Challenges in Primary Care Recognition, Diagnosis and Management of Dementia

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Objectives

- Talk about system problems which create challenges in meeting the needs of the elderly in communities
- Dive into some specific concerns in dealing with dementia recognition, diagnosis and management
- Discuss a way forward for Alberta in dealing with these interrelated issues

I have no specific challenges dealing with recognition, diagnosis and management of dementia

Personal Illness Experience

Financial Issues

Mental Health

Mixed Cognitive Concerns

Homelessness

Psychosocial Stress

Other Physical Illness Burden

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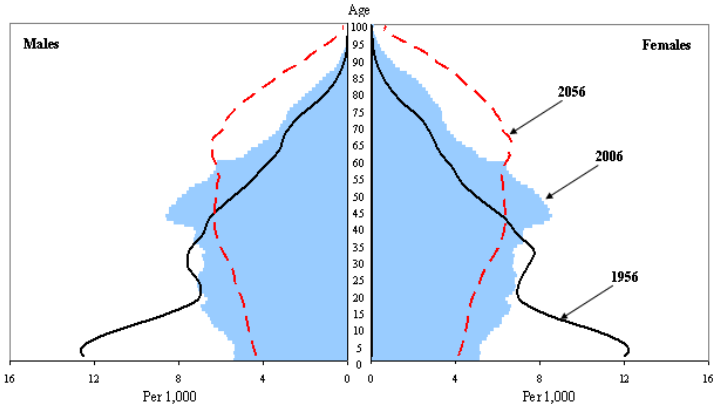
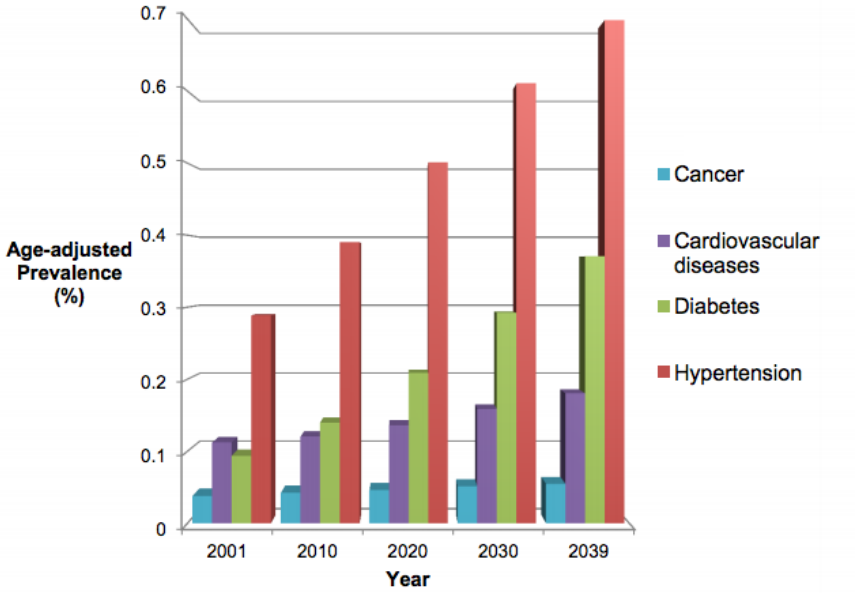




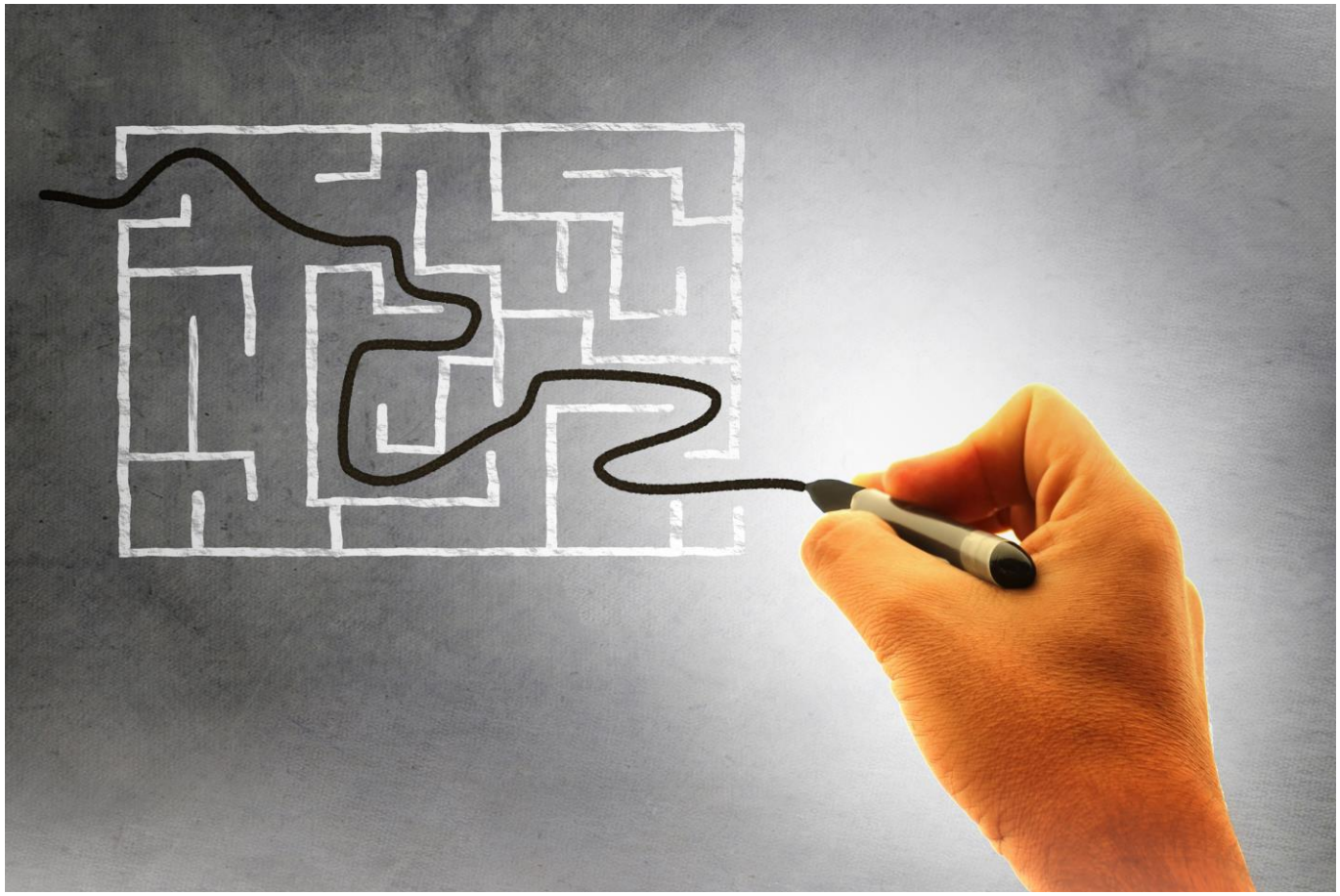
By 2038:

- 1,125,200 will have Dementia in Canada – 2.8% of the Canadian population
- The cumulative economic burden will be $872 billion
- Demand for long-term care will increase 10-fold

Mary - 92

- HTN
- Type 2 DM
- Coronary Disease
- Previous Bypass Grafting
- Congestive Heart Failure
- Chronic Kidney Disease
- Macular Degeneration
- Alzheimer's Type Dementia
- Osteoarthritis
- Previous Hip Fracture
- Osteoporosis
- Urinary Incontinence
- Fall Risk

- CHEP Guidelines
- Canadian Diabetes Guidelines
- Cardiology
- Cardiac Surgery
- Heart Function Clinic
- CKD Pathway and Renal Clinic
- Optometrist
- Geriatrician – Memory Clinic?
- Orthopedics
- Osteoporosis Guidelines
- Urologist
- Home Care, Dietician, CDM Nurse
- Primary Care Provider



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Biggest challenge in dealing with the complex elderly in primary care is that our system is designed to treat the body part or illness, but not the person

Disclaimer

- I use and love the services offered by the Red Deer Acute Care of the Elderly Team (ACE)
- I thought the antipsychotic work done by the seniors SCN was well done and empowered providers in community and facility to think differently
- As a primary care provider I cannot function without specialized services

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Challenges of Recognition and Diagnosis

- Continuity with primary care provider and team
- Time
- Team knowledge and skill in using recognition tools
- Broad differential diagnosis in the complex patient
- Access to diagnostics when needed
- Access to specialized services when needed
- Patient and family fear and concern

Challenge of Management

- Continuity with primary care provider and team
- Time
- Team knowledge and skill
- Limited medication options, limited efficacy and in real world many side effects
- Providing needed community support to allow those with cognitive disorders to age in place with minimal transition
- Safety concerns, functional concerns
- Access to diagnostics and specialized services when needed
- These patients can have very complex care needs which require a high level of coordination

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Long Term Care / Supportive Living

- Socially isolated
- Can mean loss of long term relationship with primary care provider and team
- Alternately PC provider and team may be outside of care circle
- Often enter a mode of “putting out fires” not proactively planning care
- Staff turnover and knowledge at facility
- Behavior management sometimes the focus
- This all leads to increased acute care utilization

Hospital

- Once in . . . can be impossible to get them out!!
- Delerium often quick to follow and high mortality rate
- Difficult to functionally recover, leads to a gradual step wise functional decline
- Changes not always communicated to primary care provider and team
- Can quickly add many “cooks to the kitchen”
- Transition home is difficult for patient and family

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What if we focused on . . .

1) Continuity and Relationship to Primary Health Care
2) Build local team skill, knowledge and capacity to manage cognitive syndromes and assess function
3) Care plan proactively and tie to community services
4) Reorient system to serve patients in community
5) Easy access to specialized services when needed and seamless transitions

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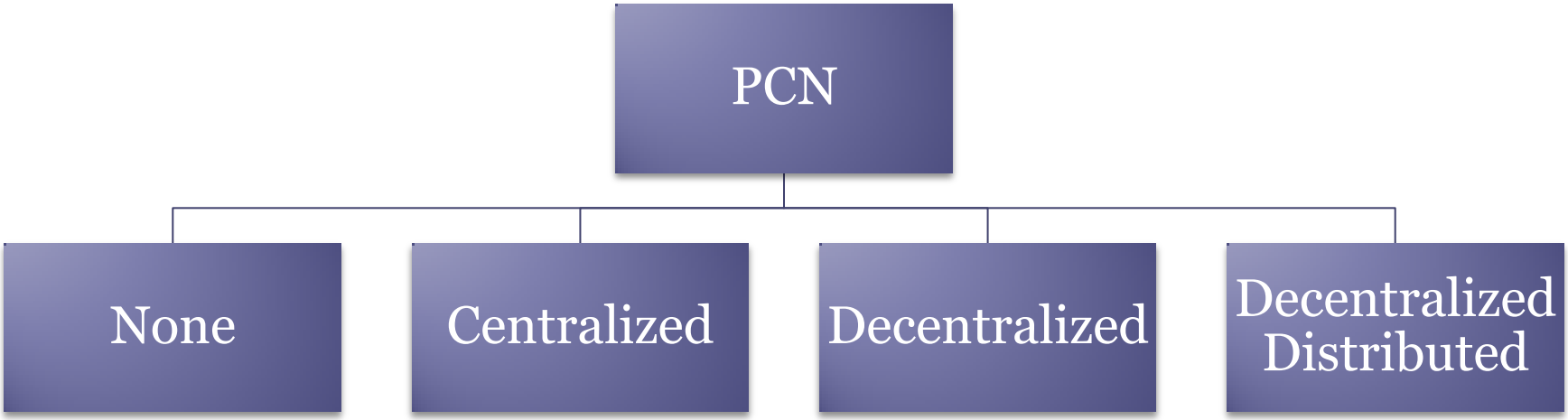
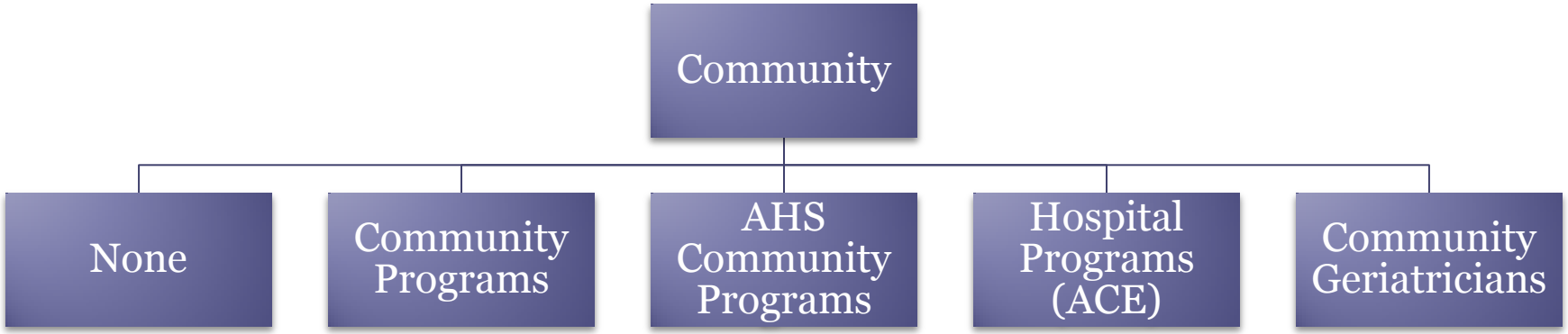
Primary Care Networks

- Teams can be centralized or distributed
- Variable in terms of programming
- Majority would not have specialized dementia / cognitive programs
- But many WOULD have chronic disease nurses, panel managers or other team members who deal with frail elderly patients

Current State Geriatric Services in PCNs



Current State Geriatric Services in Community



Primary Care Providers

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Specialized Geriatrics

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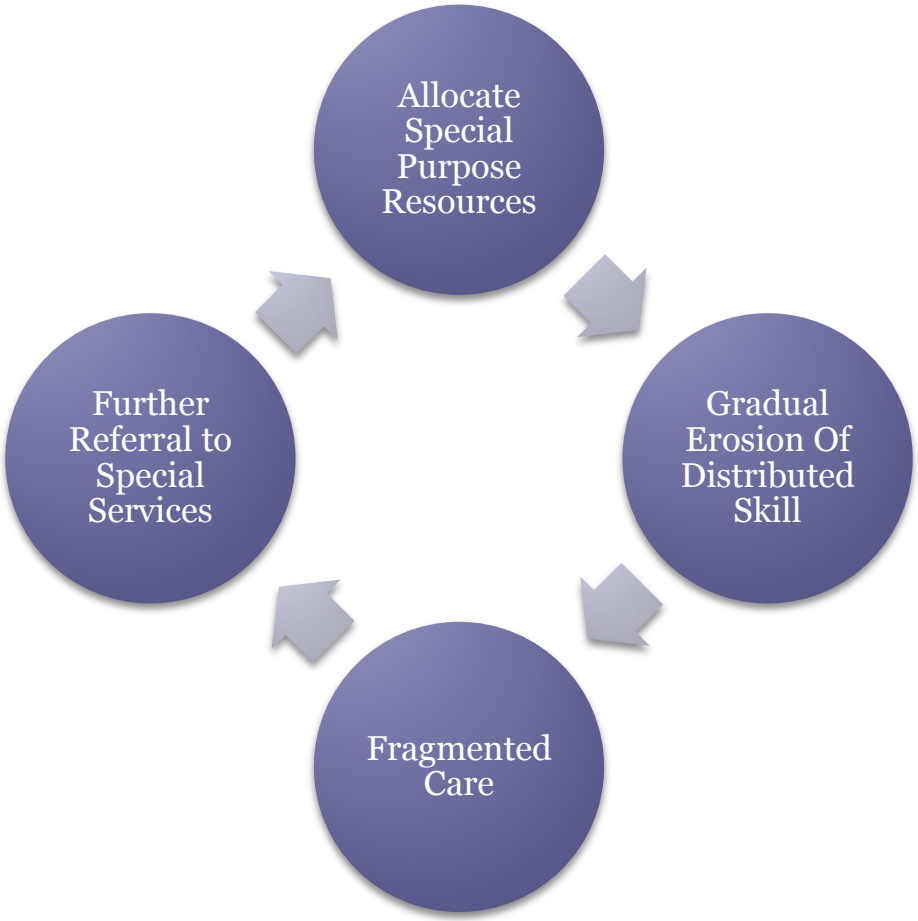
To specialize or to broaden in a PCN?



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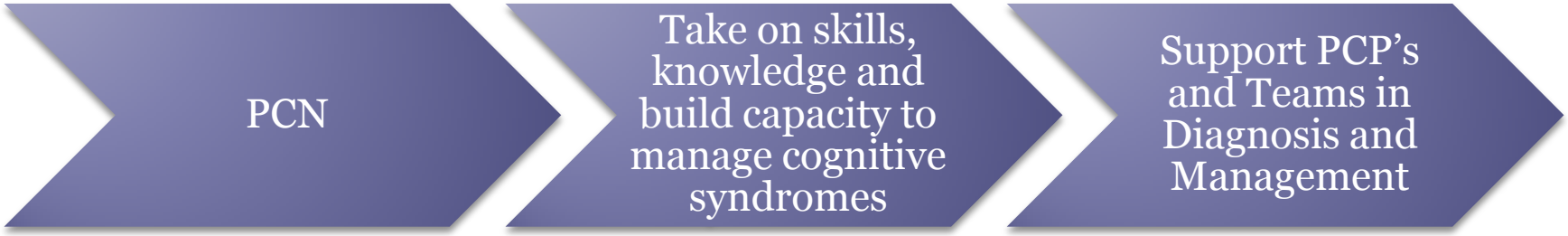
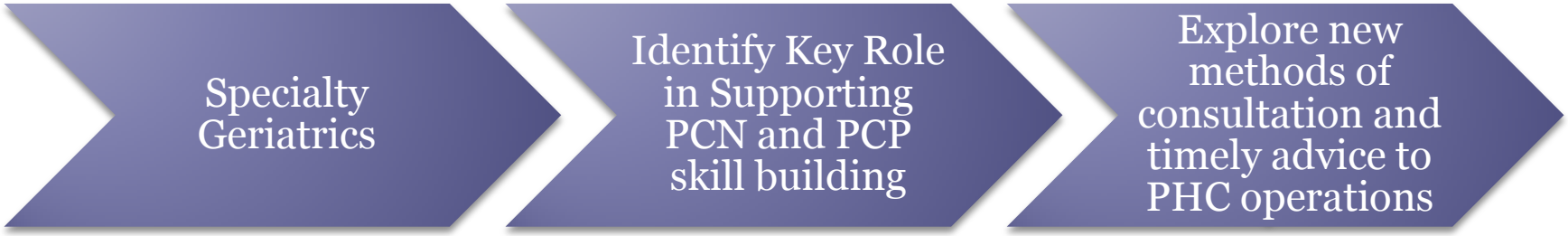
We have;

- A “meso” layer primary care system in place with Primary Care Networks that could take a roll of integration and support to practices
- The knowledge, skills and tools within a Senior’s SCN that can inform best practices
- Pockets of excellence in consulting community geriatrics
- A system that is ready for a shift

Everyone needs to evolve . . .

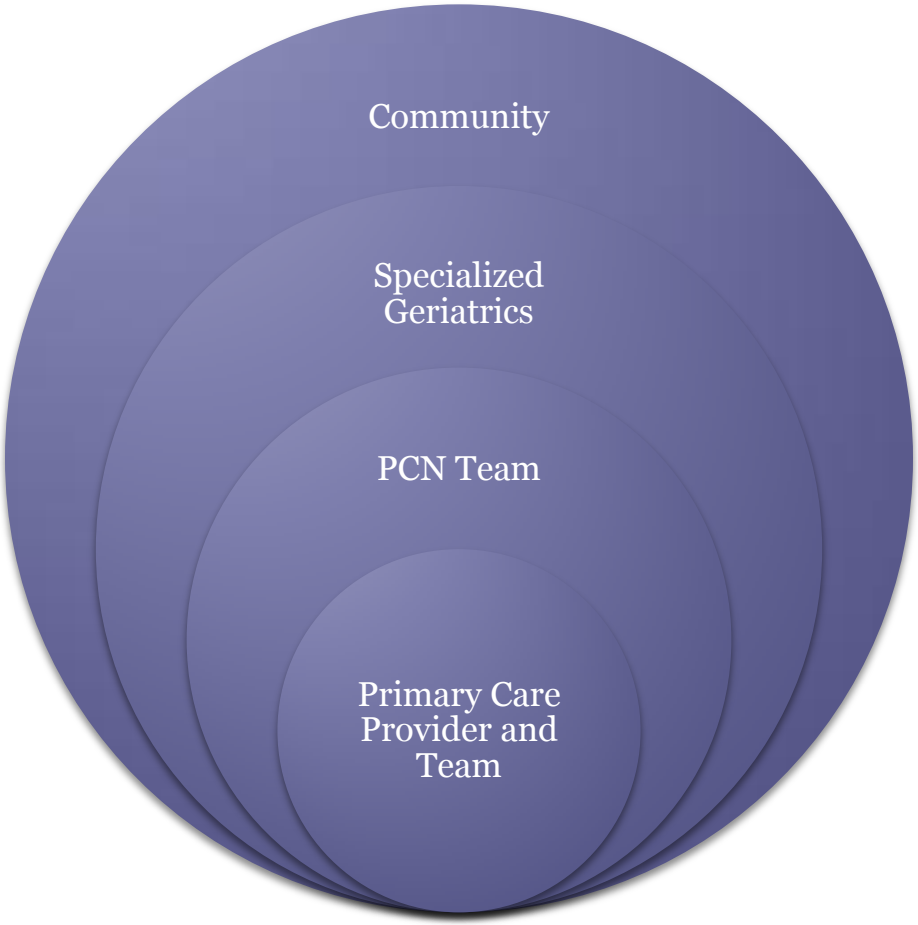
For us to meet the needs of an aging population everyone involved in care of the elderly and management of those with cognitive syndromes will need to evolve

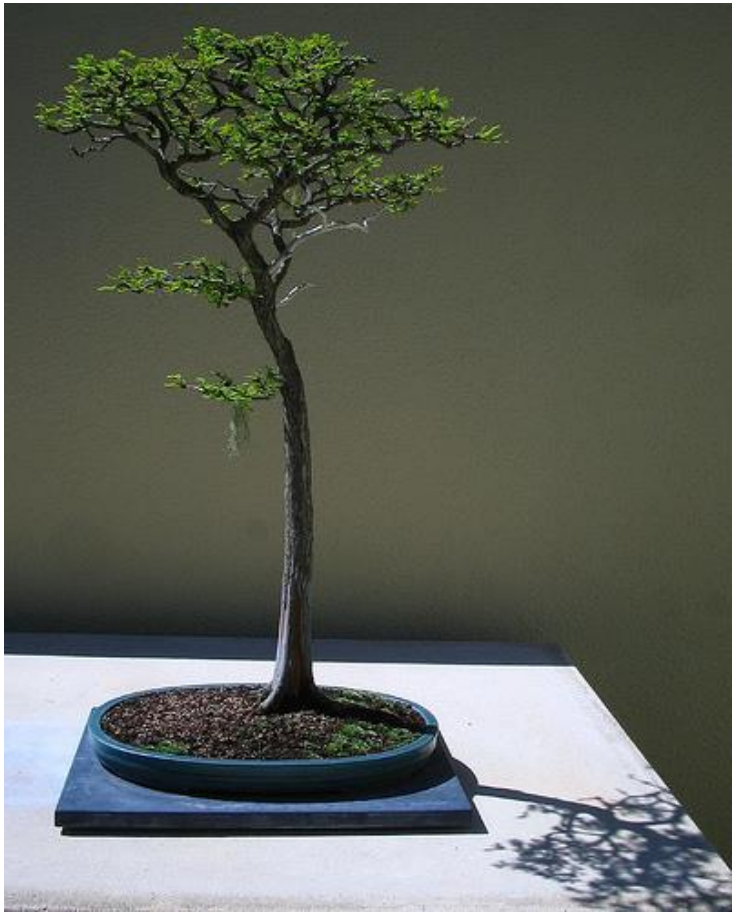

PCN
Take on skills, knowledge and build capacity to manage cognitive syndromes
Support PCP's and Teams in Diagnosis and Management


Specialty Geriatrics
Identify Key Role in Supporting PCN and PCP skill building
Explore new methods of consultation and timely advice to PHC operations


System
Must evolve to point resources to community
Design services to help patients age in place, not support them when already in acute care

Build care plans around the core relationship between patient and PC team





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