Alzheimer Knowledge Exchange

CDRAKE
CANADIAN DEMENTIA RESOURCE AND KNOWLEDGE EXCHANGE

Sharing and creating knowledge together, to improve practice.

Strategic Engagement of Primary Care to Improve Care for Seniors with Complex Care Needs: *System Integration*

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Seniors with Complex Care

"Our society now confronts a growing phenomenon – that of a burgeoning aging population of individuals living with frailty and/or multiple co-morbidities, all of which may be confounded by the challenges of dementia."

- Dr. David Walker, Provincial ALC Lead, 2011

Seniors with Complex Care

- 90% of community-dwelling seniors with dementia have two or more coexisting chronic medical conditions
- Challenges self-managing general health and chronic conditions (e.g., diabetes, coronary artery disease, heart failure, chronic pulmonary disease)
- Cycles of ED use and hospitalization, stabilization, discharge, poor self-management, deterioration, and readmission to the hospital
- Heightened risk for delirium and functional impairments with acute illness – slow and incomplete recovery = long hospital stays, alternate level of care days, or premature long term care (LTC)

The Role of Primary Care

- Central role in the care of seniors with multiple co-morbid conditions and the interplay of these
- Primary care providers *need* and *want* to be engaged and supported within the context of a broader integrated system to build capacity and foster integrated responses to prevention and complex care management

Primary Care Strategic Elements

- Developed through Behavioural Supports Ontario (BSO) project
- Include:
  - Leadership
  - Engagement
  - Education
  - System Integration
  - Tools and Processes

This Series

- Share the Strategic Elements for broad application
- Share examples of how strategic elements are being implemented
- Identify success factors and lessons learned related to the strategic element
- Gather information, resources and tools related to the element

Strategies for Engagement should…

- take a multi-pronged approach
- include activities that fall under most, if not all, of the 5 strategic elements
- be based on local needs in *how* they are implemented

Primary Care Leadership

- Dedicated responsibility of an individual or group to continue to engage and support primary care

Engagement

- Early and meaningful engagement of primary care as partners and collaborators early in the development of initiatives to support those with complex care needs or the primary care sector itself

Education

- Complexity of care requires specialized understanding of the needs related to this population
- Varied approaches to learning for the primary care team based on needs

Tools and Processes

- Support to provide better in-the-moment, evidence-based, best practice tools and processes to care to patients with complex care needs and their families

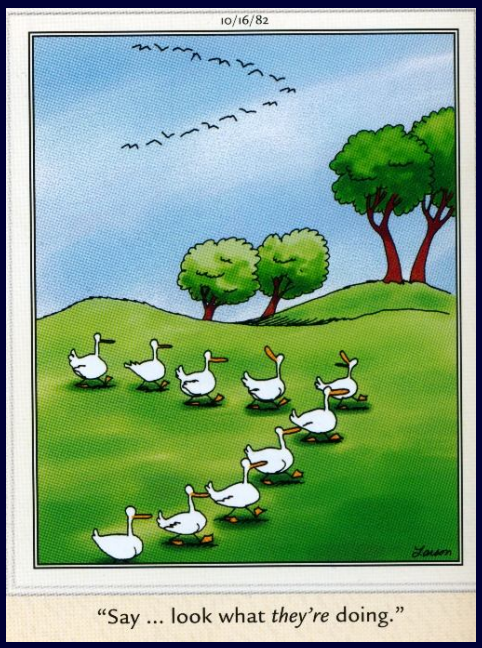
System Integration

- Wrap services around primary care to enable better flow of information, referral and collaboration between Primary Care, specialist services and other community service providers

System Integration

Keys to Success:

- Involve all partners across sectors in developing strategies for system integration
- Ensure a person-centred approach to care informs all integration strategies
- Embed mechanisms to link tertiary and specialized mental health work with primary care
- Explore opportunities and mechanisms for shared leadership models between specialty and tertiary care



Primary Care Memory Clinics:

Improving Care for Patients with Memory Difficulties Through Integrated Team-Based Care

Linda Lee, MD, MCl(Sc),CCFP, FCFP

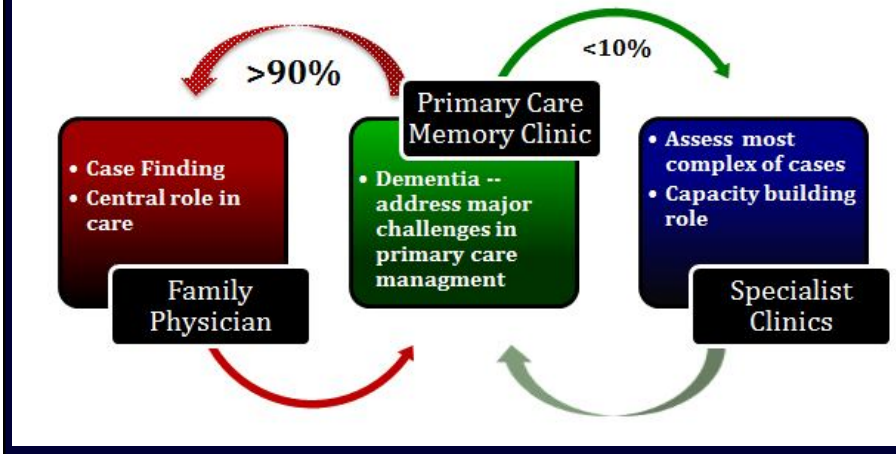
2013

What is a Primary Care Memory Clinic?

- An *intermediary* clinic
- An interdisciplinary model of co-active team-based case management, rooted in primary care practice
  - efficiently integrates specialist and community resources
  - assists with *the most challenging aspects* of dementia care
  - ensures the patient's family physician maintains central role in care → defragmented care
- *Builds capacity* within primary care practice
  - Moves much of dementia care from specialty care into primary care
- Unique!

Primary Care Memory Clinics in Ontario

- Standardized training and assessment procedures, MainPro-C accredited; 70+ family physicians and 200+ AHPs trained since 2008
- 40 primary care Memory Clinics in Ontario, servicing over 500 family practices, in Family Health Teams, Family Health Organizations, and Community Health Centre
- Clinic team members: 1-4 family physician leads, NP/RN/RPNs, Social Worker, Pharmacist, Occupational Therapist, Alzheimer Society member
- Geriatrician or geriatric psychiatrist for e-mail or telephone support
- Clinics operate on a minimalist basis



Lee L, et al. Journal of the American Geriatric Society. 2010;58(11):2197-2204
Lee L, et al. Journal of Continuing Education in the Health Professions. 2013;33(1):24-32
Lee L, et al. Alzheimer's & Dementia. 2012;8(4):P443

2006 - Primary Care Memory Clinic established to support 17 CFFM FHT family doctors
- 30,000 current patient base

2008 - MOHLTC grant
- expansion includes Social work
Pharmacy
Nursing
Medicine
Occupational Therapy

- development of an accredited interprofessional Training Program in partnership with the Ontario College of Family Physicians, with guidance from geriatricians

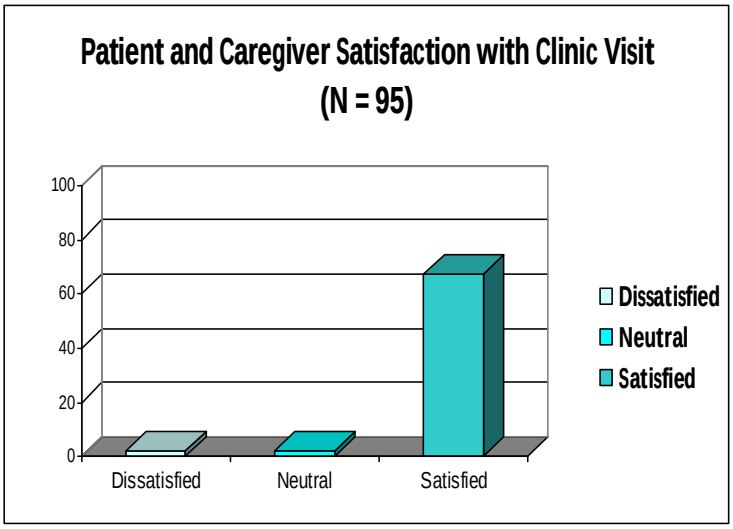
2010 – integration of Alzheimer Society members into new Memory Clinic teams

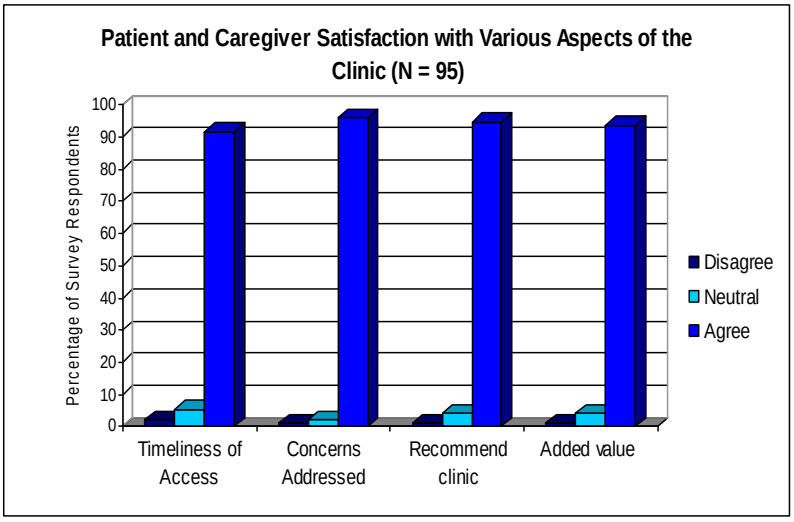
Principles of the Memory Clinic

- Increase capacity and quality of care for patients with memory disorders
- Proactive, holistic interprofessional care and support of patients and caregivers → aim to reduce ER visits, hospitalization, and premature institutionalization,
- Balance diagnostic accuracy and effective interventions with efficient, sustainable utilization of resources.
- Reduce referrals to specialists and community resources to only the most necessary

Primary Care Memory Clinic

- Team members:
  - 1-3 family physician leads
  - 2 nurses/nurse practitioners
  - Social worker
  - Pharmacist
  - Occupational therapist
  - Alzheimer's Society member
  - Specialist e-mail or telephone support
- Function as an intermediary, to assist the family physician in accurate diagnosis and management, and to streamline use of limited geriatric resources





Agree = sum of "agree" & "strongly agree" ratings

Increase to Alzheimer Society Services

Site	Pre-AS involvement (6 months)	Post- AS involvement (6 months)	Percent increase
Site A	0	10	100%
Site B	3	22	663.33%
Region A (4 FHTs)	4	22	450.00%
Total (Across 6 FHTs)	**7**	**54**	**671.43%**

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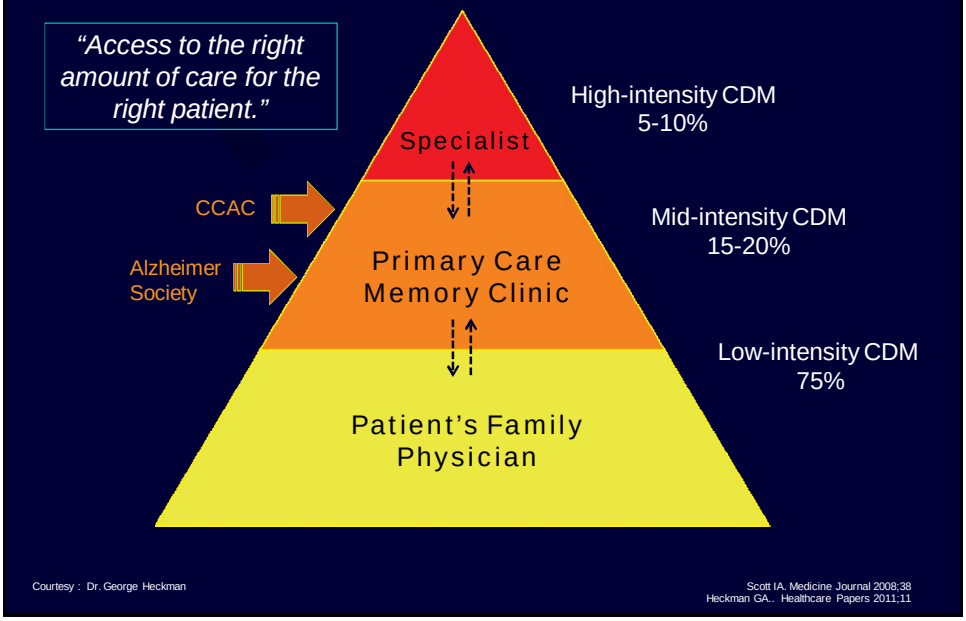
Sustainable, Efficient Care.



Courtesy : Dr. George Heckman

Scott IA. Medicine Journal 2008;38
Heckman GA.. Healthcare Papers 2011;11

Keys to Success

- Co-active team based care navigation; shared leadership
- Systematic integration of interprofessional care providers and community-based care providers, primary care physicians and specialist physicians
- Holistic, person centered approach with confluence of patient, treatment, and healthcare system goals

For more Primary Care Resources…

www.akeresourcecentre.org/PrimaryCare

Upcoming Sessions in the Series

December 11

- Tools and Processes
- Leadership

January 15

- Engagement
- Education