Optimizing Outcomes For Frail High Risk Seniors Through Specialist-Specialist and Primary Care-Specialist Collaborative Models

RGPs of Ontario
Primary Care Collaborative Memory Clinics in Ontario (Presentation 4)

Dr. Linda Lee
Centre for Family Medicine
RGPs of Ontario
Primary Care Collaborative Memory Clinics in Ontario

L. Lee, MD, MCISc(FM), CCFP(COE), FCFP
lee.linda.lw@gmail.com
Primary Care Collaborative Memory Clinics

Diagnosis + Drugs + CARE
In typical primary care practice...

![Diagram showing the processes of case finding, diagnosis, and management in family physician and specialist clinics. The diagram indicates that 70%-82% of patients go through this process.]
High quality care based on geriatrician chart audit
- De-fragmented care: many Clinic team members drawn from existing circle of care; integration of community support, eg. Alzheimer Society
- Efficiency: one Clinic day/month/10,000 family practice base
- “Dementia chronic care model”
- 206 family physicians and >600 AHPs trained through standardized accredited training program
- 28 supporting geriatricians/geriatric psychiatrists
- Currently, 89 Clinics support 1600 family practices with a combined patient base of 2.4 million
“With the memory clinic there’s always somebody there and they guide you through… I feel like it’s a family I never had before… I feel I can do this journey, I feel safe, I’m so happy to have them.”

Minister’s Medal Award 2014

“Our association with the memory clinic didn’t end with the diagnosis,” says Pat. “That was really just the beginning of our long and wonderful relationship.”

Alzlive.com 2014

“He lived at home for five years (after diagnosis). I would not have been able to keep him home that long without their support.”

Ottawa Citizen, 2014

“It’s a safety net,” Jack said. “It’s a very comforting safety net.”

KW Record, 2010
12 Champlain Primary Care Collaborative Memory Clinics: Pre-program and follow-up ratings* of perceived level of collaboration among health care professionals for dementia care

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>Pre-Survey</th>
<th>Follow-up Survey</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Specialists (N=12)</td>
<td>2.7 (1.2)</td>
<td>4.5 (1.0)</td>
<td>.001**</td>
</tr>
<tr>
<td>Family physicians (N=20)</td>
<td>4.1 (1.1)</td>
<td>4.3 (.80)</td>
<td>.569</td>
</tr>
<tr>
<td>Pharmacists (N=11)</td>
<td>3.6 (1.6)</td>
<td>4.3 (1.1)</td>
<td>.319</td>
</tr>
<tr>
<td>Nurses (N=20)</td>
<td>4.0 (1.2)</td>
<td>4.6 (.89)</td>
<td>.142</td>
</tr>
<tr>
<td>Social workers (N=14)</td>
<td>3.7 (1.1)</td>
<td>4.6 (.65)</td>
<td>.034**</td>
</tr>
<tr>
<td>Occupational therapists (N=3)</td>
<td>2.3 (1.2)</td>
<td>4.7 (.58)</td>
<td>.118</td>
</tr>
<tr>
<td>Alzheimer Society members (N=13)</td>
<td>2.9 (1.8)</td>
<td>4.5 (.78)</td>
<td>.014**</td>
</tr>
<tr>
<td>CCAC case managers (N=11)</td>
<td>2.7 (1.3)</td>
<td>2.3 (1.2)</td>
<td>.296</td>
</tr>
<tr>
<td>Behavioural Support Ontario team members (N=0)**</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

*5-point rating scale: 1 = not at all collaborative; 5 = extremely collaborative.
**p<.05.
*There were no matched pre and post responses to this question, likely reflecting lack of involvement with these professional
Who Is Involved

STRENGTHS
- Collaboration between
  - Family MD-PCCMC MD
  - PCCMC MD-AHP
  - AHP-AHP
  - PCCMC-Agency (AS)
  - PCCMC MD-specialist

WEAKNESSES
- Turnover of team members
- Inequitable distribution of disciplines in some sites (resource dependent)

OPPORTUNITIES
- Increase collaboration between PCCMC MD and specialists (geriatrician, geriatric psychiatry, cognitive neurology)
- Engage CCAC

THREATS
- Inequitable funding support across sites
**Funding Sustainability**

**STRENGTHS**
- Incorporated into existing health care system (FHTs, CHCs)

**WEAKNESSES**
- Inadequate funding – current funding model is based on service volumes

**OPPORTUNITIES**
- LHIN/?provincial funding
- Economic evaluation

**THREATS**
- Grant-dependent funding to support training of new teams/team member turnover and development of CoP
- Dependence on good will
**STRENGTHS**

- 2014 Premier’s Mandate: new Memory Clinics
- Aligned with 2015 Patients First Action Plan for Health Care

**WEAKNESSES**

- Lack of national and provincial dementia strategy

**OPPORTUNITIES**

- Development of national and provincial dementia strategy

**THREATS**

- Lack of national and provincial dementia strategy
<table>
<thead>
<tr>
<th>Setting</th>
<th>WEAKNESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Specialists are usually not co-located in Primary Care settings</td>
</tr>
<tr>
<td></td>
<td>• Lack of AHPs to support non-FHT and non-CHC settings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STRENGTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Embedded in Primary Care, many team members within existing circle of care</td>
</tr>
<tr>
<td>• Care is delivered in a location close to home and continuing over time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPPORTUNITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expansion to regionalized PCCMC model</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inequitable funding</td>
</tr>
<tr>
<td>• Inequitable infrastructure support for PCCMCs not located in FHTs or CHCs</td>
</tr>
</tbody>
</table>
**STRENGTHS**
- Real-time multidisciplinary team-based assessments and care plan development
- Shared care between Family MD and PCCMC MD

**WEAKNESSES**
- In some sites, specialist role is consultative

**OPPORTUNITIES**
- Continue to improve specialist integration and collaboration

**THREATS**
- Inconsistent funding for specialist involvement and for full complement of interdisciplinary team members at some sites
Geriatrician Selection

STRENGTHS
• Preferentially builds on existing specialist-PCCMC MD relationships
• Efficient use of limited available geriatric specialist resources

WEAKNESSES
• Some inconsistency in specialist support

OPPORTUNITIES
• Continue to develop standardized processes for specialist integration and relationship building

THREATS
• Inconsistent funding support
• Competing interests
Patient Selection

**STRENGTHS**
- Family physician can refer any patient with cognitive concerns
- Needs of care partner addressed at each visit
- Care is continuing over time

**WEAKNESSES**
- Inconsistent information access if referring sites are not connected by EMR

**OPPORTUNITIES**
- Centralized intake can triage referrals to PCCMCs vs other local geriatric services
- Regionalized access
- Expansion to other chronic complex geriatric conditions

**THREATS**
- Inequitable patient access to PCCMCs
**S**
- Meets all of the elements of AGS person-centred care
- High level of satisfaction of patients, care partners, PCCMC teams, referring MDs
- Leverages existing primary care infrastructure

**W**
- Inconsistently sustained data collection (funding dependent)

**O**
- Data collection to support continued evaluation of outcomes

**T**
- Inconsistent funding support
- Inequitable patient access to PCCMCs
Key factors that have led to successful collaboration...

- Standardized training for interdisciplinary teams
- Face-to-face communication
  - Effective information sharing and decision-making
  - Synergistic care plan development and implementation
  - Team building, bonding, learning and growth
- Structured integration of specialists and community partners
- Development of a Community of Practice
Integration of team members from Specialized Geriatric Services, Geriatric Assessment Clinics...

Examples:
- Freeport Hospital Geriatric Assessment Unit (WWLHIN)
- GAIN clinics (CE LHIN)
- Primary Care Geriatric Assessor (Champlain LHIN)

CCAC

Centralized intake
- Specialized Geriatric Services and Primary Care Collaborative Memory Clinics (WWLHIN)
Strategies to overcome existing and anticipated hurdles...

- Need for *sustained, equitable* access to resources