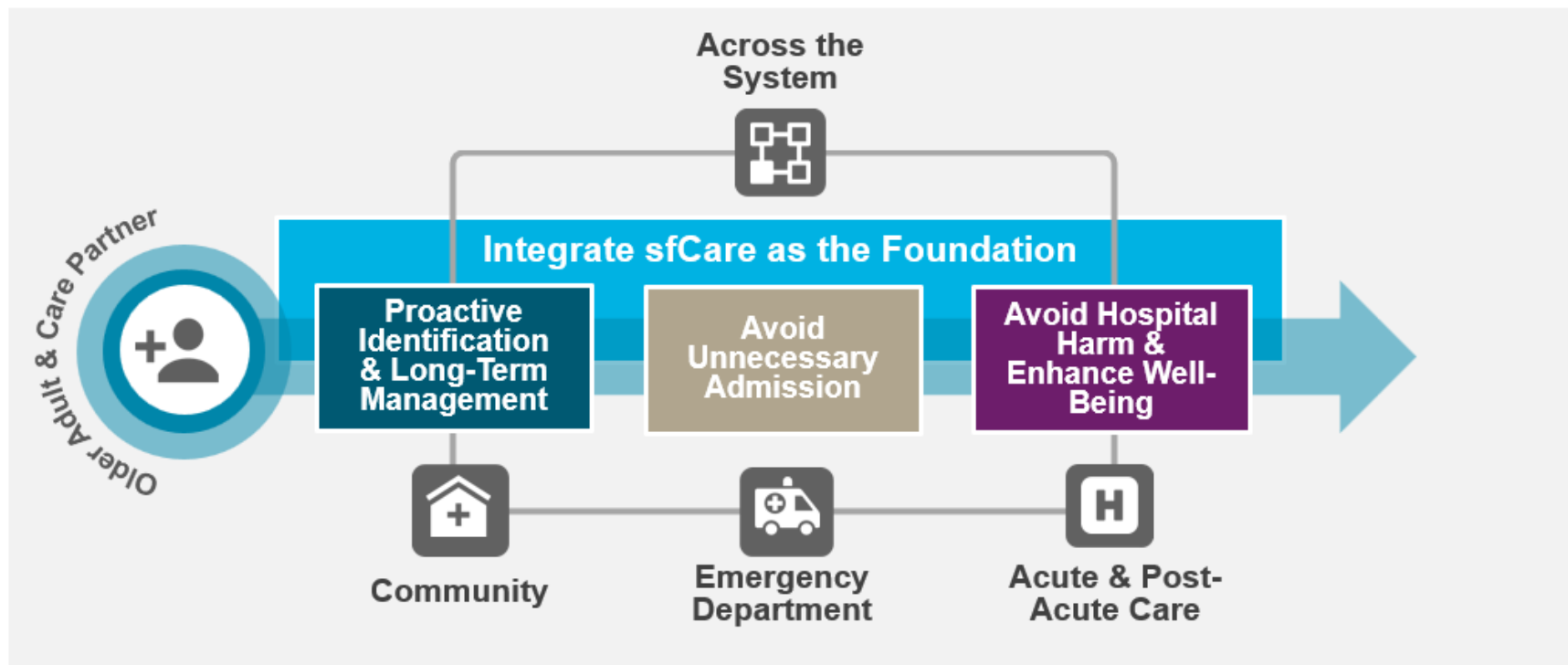
ACCREDITATION
CANADA

Provincial Clinical Guidelines

- ✓ **sfCare™**
- ✓ Interprofessional CGA Competency Framework
- ✓ Rehabilitative Care Best Practice for Older Adults Living With/At-Risk of Frailty
- ✓ Post-Fall Rehabilitative Care Pathway
- ✓ Direct Access Priority Process
- ✓ Quality Standards:
 - Dementia; Behavioural Symptoms of Dementia; Delirium; Transitions from Hospital to Home
- ✓ PIECES of my Personhood & Supporting Transitions



Care Trajectory



A photograph of an elderly woman being held by a caregiver, overlaid with a green filter and a white frame. The woman is wearing a white top and a necklace. The caregiver is wearing a light blue shirt. The text "Key Messages" is centered within the white frame.

Key Messages

Key Take Aways For OHTS - Planning



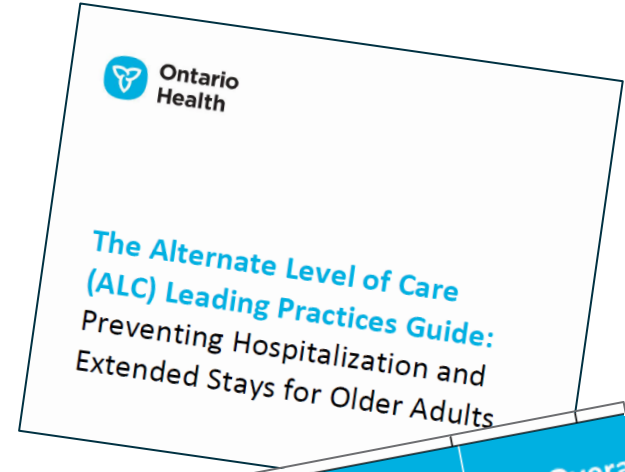
Use the ALC Leading Practices to inform OHT planning for ALC avoidance



Complete the Self-Assessment Tool to identify strengths and areas for improvement



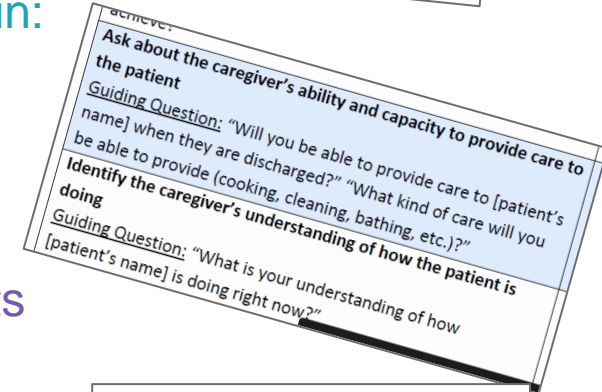
Engage Caregivers in co-design at your planning tables focused on ALC solutions and improved transitions



| Older Adult & Caregiver Experience & Communication | Overa |
|--|--------|
| Leading Practices | Status |
| 14. A process is in place to ensure that the older adult and their designated caregiver / Substitute Decision Maker (SDM) are included as part of the care team.* sf | MET |
| and expected results of care ll members | UNMET |

Key Take Aways For OHTS – Point of Care

- ✓ Build processes to formally identify caregivers to facilitate their inclusion as partners in care
- ✓ Build processes and training to include caregivers in:
 - ✓ Early, pro-active assessment
 - ✓ Early, pro-active care planning
 - ✓ Early, pro-active transition planning
- ✓ Pro-active, transparent communication with patients and caregivers about ALC designation
- ✓ Connect caregivers with the supports, tools and resources they need



The Ontario
Caregiver Helpline
1.833.416.2273

Caregivers... an essential part of the care team



Questions?



We want to hear from you. Type your questions in the chat box!



Chat

From Me to [Everyone](#):

Please type your questions and comments in the chat-box.



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providers

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Appendix A: Sources

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