Dementia Pathways Framework

John Forward
Director Healthy Ageing & Community Rehabilitation
CNAHS

30 March 2010

- Dementia Pathways carried out over 2009

- Lin Monash Chief Project Officer

Policy Drivers

Health Service Framework for Older People 2009-2016

Key recommendations regarding Dementia

- Implementation of prevention and health promotion strategies
- Improved early diagnosis and management of dementia
- Improved service responsiveness to overall health care needs
- Delirium prevention
- Improved access to specialist geriatric and psycho geriatric services
- improved chronic disease care management
- Advance care planning directives

Policy Drivers

SA Dementia Action Plan

Identified the need for Translating Dementia Care Principles into Practice

Key issues identified in the Plan were:

- incorporate dementia care standards into acute care and community care.
- Identify and implement acute care standards
- Improve diagnosis and management in public hospitals;
- Make hospital settings safer for people with dementia;
- Utilise hospital avoidance programs or readmission diversion programs where appropriate;
- Ensure that people with dementia, their carers and service providers are all involved in discharge planning.

Statistics

- There are an estimated 245,000 Australians with dementia
- 4th leading cause of death in Australians over 65 years, after heart disease, stroke and lung cancer.
- Dementia prevalence is outpacing the ageing demographic.
- Australian Institute of Health and Welfare [AIHW] projected the national health care costs for dementia alone to be almost $18 billion dollars by 2033.
- Estimated 22,200 people with dementia in South Australia in 2009; this number projected to increase 3.6-fold, across all age cohorts, to 80,800 (range: 76,200-84,300) people by 2050.
- Dementia prevalence projections: 2006 to 2050 indicate that the Northern and Southern areas of metropolitan Adelaide will be disproportionately impacted as these populations age, as will specific country regions
- Dementia expected to become the leading cause of death- within the next 15 – 20 years.

Dementia Pathways Framework

Aims

- improve the service and workforce capacity of the SA Health system to manage effectively people with dementia across the health care continuum
- development of state wide health care pathways and operating protocols
- effective referral linkages to the community care sector.

Dementia Pathways

Primary Health Care: prevention and risk intervention

- There are a range of Primary Health Care opportunities and targets for intervention to address dementia risk factors e.g. to reduce cardiovascular and hypertensive conditions and type 2 diabetes, which increase the risk of developing dementia

Early diagnosis and Treatment

- Access to early diagnosis and information is essential to enable a person with dementia and their families and carers to understand the symptoms, access and choose early intervention, treatment and rehabilitation options

Dementia – The Chronic Care Pathway

- Dementia has one of the longest chronic courses of almost any other chronic disease. Articulating the chronic care pathway in dementia is vital in identifying appropriate points of service intervention and broader supports; Collaborative and Person Centred Care approaches, including rehabilitation access, are foundational to this process.

Dementia Pathways

Community Based memory clinics/ mobile teams

- Benefits of community based memory clinics include increasing the number of people seen for early intervention, reducing total care expenditure, increasing consumer choice and reducing stigma and barriers to diagnosis.
- A range of models exist for establishing community based memory clinics (e.g. the well established Victorian Cognitive Dementia and Memory Services network).

Access and Equity: population groups with specific needs

- A number of population groups experience particular barriers to dementia information, services and supports, such as Aboriginal and culturally and linguistically diverse populations, people in rural and remote locations, homeless and transient populations.

Cognitive Impairment – Clinical Coordination

- Care coordination for the person with cognitive impairment within the acute length of stay.
- The Coordinator has a lead role in implementing and oversighting cognitive impairment screening tools and protocols and developing individual admission support plans.

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Acute Entry Point: cognitive impairment indicators

- Many forms of cognitive impairment, including dementia, are currently under diagnosed at entry points to acute services.
- Better screening for cognitive impairment at acute entry points
- When diagnosed during hospital stay services are organised with mobile teams to follow through at discharge

Pre-anaesthetic clinics – cognitive impairment screening protocol

- Some evidence on the risks of particular anaesthetics for people with dementia, and particularly attaches to the progression of Alzheimer’s type dementia.

Behaviour management advisory services

- Multidisciplinary behaviour management specialist advisory services should be available at all points of care
- Need to link with Mental Health Services for Older People and Alzheimer's Association

Dementia Pathways
Enablers

Collaborative Partnerships in Care – Inter sectoral Partnerships and Agreements

- At a state wide level, an inter sectoral partnership model will be developed, incorporating medico-legal aspects of memorandums of understanding to facilitate care transitions, care transfer and case management protocols and consent/confidentiality agreements.

Client-held Health Record/E-record

- Development of a client-held health record and/or e-record will provide a range of benefits for dementia care and service provision in SA

Dementia – Health Workforce Development Strategy

- Dementia requires specialist skills – a skilled workforce must be built up to support the new service demands that will eventuate.

State wide Tele-Health/Medicine Service

- Expansion of these systems is required to provide effective workforce and regional health service supports. New technologies, combined with an expanded tele-health system can provide advanced remote diagnostics, enhancement of skill sets and intersectoral working, and enhance support for the dementia care pathways discussed (e.g. early intervention, palliative care).

Next Steps

Dementia Pathways will provide a significant input into the next stage of health services for older people.

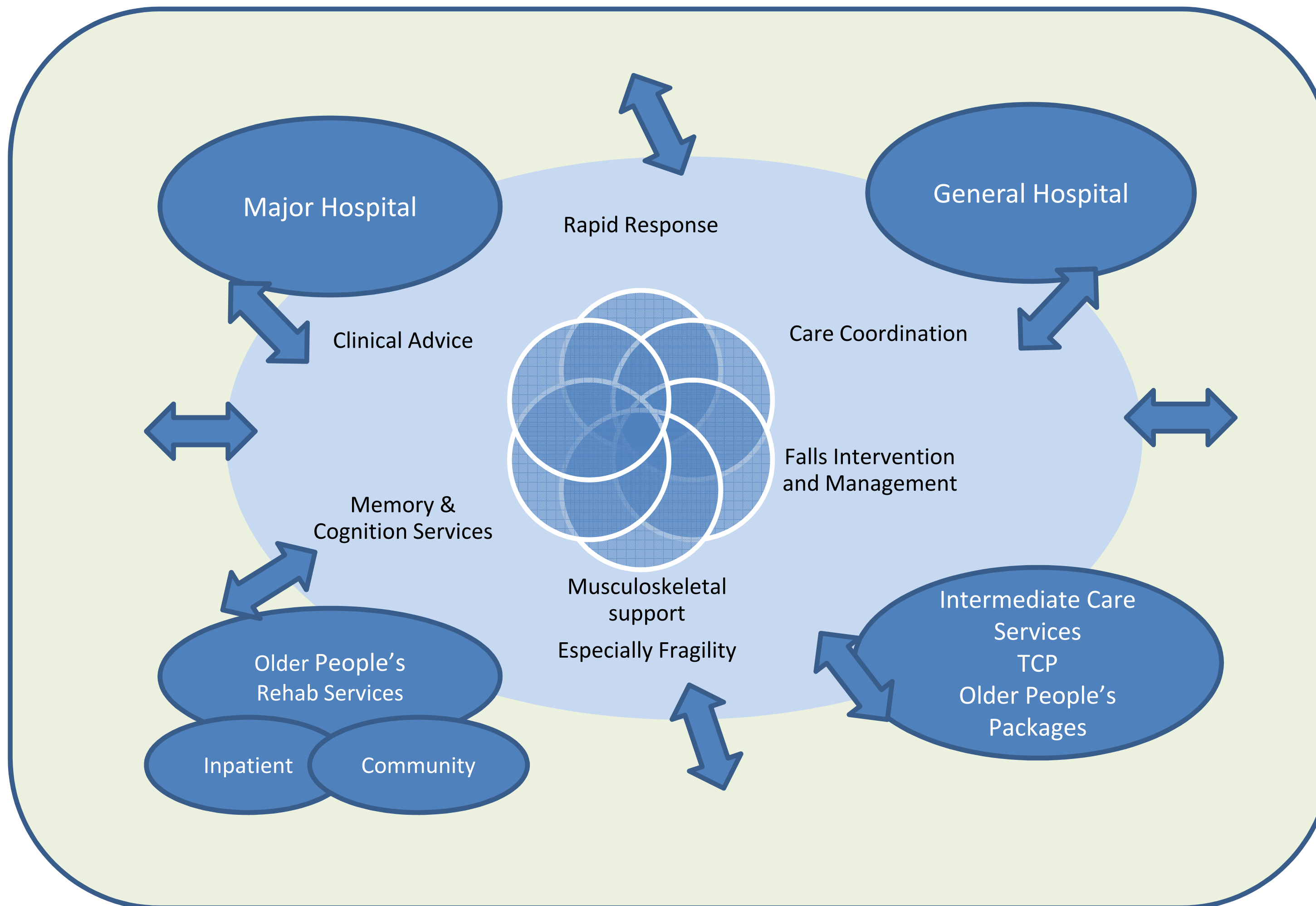
CNAHS is now developing an implementation plan for the Health Service Framework for Older People

As described in the plan this calls for the development of Regional Older People's Health Services which integrate acute services and ambulatory services into a single system.

Among the first steps will be will be the development of older people's health teams.

These teams could:

- Provide support and advice to health and community care providers including General Practitioners, residential services, HACC services and primary health services,
- Provide specialist "in reach" consultation and liaison to and with other specialist services/teams – including TCP, Patient Flow, hospital services
- Provide specialist services for older people including falls, memory, musculoskeletal and neurological clinics and services
- Link with specialist mental health, rehabilitation and palliative care services for coordinated care
- Provide a care coordination function for older people with complex care needs;
- Provide Mobile specialist community assessment service with rapid response capability
- Monitor and follow up older people with complex health care needs following discharge post acute.



Major Hospital
Rapid Response
General Hospital
Clinical Advice
Care Coordination
Falls Intervention
and Management
Memory &
Cognition Services
Musculoskeletal
support
Especially Fragility
Older People's
Rehab Services
Inpatient
Community
Intermediate Care
Services
TCP
Older People's
Packages

- Thank you
- Any questions?