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  What We Heard
The Women’s Christian Association (WCA) has set a ten-year goal to be a leader in dementia care by 2022. The WCA is exploring what it means to be a leader in dementia care to determine options for the WCA to consider in pursuit of this goal.

The WCA is a registered charity serving those in need in the London community since 1874. The WCA owns and operates McCormick Home, a 160 bed long term care facility and Alzheimer Outreach Services (AOS) which provides day programs for those with Alzheimer disease and related dementias as well as support programs to caregivers. A community-based, volunteer board of directors governs the WCA. Steven Crawford, CEO; Sheila Brown, Administrative Assistant; and Monica Fleck, Director of Communication are the only employees of the WCA. McCormick Home and AOS have their own management teams and staff.

To help the WCA achieve this goal, Gestalt Collective (GC), a knowledge brokering consultancy, was hired to undertake a review to:

- Identify what it means to be a leader in dementia care
- Identify the elements required of successful centres of excellence and learning
- Include a review of relevant initiatives in the province or elsewhere
- Identify potential partners
- Include an assessment of WCA’s current strengths and weaknesses
- Identify realistic options for WCA to consider, including an assessment of the risks and benefits of each option
- Identify the preferred options including rationale
- Include an implementation plan with estimated phases, timelines and costs
DEMENTIA LEADERS CONSULTATIONS

WHAT WE DID

From February through April 2013, the WCA worked with GC to consult with internal and external stakeholders and received feedback in relation to the WCA's goal to become a leader in dementia care. The purpose of these consultations was to enhance awareness of the WCA and yield advice from stakeholders within the context of their experience and awareness of dementia care practice in London, throughout Ontario and across Canada.

GC worked with the WCA to develop a purposive sample of key leaders in dementia care and representatives of organizations with a potential interest in future collaborations with the WCA as well as members of the WCA Research Advisory Committee, the Strategic Planning Committee and staff. Stakeholders were invited to participate in either a 1-hour, one-on-one telephone interview or one of two (2), 2-hour online knowledge exchange roundtables (See Table 1 for Consultation Activities and Timeline).

Consultation questions were derived using the STEEPLED and SWOT frameworks (Figure 1).

All stakeholders consulted by telephone interview and online knowledge exchange roundtable were asked his or her thoughts on:

- The current social and cultural considerations affecting dementia care
- Technologies influencing dementia care
- The important economic factors affecting dementia care
- The status of “dementia-friendly” or “age-friendly” environments
- Key political drivers affecting dementia care
- Current and impending legislation that may affect dementia care
- Current and impending opportunities to build capacity of the current and future dementia-care work force
- Population considerations affecting dementia care

Figure 1. STEEPLED and SWOT frameworks
Internal stakeholders were also asked their perspectives on:

- What the WCA brings to the dementia sector
- What the unique challenges are faced by the WCA
- What they see as opportunities in the dementia sector for the WCA
- What could threaten the WCA's ability to achieve their goal

Internal stakeholders are those who work with the WCA, McCormick Home, and AOS, as well as current partners within the southwest region.

External stakeholders were asked what it means to be a leader in dementia care and opportunities for leadership in dementia care. External stakeholders are individuals and organizations that influence or are influenced by the work of the WCA and the dementia care sector in Canada.

The SWOT findings outline perceptions specific to the WCA's capacity. These findings will be leveraged for internal use only and will not be provided within this consultation summary. For information regarding the SWOT outcomes, please contact the WCA.

INTERVIEW METHODS
GC contacted and interviewed eight (8) individuals by telephone. An email invitation including the purpose of the project and the topics to be covered in the interview was used in contacting and arranging a time by the interviewer. An Interview Guide was developed and used to focus and capture the interview discussions. The stakeholders interviewed (and to be interviewed) are outlined in Table 2.

KNOWLEDGE EXCHANGE METHODS
GC facilitated two (2), 2-hour online knowledge exchange roundtables to engage stakeholders and learn their perspectives on the current state of dementia care and their opinions on leadership in dementia care:

1. "Looking Out and Looking In" Webinar for members of the WCA Research Advisory Committee, the Strategic Planning Committee and staff (See Table 3 for a list of participants)

2. "Dementia Leaders’ Roundtable" Webinar for regional, provincial and national leaders in dementia care (See Table 4 for a list of participants)

To recruit participants, an email invitation outlining the purpose of the project and the topics to be covered was sent and follow up telephone calls were placed as needed. A total of 19 participants took part in the online knowledge exchange roundtables using a toll-free teleconference line and webinar technology.

One GC team member led the group through discussion, a second managed the technology and a third live transcribed the discussion. In Webinar 1, participants were asked to share their thoughts and discuss dementia care and how it is affected by current social, technological, environmental, economic, political, legal, education, and demographic conditions. Participants were then asked their opinions on the WCA's strengths and weaknesses as well as what opportunities and threats may exist and have an affect on their pursuit to be a leader in dementia care. During Webinar 2, participants were asked their thoughts on first, what it means for an organization to be a leader in dementia care and second, what an organization should do to become a leader in dementia care. The transcribed notes were prepared and combined with the interview data for analysis.

ANALYSIS OF FINDINGS
The information collected was themed and topped up with the results of an informal online scan of current trends, resources and opportunities related to dementia care in Canada. The findings were then shared back with participants to gather additional feedback and validate what we heard.
### TABLE 1: CONSULTATION ACTIVITIES AND TIMELINE

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
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<tbody>
<tr>
<td>February 18 to April 5</td>
<td>Online environmental scanning</td>
</tr>
<tr>
<td>March 5 to May 8</td>
<td>One-on-one telephone interviews</td>
</tr>
<tr>
<td>March 18</td>
<td>Internal Stakeholder Knowledge Exchange Roundtable &quot;Looking Out and Looking In&quot; Webinar</td>
</tr>
<tr>
<td>April 4</td>
<td>External Stakeholder Knowledge Exchange Roundtable &quot;Dementia Leaders’ Roundtable&quot; Webinar</td>
</tr>
<tr>
<td>March 18 to May 8</td>
<td>Analysis of consultation findings</td>
</tr>
</tbody>
</table>

### TABLE 2: ONE-ON-ONE TELEPHONE INTERVIEWS (N = 8)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Organization / Affiliations</th>
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<tbody>
<tr>
<td>Bernie Blais</td>
<td>Bruyère Continuing Care</td>
</tr>
<tr>
<td>J. Kenneth LeClair</td>
<td>Canadian Dementia Resource and Knowledge Exchange, Alzheimer Knowledge Exchange, Providence Care</td>
</tr>
<tr>
<td>Paul Dickie</td>
<td>Family Caregiver &amp; General Practitioner</td>
</tr>
<tr>
<td>Elaine Gibson</td>
<td>WCA Board of Directors</td>
</tr>
<tr>
<td>Lisa Goos</td>
<td>Rotman Research Institute, Baycrest</td>
</tr>
<tr>
<td>David Harvey</td>
<td>Alzheimer Society of Ontario, Alzheimer Knowledge Exchange</td>
</tr>
<tr>
<td>Sandra Kleinstiver</td>
<td>The McCormick Home Foundation</td>
</tr>
<tr>
<td>Betsy Little</td>
<td>Alzheimer Society of London and Middlesex</td>
</tr>
</tbody>
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BY 2022
THE WCA
WILL BE
A LEADER
IN
INNOVATIVE
DEMENTIA
CARE.

TABLE 3: "LOOKING OUT AND LOOKING IN" WEBINAR (N = 7)

<table>
<thead>
<tr>
<th>Participant</th>
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<tbody>
<tr>
<td>Anne Alexander</td>
<td>WCA Board of Directors</td>
</tr>
<tr>
<td>Michael Borrie</td>
<td>South West Ontario Regional Geriatric Program</td>
</tr>
<tr>
<td>Magdalen Carter</td>
<td>Alzheimer Outreach Services</td>
</tr>
<tr>
<td>Lou-Ann Farrell</td>
<td>WCA Board of Directors</td>
</tr>
<tr>
<td>Janet Groen</td>
<td>McCormick Home</td>
</tr>
<tr>
<td>Sandra Letton</td>
<td>WCA Board of Directors</td>
</tr>
<tr>
<td>JB Orange</td>
<td>Western University</td>
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</tbody>
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TABLE 4: "DEMENTIA LEADERS’ ROUNDTABLE" WEBINAR (N = 12)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Organization / Affiliations</th>
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<tbody>
<tr>
<td>Lisa Van Bussel</td>
<td>Regional Mental Health Care</td>
</tr>
<tr>
<td>Larry Chambers</td>
<td>Alzheimer Society of Canada</td>
</tr>
<tr>
<td>Steven Crawford</td>
<td>Women’s Christian Association</td>
</tr>
<tr>
<td>Josie D’Avernas</td>
<td>Schlegel Research Institute for Aging</td>
</tr>
<tr>
<td>Dorothy Forbes</td>
<td>University of Alberta</td>
</tr>
<tr>
<td>Maggie Gibson</td>
<td>St. Joseph’s Health Care</td>
</tr>
<tr>
<td>David Harvey</td>
<td>Alzheimer Society of Ontario, Alzheimer Knowledge Exchange</td>
</tr>
<tr>
<td>J. Kenneth LeClair</td>
<td>Canadian Dementia Resource and Knowledge Exchange, Alzheimer Knowledge Exchange, Providence Care</td>
</tr>
<tr>
<td>Lisa Loiselle</td>
<td>Murray Alzheimer Research and Education Program</td>
</tr>
<tr>
<td>Carrie McAiney</td>
<td>McMaster University</td>
</tr>
<tr>
<td>Suzanne Tolban</td>
<td>Alzheimer Society of Canada</td>
</tr>
<tr>
<td>Kim Wilson</td>
<td>Canadian Coalition for Seniors’ Mental Health</td>
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Findings from the consultations have been organized as follows:

POPULATION TRENDS
CULTURE & SOCIETY
THE HEALTHCARE SYSTEM & GOVERNMENT
DESIGN & TECHNOLOGY INNOVATIONS
EDUCATION, LEARNING & CAPACITY BUILDING
LEADERSHIP IN DEMENTIA CARE

The information captured is not intended to be an exhaustive account of the current state, or a systematic review, but is meant to reflect the priorities and opinions of the stakeholders engaged in the environmental scan to provide a picture of the perceived current state and inform future opportunities for action. The findings from these consultations will inform an options and implementation strategy to support the WCA in their endeavor to become a leader in dementia care.
Population Trends

OPINIONS FROM DEMENTIA LEADERS ABOUT WHAT IS AFFECTING DEMENTIA CARE TODAY

"An additional 24 billion is needed to meet the care of our demographic" - Sinha, 2012

What we heard about population trends related to dementia care from WCA stakeholders can be organized into the following themes:

- Aging population
- Risk for dementia and other complex chronic disease
- Access to informal caregivers
- Implications of the sandwich generation
- Family economics

AGING POPULATION

Participants identified that the most obvious pressure on the current system that provides care for persons with dementia is the aging population, resulting in growing numbers of people at risk for dementia and requiring complex care for both the dementia itself and the often present comorbidities. The participants acknowledged statistics and trends associated with the aging population are well documented.

DEMENTIA AND COMPLEX CHRONIC DISEASE RISK

Given the population pressures, participants expressed the importance of raising awareness of the risks associated with dementia, many of which are also risk factors for other diseases, especially cardiac diseases (e.g. high cholesterol and blood pressure) (Rising Tide, 2008). Promoting healthy bodies and healthy brains was seen as having multiple benefits as a prevention strategy. Participants noted that healthcare heavyweights such as the World Health Organization strongly endorse primary and secondary prevention models and national policy and planning includes raising awareness, timely diagnosis, commitment to good quality continuing care and services, caregiver support, workforce training, prevention and research (WHO, 2012). Countering risk factors for vascular disease, including diabetes, midlife hypertension, midlife obesity, smoking, and physical inactivity, was viewed by participants as an important investment, particularly in lieu of a cure for dementia (WHO, 2012).

ACCESS TO INFORMAL CAREGIVERS

Participants identified the problem of an aging population that requires more complex care coupled with the decrease in fertility rates is resulting in fewer children to care for their parents as they age (Eldercare Stats Can Report, 2008). Participants noted that these population changes will lead to a subsequent increased demand on community-based care services. In addition, it was felt that as children aren’t staying in the same geographical area as their parents, the risk of isolation will increase and also increase the burden on the community-based care sector.

THE SANDWICH GENERATION

The dynamics of families have changed significantly in the last few decades. Participants noted that Baby Boomers (people currently between 45 and 60 years of age)
are a generation that tended to delay marriage, postpone having children, and have contributed to the increasing participation of women in the workforce. Boomers now live in a world of paid work, caring for children (with more adult children still living at home) and increasingly long-lived parents and friends. It was identified that the children of boomers are also delaying their life-transitions, which in the coming years will result in adults caring for both parents and children at the same time, increasing demands on informal caregivers and the capacity for children to care for their parents.

**FAMILY ECONOMICS**

It was felt that the increasing rates of dementia were having an earlier impact on family economics (who may have been ‘planning’ for more health issues later in life). Participants identified that, without the supports in place to age and be cared for in the home, retirement homes will become increasingly popular as a housing solution. It was noted that The Ministry of Health and Long-Terms Care is currently working to put standards on retirement homes in response to this shift in where care is taking place. Participants also raised that people with dementia and their families also face significant financial burdens due to care options and loss of income (WHO, 2012). It was identified that in this economic downturn, and linked to the trend of delaying life-transitions, unemployed children who are living with and caring for their parents may support themselves by way of their parents savings.

**EVIDENCE:**

**Culture & Society**

**OPINIONS FROM DEMENTIA LEADERS ABOUT WHAT IS AFFECTING DEMENTIA CARE TODAY**

"There is an expectation for an instant coffee response for something that requires percolation" -Participant

What we heard about Canadian culture and societal issues related to dementia care from WCA stakeholders can be organized into the following themes:

- The informed health consumer
- Health resource allocation
- Institutionalized care
- Fear and stigma
- Challenges tailoring to diverse communities
- Risk aversion

**THE INFORMED HEALTH CONSUMER**

Participants identified that both persons with dementia and their caregivers are more informed; they are perceived as demanding, assertive and as having very high expectations for personalized, always-available one-to-one care. In addition, it was identified that the impact of the Internet and mobile technology has contributed to a generation of older persons that is technologically savvy, enabling both self-directed information and a desire to be individualistic and independent.

**HEALTH RESOURCE ALLOCATION**

"We need to re-think what growing old means" -Participant

It was strongly felt by participants that continuing research related to curing dementia and improving care is critical; however, given that a cure is not imminent, participants identified the importance of continuing to fund, and increase resources allocated to social programs that support the person and family. These programs, including non-profit organizations and their mandates, were viewed as a necessary complement to required medical interventions.

In addition, participants noted a need to better balance long-term treatment care plans and advance care planning with planning for quality of life. It was felt that resources spent to lengthen life regardless of quality, could possibly be re-allocated and that a conversation needs to start about reconciling quality of life with length of life.

**INSTITUTIONALIZED CARE**

Institutionalized care was perceived as being more socially acceptable. Participants identified that fewer families have the ability to care for older family members due to the competing demands of caring for children and parents at the same time as a result of delayed life transitions and economic pressures. Retirement or other private homes were seen as becoming increasingly popular as housing options and being marketed as being able to provide specialized care for persons with demands.
FEAR AND STIGMA

“In our favour there is a lot of awareness about aging and dementia. BUT there are still myths about what dementia is and is not.”

-Participant

Another cultural consideration prevalent in the current context is that of increasing fear, in part due to stigma associated with dementia. Demographics are changing - “50% of persons in long-term care now live with dementia”; participants felt that this shift is impacting the comfort level of other families looking to move loved ones in. Participants noted that the recent and well-publicized incidents of violence and resident abuse in long-term care homes has contributed to an increasing fear of behavioural issues associated with dementia. This fear has added to the already existing stigma and decreased cultural value placed on older adults. Participants felt there was a need to address the fears and stigma and ensure people have correct information through early, accurate and effective education.

Participants did identify that significant strides in terms of aging and dementia awareness had been made. In particular, it was identified that the conversations about mental health, dementia and suicide have been changing of late (i.e. acknowledging the risk of suicide in those with dementia or mental health).

CHALLENGES TAILORING TO DIVERSE COMMUNITIES

It was identified that there are significant challenges tailoring service to ethnically diverse communities. Factors of immigration have changed, the demographics in the London region, across Ontario and Canada have changed and it was felt that newer populations have not been reached and serviced well.

RISK AVERSION

Participants identified that Canadian culture is risk averse and liability conscious. They noted that there was a tension between the autonomy of the older person for decision-making and dependency for assistance. Safety was perceived as a main driver for care and as a result it was felt that service providers lose focus on enabling the person’s autonomy and self-respect.
The Healthcare System & Government

OPINIONS FROM DEMENTIA LEADERS ABOUT WHAT IS AFFECTING DEMENTIA CARE TODAY

What we heard about the Canadian Healthcare System and Government as it relates to dementia care from WCA stakeholders can be organized into the following themes:

- Readiness
- Community-based care
- Funding issues
- System navigation and fragmentation issues
- Health human resources

Readiness

Ontario is moving forward in developing its Seniors Care Strategy, which will help older Ontarians (age 65 and older) stay healthy, live at home longer and receive the right care, at the right time and in the right place (MOHLTC, 2013). Participants identified that there are an increasing number of high-profile Canadians talking about dementia, coupled with government-based legislation and initiatives such as the Seniors Care Strategy, the Behavioural Supports Ontario project, the Excellent Care for All Act and others, and that there is an appetite for change in the way care is provided for persons with dementia and their families.

Community-based care

Participants felt that with people remaining in the community longer (until they are frail) and entering long-term care homes with a higher level of needs, there is a desirability for people to age at home that can not be met by the current community care infrastructures and systems of support. Participants also noted that the current government focus on aging through the release of recommendations related to a Seniors Care Strategy has further increased pressure on community care. It was felt that the community care sector was drastically under resourced and unable to provide the quality of care needed now, and will continue to be needed as more people develop dementia and other complex chronic diseases. Without increased funding for community capacity it was felt that aging in place was not yet possible.

Funding issues

While important, participants identified that new information regarding the costs associated with healthcare from the Institute of Clinical Evaluative Sciences and the Canadian Institute for Health Information has pulled attention away from the people needing care and focused more on the economics and issues related to the sustainability of the system.

Through the Excellent Care for All Act, there is a Health System Funding Reform moving Ontario’s healthcare system away from a global funding system towards what is known as Patient-Based Funding (PBF). Participants thought this change might eventually positively change community care funding and negatively affect long-term care funding.
SYSTEM NAVIGATION AND FRAGMENTATION

Participants identified significant communication challenges across care settings. They felt the “parade of services in the community” was overwhelming to families and that the current system doesn’t support people well, despite the pressure currently faced by the Local Health Integration Networks to provide the “right care settings”. They identified that there is opportunity to improve transitions between care settings that require communications between partners and facilities. Participants that are long-term care and community care consumers identified challenges in the communications among primary care, home care and outreach services in regards to care for persons with dementia.

HEALTH HUMAN RESOURCES

Participants identified issues related to Health Human Resources (HHR). It was felt that HHR continue to improve their dementia care practices, however, there are not enough people to do the work well. Participants that are long-term care consumers identified issues related to the lack of support for part-time staff, relative to that for full-time staff, to develop in-depth person-centred knowledge that would guide care.

It was felt that there is a pressing need to both attract students to the field and engage in task-shifting to expand the pool of human resources for dementia care. Task-shifting is the name given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. By reorganizing the workforce in this way, task shifting presents a viable solution for improving healthcare coverage by making more efficient use of the human resources already available and by quickly increasing capacity while training and retention programs are expanded (WHO, 2013).

Issues related to recruitment and retention were also discussed including inadequate salaries, increasingly unionized environments, fears associated with working with this population, and increased organizational accountability.

EVIDENCE:

- Aging at Home Strategy
- Behavioural Supports Ontario Project
- Better access, better quality, better value
- Centres for Learning, Research and Innovation (LRI): Schlegal, Baycrest, Bruyère Continuing Care
- Community-based services and home care, assisted living and Long-Term Care: http://health.gov.on.ca/en/pro/programs/ecfa/action/community/
- Excellent Care for All Act (ECFAA), 2010
- Excellent Care for All: Health System Funding Reform (HSFR)
- Falls Prevention
- Faster Access to Stronger Family Health Care
- Health Links
- Healthy Change: Right Care, Right Time, Right Place
- Keeping Ontario Healthy
- Living Longer, Living Well: Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to Inform a Seniors Strategy for Ontario by Dr. Samir K. Sinha, MD, DPhil, FRCP(C), Provincial Lead, Ontario’s Seniors Strategy, December 20, 2012
- Mental Health Integration
- Ministry of Health and Long Term Care Patient-Based Funding Overview
- Ontario Aging at Home Strategy
- Ontario’s Action Plan for Healthcare priorities
- Ontario’s Action Plan for Health Care: Making Healthy Change Happen, January 2013
- Policy and clinical decisions must be driven by evidence and healthcare: http://health.gov.on.ca/en/pro/programs/ecfa/quality/
- Quality Improvement / Health Quality Ontario
- Quality Research for Quality Health Care in Ontario: A Health Research Strategy
- Senior-Friendly Hospital (Design)
- Seniors and Alternate Level of Care: Building our knowledge
- Seniors Health Knowledge Network, Alzheimer Knowledge Exchange, Ontario Research Coalition
Design & Technology Innovations

OPINIONS FROM DEMENTIA LEADERS ABOUT WHAT IS AFFECTING DEMENTIA CARE TODAY

What we heard about design and technology innovations related to dementia care from WCA stakeholders can be organized into the following themes:

◦ Integration of design in dementia care
◦ Technology to support care
◦ Technology to support learning and education
◦ Technology to support assessment and evaluation

DESIGN IN DEMENTIA CARE

“How can we create smaller scale housing for people with dementia that is more accommodating if they develop a disability by building supportive housing to begin with.” -Participant

Participants identified environmental design as an emerging concept related to dementia and senior friendly care (e.g. design considerations are mentioned in the Ontario Action Plan for Seniors). Participants felt that design-related conversations need to shift to the more inclusive ‘universal design’ concept rather than ‘age-friendly and dementia-friendly’ design, given “what is good for an older person is also good for young mothers, persons with disabilities etc.” Age-friendly and dementia-friendly design concepts can also reinforce stigma and detract from the concept of inclusive design. Finally participants identified a need to creatively address the physical design of housing to support aging in place.

TECHNOLOGY TO SUPPORT CARE

Technology is becoming more user-friendly and accessible. Participants identified that significant advancements have been made in terms of innovative technology to support safety and care, reduce isolation and increase engagement for persons with dementia and the family. Cognitive improvement technologies are widely available, though participants identified that their effectiveness is yet to be determined.

It was felt that there are significant ethical issues to resolve in the use of technology at the intersection of safety, monitoring and privacy. It was noted that participants felt pressure to better integrate technology into their long-term care practice; however, showed concern that effective integration would have significant impacts on infrastructure, staffing and funding.

Finally, it was also felt that persons with dementia will soon be arriving to long-term care with technology devices to support care that the care providers will need to know how to use and work with, resulting in a need for staff education. Specific examples of technology identified by participants as relevant to help support the person with dementia included:

◦ Technology to help support for the person and family:
  » Safely Home wrist bracelets (ASC)
  » Monitors, alarms, pagers
  » Fall detectors
  » Lighting
  » Smart stove tops
  » Bed sensors
BY 2022 THE WCA WILL BE A LEADER IN INNOVATIVE DEMENTIA CARE.

TECHNOLOGY TO SUPPORT ASSESSMENT AND EVALUATION

Participants also briefly discussed the role of technology in monitoring best care practices and knowing what is happening at the bedside. Using tools such as the MDS RAI 2, participants felt care providers should be better able to compare care practices across and within facilities, and review the variability of practice related to pharmacotherapy and other care practices. Participants identified an opportunity to improve the access of this information for families so they can make more informed choices regarding care and housing for persons with dementia.

EVIDENCE:

◦ AKE dementia-friendly, topic-specific recommendations: http://www.akere-sourcentre.org/design
◦ MAREP: http://afc.uwaterloo.ca/
◦ Schlegel Villages: http://schlegelvillages.com/living-choices
◦ Senior-friendly hospital, SW LHIN priority: http://www.southwestlhin.on.ca/Page.aspx?id=5526&ekmense=l=e2f22c9a_72_288_5526_15
◦ Senior-Friendly Hospitals Provincial: http://seniorfriendlyhospitals.ca/

TECHNOLOGY TO SUPPORT LEARNING AND EXCHANGE

In addition to the technology to support the provision of care, participants identified that technology is being used to connect caregivers across the healthcare system to exchange knowledge related to promising practices (e.g. OTN, webinars). By enabling learning and exchange, this technology is being used within organizations to support informed, collaborative care at the bedside and to assess care practices across the system. It was also identified that mobile devices such as smart phones or tablets present opportunities to provide more informed and timely care when used by care providers but that how to leverage the potential of mobile technology is not yet fully understood.

◦ Automatic taps
◦ Accelerometers
◦ Technology to support communication:
  » Talking mats
  » Photo phone
  » Picture exchange / Skype etc. to be part of digital family loop
  » Vision mirrors to communicate care practices such as hand washing (study funded by CIHR/ASC)
◦ Technology to support self-care:
  » Date/ time reminders
  » Item locater devices
  » Medication reminders/ dispensers
◦ Technology to support for formal care providers:
  » Call buttons
  » Adjustable comfort beds
  » RAI MDS
  » iPads, smart phones or other mobile technology
  » Emergency response buttons with GPS for wandering
“Capacity-building of the workforce is essential to improve knowledge and awareness of the benefits of a coordinated response to care”

-WHO, 2012

What we heard about education, learning and capacity building from WCA stakeholders can be organized into the following themes:

- Formal education
- Information education
- Learning and technology

**FORMAL EDUCATION**

Participants noted that several universities offer gerontology programs such as University of Guelph, McMaster University, Lakehead University, and the University of Waterloo; however, it was felt that students tend to “default” into the program rather than plan for a career in gerontology early on. Outreach to colleges and universities to better market the opportunities in gerontology could help meet the HHR and capacity needs.

**INFORMAL LEARNING**

It was identified by participants that organizations are looking to increase capacity building opportunities for their staff more than ever, despite the difficult economic climate. Individuals are seeking out alternative learning opportunities through knowledge exchange events, networks and communities of practice, spreading promising practices and mobilized opportunities for shared solution finding. It was noted that taking a multidisciplinary, collaborative approach to learning is supported by the World Health Organization who reported that “dementia care, long-term care and chronic disease management incorporating a multidisciplinary team should form part of professional education and should be supported by the development of appropriate practice guidelines”. Through the Behavioural Supports Ontario Project, there has been a recent influx of education and training related to dementia care; however, while the LHIN-based BSO implementation will continue, the provincial coordination funding has just ended (March, 2013).

**LEARNING & TECHNOLOGY**

Generally it was felt that, with the exception of eLearning, there were relatively unremarkable opportunities for learning that leverage technology. The availability of mobile technology has allowed people to be more accessible to each other; however, participants identified that this was not happening as often as it should (untapped potential). The eLearning shift was identified as a positive way for learners to engage with content independently and on their own schedules, while saving the resource-intensive in-person exchange for knowledge application and collaborative problem solving.
BUILDING CAPACITY FOR THE PERSON AND FAMILY

Participants identified that without increased funding to build the capacity of the person and family to support care in the person's home, aging in place, en masse, was not yet possible. They noted a need for accessible, practical and hands-on opportunities to learn how to provide quality, safe and respectful care in the home, and a need to assist with the navigation of community resources to support aging in place.
Leadership in Dementia Care

OPINIONS FROM DEMENTIA LEADERS ABOUT WHAT LEADERSHIP IN DEMENTIA CARE LOOKS LIKE

"Lead in some areas and follow in others; most effective leaders follow in many areas and lead in a few" -Participant

What we heard about leadership in dementia care from WCA stakeholders can be organized into the following themes:

"Leaders in dementia care are"

◦ Engaged in research
◦ A community resource
◦ Dedicated to measuring success
◦ Identified as a leader internally and externally
◦ Focused
◦ Collaborative
◦ Supportive of capacity building
◦ Innovative

ENGAGED IN RESEARCH

◦ Formalize relationships with universities and academic health science centres; McCormick could be recognized as a research setting (different than acute setting)
◦ Integrate best evidence continuously as a core philosophy
◦ Involve students in meaningful ways to enhance programs as students assist with care processes and ask questions
◦ Engage students to help steer research of faculty supervisors
◦ Provide grants for graduate students to help redirect graduate students to conduct research in areas of interest with respect to older adults (e.g. $10,000-20,000); students have been receptive and it solidifies production and creation of new research
◦ Employ participatory translational approaches to research; involve interdisciplinary teams
◦ Identify issues that are relevant to people in the field and persons with dementia and pursue those
◦ Design research questions to increase attention and possible funding; funders are expecting that those affected are involved in research
◦ Communicate with researchers what you know works in terms of communicating with providers, staff, residents
◦ Work with researchers to shape agendas and translate results of research
◦ Physically co-locate research education and practice if possible (increases researcher’s ability to understand issues, educators able to translate practice environment into curriculum)
◦ Pursue a research chair for strong marketing / profile opportunities

A COMMUNITY RESOURCE

"A leader is a resource to the community, not an institution" -Participant

◦ Define overarching approach (better health, better care, better value)
◦ Improve experience, quality and costs for the community
◦ Provide services to the community that are focused on prevention, person-centred care and transitions between points in the system and in people’s lives
◦ Be responsive to the opportunities in the community, rather than being driven by the Home, and consider where you can act as the glue and pull together advocates to move forward
◦ Become the place to go for practicums across range of disciplines, engaging stu-
BY 2022 
THE WCA 
WILL BE 
A LEADER 
IN 
INNOVATIVE 
DEMENTIA 
CARE.

Leadership in Dementia Care Options Study 20

DENTS outside of typical health professions
○ Think broadly to build interprofessional 
teams and skills
○ Understand the needs of the community 
you are serving by engaging persons with 
dementia
○ Extend further than walls of long term 
care and connect to community
○ Embed long term care and other residential 
settings as part of the community
○ Bring forward a positive stance with 
respect to mental health status and 
emotional status to reduce stigma
○ Be inclusive
○ Advocate for change by asking the diffi-
cult questions, ask for a ‘stretching’ to 
consider new perspectives

DEDICATED TO MEASURING SUCCESS
"We work ‘on’, ‘with’ or ‘for’...how do we measure 
how we are doing this?” -Participant
○ Consider how to reinforce and measure 
capacity for person-centred care and 
prevention of disability
○ Vigorously define indicators and evalua-
tion approaches for prevention, person-
centred care and transitions

IDENTIFIED AS A LEADER INTERNALLY AND 
EXTERNALLY
"You can’t just be a leader, you need to be seen 
as a leader." -Participant
○ Purposefully establish / identify yourself 
as leader
○ Achieve internal identification; critical to 
also get that external identification
○ Profile / build public recognition that the 
organization / group is cutting edge
○ Ensure congruency of behaviour with 
values
○ Engage in non hierarchical behaviour-
everyone in organization (staff, resident, 
family) have something to contribute 
and are leaders in their sphere of influ-
ence

FOCUSED
○ Start small and have a focused approach 
before broadening out
○ Determine who you are trying to lead, 
who you want to follow, what your sphere 
of influence is; this will impact where 
you dedicate resources and how others 
see you
○ Link to what is available but also look

internally and identify within your orga-
nization what you want to focus on (and 
being clear about this) and then look for 
opportunities to link to others in these 
areas
○ Avoid taking on too much or spreading 
too thin
○ Avoid focusing on an area that isn’t the 
interest of your organization
○ Consider your available resources when 
selecting a focus
○ Consider whether you want to be a leader 
or something else with a different nu-
ance (model, mentor, exemplar of best 
practice); the effort and energy will vary 
based on the status you aim for
○ Capitalize on WCA strengths (respected 
for values, compassion, integrity) to 
shape wherever WCA wants to make their 
ame
○ Consider focusing on transitions due to 
McCormick Home’s strength in service

COLLABORATIVE
"Hang around smart people" -Participant
○ Don’t call yourself an institute
○ Take off own ‘expertise’ hat and look 
around to learn from others to improve 
your own practice
○ Collaboratively partner with non-gov-
ernmental organizations and clinicians; 
they are willing to be an active testing 
ground for innovation
○ Look first at what’s important in your or-
ganization and look to others for support
○ Include persons with dementia in re-
search and in knowledge translation
○ Constantly scan for people within reach 
that share the same passion for work 
and development of new knowledge
○ Consider families and their perspectives 
and experience within long-term care to 
inform opportunity for McCormick Home

SUPPORTIVE OF CAPACITY BUILDING
○ Think about how to ensure people in the 
organization can engage in opportuni-
ties such as participating in research, 
discussions with LHIN, stakeholder 
activities, knowledge translation and 
exchange, etc.
○ Be open to participating in different 
types of activities and be willing to 
initiate activities within the community 
at times to build your organizational 
resume
○ Consider that only 3% of staff come out
of colleges/ institutions and the other 97% are in the field already; how do we increase skills in these areas of this workforce?

- Consider what prevention, person centred care and transition support looks like and build capacity around those indicators of success
- Must generate and support learning as part of the organizational culture

INNOVATIVE

“Innovation is never being satisfied”
-Participant

- Make your primary philosophy that of innovation
- Figure out how to do things better/ different with the same or less money
- Consider the Conference Board of Canada Report: 5 preconditions for effective innovation
- Be grounded in lived experience / person-centred care
- Don’t be bound by minimum standards
For more information about this initiative or the WCA, please contact:
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