Building Capacity to Care for Persons with Dementia: The Central Role of Primary Care

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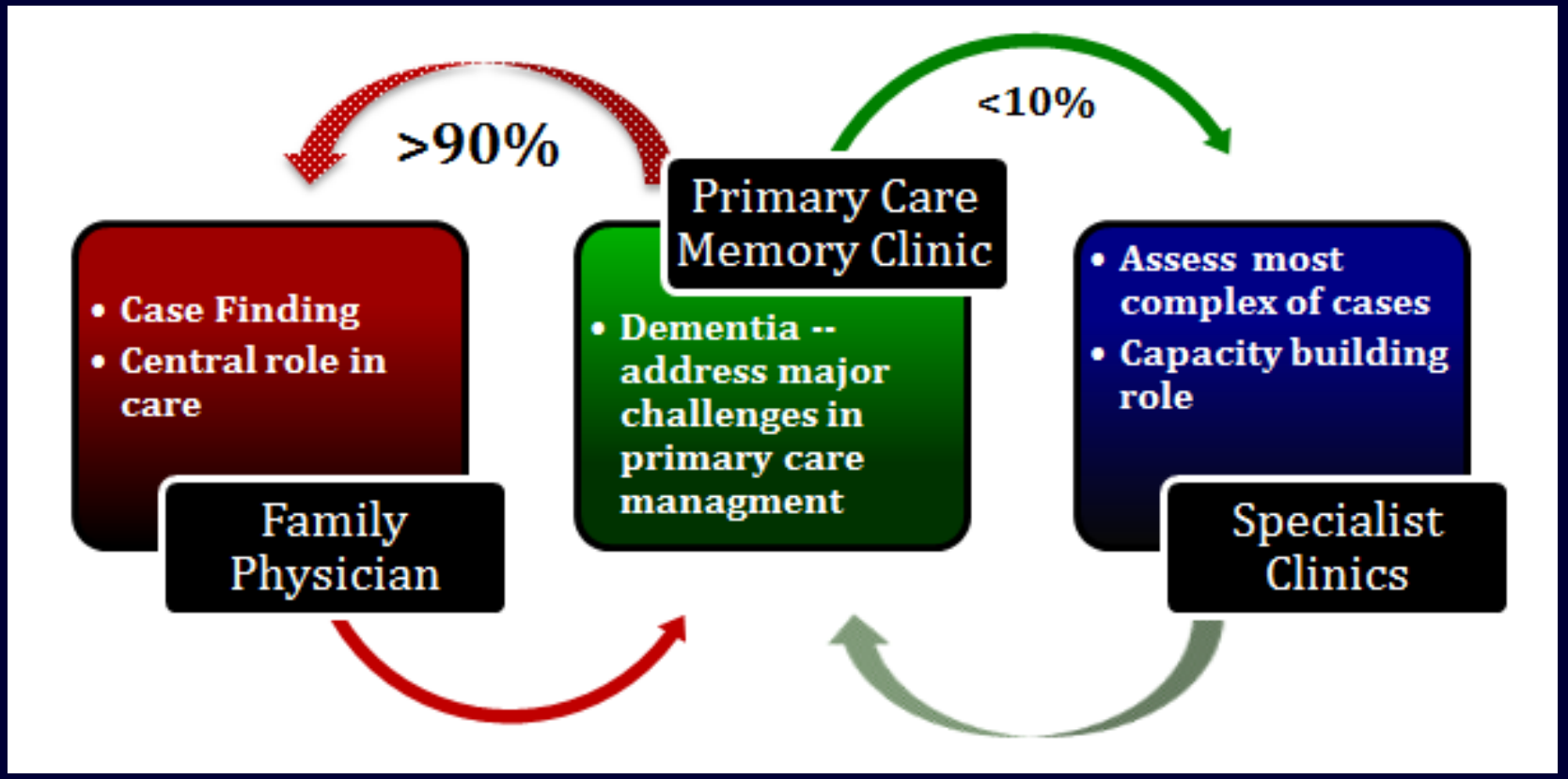
Primary Care Memory Clinics: A new model of care!



- High quality care based on geriatrician chart audit
- Collaboration: interdependence

Lee L, Hillier L, Stolee P, et al. J Am Geriatr Soc, 2010
Lee L, Hillier L, Heckman G, et al. Can J Aging, 2014

What is a Primary Care Memory Clinic?

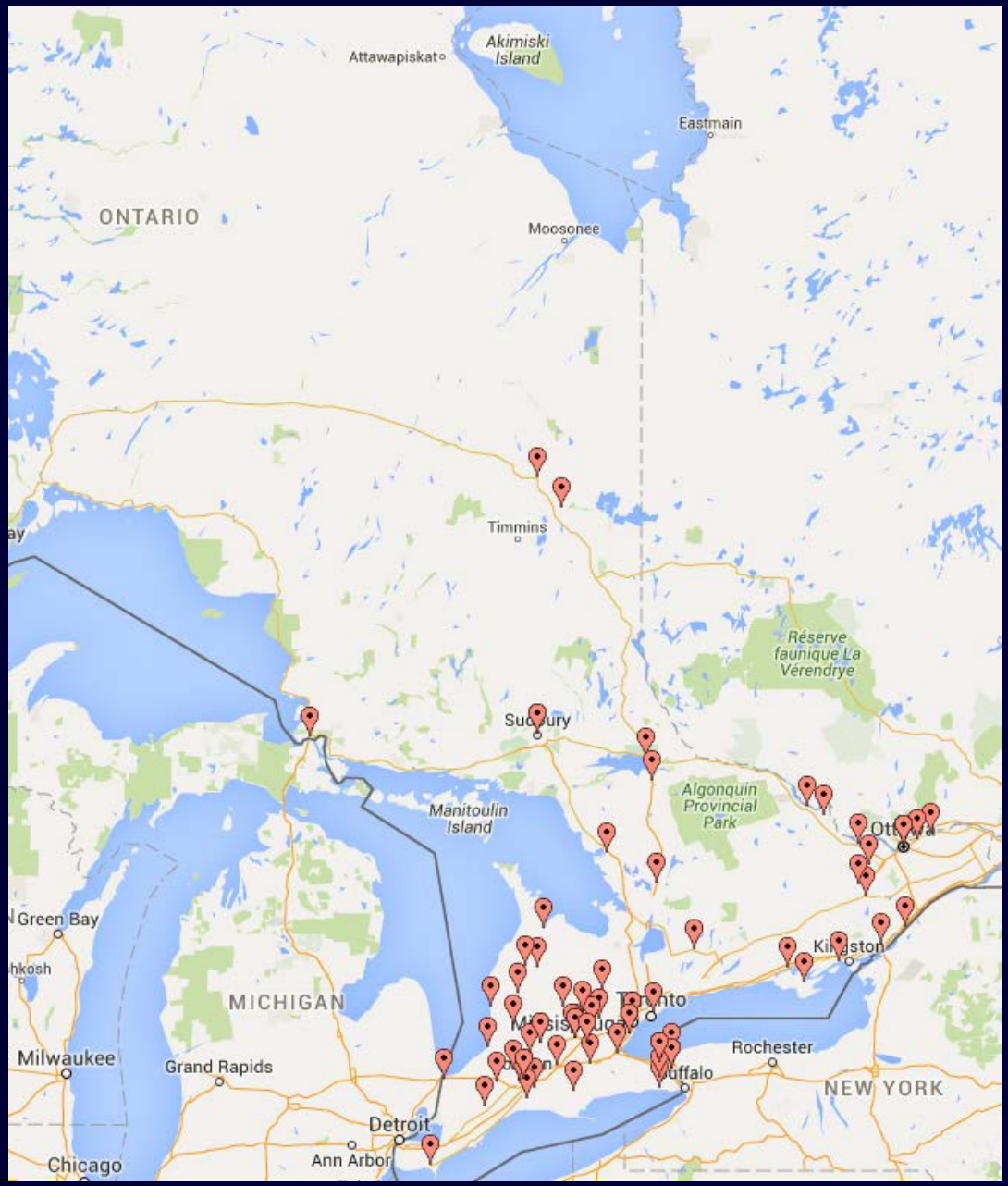
- A *point of access* to comprehensive, integrated care that did not previously exist
- A interdisciplinary model of team-based case management, rooted in primary care practice
  - efficiently integrates specialist and community resources
  - assists with *the most challenging aspects* of dementia care
  - ensures the patient's family physician maintains central role in care → *defragmented care*
  - Aims to reduce crises and avoidable ER visits and hospitalizations and delay institutionalization
- *Builds capacity* within primary care practice
  - Moves much of dementia care from specialty care into primary care
- Unique!

Primary Care Memory Clinic

- Possible Team members:
  - 1-3 family physician leads
  - 2 nurses/nurse practitioners
  - Social worker
  - Pharmacist
  - Alzheimer Society member
  - Specialist for e-mail or telephone support

- Aims to reduce crises and avoidable ER visits and hospitalizations and delay institutionalization

- 78 trained Primary Care Memory Clinics in Ontario
- Service >1000 family practices with combined patient base >1.4 million, in all models of primary care practice
- 25 geriatricians and 3 geriatric psychiatrists provide specialist support
- 165 Family Physicians and 600+ Interprofessional Health Care providers trained through this program



Objectives

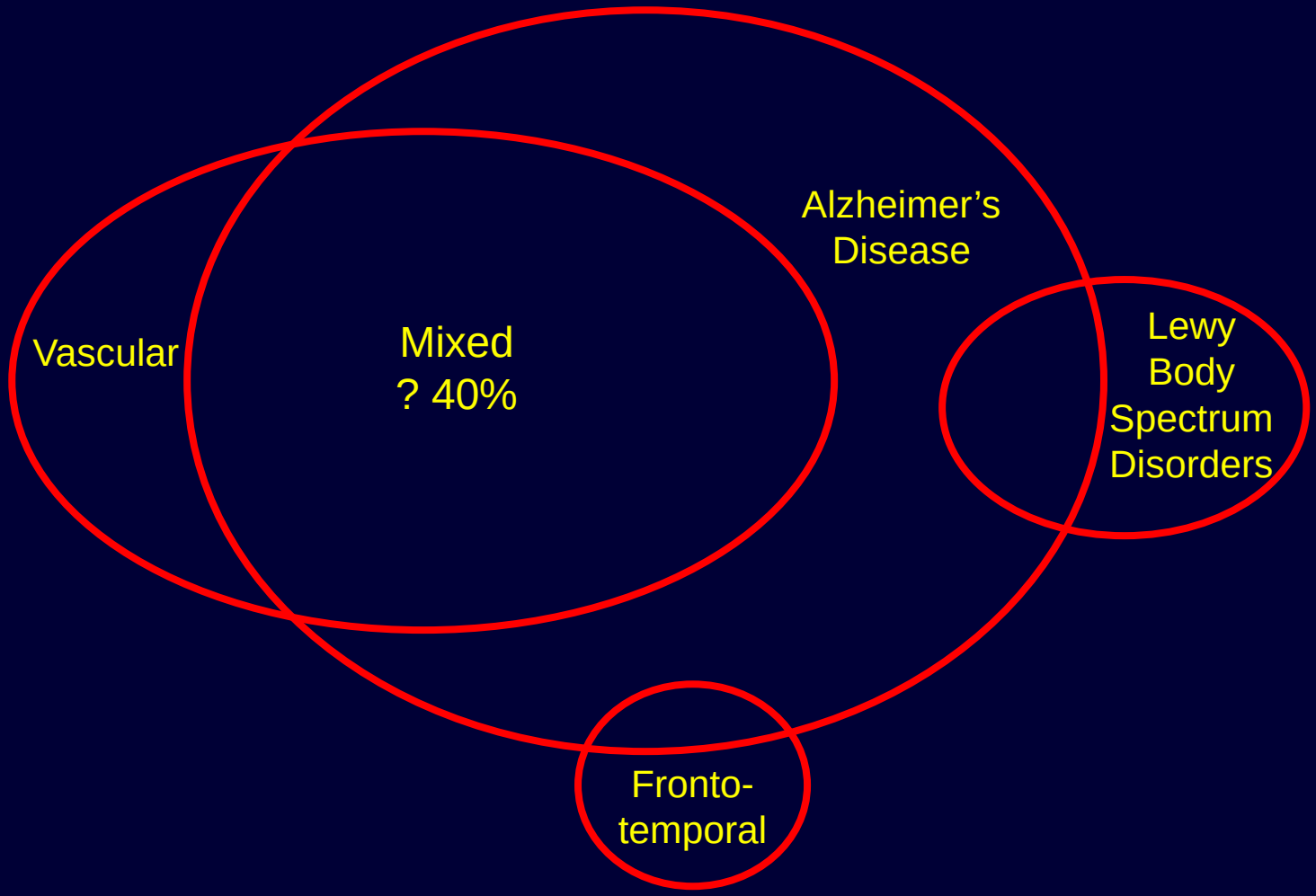
- Review the central role of primary care practice in caring for persons living with dementia and care partners
- Describe essential elements of person-centred care and key attributes of successful innovations for consideration in programs to improve dementia care
- Discuss key elements in the successful implementation and expansion of the Primary Care Memory Clinic model across Ontario

Challenges in Primary Care

- Psychosocial and ethical aspects of declining cognition
- Failure to adopt sick role
- Caregiver needs
- Time and reimbursement constraints
- Difficulty obtaining referrals
- Diagnostic challenges
- Knowledge barriers

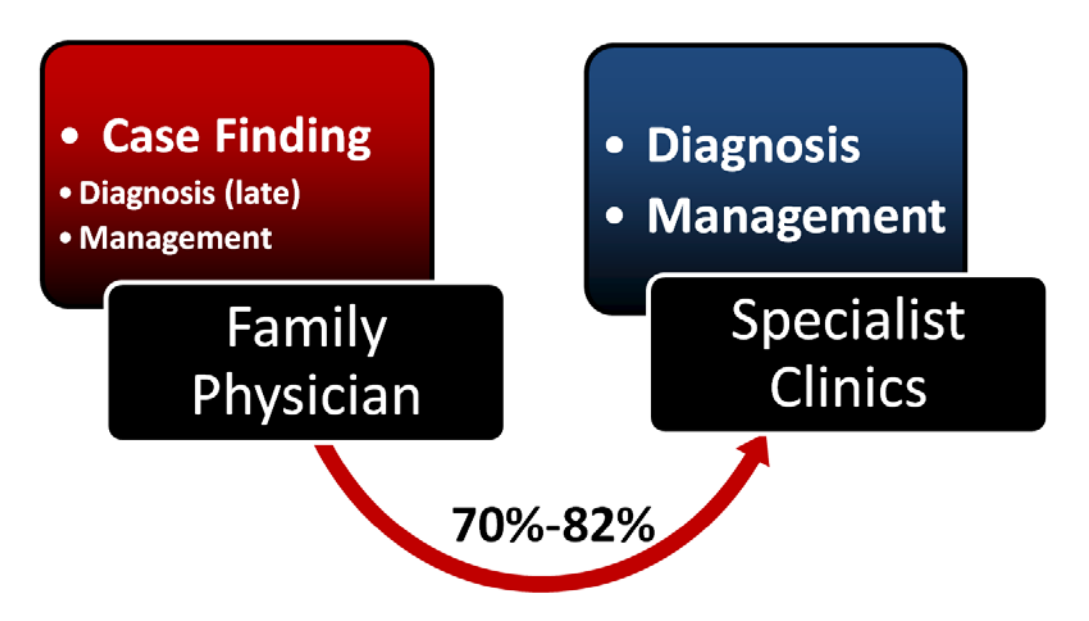
Foster LF. J Geriatr Psych Neurol 2001

Common Types of Dementia



Langa KM et al. Mixed Dementia JAMA 2004

In typical primary care practice…



2003 BCMA survey of 312 family physicians:

- 70% of patients were referred “frequently” or “very frequently” to Geriatric Medicine

BCMH COHP data, courtesy of D. Robertson
Pimlott NJG, et al. Can Fam Physician 2006

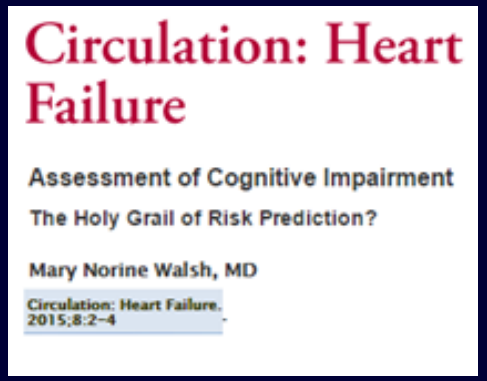
Dementia destabilizes other complex chronic conditions

- Dementia is the number one diagnosis contributing to increasing Alternative Level of Care rates and long term care placements

Walker JD, et al, Healthc Q 2009

Bronskill S, et al, ICES 2011

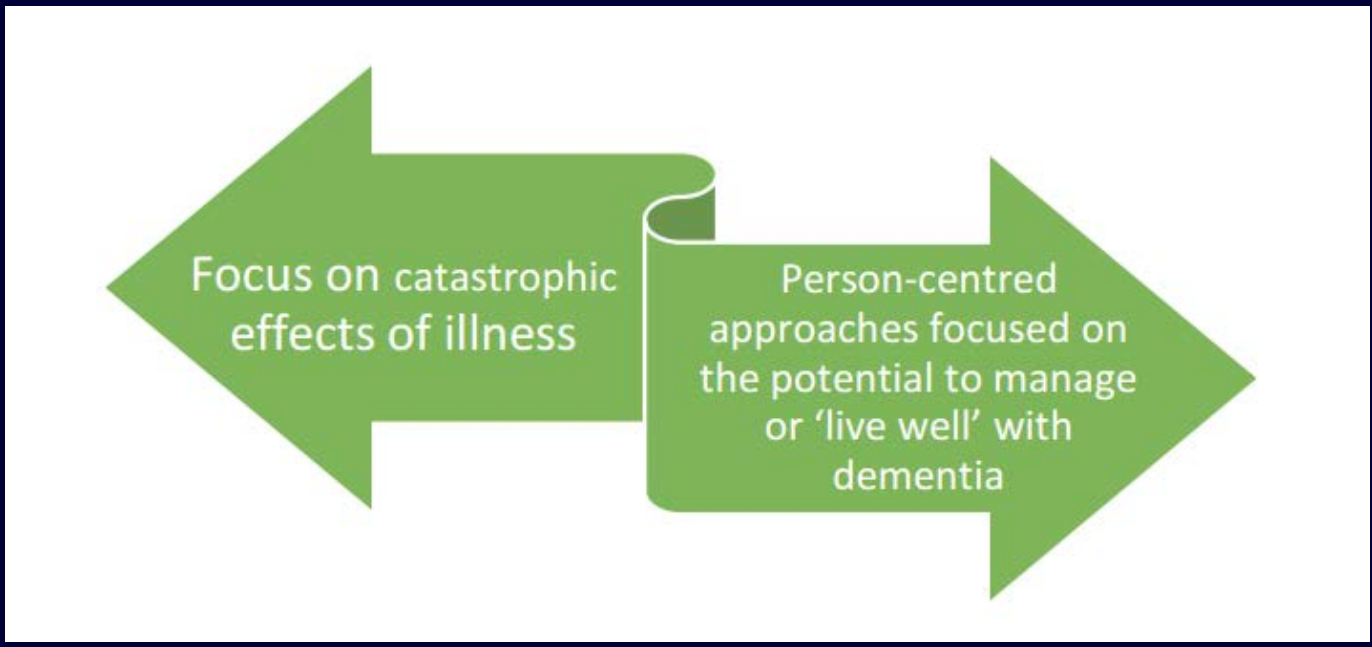
- Dementia/Mild Cognitive Impairment co-exists in at least 1/3 of persons with Heart Failure, or COPD, or hip fractures



Vileneuve S, et al. Chest 2012

Scandol JP, et al. Injury 2012

Gure TR, et al. J Am Geriatr Soc 2012


Focus on catastrophic effects of illness
Person-centred approaches focused on the potential to manage or 'live well' with dementia

A first step is timely, accurate diagnosis…

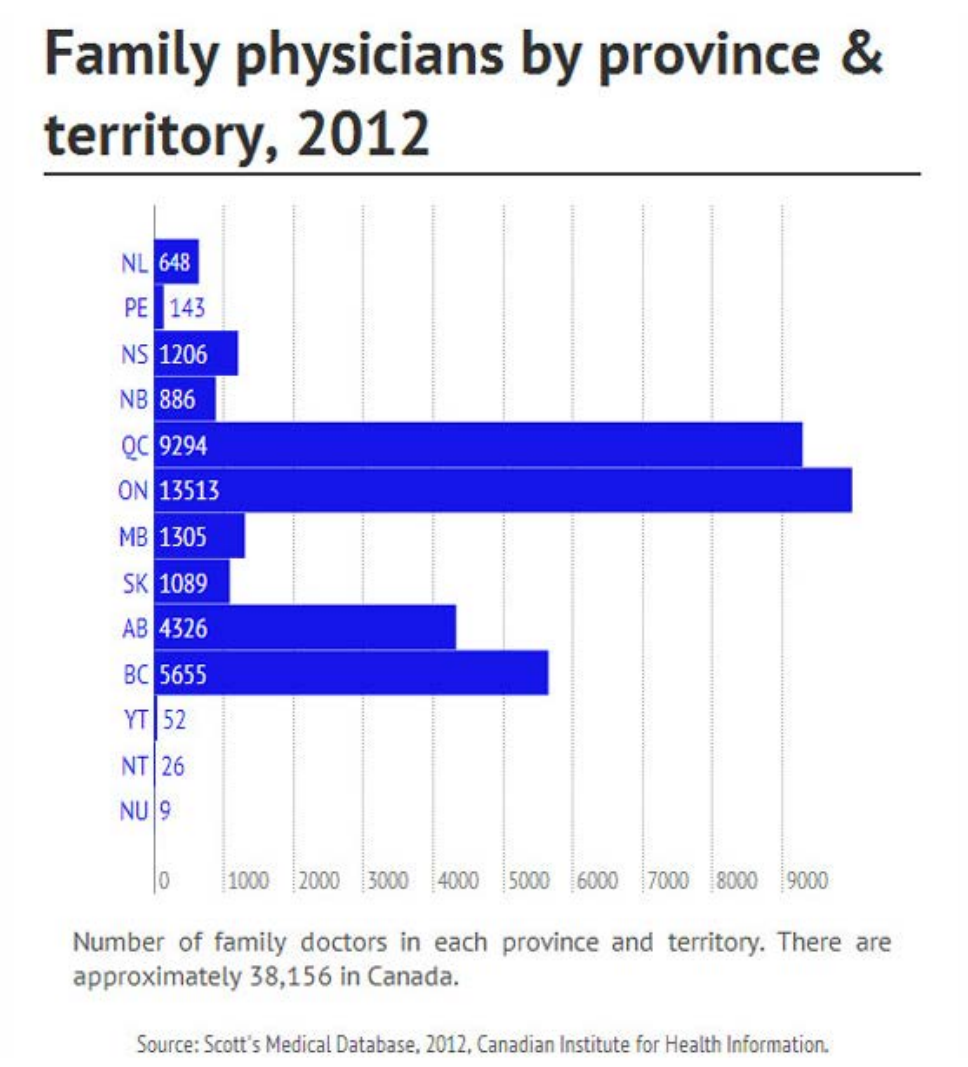
In primary care, dementia detection rate is poor

- 2009 systematic review
- primary care physicians' diagnostic sensitivity for dementia:
  - 0.26-0.69 overall
  - 0.09-0.41 for mild dementia

Bradford A, et al. Alzheimer Dis Assoc Disord 2009

…as a gateway to necessary care

Why Primary Care?



Why Primary Care?

"Primary care is person-focused, not diseased-focused care over time"

- Accessible
- Comprehensive
- Continuous over time
- Coordinating when care is required elsewhere
- Relies on knowledge of the patient that accrues over time
- Health care practitioners and patients work together to reach mutual decisions often requiring long-standing relationships

Person-focused care
Refers to interrelationships over time
Considers episodes as part of life-course experiences with health
Views diseases as interrelated phenomena
Often considers morbidity as combinations of types of illnesses (multimorbidity)
Views body systems as interrelated
Is concerned with the evolution of people's experienced health problems as well as with their diseases

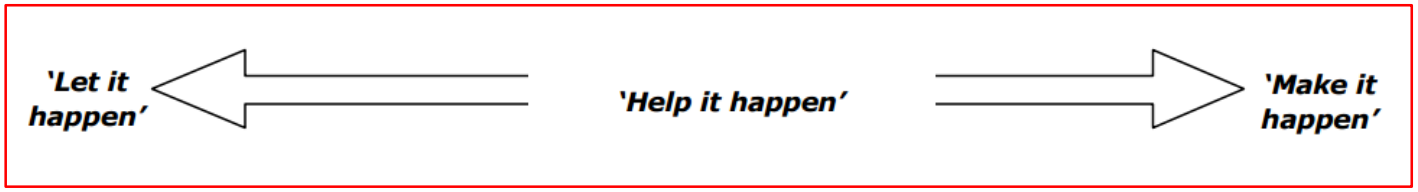
Starfield B. Perm J 2011

Person-Centred Care

- Considered the gold standard for health care
- Essential elements
  - Individualized, goal-oriented care plan based on person's preferences
  - Ongoing review of person's goal and care plan
  - Interprofessional team – "team based care is critical"
  - One point of contact
  - Active coordination among all healthcare and service providers
  - Continual information sharing, integrated communication
  - Education and training for health providers and health education for the person/those important to the person
  - Performance measures with feedback from the person/caregivers

Person-centred care: A definition and essential elements. J Am Geriatr Soc 2016
Coulourides Kogan A, et al. Person-centred care for older adults with chronic conditions and functional impairment: A systematic literature review. J Am Geriatr Soc 2016

Paradigms of diffusion and dissemination: underlying concepts, theories and metaphors on the nature of spread



	'Let it happen'	'Help it happen'	'Make it happen'
Features	Unpredictable, unprogrammed, uncertain, emergent, adaptive, self-organising	Negotiated, influenced, enabled	Scientific, orderly, planned, regulated, programmed, systems 'properly managed'
Underpinning theory	Complexity theory	Knowledge creation cycle; Social network theory; Organisational theory; Knowledge management theory	Classical management theory
Assumed mechanism for spread of innovations	Natural, emergent	Social, organisational and technical	Managerial
Metaphor for spread of innovations	Emergence; Adaptation	Knowledge creation; Sense making; Diffusion; Negotiating; Influencing; Knowledge transfer; Disseminating; Cascading	Change management; Re-engineering
Examples of research traditions	Complex adaptive systems, emergent movements	Organisational sense making, narrative in organisations	'Diffusion of innovations' through social networks, inter-organisational networks, fads and fashions, communication, marketing; Knowledge management, decision support, EBM and guideline development, classical health promotion	Organisational development ('n' step models)

Greenhalgh T, et al. Report for NICCSDO 2004

Key Attributes of Successful Innovations

- Relative Advantage – clear, unambiguous advantage in effectiveness or cost-effectiveness
- Compatibility - with adopters' values and perceived needs
- Trialability - ability for experimentation on a limited basis
- Observability - benefits need to be visible to adopters
- Reinvention - ease of adaptability to suit their own needs
- Risk – low degree of uncertainty of outcome
- Task Issues - potential for improved relevant work performance

Greenhalgh T, et al. Diffusion of innovations in service organisations: Systematic review and recommendations. Milbank Q 2004

Key Attributes of Successful Innovations

- Fuzzy Boundaries –complex innovations have a “hard core” (irreducible elements of the innovation) and a “soft periphery” (adaptable organizational structures and systems required for implementation)
- Low Complexity - perceived as simple to use; can be reduced by practical experience/demonstration or broken down into more manageable parts and adopted incrementally
- Nature of Knowledge Required - ease of knowledge transfer within various contexts
- Augmentation/Support – provision of technical support, eg. customization, training

Greenhalgh T, et al. Diffusion of innovations in service organisations: Systematic review and recommendations. Milbank Q 2004

Key Elements in the Successful Implementation and Spread of the Primary Care Memory Clinic Model Across Ontario

1. Focus: Dementia is the keystone chronic condition
2. Standardized training
3. Efficient use of existing resources
4. Collaboration between disciplines, family physicians/geriatric specialists, and community agencies
5. Person-centred care

1. Focus

Dementia is the “keystone” disease

- Dementia can destabilize other chronic conditions
- In the elderly, optimum chronic disease management begins with identification of cognitive impairment

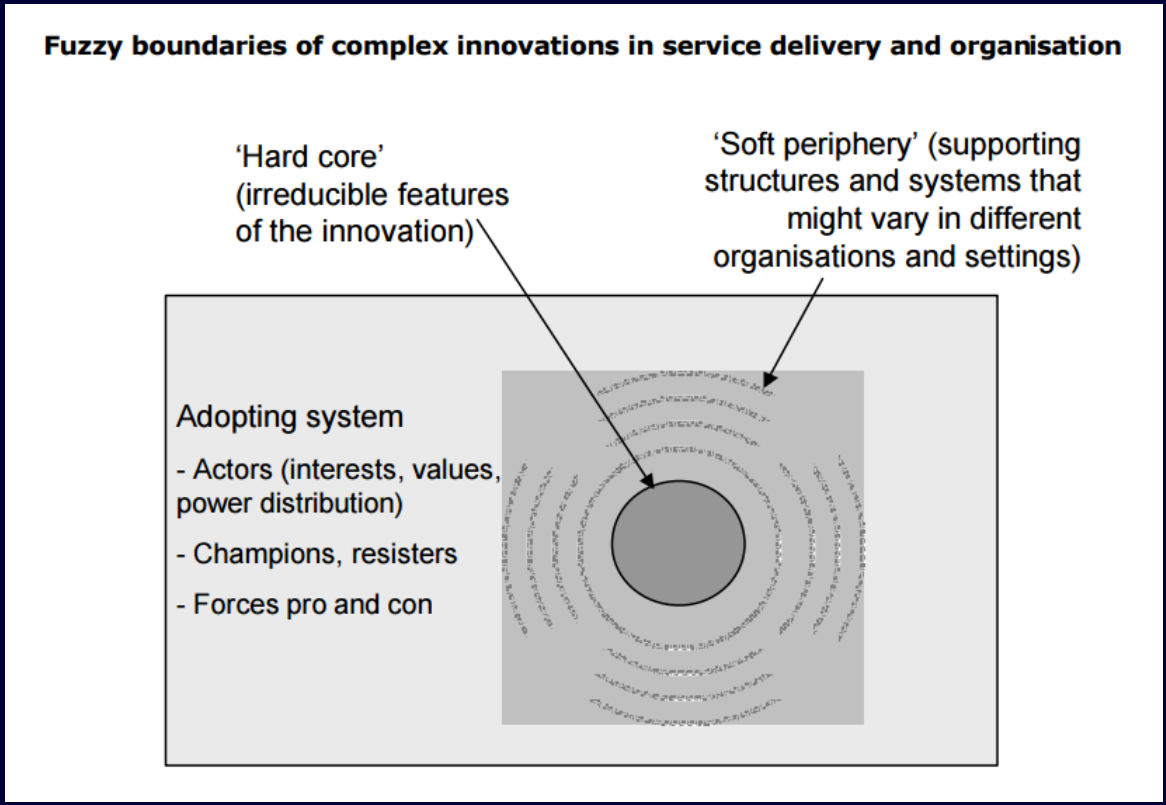
2. Standardized training

CFFM Memory Clinic Training Program

- 2-day case-based interprofessional Workshop
- 1-day Observership
- 2 days of Mentorship at the new Memory Clinic site
  - Discipline-to-discipline mentoring
  - Model adapted to local needs and available resources

Accredited for 17 hours MainPro-C credits by the College of Family Physicians of Canada

- Not for profit, funded via various grants and community agencies and Local Health Integration Networks



Greenhalgh T, et al. Report for NICCSDO 2004
(citing source based on Denis et al. 2002)

Fuzzy Boundaries –complex innovations have a "hard core" (irreducible elements of the innovation) and a "soft periphery" (adaptable organizational structures and systems required for implementation)

Greenhalgh T, et al. 2004

3. Efficient use of existing resources

Stratify patients according to risk of poor outcomes and tailor intensity of Chronic Disease Management (CDM) intervention accordingly

- Low intensity CDM – 75% with chronic disease
- Mid intensity CDM – 15-20% with chronic disease
- High intensity CDM – 5-10% with chronic disease

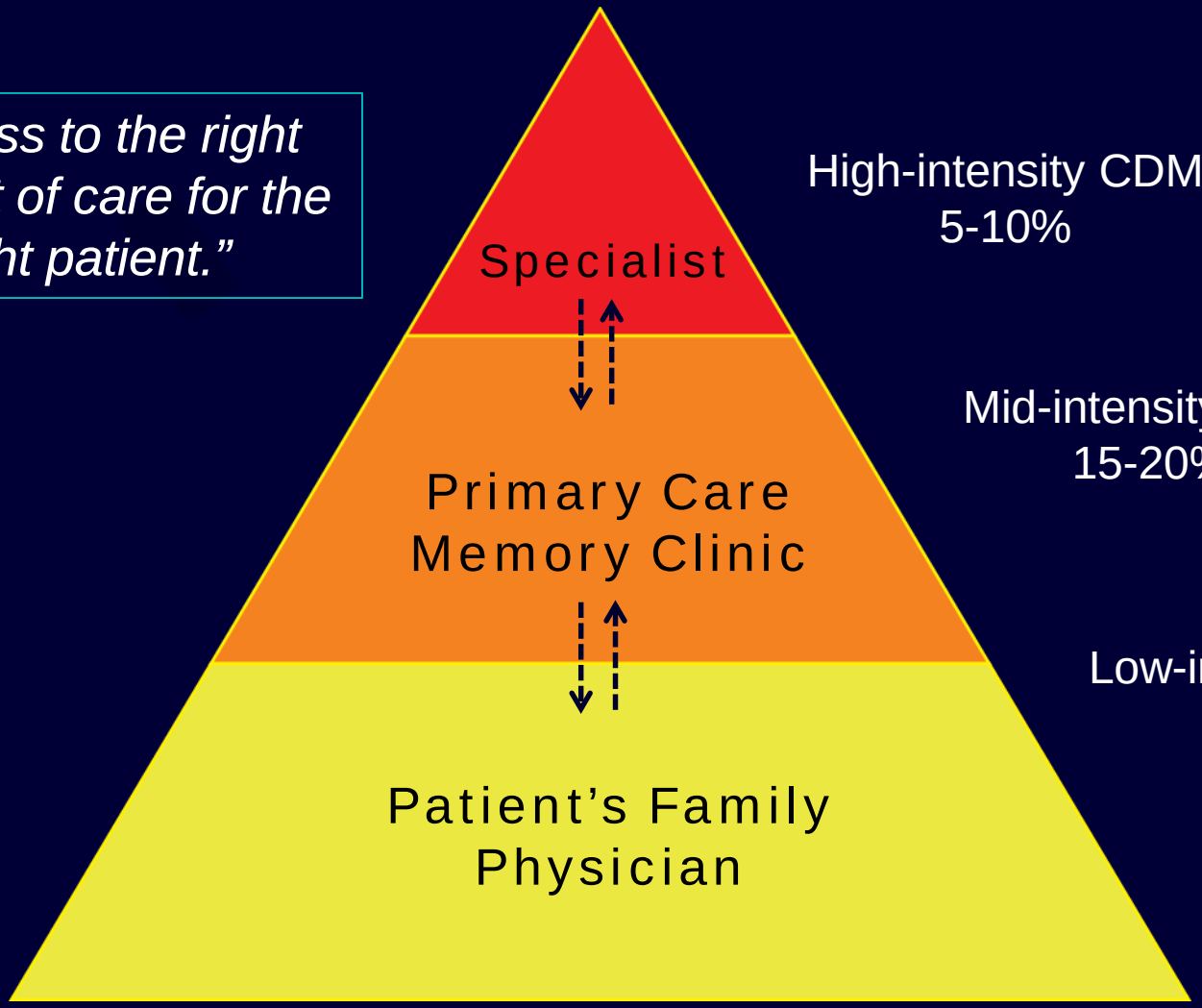
➢ All patients will do well with a “Cadillac” approach to care, but not all require this

Scott IA. Chronic disease management: a primer for physicians. Internal Medicine Journal 2008

Heckman GA. Integrated care for the frail elderly. Healthcare Papers 2011

Sustainable, Efficient Care

"Access to the right amount of care for the right patient."



High-intensity CDM
5-10%

Mid-intensity CDM
15-20%

Low-intensity CDM
75%

Courtesy : Dr. George Heckman

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

Primary Care Memory Clinics
- a highly efficient model!

- 1 clinic day per month supporting 10,000 patient base
- Referrals to specialists streamlined to only the most complex (<10%); specialists receive well-worked up cases and can rely on Primary Care Memory Clinics for follow-up
- Highly-functioning interprofessional team collaboration with seamless information sharing and synergistic interprofessional management

Relative Advantage – clear, unambiguous advantage in effectiveness or cost-effectiveness

Greenhalgh T, et al. 2004

4. Collaboration

- An interprofessional process of communication and decision making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the patient care provided.

Soklaridis S, et al. Family Health Teams: can health professionals learn to work together? CFP 2007

- Team members share goals and are held mutually accountable for meeting them, they are interdependent in their accomplishment, and they affect the results through their interactions with one another.

Borill C, et al. Team working and effectiveness in health care: findings from the health care team effectiveness 2002. Birmingham: Aston Centre for Health Service Organization

5. Person-Centred Care

- Considered the gold standard for health care

- Essential elements
  - √ Individualized, goal-oriented care plan based on person's preferences
  - √ Ongoing review of person's goal and care plan
  - √ Interprofessional team – "team based care is critical"
  - √ One point of contact
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Annual Booster Days

- Knowledge and process updates, review of challenging cases
- Sharing of best practices within disciplines
- Building a *community of practice*

Webinars

- Hosted by Alzheimer's Knowledge Exchange/Brain Xchange
- Designed to meet the needs of Memory Clinics and supporting specialists