Champlain
Dementia Network

Réseau de la démence
de la région Champlain

Mapping competencies and providing education and training to organizations, community service workers, healthcare staff and volunteers that care for people living with dementia

Mapping the Competencies of People Caring, Working and Volunteering in the Dementia Service System

A WORKING DOCUMENT OF THE Champlain Dementia Network

Last Updated by the CDN Education and Training Collaborative – October 2021

Contents

Background for Partners

The Champlain Dementia Network receives funding from the Champlain LHIN/Ontario Health to:

- Coordinate dementia information and education and ensure these are accessible to the four target groups: persons with dementia, caregivers, service providers (including pre-professionals) and the general public.
- Create linkages with other related and relevant networks or strategies allowing for joint or complementary activities e.g. Regional Falls Prevention, Lung Health Network, Behavioural Supports Ontario, Champlain Stroke Network, Champlain Diabetes Regional Coordination Centre.

The Regional Education and Training Collaborative represents a variety of organizations and individuals who have come together to achieve the following objectives:

- Ensure education and training provided in dementia and dementia-related fields is of high quality and evidence-based:
    - Identify and share better practices for education and training in dementia and dementia-related fields
    - Identify and share better practices for translation of education and training to front-line practice
- Increase uptake of available dementia and dementia-related education and training opportunities:
    - Share and promote education and training opportunities
- Promote and support leadership and advocacy in dementia and dementia-related fields in the areas of education and training
    - Provide advice through the CDN to the developing provincial dementia strategy
    - Work with groups to access education and training available
    - Identify gaps within education and training The Collaborative will work to ensure online and other materials are available in both French and English, recognizing that resource constraints may limit the extent to which this can be accomplished.

To this end, the Collaborative first created the "Mapping Competencies Framework" in 2017 to identify the knowledge, skills and abilities of people working and volunteering in services that work with people living with dementia and their families. This version of the framework, which should always be considered a working document, reflects the Collaborative's learnings over the last three years, and incorporates:

- An essential "Knowledge Translation to Practice" approach to ensure the education provided enhances the way in which care and support is provided,
- Updated competencies across broad thematic areas,
- A breakdown of competency level by role played by staff, volunteers and caregivers,
- Standards in education and training requirements for people at levels one and two in the competency framework.

The intention of this latest version of the framework is to enable any person or organization providing care to people living with dementia to be able to identify where they fit within the framework, identify broad and specific learning goals / objectives, and what specific education and training is available to assist them in meeting those goals / objectives. **This is a framework that will continue to evolve, and we want to ensure it is a practical tool for organizations, especially during COVID-19.**

The Education and Training Collaborative is available to assist organizations in assessing their current needs and learning plan objectives based on this framework and we encourage you to contact our Project Manager, Natasha Poushinsky, at natashapoushinsky@gmail.com for any questions, comments, or next steps related to this framework.

Dean Henderson, Chair (Director, Client Experience, Education and Innovation, Dementia Society of Ottawa and Renfrew County)
Jennifer Cavanagh, Vice Chair (Clinical Manager, Geriatric Psychiatry Community Services of Ottawa)

Ensuring Success of Translating Knowledge to Practice: Local Learnings Based on Evidence

Since 2016, the Champlain Dementia Network has tested and refined the competencies outlined in the following sections in a variety of projects to:

a) validate the competencies and
b) test different approaches that support the translation of learning to front-line practice. Our goal was to develop a practical approach that fosters supportive environments where staff are empowered to put their training and education into practice, and family/caregivers understand the rationale underlying different approaches (including what strategies are helpful on a daily basis when living with someone with dementia).

To this end, we have piloted and evaluated the Renfrew County Dementia Navigation Specialist Project, the Community Behaviour Supports in Adult Day Programs Project, the Teepa Snow Online Caregiver Series, the Teepa Snow Coaching Project, and the Central Ottawa Collaborative Project.

Based on these experiences, the CDN can identify the following essential elements that leading organizations consider as they strive to enable their staff, volunteers and caregivers to effectively translate education to practice change – organizations are encouraged to reach out to the CDN for support in implementing these elements:

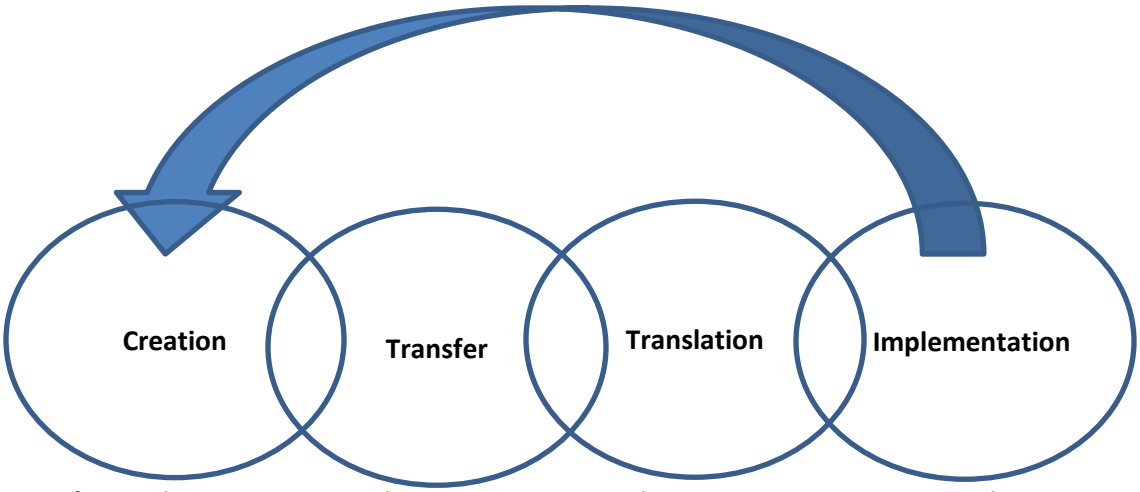
- Complete assessment of learning needs using the Competencies Framework,
- Identify and provide targeted education opportunities aligned with specific competencies in the framework,
- Conduct pre- and post- evaluation surveys of the education opportunity - the CDN can share templates)
- Identify within-level and across-level networks of staff, volunteers or caregivers who can learn from each other
    - Follow-up practical coaching and mentorship of staff, volunteers or caregivers post-education to support them in implementing and practicing their new knowledge and skills. This can be built into, but goes beyond, the organization's regular staff check in/performance appraisal processes,
- Ensure policies and practices are in place that enable people in effectively putting their knowledge into practice – of particular importance is concerns about risks and liability, and
- For staff, support from management and support from families can be critical in achieving sustained practice change.

Recognizing that each of the CDN pilot projects focused on some or all of the above elements, common indicators of success across these effective KT2P (Knowledge Translation to Practice) include:

- Improved management of client actions or reactions that express distress or an unmet need and communication with family members to prolong tenure,
- Improved understanding of when and how to refer clients to additional services / assessments,
- Improved staff and caregiver morale,
- Better utilization of community resources for people from different cultural backgrounds,
- Increased staff empowerment,
- Increase in proactive versus reactive care planning for clients,
- Less chaotic work environment,
- Decreased feelings of staff being overwhelmed,
- Better problem solving by staff in meeting client and family needs,
- Improved care planning for clients and communications with families, and
- Increased sense of staff confidence in own ability to effectively support clients who are exhibiting responsive behaviors that indicate an unmet need and decreased reactivity by staff (i.e. level to which they were bothered or stressed by these personal expressions of an unmet need).

This approach is situated within the Regional Geriatric Programs' Knowledge to Practice Framework (Figure 1)[1] and the Behavioural Education and Training Supports Inventory [2](BETSI) in which Behaviour Supports Ontario translates this framework into implementation approaches.

Figure 1: A Knowledge-to-Practice Process Framework



Creation	Transfer	Translation	Implementation
Programs of Research	Articles	Education	Innovation characteristics such as relative advantage, compatibility, complexity, and trial-ability
Systematic Reviews	Books	Opinion	Individual factors such as beliefs about self-efficacy, utility, value, expectancies and time
Meta-analyses	Reports	Leadership	Organizational factors such as policy, readiness, information systems, quality processes, priorities
Knowledge Syntheses	Manuals	Explanation	Inter-organizational factors such as boundary and expectancy management
Consensus Processes	Posters	Interaction	
Care Plans	Lectures	Socio-technical facilitation	
	Film/video	Coaching	
	Podcasts	Modelling	
	Advertising	Detailing	
	Web Portals	Adapting	

[1]Regional Geriatric Programs Knowledge to Practice Framework (2013), prepared by David Ryan, https://www.rgps.on.ca/wp-content/uploads/2019/03/Regional-Geriatric-Programs-Knowledge-to-Practice-Framework.pdf

[2] BETSI, version 2.0, March 2019, Behaviour Supports Ontario, file:///C:/WORK/CDN/EducationTraining/MappingCompetencies/Behavioural-Education-and-Training-Support-Inventory-March-2019.pdf

Mapping Competencies by Dementia Knowledge Level

Figure 2, the Mapping Competencies Pyramid, outlines competencies across five levels, with the goal being to encourage caregivers, volunteers, and staff to work towards the level identified based on their particular role. The Education Collaborative also recognizes that within a particular service, there is a range of knowledge and experience: there will be staff who are at the identified level, staff who are working towards that level, as well as some staff who actually exceed the competency level. The intent of the pyramid is to assist people in understanding where they "fit", how they inter-relate to other levels, and what knowledge needs to be fostered and developed to best fulfill their role.

We have also developed a functional overview (Figure 3) by competency level to further describe what competencies you might expect to be developing through your individual or organizational learning plan. The Collaborative recognizes there is no 'hard and fast' rule for who does what, but has provided a guide on what types of functions are provided across levels – the functional overview also helps to highlight that, depending on your role in the system, you may have more expertise in some areas than others, even if you might typically be at a Level 1 or 2 generally speaking.

Figure 2: Mapping Competencies Pyramid

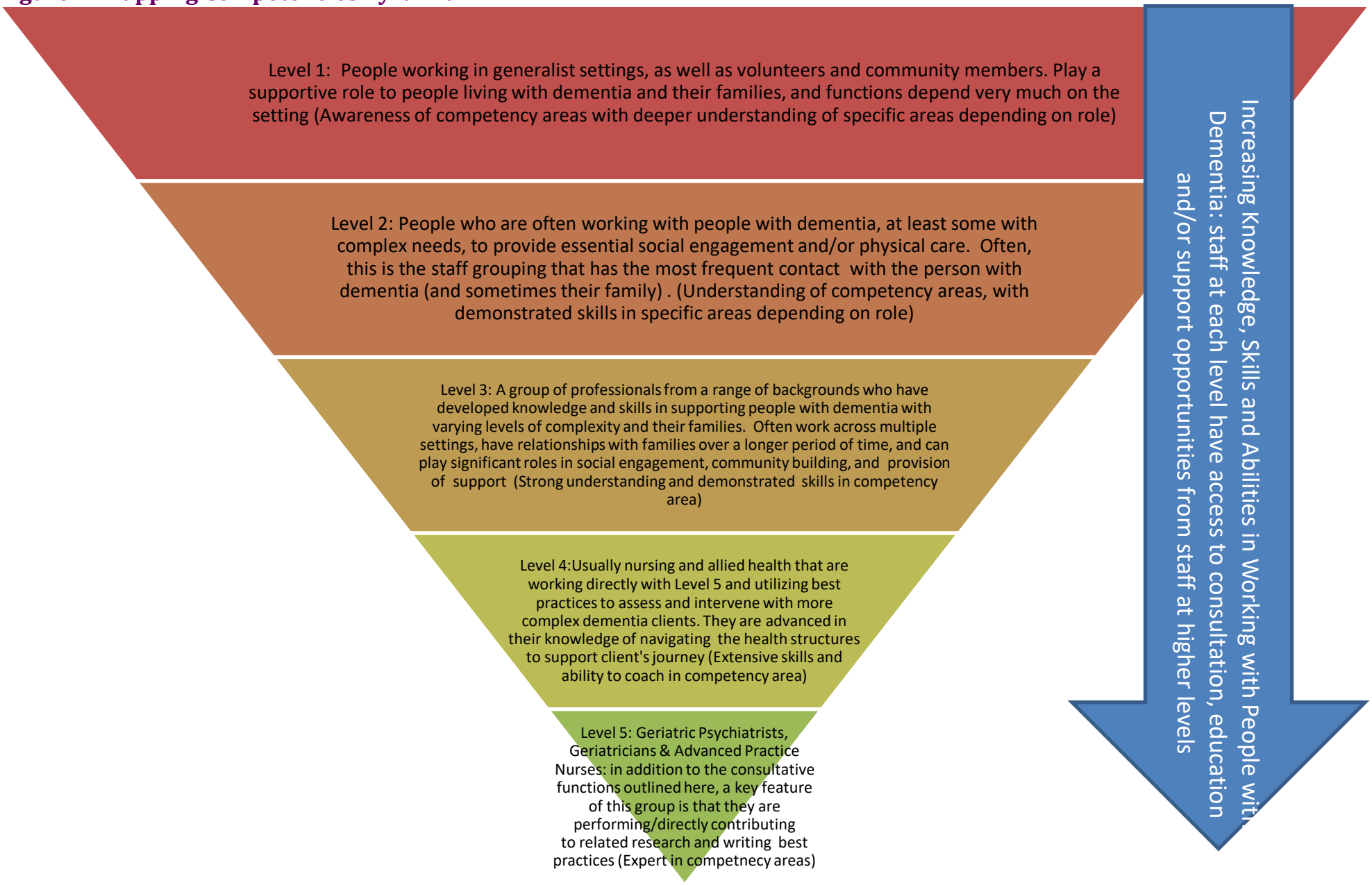


Figure 3: Functional Overview of Competency Levels

	1: People working in generalist settings, volunteers and community members, who play a supportive role to people living with dementia and their families, and functions depend very much on the setting	2: People who are often working with people with dementia, at least some with complex needs, to provide essential social engagement and/or physical care. Often, this is the staff grouping that has the most frequent contact with the person with dementia (and sometimes their family)	3: A group of professionals from a range of backgrounds who have developed knowledge and skills in supporting people with dementia with varying levels of complexity and their families. Often work across multiple settings, have relationships with families over a longer period of time, and can play significant roles in social engagement, community building, and provision of support	4: Usually nursing and allied health that are working directly with Level 5 and utilizing best practices to assess and intervene with more complex dementia clients. They are advanced in their knowledge of navigating the health structures to support client's journey	5: Geriatric Psychiatrists, Geriatricians & Advanced Practice Nurses: in addition to the consultative functions outlined here, a key feature of this group is that they are performing/directly contributing to related research and writing best practices.
Education provision			Yes	Yes	Yes
Coaching and Teaching			Yes	Yes	Yes
Consultation and Case Review				Yes	Yes
Clinical Assessment			Sometimes	Yes	Yes
Therapeutic Interventions			Sometimes	Yes	Yes
Care Coordination		Sometimes	Yes	Yes	Sometimes
Navigation	Sometimes	Yes	Yes	Yes	Sometimes
Referral	Sometimes	Yes	Yes	Yes	Sometimes
Intake / Needs Assessment		Sometimes	Yes	Sometimes	
Supportive Interventions: support groups, supportive counseling		Yes	Yes	Sometimes	
Assistance with Daily Living	Sometimes	Yes	Sometimes		
Social activation and engagement	Sometimes	Yes	Yes	Sometimes	
Change Management	Sometimes	Sometimes	Sometimes	Sometimes	Sometimes
**Other functions depending on role					

Competency Overview

In contrast to our first iteration of the Mapping Competencies Framework (2017), this version identifies common competency areas for all volunteers, staff, and caregivers providing care for people living with dementia – the difference across levels is rooted in their knowledge and skills for each area. People identified at "Level 1", for example, generally have an awareness of a particular competency area, whereas people at a "Level 4", and extensive skills and ability to coach in the competency area.

1 Awareness of competency area
2 Understanding of competency area in the context of people with dementia
3 Strong understanding and demonstrated skills in competency area
4 Extensive skills and ability to coach in competency area
5 Expert in competency area

PERSON CENTRED Competency Areas

- Quality of life
- Person-centred (both client **and** family) collaboration and language
- Safety and risk
- Advocacy for the person and family's rights
- Respect and understanding of diversity and cross-cultural awareness

KNOWLEDGE Competency Areas

- Types of dementia (including young onset dementia) and disease trajectories
- Caregiver wellness, coping strategies and abilities, and potential impacts on person with dementia
- Geriatric mental health (conditions, treatment interventions, and approaches)
- Geriatric management of the older adult with multiple, complex medical conditions
- Falls and mobility in people with dementia
- Risks, impacts and interventions related to delirium, pain management, nutrition, bowel and bladder management
- Functional deficits and communication challenges (including cognitive, neurological and behavioural symptoms of conditions)
- Responsive behaviours, triggering factors, potential interventions (including non-pharmacological strategies and practices to promote quality of life)
- Advance care planning
- Consent, Capacity, POA, SDM (SDM Act & MH Act)
- Substance use in the context of dementia (conditions, treatment interventions, and approaches)
- Neurological conditions (conditions, treatment interventions, and approaches)

SCREENING (RISK IDENTIFICATION) and ASSESSMENT Competency Areas

- Changes in behaviour that merit screening and/or referral for screening (both pre and post diagnosis of dementia)
- Screen caregivers for wellness / burden with standardized tool
- Conduct an assessment of the person with dementia (or suspected dementia) within identified domains of the service using a combination of education, experience and abilities) in conjunction with standardized instruments as appropriate
- Comprehensive Geriatric Assessment within the parameters of geriatric medicine
- Comprehensive Geriatric Assessment within the parameters of geriatric mental health
- Within the assessment process:
    - *Use a holistic approach in the assessment process taking into consideration the person's physical, medical, cognitive, psychiatric, functional and social determinants of health using appropriate tools*
    - *Knowledge of medications management including completing a BPMH, identifying potentially inappropriate medications, recognizing polypharmacy, promoting adherence to drug regimen*

- *Identify reliable sources of information to inform the patient history (e.g. Cumulative Patient Profile, involved family etc.) including collateral information sources*
- *Gather information relating to the person's Advance Care Plan (wishes, values and beliefs) or facilitate a discussion about ACP*
- *Recognize and identify risk factors for and assess the presence of abuse/neglect (i.e. financial, physical, emotional, sexual)*
- *Perform and/or interpret an environment safety screen - e.g. living alone*
- *Assessment of the meaning, contributing factors and associated risks of behaviours*

- Within the analysis process:
  - *Analyze and interpret results of the assessment against age-appropriate and person-specific norms*
  - *Analyze and take appropriate action related to important clinical indicators to promote patient safety*
  - *Evaluate the reason for change from baseline pre-morbidity to current functional status*
  - *Demonstrate the ability to deal effectively and efficiently with clinical complexity by prioritizing problems*

COORDINATING CARE (DEVELOPING AND IMPLEMENTING PLAN OF CARE) Competency Areas

- Engage patients, families, and relevant services in shared decision-making to develop a plan of care.
- Evaluate the level of engagement and capabilities of caregiver(s) to meet the needs of the person and include interventions to alleviate caregiver burden / increase caregiver wellness in the care plan.
- Negotiate situations of conflict between older adults and their family members in relation to care planning.
- Knowledge and integration of evidence-informed practices in care plan completion, including but not limited to: person's goals, beliefs, concerns and expectations in the context of their health trajectory; synthesize the agreed interventions and responsibilities including follow-up actions; ensure individual responsibilities across the team are explicit; promote safety while respecting the person's autonomy; ensure optimization of opportunities for health promotion and community connections
- Knowledge and integration of non-pharmacological strategies (preventive, adaptive and therapeutic) that are abilities focused and person-centred within the care plan
- Negotiate situations of barriers to service and/or inter-agency conflicts
- Provide mentoring and coaching to family and staff in implementation of the care plan
- Evaluation of the ongoing effectiveness of the implemented care plan and making adjustments as needed.
- Team leadership and change management skills in adopting new approaches to development / implementation of care plans
- Knowledge of applicable regulations and/or other legislation in the context of the development and evaluation of the care plan i.e. LTC, Tenancy, Mental Health (depends on person's needs)
- Service system resources and when to refer the person / family to other services or community resources

Levels of Competency: Volunteers and Staff

This section speaks to which level of competency (generally) various staff and volunteers fall into – the Education Collaborative fully recognizes that a) not all people in a particular service will be at that level, they may either be working towards attaining that level, or have exceeded that level and b) depending on the functions of the service they work or volunteer in, they may be higher or lower level in specific competency areas, or some competencies may not be applicable. Our expectation is that we will learn over time, and adjust levels and groupings as appropriate

1 Awareness of competency area
2 Understanding of competency area in the context of people with dementia
3 Strong understanding and demonstrated skills in competency area
4 Extensive skills and ability to coach in competency area
5 Expert in competency area

Service Category	Level of Competency by Staff or Volunteer Service Type
Emergency Services	Call-centre staff
	Paramedics
	Community paramedics
	Firefighters
	Police
	Police (subset group that receives additional training)
	ED - Nursing
	ED Physicians
	ED - associated staff (admin, security)
	Mgt
	Psychiatric Emergency Service
	GEM Nurses
	PSW / Health Care Aide
Primary Care: FHT, FHG, CHC, FFS	Care of the Elderly Physicians
	Family physicians
	Nursing
	Allied health
	Administrative Support
	Linda Lee Clinics
Home & Community Supports (CSS, LHIN Home & Community Care, Contracted Providers)	Mgt (All agencies)
	Administrative Support (All agencies)
	Assisted Living Services: PSW & RN (CSS)
	Dementia ADP Program Staff (CSS)
	ADP Volunteers (CSS)
	Friendly Visiting (CSS)
	Transportation - Volunteers (CSS)
	Transportation - Paid (CSS)
	Foot Care (CSS)

	Home support - personal care (can include respite) *CSS & Contracted
	Home Support - Housekeeping *CSS & Contracted
	Meals on Wheels (CSS)
	Non-Dementia ADP Program Staff(CSS)
	LHIN Home and Community Care coordinators
	In-home nursing and other health services *LHIN & Contracted
	Elder Mediators (LHIN Home and Community Care)
	LHIN Information & Referral Team, LHIN Rapid Response Nurses
	Health Links Care Coordinators (cross agency)
DSORC / ASCD *note that some additional community support programs are provided (covered in other area)	Management – minimum Level 3, may be as high as 4 depending on setting
	Dementia / First Link Coaches
	DSORC / AS Volunteers
	Support group facilitators
	Administrative staff
	Educators
Geriatric Services: staff skill mix typically represented with combination of nursing and allied health, social work and specialist depending on the services being provided which can include geriatric day hospitals, geriatric assessment and/or geriatric mental health community teams, acute and specialized inpatient teams, and outreach teams to LTC and retirement home settings, SBSU	Administrative Management
	Service Management
	Specialist Physicians (Geriatrician, geriatric psychiatrist)
	Advanced Practice Nurses
	Community nursing & allied health
	Community Geriatric Assessment Team
	Community Geriatric Mental Health Team (including Behaviour supports)
	LTC Outreach Teams: Behaviour Supports (RN, SW, Behaviour therapists)
	LTCH Outreach Teams: Nurse Practitioner-led
	Psychogeriatric Resource Consultants (PRCs)
	LHIN Home & Community Care Geriatric Assessors
	Inpatient geriatric beds nursing, allied health, social work
	Inpatient geriatric beds PSW & Health Care Aide
	Inpatient geriatric beds geriatric psychiatry, geriatricians, APN
	Inpatient / Consultative BSO nurses
Other hospital services	Discharge planners / social work - acute hospital settings
	Specialist physicians (palliative care, nephrology, respirology etc. - key cross over areas)
	Inpatient palliative care units
	Inpatient rehab & CCC units
Long Term Care	Mgt
	Physicians, Nurse Practitioners
	RNs/RPNs
	PSW
	BSO Champions
	Housekeeping, Food Services
	Allied Health & Supportive services (social work, dietician, PT, OT, rec therapy, pharmacist
	Volunteers
	Diagnostic services: lab, dentistry, x-ray
	Counselors (SW, Counseling, Social Service diploma)

Adult Mental Health Services: LHIN-funded community MH & addictions services, inpt/outpt, crisis, assertive community treatment teams	Case managers (RN, SW etc.)
	Central access workers (usually clinical background)
	Psychiatrists
	RNs
	Volunteers
	Administrative staff
	Mgt
Retirement homes (including short stay beds)	Mgt
	PSW, RN, RPN - regular units
	PSW - Memory Care Unit
	Memory Care Unit: RN, RPN, Mgt
	Housekeeping, Maintenance, Food Services
	Allied Health & Supportive services (dietician, PT, OT, rec therapy)
	Volunteers
Other key partners / services	Supportive housing workers
	Social housing workers
	Local volunteers: Huntington's, Hearing Society, CNIB, Cancer, Kidney
	Elder Abuse Services
	Community palliative care volunteers
	Palliative Consultation Teams
	Residential hospice beds
	Community pharmacists
	Ottawa Public Health Nurses - Caregiver support
College & University Students: Level goals for certain professionals will be different depending on what job they are in after graduation - the goal of this is to ensure a basic understanding of people living with dementia	PSW
	OT
	PT
	OT Aide
	PT Aide
	RN
	SW
	Social service diploma
	MD
	RPN
	Paramedic
	Police Foundations?
	Dental
NOTE – the following categories are more general community categories that do not need to meet Level 1 across all competency areas	Banks
	Transportation providers
	Grocery stores
	Community Living Associations and other developmental services
	Uber, Lyft

Levels of Competency: Caregivers

Caregivers' levels of competency vary based on where they are at in their journey and corresponding needs – the following outlines level by competency, including some additional competencies specific to caregivers, recognizing that early in their journeys, some competencies are not applicable, or the level of competency can be lower.

PERSON CENTRED Competency Areas	**Level of Competency:**
Quality of life	1
Safety and risk	1
Advocacy for the person and family's rights	2
KNOWLEDGE	
Types of dementia (including young onset dementia) and disease trajectories	1
Caregiver wellness, coping strategies and abilities, and potential impacts on person with dementia	3
Falls and mobility in people with dementia	1
Risks, impacts and interventions related to delirium, pain management, nutrition, bowel and bladder management	2
Functional deficits and communication challenges (including cognitive, neurological and behavioural symptoms of conditions)	2
Responsive behaviours, triggering factors, potential interventions (including non-pharmacological strategies and practices to promote quality of life)	2
Advance care planning	2
Consent, Capacity, POA, SDM (SDM Act & MH Act)	2
SCREENING (RISK IDENTIFICATION) and ASSESSMENT	
Changes in behaviour that merit screening and/or referral for screening (both pre and post diagnosis of dementia)	2
Screen caregivers for wellness / burden with standardized tool	2
COORDINATING CARE (DEVELOPING AND IMPLEMENTING PLAN OF CARE)	
Engage patients, families, and relevant services in shared decision-making to develop a plan of care.	n/a
Evaluate the level of engagement and capabilities of caregiver(s) to meet the needs of the person and include interventions to alleviate caregiver burden / increase caregiver wellness in the care plan.	n/a
Negotiate situations of conflict between older adults and their family members in relation to care planning.	2
Knowledge and integration of evidence-informed practices in care plan completion, including but not limited to: person's goals, beliefs, concerns and expectations in the context of their health trajectory; synthesize the agreed interventions and responsibilities including follow-up actions; ensure individual responsibilities across the team are explicit; promote safety while respecting the person's autonomy; ensure optimization of opportunities for health promotion and community connections	2
Knowledge and integration of non-pharmacological strategies (preventive, adaptive and therapeutic) that are abilities focused and person-centred within the care plan	2
Negotiate situations of barriers to service and/or inter-agency conflicts	2
Evaluation of the ongoing effectiveness of the implemented care plan and making adjustments as needed.	2
Knowledge of applicable regulations and/or other legislation in the context of the development and evaluation of the care plan i.e. LTC, Tenancy, Mental Health (depends on person's needs)	1

Service system resources and when to refer the person / family to other services or community resources	2
ADDITIONAL COMPETENCY AREAS FOR CAREGIVERS	
Activities of Daily Living	Levels 1-3
Social engagement and supports	Levels 1-3
Relationship impact	2
Provision of personal care, including toileting and continence issues (basic level – advanced skill-building options identified under behaviour management)	3
Communication and understanding behaviour:	Levels 1-3
§ Basic skill development sessions:	
· Communication and connecting	3
· Apathy / boredom	3
· Identifying and addressing triggers	3
§ Advanced skill development sessions:	
· Managing behaviours in the context of personal care,	3
· Wandering, guarding/territorial behaviours	3
· Vocalizations/repetitive behaviours	3
Sexuality and intimacy	2
How to be a substitute decision maker (including in the context of Power of Attorney, Advanced Care Planning) and building an Advance Care Plan	2
Transitioning to new living environments (including long term care) and tools to support caregivers in the decision-making and transition processes,	2
Medications: management, strategies, problem-solving issues	1

Education and Training Requirements: Levels One and Two

The Collaborative undertook to update existing education and training suggestions to more closely align with specific services and roles people play at Levels one and two. The intention is that the education and training outlined for Level Two, builds on Level One and so both should be completed – even within levels, depending on your role, you would begin with the general public outline, and continue to build on this learning with modules identified within additional groups (for each group, specific instructions for module completion are at the top of the last column). The Collaborative plans to learn from this initial outline and will be considering building these types of learning programs for Level 3 staff, volunteers and caregivers, and potential other next steps over time.

LEVEL ONE: GENERAL PUBLIC	**If you:** Are a member of the General Public or You work with the General Public (example: bank employee, cashier, taxi driver, public transportation)	**You should know about:** What is dementia? What is normal aging vs. dementia? General Communication Skills. Where to get help.	**Here is where to learn more – at your own speed: (FR/EN)** 1. St. Elizabeth Foundation: (<5 min, available in English, French, Spanish, Punjabi, and Simplified Chinese) https://carechannel.elizz.com/resources/mental-changes-with-dementia/ 2. Champlain Dementia Network: http://www.rethinkdementia.ca/#section-interested-in-dementia Dementia Friendly Communities info: 4 videos (Listening Skills, Approach Strategy, Reducing Anxiety, Handling Tasks) (<12 min total) **And depending where you live, more resources are available:** 3. Alzheimer Society of Cornwall & District https://alzheimer.ca/en/cornwall/About-dementia **OR** 4. Dementia Society of Ottawa & Renfrew County: https://dementiahelp.ca/understanding-dementia/resources-factsheets/ Topics include: About Dementia, Caring for Someone with Dementia, Changed Behaviour, Early Signs & Risk Factors

LEVEL ONE: CAREGIVERS	**If you:** Are a Caregiver	**You should know about:** What is dementia? What is normal aging vs. dementia? What are some early signs of dementia? General communication skills. Aware of community support services. Understands different caregiving issues & possible challenges along the dementia journey. Aware of caregiver stress.	**If you have completed the training for the General Public, here is where to learn more – at your own speed: (FR/EN)** 1. Introduction to Caregiving for Someone with Dementia and resources (video: 13 minutes info and 30 min Q&A) https://igericare.healthhq.ca/events/coping-with-caregiving **And depending where you live, more resources are available:** 2. Dementia Society of Ottawa and Renfrew County: Caring for Someone with Dementia: https://dementiahelp.ca/understanding-dementia/resources-factsheets/ **OR** 3. Alzheimer Society of Cornwall & District: Caring for Someone with Dementia: https://alzheimer.ca/en/cornwall/Living-with-dementia/Caring-for-someone **ADDITIONAL OPTIONS:** 4. Living Safely with Dementia -- Interactive Resource Guide (15 mins) http://findingyourwayontario.ca/livingsafely-with-dementia-en/story_html5.html 5. Teepa Snow's Positive Approach® to Care: 7 videos (5-15 min each) Topics include: Brain Changes, Stages, Behaviour, Meaningful Day and Music https://teepasnow.com/ 6. iGeriCare at McMaster University – 10 Online Lessons (10 - 35 mins each): Topics related to Dementia Knowledge, Caregiving and Behaviour (including links to additional videos such as Consent & Capacity): https://igericare.healthhq.ca/lessons 7. Regional Geriatric Program of Ontario: 8 detailed older adult medical issues for caregivers such as Bladder Health and Delirium (can be read online or taken together as a free course (7.5 hours, 1 hour modules once a week is suggested) https://rgps.on.ca/caregiving-strategies/

LEVEL ONE: EMERGENCY SERVICES	**If you:** Are Call-centre staff Are a First Responder (Paramedic, Firefighter, Police)	**You should know about:** What is dementia? What is normal aging vs. dementia? What are some early signs of dementia? General communication skills. Aware of community support services.	**If you have completed the training for the General Public, here is where to learn more – at your own speed: (FR/EN)** **Depending on where you live/work:** 1. Dementia Friendly Communities Training (tailored and delivered by Dementia Society of Ottawa & Renfrew County: https://dementiahelp.ca/programs-services/dementia-friendly/ **OR** 2. Alzheimer Society of Cornwall & District: https://alzheimer.ca/en/cornwall/Get-involved/Dementia-Friend/latest-dementia-friends **ADDITIONAL OPTIONS:** 3. How to recognize Alzheimer's, communicate and search in an emergency (4 videos of 2-3min. each) + Handbook including info on MedicAlert and Locating Devices: https://alzheimer.ca/en/Home/Living-with-dementia/Day-to-day-living/Safety/first-responders 4. Living Safely with Dementia -- Interactive Resource Guide (15 mins) http://findingyourwayontario.ca/livingsafely-with-dementia-en/story_html5.html First responder tips, link to register free online general course http://findingyourwayontario.ca/first-responders/

LEVEL ONE: COMMUNITY & HOME SUPPORT	**If you:** Are working or volunteering in community support services: (example: Administrative Support, Foot care, Adult Day Programs, Friendly Visiting, Community Palliative Care, Meals on Wheels) Are you working in Adult Mental Health Services: (example: Counselors/Social Work, Case managers)	**You should know about:** What is dementia? What is normal aging vs. dementia? What are some early signs of dementia? General communication skills. Aware of community support services.	**If you have completed the training for the General Public, here is where to learn more – at your own speed: (FR/EN)** 1. 10 Warning Signs of Alzheimer's Disease https://alzheimer.ca/en/Home/About-dementia/Alzheimers-disease/10-warning-signs **AND** 2. Supporting Someone with Dementia: The Ontario Centres for Learning, Research, and Innovation in Long-Term Care (6 mins, English) https://clri-ltc.ca/resource/how-to-support-residents-living-with-dementia/ **ADDITIONAL OPTIONS:** 3. Living Safely with Dementia -- Interactive Resource Guide (15 mins) http://findingyourwayontario.ca/livingsafely-with-dementia-en/story_html5.html 4. Teepa Snow's Positive Approach® to Care: 7 videos (5-15 min each) Topics include: Brain Changes, Stages, Behaviour, Meaningful Day and Music https://teepasnow.com/ 5. Caring for the Person with Dementia at Home Lesson (Resistance, Public and Private options) https://igericare.healthhq.ca/lessons/caring-for-dementia-at-home (20-25min) 9 other topics related to Dementia Knowledge, Caregiving and Behaviour from iGericare at McMaster University (10 - 35 mins each): https://igericare.healthhq.ca/lessons

LEVEL ONE: DEMENTIA/ALZHEIMER SOCIETY	**If you:** Are administration staff/volunteer at Dementia Society of Ottawa and Renfrew County or Alzheimer Society Staff.	**You should know about:** What is dementia? What is normal aging vs. dementia? What are some early signs of dementia? General communication skills. Aware of community support services. Aware of caregiver stress. Understands different caregiving issues & possible challenges along the dementia journey.	**If you have completed the training for the General Public, here is where to learn more – at your own speed: (FR/EN)** **1.** 10 Warning Signs of Alzheimer's Disease https://alzheimer.ca/en/Home/About-dementia/Alzheimers-disease/10-warning-signs **AND** **2.** Caring for the Person with Dementia at Home (Resistance, Public and Private options) https://igericare.healthhq.ca/lessons/caring-for-dementia-at-home (20-25min) **OR** **3.** Living Safely with Dementia -- Interactive Resource Guide (15 mins) http://findingyourwayontario.ca/livingsafely-with-dementia-en/story_html5.html **And depending where you live, more resources are available:** **4.** Dementia Society of Ottawa and Renfrew County: Dementia and Caregiver Education and Programs https://dementiahelp.ca/ **OR** **5.** Alzheimer Society of Cornwall & District: Dementia and Caregiver Education and Programs https://alzheimer.ca/en/cornwall

LEVEL ONE: PRIMARY CARE	**If you:** Work as support or admin staff in Primary Care: Family Health Teams, Community Health Centres	**You should know about:** What is dementia? What is normal aging vs. dementia? What are some early signs of dementia? General communication skills.	**If you have completed the training for the General Public, here is where to learn more – at your own speed: (FR/EN)** 1. 10 Warning Signs of Alzheimer's Disease https://alzheimer.ca/en/Home/About-dementia/Alzheimers-disease/10-warning-signs **AND** 2. Caring for the Person with Dementia at Home (Resistance, Public and Private options) https://igericare.healthhq.ca/lessons/caring-for-dementia-at-home (20-25min) **OR** 3. Living Safely with Dementia -- Interactive Resource Guide (15 mins) http://findingyourwayontario.ca/livingsafely-with-dementia-en/story_html5.html **ADDITIONAL OPTIONS:** 4. iGericare at McMaster University – 10 Online Lessons (10 - 35 mins each): Topics related to Dementia Knowledge, Caregiving and Behaviour (including links to additional videos such as Consent & Capacity) https://igericare.healthhq.ca/lessons

LEVEL ONE: LONG-TERM CARE	**If you:** Are staff in areas such as Housekeeping, Food Services Volunteer Services in long-term care facilities and retirement homes	**You should know about:** What is dementia? What is normal aging vs. dementia? Quality interaction skills Recognizing and Understanding caregiver stress	**If you have completed the training for the General Public, here is where to learn more – at your own speed: (FR/EN)** 1. Supporting a Resident with Dementia: The Ontario Centres for Learning, Research, and Innovation in Long-Term Care (6 mins, English) https://clri-ltc.ca/resource/how-to-support-residents-living-with-dementia/ **And depending where you live, more resources are available:** 2. Alzheimer Society of Cornwall & District https://alzheimer.ca/en/cornwall/About-dementia **OR** 3. Dementia Society of Ottawa & Renfrew County https://dementiahelp.ca/understanding-dementia/resources-factsheets/ Topics include: About Dementia, Caring for Someone with Dementia, Changed Behaviour, Early Signs & Risk Factors **ADDITIONAL OPTIONS:** 4. Teepa Snow's Positive Approach® to Care: 7 videos (5-15 min each). Topics include: Brain Changes, Stages, Behaviour, Meaningful Day and Music https://teepasnow.com/ 5. iGeriCare at McMaster University – 10 Online Lessons (10 - 35 mins each): Topics related to Dementia Knowledge, Caregiving and Behaviour https://igericare.healthhq.ca/lessons Additional videos such as I want to go home and Communication Issues) https://igericare.healthhq.ca/resources

LEVEL TWO: EMERGENCY SERVICES	**If you:** Are a Community Paramedics Are Police (receiving additional training) Are ED - Nursing Are ED- Physicians Are Psychiatric Emergency Service [working directly with persons with dementia]	**You should know about:** What is dementia? What is normal aging vs. dementia? What are some early signs of dementia? General communication skills. Aware of community support services. Aware of caregiver stress. Understands different caregiving issues & possible challenges along the dementia journey.	**COMPLETE LEVEL ONE TRAINING AND THEN ADDITIONAL OPTIONS:** 1. Finding Your Way -- Alzheimer Society http://findingyourwayontario.ca/first-responders/communication-tips/ 2. Communication Tips for First Responders 4 MODULES (15 min each): Understanding dementia and its associated risks Communicating with a person with dementia Helping people with dementia to live safely in the community Interacting with a person with dementia who may be lost http://findingyourwayontario.ca/online-learning
LEVEL TWO: COMMUNITY & HOME SUPPORT	**If you:** Are staff working in community support services: (example: Ontario Health Home & Community Care Coordinators, Adult Day Program Coordinators)	**You should know about:** What is dementia? What is normal aging vs. dementia? What are some early signs of dementia? General communication skills. Aware of community support services. Aware of caregiver stress. Understands different caregiving issues & possible challenges along the dementia journey. Knows that activities and the environment impact the person with dementia.	**COMPLETE LEVEL ONE TRAINING AND THEN ADDITIONAL OPTIONS:** 1. Living Safely with Dementia -- Interactive Resource Guide (15 mins) http://findingyourwayontario.ca/livingsafely-with-dementia-en/story_html5.html 2. Teepa Snow's Positive Approach® to Care: 7 videos (5-15 min each) Topics include: Brain Changes, Stages, Behaviour, Meaningful Day, and Music https://teepasnow.com/ 3. iGericare Lesson # 9 Managing Behavioural Issues in Dementia (35-40min) https://igericare.healthhq.ca/lessons/managing-behavioural-issues-in-dementia **ALSO, AVAILALBLE:** 4. iGeriCare at McMaster University – 10 Online Lessons (10 - 35 mins each): Topics related to Dementia Knowledge, Caregiving and Behaviour (including links to additional videos such as Consent & Capacity): https://igericare.healthhq.ca/lessons 5. Regional Geriatric Program of Ontario: 8 detailed older adult medical issues for caregivers such as Bladder Health and Delirium (can be read online or taken together as a free course (7.5 hours, 1 hour modules once a week is suggested) https://rgps.on.ca/caregiving-strategies/

		Able to conduct a needs assessment for Adult Day Programs.	6. Unregulated professional: U-First! Understanding Behaviour Certificate granted for attending in-person workshop, 1 - 6 hr workshop, eLearning takes 6 hrs. max. Both for $75. http://u-first.ca/training-registration/ **OR** 7. Regulated professional: P.I.E.C.E.S. Behaviour Assessment Framework (2 days over 2 weeks in person workshop, 16hours) http://pieceslearning.com/ontario/ 8. DementiAbility (increase engagement in meaningful activities). Two-day program focuses on DementiAbility Methods – The Montessori Way - $400 for course. https://www.dementiability.com/the-montessori-way
LEVEL TWO: DEMENTIA/ALZHEIMER SOCIETY	**If you:** Are program and support staff at Dementia Society of Ottawa and Renfrew County or Alzheimer Society Staff.	**You should know about:** What is dementia? What is normal aging vs. dementia? What are some early signs of dementia? General communication skills. Aware of community support services. Aware of caregiver stress. Understands different caregiving issues & possible challenges along the dementia journey.	**COMPLETE LEVEL ONE TRAINING AND THEN ADDITIONAL OPTIONS:** 1. Living Safely with Dementia -- Interactive Resource Guide (15 mins) http://findingyourwayontario.ca/livingsafely-with-dementia-en/story_html5.html 2. Teepa Snow's Positive Approach® to Care: 7 videos (5-15 min each) Topics include: Brain Changes, Stages, Behaviour, Meaningful Day, and Music https://teepasnow.com/ 3. iGericare at McMaster University – 10 Online Lessons (10 - 35 mins each). Topics related to Dementia Knowledge, Caregiving and Behaviour https://igericare.healthhq.ca/lessons Additional videos such as Communication Issues and Consent & Capacity https://igericare.healthhq.ca/resources 9. Regional Geriatric Program of Ontario: 8 detailed older adult medical issues for caregivers such as Bladder Health and Delirium (can be read online or taken together as a free course (7.5 hours, 1 hour modules once a week is suggested) https://rgps.on.ca/caregiving-strategies/

LEVEL TWO: PRIMARY CARE	**If you:** Are an Allied health professional Are a Care of the Elderly Physician Are a Family Physician Are a Nurse [regulated health care professionals]	**You should know about:** What is dementia? What is normal aging vs. dementia? What are some early signs of dementia? General communication skills. Aware of community support services. Aware of caregiver stress. Understands different caregiving issues & possible challenges along the dementia journey.	**COMPLETE LEVEL ONE TRAINING AND THEN ADDITIONAL OPTIONS:** 1. iGeriCare Lesson #2 What is Mild Cognitive Impairment (15-20min) https://igericare.healthhq.ca/lessons/what-is-mild-cognitive-impairment + Lesson #3: How to promote brain health (10-15min) https://igericare.healthhq.ca/lessons/how-to-promote-brain-health 2. 8A's of Dementia - The Ontario Centres for Learning, Research, and Innovation in Long-Term Care (30 mins) English Version: https://clri-ltc.ca/emodules/LTC-9-Dementia/Caring-for-Persons-with-Dementia/story.html French Version: https://clri-ltc.ca/emodules/LTC-9-Dementia/Prendre-soin-de-personnes-atteintes-de-démence/story.html **ALSO, AVAILALBLE:** 3. Comprehensive Geriatric Assessment Toolkit (Cognition Screening Tools, e-modules and videos on Dementia, Delirium and Behavioural Issues) https://cgatoolkit.ca/6/Cognition/ 4. Regulated professional: P.I.E.C.E.S. Behaviour Assessment Framework (2 days over 2 weeks in person workshop, 16hours) http://pieceslearning.com/ontario/ **OR** 5. Unregulated professionals: U-First! Understanding Behaviour Certificate granted for attending in-person workshop, 1 - 6 hr workshop, eLearning takes 6 hrs. max. Both for $75. http://u-first.ca/training-registration/
LEVEL TWO: LONG-TERM CARE	**If you:** Are Personal Support Worker Staff in long-term care facilities and retirement homes, Adult Day Programs [unregulated health professionals]	**You should know about:** What is dementia? What is normal aging vs. dementia? What are some early signs of dementia? General communication skills.	**COMPLETE LEVEL ONE TRAINING AND THEN ADDITIONAL OPTIONS:** 1. 8A's of Dementia - The Ontario Centres for Learning, Research, and Innovation in Long-Term Care (30 mins) English Version: https://clri-ltc.ca/emodules/LTC-9-Dementia/Caring-for-Persons-with-Dementia/story.html French Version: https://clri-ltc.ca/emodules/LTC-9-Dementia/Prendre-soin-de-personnes-atteintes-de-démence/story.html

		Aware of community support services. Aware of caregiver stress. Understands different caregiving issues & possible challenges along the dementia journey. Knows that activities and the environment impact the person with dementia.	**ALSO, AVAILALBLE:** 2. Gentle Persuasive Approach (GPA) Certificate granted for attending 4 modules, 7.5 hr day in person workshops, $21/manual (in-house facilitator). GPA eLearning 2-3 hrs for course -- $45. https://ageinc.ca/about-gpa-2/ 3. DementiAbility (increase engagement in meaningful activities). Two-day program focuses on DementiAbility Methods – The Montessori Way - $400 for course. https://www.dementiability.com/the-montessori-way 4. U-First! Certificate granted for attending in-person workshop, 1 - 6 hr workshop, eLearning takes 6 hrs. max. Both for $75. http://u-first.ca/training-registration/

Appendix A: Key thematic areas related to barriers to implementing learning from education and training opportunities

- An overarching principle of this work is how we can best support environments where staff are empowered to put their training and education into practice, and family/caregivers understand the rationale underlying different approaches (including what strategies are helpful on a daily basis when living with someone with dementia),
- There can be policies and practices in place that prevent people from effectively putting their knowledge into practice – of particular importance is concerns about risks and liability,
- In certain settings, there are regulations or other reporting requirements that impact people putting knowledge into practice
- Support from management and support from families can be critical in supporting changing of practice – there is an overall culture that supports evidence-based practice
- Front-line workers require access to coaching and mentoring – within their work environments but also opportunities to see how "like" environments function

	BARRIERS	**INTERVENTION ACTIVITIES**
CAPABILITY	Attitudes and beliefs about dementia Lack of knowledge about dementia Perceived lack of skills to implement intervention Fear of liability / risk Client/family beliefs about Dementia and level of care	Classroom education Follow-up education (e.g. one-on-one coaching) Staff and patient posters Promotions Patient pamphlets/ handouts Display Seniors' groups Volunteer activities
OPPORTUNITY	Time constraints and heavy workload Lack of clarity regarding roles and responsibilities High level of documentation requirements Physical environments (e.g. for LTC) Presence of other priorities and initiatives Existing climate/culture of organizations Lack of communication between health-care providers and with the family and clients regarding client's care plan Lack of resources Lack of accountability Client's acuity	Leadership activities Huddles Staff meeting/rounds Promotions Reminders Dementia champions Volunteer activities Documentation Equipment
MOTIVATION	Attitudes and beliefs about Living well with dementia Resistance to implement interventions Lack of clarity regarding roles and responsibilities Existing climate/culture of organizations Lack of accountability Client/family beliefs about Living well with dementia Client's symptoms / behaviour	Reminders Education and training champions Follow-up education (i.e. one-on-one coaching) Audits Documentation Leadership activities Volunteer activities Patient social Activities

Appendix B: Care Coordination - Practice-level Considerations

Overview

Care coordination is based on a population and their needs, and is a way to deliberately and systematically organize care. There is an infrastructure (including policies, communication, and resources) to support care coordination. Essentially, care coordination helps to ensure that the person's needs and preferences for health services and information sharing across people, functions, and sites are met over time.

Broadly, the Care Coordinator is the person who assists people in navigating to the right services – this role could be fulfilled by the person receiving care and services who navigates systems on their own behalf. A care coordinator can also be a family caregiver, a volunteer from a community agency or within a system, and it can be a professional within a system or hired directly by a person receiving care and supports (or their family on their behalf).

The primary roles of a care coordinator include:

- The person who is most responsible for identifying an individual's health goals and coordinating services and providers to meet those goals: they are the "go-to" person for the client and caregiver when they have questions,
- Works with the client to identify life and health goals, and coordinates services and providers to work towards better health outcomes,
- Ensures there is "warm hand-off" when people are transitioning to new services, or new living environments.

The frequency and intensity of client contacts, and the way in which these contacts are made, depend on the client group. It is clear that, at a minimum, an in-person meeting is required to begin the care coordinator / client relationship, and that this in-person meeting should focus on what the client and family goals are – both today, and in consideration of future planning. This concept of "levels of care coordination" and what practices, knowledge and skills are required at each level, will be more fully explored in the project's final report, and in concert with the emerging levels of knowledge work being undertaken by the CDN Education & Training Collaborative.

- Steps in care coordination:
  - Information gathering process: Care coordinator conducts relevant assessments (or gathers information of relevant assessments) and meets with clients and the natural support network (family, friends, caregivers) to identify current and future needs,
  - Value proposition: Care coordinator outlines all possible services that can be provided / referred to, and which work together with the person's own resources
  - Service design: care coordinator defines the components of the individual's chose services – then identifies where there will be coordination among providers in the service plan, outlining each person's responsibilities
  - Service delivery: care coordinator ensures services are delivered as identified in the plan and ensures ongoing collaboration among the players, and ongoing evolution of the plan based on the person's needs and wants.

Care coordinators could be from a variety of agencies and backgrounds (such as a CCAC care coordinator, social worker, physician, nurse practitioner) but could also be a lay person (family member or peer support worker). At the project initiation, a variety of key competencies in care coordination were identified, and the following begins to organize these competencies using a levelled approach – again, this will be more fully developed in the final report, but presents some initial learnings. **Although the key roles of care coordinators identified above would be fulfilled at every level, the complexity of the client would increase moving from novice to expert levels.**

The Key Elements of Effective, Meaningful Care Coordination

The interim report identified a number of 'emerging directions' with respect to care coordination – we summarize these key elements below together with examples of what this means at a practice level.

Key element: Care coordination needs to be structured and supported in such a way that people are able to ask the right questions, at the right time and in the right setting when working with people living with dementia and their caregivers. This means Investing more time up front with people living with dementia and caregivers in understanding the current situation, and future needs, potentially saves time later. There are different client groups in terms of levels of care: this should be reflected in the way in which care coordination is provided to these groups – for people requiring higher levels of care, for example, in-person assessment and care coordination is crucial, particularly at the beginning of the relationship with the client and caregiver,

Practice level:

- The first question asked is about the person's goals – planning in that moment and in the future is based on these goals, and the degree of risk tolerance / risk management reflects the person's goals
- Assessment methods and timing are flexible based on the person's needs i.e. if client is not a morning person, then the assessment shouldn't take place then, even if it's the regular policy
- Face-to-face, in-home contact is really important especially for people whose needs are increasing
- People are provided enough time to do the work with clients and caregivers that's needed – from developing a care coordination plan to providing a bath in the home
- If the assignments are task-oriented and the nursing or personal support staff are coming in to do one specific task, they are observant of the other issues that are going on, and report back to the rest of the care team
- When a staff from one organization reports their observations to staff in another organization, this needs to be actioned and original staff is provided with feedback on the outcome
- Circle of care is an enabler not a barrier and staff actively work within this philosophy and are supported by their management and organizational policies in doing so

Key element: Effective care coordination occurs across the system – there may be transitions from one organization to another, or one care coordinator to another, but this process should be straightforward, clear, and supportive for clients and caregivers

Practice level:

- Every person living with dementia and caregiver must have a go-to person (care coordinator) they can approach if there is a problem or symptom change, or other question
- All organizations are welcoming to people, even if it's not the correct organization for them to be at – this means that they are committed to a "warm transfer" policy i.e. they stay with a person until they get to the place they need to be (e.g. call this number and, if you have any further issues, please call me back)
- In some of circumstances, it may be that one organization needs to continue with their care coordination even beyond the point that they would normally do so – this would not occur often, but for people with complex issues, significant behavioural support needs, or where there are safety concerns, exceptions to policies should be made e.g. transition to long term care homes for a small number of clients
- Community care coordinators must be part of care planning conferences when person is in hospital
- Families where spouses are both receiving care coordination services should have the same care coordinator, to the greatest extent possible
- Where individual staff are interpreting rules for access differently, organizations have policies in place where they can go to management or other sources to seek clarification on the rules

Key element: Coordination among primary care, community care and specialized geriatric services (geriatric mental health, geriatrics, care of the elderly physicians) supports clients and families in their journey, and to live well with dementia. As noted, client confidentiality and privacy requirements shouldn't be a barrier to cross-organization collaboration, in the context of effective care coordination and navigation. Members of the care team trust one another's judgement and knowledge.

Practice level:

- The care team needs to include the people who are engaged with the person living with dementia and the caregiver – this can include the family physician or nurse practitioner, geriatricians, geriatric psychiatrist,

community support services, care coordinators, paramedics, inpatient and outpatient hospital staff, pharmacy, LTC homes, retirement homes, police, older adult protection services etc.

- The team reflects the goals of the client and the expectation is that there are care team members who are not regulated health professionals.
- The team puts together a plan based on the person's goals and wishes for service.
- The team ensures that medication reconciliation is completed. They further ensure that, to the greatest extent possible, the person utilizes one community pharmacy – this is particularly important in complex or complicated situations.
- The team doesn't just identify issues – it follows through on needed actions
- The team ensures that as disease progresses or changes, management and follow-up by specialized geriatrics is timely
- Every team designates who is the 'lead' or 'go-to' at any point in time - there is a continuous feedback loop that ensures that care coordinator informs services / physicians of changes and issues and this is reciprocated
- The care team moves with the person in and out of hospital – you plan with the people who know the client best and that the client knows and trusts.
- Integrating collective knowledge about a client and family and ensuring the circle of care conversations are taking place (i.e. if one member of the care team can go into the home, and then can coordinate with other members of the team on contributing that knowledge towards the overall assessment)
- Participating in the assessment process when required – as well, if one member of the team has done an assessment, other members don't repeat elements that are already captured in that assessment, they add to the 'picture'
- Recognize that there are circumstances where different service providers such as should be present for or involved in an assessment
- The onus is on the care team to ensure the clients and families have clear messaging about diagnosis, recommendations on actions needed, and how best to support goals– where there's disagreement or miscommunication within the team, the team needs to resolve this so that the family is not receiving different and potentially conflicting messaging

Key element: Workers need to be provided with training and education to support people living with dementia and their caregivers. Moreover, management at organizations recognize that they are responsible for the wellbeing of their staff, and that this directly translates to the quality and effectiveness of care coordination and services provided.

Practice level:

- All organizations reflect on the dementia knowledge pyramid and levels of care coordination table – they identify their current and future desired state. They actively build linkages with organizations at higher level for the purpose of practical training and education, coaching and mentorship for consolidating skills learned, and consultation in complex or complicated situations.
- Organizations within the same level outreach to each other to share upcoming education and training opportunities that can be provided across organizations.

Key element: Every person living with dementia and their caregivers need to have access to specific in-home supports that they need and want – this includes, but is not limited to, in-home supports may include personal care, housekeeping, home maintenance, and respite,

Practice level:

- Organizations review their programming in the context of the CDN multi-year respite strategy to ensure the highest degree of flexibility
- Organizations actively identify ways in which they can utilize funds flexibly to meet the needs of people living with dementia and caregivers
- Organizations demonstrate how people living with dementia and caregivers are actively designing the programming

- Caredove is used by service providers to navigate clients to appropriate in-home supports – eligibility criteria are applied flexibly in unique situations

Key element: Documentation requirements can hamper amount of time spent with clients and should reflect the information that's needed to reasonably monitor the system.

Practice level:

- Organizations need to regularly review what they ask their staff to document to make sure it reflects client needs

Key element: Integration and collaboration is most effective when it's occurring at both the management levels and front-line levels across organizations.

Practice level:

- There needs to be clear expectations of accountability in collaboration – clear process on how to clarify interpretation of rules
- Front-line staff have opportunities to input to systems activities to give a true picture of 'what is' versus 'what it should be'

The following outlines some potential areas / strategies for education and training for people providing care coordination, and may be more or less relevant according to the type and intensity of care coordination being offered:
○ Orientation to allied partner organizations and referral patterns
○ Job Shadowing
○ Risk and Crisis Management
○ Future planning
○ Respite Services: Options and Accessing Services
○ Advance Care Planning
○ Consent & Capacity
○ Person-centred care and goal-setting training such as motivational interviewing (or other equivalent)
○ Practice case scenarios
○ Cultural Safety
○ Living Healthy Champlain training on self-management
○ Brief action planning / Bruyère
○ Mediation training (modelled on training incorporated as part of the Elder Mediation / Respite and Relief Program)