5 M's
Personalized Integrated Care and Support Plan

Red Deer Primary Care Network
Elder Care Assessment Clinic Team

Presenter Disclosure

- Catherine Banks
- Lori Watts
- Kathy Sayyad
- Keith Clarke
- Lana King-Kottmann
- Stewart Adams
- Laurie Grande
- Karen Horsley

No relationships with commercial interests or conflicts of interest to disclose

Priority Messages from the Coalition Meeting

The need for:

- quality dementia education
- collaboration and effective communication between service providers
- a multi-disciplinary team assessment
- timely diagnosis and development of a shared care-plan
- increased awareness of community supports/services and how to access
- proactive follow-up care versus crisis response
- importance of planning for the future (EPOA's, PD and GOC)

Traditional Care Planning

It is well recognized that care planning is a process that helps people living with dementia and their care-partners by providing information about:

- Medical treatments
- Non-medical treatments
- Community support services

Often resulting in:

- fewer emergency room visits and hospitalizations
- better medication management
- improved outcomes and quality of life

Personalized Integrated Care and Support (PIC's) Plan

What is it and how is it different from a traditional care-plan?

Collaborative process whereby the person with dementia, care-partner and ECAC team discuss together:

- What is *important* to the person with dementia and care-partner
- *Proactive measures* to live well and stay well
- Builds on *personal strengths*
- *Preferences* for care in the future

As needs change, details of care and support may change but the approach remains the same

"5 M's"
Personalized Care and Support Plan

- **Mind:** cognition and mood
- **Mobility:** fall and injury prevention; balance and gait assessment; driving and transportation
- **Medications:** optimal prescribing, poly-pharmacy, adverse effects, and medication burden, de-prescribing whenever possible
- **Multi-complexity:** complex bio-psycho-social situations; comorbidities and frailty
- **"Matters Most":** each individuals own meaningful outcomes, goals and care preferences

Copies to patient (Green Sleeve), family/care-partners, family physician

Case-Presentation

Ms. T. 78 year old widow referred to the RDPCN ECAC with a history of both cognitive and functional decline, anxiety and recent weight loss.

- Recent diagnosis of Primary Progressive Aphasia
- Lives alone on an acreage 20 minutes outside Red Deer
- Stopped cooking and driving 2 years ago
- Often forgets to eat meals and take medications
- Medications include: NSAID for arthritis, diazepam prn for anxiety and OTC antihistamine to help her sleep
- One son living in Vancouver visits occasionally
- Daily visits and meals provided by neighbour (who has expressed feelings of “burnout”)
- Ms. T.’s wishes are to remain in her own home for as long as possible

Mind

- Primary Progressive Aphasia / Dementia
- Anxiety and Depression

Mobility

- High fall risk due to shuffling gait, no mobility aid and TUG > 45 seconds
- Referral to Physiotherapy for assessment and mobility aid
- Referral to Occupational Therapy for home environment assessment

Medications

- Anticholinergic effects of dimenhydrinate
- Avoid long term benzodiazepines
- De-prescribe when possible

Multi-Complexity

- Moderate frailty (5-6 Clinical Frailty Scale)

- Care Home application
- Lifeline
- Formal (Home Care/ASANT First Link) and Informal support (neighbors)
- Goals of Care

Matters Most

- To live safely and independently in her own home for as long as possible

Follow-Up and Case Summary