

Ontario Alzheimer Strategy ... *T r a n s i t i o n*

**ALZHEIMER STRATEGY TRANSITION  
PROJECT**

***ALZHEIMER'S DISEASE AND RELATED DEMENTIAS  
RECOMMENDATIONS FOR PREVENTION, CARE AND CURE***

**REPORT 3: HEALTH HUMAN RESOURCES STRATEGY**

**April 2007**

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## EXECUTIVE SUMMARY

People with Alzheimer's disease and related dementias (ADRD) and their families require access to qualified health care and social support service workers who are able to recognize changes in health status and who can also recognize the need for additional, qualified human resources to manage the different manifestations of dementia through the progression of the disease.

Planning for health human resources should be based on the health and social support needs of the population, and must consider factors that affect the availability of qualified health care and social support service professionals and unregulated workers across the province. This means having qualified human resources with the right skills, in the right place, and at the right time, to optimize the quality of life of people with dementia and their families.

Under the Alzheimer Strategy Transition Project (ASTP), a provincial Health Human Resources Strategy Task Force (Task Force) was struck in the fall of 2006 to examine the issue of health force planning. The goal of the Health Human Resources Strategy is to ensure that adequate human resources are available to enhance the ongoing development of care and services for people with dementia and their families across the health care continuum. This includes optimizing opportunities for local champions and experts in dementia care and education to inform the valuable work that Local Health Integration Networks (LHINs) will complete through priority areas such as senior/elder care, mental health, and the chronic disease prevention and management sectors.

The Task Force concluded that a great number of complementary efforts are under way to address the health human resource needs of Ontario in the coming years. Rather than duplicate these efforts, the Task Force focused on three areas required for sustaining the gains made during the *Alzheimer Strategy* and *Transition period* and to continue to improve access to human resources trained in best dementia care and support practices:

- Policy,
- Framework for Dementia Care Education, and
- Infrastructure requirements.

There are significant data to suggest that recognizing and addressing dementia as a co-morbid chronic disease and as an integral factor in the Chronic Disease Prevention and Management Framework (CDPM) will result in significant cost savings to the health care system. For example, having appropriately educated and trained health and social service human resources who are able to recognize the disease in its early stages will provide opportunities to delay the onset of symptoms, and result in better patient flow across the continuum of care and more effective utilization of costly acute care resources.

The Framework for Dementia Care Education is still evolving. The core competencies, which appear in Appendix 4, are an essential building block for Ontario to embrace in order to achieve high standards of care and services for the increasing numbers of people who will face dementia as the baby boomer population ages. The Task Force recommends that these competencies in dementia care be integrated into the curriculum of health and social services education programs. Employers are also encouraged to ensure that their cultures, policies, and practices include dementia care education, including the demonstration of core competencies, as integral components of their human resource policies.

The academic community is strongly encouraged to adopt and adapt the core competencies in the curriculum of educational programs for regulated and unregulated health and social support care workers at both the university and college levels. The outcomes achieved through integrating core competencies in dementia care should be consistent between colleges and private career colleges who are educating Personal Support Workers.

Recommendations concerning opportunities to strengthen the roles and relationship between Psychogeriatric Resource Consultants (PRCs) and Public Education Coordinators (PECs) are timely in that the Ministry of Health and Long-Term Care (MOHLTC) and LHINs now need to look at aligning resources to ensure that all people with dementia have access to the support of these resources, who are able to contribute to improved knowledge, training and practices locally. It is recommended that all long-term care homes and community support services have appropriate access to PRCs and PECs.

The proposal for a Dementia Care Institute (DCI) as a necessary infrastructure component resulted from discussions at the Provincial Alzheimer Group and the Staff Education Steering Committee. It is believed that this concept provides a significant opportunity to sustain the gains of the *Alzheimer Strategy and Transition period*. The report recommends that the ADRD Planning Framework and the Toolkit be maintained temporarily under the leadership of the DCI. The strength of this model lies in the flexibility to use in-person and virtual technologies to maximize opportunities for collaboration and partnership across many sectors. It also has the goal of ensuring that best practices in dementia care continue to evolve and be accessible to those people working in the knowledge transfer and exchange cycle so that new standards continue to be set, achieved, and surpassed.

Task Force members brought broad experience from a wide variety of backgrounds in academic and health care environments. Although the Task Force was not able to delve deeply into many of the topics that it raised in response to the challenge of recommending health and social support human resource strategies for sustaining the gains of the *Alzheimer Strategy and Transition period*, the commitment and passion to continue to improve care and services for people with ADRD and their families was evident in all discussions.

It is hoped that this report, which is presented as a foundational document to promote further discussions and planning, will be a rich complementary document to the many other health human resource activities that are ongoing through *HealthForceOntario*, and other initiatives.

## SUMMARY OF RECOMMENDATIONS AND REQUIRED ACTIONS

<b>Recommendation # 1: Impact of ADRD as a Co-Morbid Condition</b>	
<b><i>Recommend that the MOHLTC recognize Alzheimer’s disease and related dementias (ADRD) as a chronic disease including the development of a Health Human Resources Strategy pilot project.</i></b>	
<b>Target Audience</b>	<b>Action Required</b>
<b>MOHLTC</b>	<ol style="list-style-type: none"> <li>1. Recognize Alzheimer’s disease and related dementias (ADRD) as a chronic disease and integrate it into the Ministry’s chronic disease strategic plan.</li> <li>2. Support the participation of Family Health Team members (e.g. physicians, nurses, nurse practitioners) in a pilot project in chronic disease management to study the impact of interventions and prevention strategies in diabetes care as mechanisms to delay the onset of dementia—thus reducing the stresses associated with dementia on individuals and society.</li> <li>3. Incorporate core competencies in dementia care into the policy framework for Chronic Disease Management for Dementia.</li> </ol>
<b>LHINs</b>	<ol style="list-style-type: none"> <li>1. Ensure that local population-based planning for people with ADRD considers the health human resource implications.</li> </ol>

<b>Recommendation # 2: Partnerships and Linkages</b>	
<b><i>Recommend that LHINs establish strong linkages locally with the dementia care community to ensure that dementia-related knowledge and disease-specific strategies are incorporated into decision-making affecting persons with complex needs.</i></b>	
<b>Target Audience</b>	<b>Action Required</b>
<b>LHINs</b>	<ol style="list-style-type: none"> <li>1. Include Dementia Networks and local champions (for example, ASO Chapter Executive Directors) on LHIN committees: such as Health Human Resource Strategy Advisory Groups and the chronic disease, mental health and seniors/elder care forums in order to ensure that dementia-related issues are considered in planning.</li> <li>2. Ensure that members of the LHIN population-based planning committees for persons with dementia include stakeholders who are representative of the local diversity of the target population.</li> <li>3. Maximize opportunities for the Dementia Care Institute (see Recommendation # 5), Dementia Networks, and local champions to create partnerships and linkages with other priority initiatives such as Family Health Teams, elder abuse, chronic disease management, wait list strategy.</li> </ol>

<b>Recommendation #3: Education</b>	
<p><b>a. Request that the MOHLTC including HealthforceOntario and the Ministry of Training Colleges and Universities (MTCU) promote education and training in ADRD.</b></p> <p><b>b. Recommend that the MOHLTC support an evaluation of the Personal Support Worker (PSW) education program delivered by colleges and private colleges.</b></p> <p><b>c. Recommend that colleges, private career colleges, boards of education and non-profit institutions (i.e. OCSA) implement core competencies in dementia care in teaching programs for Personal Support Workers and other training programs for health and social service workers.</b></p> <p><b>d. Recommend that the Universities Branch of the MTCU and regulatory bodies for health professionals review their curricula to ensure that education in ADRD is current.</b></p>	
<b>Target Audience</b>	<b>Action Required</b>
<b>MOHLTC MTCU</b>	<ol style="list-style-type: none"> <li>1. Support vocational outcomes in dementia care (e.g. knowledge of disease processes, stages and progression; strategies to promote optimal quality of life) for college programs for health and social service worker training programs.</li> <li>2. Request that the Ministers make public the recommendations received from the Health Professions Regulatory Advisory Council in its review of Personal Support Workers.</li> </ol>
<b>HealthforceOntario Human Resources Skills Development Canada</b>	<ol style="list-style-type: none"> <li>1. Incorporate a focus on care of the elderly, including persons with dementia, into the recruitment and retention strategies for attracting and hiring internationally trained health and social service delivery workers.</li> <li>2. Include a focus on dementia care in the training of Interprofessional Care Teams working with the elderly.</li> <li>3. Work in partnership with MOHLTC and MTCU to address wage and benefit disparity of PSWs across the health and social support sectors.</li> </ol>
<b>MTCU Ministry of Citizenship and Immigration</b>	<ol style="list-style-type: none"> <li>1. Recommend that the MTCU establish mechanisms for a periodic review (e.g. every five years) of the curriculum for PSWs to ensure that course outcomes recognize the evolving needs in healthcare as they relate to people with dementia.</li> <li>2. Set standards for private career colleges providing education for PSWs to ensure course duration, competency in dementia care, and literacy standards enable PSWs to meet expectations of long-term care homes as outlined in Bill 140, <i>Long-Term Care Homes Act</i>.</li> <li>3. Recommend that colleges and universities regularly monitor the labour market demands for health and social service workers and adjust training spaces accordingly.</li> </ol>
<b>Universities</b>	<ol style="list-style-type: none"> <li>1. Include dementia specific content in curricula and exam questions in undergraduate and graduate programs (e.g. medical, nursing, social work). As the content and exam questions are modified over time, continue to ensure that knowledge of ADRD is a content requirement.</li> </ol>
<b>Colleges</b>	<ol style="list-style-type: none"> <li>1. Ensure the curriculum addresses the core competencies and include dementia exam questions in courses for front-line workers including PSWs and Social Work Assistants. As the curriculum and exam questions are modified over time, continue to ensure that current knowledge of ADRD is a content requirement.</li> </ol>

	2. Ensure that Advisory Committees reviewing the curriculum of front line workers, such as PSWs, and other professionals in nursing, social work, etc., include opinion leaders and experts from Alzheimer Chapters (e.g. Executive Directors) and employers from long-term care homes and the community sector who are caring for people with dementia.
<b>Provincial Associations Host Agencies</b>	1. Participate with colleges and other educational institutions in jointly setting discipline-specific, standard vocational outcomes for front-line workers (e.g. PSWs) based on the draft core competencies developed by the Framework for Dementia Care Education Work Group.

<b>Recommendation # 4: Training and Upgrading</b>	
<p><b>a. Encourage health and social support service providers to include continuing education in the management of responsive behaviours, best practices in dementia care, etc. in their ongoing staff education planning.</b></p> <p><b>b. Request that the MOHLTC support organizations to obtain e-technologies for accessing the expertise of professionals to advance the care and treatment of people with ADRD and for accessing cost-effective education and training resources.</b></p>	
<b>Target Audience</b>	<b>Action Required</b>
<b>MOHLTC</b>	<ol style="list-style-type: none"> <li>1. Continue to provide funding support for initiatives from the Alzheimer Strategy (1999-2004) such as physician education initiatives (e.g. curriculum design, peer presenters, and preceptors), the Enabler Program, P.I.E.C.E.S and U-First! training for staff in long-term care and community agencies.</li> <li>2. Improve awareness of other educational tools and programs available for continuing education by identifying quality educational tools and programs that currently exist or will be developed.</li> </ol>

<b>Recommendation # 5: Building Integrated Dementia Care</b>	
<p><b>Establish a Dementia Care Institute (DCI), supported by the Alzheimer Knowledge Exchange (AKE), that brings together the dementia care community and promotes and facilitates the application of best dementia care and support practices using the knowledge exchange and transfer cycle.</b></p> <p><i>(The developmental year will occur in 2007-08.)</i></p>	
<b>Target Audience</b>	<b>Action Required</b>
<b>MOHLTC (Lead) MTCU Ministry of Labour LHINS</b>	<ol style="list-style-type: none"> <li>1. Endorse, support and promote a Stakeholders Group to work with a Facilitation Implementation Team including organizations presently funded for Strategy initiatives, e.g. Alzheimer Society of Ontario (ASO, including the AKE), the Ontario College of Family Physicians (OCFP), and the Ontario Community Support Association (OCSA) and representatives from the academic and health sectors to confirm the vision and develop a framework and guiding principles for a Dementia Care Institute.</li> <li>2. After the first year of operation, support an evaluation of the</li> </ol>

	<p>Dementia Care Institute and liaise with the ASO for support in seeking sustainable funding from government, LHINs and other sources.</p> <ol style="list-style-type: none"> <li>3. Support the Dementia Care Institute in building strong partnerships with <i>HealthForceOntario</i>, other networks, and other communities of practice.</li> <li>4. Facilitate dialogue between the MOHLTC and the Ministry of Labour to review the terminology to ensure consistency with the Bill 140, <i>Long Term Care Homes Act</i>.</li> </ol>
<p><b>Alzheimer Society of Ontario</b></p>	<ol style="list-style-type: none"> <li>1. As recommended by the Health Human Resource Task Force, act as lead agency (through the AKE) in the Facilitation Implementation Team during the developmental year (2007-08).</li> <li>2. Plan for the sustainability of the DCI including evaluation mechanisms.</li> <li>3. Coordinate meetings for the Facilitation Implementation Team and the Stakeholders Group through the developmental period.</li> <li>4. Lead the continued development of the AKE as Ontario's broad-based network for the ADRD community.</li> </ol>
<p><b>Stakeholders Group</b></p>	<ol style="list-style-type: none"> <li>1. Steer the development of the vision, framework and guiding principles for the DCI so that it is responsive to the needs of all member groups.</li> <li>2. Encourage and promote activities that will further the development of best dementia care and support practices.</li> <li>3. Collaborate in knowledge transfer discussions.</li> <li>4. Provide in-kind contributions for specific initiatives of interest to each organization.</li> <li>5. Participate through involvement and coordination with the <i>HealthForceOntario Interprofessional Care Project</i>.</li> <li>6. Continue the development of a Framework for Dementia Care Education that incorporates core competencies developed through this Task Force.</li> <li>7. Disseminate the core competencies in dementia care and provide feedback in using them.</li> <li>8. Provide input and advice concerning an informal environmental scan as it relates to dementia care.</li> <li>9. Assist in the evaluation of the AKE and the DCI.</li> <li>10. Identify strategies and technologies that help connect people with dementia and their family partners in care to formal providers who are working in a variety of organizational environments (small individual agencies to large providers with many sites).</li> </ol>
<p><b>Facilitation Implementation Team Members (ASO, AKE, OCFP, OCSA)</b></p>	<ol style="list-style-type: none"> <li>1. Under the leadership of the ASO through the AKE, plan for the sustainability of the DCI including the ongoing needs to support the network through promoting:             <ul style="list-style-type: none"> <li>• the knowledge transfer and exchange cycle as a mechanism to disseminate best dementia care and support practices through a one-stop concept;</li> <li>• collaborative and partnership opportunities;</li> <li>• recommendations for expanding the capability of the AKE; and</li> <li>• the identification of potential funding resources.</li> </ul> </li> </ol>



	<ol style="list-style-type: none"> <li>2. Work with the Stakeholders Group and others to develop a vision, framework, and guiding principles for the DCI.</li> <li>3. Provide in-kind resources for the developmental year to coordinate meetings and ensure goals are met.</li> <li>4. Continue to serve as “bankers” for funds currently entrusted to initiatives from the <i>Alzheimer Strategy and Transition period</i>.</li> <li>5. Engage in and coordinate Dementia Care Institute activities with the <i>HealthForceOntario Interprofessional Care Project</i>.</li> <li>6. Collaborate with the successful respondents of the Canadian Institutes of Health Research’s Request For Application on developing a Canada-wide <i>Knowledge Translation Network in Alzheimer Disease</i>.</li> <li>7. Foster representation of people with dementia and/or their partners in care on decision-making and advisory groups.</li> <li>8. Continue to improve upon and promote the development of the gains and functionality of the AKE.</li> <li>9. Build and sustain relationships and facilitate access between organizations, partners, and individuals working in dementia care in different sectors.</li> </ol>
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<b>Recommendation # 6: Recruitment</b>	
<p><b>a. It is recommended that the Physician Education Initiative, through the Ontario College of Family Physicians, continues to recruit adequate numbers of peer presenters and educators to meet the needs of Family Health Teams in promoting best dementia care and support practices.</b></p> <p><b>b. It is recommended that colleges and universities increase enrolment in key program areas so that adequate numbers of qualified providers, educated in the core competencies, are available to work with people who have ADRD.</b></p>	
Target Audience	Action Required
<b>MOHLTC HealthForceOntario</b>	<ol style="list-style-type: none"> <li>1. Consider expanding the scope of practice of Health Human Resources in Dementia Care (e.g. Nurse Practitioner).</li> </ol>
<b>Provider Organizations/Unions</b>	<ol style="list-style-type: none"> <li>1. Examine models of fair remuneration and establish more equitable wage rates and benefits across the healthcare sectors. Focus on employees in the community sector to stop the migration of workers to the institutional sectors and out of healthcare.</li> </ol>
<b>LHINs</b>	<ol style="list-style-type: none"> <li>1. Develop strategies to include population-based human resource planning and allocation of resources so that people with ADRD and their partners in care have access to the right people with the right skills at the right time and in the right place.</li> </ol>

<b>Recommendation # 7: Quality of Work Life and Employee Retention</b>	
<p><b>a. Recommend that HealthForceOntario integrate Personal Support Workers into the Interprofessional Care Project teams.</b></p> <p><b>b. Recommend that the MOHLTC and Ministry of Labour support health and social support service providers in developing and sustaining a healthy and safe workplace for staff who are caring for residents/clients with ADRD.</b></p> <p><b>c. Recommend that the MOHLTC develop and disseminate best practices in human resource management in work environments that provide care and services to people with ADRD.</b></p>	
<b>Target Audience</b>	<b>Action Required</b>
<b>Host Agencies/Employers</b>	<ol style="list-style-type: none"> <li>1. Provide all employees working with people with ADRD an opportunity to receive training and upgrading in the core competencies in dementia care.</li> <li>2. Undertake succession planning for interdisciplinary team members working in the field of ADRD to account for people leaving the workforce through retirement and other reasons.</li> <li>3. Include aging and generational issues as components of diversity training in order to minimize stigmas related to an aging workforce.</li> <li>4. Promote health and wellness initiatives that include stress relief and coping strategies for staff working with people with ADRD.</li> </ol>
<b>LHINs Ministry of Labour</b>	<ol style="list-style-type: none"> <li>1. Develop, monitor, and evaluate consistent Quality of Life Indicators related to staff health and safety for formal care providers of people with dementia. This may mean organizational and systemic changes that focus on prevention of behaviours.</li> </ol>

<b>Recommendation # 8: Clarifying roles and local support for Psychogeriatric Resource Consultants (PRC) and Public Education Coordinators (PEC)</b>	
<p><b>a. Recommend that the MOHLTC review the current distribution of PRCs and PECs and provide funding, where required, to augment existing human resources to ensure a more equitable distribution of PRCs and PECs based on population and geographic needs.</b></p> <p><b>b. Reaffirm the core mandates for PRCs and PECs.</b></p> <p><b>c. Ensure that all long-term care homes have access to PRC and PEC resources to assist in education and care of people with dementia.</b></p> <p><b>d. Provide provincial leadership oversight across the province by convening a meeting of the MOHLTC, LHINs, host agencies, PRC and PEC staff to achieve greater role clarity and consistency in service delivery based on original role mandates of PRCs and PECs.</b></p> <p><b>e. Review the compensation level of PECs based on their evolving role and mandate within the LHIN environment.</b></p>	
<b>Target Audience</b>	<b>Action Required</b>
<b>LHINS</b>	<ol style="list-style-type: none"> <li>1. Support an enhanced role for host agencies in integrating the work of the PRC/PEC.</li> <li>2. Include performance expectations for PRCs and PECs in any service accountability agreement with host agencies.</li> <li>3. Achieve closer collaboration between PRCs and PECs at the local</li> </ol>

	<p>level to support long-term care homes and the community sector including CCAC case managers, community agencies, and the general public.</p> <p>4. Support the role of Dementia Networks as leaders in promoting collaboration, service integration and partnership between PRCs and PECs within the LHIN environment.</p>
<b>Dementia Networks</b>	<p>1. Recognize expertise of incumbents (PECs and PRCs) and ensure their participation as active members on Dementia Networks and work groups.</p>
<b>Dementia Care Institute</b>	<p>1. Organize forums for PECs/PRCs and host agencies (at least annually) to share best practices and collaborative strategies.</p>
<b>Host Agencies</b>	<p>1. Transition the role of the PRC/PEC to its core mandate when hiring a new incumbent if the core mandate is not current practice.</p> <p>2. Identify performance outcomes for PRCs/PECs to include in the service accountability agreement with the LHIN.</p> <p>3. Ensure continuing education opportunities are provided to PECs and PRCs.</p>
<b>Psychogeriatric Resource Consultants</b>	<p>1. With support from the host agency, transition roles to realign responsibilities to carry out the core mandate of the role if this is not current practice.</p> <p>2. On a regional basis, work closely with specialized geriatric mental health outreach programs to ensure effective and efficient use of resources.</p> <p>3. Strengthen collaboration with PECs and others in the dementia community and participate in joint planning based on local needs, preparation of educational materials and sharing the workload for inevitable areas of overlap with the PEC.</p> <p>4. Provide advice on local issues through participation on Dementia Networks, LHIN committees, etc.</p>
<b>Public Education Coordinators</b>	<p>1. With support from the host agency, transition roles to realign responsibilities to carry out the core mandate of the role if this is not current practice.</p> <p>2. Strengthen collaboration with PRCs and others in the dementia community and participate in joint planning based on local needs, preparation of educational materials and sharing the workload for inevitable areas of overlap with the PRC.</p> <p>3. Provide advice on local issues through participation on Dementia Networks, LHIN committees, etc.</p>

<b>Recommendation # 9: “In the Field” Leadership Support</b>	
<p><b>a. Recommend that provider organizations continue to share best practices in defining workplace supports, such as the Algorithm on the Decision Making Tool for Dementia Education, for leaders, managers, and front-line supervisors.</b></p> <p><b>b. Recommend to Councils on Aging and provider organizations that “senior friendly” environments incorporate the core competencies for dementia care into staff training programs and “senior friendly” audits.</b></p>	
<b>Target Audience</b>	<b>Action Required</b>
<b>Councils on Aging and other Elder Friendly Groups</b>	1. Include information on core competencies for dementia care into the frameworks for training and audits of organizations.

## INTRODUCTION

This report is the third in a series of four reports being prepared to help support and enhance Alzheimer's disease and related dementias (ADRD/dementia) services into the future as the *Alzheimer Strategy* and its succeeding *Transition Project* come to a close (spring 2007). The four reports in the series, which is entitled *ADRD—Recommendations for Prevention, Care and Cure*, are:

- REPORT 1: Business Case to the Ministry of Health and Long-Term Care and the Ontario Seniors' Secretariat (released September 2006)
- REPORT 2: Business Case to Local Health Integration Networks (to be released spring 2007)
- REPORT 3: **HEALTH HUMAN RESOURCES STRATEGY** (this report)
- REPORT 4: A Report to Service Providers and People with ADRD and their Partners in Care (to be released spring 2007)

## BACKGROUND

Dementia has a profound effect on the psychological, physical, social, and financial well being of people with dementia, their families and other partners in care. Although there are common symptoms, the impact of the illness is unpredictable and different for each individual. Supporting someone with dementia involves an ever-increasing role in understanding and meeting their complex and changing needs.

The cost of dementia, both economically and in quality of life terms, continues to increase dramatically. Dementia will soon become the most disabling of all chronic diseases.

Dementia is in the top ten of chronic diseases facing Ontarians. This rank will climb over the next ten years, as the population of people 55 years of age and older increases more than 30% and the population of those under 55 years of age increases less than 5%.

Dementia does not often present as a singular chronic condition, but rather the following applies to chronic conditions in Ontario:

- 66% of Ontarians over age 45 have a chronic condition
- 55% suffer from two or more chronic conditions
- 80% of primary care visits are for a chronic condition
- 67% of all people admitted to hospital suffer from a chronic condition.

There are currently 160,000 people in Ontario with dementia—by 2031, there will be twice this number. Dementia currently impacts a million and a half Ontarians—by 2031, this figure will exceed three million.

The current direct and indirect annual economic cost of dementia in Ontario is estimated to be \$5-7 billion. This is more than the costs attributable to stroke, heart disease, and cancer, a phenomenon also identified in other countries. Like the growing prevalence rates of dementia, these costs too will increase dramatically in the coming years.

Half of the people with dementia live in the community and almost all of them have informal partners in care. The healthcare and social support systems have not recognized these caregivers as clients who are eligible for services and thus, the unfulfilled demand for professional healthcare and social support workers to provide this support is significantly under-reported. Also, currently, less than 10% of informal caregivers who could benefit from respite support have access to the service.

All of these factors place a burden of epic proportions on Ontario as a society, on the entire health care and social support sectors, on healthcare and social support professionals trained in dementia care and on seniors with other chronic diseases. This reality leaves the Local Health Integration Networks (LHINs) needing to ensure that their planning for human resources places the needs of people with dementia prominently within their human resource priorities.

This strategy is a response from a dementia perspective to this looming health and social support human resource crisis; a crisis that, given an already significantly inadequate supply of health and social support professionals to care for people with dementia, will mean the need for an estimated tripling of the current supply of human resources in order to manage future demands for care. Thus, this strategy presents recommendations to a broad cross-section of stakeholders, all with responsibility in helping to ensure an adequate supply of trained healthcare and social support professionals for our rapidly growing senior population with dementia. This report is intended to be a foundational document that will stimulate further discussion and planning that will evolve incrementally to improve the care for people with ADRD and their partners in care.

## **HEALTH HUMAN RESOURCES TASK FORCE**

In the fall of 2006, a Health Human Resources Task Force (Task Force) was established by the Alzheimer Strategy Transition Project to examine the human resource issues affecting the quality of life for people with dementia, and to provide recommendations that will address issues and ensure care and treatment to meet future needs is available in all settings and sectors. The Terms of Reference and membership of the Task Force are found in Appendix 1.

### **Activities of the Health Human Resource Task Force**

#### ***Environmental Scan***

The environmental scan included an examination of human resource issues from a national and provincial perspective. A report of the National Advisory Council on Aging suggests that:

the challenges posed by dementia to individuals, communities and Canada's health and care systems will be enormous...The current challenges related to Alzheimer's disease are serious, but the real ones are ahead of us...Canada's health care system is about to be struck by a wave of Alzheimer's disease that will last a quarter of a century.<sup>1</sup>

A sobering report prepared by the Canadian Policy Research Networks (CPRN) on behalf of the Canadian Council on Learning<sup>2</sup> states that more than one-half of Canada's workforce of 2015 is currently employed. The imperative, in terms of the growth in dementia as baby boomers begin to turn 65 (2012), is to ensure that those health professionals and direct health and social workers coming into the healthcare system are adequately prepared, from an educational and training perspective, for the challenges that they will face in caring for a growing number of people with dementia.

Ontario faces a significant reduction in its health human resources workforce by 2010. Unless new ways of practicing health care are introduced, Ontario will face a significant shortage of health care workers and Ontarians will risk receiving sub-optimal care.<sup>3</sup>

In response to the real shortage of healthcare workers facing the province, Ontario established *HealthForceOntario* in May 2006 as a joint initiative between the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Training, Colleges and Universities (MTCU). It has the

<sup>1</sup> National Advisory Council on Aging. *The NACA Position on Alzheimer Disease and related dementias*. No. 23, October 2004. page 2.

<sup>2</sup> Goldenberg, M., *Employer Investment in Workplace Learning in Canada*. Canadian Council on Learning, 2005.

<sup>3</sup> *HealthForceOntario* eNewsletter, Interprofessional Care Project, Winter, 2007.

ultimate goal of making the province the employer-of-choice. Activities of *HealthForceOntario*, aimed at achieving health human resource self-sufficiency, include:

1. Educating and retaining domestic graduates;
2. Attracting and properly utilizing foreign-educated health care professionals;
3. Facilitating entry into the Ontario healthcare job market through web-based communication: regulatory requirements to practice, immigration requirements, cost of living, quality of life and other relevant environmental expectations for those considering a move to the province; and
4. Establishing a number of funds that will assist health providers in upgrading their education and also in working collaboratively to deliver team-based care.

### *Maximizing the Workforce*

Statistics show that Ontario is the most culturally diverse province of Canada and received 53% of Canada's immigrants (130,000) in 2004-05. A full 66% of immigrants arriving from 1996-2001 had post-secondary qualifications.

The following four trends are changing the status of diversity and mean that diversity must be embedded in the organization's values and culture:

1. The global economy;
2. Increasingly diverse backgrounds of consumers (in this case, people with dementia and their families);
3. The changing composition of the labour force; and
4. The need for increased productivity (cost-effective care).

The definition of diversity has now been expanded beyond the four traditional groups (women, visible minorities, those with disabilities, and gay, lesbian, bisexual, or trans-gendered people) to encompass diversity of age, life situations, personality, and motivation. More and more employers are emphasizing inclusiveness and have become aware that building a healthy work environment also means promoting, managing, and mentoring a diverse workforce through diversity-sensitive practices and human resource policies that will aid recruitment and retention. Several sources have identified that employee retention will be a key success factor in having adequate human resources to address the needs of an aging population. This fact holds true for a subset of the aging population—those with dementia.

Maximizing the workforce through appreciating diversity has implications both for people with dementia and their families who may represent a diverse constituency as well as for employers of diverse workforces. Healthcare employers may not be ready to maximize the available human resources as *HealthForceOntario* puts these credible recruitment and retention strategies in place. For instance, the Conference Board of Canada's first diversity outlook <sup>4</sup> reveals the irony concerning diversity in the workplace.

Only 21% of organizations responding to the Conference Board's survey felt that their organizations were highly inclusive, while more than 25% of organizations rated their organizational culture as "low" on inclusiveness. Only 58% of organizations have a strategic plan for diversity; and only 33% of survey respondents have a diversity budget. Fewer than 40% of organizations require all employees and managers to participate in diversity training while those that do, state that their diversity-related initiatives focus on training, cultural events, and attending conferences. According to the report, this situation has serious implications (in health care) at a time when it is widely acknowledged that the richer the mix of people, skills, and cultures in an organization, the greater the range of inputs, viewpoints, and experiences—and the greater the creativity and innovation. Given that it takes time to implement major organizational policies and

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<sup>4</sup> Conference Board of Canada. (2006). *Report on Diversity: Practices, Priorities and Performance in Canadian Organizations*. The report is based on 120 completed questionnaires.

practices, organizations must consider and respond to these findings as they plan their human resource strategy for the immediate and mid-term.

#### *Trend Towards Earlier Retirement Age*

The average retirement age in Canada has dropped from 64.9 years in 1976 to 61.4 years in 2005.<sup>5</sup> Almost 80% of the organizations responding to a 2006 Conference Board of Canada survey believe they will face the consequences of an aging workforce within the next five years, and nearly a quarter of respondents say they are already feeling the effects. Even though their most experienced employees are beginning to retire, few organizations are taking steps to address impending labour scarcity and talent shortages—more than half of the respondents devote little or no effort to retraining mature workers. And even though many baby boomers will want to supplement their income or keep active after retirement, very few employers plan to recruit from this large, under-utilized labour pool.

At the organizational level, the Conference Board of Canada advises employers to focus on eliminating ageism by offering flexible work arrangements and “age-friendly workplaces” through job and workplace redesign and training.<sup>6</sup>

#### *Development of Interprofessional Care Teams to Improve Quality of Care and Address Shortages of Professionals*

There is no doubt that healthcare employers in the future will be faced with shortages in nurses and other regulated professionals who make up the traditional complement of positions in any healthcare setting. *HealthForceOntario* has anticipated this issue and is preparing healthcare teams to fill in the need left when a full team complement is not available.

*HealthForceOntario*, has stated that:

The education system needs to prepare current and future providers to work in multi-disciplinary, collaborative, team-based models. [There is] a growing understanding that interprofessional care can help improve patient care while increasing provider satisfaction within a respectful and collaborative environment.<sup>7</sup>

#### **Presentations to the Health Human Resource Strategy Task Force**

A presentation from the Ontario Safety Association for Community and Healthcare (OSACH) summarized issues facing seven healthcare sectors from a work environment and client and worker safety perspective. OSACH assists organizations and their employees to achieve safe and healthy work environments through the prevention and reduction of workplace injuries and disease. According to OSACH, data from a snapshot period in September 2006 shows a direct correlation between workplace injuries and responsive behaviours from clients/residents/patients. Workplace violence or aggression resulted in the community and healthcare sector having 37.5% of all lost time injuries across industries and accounted for 8.4% of accidents in the community and healthcare sector. The top three sectors with the highest incidence of lost time were hospitals (27.8%), homes for nursing care (24.9%), and group homes (21.4%).

The Task Force also received presentations on the Chronic Disease Prevention and Management Framework (Diabetes Program Coordinator, MOHLTC) and the Algorithm on the Decision Making Tool for Dementia Education (Director - Special Projects, Ontario Community Support Association, on behalf of Education for Safe and Healthy Places to Live and Work Collaborative Group).

<sup>5</sup> Conference Board of Canada. *InsideEdge*, Vol. 10, #4, 2006.

<sup>6</sup> Conference Board of Canada: *InsideEdge*, Vol. 9, #3, 2005

<sup>7</sup> Conference Board of Canada: *InsideEdge*, Vol. 10, #4, 2006



Following this process the Task Force agreed, through a member voting process, that the priorities to address human resource issues in this report would focus on three themes:

1. Policy
2. Framework for Dementia Care Education
3. Infrastructure Requirements

Subsequent meetings examined these topics from several perspectives, including the perspective of persons with ADRD and their partners in care, the priorities of the MOHLTC, the MTCU, the Ministry of Labour, LHINs, service providers, and front-line workers.

### **Gap Analysis**

Task Force members undertook a gap analysis between the vision for people with ADRD and the current reality facing people with dementia and their families. This vision, found on page 16, was developed by the Roundtable on the Future Planning for People Affected by Alzheimer Disease and Related Dementias.

Other areas of gap analysis related to considering the current education and training of formal providers and informal caregivers required to care for people with dementia and their families. This issue is described in more detail in the section on “Process Mapping”.

### **Sustaining the Gains of the Transition Period**

Many times over, the Task Force acknowledged that excellent gains had been made during the *Alzheimer Strategy and Transition period*. An issue, previously discussed at meetings of the Provincial Alzheimer Group, was how to sustain and build on these gains, including enhancing the role of Psychogeriatric Resource Consultants (PRCs), Public Education Coordinators (PECs) and Psychogeriatric Resource Persons (PRPs), and the successful education and training initiatives for family physicians and formal and informal partners in care (P.I.E.C.E.S. and U-First!). Hence, the Task Force’s deliberations also included discussions on opportunities to facilitate enhanced stakeholder collaboration on best practices across the knowledge transfer and exchange cycle through mechanisms such as establishing a Dementia Care Institute. The background to this recommendation is described under Recommendation # 5.

## **PURPOSE OF THIS REPORT**

### **Objectives**

An ADRD Health Human Resources Strategy (HHRS) incorporates the following objectives:

- a. To facilitate the development and enhancement of an ADRD Strategy and improve the ongoing development and enhancement of care to those with dementia across the health care continuum.
- b. To acknowledge the importance of the *knowledge/evidence to practice cycle* and the value added from building partnerships across LHINs and with a broad range of stakeholder groups in order to prepare health care and informal teams through education, training, and continuing education.
- c. To develop a framework that provides a coordinated menu of base-level training and education within educational and academic institutions in health, social services, and allied health sectors, which is competency-based, linked to standards of practice in dementia care, and measured against performance evaluations.

- d. To support integration and linkages between networks and service providers in order to enhance access to trained staff and volunteers for persons with dementia and their partners in care.
- e. To support the continuums of care across the senior/elder care, mental health, and chronic disease management sectors.
- f. To leverage lessons learned from other health human resource strategies.

## Scope

The Task Force held four meetings between November and February 2007. Their work built on several existing documents from the *Strategy* and the *Transition period*. Task Force members agreed that this work would not duplicate other important activities that are under development by groups such as *HealthforceOntario*, LHIN Human Resource Advisory Committees, and Education for Safe and Healthy Places to Live and Work Collaborative Group. It was acknowledged early on that the Task Force had insufficient time to undertake an in-depth analysis of human resource data, and hence, members relied on data readily available through the literature, documents from the Strategy and Transition period, and their personal experience with the healthcare system.

## Audiences

Recommendations have been grouped in broad categories including policy makers (MOHLTC, MTCU, Ministry of Labour, Ministry of Citizenship and Immigration including the Ontario Seniors' Secretariat, and LHINs) and transfer payment agencies and individuals involved in education and in the care and service to people with ADRD. In some cases, recommendations also are made to stakeholders in the broader community including associations representing healthcare sectors and those involved in the knowledge transfer and exchange cycle.

## ANALYTICAL FOUNDATION AND FRAMEWORKS

### Process Mapping

Tazim Virani of Tazim Virani & Associates was retained to conduct a process mapping exercise in order to identify areas of opportunity and gaps where strategies can be used to enhance human resources to treat and care for people with dementia.

The objectives for this work were as follows:

- Define the key processes in the following broad activity areas: advocacy, policy formulation (MOHLTC, MTCU), programmatic strategy development, curriculum development, education of care providers, and implementation of provider roles, continuing education, and promotion of best practices.
- Identify areas of opportunity and gaps for enhancement of human resource competencies and capacity. (Limit initial activity and discussions to the following three groups: physicians, nurses, and Personal Support Workers).

Integrating a newly developed algorithm developed by the Education for Safe and Healthy Places to Live and Work Collaborative Group enhanced the continuum of the mapping process. This Collaborative, co-chaired by the Ontario Association of Non-Profit Homes and Services for Seniors and the Ontario Long Term Care Association, developed a tool, Dementia Education Needs Assessment (DENA), to support leaders in selecting appropriate educational and training programs based on local factors within long-term care and other settings.

Task Force members and other opinion leaders participated in constructing a process map through a series of telephone interviews and in-person sessions. Tazim Virani met with the Task Force or a subset of members on three occasions. In addition, nine key informants were contacted by telephone during the period of January 3-10, 2007. Definitions of terms used in the process mapping exercise are contained in the Glossary.

Recommendations from the process mapping exercise have been incorporated into the recommendations, analysis, and discussions that follow. The Process Mapping Report and a list of opinion leaders interviewed in the development of the process map is found in Appendix 2.

## Frameworks

This report has been developed with three frameworks as the foundation: ADRD Planning Framework, the Chronic Disease Prevention and Management Framework, and the Strategic Alignment Model. These frameworks were selected because each one contributes to a broad understanding of the human resource issues and interventions necessary to transform the health and social services system in order to optimize the health and quality of life for persons affected by ADRD.

### ***ADRD Planning Framework<sup>8</sup>***

Earlier in the Transition period, the Roundtable on Future Planning for People Affected by Alzheimer Disease and Related Dementias was convened to develop an integrated and broadly-based planning framework that would address the impact of ADRD on government programs, communities, and Ontario as a whole. The Roundtable recommended that the Provincial Government adopt this framework in all planning activities that affect Ontarians living with ADRD and their partners in Care.

The Roundtable developed a vision statement that serves as the outcome to be achieved for Ontario as:

**a place where all persons with ADRD and their partners in care can live meaningful lives across the progression of the illness through active personal and community engagement.**

The framework has several structural components that the Task Force considered in their deliberations.

- A set of guiding principles that stresses:
  - A relationship-based approach;
  - The ethical principle of “Do No Harm”;
  - Citizenry rights, including autonomy and self-determination, independence, full engagement in life, and respect and dignity;
  - Respect for diversity and inclusiveness;
  - Fairness in eligibility and accessibility; and
  - Accountability.
- Three planning pillars:
  - Promoting an informed society;
  - Creating enabling and supportive environments; and
  - Sustaining personal, social, and system connectedness.

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<sup>8</sup> Roundtable on Future Planning for People Affected by Alzheimer Disease and Related Dementias: An ADRD Planning Framework, 1<sup>st</sup> Edition, September 2006, available at [www.akeontario.org](http://www.akeontario.org).

- Five enabling mechanisms:
  - Government policy, support, and adequate resource allocation;
  - Legislated processes and legal mandate;
  - Engagement of ADRD and broader communities in planning;
  - Community-based partnerships enabling collective wisdom; and
  - Performance-based service planning, delivery, and evaluation.

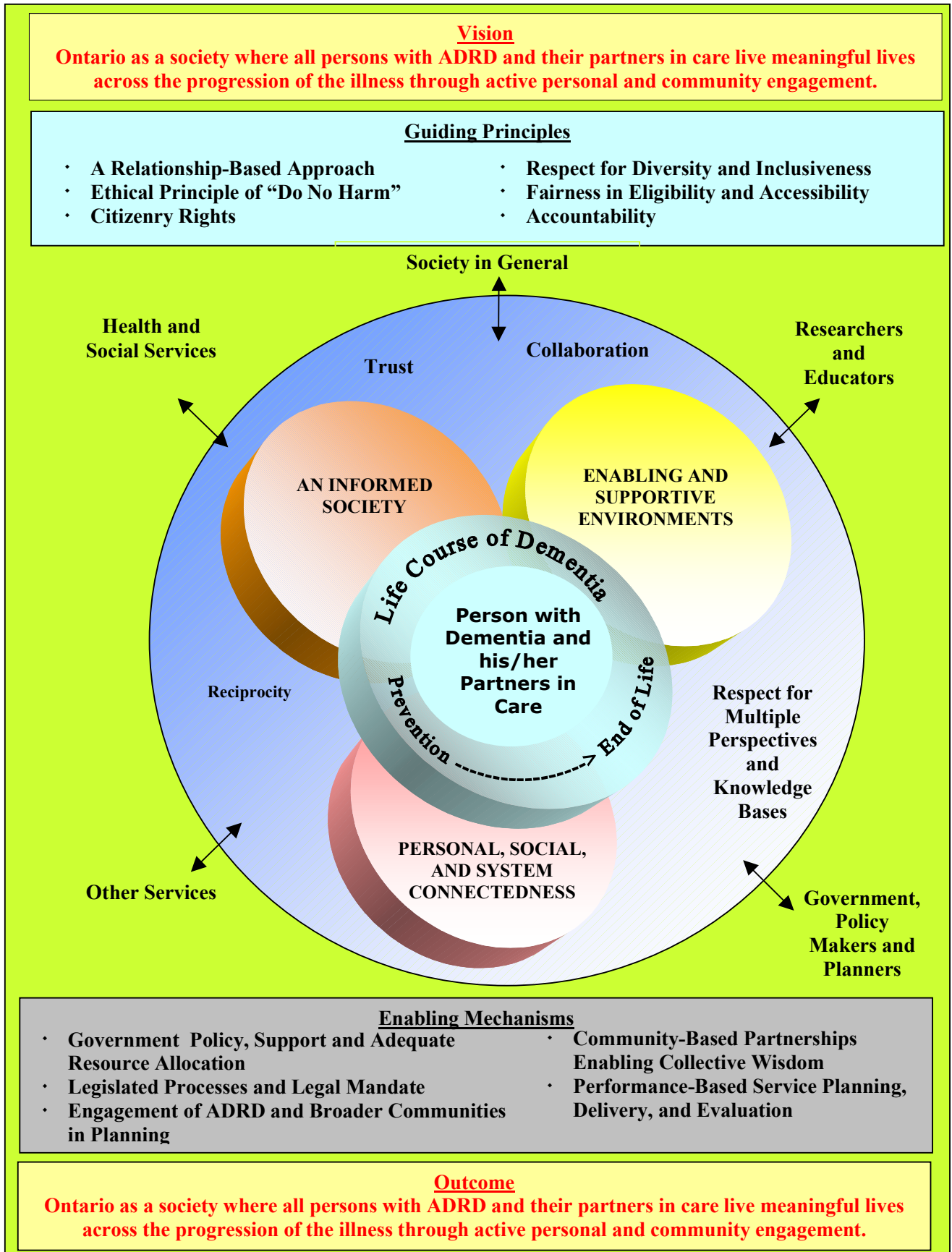
The diagram on the following page is a compilation of the framework components. Of particular note in this model are the three planning pillars. Discussions at Task Force meetings adapted the pillars to focus on HHRS components in order to achieve the vision for people with ADRD.

The experience of Ontario's Strategy for Alzheimer Disease and Related Dementias 1999-2004 demonstrated that the government's leadership and support, together with adequate funding and resources, played a paramount role in ensuring the success of the Strategy.<sup>9</sup>

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<sup>9</sup> Ibid, pg. 21.

## ADRD PLANNING FRAMEWORK OVERVIEW DIAGRAM



### **Chronic Disease Prevention and Management Framework**

Chronic Disease Prevention and Management (CDPM) is an integrated systems approach aimed at keeping individuals and populations as healthy as possible through the prevention, screening, diagnosis, treatment, management, monitoring, and continuous reassessment of health and/or disease states.

As Ontario shifts policy from a healthcare model oriented to the treatment of acute illness, the emphasis on the CDPM model is appealing because it results in an integrated policy framework that addresses both the prevention and management of chronic disease and highlights the crucial importance of the community domain in a population health promotion approach. In the CDPM model, there is a role for both chronic and acute care.

Alzheimer's disease is a progressive neurodegenerative disease (characterized by memory loss, language deterioration, impaired visual-spatial skills, poor judgment, and indifferent attitude, but preserved motor function). The probability of occurrence of the disease increases with age. Presently, there is no cure for Alzheimer's disease and no way to slow the progression of the disease. Research into prevention and developing ways to slow the onset of the disease are being sought and tested. Thus, the fit of Alzheimer's disease within the CDPM Framework is becoming more widely accepted and supported.

CDPM, as a provincial strategy framework, is based on the work of Wagner.<sup>10</sup> Many of the components of the framework are applicable to caring for people with ADRD (e.g., the use of multi-disciplinary teams, provider education, access to specialists and specialized programming, supporting and emphasizing the central role of individuals and their families in care and decision-making, and providing supportive environments). These parallels make linking ADRD with the CDPM framework a logical, if not necessary outcome.

Members of the Task Force had significant discussion of the model and its applicability to dementia care. The Task Force agreed that dementia is a chronic condition that often presents alongside other chronic diseases, such as diabetes and osteoporosis. The symptoms of dementia, as a co-morbid condition, can impact treatment plans dramatically and, in some cases, compromise outcomes. Early detection of dementia is crucial in the assessment process and in developing and optimizing a realistic treatment plan.

### **Strategic Alignment Model**

The Strategic Alignment Model<sup>11</sup> was introduced to the Task Force to ensure that the priority activities of recommending a Framework for Dementia Care Education and infrastructure components for dementia care would address three core areas of strategy execution: structures, skills and the culture required to achieve the strategy of sustainability and building on the gains of the *Alzheimer Strategy and Transition period*. This model was particularly helpful in framing discussions concerning the supports required to sustain the training initiatives such as the Gentle Persuasive Approach, P.I.E.C.E.S. and U-First!

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<sup>10</sup> Wagner, EH. (1998). Chronic Disease Management: What will it take to improve care for chronic illness? *Effective Clinical Practice*.1:2- 4.

<sup>11</sup> Quantum Learning Solutions. All rights reserved.

## HEALTH HUMAN RESOURCE ISSUES AND SOLUTIONS

Each of the following sections has a set of **Recommendations and Required Actions** to address health and social support human resource and education and training needs for the future. Recommendations appear in the body of the report for each of the areas of focus. However, additional activities, contained in “Required Actions”, are relevant to achieve the recommended outcomes and are found only in the opening section (Summary of Recommendations and Required Actions) and are not repeated in the body of this report.

### A. IMPACT OF ADRD AS A CO-MORBID CONDITION:

#### Problem—Analysis--Discussion

Our vision is of a system where all providers speak to one another in the same language, where there are no longer impenetrable and artificial walls between stakeholders and services; a system driven by the needs of patients and not providers.

*The Honourable George Smitherman*

The economic burden of chronic disease in Ontario is estimated at 55% of total direct and indirect health costs<sup>12</sup>. Almost 80% of Ontarians over the age of 45 have a chronic condition, and of those, about 70% suffer from two or more chronic conditions<sup>13</sup>. By 2010 the number of cases of dementia in Ontario is estimated to increase by nearly 40% over current levels.<sup>14</sup> ADRD is a specialty that needs to be acknowledged across the continuum of health care providers, informal caregivers and volunteers.

LHIN Health Human Resource Strategy Advisory Groups need to plan for human resources across the entire health care system. LHINs can support and encourage high-quality outcomes for people with ADRD by promoting human resource policies that facilitate changes in the culture of the workplace, and by advocating for flexible policies including education, training and educational recognition systems. Examples of initiatives include: staff given time to take courses, barriers removed, and incentives in place.

Dementia Networks and local champions can assist LHINs achieve accountability for chronic disease management, mental health and senior/elder care by interpreting how the policies of the MOHLTC translate into care delivery locally. In addition, Dementia Networks and local champions will provide leadership for the education and training of formal professional, clinical and other health care and social support staff as well as informal caregivers, such as family members and volunteers.

### RECOMMENDATION # 1: Impact of ADRD as a Chronic Condition

***Recommend that the MOHLTC recognize ADRD (dementia) as a chronic disease including a health human resources strategy pilot project.***

<sup>12</sup> Health Canada, *Economic Burden of Illness in Canada*, 2002.

<sup>13</sup> Cited in MOHLTC, Primary Health Care Renewal/Chronic Disease Prevention and Management Subcommittee, *Discussion Paper: A Framework for Chronic Disease Prevention and Management*, June 30, 2004, revised September 14, 2004.

<sup>14</sup> *ADRD Planning Framework*, 2006

## **RECOMMENDATION # 2: Partnerships and Linkages**

***Recommend that LHINs establish strong linkages locally with the dementia community to ensure that dementia-related knowledge and disease-specific strategies are incorporated into decision-making affecting persons with complex needs.***

### **B. EDUCATION**

#### **Problem—Analysis--Discussion**

Draft core competencies, previously recommended during the Transition period by the Provincial Alzheimer Group, were reviewed, revised and made available to the Framework for Dementia Care Education Work Group (Terms of Reference in Appendix 3).

There are various approaches/models being used in the education and training of formal and informal providers and caregivers of people with ADRD. Consequently, people with ADRD and their partners in care are exposed to variable experiences (or lack thereof) and practices throughout the course of their disease.

People with dementia appear in all care settings. Based on the co-morbidity of Alzheimer's disease as a chronic disease along with other health conditions, adequate numbers of people trained in dementia care are required across the entire continuum of care. Education and training in the core competencies should be a prerequisite in education and training programs for all professional, clinical and unregulated workers within the health care and social support system. Early intervention will contribute to wellness, faster recovery, and a reduced length of stay in higher-cost settings such as acute care. Early treatment will also sustain people with ADRD at more optimal levels of functioning, hence improving their quality of life.

The Framework for Dementia Care Education was deemed to be a priority tool for sustaining education and training in a cost-effective manner. The Work Group reviewed and updated the core competencies developed earlier in the *Strategy* and *Transition period*. Core competencies address dementia care: knowledge, relationships, behaviours, teams, and the emotional intelligence of interdisciplinary team members. An underpinning of the competencies is communication. Core competencies at the novice level, for new graduates as well as regulated and non-regulated health care and social support practitioners working in the field, are found in Appendix 4.

Time did not permit the Work Group to complete all the deliverables outlined in the Terms of Reference. It is recommended that the Dementia Care Institute continue to focus on the development of the Framework for Dementia Care Education.

Many graduates working in dementia-care settings come from the community colleges sector that relies on Advisory Committees to provide advice on updating the curriculum. Advisory Committees are composed of experts from the field and employers who understand the basic job demands and responsibilities that front-line health and social service workers will face in health care settings. It is strongly suggested that community colleges ensure that Alzheimer Chapter Executive Directors, or their designate, sit on Advisory Committees to ensure that the curriculum includes core competencies in dementia care.

## **RECOMMENDATION # 3: Education**

- a. Request that the MOHLTC, including HealthForceOntario and the MTCU, promote education and training in ADRD.***
- b. Recommend that the MOHLTC support an evaluation of the Personal Support Worker education program delivered by colleges and private colleges.***



- c. **Recommend that the colleges, private career colleges, boards of education and non-profit institutions (i.e. OCSA) implement core competencies in dementia care in teaching programs for Personal Support Workers and other training programs for health and social service workers.**
- d. **Recommend that the Universities Branch of the MTCU and regulatory bodies for health professionals review their curricula to ensure that education in ADRD is current.**

## **C. TRAINING AND UPGRADING**

### **Problem—Analysis—Discussion**

Currently, funding through the *Strategy* has supported end-user education such as training in P.I.E.C.E.S. and U-First! Training continues to be a necessary support for front-line care providers and caregivers and has been an initial step in managing the responsive behaviours exhibited by people with ADRD. However, a more cost-effective solution would be for core competencies, based on outcomes, to be a prerequisite in the design of undergraduate education and training programs in universities and colleges for all health care and social support providers including front-line workers. Without including the core competencies in the educational curriculum, there is a risk that the gains achieved through the *Strategy* and *Transition period* will not be sustained, strengthened, and built upon as the number of people with ADRD continues to grow exponentially.

The Framework for Dementia Care Work Group also recommends that employers of regulated and unregulated employees, who have not received training in the core competencies as part of their education, receive this training in the workplace. The vision of the Work Group would be that all components of the workplace including orientation, ongoing training, job descriptions, and performance management systems require consistent practice-setting outcomes in the core competencies. Discussions by the Task Force emphasized the requirement of leaders/managers to ensure that workplace systems and supports required by the care and service delivery team members build upon the core competency statements and be in place to maximize the benefits of education, training, and upgrading.

The Task Force considered the qualifications of the ideal candidate to work in Dementia Care Units. The Task Force also recommends that unions and labour organizations work with employers to ensure that the right providers with the right skills and the empathy to manage responsive behaviours are caring for people with ADRD. Education in dementia care should be a requirement for employment in Dementia Care Units within the community and long-term care sectors.

### **RECOMMENDATION # 4: Training and Upgrading**

- a. **Encourage health and social support service providers to include continuing education in the management of responsive behaviours, best practice in dementia care, etc. in their ongoing staff education planning.**
- b. **Request that the MOHLTC support organizations to obtain e-technologies for accessing the expertise of professionals to advance the care and treatment of people with ADRD and for accessing cost-effective education and training resources.**

## **D. BUILDING INTEGRATED DEMENTIA CARE**

### **Problem—Analysis—Discussion**

The Task Force recognized that several initiatives, begun during the *Alzheimer Strategy* and *Transition period* are not adequately connected and supported beyond March 2007. The lack of “glue” from both a human resource and education perspective will negatively affect the quality of dementia care.

**Note:** The “glue” is (1) technology, (2) framework, and (3) leadership.

Throughout the course of the *Transition period*, and the work of the Staff Education Steering Committee and the Health Human Resource Strategy, there have been many discussions endorsing the concept of an organization/structure to lead in the development of a more coordinated approach to dementia care.

The Dementia Care Institute (DCI) is perceived to be a necessary infrastructure component to sustain the gains of the *Alzheimer Strategy* and *Transition period* and to continue to enhance the implementation of best dementia care and support practices.

In order to continue to enhance standards of practice in dementia care, members in the knowledge exchange and transfer cycle need to be able to identify each other and have easy access to other stakeholders across sectors in health, social support, and education. Joint problem solving and sharing of lessons learned is an essential strategy for health-care organizations facing current and future shortages of health professionals and other providers.

The DCI model is intended to form collaborative linkages and to be inclusive of all those individuals and organizations currently working in the dementia care *Community of Practice*. “Alzheimer’s disease”, as a *Community of Practice* of the Seniors Health Research Transfer Network (SHRTN), builds on the foundation of the Alzheimer Knowledge Exchange (AKE) and complements the evolving vision of SHRTN.

### **RECOMMENDATION # 5: Dementia Care Institute**

***Establish a Dementia Care Institute (DCI), supported by the Alzheimer Knowledge Exchange (AKE), that brings together the dementia care community and promotes and facilitates the application of best dementia care and support practices using the knowledge exchange and transfer cycle.***

*(The developmental year will occur in 2007-08.)*

#### **Dementia Care Institute**

It is proposed that the Dementia Care Institute, which will be supported by the AKE, will be made up of two key groups:

- Stakeholders Group, with inclusive membership from all involved in the knowledge generation, transfer and exchange cycle; and
- Facilitation Implementation Team

#### **Critical Success Factors**

Endorsement and support for a DCI is required from a number of government ministries. A developmental year (2007-08) is necessary to finalize the vision, framework, structure and membership and to ensure broad input and buy-in from stakeholders involved in the knowledge

transfer and exchange cycle. Also, a commitment to collaborate and develop partnerships among the *Alzheimer Strategy* initiatives, SHRTN and other communities of interest is required.

The background to specific early initiatives is the knowledge transfer and exchange cycle, of which the components are given in the Glossary.

### **Assumptions**

In recommending an interim developmental structure for the DCI, it is assumed that:

- The developmental period will be one year (2007-08).
- The most leveraged action will be one where all organizations involved in dementia care work together collaboratively.
- The Stakeholders Group should set the direction of the DCI based on defining a practical and useful framework that will continue to provide momentum for the excellent progress that has been made within the dementia care community; the Facilitation Implementation Team's role is to ensure that the process is in place to coordinate meetings and ensure that the deliverables are achieved.
- There will be no new resources during the developmental year but there will be in-kind resources required from partnering organizations (Facilitation Implementation Team and Stakeholders Group) in order to develop the vision, framework, and guiding principles.
- The proposal for a DCI excludes the resources required to continue current funded programs such as employing Public Education Coordinators, Psychogeriatric Resource Consultants, supporting the AKE, P.I.E.C.E.S. and U-First! training, and the Physician Education Project.

### **Value Added by Establishing a DCI**

1. Provides leadership and resources to continue the evolution and dissemination of dementia care activities that further the development of best dementia care and support practices.
2. Provides a one-stop point of access for in-person and/or virtual access to current information and resources in dementia care.
3. Supports and links stakeholders in the knowledge transfer and exchange cycle.
4. Builds on opportunities for collaboration and synergy through the SHRTN.
5. Provides a forum for posing questions and discussing topics in dementia care with other practitioners and clinicians, including experts in other sectors (e.g. fireside chats).
6. Provides a forum for promoting dementia care in relation to ministry priorities, such as chronic disease management, Family Health Teams, employee Health and Safety and the Interprofessional Care Project.
7. Ensures that an acceptable "standard" of best practice in dementia care continues to evolve.
8. Provides temporary leadership in maintaining the ADRD Planning Framework and the Toolkit developed by the Roundtable.
9. Continues the work of developing a Framework for Dementia Care Education.

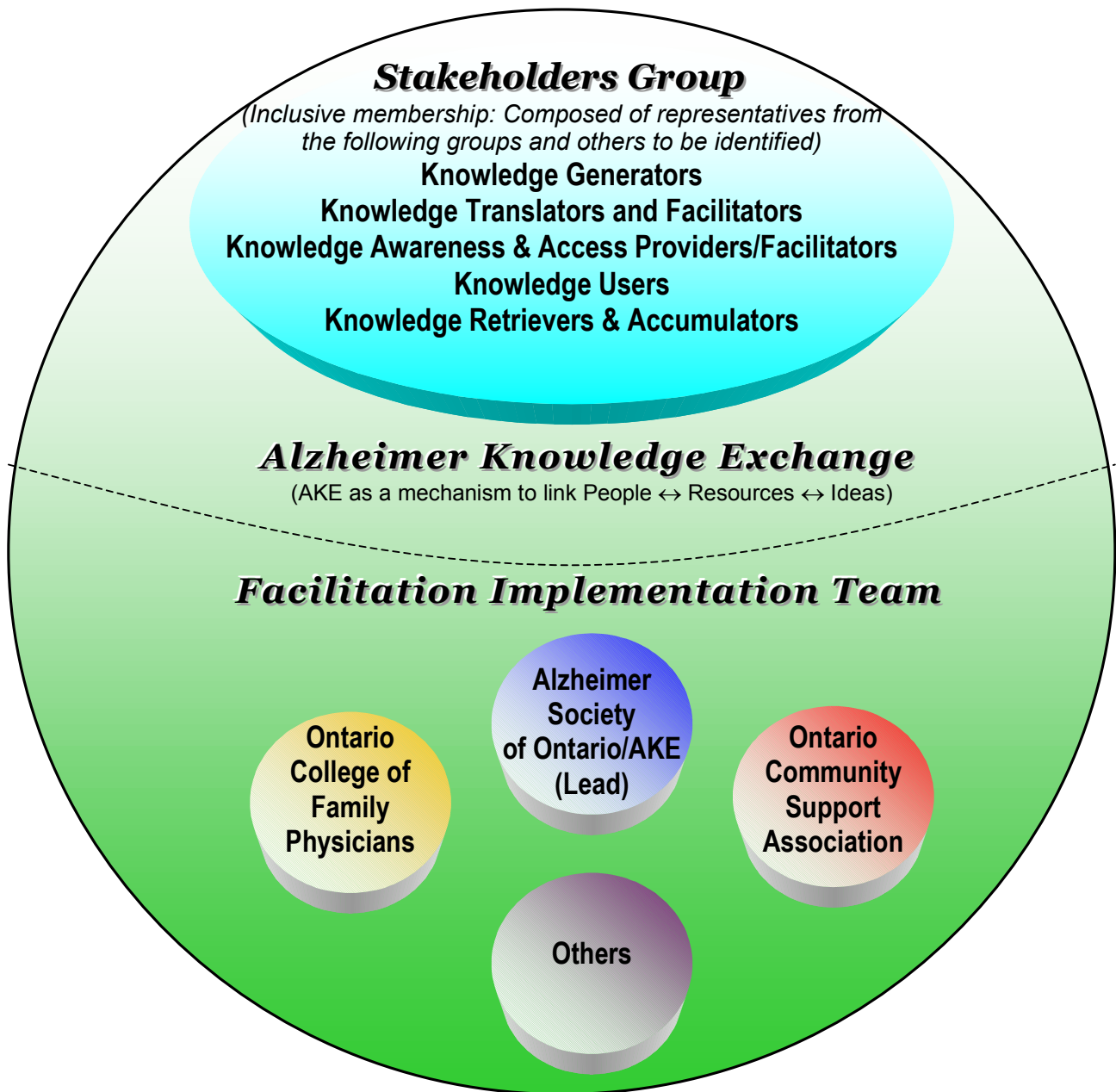
### **Proposed Transition Structure**

A diagrammatic representation of the transition structure is available on the next page.

## DEMENTIA CARE INSTITUTE

### Vision:

(To be developed by the Stakeholders Group and the Facilitation Implementation Team)



### **Rationale for Including the Partners in the Facilitation Implementation Team**

The composition of the Facilitation Implementation Team includes, but is not limited to, organizations funded for current educational and training initiatives during the *Alzheimer Strategy* and *Transition period*.

It was felt that bringing together organizations that continue to receive funding through the *Alzheimer Strategy* and *Transition period* as members of the Facilitation Implementation Team would be beneficial in ensuring that future initiatives have consistency across the health care and social support sectors. There is also agreement by the Task Force that the role of coordination should be assigned to a facilitation body prior to the end of the transition period. The membership of the Facilitation Implementation Team requires representatives from the Stakeholders Group.

- **Alzheimer Society of Ontario – (Lead, through AKE)** – Advance Care Planning, Public Education Coordinators, Research Priorities
- **Alzheimer Knowledge Exchange** – Four main roles include:
  - Connecting People and Knowledge expertise – Knowledge brokering
  - Connecting People to Resources – Alzheimer Resource Centre
  - Connecting People and Ideas – Facilitating interactive exchange
  - Connecting Innovations to Practice – Moving Innovations Forward
- **Ontario College of Family Physicians** – Dementia education website and resource unit, physician education (opinion leaders, peer presenters, preceptors), and advocacy.
- **Ontario Community Support Association** – staff education and training, U-First! resource development and support (i.e. Me and U-First! e-learning modules)

### **Roles**

#### *Alzheimer Society of Ontario (ASO)*

The Task Force recommends that ASO act as the lead agency through the developmental year 2007-08. For practical reasons, this role will be facilitated through the AKE. The major responsibility for ASO will be to establish the DCI as a sustainability mechanism and to coordinate meetings of the Facilitation Implementation Team and Stakeholders Group whose roles are described below. As well, there continue to be opportunities to enhance the functionality of the AKE and to forge collaborative partnerships using virtual and in-person meetings.

#### *Facilitation Implementation Team*

The main functions of the Facilitation Implementation Team<sup>15</sup> will be to:

- Work with the Stakeholders Group and others to develop a vision, framework, and guiding principles for the DCI.
- Promote the knowledge transfer and exchange cycle as a mechanism to disseminate best dementia care and support practices through a one-stop concept.
- Provide in-kind resources for the developmental year to coordinate meetings and ensure goals are met.

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<sup>15</sup> See list of Required Actions for the Facilitation Implementation Team in the Summary of Recommendations and Required Actions.

- As independent member organizations, continue to serve as “bankers” for funds currently entrusted to initiatives from the *Alzheimer Strategy* and *Transition period* as well as identify potential future funding resources.
- Continue to improve upon and promote the development of the gains and functionality of the AKE.
- Build and sustain relationships and facilitate access between organizations, partners, and individuals working in dementia care in different sectors.
- Foster representation of people with dementia and/or their partners in care on decision-making and advisory groups.

### *Stakeholders Group*

The main functions of the Stakeholders Group<sup>16</sup> will be to:

- Working with the Facilitation Implementation Team, steer the development of the vision, framework and guiding principles for the DCI so that it is responsive to the needs of all member groups.
- Encourage and promote activities that will further the development of best dementia care and support practices.
- Collaborate in knowledge transfer discussions.
- Provide in-kind contributions for specific initiatives of interest to each organization.
- Continue the development of a Framework for Dementia Care Education that incorporates core competencies developed through this Task Force.
- Disseminate the core competencies in dementia care and provide feedback in using them.
- Provide input and advice concerning an informal environmental scan as it relates to dementia care.
- Assist in the evaluation of the AKE and the DCI.
- Identify strategies and technologies that help connect caregivers of people with dementia and their families to formal providers who are working in a variety of organizational environments (small, individual agencies to large providers with many sites).

### *Membership in the Knowledge Exchange and Transfer Cycle*

The Glossary at the end of the report contains knowledge transfer and exchange categories and examples of members who would be invited to participate in the DCI. Membership will be inclusive and collaborative to generate a culture of sharing best dementia care and support practices across the province

## **E. RECRUITMENT**

### **Problem—Analysis—Discussion**

A focus of *HealthForceOntario* is to ensure that Ontario will have the right number and mix of appropriately prepared health care providers when and where they are needed. This goal has been set as a result of many contributing factors such as:

- Valuing equitable access to care across the province;
- Experiencing shortages of health care workers;

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<sup>16</sup> See list of Required Actions for the Stakeholders Group in Summary of Recommendations and Required Actions.

- Responding to a consumer climate that desires accountability for the expenditure of public funds; and
- Reacting to an imperative to shorten wait times for assessments, treatments, and procedures.

A number of strategies directly align with this goal and strengthen the education system with the health care and social support systems. For instance, recent research has focused on the education, recruitment and retraining of professional providers of care to reshape the delivery of health care in Ontario. Research, relevant to dementia care, focuses on physicians in Family Health Teams as a way of ensuring that the broad needs of a roster of patients are being met through the resources of a group of practitioners. Family Health Teams are accountable to their patients with dementia and their families through the collective expertise of team members. Opportunities available through the *Interprofessional Care Project of HealthForceOntario* should also be maximized.

A shortage in the number of nurses available to work in Ontario has been predicted for the year 2011.<sup>17</sup> Ontario has responded to the forecasted nursing shortage by relying more and more on nurses educated in other countries. Ontario had the second-highest percentage of internationally educated nurses (IENs) (11.9%) in Canada<sup>18</sup> but the highest actual number (10,684). The role of IENs is important in recruitment since data from 2005 showed that 34.1% of new RN members in Ontario were composed of IENs. Ontario produced only 52.4% of new RNs entering the workforce that year. The remaining 13.5% (441) were from other provinces. International RPN applicants show an overall increase during the past decade. However, relatively few complete the registration process.

## **RECOMMENDATION # 6: Recruitment**

- It is recommended that the Physician Education Initiative, through the Ontario College of Family Physicians, continue to recruit adequate numbers of peer presenters and educators to meet the needs of Family Health Teams in promoting best dementia care and support practices.*
- It is recommended that colleges and universities increase enrolment in key program areas so that adequate numbers of qualified providers, educated in the core competencies, are available to work with people who have ADRD.*

## **F. QUALITY OF WORK LIFE AND EMPLOYEE RETENTION**

### **Problem—Analysis—Discussion**

The concept of healthier workplaces has taken on new meaning in recent years. There is increasing focus on teams learning and working together to develop a shared commitment to a vision of care for people with dementia, as an example. One challenge for employers who care for people with dementia is the significant reliance on a workforce with a high percentage of unregulated workers. This reality challenges the traditional medical model and also the social model of care as more and more people are requiring medical interventions within the social context of care. As mentioned in the next section, the term “bio-psycho-social” has been coined

<sup>17</sup> Ryten, E. (1997). A statistical picture of the past, present, and future of nursing in Canada. Ottawa: Canadian Nurses Association, in Nursing Effectiveness, Utilization and Outcomes Research Unit, McMaster University & University of Toronto: *Fact sheet: The Aging Nursing Workforce: Some Figures and Implications for the Future.*

<sup>18</sup> Nursing Health Services Research Unit, McMaster University & University of Toronto, *Fact Sheet:*

*Internationally Educated Nurses (IENs) in Ontario at*

<http://www.nhsru.com/factsheets/international%20Educated%20factfinal290107.pdf>.

to describe the environment in which Psychogeriatric Resource Consultants find themselves working. Many people in the dementia care community live in their own homes and prefer the concept and philosophy associated with the “social” model of care. However, both terms describe the environments and workplaces of practitioners in dementia care.

While many workplaces require unregulated workers to provide care for people with dementia and their partners in care, the current model of the *Interprofessional Care Project*, does not include unregulated health care workers. It is recommended that *HealthForceOntario* integrate Personal Support Workers into the *Interprofessional Care Project*. Frequently it is the Personal Support Worker who is most familiar with a person’s altering condition, and also notices small variations in behaviours and other signals of change.

Two major focuses of a high quality of work life are often described from the perspectives of “a safe place” to work and as a place where the majority of workers are satisfied with working conditions and glad to come to work. Providers must create a culture where workers have input into workplace safety and be able to provide input into the conditions that they feel will create a satisfying work environment.

### ***Five Types of Retention Strategies in Use in Ontario***

According to a 2003 report by Ontario District Health Councils<sup>19</sup>, employers have essentially relied on five strategies for ensuring adequate numbers of employees in their workforce. These approaches remain realistic and are to:

- **Increase employee satisfaction** – through a combination of financial incentives, an increase in full time work, flexible schedules, opportunities for continuing education and career development, employee recognition, and healthy workplace initiatives.
- **Use health human resources differently** – skills, technology, and equipment upgrades, cross-training staff, rotations, implementing full scope of practice, new groups of professionals (e.g. Nurse Practitioners, interdisciplinary teams).
- **Find and use other resources** – volunteers, family members and non-professionals; promote self-care and self-management models.
- **Collaborate between two agencies** – shared resources, mentoring opportunities.
- **Collaborate among several agencies** – Back office transformation and similar initiatives.

## **RECOMMENDATION # 7: Quality of Work Life and Employee Retention**

- a. ***Recommend that HealthForceOntario integrate Personal Support Workers into the Interprofessional Care Project teams.***
- b. ***Recommend that the MOHLTC and Ministry of Labour support health and social support service providers in developing and sustaining a healthy and safe workplace for staff who are caring for residents/clients with ADRD.***
- c. ***Recommend that the MOHLTC develop and disseminate best practices in human resource management in work environments that provide care and services to people with ADRD.***

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<sup>19</sup> *From Practice to Policy: Report of the Health Human Resources Capacity and Utilization Project*. A project of the Ontario District Health Councils. October 2003.



## **G. FUTURE ROLE AND SUPPORT FOR PRC AND PEC POSITIONS**

The following report builds on activities and discussions through the Alzheimer Strategy Transition Period and at Task Force meetings concerning role clarity and related issues for the positions of Psychogeriatric Resource Consultants (PRCs) and Public Education Coordinators (PECs).

### **Problem—Analysis—Discussion**

In Ontario's Alzheimer Strategy, the goal of Strategy #3 was to increase public awareness and education about Alzheimer's disease and related dementias through the role of the Public Education Coordinators. Strategy #8 added the Psychogeriatric Consulting Services to support long-term care facilities and the community (CCAC case managers, and community agencies) with 50 full-time equivalent positions as Psychogeriatric Resource Consultants.

#### **Original Core Mandates**

The role of **Public Education Coordinators (PECs)** featured a combination of four basic service components involving public awareness and education related to ADRD. These included:

1. Activities that initiate and maintain local public education and activities that raise awareness of ADRD;
2. Activities that recruit and train volunteers with knowledge of ADRD for long-term care service agencies;
3. Activities that involve the development and facilitation of family caregiver and support groups for people with ADRD;
4. Activities that involve the co-ordination and implementation of training events for volunteers, caregivers, staff and other target groups.

Examples include: public speaking, dealing with enquiries related to ADRD and program services, providing information at awareness booths, directing people to appropriate resources, working with external organizations toward the promotion and development of customized education programs, group support, and volunteer time provided in a program service.

One unit of service is one hour of information or education.

The role of the **Psychogeriatric Resource Consultant (PRC)** is to:

1. Assist in developing and maintaining local agency networks and linkages including in-hospital and crisis intervention services;
2. Provide assistance with education and training to long-term care and community agencies; and
3. Provide assistance and support to staff in long-term care homes and community agencies in the application and interpretation of assessment tools, and care and treatment planning for persons with cognitive/mental health needs and associated behavioural issues as well as support for their family caregivers.

Examples include: contact with service providers to enhance local knowledge and skills in the community and long-term care homes, education and training (including support to staff who have attended the P.I.E.C.E.S. training); contact with community resources to facilitate linkages, assistance and support to staff in long-term care facilities and community support agencies in the application and interpretation of assessment tools for care planning and treatment for persons with cognitive/mental health needs and associated behavioural issues; contact with service providers to provide assistance with assessments, care planning, and implementing interventions for individuals with complex behavioural needs; and contact with service providers regarding local crisis intervention services.

One unit of service is one hour of consulting and education or network building.

## **Current Situation**

There is variation across the province in how the roles of the PRC and PEC have evolved. In rural areas, geography is a major challenge both in terms of collaboration between the two positions and travel time. The PRC/PEC has a huge population base to cover (e.g., in Toronto, there is one PEC serving 2 million people; Windsor has one part-time PRC). It is acknowledged that there is a high and growing demand for service from long-term care homes, community agencies and individuals. This demand affects priorities and time commitment to core roles. In fact, the newly built long-term care homes, as part of the recent long-term-care bed awards, have yet to be assigned a PRC to support their needs in dementia care.

Collaboration between PRCs and PECs works well in many parts of the province; however there are also situations where this relationship has not been maximized. The degree of collaboration between the two positions varies widely from extremely collaborative to very little communication. Many incumbents have expressed a feeling of isolation. While this separation, where it exists, may have resulted from a complex set of circumstances, these important local resources are deemed to need stronger mechanisms to enhance role clarity, collaboration, and integration. Lack of time to get together to collaborate, as well as staff turnover, are often cited as barriers. In many areas of the province, the unifying structure to bring PRCs and PECs together has been through the Dementia Networks.

Crossover in implementing roles and lack of consistency in carrying out the core mandate has resulted in role duplication and overlap within the same geographic area/or across geographic areas. Variations might reflect local context both in terms of demand for service and the availability of such other complementary resources as community outreach psychogeriatric consultation teams. As shown by the core mandates, roles and expectations vary significantly as do compensation levels.

Host agency expectations vary. Host agencies seldom communicate with each other about role expectations and models of service delivery. In the past, they have not been routinely asked for their input into how the roles are being implemented. There has been recognition by the Task Force that any recommendations will require input, support, and endorsement by host agencies.

The main issues and challenges for the PEC and PRC roles are listed separately:

### *Public Education Coordinators*

PECs operate under the community model (including long-term care settings) and require a university degree/college diploma in a related field and/or enrollment in the Dementia Studies certificate program. PECs are attached to Alzheimer Society Chapters. This structure has facilitated consistent messaging and accountability for their core mandate. A survey of PECs conducted by the Task Force in February 2007 had a response rate of 87% with 34 of 39 Chapters responding. The survey results showed that PECs spend the majority of their time as follows:

<b>Awareness:</b>	Activities that initiate and maintain local public education. Activities that raise awareness of ADRD.	<b>28.9%</b>
<b>Volunteer Recruitment and Training</b>	Activities that recruit and train volunteers with knowledge of ADRD.	<b>4.5%</b>
<b>Support:</b>	Activities that involve the development and facilitation of family caregiver support groups.	<b>16.1%</b>
<b>Education:</b>	Activities that involve the co-ordination and implementation of training events for volunteers, caregivers, staff and target groups.	<b>41.4%</b>

<b>Consultation:</b>	<i>(Not a listed core mandate, but role has evolved with Dementia Networks)</i>	<b>9.1%</b>
	Time spent in community consultation with Dementia Networks.	
		<hr/> <b>100.0%</b>

Some positions are part time and the PEC may have other commitments within the Alzheimer Society Chapter.

Historically there is high turnover of PEC incumbents—thus necessitating the continual rebuilding of relationships between the PEC and PRC. An on-line orientation package for PECs is available through the AKE. Compensation has been cited as a major reason for turnover.

#### *Psychogeriatric Resource Consultants*

PRCs operate under the bio-psycho-social model and as such, there may be a preference for multidisciplinary backgrounds. The most frequent education and training backgrounds are nursing, social work, physiotherapy, and occupational therapy. PRCs are attached to a variety of host agencies: e.g. Alzheimer Society Chapters, psychogeriatric mental health outreach teams, community mental health agencies, hospitals, and the Regional Geriatric Program of Toronto (for administrative purposes). Some positions are part time and the PRC may have other clinical responsibilities or expectations from their host agency. There is a lack of consistent orientation to the PRC role.

The following recommendations represent the discussions at Task Force meetings concerning roles and support through the MOHLTC/OSS, LHINs, host agencies, the Dementia Care Institute (described in a separate section of this report), and Dementia Networks. There are also recommended accountabilities for the roles of PRC and PEC.

### **RECOMMENDATION #8: Clarifying roles and local support for Psychogeriatric Resource Consultants (PRCs) and Public Education Coordinators (PECs)**

- a. Recommend that the MOHLTC review the current distribution of PRCs and PECs and provide funding, where required, to augment existing human resources to ensure a more equitable distribution of PRCs and PECs based on population and geographic needs within LHINs.**
- b. Reaffirm the core mandates for PRCs and PECs.**
- c. Ensure that all long-term-care homes have access to PRC and PEC resources to assist in education and care of people with dementia.**
- d. Provide provincial leadership and oversight across the province by convening a meeting of the MOHLTC, LHINs, host agencies, and PRC and PEC staff to achieve greater role clarity and consistency in service delivery based on original role mandates of PRCs and PECs.**
- e. Review the compensation level of PECs based on their evolving role and mandate within the LHIN environment.**

## **H. “IN THE FIELD” LEADERSHIP SUPPORT**

### **Problem—Analysis—Discussion**

Education and training initiatives funded by the MOHLTC through the *Alzheimer Strategy* and *Transition period* have had a significant impact on the knowledge level of formal providers of care involved in supervision, hands on care, and managing the behaviours of people with ADRD. Creating a culture of learning, knowledge uptake and implementation is the responsibility of care provider organizations. Anecdotally, front line staff have told their instructors that the work environment does not always have adequate supports for implementation of the best dementia care and support practices that are being taught through education and training institutions.

In order to maximize education and training resources and also to ensure that the quality of life for people with dementia and their partners in care is of high quality, provider organizations are encouraged to ensure that their cultures, policies and practices include dementia care education, including core competencies as integral components of their human resource policies.

### **RECOMMENDATION # 9: “In the Field” Leadership Support**

- a. *Recommend that provider organizations continue to share best practices in defining workplace supports, such as the Algorithm on the Decision Making Tool for Dementia Education, for leaders, managers and front line supervisors.*
- b. *Recommend to Councils on Aging and provider organizations that “senior friendly” environments incorporate the core competencies in dementia care into staff training programs and “senior friendly” audits.*

## **NEXT STEPS**

The next step in this work is to receive Ministry support for planning a Dementia Care Institute that will continue to strengthen the legacy of the *Alzheimer Strategy* and *Transition period*. Using e-technologies, such as the AKE as one strategy, will provide opportunities to enhance communication and the sharing of best dementia care and support practices among those involved in the knowledge exchange and transfer cycle.

## **CONCLUSIONS**

People with dementia and their families need access to qualified health care and social support workers who are able to recognize and access additional, qualified human resources to manage the different manifestations of dementia through the stages of the disease.

The Task Force concluded that a great number of complementary efforts are underway to address the human resource needs of Ontario in the coming years. Rather than duplicate these efforts, the Task Force focused on three areas that are required for sustaining the gains of the *Alzheimer Strategy* and *Transition period* and to continue to improve access to human resources trained in best dementia care and support practices: policy, Framework for Dementia Care Education, and infrastructure requirements.

The Framework for Dementia Care Education was the focus of many Task Force discussions. The core competencies, which appear in Appendix 4, are an essential building block for Ontario to embrace in order to achieve high standards of care and services for the increasing numbers of people who will face dementia as the baby boomer population ages. The Task Force

recommends that these competencies in dementia care be integrated into the curriculum of health and social services education programs. Employers are also strongly encouraged to ensure that their practices incorporate dementia care education, including core competencies, as integral components of their human resource policies.

The academic community is strongly encouraged to adopt and adapt the core competencies in the curriculum of educational programs for regulated and unregulated health care and social support workers at both the university and college levels. The outcomes achieved through integrating core competencies in dementia care should be consistent between colleges, private career colleges, boards of education and non-profit organizations (i.e. OCSA) who are educating Personal Support Workers. Recommendations concerning opportunities to strengthen the roles and relationship between PRCs and PECs are timely in that the MOHLTC and LHINs now need to look at aligning resources to ensure that all people with dementia have access to the support of these resources who can contribute to improved knowledge and training locally. It is recommended that all long-term care facilities have appropriate access to PRCs and PECs.

The proposal for a Dementia Care Institute came from recommendations made by groups since 2004. The strength of this model lies in the use of in-person and virtual technologies to maximize opportunities for collaboration and partnership. The DCI has the goal of ensuring that best practices in dementia care continue to evolve and be accessible to those people working in the knowledge transfer and exchange cycle so that new standards continue to be set, achieved, and surpassed. The Alzheimer Knowledge Exchange is an important component of the concept. However, with direction from the Stakeholders Group, the Facilitation Implementation Team can build a vision that embraces a broad mandate, structure and framework that assists those working in the ADRD community to continue to develop best practices and support for people with dementia and their partners in care.

Task Force members brought broad experience from a wide variety of backgrounds in academic and health care environments. Although the Task Force was not able to delve deeply into many of the topics that it raised in response to the challenge of recommending health human resource strategies for sustaining the gains of the *Alzheimer Strategy* and *Transition period*, the commitment and passion to continue to improve care and services for people with ADRD and their families was evident in all discussions. As a foundation for future discussions and planning in dementia care, it is hoped that this report will be a rich complementary document to the many other health human resource initiatives that are ongoing through *HealthForceOntario* and other initiatives.

## **ACKNOWLEDGEMENTS**

The Alzheimer Strategy Transition Project Team wishes to acknowledge all those opinion leaders and experts who contributed to this work. In particular, the members of the Health Human Resource Strategy Task Force are thanked for their time commitment and the valuable insights that informed this report. The Task Force acknowledges the Ministry of Health and Long-Term Care, the Ministry of Training, Colleges and Universities and the Ontario Seniors' Secretariat for their support and guidance in developing this report. The ASTP also wishes to thank the Ministry of Health and Long-Term Care for funding that resulted in the development of this report.

## GLOSSARY

### Definitions:

**ADRD**—Alzheimer’s disease and related dementias.

**AKE**—Alzheimer Knowledge Exchange.

**Advocacy**—any activity that leads to influencing a change in knowledge, attitude, or action.

**Best Dementia Care and Support Practices**—this term was chosen by the Task Force to recognize that “best practice” is not static.

**Caregiver**—Informal caregiver can include spouses, family members, friends, community members or volunteers.

**Community of Interest**—The ADRD Community of Interest is made up of any persons with an active personal or professional interest in ADRD, including individuals living with such illnesses.

**Community of Practice**—According to Etienne Wenger “Communities of practice are groups of people who share a concern or passion for something they do and learn how to do it better as they interact regularly.”<sup>20</sup>

**Coordination**—activities that help different parts of the system work with each other.

**Dementia Networks** – serve as a vehicle to facilitate people and resources coming together to improve the system of care for people with ADRD and their partners in care. Members include local champions, leaders, key service organizations and stakeholders.

**Education/Continuing Education/Curriculum**—Definition used in the Process Mapping Exercise: formal or informal acquisition of knowledge, skills, and attitudinal changes; occurring post formative period of learning and usually the learner is in the workforce; a defined set of educational objectives, standards with related content to be used to educate a target.

**Education**—occurring prior to someone entering the workforce.

**Formal Care Provider**—regulated health and social services professionals, other staff of community-based service providers or long-term care homes.

**Implementation**—issues and strategies to ensure HR roles are enacting what they are meant to enact.

**Knowledge Transfer**—see below.

**P.I.E.C.E.S.** —Training based on a framework of assessment and supportive care strategies for those working in long-term care homes, CCACs and contracted agencies of CCACs.

**Policy Formulation**—a process whereby the result leads to investment in a defined area and/or mandating an action.

**Policy Makers and Planners**—These would include local, regional, provincial and federal government employees involved in planning and policy decisions related to care for persons with ADRD. It would also include persons in health sciences educational institutions, colleges and universities, with comparable powers related to curriculum development for ADRD.

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<sup>20</sup> Wenger, Etienne: (2005). Definitions. Etienne Wenger Website. Retrieved October 28, 2005 from: <http://www.ewenger.com/theory/index.htm>

**Program Strategy**—any approach to making it happen; “it” may be a policy, decision, program, etc.

**Provincial Alzheimer Group (PAG)**—One of three component pillars of Ontario’s Alzheimer Strategy Transition Project. It is a government-community partnering forum in which stakeholder representatives reviewed gains made through the Alzheimer Strategy, identify needs and means for coordinating among the various initiatives stemming from the Strategy, and look for ways to promote systemic changes for the benefit of the ADRD community of interest. (PAG ended April 2007).

**Quality of Work Life**—nature of how individuals respond to their work situation based on work environment conditions.

**Recruitment and Retention**—attracting new HR resources in a field and after a formative induction, keeping the resources without turnover or loss.

**Responsive Behaviours**—Behavioural responses or reactions to something negative, frustrating or confusing in the person’s social or physical environment which represent the expression of an unmet need (MAREP).

**Roundtable (on Future Planning for People with ADRD)** —This is another one of the three component pillars of Ontario’s Alzheimer Strategy Transition Project. It is a multi-sector forum dedicated to reviewing the need for long range planning as Ontario continues to meet the challenges associated with an elderly population that is growing in number, and with ADRD as a primarily age related health condition that impacts on all parts of the community—including, but not limited to the health and social services sectors. (Roundtable ended April 2007.)

**Seniors Health Research Transfer Network (SHRTN)**—A government supported joint initiative convened to facilitate the sharing of knowledge about health care related to Ontario’s seniors. It envisages a future in which caregivers, researchers, and policy makers participate in knowledge exchange initiatives. The primary partners in implementing this network include the Elizabeth Bruyère Research Institute, the Research Institute on Aging, the Baycrest Centre for Geriatric Care, and the Aphasia Centre. The AKE is an invited partner organization.

**Service Providers**—Service providers include government funded, profit and non-profit providers of care and services to persons with ADRD and their families.

**U-First!** —An education program for supervisors and frontline workers that provides a common knowledge base, common language, common values and a common approach to providing care for people with ADRD.

## **Components of the Knowledge Transfer and Exchange Cycle:**

(Definitions from the Alzheimer Knowledge Exchange.)

The background to specific early initiatives is the knowledge transfer and exchange cycle, of which the components are given below:

### **Knowledge Generation**

- Engender a knowledge-sharing culture supported by information and communication technology and knowledge-brokering resources to improve the care of people with dementia.

### *Knowledge Translation and Exchange*

- Provide a mechanism of collaboration to identify and communicate with stakeholders involved in the knowledge transfer and exchange cycle (i.e., from knowledge generation to knowledge transfer and exchange to awareness to utilization, to retrieval and accumulation).

- With the assistance of a knowledge broker, facilitate the exchange of both research and knowledge based on clinical experience among researchers, educators, policy makers, and service providers.
- Link people, ideas, and resources to foster channels that provide relevant, evidence-based resources, innovations, and new information, as well as learning development opportunities, in a timely manner to the change champions and individuals using that knowledge, thereby facilitating the translation of knowledge into practice.

#### *Knowledge Awareness*

- Integrate activities in dementia care at a number of levels from macro to micro (e.g. government and LHINs to non-governmental agency leaders and staff, academics and researchers, planners, care and service providers, Dementia Networks, service coalitions, seniors, people with dementia and their families, volunteers, advocacy groups).
- Coordinate access to technology that facilitates knowledge transfer (e.g. AKE, Physicians website).
- Provide a one-stop website to access knowledge and opportunities for collaboration to meet the growing and changing needs of people with dementia.

#### *Knowledge Utilization*

- Continue to build an interactive exchange component to link clinicians through opportunities for dialogue, exchange of ideas and information, collaborative project development, and peer or expert support forums for enhanced communication and sharing of lessons locally, regionally, and provincially.
- Promote partnerships and developments at the provincial, regional, and local levels.
- Promote prevention and health with community and society involvement.

#### *Knowledge Retrieval and Accumulation*

- Provide a web-based clearing house and a central electronic repository of knowledge and resources in dementia care.
- Incorporate existing *Alzheimer Strategy* initiative websites and link to other information sites, including printed and video materials, and receive usable information from the field.
- Support the development of innovation by identifying, cataloguing and disseminating innovations in practice as well as identifying needs and developmental directions for dementia in Ontario.



## **APPENDICES**

- Appendix 1: Health Human Resources Strategy Task Force – Terms of Reference
- Appendix 2: Process Mapping Report
- Appendix 3: Health Human Resources Strategy Task Force Work Group – Framework for Dementia Care Education
- Appendix 4: Recommended Core Competencies in Dementia Care
- Appendix 5: Building a Dementia Care System.

## **APPENDIX 1: HEALTH HUMAN RESOURCES STRATEGY TASK FORCE - TERMS OF REFERENCE**

### **Background**

Ontario's five-year Alzheimer Strategy (1999-2004), through its ten initiatives, has garnered greater understanding of the needs of persons with Alzheimer Disease and related dementias (ADRD) and their partners in care. Some of these initiatives continue to receive funding support.

It is estimated that approximately 8% of Ontario's population over the age of 65 have ADRD. With the increasing number of seniors in an aging population, the number of people with ADRD in Ontario is projected to rise rapidly in the future and the supports required will become even greater.

### **Purpose**

Ontario's ability to provide access to high quality, effective, client-focused and safe health services and care for people with ADRD and their partners in care depends on the right mix of health care providers with the right skills in the right place at the right time. This provincial Task Force will build an overarching ADRD Health Human Resource (HHR) Strategy using a strategic and systems approach to provide planning advice to the Ministry of Health and Long-Term Care (MOHLTC), the Ministry of Training, Colleges and Universities, Local Health Integration Networks (LHINs) and other stakeholders.

The Task Group is established under the auspices of the Alzheimer Strategy Transition Project and will facilitate the ongoing development of an ADRD *Strategy* and build on current initiatives resulting from the Alzheimer *Strategy*. The mandate includes providing advice and recommendations for integration and enhancement of health human resources. A key outcome will be a cross-sector Framework for Dementia Care Education.

### **Membership**

The membership will bring together expertise in the areas of HHR and ADRD and will reflect regional and diverse perspectives of:

- consumers and caregivers
- policy makers
- planners
- academics/researchers
- educators
- service providers

From time to time, content experts will be invited to attend meetings of the Task Force.

### **Scope**

The HHR Strategy Task Force will provide advice and make recommendations concerning human resource issues related to the continuum of education, training, and continuing education for family physicians, professional staff, unregulated front line workers, and informal service providers and volunteers. This will include building and creating new solutions such as a Framework for Dementia Care Education. Recommendations will be specific to policy makers and transfer payment agencies involved in education and in the care and service of people with ADRD.

## Objectives

1. To facilitate the development and enhancement of an ADRD Strategy and improve the ongoing development and enhancement of care to those with ADRD across the health care continuum.
2. To acknowledge the importance of the *knowledge/evidence to practice cycle* and the value added from building partnerships across LHINs and with a broad range of stakeholder groups in order to prepare health care and informal teams through education, training and continuing education.
3. To develop a framework that provides a coordinated menu of base level training and education within educational and academic institutions in health, social services and allied health sectors which is competency-based, linked to standards of practice in dementia care and measured against performance evaluations.
4. To support integration and linkages between networks and service providers to enhance access to trained staff and volunteers for persons with ADRD and their partners in care.
5. To support the continuums of care across the senior/elder care, mental health & addictions and chronic disease management sectors.
6. To leverage lessons learned from other Health Human Resource Strategies.

## Activities

The HHR Strategy Task Group will plan its activities using a priority-setting and consensus-based approach. Ad hoc work groups will be created to carry out the tasks required.

It is recommended that the HHR Strategy Task Force:

1. Familiarize itself with contributions made during the Alzheimer *Strategy* transition period including the Alzheimer Knowledge Exchange, the Provincial Alzheimer Group, the Roundtable on Future Planning for People with ADRD (Roundtable), the Advance Care Planning Group (ACP), Research Priority Setting Project, Physicians Education Project, and the Staff Training and Education Steering Committee.
2. Conduct a review of similar framework/resources currently developed and/or in development including the Ministry of Health and Long-Term Care, Public Health HHR Strategy, LHIN HHR reports and other models and frameworks from other jurisdictions.
3. Consider ways in which the ADRD HHR Strategy could both learn from and interface with other initiatives and sectors such as chronic disease management, mental health and addictions, senior/elder care, primary care, end-of-life care and heart and stroke. This will include building on the work of other provincial/LHIN HHR strategies/resource plans.

## Deliverables

The Task Force will:

1. Develop a framework that will facilitate the advancement of an on-going ADRD Strategy through a Framework for Dementia Care Education. This framework for education and training will span the continuum for all professional groups to front-line workers and volunteers. This will include principles, values, practices, and core competencies that will support education, training, continuing education, recruitment, retention, leadership, evaluation, and accountability. The framework will clarify roles, responsibilities, and linkages for current initiatives such as:
  - a. **The Alzheimer Society of Ontario** – public and professional training through its chapters.
  - b. **Physicians Education Project - Opinion-Leader Program** (a mentorship program for family physicians who can influence practice), **Peer Presenter**

- Program** (a program supporting family physicians with ADRD expertise providing education to peers), and **Preceptor Program** (where teachers/preceptors from academic medicine training programs use educational resources on dementia and teach strategies while supervising and teaching future family physicians).
- c. **The Alzheimer Knowledge Exchange** – a framework to ensure an effective knowledge to practice cycle and increase awareness of various initiatives and activities related to ADRD.
  - d. **Ontario Community Support Association (OCSA)** – provision and coordination of all training for all sectors including community and long-term care homes, specifically U-First! training (where it is now housed).
  - e. **Staff Education Steering Committee** – post strategy committee to oversee the delivery of funded P.I.E.C.E.S. and U-First! education sessions and dementia network grants.
  - f. **P.I.E.C.E.S.** – an education curriculum geared to the health care profession including physicians in LTC and in community settings.
  - g. **Advance Care Planning**
  - h. **Dementia Networks** – enhanced role
  - i. **Education for Healthy and Safes Places to Live and Work Collaborative Group**
  - j. **Ontario Safety Association for Community and Health Care**
  - k. **Gentle Persuasive Approaches in Dementia Care**
  - l. **Murray Alzheimer Research and Education Program (MAREP)**
  - m. **National Initiative for the Care of the Elderly (NICE)**
2. Advise on the optimal roles for Psychogeriatric Resource Consultants, Public Education Coordinators and Psychogeriatric Resource Persons including the supports that should be available from their host agency.
  3. Provide advice concerning establishing and maintaining a Centre for Best Practices in Dementia Education.
  4. Provide advice/recommendations for other ADRD HHR Strategy issues that arise from an environmental scan and Task Force experience including:
    - a. **Science and Technology**
      - Network computers are reshaping concepts of diagnosis and treatment
    - b. **Demographic Influence and Globalization**
      - Aging population impacts both the incidence of the disease and the supply and demand of the workforce
    - c. **Recruitment and Retention**
      - Aspects of quality of work life including safety, environment, compensation, and job protection
    - d. **Evaluation and Performance**
      - Developing indicators and measurements to evaluate performance and outcomes thus establishing system accountability
    - e. **Delivery System and Partnership Opportunities**
      - Disease management, standardization of processes, and new partnerships in education and training

**f. Consumer Expectations**

- How the components of the strategy will add value and meet consumer expectation
5. Participate in establishing a Knowledge Exchange Advisory Group.
  6. Submit a report and recommendations, including action steps, to the Alzheimer Strategy Transition Project by February 2007.

**Working Groups:**

The Task Force will establish the following Working Groups and augment Task Force representation with other stakeholders who have expertise in the area of focus:

- Framework for Dementia Care Education
- Centre for Best Practices in Dementia Education<sup>21</sup>

**Membership**

Co-Chairs: Dianne Anderson, Project Manager, HHR Strategy (Lead)  
Scott Macpherson, Alzheimer Strategy Transition Project Manager

Members: including the following representatives:

- At least one person who specializes in HR
- Representative from Ministry of Training, Colleges and Universities
- MOHLTC representation from: Mental Health and Addictions, Senior/Elder Care, Chronic Disease Management, Primary/Community Health Care, Health Human Resources
- Alzheimer Society of Ontario
- Alzheimer Knowledge Exchange
- Ontario Community Support Association
- Physician's Education Project
- P.I.E.C.E.S. representative
- Murray Alzheimer Research and Education Program (MAREP)
- Psychogeriatric Resource Consultants, Public Education Coordinators, Psychogeriatric Resource Persons
- Long-Term Care providers
- LHIN Directors of Planning, Integration and Community Engagement
- Diversity Expertise
- CCAC Representative
- Research Community Representative
- Colleges and Universities
- Consumer representative

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<sup>21</sup> Instead of establishing a work group, consultations were held at the SHRTN Assembly (March 29, 2007), with the Ontario College of Family Physicians, Physician Education Project (March 30, 2007) and with the Roundtable and PAG (April 10, 2007).

- Staff, Alzheimer Strategy Transition Project

**Preparation of Agenda/Minutes/Committee Support:**

Staff Member, Alzheimer Strategy Transition Project

**Responsibility of Members**

- Participate in all scheduled meetings/teleconferences
- Participate on Working Groups
- Review information and provide feedback/input within seven business days

**Accountability**

The final report will be due by the end of February 2007 and will be prepared for the Alzheimer Strategy Transition Project with recommendations to the Ministries, LHINs, and stakeholder groups.

## **APPENDIX 2: PROCESS MAPPING REPORT**

### **Alzheimer's Disease and Related Dementias (ADRD) Human Resource's Strategy**

#### **Process Mapping Report**

**January 11, 2007**

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**Tazim Virani  
Tazim Virani & Associates**

**Alzheimer’s Disease and Related Dementias (ADRD)  
Human Resource’s Strategy**

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## Alzheimer's Disease and Related Dementias (ADRD) Human Resource's Strategy

### PROCESS MAPPING REPORT

#### **Purpose:**

Identify areas of opportunity and gap where strategies can be used to enhance human resources to treat and care for people with ADRD.

#### **Objectives:**

1. Define the key processes in the following broad activity areas: advocacy, policy formulation (MOHLTC, MTCU), programmatic strategy development, curriculum development, education of care providers, implementation of provider roles, continuing education and promotion of best practices.
2. Identify areas of opportunity and gap for enhancement of human resources competencies and capacity. Limit initial activity for the following three groups: physicians, nurses, personal support workers.

#### **Methodology:**

1. December 18, 2006 – Meeting with Task Force to ensure clarity of Process Mapping Activity TOR and areas to focus process mapping activity. Additionally, identify names of stakeholders for each broad activity area.
2. January 3 – 10, 2007 – Data collection – interviews with groups of stakeholders and/or individual stakeholders. See Appendix A for full list of stakeholders.
3. January 11, 2007 – Preliminary presentation and working session with Task Force members.
4. January 22, 2007 - Report with complete analysis and recommendations.

#### **Findings:**

1. Nine key informant interviews were held as well as one 2 hour focus group session with 6 members of the task force. See Appendix A for names of participants.
2. The following are summary themes from the interviews, listed under each broad process activity:
  - a) **Advocacy** (*any activity that leads to influencing a change in knowledge, attitude or action*)
    - Having key champions or ADRD knowledgeable persons participate in relevant health human resources task forces/round tables. There is a need to ensure priority is given to ADRD implications for human resources.
    - As all of the Local Integrated Health Networks (LIHN) are establishing Human Resource Strategy Advisory Groups, participation or linkages with these groups would assist in ensuring transfer of ADRD related issues, concerns, knowledge for deliberation and recommendations. See Appendix B for sample terms of reference for LIHN advisory group.

- Professional Associations such as the Ontario Medical Association (OMA), Registered Nurses' Association of Ontario (RNAO), Registered Practical Nurses' Association of Ontario (RPNAO) have a strong tradition of advocating on discipline specific human resource requirements for the province. These groups are key in advocating on mutually agreed upon messages. For example, The RNAO has been successful in lobbying for 70:30 full-time to casual staffing complements; strategies such as the late career initiative to maintain experienced nurses in the field; bridge programming for foreign trained nurses; recruitment and retention programs, etc.
- Linking/integrating with existing initiatives e.g. Quality of Work life initiative – CCHSA; Safety initiatives
- Ensuring key champions are identified to assist in advocacy work. This should include champions in the political realm such as Member for Parliament, Ministers, and the Provincial Premier.
- Creating partnerships with identified groups that have similar aims or similar end goals. E.g. seniors groups, mental health coalitions, chronic disease management related groups.
- Advocacy efforts should not only be directed to key decision makers such as government ministries (labour, health, seniors, health promotion, colleges/universities, and education), other funding agencies but also other identified stakeholders, e.g. unions.
- Ensure clear set of issues are identified, with clear messages and back ground information to allow for targeted advocacy work on human resources for people with ADRD.

**Recommendations** made by stakeholders include:

1. Establish an inventory of all LHIN HRS Advisory Groups and communicate need for population specific human resource considerations
2. Identify key associations to involve in monitoring and advocacy role – define mutually beneficial platforms
3. Identify key champions, alliances to champion platforms
4. Define key Quality of Life indicator reports for population.
5. Support key areas to advocate – e.g. funding areas

**b) Policy Formulation** (a process whereby the result leads to investment in a defined area and/or mandating of action)

- Funding for continuation of specific programs that were funded by the Alzheimer's Strategy and have been proven to be effective e.g. peer presenter program, Dementia Networks
- Examine models of fair remuneration and establish equity in remuneration across health care sectors for all health care providers. Specifically, health care providers in the community sector were not equally compensated resulting in drain from community to other sectors.
- Collaborative teams are needed for the care of people with ADRD in all sectors. These teams include formal, informal caregivers, family and the person with ADRD and need to be inter-disciplinary.
- Accountability for appropriate (right people with the right skills at the right time and the right place) human resources can be facilitated through service agreements between LHINs and provider organizations. Targets need to be defined (this can be challenging). Caveat: Population specific human resource funding has never happened.
- Consider expansion of roles of existing human resources. E.g. Nurse Practitioner role in dementia care.

**Recommendations** made by stakeholders:

6. Continue funding existing proven programs e.g. Peer presentation program, Dementia Networks
7. Ensure equity in remuneration amongst geriatricians, community based nursing staff and community based Personal Support Workers.

8. Ensure LHINs include population based human resources planning and allocation of resources.
9. Establish dementia expertise within Nurse Practitioner roles across sectors.

**The following are the Human Resource Strategy Task Force's additional recommendations:**

Create an over-arching leadership group (Dementia Leadership Institute) that would take on a major advocacy function as well as coordination and monitoring functions using defined quality indicators.

Identify and involve key groups and champions as members of the Dementia Leadership Institute. These would include: Consumer groups, Planners 7 Policy Makers, Researchers, Educational Institutions, Non-Governmental organizations and Service coalitions and Service groups.

Establish funding avenues for research to direct health human resource policy and education. Ensure structures, processes, incentives are available to translate the research into practice.

**c) Program Strategy (an approach to making it happen; "it" may be a policy, decision, program, etc)**

- LHINs are at a very early stage in their establishment but this may be a good time to ensure that dementia care and human resources implications are built into their planning.
- As there are multiple agendas at play in the province currently and likely in the future, it would be advantageous to link the dementia agenda with other broad agendas such as with care for seniors agenda, mental health, chronic illness, broader provincial and federal human resources strategy.
- Family physicians continue to have inadequate knowledge re dementias; as well as not have adequate supports in the community for follow up, services, etc.
- Many stakeholders spoke about the lack of involvement of receivers of care in the planning of policies, programs and services. Models such as the chronic management model also allow the expansion of stakeholders beyond the traditional groups and include other groups such as public service works (transportation, municipal services), etc.
- There continues to be a sense that there are limited funds and the funding is not earmarked for long term, sustainable approaches. This puts a lot of strain on interventions from a programmatic perspective.
- Profile of PSW is changing and this knowledge is not currently available or where available, not disseminated broadly. There is a current "turnover of PSW" study. The findings will be important for creation of knowledge of the PSW current profile and understanding of trends in this discipline.

**Recommendations** made by stakeholders include:

10. Develop a strategy to provide on-going dementia related information to the LHINs. Establish a regular contact with LHINs to explore linkages.
11. Ensure existing human resource programs have a coordinated linkage through PEER Presentation programs; use of knowledge networks
12. Promote use of participatory action processes, community development approaches, social change models
13. Use alliances/partnerships to conduct long term planning and use short term funding opportunities to push forward the long term plan
14. Assist in broad dissemination of the latest evidence on human resources e.g. findings and implications of the PSW turnover study.

**The following are the Human Resource Strategy Task Force's additional recommendations:**

The recommendations from the stakeholders were acceptable to the task force with the following alterations:

Need to consider programs beyond the physician based programs and include other programs that include other stakeholders that require coordination.

Resources need to be allocated for building partnerships.

Partnerships must include people with ADRD and their families in decision making.

Establish a certification process for organizations that meet specific requirements for a dementia friendly environment. Ensure funding levels are not compromised for prevention activities as they are currently in long-term care.

d) **Education/Continuing Education/Curriculum** *(formal or informal acquisition of knowledge, skills and attitudinal changes; occurring post formative period of learning and usually when the learner is in the work force; a defined set of educational objectives, standards with related content to be used to educate a target)*

- Lack of educational spots for post family practice specialization.
- Inconsistent inclusion of dementia education in curriculum of all disciplines
- Medical school exams include dementia questions – strategy of ensuring curriculum includes dementia learning
- LHINs working with academic partners but at early stages
- Professional associations have links with academic institutions
- PSW curriculum has not been revised since 1997
- Need for adequate preceptors who are interested and enthusiastic professionals
- Need to link educators with teaching resources in dementia
- Best practice information lacking
- Lack of ability of the context to receive, support and enable trained staff to implement best practices

**Recommendations** from stakeholders:

15. Advocate for mandatory inclusion of dementia education in all relevant health care disciplines. Will need to review curriculums across the province on a regular basis to ensure dementia curriculum content is not lost when curriculums are revised.
16. Include dementia exam questions in nursing, medical and personal support worker educational programs. Will need to examine questions on a regular basis to ensure dementia related questions continue to remain in the database of exam questions. Explore examination processes to influence inclusion of dementia. Need to establish structure and process of monitoring curriculum and exams every 4 years.
17. Establish close working relationships with Ministry of Colleges & Universities as well as organizations that oversee vocational educational programs for PSWs.
18. Disseminate information on competencies to all relevant schools, regulation and accreditation bodies.
19. Need review and updating of PSW curriculum
20. Develop strategy to ensure target groups have adequate and competent preceptors, mentoring/coaching in dementia
21. Promote the use of RNAO's Advance Clinical/Practice Fellowship program to develop expert preceptors for registered nurses in ADRD
22. Establish communities of practice for educators teaching dementia – to share best practices in dementia education.
23. Market knowledge exchange website to educators

24. Sort, disseminate and support use of existing context enable programs
25. Establish Center for Best Practice in Dementia Care
26. Involve professional associations in above.

**The following are the Human Resource Strategy Task Force's deliberations and additional recommendations:**

Influencing accreditation standards and processes for various educational and vocational education programs.

In addition to dissemination of best practices on dementia, it would be important to disseminate best practices on gerontology, confronting ageism, etc. These broader topic areas should be in curriculum as a lead in to dementia.

Establish a strategy for continuing education programs to respond to emerging (societal) issues, workplace issues, etc. Having courses available when needed when new issues come along. E.g., people with Down's syndrome move into long term care and facilities not being prepared for that.

Establish a certification process for those individuals specializing in dementia care.

Create opportunities for nursing student placements in the community as part of their early exposure to nursing and to health of seniors. Currently, nurses receive their first clinical placement and introduction to seniors in long-term care homes.

e) **Implementation** (*issues and strategies to ensure HR roles are enacting what they are meant to enact*)

- Lack of clarity on provincial versus LHIN role in issues of assessment of human resource availability and requirements.
- Inherently, there are challenges in defining and determining human resource targets
- Lack of clarity on roles of physicians (may also be the case for Nurse Practitioners) in dementia care management – especially, with respect to LTC but also community
- Inadequate systems to support shared approaches to care management (i.e. collaborative approaches)

**Recommendations** from stakeholders:

27. Need links with provincial Health Human Resource Strategy
28. Create forums to discuss and come to consensus on the roles of different health care providers, informal providers, others. This may be linked with the work on competencies but not limited to it.
29. Explore and encourage implementation of collaborative models e.g. with Family Health Teams
30. Use of local communities of practice approach as a possible model of shared approaches.

f) **Coordination** (*activities that help different parts of the system work with each other*)

- One of the main roles of the new LHINs is to assist in integration and coordination of the health care system.
- There have been many innovations and a lot of uncoordinated initiatives
- We do not need to create new systems, it may be better to use existing infrastructures

**Recommendations** of stakeholders include:

31. Need to align dementias with one of LHIN priority areas – e.g. Seniors, Chronic Diseases, Mental Health
32. Need frameworks and tools that will assist organizations select appropriate programs, initiatives, educational resources, etc for their local use. E.g. Algorithm on selecting appropriate educational resources.
33. Existing programs need to be contextualized for their local use. Assistance in helping organizations translate resources and programs for their local context need to be provided.
34. Role of Dementia networks should continue to take on greater role in coordination and monitoring of ADRD programs and initiatives.
35. The role of Alzheimer’s Knowledge Exchange as a connecting role needs to be promoted and maximized.

**The following are the Human Resource Strategy Task Force’s additional recommendations:**

LHINs need to link ADRD planning and monitoring with their targets of “seniors” health, Mental health and addiction and Chronic disease management.

The establishment of a Dementia Care Institute (DCI) would allow for coordination at the macro level. The DLI can provide advisory/advocacy role in conjunction with Alzheimer’s Society for Ontario.

g) **Recruitment & Retention** (*attracting new HR resources in a field and after a formative induction, keeping the resources without turnover or loss*)

- Shortages in physicians and nurses – especially acute in the North
- Need for bilingual human resources in pockets of Ontario
- Field of dementia care not attractive for care providers to specialize in
- Those who are taking on the dementia work are not always the “right” type of individuals
- Societal values for the elderly, care of people with dementias

**Recommendations** made by stakeholders include:

36. A clear recruitment and retention strategy for human resources for ADRD in Ontario needs to be planned, funded and executed with the involvement of relevant multi-stakeholder involvement.
37. Need to create compelling case/career path and incentives to attract new human resources.
38. Need to explore approaches that may assist in screening for the “right” pre-requisite aptitudes within those who may be considering a career in the ADRD field.
39. Any recruitment and retention strategy must include a broader social change agenda in order to create a long term, sustainable approach.

h) **Quality of Work Life** (*nature of how individuals respond to their work situation based on work environment conditions*)

- Physicians getting burnt out due to lack of supports in the community, not getting adequate compensation, not valued by peers and unable to do good practice.
- PSWs in community holding multiple jobs due to the nature of CCAC contracts – getting burnt out.
- Large number of PSWs using the PSW role as a job from which to springboard to other skill sets and higher paying work.
- Heavy workloads for care providers
- Concerns of safety of staff

- Issues of respite for family and other informal care providers
- Work life indicators now developed and being promoted across Canada by Canadian Health Services Accreditation – all indicators link to patient outcomes

**Recommendations** made by stakeholders include:

40. Use of work life indicators as part of monitoring indicators
41. Uses of adequate numbers of staff with right skills needs to be addressed
42. Support mechanisms such as collaborative approaches, appropriate referral sources, communication, etc – address some of the workload frustrations
43. Establish models that allow for continuity of care and advocate for necessary funding to allow this to occur

**The following are the Human Resource Strategy Task Force's additional recommendations:**

Human resources indicator monitoring should reside with the LHINs but the DCI need to have access to the reports. These indicators could include absenteeism, turnover, etc.

More research needs to occur with quality of life research from a biosocial, psychological perspective instead of a biomedical perspective. Research should include linking human resource and patient outcome indicators.

Establish a systematic process of collecting quality of life indicators.

Create action on creating safe environments for staff and people with ADRD.

Establish ways of team collaboration work in dementia care that includes all professional and non-professional disciplines, people with dementia and their families.

## **Appendix A: Process Mapping: List of Stakeholders Interviewed**

Kelly Gillis – Task Force Member, Senior Director, Planning, Integration and Engagement, South West Local Health Integration Network

Frank McGoey (referred by Anne Matte)  
North East LHIN

Marie-France Rivard; Task Force Member  
Geriatric Psychiatry Program  
Royal Ottawa Hospital

Ken Le Clair  
Clinical Director,  
Regional Geriatric Psychiatry Program  
Providence Continuing Care Centre – Mental Health Services

Melissa Barton - non-task force member  
CCHSA  
Canadian Council on Health Services

Chris Higgins  
Senior Program Analyst – Mental Health Program

Patti Boucher  
Director of clients and consultant Services  
Ontario Safety Association for Community and Health Care

Elizabeth Esteves  
Manager, Policy Initiatives  
Ontario Seniors Secretariat  
Ministry of Citizenship & Immigration

Catherine Brookman  
Project Mgr, Staff Education & Training Initiative – Alzheimer Strategy  
Ontario Community Support Association

Jan 4th group meeting: Scott Macpherson, Dianne Anderson, Cathy Conway, Katherine MacDonald, Frances Morton, Gary Schechter



## **APPENDIX 3: HHR TASK FORCE WORK GROUP - FRAMEWORK FOR DEMENTIA CARE EDUCATION**

### ***Final Terms of Reference***

#### **Background:**

In 1999, the Ontario government announced ***Ontario's Strategy for Alzheimer Disease and Related Dementias ("the Strategy")***. This was the first comprehensive Alzheimer Strategy in Canada. The government invested \$68.4 M over five years (1999-2004). The *Strategy* had four overall goals with respect to people, families and caregivers dealing with Alzheimer Disease and Related Dementias (ADRD), to:

- Improve the quality of life
- Improve treatment, care and environmental conditions
- Increase public awareness
- Develop linkages between the strategy initiatives.

When the *Strategy* ended in 2004, the government furthered its commitment by supporting a transition period (ending March 2007) to determine what was necessary in the way of commitment and resources to carry sustainability well into the future. The Alzheimer Strategy Transition Project (ASTP) was created to lead this transition.

The ASTP mandate is moving towards conclusion with a series of reports scheduled for the fall of 2006 and early 2007. The reports that will be produced are all entitled: ***ADRD-- Recommendations for Prevention, Care and Cure*** and are structured as follows:

1. Business Case to the Ministry of Health & Long-Term Care and the Ontario Seniors Secretariat, Ministry of Citizenship and Immigration
2. Business Case to Local Health Integration Networks
3. Report to Service Providers and People with ADRD and their Partners in Care
4. Health Human Resource Strategy

The Framework for Dementia Care Education Work Group will build on extensive work already done during the transition period by the **Provincial Alzheimer Group (PAG)**, the **Alzheimer Knowledge Exchange** and the **Roundtable on Future Planning for People Affected by Alzheimer Disease and Related Dementias**.

#### **Purpose:**

The Framework for Dementia Care Education Work Group will deliver a report that considers the Framework from three major perspectives:

**Acquiring knowledge:** what do we need to know? (beliefs; principles and core statements/competencies)

**Knowledge Uptake/Transfer:** tools that can be used as vehicles for learning, and required structures that support learning

**Evaluation:** evaluation of learning and performance standards.

The Work Group will consider current best practices and guidelines for education, training and continuing education in Alzheimer's Disease and Related Dementias.

The Work Group will focus on Health Human Resources involved with direct hands-on care to those with dementia. (The current scope will exclude physician education.)

The Work Group will build on the work of the Provincial Alzheimer Group, Healthy and Safe Places to Live and Work Committee, the Alzheimer Knowledge Exchange, and other recognized groups.

The Work Group will create stakeholder dialogue on the key issues of importance in educating formal and informal caregivers within the current and evolving health system.

### **Objectives:**

To develop a Framework for Dementia Care Education that will consider and make recommendations regarding:

- standards for education which have outcomes that are related to skill competencies;
- base level training and education for post-high school programs within health, social services and allied health, that is competency based;
- strategies to develop and promote ADRD specific curriculum with colleges, universities and private vocational institutions;
- Human Resource Package that includes an orientation for new hires or relocated staff who will be working in environments with clients/patients/residents who have ADRD;
- training alternatives, based on adult learning principles, that support life long learning e.g. E-learning modules or ‘*Just in Time*’ learning;
- strategies to transfer knowledge from training to best practice within the field (knowledge transfer cycle);
- opportunities to make more readily available, dementia specific resources which may be listed with, but not exclusive to the AKE; and
- strategies that support managers who promote and recognize in principle and practice, specialized knowledge and skills amongst health care workers who provide dementia care.

### **Membership:**

(Membership will first be derived from interested members of the HHR Strategy Task Force):

- Individuals and caregivers who reflect the views of people living with ADRD.
- Alzheimer Knowledge Exchange
- Community Agencies
- Educators from:
  - private colleges (Personal Support Worker program),
  - Provincial Colleges
  - Provincial Universities in Medicine, Allied Health and Social Services,
- Representative of the Alzheimer Society of Ontario and/or a Chapter
- Not For Profit Organizations such as:
  - a. Murray Alzheimer Research and Education Program, University of Waterloo
  - b. Ontario Association of Community Care Access Centres

- c. Ontario Association of Not for Profit Homes and Services for Seniors (OANHSS)
- d. Ontario Community Support Association (OCSA),
- e. Ontario Long Term Care Association (OLTCA)
- f. Ontario Retirement Communities Association (Orca),
- g. Ontario Hospital Association
- h. Registered Nurses Association of Ontario (RNAO).
- i. Registered Practical Nurses Association of Ontario (RPNAO)
- Representatives of Practice Groups such as: Advanced Practice Nurse, Registered Practical Nurse, Psychogeriatric Resource Consultant, Public Education Coordinator
- Representatives of the Alzheimer Strategy Transition Project

**Chair:** Marg Eisner, Member, Health Human Resource Strategy Task Force

**Committee Support:** Dianne Anderson, Co-Chair, Health Human Resource Strategy (HHRSS) Task Force and HHRSS Project Manager

**Accountability:** The Framework for Dementia Care Education Work Group is accountable to the Health Human Resources Strategy Task Force.

## **APPENDIX 4: RECOMMENDED CORE COMPETENCIES IN DEMENTIA CARE**

The Roundtable on Future Planning for People Affected by Alzheimer Disease and Related Dementias report on an ADRD Planning Framework, September 2006, defined Guiding Principles that form the basis for the recommended Core Competencies. This framework encompasses three planning pillars: an informed society; enabling and supportive environments; person, social, and system connectedness. The framework complements the Chronic Disease Prevention and Management Framework and considers ADRD within the context of other co-existing conditions/health care needs.

Communication plays an integral role in achieving outcomes, and as such, is emphasized as an overall goal among care and service team members in selecting, initiating, and incorporating appropriate strategies to enhance the quality of life for the individual with dementia throughout the disease process.

The core competency statements assume competence at the novice level and are outcomes to be achieved by all health and social service delivery human resources entering the workforce upon graduating from an educational institution. The competencies apply across an array of settings, including community, hospital and long-term care. Specific roles and competencies of individual disciplines/members of the care and service team will work within the core competencies as determined by their context of practice.

The Core Competencies encompass five main categories: Knowledge, Relationships, Behaviours, Teams, and the Emotional Intelligence of interdisciplinary team members. Required companion activities relate to:

- (1) Colleges and employers jointly setting discipline-specific, standard vocational outcomes for direct hands-on health care providers and social service workers
- (2) Universities and Regulated Professional Colleges including education on ADRD as part of the curriculum for interdisciplinary team professionals and clinicians
- (3) The requirement of leaders/managers to ensure that workplace systems and supports required by the care and service delivery team members build upon the core competency statements and are in place to maximize the benefits of education, training and upgrading.

### **Core Competency 1: Knowledge**

**Demonstrates knowledge of dementia in the delivery of care and its effect on the person with dementia and their family members and other partners in care.**

This will include knowledge of:

- a) most prevalent types and related causes
- b) disease processes, stages and progression
- c) diagnostic and assessment process
- d) cognitive or neurological symptoms
- e) current treatment interventions
- f) communication skills appropriate to needs of the person
- g) strategies to promote optimal quality of life
- h) experience of dementia from the perspective of the person with dementia and their family members and other partners in care

## **Core Competency 2: Relationships**

**Delivers relationship-centred care which recognizes both the uniqueness of each person with dementia and an awareness of one's own contribution to that relationship including personal attitudes, values and actions.**

This includes:

- a) contributing to the development of the relationship-centred philosophy of care;
- b) promoting and preserving the abilities and self-esteem of the person with dementia;
- c) promoting the person with dementia's integration to their environment;
- d) using effective communication and interpersonal skills when interacting with the person with dementia, family members and other partners in care, and other care providers; and
- e) understanding emotional attachment to the person with dementia and the effect caregiving has on personal emotional health.

## **Core Competency 3: Behaviours**

**Conducts an assessment and describes interventions with respect to the behaviours of persons with dementia.**

The specific competencies are:

- a) recognize that all observable behaviours have meaning and therefore the etiology of the behaviours must be assessed and accounted for in the care giving process;
- b) assess the meaning, etiology and inherent risk of behaviours using an objective, systematic and holistic process that takes into account the history of the person; physical, intellectual, emotional and functional capabilities of the person, as well as the environmental and social aspects of their surroundings; and
- c) identify strategies to prevent and respond in respectful ways to behaviours that are abilities-focused, relationship-based and age-appropriate for responding to behaviour and managing associated risks.

## **Core Competency 4: Teams**

**Collaborates and contributes as a valued member of the interdisciplinary team in the delivery of holistic care, acknowledging and respecting the strengths, contributions, relationships and the roles of team members.**

Team members include:

- a) the person with dementia
- b) family members and other partners in care
- c) inter-professional members including professional, para-professional and specialized resources
- d) front-line staff within community, acute, and long-term care
- e) non-direct care staff within community, acute, and long-term care.

## **Core Competency 5: Emotional Intelligence**

**Demonstrates the abilities associated with emotional intelligence.**

The specific competencies are:

- a) Self-awareness, recognizing and monitoring personal feelings as they happen.
- b) Management and regulation of personal emotions so they do not interfere with one's capacity to think.
- c) Motivation of oneself and one's peers to persist in the face of frustrations and continually strive to improve one's capabilities as a care giver.
- d) Recognition of emotions in others and being able to empathically attune to the subtle signals that indicate what others need or want.
- e) Connecting and working cooperatively with others.

## **APPENDIX 5: BUILDING INTEGRATED DEMENTIA CARE**

Knowledge transfer and exchange categories (e.g. knowledge generators, knowledge translators and facilitators, knowledge awareness and access providers/facilitators, knowledge users, knowledge retrieval and accumulation facilitators).

Broad categories include, but are not limited to the following categories and examples:

People with Dementia and their Partners in Care: Informal Caregivers, Persons with Dementia

Academia: Researchers, Teachers, Educators, RGPs

Government: Federal, Provincial, Regional, Municipal Provincial Associations such as OLTCA, OANHSS, OACCAC, OHA, OCSA, ASO, ORCA, OHCA

Policy Makers: Elected Officials and Ministry Staff

National Organizations

Professional Colleges and Societies

Service Providers

Service Coalitions

Provincial Support Groups

“In the Field” Innovators

Local Service Centres and Networks

Policy Institutes

Recipients of Training

Seniors Advocacy Groups

Clinical Practitioners

Peer Educators

Research Institutes

Regulated Health Professionals

Unregulated Health Care Workers

Sponsors of Education and Training Programs

General Public

Others