Recommendations for Adoption: Dementia Care in the Community

Quality Standards

Recommendations to enable widespread adoption of this quality standard

Health Quality Ontario

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About This Document

This document summarizes recommendations at local practice and system-wide levels to support the adoption of the quality standard on dementia care in the community.

At the local and regional levels, health care providers and organizations in all applicable settings, local health integration networks (LHINs), and other health system partners are encouraged to use the quality standard as a resource for quality improvement. While many organizations and providers may be offering the care described in the quality standard, the statements, related measures, and adoption supports are designed to help organizations determine where there are opportunities to focus their improvement efforts. The *Getting Started Guide* outlines the process for using this quality standard as a resource to deliver high-quality care.

An important next step will be to put the recommendations included in this document into action. In some situations, this may require a more detailed plan or new resources, or it may require leveraging or expanding existing programs. Many aspects of the quality standard represent care that can and should be made available today.

A monitoring and evaluation strategy is included in the final section, with suggested measures to monitor and track progress. Health Quality Ontario's Quality Standards Committee will review these regularly, including the actions needed to support implementation.

The Dementia Care in the Community Quality Standard

This quality standard addresses care for people living with dementia in the community, including the assessment of people suspected to have dementia or mild cognitive impairment. The quality standard focuses on primary care, specialist care, hospital outpatient services, home care, and community support services. It also provides guidance on support for caregivers of people living with dementia.

Click here to access the quality standard.

For a quality standard that addresses care for people living with dementia and the specific behaviours of agitation or aggression who are in an emergency department, admitted to a hospital, or in a long-term care home, refer to Health Quality Ontario's quality standard *Behavioural Symptoms of Dementia: Care for Patients in Hospitals and Residents in Long-Term Care Homes*.

The Recommendations for Adoption

The purpose of these recommendations is to support the use of quality standards to promote practice improvement among health care professionals.[1-3] They are designed to bridge the gaps between current care and the care outlined in the quality statements.

Click here to download the detailed process and methods guide for a description of how the quality standard and recommendations for adoption were developed.

The recommendations for adoption were developed after a review of the available evidence on implementation and a scan of existing programs, as well as extensive consultation with the Dementia Care in the Community Quality Standard Advisory Committee, key stakeholders, and organizations that work in this area; public comment on the quality standard; a series of structured interviews with clinicians; and a survey sent to clinicians across the province. (Engagement details specific to the development of these recommendations are provided in Appendix A.)

These consultations highlighted some common themes:

- The need for staff and clinician education and training on best practices in dementia care
- The need for more flexible and accessible education and training for people living with dementia and their caregivers
- The need for a person-centred approach to ensure that education and support services reach the people who need them and that personal preferences and unique needs of individuals are considered in the provision of care
- Consideration and integration of cultural, linguistic, age, and geographical differences in the provision of support services for people living with dementia and their caregivers
- The balance between standardization and customization of support services available in LHINs across the province
- The need for early intervention to proactively connect people living with dementia and their caregivers to appropriate supports and services in their communities

Equity considerations: A number of equity considerations have been identified related to this quality standard topic, including gender, age, geography, socioeconomic status, language preferences, and disability. These issues should be taken into consideration to ensure specific adoption strategies do not reinforce current states of inequity and inequality. Where possible, they should contribute to improvements or highlight areas of opportunity for equity and equality.

The adoption recommendations are organized as follows:

- Integrating the quality standard into practice
  - Quality improvement
  - Access to care
  - Coordination of care
- Education and training
- Policy and system planning

We describe three time frames for adoption: immediate (less than 1 year), medium term (1–3 years), and long term (more than 3 years).

Note that the organizations, programs, and initiatives referenced in this document are examples for consideration. They do not reflect all the organizations, programs, and initiatives doing work in this area.

Appendix B provides a list of these same recommendations aligned to specific organizations and groups.

References

[1] French SD, Green SE, O'Connor DA, et al. Developing theory-informed behaviour change interventions to implement evidence into practice: a systematic approach using the Theoretical Domains Framework. Implementation Sci. 2012;7:38. Available from: https://implementationscience.biomedcentral.com/track/pdf/10.1186/1748-5908-7-38?site=implementationscience.biomedcentral.com.

[2] Bero LA, Grilli R., Grimshaw JM, Harvey E, Oxman AD, Thomson M. (1998). Closing the gap between research and practice: An overview of systematic reviews of interventions to promote the implementation of research findings. BMJ. 1998;315:465-68.

[3] National Implementation Research Network. Implementation Drivers [Internet]. Chapel Hill, NC: FPG Child Development Institute, University of North Carolina [cited 2017 Feb 8]. Available from: http://nirn.fpg.unc.edu/learn-implementation/implementation-drivers.

Integrating the Quality Standard into Practice - *Quality Improvement*

Gap: There is a lack of practical tools to help providers and organizations integrate the quality standard into daily care practice. Use of common tools would help mitigate duplication of information.

Recommendations	Quality Statements	Action Needed By	Time Frame
Assess the care that is being provided against the quality standard using Health Quality Ontario's *Getting Started Guide*, and refer to the action plan template as a tool for quality improvement.	All	Health care organizations Health care providers LHINs	Medium term
Embed the quality standard into existing decision support tools, such as order sets, information systems, and/or electronic medical record (EMR)–based solutions and clinical pathways to ensure completion of comprehensive assessments and individualized care plans.	All	Health care organizations	Medium term
Incorporate the quality standard into existing provincial programs and initiatives to support its dissemination and implementation.	All	Health Quality Ontario Provincial dementia care organizations and associations	Medium term

Adoption Consideration

- *Existing initiatives and partners, such as Regional Geriatric Programs, Behavioural Supports Ontario, Alzheimer Society of Ontario, and local networks or health care teams working with people living with dementia may disseminate and support implementation of the quality standard.*

Integrating the Quality Standard into Practice - *Quality Improvement (continued)*

Gap: Better access to timely data that will enable organizations and providers to track performance and improvement is required.

Data related to dementia care and services in the community are limited. Current sources do not adequately identify who has dementia and to what degree of severity. Reducing this gap can help guide service assessment and track progress.

There is a lack of standardization around data collection and assessment for people living with dementia in both the home and community care sectors.

Recommendations	Quality Statements	Action Needed By	Time Frame
Simplify data-sharing agreements to promote a shared information source.	All	LHINs Health care organizations Data providers	Long term
Support efforts to collect standardized data across organizations, with unique identifiers on the use of community programs by people living with dementia and their caregivers, and track outcomes related to health, quality of life, services, and patient satisfaction.	All	LHINs Health care organizations and providers	Long term
Identify the most appropriate means for advancing quality standards via annual Quality Improvement Plans (QIPs).	All	Health Quality Ontario	Medium term

Integrating the Quality Standard into Practice - *Access to Care*

Gap: There is variation in access to and availability of support and respite services across the province.

Non-medical supports (e.g., education, social engagement) are not always considered part of care planning following diagnosis.

Improved access to personal support workers, primary care providers, and specialists is required.

Primary care providers might not take on complex patients with dementia, as these patients require more time than providers can effectively allot.

Cost can be a significant barrier to accessing housing (e.g., retirement homes) or making home modifications necessary to remain in the community.

Recommendations	Quality Statements	Action Needed By	Time Frame
Conduct capacity planning to enable more efficient use of finite resources across the health care system so that people living with dementia and their caregivers can safely live well in the community for longer. Capacity planning should compare service availability with local needs to identify and address service gaps and/or capacity pressures.	7: Access to Support Services 8: Caregiver Assessment and Support 9: Safe Living Environment 10: Access to a Primary Care Provider	LHINs	Long term

Integrating the Quality Standard into Practice - *Coordination of Care*

Gap: Barriers to effective communication and coordination among care settings include lack of provider access to patient records; variations in information within those records; duplication of testing, assessments, and other medical records; and privacy issues related to information sharing.

Continuity of care is lacking due to health information systems that neither communicate with one another nor enable information sharing among providers.

Suboptimal collaboration and integration between community supports and primary care, and between primary care and specialists, hampers system navigation.

Greater connections are needed among primary care providers, specialists, and community support persons, including personal support workers, to ensure people living with dementia and their caregivers are aware of available community supports and receive the care they need.

Recommendations	Quality Statements	Action Needed By	Time Frame
Create formal processes and systems that allow organizations to coordinate care and share necessary information electronically, including assessments, care plans, and test results.	All	LHINs Health care organizations and providers	Long term
Insert information related to care plans and assessments, as outlined in the quality standard on dementia care in the community, in health information systems.	All	LHINs Health care organizations and providers	Long term

Integrating the Quality Standard into Practice - *Coordination of Care (continued)*

Gap (continued): Barriers to effective communication and coordination among care settings include lack of provider access to patient records; variations in information within those records; duplication of testing, assessments, and other medical records; and privacy issues related to information sharing.

Continuity of care is lacking due to health information systems that neither communicate with one another nor enable information sharing among providers.

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Greater connections are needed among primary care providers, specialists, and community support persons, including personal support workers, to ensure people living with dementia and their caregivers are aware of available community supports and receive the care they need.

Recommendations	Quality Statements	Action Needed By	Time Frame
Foster connections between primary care and specialists, community support services, and community care organizations to help individuals living with dementia age in place.	All	LHINs Community support services Home and community care organizations Municipalities Alzheimer Society of Ontario	Long term

Integrating the Quality Standard into Practice - *Coordination of Care (continued)*

Gap (continued): Barriers to effective communication and coordination among care settings include lack of provider access to patient records; variations in information within those records; duplication of testing, assessments, and other medical records; and privacy issues related to information sharing.

Continuity of care is lacking due to health information systems that neither communicate with one another nor enable information sharing among providers.

Suboptimal collaboration and integration between community supports and primary care, and between primary care and specialists, hampers system navigation.

Greater connections are needed among primary care providers, specialists, and community support persons, including personal support workers, to ensure people living with dementia and their caregivers are aware of available community supports and receive the care they need.

Adoption Considerations:

- *Dementia-friendly community initiatives, such as Finding Your Way and other similar programs, as well as links to law enforcement officers and emergency medical services/paramedic services in local communities can promote safe living environments for individuals living with dementia and support their caregivers.*
- *Alzheimer Society of Ontario provides many community-based programs and services, including First Link, which connects people with dementia and their caregivers to information, services, and supports as soon as possible after diagnosis.*
- *Echoing Recommendation 8 from the* 2015 Report of the Expert Group on Home and Community Care*, "improve two-way communication between primary care providers and home and community care providers."*
- *Virtual care models that help individuals manage their care between visits to a primary care provider (e.g., Ontario Telemedicine Network) particularly in rural areas. Digital enablers, such as eConsult and eReferral platforms, can address the gap between primary care providers and specialists.*
- *Health Links coordinated care plans and innovative practices can support enhanced communication about and adoption of the quality standard.*

Education and Training

Gap: More education and training for health care providers is needed at the postsecondary level, as well as ongoing training to build core competencies for practising health care providers.

Training and support for primary care providers and personal support workers in the community are required in the following areas:

- Comprehensive assessments, specifically what they should include; expectations around information sharing and related roles/responsibilities; and what elements of the assessment should be provided by whom and at what stage
- Early identification and prevention
- Culturally appropriate, safe care and related competencies
- Availability of supports
- Involving people living with dementia and their caregivers in developing and implementing the care plan.

Time and resource constraints can impede a provider's ability to participate in training and education.

Although many education and training programs currently exist in Ontario, they vary in availability and often lack flexibility to accommodate the realities of caregiving and the needs of people living with dementia.

Recommendations	Quality Statements	Action Needed By	Time Frame
Update geriatric/older adult education within postsecondary curricula for health care providers using the quality standard	All	Postsecondary institutions Private colleges	Long term
Enhance accessibility of education programs for people living with dementia, their caregivers, and providers	All	Alzheimer Society of Ontario	Immediate

Education and Training (continued)

Gap (continued): More education and training for health care providers is needed at the postsecondary level, as well as ongoing training to build core competencies for practising health care providers.

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Recommendations	Quality Statements	Action Needed By	Time Frame
Embed the quality standard into professional development programs for providers	All	Clinical and continuing education programs Health regulatory colleges	Medium term
Enable primary care and other providers to participate in training and education	All	LHINs Health care organizations Health regulatory colleges	Long term

Education and Training (continued)

Gap (continued): More education and training for health care providers is needed at the postsecondary level, as well as ongoing training to build core competencies for practising health care providers.

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Adoption Considerations:

- *A competency framework is being developed that may provide guidance for training and education programs on core competencies for individuals interacting with people living with dementia.*
- *Programs delivered by and for professional practice groups (e.g., for general practitioners by general practitioners) should be made available to health care professionals.*
- *Existing education/training programs, such as (but not limited to) the Reitman Centre Training Institute, the P.I.E.C.E.S. Framework, the Gentle Persuasive Approach, Dementiability workshops, the Geriatric Certificate Program at McMaster University, the Psychogeriatric Resource Consultant for Primary Care Program, the RNAO* Delirium, Dementia, Depression *course, U-First! training, the Indigenous Cognition and Aging Awareness Research Exchange culturally safe program (i-caare), and Ontario College of Family Physicians (OCFP) workshops, can support implementation of the quality standard.*

Education and Training (continued)

Gap (continued): More education and training for health care providers is needed at the postsecondary level, as well as ongoing training to build core competencies for practising health care providers.

Training and support for primary care providers and personal support workers in the community are required in the following areas:

- Comprehensive assessments, specifically what they should include; expectations around information sharing and related roles/responsibilities; and what elements of the assessment should be provided by whom and at what stage
- Early identification and prevention
- Culturally appropriate, safe care and related competencies
- Availability of supports
- Involving people living with dementia and their caregivers in developing and implementing the care plan.

Time and resource constraints can impede a provider's ability to participate in training and education.

Although many education and training programs currently exist in Ontario, they vary in availability and often lack flexibility to accommodate the realities of caregiving and the needs of people living with dementia.

Adoption Considerations (continued):

- *Psychogeriatric Resource Consultants (PRCs), who deliver capacity-building activities (e.g., training and education) to health care teams and who are located in community-based mental health centres, hospitals, and/or Alzheimer Society chapters across the province, may play a role in supporting knowledge exchange.*
- *Education should include information for providers about where individuals living with dementia can find available community support services.*
- *The* 2017 Final Report: Legal Capacity, Decision-making and Guardianship *released by the Law Commission of Ontario is a comprehensive resource on laws and policies related to powers of attorney, guardianship, and health care consent.*
- *The caregiver organization may serve as a resource for caregivers, people living with dementia, and health care providers.*

Policy and System Planning

The recommendations for adoption include those needed at the system level. In accordance with Health Quality Ontario's mandate, set out in the *Excellent Care for All Act*, the board of directors has formally provided the following recommendations about the *Dementia Care in The Community* quality standard to the Minister of Health and Long-Term Care.

Recommendations	Time Frame
1. As part of Ontario's strategy for supporting caregivers:	
• Include the patient and resident reference guides for this quality standard in the inventory of supports to be distributed by the caregiver organization.	Medium term
• Enhance respite programs and supports for caregivers, ensuring that safeguards are in place that enable equitable access to quality services.	Medium term
2. As part of the deployment of the dementia strategy and dementia capacity planning:	
• Enhance competencies of personal support workers and primary care providers to provide care as outlined in the quality standard.	Immediate
• Ensure support programs for people living with dementia and their caregivers under the dementia strategy are flexible, accessible, and inclusive, and offer personal choice. This includes providing access to programs outside of business hours in multiple languages and formats (e.g., online, peer groups).	Medium term
• Develop a provincial approach to standardized performance monitoring and evaluation as part of the dementia care data strategy.	Medium term
• Simplify data-sharing agreements to promote a shared information source on dementia care in Ontario.	Medium term
• Support efforts to collect standardized data across organizations, with unique identifiers on the use of community programs by people living with dementia and their caregivers, and track outcomes related to health, quality of life, services, and patient satisfaction.	Long term
• Improve collaboration between primary care providers and specialists (geriatricians, psychiatrists, and others).	Long term

Policy and System Planning (continued)

The recommendations for adoption include those needed at the system level. In accordance with Health Quality Ontario's mandate, set out in the *Excellent Care for All Act*, the board of directors has formally provided the following recommendations about the *Dementia Care in The Community* quality standard to the Minister of Health and Long-Term Care.

Recommendations	Time Frame
3. Ensure resources, supports, and/or incentives are available to enable individuals living with dementia to age in place within the home and community. Expand self-directed care models to people living with dementia and their caregivers, ensuring that safeguards are in place that enable equitable access to quality services.	Long term

Measurement and Reporting

Health Quality Ontario will develop a monitoring and evaluation plan for these recommendations as part of the broader quality standards evaluation. This plan may require the development of measures and/or a resource plan to support data collection and monitoring. The evaluation will include the following components:

1. Use existing databases for ongoing monitoring of the key indicators identified for this quality standard. Note gaps and areas for improvement. For this standard, the outcome indicators below are currently measurable at the provincial level and have been prioritized:
   - Rate of emergency department visits for people living with dementia in the community (proxy indicator: proportion of emergency department visits that were for dementia).
   - Alternate-level-of-care days for people living with dementia in the community (proxy indicator: alternate-level-of-care days for people admitted for dementia).
2. Monitor the uptake of the recommendations for adoption.

The Ontario Quality Standards Committee will receive annual updates on the progress of the recommendations and review any additional measurement that may be needed to assess impact.

Appendix A: Process and Methods for Developing the Recommendations for Adoption

The development of the recommendations for adoption involved extensive consultation with stakeholders across the province from a variety of professional roles and perspectives.

The following organization and groups were consulted in the development of these recommendations:

- Ministry of Health and Long-Term Care
- Alzheimer Society of Elgin-St. Thomas
- Alzheimer Society of Ontario
- Behavioural Supports Ontario
- Champlain Dementia Network
- Geriatric Assessment Intervention Network (GAIN) clinics
- Gerontological Nursing Association of Ontario
- LHIN/Health Quality Ontario Regional Clinical Quality Leads
- Regional Geriatric Program of Ontario

Note: Between June and August 2017, Health Quality Ontario connected with more than 150 individuals and organizations within primary care, community care, home care, research, mental health, LHINs, and professional associations from across the province through public comment, structured meetings, targeted interviews, and a survey, as well as a virtual town hall, in which 87 individuals participated. This engagement was informed by the Theoretical Domains Framework, which uses 14 domains (knowledge, skills, attitudes, etc.) to identify barriers to behavioural change and/or the ability to put the quality standard into practice. The results of the focus groups, surveys, and meetings were used to inform the gaps and recommendations in this document.

Appendix B: Summary Recommendations for Health Sector Organizations and Other Entities

Health Quality Ontario	Time Frame*
Incorporate the quality standard into existing provincial programs and initiatives to support its dissemination and implementation.	Medium term
Identify the most appropriate means for advancing quality standards via annual Quality Improvement Plans (QIPs).	Medium term

Local Health Integration Networks	Time Frame*
Assess the care that is being provided against the quality standard using Health Quality Ontario's *Getting Started Guide*, and refer to the action plan template as a tool for quality improvement.	Medium term
Simplify data-sharing agreements to promote a shared information source.	Long term
Support efforts to collect standardized data across organizations, with unique identifiers on the use of community programs by people living with dementia and their caregivers, and track outcomes related to health, quality of life, services, and patient satisfaction.	Long term

Conduct capacity planning to enable more efficient use of finite resources across the health care system so that people living with dementia and their caregivers can safely live well in the community for longer. Capacity planning should compare service availability and local needs to identify and address service gaps and/or capacity pressures.	Long term
Enable primary care and other providers to participate in training and education	Long term
Create formal processes and systems that allow organizations to coordinate care and share necessary information electronically, including assessments, care plans, and test results.	Long term
Insert information related to care plans and assessments, as outlined in the quality standard on dementia care in the community, in health information systems.	Long term
Foster connections between primary care and specialists, community support services, and community care organizations to help individuals living with dementia age in place.	Long term

Postsecondary Institutions, Private Colleges, and Continuing and Clinical Education Programs	**Time Frame***
Update geriatric/older adult education within postsecondary curricula for health care professionals using the quality standard.	Long term
Embed the quality standard into professional development programs for providers.	Medium term

Health Care Organizations and Providers	Time Frame*
Assess the care that is being provided against the quality standard using Health Quality Ontario's *Getting Started Guide*, and refer to the action plan template as a tool for quality improvement.	Immediate
Embed the quality standard into existing decision support tools like order sets, information systems, and/or electronic medical record (EMR)–based solutions and clinical pathways to ensure completion of comprehensive assessments and individualized care plans.	Medium term
Insert information related to care plans and assessments, as outlined in the quality standard on dementia care in the community, in health information systems.	Long term
Create formal processes and systems that allow organizations to coordinate care and share necessary information electronically, including assessments, care plans, and test results.	Long term
Simplify data-sharing agreements to promote a shared information source.	Long term
Support efforts to collect standardized data across organizations, with unique identifiers on the use of community programs by people living with dementia and their caregivers, and track outcomes related to health, quality of life, services, and patient satisfaction.	Long term
Enable primary care and other providers to participate in training and education.	Long term
Health Regulatory Colleges	**Time Frame***
Embed the quality standard into professional development programs for providers.	Long term
Enable primary care and other providers to participate in training and education.	Long term

Community Care Organizations, Community Support Services, and Municipalities	Time Frame*
Foster connections between primary care and specialists, community support services, and community care organizations to help individuals living with dementia age in place.	Long term

Alzheimer Society of Ontario	Time Frame*
Enhance accessibility of education programs for individuals living with dementia, their caregivers, and providers.	Immediate
Foster connections between primary care and specialists, community support services, and community care organizations to help individuals living with dementia age in place.	Long term

Provincial Dementia Care Organizations and Associations	Time Frame*
Incorporate the quality standard into existing provincial programs and initiatives to support its dissemination and implementation.	Medium term

Data Providers	Time Frame*
Simplify data-sharing agreements to promote a shared information source.	Long term

*Three time frames for adoption are referenced: immediate (less than 1 year), medium term (1–3 years), and long term (more than three years).

Quality Standards

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