Alzheimer Knowledge Exchange

Sharing and creating knowledge together, to improve practice.

Working Together to Improve Primary Care for Seniors with Complex Care Needs

A Health Links Discussion

Our Purpose

- "The opportunity to help make connections for those organizations involved with Health Links to build upon the work of BSO (principles of 'building on existing services' or 'service redesign') and the learning - given our LHIN has been involved in the community with three models for BSO that directly impact a subset of the Health Links population (BSO) and could be easily built-upon for other populations"

Agenda

Your challenges, ideas, strategies & resources for…

- Understanding how seniors with complex care needs fit into Health Links target population (and implications for effective care management)
- Enabling *true* person-centred care and engagement
- Developing best practices *with* flexibility for local adaptation

- Opportunities to move forward together

UNDERSTANDING HOW SENIORS WITH COMPLEX CARE NEEDS FIT

Your Challenges

- What exactly defines complex care?
- Falls prevention - the continuum of falls prevention from healthy to frail elderly.
- Bridging care when people are approaching end of life.
- Need to understand source of people accessing ED-where are they coming from(e.g. LTC, community)?

Considering Dementia as a Major Contributor to Complexity

"...the data being reviewed in our area pertains to the primary diagnosis only. We are advocating for including the secondary diagnosis which often includes dementia. We are finding that so far this is not a consideration"

The Contribution of Dementia

- *"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

Cumulative Effects

- 90% of community-dwelling seniors with dementia have two or more coexisting chronic medical conditions.
- Challenges self-managing their general health and chronic conditions (e.g., diabetes, coronary artery disease, heart failure, chronic pulmonary disease, etc.) due to problems with memory, perception of symptoms, decision-making and expressive language.
- Often fail to receive the level of care recommended according to clinical guidelines.

Seniors with Dementia are...

- Twice as likely to be hospitalized compared to seniors without the disease
- Twice as likely to visit emergency departments for potentially preventable conditions
- More than twice as likely to have ALC days when hospitalized
- Nearly three times more likely to experience fall-related emergency room visits

Impact on ALC Days

- One out of four Canadian seniors hospitalized with ALC days in 2009/10 had a diagnosis of dementia (CIHI)
- Hospital stays were twice as long on average (median, 20 versus 9 days) than seniors without the disease

ENABLING *TRUE* PERSON-CENTRED CARE AND ENGAGEMENT

Your Challenges

"The focus of our Health Link at the moment is instilling the person-centred approach in all our contributing providers. Many of them believe they have a person-centred approach already, and it's true they have engaged their patients in many ways, but mostly not to the extent required to have a robust person-centred approach."

- Get caught discussing changes that will improve the provider processes.
- Voice of the person and family sometimes gets lost among the health professionals; not 'true' person-centred care
- Reconciling person-centred care with regulations/policies/processes/organizational culture.

DEVELOPING BEST PRACTICES *WITH* FLEXIBILITY FOR LOCAL ADAPTATION

Your Challenges

- How do we build in consistency, efficiency and local reality into the process?
- How does BSO fit into Health Links for seniors? (principles of 'building on existing services' or 'service redesign')
- Learning needs re dementia assessment, management of behaviours, delirium assessment and management, knowledge re: resources available

Other Challenges

- ***Inter-agency Collaboration***
  - ***Many stakeholders*** to bring together in such a way that keeps the patient at the centre of care
  - Need for ***care coordination and one access point*** but recognition that seniors with complex care don't always enter the system from the same point and vary in preference of who and what should be their central point of care
  - How do ***Community Support Services*** contribute to Health Links?
  - Sharing of ***patient information*** and data

- ***System Design/Process Barriers***
  - Existing structures and processes ***not easily adaptable*** to meet the needs of this complex group and their caregivers.
  - At times the ***resources simply aren't available***.
  - Primary care providers and organizations have identified ***challenges with accessing specialist support*** including geriatric psychiatry, language, transportation, availability of home supports, system coordination and navigation

- ***Facilitating Change***
  - Opportunity to try ***small tests of change close to the front line***, to make sustainable and effective changes that lead to improvements in our system

What are the ideas, strategies and resources for responding to these challenges?