PSYCHOGERIATRIC RESOURCE CONSULTATION PROGRAM IN TORONTO: PROGRAM OVERVIEW

Service Provider Name:	Date:
Regional Geriatric Program of Toronto	**March 31, 2011**

1. Agency Service Plan Development:

The initial 2002 service plan for the Psychogeriatric Resource Consultation Program in Toronto (PRCProgram) was undertaken following consultations with internal and external stakeholders, including the Department of Geriatric Psychiatry, the RGP Board, CCAC representatives, the Alzheimer's Society, the Centre for Addictions & Mental Health and members of the RGP network of hospitals who were asked to indicate their willingness to participate as host organizations. Inputs were also collected from the Ontario Long Term Care Association, the Ministry of Health and Long-Term Care and focus groups of seniors.

Subsequent service plans have been informed by focus group consultations with Community Service Agencies, intersectoral meetings of health professionals engaged in dementia care, focus groups of family care-givers, host organization administrators, our own annual program retreats and our interactions with the task forces and committees with which the PRCProgram work (see table 1a) by a survey of Long-Term Care Administrators, the MOH/LTC Seniors Mental Health Steering Committee process and most recently by the emergence of LHINs.

2. Agency Profile:

The Psychogeriatric Resource Consultation Program in Toronto

Frail seniors with mental health challenges are a fast growing demographic group in Ontario. Though dementia is not an inevitable characteristic of frailty, nor an inevitable consequence of aging, the burgeoning population of seniors and an incidence rate of 6% for seniors over age 65 years and 35% for seniors over 85 years makes dementia an issue of epidemic proportions. But dementia is one of several mental health issues experienced by seniors such as psychosis, paranoia, personality disorder, and bipolar disorders that, like dementia, present residents/clients and caregivers with significant behavioral and high-risk consequences. The incidence of depression and psychosis in long-term care homes is 15-25% and 12-21%, respectively. Unlike agitation associated with dementia, which is limited to a particular stage of the dementing process, agitation arising from these other psychiatric disorders can be prolonged and are less likely to be self-limiting. The PRCProgram is an enduring legacy of the MOHLTC's Alzheimer's Strategy.

The Psychogeriatric Resource Consultation Program in Toronto is comprised of an interdisciplinary team of health professionals providing educational knowledge to practice services to those providing care to people with a dementing illness in the city's long-term care facilities, community service agencies and CCACs.

The team collaborates with ongoing related initiatives such as the provincial PIECES and U-First! curriculum initiatives and the dementia networks and finds opportunities to facilitate inter-sectoral collaboration in dementia care and seniors mental health.

The team maximizes its capacity for self-direction in order to meet the needs of its customers at the times that is convenient to them and is able to provide services across all shifts and on weekends as necessary.

Each of the eleven educators is an employee of a host organization (hospitals with one exception - Baycrest); in order to more effectively liaise with caregiving in-patient and community psychogeriatric services. Each educator has a set of LTCHs for which they are primarily responsible. As well, each educator has an area of special interest that can be called upon across the region. Areas of special interest include Diversity, Pain, Acquired Brain Injury, stroke, provincial curricula and etc.

The program is managed by the Regional Geriatric Program of Toronto in a distributed matrix management model that is governed by service agreements, as outlined below. Each host organization is a member of the RGP Network of 28 institutions providing or developing specialized geriatric services for frail seniors. The Program provides services in five LHINs: Toronto Central, Central, Central East, Central West and Mississauga-Halton.

The Mission of the RGP

The Regional Geriatric Program of Toronto (RGP) provides leadership in service, teaching, research and advocacy regarding the care of frail seniors across the GTA. Frail seniors are the fastest growing demographic group in the province and are characterized by complex and co-occurring bio-psycho-social and functional problems.

RGP services include outreach teams, ambulatory care clinics, acute geriatric assessment units, internal consultation teams, geriatric rehabilitation programs, day hospitals and geriatric emergency management services. Together, these services should provide a seamless continuum of care to treat acute illness and return a frail senior to the highest possible level of independent functioning fully linked with the services provided by their primary care physicians and CCAC. More than 50% of the frail seniors serviced by the RGP affiliated specialized geriatric services are coping with a dementing illness.

The RGP Affiliated Network of Services for People with a Dementing Illness

Caring for people with dementia is part of the every day work of Toronto's Specialized Geriatric Services teams. The proportion of patients with cognitive impairment in our services ranges from greater than 75% in our Ambulatory Clinics to greater than 50% in our Outreach Services and Acute Geriatric Units. Caring for people with dementia is a significant part of our work. Despite the prevalence of dementia, we help people to maintain community tenure. On our Acute Geriatric Units, for example, 84% of admissions are returned to their community upon discharge.

The RGP Service Network

The RGP's participating organizations have provided services to frail seniors since 1989, and have grown in number from the seven founding members situated in the city’s teaching hospitals to include a network of 29 hospitals across the GTA and surrounding areas. The key criterion for becoming an RGP participating organization is the wish to develop and support specialized services for frail seniors. Ideally, these services include, outreach teams, and ambulatory care clinics, acute geriatric assessment units, internal consultation teams, geriatric rehabilitation programs, day hospitals and geriatric emergency management services. Together, these services should provide a seamless continuum of care to treat acute illness, and return a frail senior to the highest possible level of independent functioning linked with the services provided by their primary care physician and CCAC.

The Ministry of Health and Long-Term Care fund Regional Geriatric Program of Toronto services.

RGP Governance

The RGP is an incorporated organization governed by a board of directors, with a broad representation providing oversight and direction. The RGP's operations are led by a Program Director who chairs the Network Advisory Council, comprising of medical directors and the administrators responsible for specialized geriatric services in each participating organization. These, in turn, are served by a small "head office" team comprising of specialists in administration, education and knowledge transfer, information management and program evaluation. The RGP manages a modest budget to support clinical services among its founding members, and provides educational, information and advocacy services to add value to newer participating organizations.

The driving force behind the RGP alliance is its capacity to find synergies and add value to its membership and the community through collaborative action.

Maintenance of a Strong Independent Identity for the Psychogeriatric Resource Consultation Program

The RGP undertook the management of the PRCProgram, because it's distributed network of hospitals and affiliated organizations lends itself to the Ministry of Health and Long Term Care's vision of a Toronto-wide educational consultation program. Each of Toronto's eleven PRCProgram consultants is an employee of one of the 10 host organizations, all of whom are members of the RGP alliance, with a strong commitment to community focused psychogeriatric and geriatric services.

The RGP continues to ensure that the program's resources remain dedicated to the mission of the PRC Program. While integrated within the RGP distributed network management framework, the program is managed independently from the RGP's Specialized Geriatric Services, and that while distributed across the city, the consultants are able to maintain strong connections and a program identity.

The responsibilities of the RGP outlined in the participation agreements include(d):

- Use explicit criteria to identify appropriate host organizations.
- Development of an initial role profile
- Assist in recruitment
- Manage the program's overall budget
- Facilitate consultant training and development
- Convene regular meetings of consultants
- Provide a means of electronic support to consultants (email and chat services)
- Provide an online knowledge resource base for consultants
- Assist with risk management
- Support learning needs assessments and outcome evaluations
- Facilitate the development of a communications initiatives
- Recruit and support an administrative assistant (.6 FTE)
- Explore integration with the RGP information system
- Preparation of reports to the Ministry
- Ensure coordination of an on-call weekend coverage rotation
- Be accountable to the Ministry for the use of funds
- Ensure the maintenance of quality assurance activities
- Provide program focused performance appraisal
- Ensuring that complaints from agencies or the public are managed effectively

The responsibilities of host organizations include:

- Recruitment in light of job description guidelines
- Provision of office space and information services
- Provide organization focused performance appraisal
- Management of salary and expenses allocations
- Clinical supervision and mentorship
- Participate in the formulation of an agreement of participation

PRCP and PIECES

The RGP takes its responsibility to the region's long-term care facilities very seriously. It was a lead organization along with the Division of Geriatric Psychiatry at the University of Toronto, in coordinating the Long-Term Care/Mental Health Interface Training Initiative, which implemented the PIECES Psychogeriatric Guide and Training Program in South Central Ontario. This was an area that stretched from Etobicoke to Peterborough and from Penetanguishine to Lake Ontario. At that time, the RGP convened PIECES workshops for facility administrators and the Association of Physicians in Long-Term Care and has provided assistance to projects coaching transfer of training through educational teleconferencing.

An important role of the Psychogeriatric Resource Consultant (PRC) is to support the in-house PIECES resource person(s) in each of the Long-Term Care Homes. Coaching resource persons in the use of PIECES is ongoing. Our consultants report that they use the PIECES materials "all the time".

The Six Question Template, the PIECES framework and the ABC approach are among the most valued and frequently used elements of PIECES. Several consultants have developed materials to augment PIECES, such as a PIECES worksheet to assist staff in problem solving.

The PRCProgram also supports the Scarborough Psychogeriatric Action Network (SPAN) formed to provide information services, allowing PIECES prepared staff to more easily request advice/guidance from the Scarborough PRCProgram, and from each other.

Specific contributions to PIECES and U-First include PIECES LTC training, PIECES community training, Enabler training and U-first training.

To encourage and support the PIECES and U-First! programs, the PRCP consultants also liaise closely with psychogeriatric community services, are members of the Psychogeriatric Community Services Working Group, and other psychogeriatric service committees and working groups as outlined below.

PRCP, Psychogeriatric Outreach Teams and Inpatient Behavioral Units

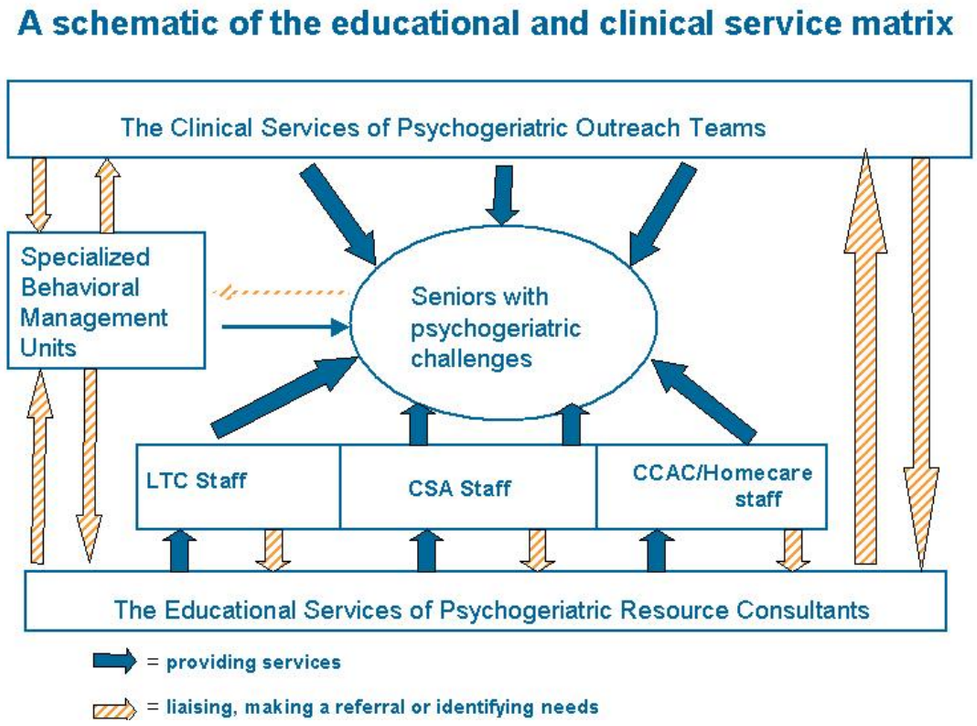
The MOHLTC investment in expanded clinical psychogeriatric outreach services in Toronto has provided a context in which the PRCProgram was able to expand the domain of its educational services beyond a primary focus on dementia to include the broader issues of behavioral and high risk behaviors associated with these other high frequency psychiatric disorders.

In 2007/08 an expansion of Psychogeriatric Clinical Outreach Teams was completed with oversight provided by MOHLTC Psychogeriatric Services Steering Committee and its associated task forces. The PRCProgram aligned itself with new Psychogeriatric Outreach Team's and has developed a best practice in providing knowledge to practice services at the interface of LTC homes and Inpatient Behavioral Assessment and Management Units.

In order to maintain close liaison with the Clinical Psychogeriatric Service Community the PRCProgram has also undertaken the following:

- Membership on the steering committee and task forces associated with the Long-Term Care/ Mental Health Steering Committee Process
- Membership on the city-wide Psychogeriatric Clinical Care Committee
- Cross-referrals and collaboration with 13 of the city's geriatric psychiatrists
- Direct matrixed reporting relationships with four community psychogeriatric teams
- Co-location with community psychogeriatric services in four locations
- Facilitation of educational events for psycho-geriatricians in long-term care settings.
- Participation in monthly meetings of community psychogeriatric services in four locations,
- Other Memberships
    - Community Advisory Committee for Geriatric Psychiatry at Toronto Rehab. Institute
    - CAMH Community Advisory Panel membership
    - Scarborough Psychogeriatric Service Group
    - CPSE team (Community Psychiatric Services for the Elderly)
    - Baycrest Geriatric Psychiatry Community Services Team
- Provincial Psychogeriatric Service Involvement
    - Ontario Psychogeriatric Association Board memberships
    - Co-editor of the Ontario Psychogeriatric Association Newsletter

The following diagram provides one perspective on the relationship between PRC, POP and Inpatient Units:



Building PRCProgram Services in the Community

The enhanced clinical psychogeriatric outreach teams, focused their attention to Long Term Care and this provided an opportunity for the PRCProgram to enhance its services in the community sector and more able to respond to the needs of Community Service Agencies and CCACs. Since 2007, the PRCs have set goals to enhance their services in these communities that includes Community Service Agencies (CSA), Community Care Access Centres (CCAC) and other community focused dementia caregivers within such organizations as Primary Health Care Teams, Police and EMS services and Supportive Housing. Finally, a summary of our educational resources to the broader community is found below. This process will continue into the 2011/12. Table 1a provides an overview of the distribution of PRCProgram services across the sectors of care.

The distribution of PRCProgram activities across its' three key client groups since program start-up is summarized in Table 1a. Since start-up the proportions of direct service to our CSA, LTC and CCAC caregivers/clients have hovered around 10%, 87% and 3% respectively. The program has consistently met its performance targets.

Table 1a. Proportions of service by client group since program start-up

	Number of Caregivers/Clients			Number of Direct Education Hours			*Other Activities		
YEAR	CSA CG	LTC CG	CCAC Clients	CSA Hours	LTC Hours	CCAC Hours	CSA	LTC	CCAC
2001/02	2361	7936	693	489	973	95	N/A	N/A	N/A
2002/03	3745	17176	1183	646	2323	201	1286	5076	406
2003/04	3293	15765	960	674	2414	202	1590	6275	502
2004/05	3124	21337	1146	1058	4076	235	1475	5824	466
2005/06	2945	22990	1643	907	4536	324	1504	5938	475
2006/07	2358	19866	766	799	4166	138	1000	5062	187
2007-08	2266	20564	337	595	4823	100	774	6120	140
2008-09	1648	23842	439	355	5349	140	447	6819	149
2009-10	2201	23753	885	355	5720	166	380	5836	127
2010-11	1926	22093	924	406	5864	107	390	5978	130

*Other Activities include Planning, Preparation, Meetings, Travel, Committees, Continuing and Intersectoral Education.

CSA = Community Service Agencies
CCAC = Community Care Access Centres
LTC = Long-Term Care Facilities
CG = Caregivers

PRCProgram Services to Emergency Responders and Primary Care

The PRCProgram consultants are involved with the region's Emergency Response Teams, Emergency Room staff and family physicians as follows:

1. As a result of the regions Seniors Mental Health and Long-Term Care Planning initiatives, a framework for knowledge to practice (KTP) work in support of seniors mental health was developed in collaboration with Toronto Police Services. The framework comprises 7 elements, which while standing alone as value adding KTP services, together comprise a complete KTP program. Discussions in support of the framework are ongoing.
2. The PRCProgram manager is co-investigator in the PERIL program developing the capacity of EMS services staff to identify seniors at risk during responses to 911 calls.
3. The PRCProgram Director is a participant in the inter-governmental 'Emergency Preparedness and seniors' initiative led by the Public Health Agency of Canada.
4. During each local 2-day PIECES training event a GEM nurse provides a training component on senior's services and Emergency Management. The regions Geriatric Emergency Management Nurses and PRCProgram staff are also discussing the deployment of the PIECES-ED curriculum and worked together on this at the 4th Annual Geriatric Emergency Management Conference in April 2008.
5. The PRC consultants regularly serve as faculty for continuing education for physicians including the annual Dementia conferences, CAMH and Baycrest Centre educational events.
6. The team has developed a 16 hour training curriculum and knowledge to practice process to support the development of behavioral support units e.g. Cummer Lodge

Understanding learning needs in LTC and the community

The services that the PRCprogram provide to LTC and CSAs have been informed by several sources including focus groups of CSA administrators and staff, along with learning needs surveys that were distributed to all client groups. Table 4 provides an overview of the subjective learning interests of 629 CSA staff and compares those learning interests with those of staff in LTC Homes.

Table 2 The percentage of CSA and LTC staff indicating a learning interest in each of 22 interest areas.

Learning Interests	CSA % N = 621	LTC % N = 1451
Activities of Daily Living	33	35
Aggression	48	57
Agitation in Environment	40	46
Anxiety	52	49
Behavioural Assessment	44	49
Caring for dying patients	45	46
Delirium	33	35
Dementia	51	52
Depression	61	61
Developing Care Plans	41	42
Different cultures	41	42
Elopement	28	37
Pain	50	49
Psychotropic Drugs	42	44
Rummaging/Hoarding	28	36
Schizophrenia	49	49
Sexually Expressive Behaviour	29	35
Suspiciousness/Paranoia	45	47
Wandering	38	44
Withdrawal	39	42
Work related stress	48	57
Working with Families	41	45

In addition to completing the checklist of learning interests many staff from our client groups completed several knowledge quizzes. Table 3 provides a summary of the learning needs of CSA, CCAC and LTC staff as indicated in their responses to several knowledge quizzes.

Table 3 Knowledge quiz scores by sector and in total

Respondents	Alzheimer's Disease Knowledge Quiz (9 questions) (Mean & % Correct)	Depression & Alcohol Use in Late Life (13 questions) (Mean & % Correct)	Facts on Aging Quiz (24 questions) (Mean & % Correct)	Mental Health Quiz (6 questions) (Mean & % Correct)
Overall	**5.11 (56%)**	**8.88 (67%)**	**13.58 (57%)**	**3.91 (65%)**
LTC[1]	**4.55 (51%)**	**8.45 (65%)**	**13.65 (57%)**	**3.96 (66%)**
CSA[1]	**4.78 (53%)**	**9.01 (69%)**	**14.64 (61%)**	**3.94 (66%)**
CCAC[2]	**7.40 (82%)**	**11.20 (86%)**	**19.33 (81%)**	**4.40 (73%)**

1. Nursing (RN, RPN, HCA and PSW), Other Health Professionals, Management/Administration, Housekeeping, Food Services, and Other.
2. Case Managers (Five)

The educational services provided to CSA and CCAC staff in response to these learning needs surveys and other data sources are listed in Table 6 in alphabetical order. An examination of this Table 4 indicates that these topics fall into eight categories: syndromes and symptoms, assessment and interventions, ethico-legal issues, psychogeriatrics and pharmacology, therapeutic environments, organizational issues and workplace safety, and patient/family focus.

Table 4 The topics of training services provided by PRCProgram staff in the community sectors

Training Topics	CSA	CCAC
Acquired Brain Injury	X	X
Advocacy		X
Aging and End of Life Care	X	X
Aging and Homelessness	X	X
Aging Simulation	X	
Alcohol use and Misuse in the Elderly	X	
Alzheimer's Disease	X	X
Antipsychotics	X	
Anxiety and Nervousness in Older People		X
Anxiety in the Elderly	X	
Apathy in dementia; How to motivate your loved one	X	
Assessment Training Workshop	X	
Behaviour Jeopardy	X	
Bipolar Affective Disorder	X	
Bipolar Disorder and Personality Disorders	X	
Brain and Behaviour	X	
Building Therapeutic Relationships	X	
Caregiver Stress and Coping Skills	X	X
Caregiver Support	X	
Caregiving issues in advanced dementia	X	
Casa Verde Coroner's Inquest		X
Case consultations on clients living with dementia in the community	X	
Case Management	X	
Challenging Behaviour	X	X
Cognitive Assessment Tools	X	
Communicating with Residents with Language Barriers		X
Communication in Dementia	X	X
Communication Skills in Palliative Care	X	
Communication with Co-workers	X	
Communication: Relatives with Alzheimer's Disease	X	
Community resources: How to find and use them	X	X
Compassion Fatigue	X	
Continence issues		X
Cultural Diversity		X
Delirium	X	X

Delirium and Depression		
Delusional Disorder	X	
Dementia	X	X
Dementia and Challenging Behaviour	X	
Dementia and Depression		X
Dementia and Infection Control	X	
Depression and the Elderly	X	X
Depression and Suicide in the Elderly	X	X
DOS and CMAI	X	
Early Onset Alzheimer's Disease	X	
Educational Planning in Psychogeriatrics for case managers		X
Effective Communication Strategies	X	
Elder abuse	X	X
Elements of Dementia: Alzheimer Disease		X
Enabler training	X	X
End of Life Care	X	X
Exit Seeking	X	
Falls in the elderly	X	
Financial resources for community services	X	
Frontal Temporal Lobe Dementia	X	
Gentle Persuasive Approach	X	X
Heart and vascular disease prevention	X	
Hoarding	X	
How to use the Cohen Mansfield Agitation Inventory	X	
Huntington's Disease	X	
Incontinence	X	
Infection Control in the context of Dementia/ Aging	X	
Intimacy and the Elderly	X	
Lawton Brody Scale	X	
Lewy Body Disease	X	
Lifts and Transfers	X	
Living wills	X	
Managing Agitation	X	X
Managing Challenging Behaviours/Personalities	X	X
Managing Work Related Stress	X	
Mini-Mental State Exam	X	
Montessori Programming for Dementia	X	
Mood Disorders	X	
Multi-cultural Caregiving		X
Normal Aging: Health and Wellness Resources	X	
Pain	X	
Palliative Care	X	
Paranoia and suspicious behaviour	X	
Parkinson's Disease	X	
Personality Disorders	X	
PIECES training	X	X
Polypharmacy and PIECES training		X
Power of Attorney	X	
Psychogeriatric Assessment Tools	X	
Psychogeriatric Focused Training		X
Psychogeriatric Resources	X	
Repetitive Vocalization/Profanity with Dementia	X	
Resident's Bill of Rights	X	
Resource sharing	X	
Responding to racial and discriminatory comments by clients	X	
Responsive Behaviours: Hoarding	X	
Role of PSWs re: Medication Administration in the Context of Dementia	X	
Schizophrenia in older persons	X	
Self Care	X	
Self Neglect (Diogenes Syndrome)	X	

Sexually Expressive Behaviour & Dementia	X	X
Social Readjustment Scale and Caregiving	X	
Spirituality		X
Stress management and Stressful Work Environments	X	
Stress Management for Volunteers	X	
Stroke and Cognitive Impairment	X	
Substance Abuse	X	
Suicide in the Older Person	X	
Support Group Educational Planning	X	X
System Issues in Dementia Care	X	
The Suspicious Client		X
Therapeutic Relationships	X	
Transgender sensitivity	X	
Trusteeship and Financial Competency	X	
U-FIRST Training	X	X
Understanding & Coping with Responsive behaviours	X	
Working together in Long-Term Care	X	
Working with Families	X	X

Educational Resources in the PRC "library"

The PRCProgram maintains a library of structured materials to enable rapid and distributed response to customer needs. These include:

- Caring for Aggressive Older Adults video (American Psychiatric Nurse Association)
- "The many Faces of Alzheimer's Disease" which comes in English, Italian, Portuguese, Vietnamese, Filipino (Tagalog), Greek, Punjabi, Spanish, and Plains Cree Versions (Alzheimer Society)
- Misconceptions of Head Injury and The Challenges of Brain Injury- a team perspective (Ontario Brain Injury Association)
- A Trilogy of Caring (SME Productions)
- Choice and Challenge: Caring for Aggressive Older Adults (Terra Nova Films)
- Dealing With Physical Aggression in Caregiving: Non-Physical and Physical Interventions (Terra Nova Films)
- Delirium in the Elderly (Tassonyi Productions)
- Dementia with Dignity (Terra Nova Films)
- Elder Abuse … A Portrait - English and French versions (Home Support Program)
- Everyone Wins! Quality Care without Restraints (Terra Nova Films)
- The Heart Has No Wrinkles (Terra Nova Films)
- Freedom of Sexual Expression (Terra Nova Films)
- Hello in There – Understanding the Success of Person-Centred Care (McMaster's Educational Centre for Aging and Health)
- Overcoming Depression (Centre for Depression and Anxiety, Calgary, Alberta)
- Psychosis in the Elderly (Tassonyi Productions)
- Simulated Dementia (PRCProgram Simcoe County)
- Administration and Scoring of the Folstein Mini-Mental Status Exam and the Cornell Depression Scale (Victoria Madsen)
- Managing and Understanding Behavior Problems in Alzheimer's Disease and Related Disorders (University of Washington Alzheimer's Disease Research Center)
  Module 1 – Overview Part I: Alzheimer's Disease and Related Diseases
  Module 2 – Overview Part II: Delirium and Depression
  Module 3 – ABCs: An Introduction
  Module 4 – Managing Aggressive Behaviors: Anger, Irritation, & Catastrophic Reactions
  Module 5 – Managing Psychotic Behaviours: Language Deficits
  Module 6 – Managing Psychotic Behaviours: Hallucinations/Delusions, Paranoia
  Module 7 – Managing Personal Hygiene: Bathing and Dressing
  Module 8 – Managing Difficult Behaviours: Wandering & Inappropriate Sexual Behaviors
  Module 9 – Managing Difficult Behaviours: Depression
  Module 10 – Caregiver Issues

Useful printed materials promoted by the PRC staff

1. Practical Management of Depression in Older People (2001) Arnold Publishers Editors: Stephen Curran, John P. Wattis, and Sean Lynch http://www.arnoldpublishers.com
2. Behavioral and Psychological Symptoms of Dementia. Educational Pack (1998) Publishers: Gardiner-Caldwell Communications Ltd. and the International Psychogeriatric Association.
3. Communicating with Seniors (Health Canada) http://www.phac-aspc.gc.ca/seniors-aines/pubs/communicating/pdf/comsen_e.pdf
4. The Frequently Asked Questions Overview being developed by PRC and RGP on behalf of the Toronto Dementia Network. This FAQ responds to the common misunderstandings and frequently asked questions arising from an intersectoral focus group of professional and lay dementia caregivers both.

Useful online resources promoted by the PRC staff

The PRCProgram staff examined several more online curricula but cannot at this time fully recommend their use because of the limited internet access characteristic of most community based agencies. Still several resources requiring modest bandwidth are recommended

1. The Toronto Dementia Networks service locator at http://dementiatoronto.org
2. The Ontario Community Support Association Website at http://www.ocsa.on.ca
3. The Murray Alzheimer Research and Education Program at http://www.marep.uwaterloo.ca
4. The PIECES Canada website at http://www.piecescanada.com/
5. A compendium of functional assessment tools http://www.chcr.brown.edu/pcoc/functi.htm
6. The Regional Geriatric Program of Toronto at http://rgp.toronto.on.ca
7. The caremapsforseniors compendium at http://caremapsforseniors.ca
8. E-health Online website at http://www.responsivebehaviour.ca/
9. The Geriatrics, interprofessional practice and interorganizational collaboration toolkit at http://giic.rgps.on.ca

New Educational Resources developed by the PRCProgram to meet customer needs

Several new educational areas are emerging that prompt requests for PRCProgram training for which there are limited available resources. The PRCProgram consultants anticipate the development of educational resources (i.e. mini video/DVD and structured message cards) in these areas that are often particularly relevant to community care.

The areas include:

Understanding PHIPPA, the circle of care and the meaning of informed consent
ABI training
Understanding the needs of the developmentally disabled person with dementia
The PRCProgram's “options approach” to managing aggressive behavior that occurs despite staffs best efforts to avoid it.
The Dementia education program for volunteers (e.g. meals on wheel, friendly visiting)

As well, the PRCProgram is finding resources to replicate for the community such enduring resources as:

The Aging simulation exercise
The Behavioral Bingo experiential learning exercise
Montessori influenced dementia training

3. **Service Information 2010/11:**

SERVICE TYPE: *List service provided*	**24,943 (participating caregivers)** **6,377 (hours of direct teaching)**
Information on clients served: Age range Gender Language Ethnocultural and racial community	**Staff in long-term care facilities, community service agencies and community care access centres**
Hours of operation (by site and location if different)	**Five days weekly providing service around the clock based on staff's work schedule**
Availability of on-call services yes/no)	**YES**
Client fee policy: Amount charged for service How client is assessed Availability of sliding fee (yes/no)	**Not applicable**
Provision of services in French	**Services in French are available**
Provision of services in other languages (List)	**The program is now able to provide services in French, Spanish, Italian, Greek, Finnish, Hindi, Kannada, Konkani, Swahili, Maltese, American Sign Language, basic Tamil and Malayalam.** **As well, we have translated learning needs surveys to meet the needs of Chinese, Greek, Hungarian, Polish and other communities. We continue to compile test materials such as the Folstein and Geriatric Depression Scale which have been translated into many languages and make them available to our customers.**

4. **Proposed and Actual Performance 2010/11**

Name of Service	**A** **20010/11 proposed Fiscal**	**B** **2010/11 Actual Fiscal**	**C** **% Variance**
Number of Units	**6,000**	**6,377**	**+.06%**
Number of Individuals	**24,000**	**24,943**	**+.04%**

Of note, the program has consistently exceeded its workload targets since 2007-08.

5. **Service Trends, Key Service Delivery Objectives and Responsiveness to the Clients:**

Service Trends

Several significant trends in our service can be seen in the foregoing i.e. engagement with expanded psychogeriatric clinical services and expansion of services to the community, but there is an additional and perhaps more important development that we anticipate. This is the appearance of residents in Long Term Care homes and in the community with a much broader range of mental health issues along with the emergence of an emergence of much younger people with acquired brain injury. An associated issue is the development of curricula from non-profit associations supporting specific diseases and syndromes e.g. stroke, Parkinson's disease, chronic disease management etc who are turning to the PRC to assist them in deploying the materials to the programs customers and new dementia focused curriula such as Gentle Persuasion and Montessori.

In response to these service trends, the PRCProgram has recruited new staff who will develop special competencies in these areas most notably ABI, Stroke, online learning and case management. These new special competencies augment the existing competencies in structured curriculum delivery (PIECES, U-First!, Enabler, Gentle Persuasion, and Montessori), crisis prevention, sexuality and dementia and pain management.

This is an extension of a long standing program of policy of having each consultant responsible to customers in their region for the generic work of the PRCProgram – the behavioral issues arising from dementia – while developing a special area of competence/interest that can be delivered across the regions depending upon need.

A second service trend is the emergence of specialty units within long-term care homes. These might be dementia units, behavioral units, dialysis units and etc. As these new units come on stream they often turn to PRC to assist in staff development. In response to this trend, PRC has adopted a policy of being involved in the early stage building staff development into the design and development of these new services.

A recent PRCProgram retreat attended by TCCAC staff promises a new PRC focus – facilitating discharge of behaviorally challenging clients.

Key Service Delivery Objectives:

Primary and secondary units of service

One hour of consultation service will be the primary "unit of service". These may be topic or case-based meetings or telephone/email interaction. Most consultations will require travel, and all will require record keeping. Still, we estimate that each hour of consulting service will require 30 minutes of travel and report writing time, and one or more hours of preparation time. The projected number of primary units of service for 2008/09 is 6,000 units.

Within a primary unit of service, several people might be served. This might be the case if a consultant meets with a LTC facility resource person to discuss a number of patients, if the consultant provides a one-hour workshop to a dozen people, or if CCAC personnel are involved in a one-hour telephone conference. Alternatively, in the context of a home visit or LTC consultation, one person might be seen in a primary unit of service.

The number of people involved in the primary units of service (including both caregiving staff and family members) will be the secondary “unit of service**”**.

After testing several models and capturing a variety of configurations of "the number of people served" within each primary workload unit (i.e. an hour of consultation), we estimated that the program would serve 24,000 people in 2010/11 which remains the ‘secondary” performance target.

Responsiveness to clients

PRCProgram services are provided at the times that its clients are available. The program’s self-directed work team management style allows consultants to adjust their work schedules, to provide educational consultation services across all shifts and weekend periods.

The program operates without a waiting list.

Though employees of a network of hospitals, the consultants seek opportunities to enhance their responsiveness to their clients/caregivers in long-term care facilities, community service agencies and community care access centers. The ratio of direct to indirect client service provision meets or exceeds provincial benchmarks.

The consultants spend most of their time in the community. Placing several consultants’ offices in the community at Sprint Community Services, and the Leisureworld LTC facility also enhances responsiveness.

Responsiveness is assisted by PRCP representation on many important committees including:
Acquired Brain Injury Group
Alzheimer's Knowledge Exchange Teaching Materials Committee
Baycrest Centre Nursing Clinical Resource Group
CAMH Advisory Committee
Canadian Coalition for seniors' Mental Health review of Best Practice Guidelines
Caregiver Coalition
CAMH Healthy Aging Committee
CARG (Caring for Aging Relatives-Scarborough Consortium)
CNSIG – Clinical Nurse Specialist Interest Group
Toronto Dementia Network Steering Committee
Toronto Dementia network (All PRCs are members)
Etobicoke Elder Needs Committee
Fudger House Nursing Management Committee
Geriatric Emergency Management Task Force
Homeless and Marginal Persons
Lakeshore Mental Health Interest Group
Lakeshore West End Advisory Committee
LAMP interagency Group
LOFT – Collegeview Interagency Group
MTCH/MH Psychogeriatric Inventory Working Group
Norfinch Behaviour Management Team
North York Elder Abuse Network
Older Persons Mental Health and Addictions Network (OPMHAN)
OPMHAN Raising Awareness Series Planning Group
Ontario Gerontological Nurses Ass
PACE West Outpatient Team
PEACE – Prevention of Elder Abuse Coalition – Etobicoke/York
PIE – PIECES in Etobicoke Group
Providence RGP Client Review Team
Psychogeriatric Team Exchange Planning Committee
RGP Elder Abuse Committee
Scarborough Elder Abuse Network (SEAN)
SACCS (Scarborough Advisory Committee for Community Services)
Scarborough Psychogeriatric Network
Seaton House 4th floor Birchmount Rd. Facility client review group
SPAN (Scarborough Psychogeriatric Action Network)
Seniors' Health Research Transfer Network (SHRTN)
Stroke Network LTC Specialists in Etobicoke
TAASC/ Older Persons Committee (Toronto Area Addictions Services Coalition)
Versa Care Nursing Management Committee

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6. Human Resource Issues:

A. The 11 PRCProgram consultants share the following core competencies:

- Minimum Bachelors in one of the following health professions: Nursing, Social Work, Psychology, Occupational Therapy, and Physiotherapy.
- Experience in psychogeriatrics, geriatrics, long-term care or community based care with preference to those having experience in two or more of these areas.
- Demonstrated understanding of the dynamics of inter-organizational collaboration, the consultation process and adult education.
- Capacity to use communication technologies such as Word, Powerpoint, Email and Web-Browsers.
- Competence in the use of standard psychogeriatric assessment tools is essential.
- Experience with the PIECES program would be an asset, and to have competence in the use of standard assessment tools.
- Car available for work related travel in the community.
- The ability to converse in other languages will be an asset.
- Capacity to participate in a weekend telephone response rotation.

They are allocated on a population basis to LHIN regions and host organizations as follows:

LHIN Region	Host Organizations	No. of FTE
Central	North York General	1
	Baycrest Centre	1
Toronto	SHSC	1
Central	CAMH PACE Central	1
	St. Michael's Hospital	1
	Toronto Rehab Institute	1
	Providence Healthcare	1
	Toronto East General	1
Central East	The Scarborough Hospital	1
Central West	West Park Healthcare	1
Mississauga Halton	CAMH PACE West	1

Program Coordinator

A .60 FTE program coordinator provides linkages amongst the consultants and reduces the need for administrative redundancies in recruitment, resource sharing and scheduling of coordinated activities (e.g. on call service). The 2% administrative overhead typically charged by Sunnybrook for managing the accounts has been waived, because of their RGP focused services. This is an example of the added value of RGP sponsorship of the PRC Program.

Human Resource Retention

Until the 07/08 fiscal year, the PRCProgram staff complement has been stable. In performance appraisals, staff continues to express considerable satisfaction with their work.

In 2004/05 the program managed through a maternity leave that required one host organization to cover the $64,000 overage arising from the staff replacement and maternity benefits. In 2006/07 we managed another maternity leave but without the resources to replace the position. The host organization graciously agreed to fund a part-time (.4 FTE) staff replacement and allowing us to ensure that ensure PIECES training to affected organizations and respond to high need circumstances. In the future, the program will have to operate without replacement as zero-based budgeting within host organizations is increasingly precluding them from providing 'top up' funding for the program.

In 2007/08 the program operated with 3 vacancies arising from staff taking other positions offering substantial salary increases.

The level of salary support continues to represent a threat to human resource retention. First, because we have recruited very highly trained candidates who could, and in one instance, have commanded higher salaries in other positions. A continuing disparity between "hospital sector" and "community sector" requires several host organizations to manage deficits supporting their PRCProgram consultant(s) as collective agreements in host organizations continue to increase salaries and benefits of PRC staff without parallel increases in program funding. This has been an ongoing issue that we have described in each of the previous service plans.

7. Monitoring and Evaluation:

Program monitoring and evaluation continues to be guided by a balanced scorecard framework comprising: financial accountability, internal service, innovation, and customer satisfaction.

Financial accountability:

Please refer to budgetary documents submitted through the WERS and MIS Trial balance submission reporting systems and our audited documents.

Internal processes

An electronic workload recording and database utility provides data upon which to provide oversight on key internal processes including:

1. Number of topic-based, case-based and telephone/email consultation hours (i.e. Primary workload units)
2. Number of staff involved in training (secondary workload units)
3. Service sector (i.e. LTC, CCAC, CSA)
4. Specific consultation
5. Content of educational activities
6. Preparation time
7. Dementia Network hours
8. Inter-sectoral collaboration time
9. Travel time
10. Consultant's Continuing Education time

Innovation

In the first year, our work focused on providing educational events to groups of staff on topics of interest. A list of teaching topics and materials has been compiled that reflects this topic-based educational process. Over the two subsequent years, our educational services have increasingly provided case-based educational interventions to individual or small teams of staff, in response to the needs of specific patients. This transition from topic to case-based training was an anticipated trajectory of our service that reflects the developing acceptance and trust in our team of eleven educators on the part of our customers.

We note a continued growth in the proportion of case to topic-based educational services, an increase in more focused bedside/home educational assistance provided by a consultant to one or two attending staff, rather than groups of staff convened in class-like settings, as well as increased involvement in "informal influence processes" reflecting the emergence of the PRCs as important educational opinion leaders. Small-group case-based workshops have sometimes evolved towards scheduled 'behavioral management rounds' in organizations who are able to support these activities that will assist the clinical service providers associated with the emerging network of psychogeriatric outreach teams.

Enhancements to the inpatient specialized behavioral assessment and management units will increase the level of service provided to the community by these services. The PRCProgram has adjusted its educational services to assist LTC facilities in their liaison with these behavioral assessment and management units. Before a case is referred to a behavioral management unit, a PRC has typically been involved. First, helping staff to problem solve with existing resources and subsequently helping them to achieve an effective transition. The most important part of the PRC/inpatient collaboration though comes upon the patient's transition 'home'. Through their ongoing liaison with inpatient unit discharge staff, PRCs encourage timely transfer of documentation prior to the discharge, the translation of recommendations to the receiving team and assisting the team to adhere to these recommendations. As well, because the 'home' and in-patient units typically have different environments, resources and level of staffing, the PRCs add value in helping the in-patient units to develop recommendations and care plans that are appropriate for the characteristics of the 'home' environment and resources.

Expansion of the "special interest" areas of each PRC is an important innovation direction which has developed since 2008/09.

Supporting organizational renewal and new program developments

A second reflection of increasing trust and acceptance of the PRCProgram staff is their increasing involvement in program planning and the organizational renewal of our customer organizations.

In this latter regard, for example, we have worked closely with the City of Toronto's Homes for the Aged in training staff for new services for people with dementia, and with Heritage House as they developed policies regarding the care of homeless seniors with cognitive impairment and other psychogeriatric problems.

As well, when there are instances of new beds being added to in-place homes and new buildings being constructed, the PRC team is involved in educational planning and the training of new staff.

This is of great interest because recent surveys indicate that new staff often feel unprepared for work in geriatric services and find formal skill development resources unavailable.

Customer Satisfaction

LTC administrators' ratings of satisfaction

In past years the program has collected data from one or more stakeholder communities. For 2005/06, for example, our focus was on LTC administrators' satisfaction with the program**.** Sixty (70%) of the region's 86 Directors of Long-Term Care completed our online survey.

Sixty-eight percent (68%) said that they consider the PRCs an integral part of their organization's human resource development plan.

They expect to use PRCP services more next year that they do presently and their level of satisfaction with the program is very high (4.5 on a 5-point scale).

They see staff turnover, renovations, other guideline implementation and emerging new populations as significant challenges in the year ahead. This in turn has guided PRC staff towards adapting and/or developing training materials in anticipation of these expected changes.

Since the 2007/08 fiscal year we halted our own process of determining customer satisfaction and blended our interests with those of the broader long-term care mental health steering committee whose surveys continue to demonstrate high levels of satisfaction and intention to use the PRCProgram.

Culturally sensitive service capacity

The program continues to provide a range of culturally sensitive services. We are able to provide educational services in French, and several tools have been translated into French. As well, we are able to offer services using Spanish, Italian, Greek, Finnish, Hindi, Kannada, Konkani, Swahili, Maltese, American Sign Language, basic Tamil and Malayalam.

In partnership with customer agencies, we have developed a model of translating elements of learning needs surveys to meet the needs of Chinese, Greek, Hungarian, Polish and other communities and we continue to compile test materials, such as the Folstein and Geriatric Depression Scale, which have been translated into many languages and make them available to our customers.

Workplace sensitive educational scheduling

Our customers are particularly pleased with the flexible scheduling of interventions by the consultants, who have made a point of making themselves available outside of the traditional 9 to 5, 5 day per week schedule.

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8. Efficiency and Effectiveness of Service Delivery:

The RGP provides administrative and budgetary oversight for the Psychogeriatric Resource Consultation Program. Though the 11 Psychogeriatric Consultants are employees of host organizations, their relationship with the Regional Geriatric Program is managed by Participation Agreements, which outlines mutual goals and responsibilities.

The program's distributed matrix management model facilitates sharing and the effective use of special skills and interests across organizations and regions, even though each consultant is an employee of a different organization.

The coordination of activities across the city is aided by a set of purpose built electronic resources, including an online workload utility, a private email list service, and a program website.

The program assistant provides linkage amongst the consultants, and reduces the need for administrative redundancies, to support recruitment, resource sharing and scheduling of coordinated activities (e.g. on call service). The program coordinator's services expanded in 2005/06 as the program undergoes operational changes to increase efficiency and effectiveness as outlined below.

The program has met its objectives for primary and secondary workload (hours of educational consultation and number of staff seen respectively) and its performance in this regard are above the provincial average while the ratio of direct and indirect service is consistent with the provincial average.