Alberta Health Services

Assessing Gaps in Care of People Living with Dementia:

AMA Survey Response Analysis
Seniors' Health Strategic Clinical Network

September 28, 2015

The Seniors Health Strategical Clinical Network (SH SCN) conducted a two-part survey of all primary care physicians in Alberta to assess physician's perspectives on gaps in both palliative and end of life care (PEOLC) and care of people living with dementia (PLWD) in the primary care setting. Participation was voluntary, the survey was distributed through the Alberta Medical Association (AMA), and was open to participants from June 23 – July 9. Of the 4035 surveys distributed, 275 primary care physicians responded, a response rate of 6.8 %.

This report is the analysis of the responses provided by the respondents examining physician perspective on gaps in care of (PLWD) in the primary care setting or Part 2 of the Survey.

Background

Primary health care practitioners are usually the first points of contact and provide ongoing care for PLWD and their care partners. Family physicians and other members of primary health care teams are best situated to have timely discussions regarding diagnosis and management of dementia in the community and to ensure continuity of care throughout the dementia journey.

The following themes have been identified as important for the recognition, diagnosis and management of PLWD.

Theme 1

Primary Health Care (PHC) is the foundation for care of persons with cognitive impairment and dementia and their care partners throughout their journey – community through all alternate living placement options. All PHC team members need to be equipped with the skills and knowledge to recognize and care for the majority of persons with the goal of maintaining independence and autonomy for as long as possible while supporting care partners.

Theme 2

Focused diagnostic services for assessment of persons with cognitive concerns are needed within PHC to support individual Primary Care Networks (PCN) or groups of PCN's. The role of these services is to make diagnoses and develop care plans that address medical management, advanced care planning, driving cessation and caregiver health.

Theme 3

Formal referral linkages with specialized resources should be established to support primary health care and improve access for consultation and management advice for persons with complex issues.

Theme 4

Appropriate compensation is needed for physicians providing diagnostic and related services for persons living with cognitive impairment and dementia and their care partners.

Theme 5

Information and technology is needed to support communication and service delivery to rural and remote areas and improve transitions of care.

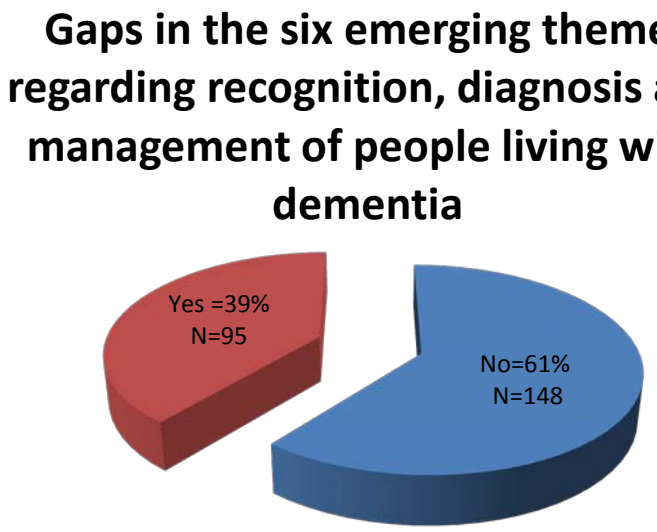
Theme 6

An evidence based guideline for safe driving/driving cessation should be developed. Patients with mild dementia may be safe to drive but require a review of co-morbid medical conditions and medication use as well as advice regarding risks, self-regulation and ultimately driving cessation. The gold standard is a comprehensive on-road assessment.

Survey Results

Question: Are there gaps in the six emerging themes regarding recognition, diagnosis and management of people living with dementia?

- 61 % of the respondents answered “NO”, 39 % answered “YES”

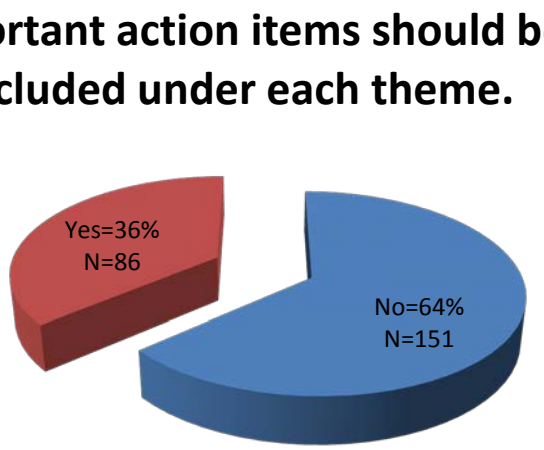


- For the respondents that answered “YES”, themes that emerged from the responses include:

  - Theme Focusing on Family Caregiver/Family Advocate
  - Theme Focusing on Rural Setting – unique attributes need to be noted
  - Theme Focusing on Homecare and Homecare supports
  - Theme Focusing on Developing Formal Linkages to other Community Supports
  - Theme Focusing on Community Crisis Interventions

Question: Are there important action items that should be included under each theme?

- 64% answered "NO" and 36% answered "YES"

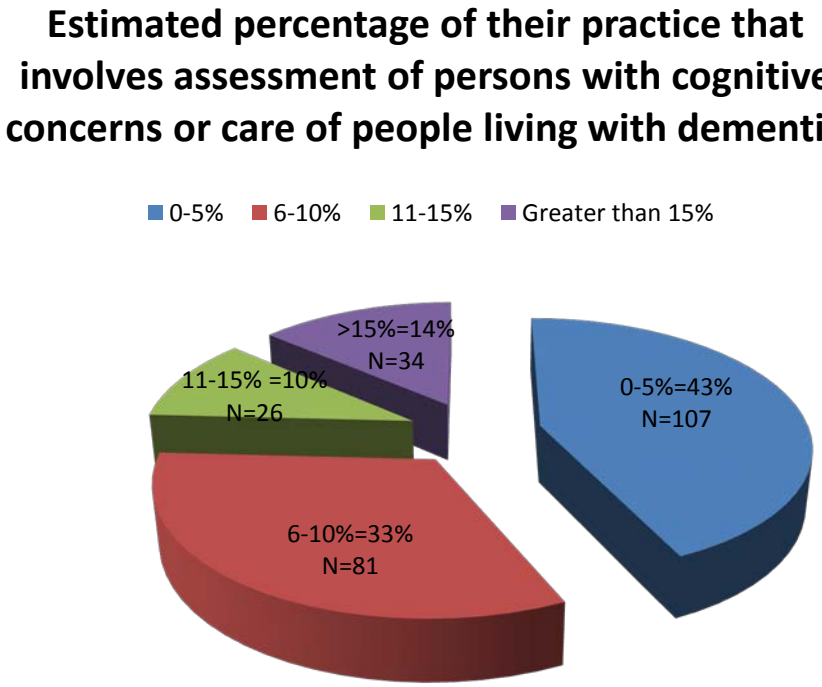


- For the respondents that answered "Yes", action items under each that should be included were:

THEME	Potential Action Items to be Included
#1 (PHC is the foundation for recognition, diagnosis and management of PLWD)	• Increased in-home help and resources • Information Linkages • 24 hour "hit squads" that could access services and respite for crisis intervention • Access to a "companion" made available through agencies available 24/7 for families experiencing stressful situations • Dementia care being treated in a "team approach" • Accept Medicentres as a PCN. • Primary Care Physicians need education regarding all the resources available • Easier access to other health care team members such as OT/PT/SW to support the person living at home without necessarily accessing geriatricians • Education required for families, community and clinicians • More day programs, more respite care and more drop in centers • Specialized Home Care Nurses, aligned with PCN's and MH to ensure patient's attachment is maintained • Diagnostic Tools • More information is needed for patients to plan for the future before cognitive decline is severe

	• Rotations in Medical schools – Primary Care should not be an elective and there should be an emphasis on dementia investigation, diagnosis and treatment. • Provide list of people able to assess capacity • Include Community Pharmacies
#2 (Focused diagnostic services to support PCN's)	• Provide ongoing support to primary care, PCN Geriatric Nurse and PCN Geriatric Assessment Clinic increases access to Geriatricians • PCN Geriatric Assessment Clinics • Timely access to geriatric assessment • For most patients, the dx/management of dementia can be done by a family doctor and does not require specialist care. • Support for Physicians assessing early onset dementia is lacking • Family Doctors do not have 1.5 – 3 hours to spend with PLWD to diagnose and address their complicated issues
#3 (Formal Referral Linkages)	• AHS should provide supports and services for mental health care for the patient and their family • Referral resources centralized and clear • Rural access to Geriatricians is difficult, especially considering the hardship of travel • Need stabilization units for psychiatry/geriatrics • Quick access phone consult service that can help GP's
#4 (Physician Compensation)	• Physician compensation SOMB rule change • Compensation time for time in assessment and family/pt discussions • Fee for service doesn't work • Pay to review and reduce medications
#5 (Information and Technology)	• IT is not just needed for rural, it is needed everywhere • Better organized referral system
#6 (Evidenced Based Guideline for Safe Driving)	• Consider mandatory non-medical drivers evaluations over 75 years • Access to on road assessments for driving • Driving assessment fee covered by AHS • Drive Able – implement – evidenced based • Driving Assessment – arms length from Physician • Access to driving assessment in rural areas is non-existent. • Training PHC providers to make assessment on driving competency

Question: What percentage of your practice do you estimate involves assessment of persons with cognitive concerns or care of people living with dementia?



Question: Please indicate the extent to which you agree or disagree with the following statement: I have additional skills/training in the area of recognizing and providing care to persons with dementia and their families?