

Older Adults Behavioural Support System: Policy Analysis and Implementation

Introduction

The Older Adults Behavioural Support System described in this report is designed to be a highly practical system of support to older Ontarians whose cognitive impairment is accompanied by responsive behaviours. It is intended to help people who are responsible for the care of individuals at home, in acute care facilities or in long term care homes. It is also intended to provide support for people whose needs are transient, persistent or permanent. The model's design is predicated on the notion of building a hierarchy of supports to match the care requirements of increasingly complex needs, while focusing on compressing that hierarchy and supporting individual with behavioural support needs where they reside. Its practicality extends beyond its flexibility and its scalability. Its practicality is grounded in the fact that this solution is highly implementable.

Ontario is relatively rich in resources to support older adults with behavioural and psychological symptoms of dementia, mental health or other neurological conditions. However these resources are not equitably distributed across the province. As well, they are neither integrated with each other nor with the other essential components of the province's health and social systems. The Older Adults Behavioural Support System builds on existing expertise and resources. This report offers advice on matching resources to community needs and recommends policy actions to integrate services.

While managing responsive behaviours requires the availability of specialized expertise which can be accessed from time to time, the most important success factor in the day-to-day maintenance of the health and well-being of individuals is the provision of person-centred care. Person-centred care and the adoption of a less stigmatized, less ageist, more individualistic approach to care is a hallmark of quality care in *all* health care settings - primary care, community care, acute care, or long-term care. Person-centred care promotes respect for the unique needs of individuals in their care and empowers staff to respond to these needs expertly, tenderly and respectfully.

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We need family physicians who will take the time necessary to complete a full medical history with older adults with complex co-morbid health issues and to solicit their observations and desires. We need community seniors' services and mental health support services to get involved much earlier in the older person's illness to support management through the caregiver and prevent responsive behaviours from escalating. We need hospitals that implement restraints as an intervention of very last resort for client safety. We need long term care homes that are adequately staffed by well-trained personnel who understand that responsive behaviours often arise from real needs – hunger, thirst, pain – and know the safest and most effective means of dealing with these behaviours. We need far more person-centredness than we are currently getting.

With over 65% of the people currently residing in long-term care homes in Ontario identified as older people with behavioural issues needing specialized behavioural supports, providing person-centred care in long term care homes will have the most immediate and significant beneficial impact on hundreds of peoples' day-to-day lives. A critical success factor will be a culture change in long term care.

Pulling the Pieces Together

Ontario has made a number of investments over the last several years which have provided many of the key components of an exemplary behavioural support system. The main feature of these investments has been the Ontario Strategy for Alzheimer's Disease and Related Dementias. Under the auspices of this program, \$68 million was invested in:

- Psychogeriatric Consulting Resources - Fifty new psychogeriatric consulting resource positions were created to provide support for staff serving persons with dementia, including those with challenging behaviours, and individuals with complex cognitive/mental health needs. These consulting resources are available across Ontario to workers in long-term care facilities, community care access centres, community support agencies and other community partners.
- Co-ordinated Specialized Diagnosis and Support - coordination and promotion of services for persons, families and caregivers living with dementia through the creation of new networks or the maintenance of existing dementia networks across Ontario.

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- Staff Education and Training- educational opportunities for staff working in long-term care homes, Community Care Access Centres, and long-term care community services, including “Putting the P.I.E.C.E.S. Together” and “U-First.” As well, educational programs targeting family physicians and medical students on early detection and diagnosis of Alzheimer Disease and related dementias and on use of local and specialized resources, and advance care planning were developed in collaboration with the Ontario College of Family Physicians, family physicians, geriatricians, geriatric psychiatrists, clinicians, service providers, and caregiver advocates.
- Respite Services for Caregivers -new funding to 84 community agencies across the province to expand or enhance adult day programs and in-home respite programs.

Additionally, in 2007, the Ontario government invested over \$1 billion over four years to support its Aging at Home Strategy. The Aging at Home Strategy, which is currently being evaluated, was designed to expand community services for older adults and their caregivers, with a view to keeping seniors safely and independently at home.

Together, these investments and policies have led to a relatively rich mix of resources available to assist individuals with behavioural challenges, but the resources are not well-distributed. For instance, some major urban centres have the benefit of behavioural units that are staffed with interdisciplinary teams of experts in geriatric psychiatry, nursing, occupational therapy, physiotherapy, recreation therapy and pharmacy. However, these resources are not routinely available in other parts of the province, much less organized in well-functioning teams.

Outreach teams are not currently tied to behavioural units; nor are specialized behavioural resources normally coordinated with either geriatric resources or broader mental health resources.

A well functioning system will be integrated vertically (i.e. integrating behaviour support resources in a given community) and horizontally (i.e. alignment of behaviour support resources with other health services needed by the individual or caregiver – mental health services, primary care, acute care and long term care). As demand inevitably increases, integration will be necessary in order to provide services that are of consistently high quality and in order to use resources as efficiently as possible.

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The main goals of integrated behavioural support services are:

- better distribution across the province;
- improved coordination amongst the specialized resources;
- better integration between these specialized resources and other relevant health and social services;
- ongoing investment in training, capacity-building and knowledge transfer;
- leveraging knowledge through interprofessional collaboration;
- and
- accountability for achieving person-centred goals.

Policy Context

Ontario is not the only jurisdiction struggling to deal with how best to manage the increasing number of individuals with psychological and behavioural symptoms of dementia and other cognitive impairments. Before considering an Ontario-specific response, it may be useful to consider what is happening in other settings.

International

Australia, Norway, the Netherlands, France, and the United Kingdom have each developed specific plans or frameworks for dealing with dementia. These system frameworks are largely directed at greater integration of health and social policies; establishing more home-based programs; adapting care facilities to better meet the needs of residents with dementia; providing education for people with dementia, their families, health professionals and the public; and investing in research. In 2008, the Council of the European Union passed a number of resolutions committing the European Parliament to support European action to combat neurodegenerative diseases, particularly Alzheimer's disease.

Some specific behavioural support initiatives include:

Australia:

- Primary care guidelines;
- Expanded psychogeriatric consults;
- Early intervention focus;
- Caregiver training;
- Home support for behaviour problems;
- Workforce training.

Netherlands

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- Cluster housing;
- Case management;
- Person-centred policy development.

Norway:

- Adapted living facilities;
- Workforce training;
- Interprofessional collaboration;
- National standards to improve medical services in nursing homes.

France:

- Integrated access points;
- Increased investment in case managers;
- In-home specialist care;
- Workforce training.

United Kingdom

- Early intervention;
- Specialist home care services;
- Development of a comprehensive model of care;
- Continuing professional development in dementia for care professionals.

In March 2009, the Ontario Ministry of Health and Long-Term Care prepared a literature review looking for relevant government policies addressing neurological conditions, including Alzheimer's disease and other dementias. Of the eleven countries examined, only one – the United Kingdom (UK) with its National Service Framework (NSF) for Long-Term Conditions – has adopted an explicitly integrated framework to address all long-term neurological conditions. The report identified that “dementia is a relatively new area of policy focus and few countries have specific policies to address the disorder.”

National

While Ontario is the only province to have made significant investments in a dementia strategy and is the leading province in Aging at Home strategies, Ontario can learn from experiences in other provinces. Ontario can turn to British Columbia with regard to physician education on dementia as a chronic condition; learn from Saskatchewan with respect to its Patient First initiative; and from Quebec regarding its yet-to-be-funded dementia strategy, with its emphasis on home support in advanced stages of dementia and on locally-responsive, personalized and coordinated services. (The proposed dementia strategy is a companion to social and health

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system reform in Quebec that created integrated services delivered through health and social service centres (CSSS), along with family medicine groups (GMF) and clinical networks.)

A review of dementia strategies from several countries and several Canadian provinces reveals general agreement on key elements to be factored into any comprehensive dementia strategy:

- the public needs better access to information to increase awareness, to overcome stigma, and to seek help such that early interventions can be initiated;
- people who provide care to individuals with dementia need knowledge support to ensure that dementia is recognized and that the professionals know what treatments and care strategies are appropriate for different stages in the disease;
- caregivers need help to cope, including reducing the financial disincentives to fulfill caregiving roles and ensuring that caregivers are supported with respite and training are critical features;
- case management and system navigation are important features of dementia strategies;
- organizing services along the lines of the chronic disease prevention and management model is congruent with current policy direction in several jurisdictions.

Person-Centred Care: A Culture Change

The authors have talked to a number of individuals, including community services staff, caregivers, long term care home operators, academics and clinicians, who have independently offered the view that more benefit would accrue from a culture change in long term care homes than from policy change. Each has offered different reasons for this view and different examples to support the contention, but there is considerable overlap in perspectives. These perspectives are consistent with the observations of caregivers.

Collectively, the sort of culture change that is envisioned is one toward a new state where older people and their families can take confidence in decisions being guided by what is in the best interests of the individual person in need. This would include a viable care plan for every resident that is based on an amalgam of the expressed desires and goals of the individual and the provider's knowledge of leading practices.

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Legislation and regulations need to support person-centred care. The new Regulations under the 2007 Long Term Care Homes Act address the issue of responsive behaviours by requiring long-term care homes to develop:

1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

While the regulations require that the processes for managing responsive behaviours are based on both the resident's assessed needs and current best practices, there is a presumption of standardized responses, rather than an orientation to understanding the individual's unique needs, modes of communication and responses to environmental triggers and cues. Responsive behaviours are treated in the regulations as discrete resident management issues, separate from pain, hunger and hydration – the usual triggers for responsive behaviours.

Clearly, regulations are a relatively weak instrument for culture change generally, or for promoting person-centred care in particular. The new Long Term Care Homes Act and its Regulations are a major improvement over prior legislation with regards to promoting person-centred care, but it will take more than these to make the necessary culture change.

Leadership, hiring for attitude and rewarding person-centred behaviours are far more important. However, regulations are concrete while person-centredness is relatively abstract. A system that is compliance-oriented and focuses on the presence of protocols and standardized strategies, while silent on the attributes of person-centredness is likely to achieve the focus it is designed to achieve – compliance trumps person-centredness.

Person-centredness, along with patient-centredness and other manifestations of the same concept, is an idea whose time has come. It's been a long time coming – in the United States the Planetree

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Foundation has been promoting healing environments and patient-centred care since the late 1970s and the Commonwealth Fund uses patient-centredness as one of several domains in their international health system comparisons. Care teams responding to the goals expressed by patients is a cornerstone of chronic disease management, the most important way of re-thinking care processes to emerge in a long time. In the United Kingdom, the National Health Service is taking the bold step of reducing expenditures by £15 billion to £20 billion, primarily through radical patient-centred service redesign.

Triple Aim, a concept imported from the US via the Institute for Healthcare Improvement is about improving the patient experience while improving population health in a sustainable way. The Ontario LHINs are in agreement on the importance of Triple Aim as a conceptual basis for quality improvement. The Ontario Health Quality Council has defined Patient-Centredness as one of the key attributes of a high-performing health system, by which they mean “healthcare providers should offer services in a way that is sensitive to an individual’s needs and preferences.” The Alzheimer Society of Canada has convened leaders in long-term care and the broader health system to consider what steps can be taken to make long-term care homes person-centred; i.e. congruent with a philosophy that recognizes that individuals have unique values, personal history and personality and that each person has an equal right to dignity, respect, and to participate fully in their environment.

What would be the attributes of person-centred care that are relevant to older Ontarians with responsive behaviours?

- The care team – professionals and family members – are pulling together and their efforts are informed by a viable care plan that is designed to maximize function, comfort, safety and enjoyment. This plan is informed by the individual’s own goals and desires.
- Staff are chosen for their caring attitudes and their competence is maintained through training relevant to the needs of the individual.
- Staff are encouraged to know the individual under their care – their particular sources of joy or comfort along with their particular triggers for responsive behaviours, and are given the authority to adjust the daily schedule to maximize the individual’s comfort.

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- The physical environment is calming and pleasing to the senses.
- The leadership rewards staff for compassion, and the organization is rewarded for performance against person-centred quality standards that include feedback from residents and family members.

Ben Chan, CEO of the Ontario Health Quality Council (OHQC), believes that public reporting on resident indicators, including resident and caregiver survey data, is a critical step in achieving person-centred care in long term care homes.

Key Enablers for Integration and Capacity-building

The implementation of Older Adults Behavioural Support System for Ontario will not start from a dead stop. There is already considerable momentum that can be leveraged, from a policy perspective.

(1) Ontario's 10-year Plan for Mental Health and Addictions being developed by Ontario's Ministry of Health and Long-Term Care

- implementation through new and existing mental health and addiction networks established in each LHIN;
- establishment of a Mental Health and Addiction Council;
- focus on strengthening front-line competency, standards of care, quality improvement;
- Emphasis on intersectoral and interprofessional collaboration.
- Focus on strengthening the role of primary care;
- Oriented to recovery and wellness.

(2) MOHLTC current priorities support managing behavioural issues where older people are residing. Support to care teams in the community and in long-term care facilities, reinforcing their capacity to manage behavioural challenges will reduce unnecessary hospitalizations and reduce ALC days arising from emergency department admissions.

(3) Supporting older adults with responsive behaviours, and the strategy for achieving this, is congruent with current policy preoccupations – (a) emergency department diversion and ALC, (b) chronic disease prevention and management; and (c) interprofessional collaboration.

(4) The focus on person-centred evidence-based support along the continuum is consistent with the Excellent Care for All Act and the revised role of the OHQC in defining and reporting on quality standards. The initial focus of the quality improvement agenda embodied in this legislation, along with the notion of tying incentives to person-centred care indicators, is on hospitals. The expectation is that, if the legislation is successful, it will have a beneficial impact on patient-centred quality improvement in primary care, long term care, and home and community care, as well as hospital-based care.

In order to achieve a successful implementation, it will be important for the Ministry of Health and Long-Term Care to set very clear expectations regarding the level of support older persons should be able to count on throughout the province. At present, LHINs have been implementing supportive initiatives in response to compelling LHIN-specific proposals. As a consequence, services such as First Link, an excellent program for acquainting newly diagnosed individuals with dementia with the services they may need, is supported in some LHINs, not in others. Some LHINs have supported the establishment of behavioural support units, others haven't. There needs to be clear direction as to the minimum services that should be available in each LHIN regarding community support, outreach services and behavioural units, along with the requisite competencies and services.

Recommended Implementation of the Older Adults Behavioural Support System

The following proposed approach to implementing the Older Adults Behavioural Support System across Ontario is made after consideration of the international, national, and provincial policy environment and the current situation regarding both existing resources and health system trends.

This implementation plan is predicated on a number of assumptions:

1. The Long Term Care Home Act and its regulations have the desired effect of shifting the orientation of long term care home management from regulatory compliance toward achieving person-centred outcomes;
2. The groundswell of interest in shifting the focus of health care delivery systems to improving the patient experience continues.

3. The province accepts the recommendations in Shirley Sharkee's 2008 report, *People Caring for People*, notably:
 - *Provincial guidelines to support funding increases for resident care over the next four years;*
 - *The development of annual staffing plans at each LTC home, which take into consideration a range of issues (including the dual goals of strengthening staff capacity for better care, and establishing a strong foundation for quality care and accountability for resident outcomes) and which involve staff, residents, families and community partners (including Local Health Integration Networks (LHINs)), in planning how resources should be better aligned to meet resident care needs and improve care outcomes; and*
 - *Annual evaluations to validate that funding is addressing resident care needs and to inform decisions about staff enhancements.*

Step One

The Ministry of Health and Long-term Care will direct each Local Health Integration Network (LHIN) to develop an Older Adults Behavioural Support System for the communities for which they are responsible, giving due regard to both current and projected need (e.g. age-adjusted population) and relevant existing resources (community support services, behavioural support units, long term care homes, hospitals, geriatric resources and geriatric mental health resources). While there is merit in providing these directions in the context of implementing the 10-Year Mental Health and Addiction Plan, it is not essential. While providing the flexibility necessitated by the characteristics of each LHIN, the Ministry should be clear as to the requisite components of an Older Adults Behavioural Support System. These would include:

- Adherence to the principles identified in this document;
- Identification of a lead agency;
- Establishment of local networks with mutual accountabilities;
- Regional System Coordinator, responsible for the functioning of the system;
- Mobile interdisciplinary Seniors Behavioural Support Outreach Team(s);
- Explicit linkages between the Older Adults Behavioural Support System and relevant local health care resources (hospitals, community mental health resources, primary care physicians,

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- long term care homes, community care access centres, and such community agencies as Alzheimer Society chapters);
- Centralized, standardized intake and referral.

At the same time, the Ministry will advise transfer payment agencies who receive funding for behavioural support units, geriatric mental health outreach services or other specialized geriatric resources that continued funding will be tied to participation in the Older Adults Behavioural Support Systems in their respective communities.

Step Two

Each LHIN will lead discussions with existing geriatric and relevant mental health resources in their respective communities with the aim of:

- Identifying a lead agency that will be responsible for the local administration of the Older Adults Behavioural Support System,
- Identifying all of the key players who will need to be part of the network;
- Negotiating the terms of a Network Accountability Agreement that will bind each network member to all other network members for adherence to network principles and standards, service volumes and other mutual obligations necessary for the effective operation of the network. The network, in turn, will be accountable to the Ministry of Health and Long-term Care, through the local LHIN.

All provider organizations will commit to adhering to the principles of the Older Adults Behavioural Support System and to shifting to mutual accountability for network success in meeting the needs of seniors with responsive behaviour problems.

Step Three

The Ministry of Health and Long-Term Care will allocate funds to each Older Adults Behavioural Support System to cover the cost of a regional system coordinator, education budget and high intensity needs funding to be administered by the network.

Step Four

The Ministry of Health and Long-Term Care will create a staffed Ontario Behavioural Support Council, comprised of regional system coordinators from each LHIN, along with specialized expertise in geriatric psychiatry and long term care. The function of the council is:

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1. To ensure a consistent, coordinated and effective implementation of Behavioural Support System across the province;
2. To identify resource issues that, if addressed, would maximize attaining system goals of improved person-centred care, improved resident and staff safety, reduced ALC and unnecessary hospitalizations;
3. To adopt or develop behavioural support quality and performance measures to be used across the province.

Step Five

The Ministry of Health and Long-Term Care will undertake an evaluation of the effectiveness and efficacy of the Older Adults Behavioural Support System model no later than five years after implementation, and will make the changes necessary to improve the model based on the findings of the evaluation. We expect that the evaluation will be favourable if:

- Ontarians are able to learn about responsive behaviours associated with cognitive impairment, and what resources are available to help (for example, through the Alzheimer Society's First Link Program), that are funded by each LHIN.
- Every Emergency Department in every hospital has a qualified GEM nurse with knowledge of the psychological and behavioural symptoms in older adults of dementia, delirium, complex mental health or other neurological conditions, is competent in managing responsive behaviours, and knows the available community resources appropriate to individuals and families experiencing these symptoms.
- Every long term care home has a designated behavioural support role (BSR) function. This individual/team is knowledgeable in responsive behaviours and their management and works in consultation with the community mobile interdisciplinary Seniors Behavioural Support Outreach Team (SBSOT).
- Home care staff working under the auspices of the CCAC are knowledgeable about responsive behaviours and their management and know when it is appropriate to request a visit from the SBSOT.
- The SBSOT provides periodic continuing education sessions for hospital GEM nurses, CCAC home care providers, community seniors support service providers, mental health service providers and long term care BSRs. These sessions

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may include outreach, inreach and opportunities for short-term seconded rotations in specialized behavioural support units.

- Caregivers who are looking after individuals in their homes are supported by the SBSOT and community service providers and are able to keep their family members in their own home longer.
- Long term care home staff are supported by the BSR and the SBSOT in caring for people with behavioural symptoms, and referrals to behavioural support units are reduced.
- Specialized behavioural support units and SBSOTs are staffed with the same cadre of professionals. This way, transitions from one's place of residence (including long term care homes) to behavioural support units and home again are more effective. This team supports the learning / knowledge transfer needs of caregivers, long term care, CCAC, and community resources. Consideration is given to seconding staff from long term care homes into behavioural support units to implement individual care plans consistently across environments and to meet ongoing training needs.
- ALC days associated with responsive behaviours due to cognitive impairment are reduced.

These five steps represent a minimalist approach to meeting the requirements of an effective Older Adults Behavioural Support System and require modest investment. This approach could be undertaken across the province or piloted in a few LHINs as an initial step. The steps are consistent with the implementation approach under consideration for the Mental Health 10-Year Plan and is also consistent with the approach proposed for *Implementing Interprofessional Care in Ontario*, developed for Workforce Ontario [Interprofessional Care Strategic Implementation Committee Final Report, May 2010].

The main deliverables to be achieved through this approach are (1) the coordination of existing resources; (2) a vehicle for achieving intraprovincial consistency; and (3) a process for ongoing knowledge translation and capacity building.

Another benefit of this approach would be the creation of the potential for establishing an Integrated Model of Care for the Elderly.

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The literature on health services integration is clear that service integration is not a panacea that will benefit all system users uniformly. There is agreement, however, that developing a coherent model of service integration for the elderly is an important policy priority that we never quite get around to, despite the well-documented benefits. It is clearly beneficial to integrate services for older Ontarians with specific and pressing needs (such as responsive behaviours) that are intermittent at first, then more persistent, as the underlying disease progresses. The model described in this report pulls together resources and integrates them to ensure competent care is available at home or in care homes, as the needs require.

However, responsive behaviours is one set of health concerns associated with older people. They are prone to many more. Most people who are elderly have multiple chronic conditions, requiring medical care, assistance with (instrumental) activities of daily living, companionship and social stimulation. The benefits that would accrue from specialized teams diminish as more teams need to be mobilized to deal with each physical and mental health problem emerges. Accordingly, the elderly is the population who would most benefit from an integrated health and social service delivery system.

In her very comprehensive *Frameworks of Integrated Care for the Elderly: A Systematic Review (Canadian Policy Research Network, 2008)* Margaret MacAdam identified four key elements of an effective framework for integrated health and social care for the elderly which can result in improved outcomes, client satisfaction and/or cost savings or cost-effectiveness. These key elements are:

1. umbrella organizational structures to guide integration of strategic, managerial and service delivery levels; encourage and support effective joint/collaborative working; ensure efficient operations; and maintain overall accountability for service, quality and cost outcomes
2. multidisciplinary case management for effective evaluation and planning of client needs, providing a single entry point into the health care system, and packaging and coordinating services
3. organized provider networks joined together by standardized procedures, service agreements, joint training, shared information systems and even common ownership of resources to enhance access to services, provide seamless care and maintain quality.

4. financial incentives to promote prevention, rehabilitation and the downward substitution of services, as well as to enable service integration and efficiency.

Consideration should be given to the benefits associated with developing integrated care for the elderly in Ontario, with LHIN-level service integration and province-level standards and philosophical guidance. MacAdam refers to the Hollander and Price framework for continuing care for people with disabilities (including elderly). This framework has “three parts: (1) philosophical and policy prerequisites that underlie ongoing support for integrated systems of care for those with disabilities; (2) a set of best practices for organizing service delivery; and (3) a set of mechanisms for coordination and linkage across the range of organizations and professionals involved in delivering continuing care services.”

Challenges

Implementing the Older Adults Behavioural Support System will not be without challenges. Quite apart from the usual hurdles to major system change (organizational inertia; myopia; power differential among providers, stigma, ageism), two challenges in particular warrant discussion:

1. Provincial Election: A provincial election is 14 months away, at the time of writing, which means that it will be front-of-mind by the time this report's recommendations are being given active consideration by government. It would be difficult to imagine a potential change in government having any bearing on the current excellence in care, quality improvement, and person-centred care trends. However, the recommendations regarding implementation require the participation of LHINs and, from our current vantage point, it looks like LHINs may be a point of contention in the next election. While, the size and number and some aspect of the role of LHINS will surely change, the authors are of the view that some form of sub-provincial planning and resource allocation will still be necessary in any scenario. At worst, the issue of LHINs, and its resolution, may be a distraction which has the potential of delaying implementation of the Older Adults Behavioural Support System.
2. Funding Constraints: The economic crisis and slow, unpredictable recovery of the last couple of years are focusing the minds of policymakers. There is current concern about the questionable return on recent investments (e.g. primary care)

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and increasing concern about government revenues. Government is already considering dramatic expenditure management strategies and it is entirely likely that Health - the largest provincial expense category – will be subjected to nervous scrutiny if not funding contraction. This is not a nurturing environment for any new policy consideration. It will be incumbent on the proponents of the Older Adults Behavioural Support System to point to the capacity of this proposal to reduce ALC days and reduce hospital admissions through Emergency Departments. It will also be important to highlight the substantial fiscal benefits sought by the United Kingdom in making the person-centred culture change. Getting on top of the issues addressed in this report now will pay dividends through the next several years of rapidly increasing prevalence of dementia and other age-related causes of responsive behaviours.

Conclusion

The approach proposed in this report is the right approach. It is consistent with the best efforts made in other jurisdictions and what is known to work in Ontario. It takes advantage of prior investments and improves access to, and utilization, of existing specialized resources. It is consistent with excellent care and with other existing government priorities. The approach is scalable and its implementation is straightforward. Most importantly, it ensures families that the needs of their elders are going to be met compassionately and competently.