



THE ONTARIO

caregiver

ORGANIZATION

Essential Role of Caregivers in Improving Transitions and Addressing Alternate Level of Care

CAREGIVER
INTEGRATION



A PRACTICAL GUIDE FOR OHTS



INTRODUCTION

Addressing alternate level of care (ALC) is one of the most pressing challenges in Ontario's healthcare system. That's why all Ontario Health Teams are required to make plans to implement services and reduce (or lower) ALC days as part of their 2022/23 Collaborative Quality Improvement Plan (CQIP).

Research showsⁱⁱ that one of three important practices to mitigate the risk of ALC is to work closely with family caregivers. The three leading practices to reduce ALC include:

- Pro-active and early assessment, care planning and transitions;
- Including caregivers in assessment, care planning and transitions; and
- The use of integrated approaches across the health and social care system.

The risk of ALC is even higher for older adults who have multiple, complex health and social conditions, or have been in the emergency department, or received acute, or post-acute careⁱⁱⁱ. According to caregivers, there are a number of issues and challenges that contribute to this risk^{xxv}:

- Patients/clients and caregivers prioritized safety, affordability, and proximity to family when considering LTC and community/homecare services, creating friction or delays when provider decisions did not align with these expectations.
- Increasing health complexities and caregivers' burnout, exacerbated by having health care needs of their own and limited homecare supports contributed to discharge delays.
- Insufficient infrastructure, including rehabilitation and LTC beds, community support, and accessible housing, contributed to delayed discharges.

According to an Ontario-based study, addressing delayed discharge requires a comprehensive approach involving collaboration between healthcare sectors, patient-caregiver engagement, and clear communication. OHTs are ideally suited to lead this work.



[Go directly to Action Steps, Tools and Resources](#)



THE EVIDENCE

Pro-active inclusion and support of caregivers across care settings can help improve transitions and reduce ALC stays for several reasons, including:

- Caregivers know the patient/client;
- Caregivers are key to successful transitions and increased patient/client safety; and
- Caregiver burnout is a risk factor for ALC.

Evidence shows that there are common characteristics of individuals who are at risk of delayed transitions in care. These include:

- People over the age of 65^{[iv,vv,vii](#)}
- Admitting diagnoses of: general medical illness, falls and dementia^{[viii,ix,x](#)}
- Presence of functional or cognitive impairments and multiple co-morbidities^{[xi,xii,xiii](#)}
- People who experience adverse events during admissions (i.e. functional decline, delirium, falls, social isolation)^{[xiv,xv,xvi,xvii,xviii,xix,xx,xxi,xxii,xxiii](#)}; and
- Caregiver stress.^{[xxiv](#)}

WHAT STEPS CAN OHTs TAKE TO CREATE AN APPROACH TO INTEGRATE THE ESSENTIAL ROLE OF CAREGIVERS IN IMPROVING TRANSITIONS AND ADDRESSING ALC?

Simple action steps that OHTs can take to integrate and include caregivers in their plans to improve transitions and ALC can include:

These action steps are further detailed in the [Action Steps, Tools and Resources section](#).

INFORM, PLAN, ASSESS

- Review relevant tools and resources, including the [Alternate Level of Care \(ALC\) Leading Practices Guide](#) and resources from the Provincial Geriatrics Leadership Ontario
- Complete a [self-assessment](#) to identify your specific strengths and opportunities for improvement
- Engage caregivers in co-design and at your planning tables

IMPLEMENT

- Build processes to formally identify caregivers
- Facilitate the inclusion of [caregivers as partners](#) in care
- Implement [Caregiver ID](#) across the OHT's various settings
- Build processes and training to include caregivers in early and pro-active assessment, care planning, and transition planning
- Create processes to ensure that pro-active and transparent communication takes place with caregivers about ALC designation
- Implement Essential Care Partner practices in OHT hospitals and long-term care settings with consideration of roles across all healthcare settings
- Provide caregivers with the supports, tools, and resources they need to provide care and to avoid caregiver burnout

TRANSITIONS AND ALC LEVELS ARE INTRINSICALLY CONNECTED - A KEY OPPORTUNITY TO COLLABORATE WITH CAREGIVERS

Proactively working with patient/client and caregivers, and having a shared understanding of the patient/client and caregiver priorities helps to facilitate a smooth transition, and mitigate or prevent ALC.^{xxv}

An Ontario-based study^{xxv} looked at the reasons for delayed discharge and calls for a ‘cross-sectoral’ solution. Integrating caregivers as members of the circle of care is foundational to this approach. The study outlines two overarching key actions:

- More collaboration between sectors with shared accountability for delayed discharge
- Strengthen the relationship between providers and patients/caregivers by identifying and negotiating shared purpose and goals



“Strengthening relationships with patients, clients, residents and caregivers as members of the team to create shared understanding of goals and priorities is required to better address this long-standing policy problem (delayed discharge).”^{xxv}

WHY IS THIS IMPORTANT TO OHTs?

OHT's can enhance patient and client experiences and health outcomes by improving transitions and mitigating the risk of ALC, which is imperative to achieving integration across health and social care and healthcare organizations. Proactive relationships with caregivers is foundational to this long-standing challenge, and can be integrated into your overall strategy. By taking steps to improve transitions and address ALC, the OHT will meet other quality goals, such as:

- Proactive identification and practices in care that prevent, slowing or reversing declines in physical and mental capacities;
- Care plan development and ongoing re-assessment; and
- Delivery of interventions and senior-friendly care and proactive transitions^{xxvi}.

The collaborative Quality Improvement Plan (CQIP), required of all Ontario Health Teams, supports a culture of quality improvement across OHTs driven by shared quality improvement objectives^{xxix}. By implementing services and supports for their attributed population, including supporting family caregivers and including them as members of the circle of care, it is expected that Ontario Health Teams will be able to influence ALC indicators.



The mandatory ALC indicator looks at the percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of their treatment.^{xxx}

ACTION STEPS, TOOLS AND RESOURCES

Through collaboration with OHTs, we've identified several ways that OHTs can implement caregiver focused strategies. The strategies in the table below include specific actions, tools, examples and resources that you can utilize to implement caregiver focused strategies to address ALC.

OHT's can start by addressing the "priority strategies" which include informing, planning and assessing where they are in terms of ALC leading practices. Once a plan has been put into place, OHTs can begin implementing caregiver focused strategies for their attributed populations.

ACTION STEPS FOR OHTS	WHAT'S IN THE TOOL/RESOURCE	TOOLS/RESOURCES
INFORM, PLAN, ASSESS		
Use the ALC Leading Practices to inform OHT planning for ALC solutions	This guide was created by Ontario Health and identifies evidence-based leading practices for the care and proactive management of older adults who are at risk of delayed transition to an appropriate care setting.	Alternate Level of Care (ALC) Leading Practices Guide
	This resource from the Provincial Geriatrics Leadership Ontario (Senior Friendly Care program) provides information on how OHTs can operationalize activities to help individuals at risk for ALC.	ALC Leading Practices: Supporting OHTs to Influence ALC Leading Practices in Community-based Early Identification, Assessment and Transition
Have the OHT complete the self-assessment to identify strengths and opportunities for improvement	This tool is intended to be used in conjunction with the ALC Leading Practices Guide and helps organizations to assess how their organization is doing in implementing leading practices in ALC.	Self-Assessment Tool

ACTION STEPS FOR OHTS	WHAT'S IN THE TOOL/RESOURCE	TOOLS/RESOURCES
<p>Engage caregivers in co-design at your planning tables to improve transitions and address ALC challenges</p>	<p>Rapid-Improvement Support and Exchange (RISE) has a number of resources to support patient, family and caregiver engagement and partnership, including a community of practice and a patient, family and caregiver group.</p> <p>The Institute for Better Health, Trillium Health Partners curated a number of resources in partnership with patients and caregivers to support relationship building, co-design and evaluation.</p>	<p>Review resources on the RISE web page: Resources to Support Patient, Family, Caregiver Engagement and Partnership</p> <p>Patient, Caregiver & Community Engagement Learning Series - Institute for Better Health</p>
IMPLEMENT: IDENTIFY THE CAREGIVER		
<p>Build processes to formally identify caregivers and facilitate their inclusion as partners in care</p>	<p>This guide was created by Ontario Health and identifies evidence-based leading practices for the care and proactive management of older adults who are at risk of delayed transition to an appropriate care setting.</p>	<p>ALC Leading Practices Guide (page 13)</p>
<p>Implement Caregiver ID across OHT settings</p>	<p>This webpage provides information about Caregiver ID and has a link to a number of resources and adaptable templates that can be used by organizations interested in implementing the program.</p>	<p>Caregiver ID</p>

ACTION STEPS FOR OHTS	WHAT'S IN THE TOOL/RESOURCE	TOOLS/RESOURCES
<p>Build processes and training to ensure caregivers are included in:</p> <ul style="list-style-type: none"> • Early, pro-active assessment • Early, pro-active care planning • Early, pro-active transition planning 	<p>This website contains a number of curated resources for policy makers, patients/ caregivers, associations/ councils and educators / researchers.</p>	<p>Alternate Level of Care Patient and Caregiver Advisory Council Better Care Journey</p>
	<p>The Caregivers as Partners e-Learning for Healthcare Providers helps set the foundation for building a culture of care partnerships. It includes the Caregivers as Partners original series (three modules) as well as the Caregivers as Partners Mental Health and Addictions series (3 modules).</p> <p>Tailored education sessions for providers offered by the Ontario Caregiver Organization.</p>	<p>Caregivers as Partners e-Learning for Health Providers</p> <p>Contact the Ontario Caregiver Organization for tailored education sessions for providers.</p>
<p>Ensure that pro-active, transparent communication takes place with caregivers about ALC designation</p>	<p>This communication tool has two components: questions that providers can ask patients and caregivers and questions that patients and caregivers can ask providers.</p>	<p>Resources Better Care Journey</p>
<p>Implement Essential Care Partner practices in OHT hospitals and long-term care settings.</p> <p>Consider roles across all health care settings, i.e. hospital, primary care, home and community care, community support services, paramedicine</p>	<p>Summary of key practices that can be included in OHT Essential Care Partner programs.</p> <p>A tool to provide OHTs with actionable tools, steps and resources to help OHTs identify, include and support caregivers.</p> <p>This toolkit was created to guide OHTs in the implementation of an ECP program based on two approaches for OHTs.</p>	<p>Essential Care Partner Programs – Key Practices for OHTs</p> <p>Essential Care Partner Programs and Practices for Ontario Health Teams</p> <p>Essential Care Partner Program Implementation Toolkit for OHTs</p>

ACTION STEPS FOR OHTS	WHAT'S IN THE TOOL/RESOURCE	TOOLS/RESOURCES
<p>Provide caregivers with the supports, tools and resources they need to be a caregiver and avoid caregiver burnout</p>	<p>Caregivers can be connected to the Ontario Caregiver Helpline, which is a one-stop, 24/7 resource for information and referrals connecting caregivers to the support they need.</p>	<p>Ontario Caregiver Helpline</p>
	<p>This toolkit includes information to support new or long-time caregivers. It was created by caregivers, for caregivers, with input from mental health professionals and resources.</p>	<p>I am a caregiver toolkit</p>
	<p>This is a collection of educational resources from the Provincial Geriatrics Leadership Ontario. The resources have been developed and/ or curated for family and friend caregivers who provide care and support for seniors experiencing frailty.</p>	<p>Caregiver Strategies Handbook Caregiver Strategies Online Course</p>
	<p>This webinar discusses how OHTs can support wellbeing of caregivers by building resilience and reducing the risk of caregiver burnout.</p>	<p>Watch the OHT Webinar recording: Supporting Caregiver Well-Being in OHTs</p>

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