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Poster

A model of integrated care for people with dementia in Primary Care

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Abstract

In the last years some RCT have demonstrated the efficacy of "integrated models of care" in the management of chronic diseases such as depression and dementia. Since 1999 the Regional Government of Emilia-Romagna deliberated the "Regional Dementia Project" (D.G.R. 2581/1999), an act that provides funds for the organization of Health and Social Welfare services in the community for people with dementia. The main strategies and tools of Dementia Project are: a) ensure good and timely diagnosis; b) global approach to PWD and his family (social and health services integrated); c) qualify existing network service (not only separate net for PWD); d) improve and support caregivers. The design includes specialized out-patient clinics with competencies for diagnosis and care planning. A targeted project of the Public Health Agency of Modena has been implemented to involve the family physician in dementia screening and follow-up, by means of accreditation courses, promotion of uniform screening instruments and structured annual following up of the patients with epidemiological reporting; the family physician is seen as pivotal in providing a continuum of care over the long natural history of the disease.

The main outcome of this agreement is to improve the quality of life and health of demented individuals and their carers, permitting people with dementia to remain at home as long as possible, and to promote the management of dementia patients by the primary care physicians (PCP). The specialized referral clinics offer diagnostic competencies and consult for specific problems.

The protocol consists of two phases: in the first phase, when the PCP suspects a diagnosis of dementia, he/she administers simple, standardized screening tests, such as the Symptom of Dementia Screener (S.D.S.) and provides an assessment of somatic morbidity and functional

status. Lastly, the PCP prescribes blood chemistries and instrumental examination, as suggested by international diagnostic guidelines.

When the S.D.S. score is >6 and the MMSE score is <26, the PCP refers the patient to the specialist; after the diagnostic work-up the patient returns to the referring PCP with a care plan and advice for future management. As needed, the family may be referred to a psychologist, for individual or group support.

In the second phase, the PCP will track the illness with a yearly multidimensional assessment. In addition, the PCP stages the emotional and psychological distress of the cares to identify the need for psychological or social support (use of indicators for psychological counselling to caregivers). As needed, the PCP can enrol the person with dementia in a program of home care assistance (ADI).

A total of 385 physicians have participated (63 % of all 610 PCP in the public health service of the province) in the period 2007-2010. The mean age of the 6.902 patients (F= 4.744, M= 2.158) enlisted was 82 years; mean MMSE score 11.92; median somatic comorbidity was 4 diseases; mean ADL 2.6. One third (31.2%) of the case series was not taking psychotropic agents; one half (53.5 % took one, 14.7% two, and 0,6 % three classes of psychoactive agents (neuroleptics, antidepressants, anticholinesterase inhibitors and memantine). A total of 72.7 % subscribed to one or more home health care services. In order to keep patients in their home or community as long as possible, specialist services will support the PCP for the management of critical situations during the course of the disease. The exchange with the specialist services and PCP must be improved to facilitate sharing of information and redirection of the support of the specialist more towards the PCP and less directly to the family.

The next step of this project is the introduction of an indicator of quality of care to people with dementia in primary care. It is expected to change the way the hard-copy reports by extracting data from the medical records of all GPs participating in the project with an appropriate query provided by the software -house reference manual entry or electronic format. The files contain informations about demographic and clinical data of biochemical and instrumental tests and therapies.

The collected data will be integrated and assembled into a single database and analyzed in order to develop a reporting, including the introduction of a composite indicator of quality of care, following the recommendations of the " Choosing Wisely " of the American Geriatrics Society and EBM in the elderly and people with dementia.

This composite indicator (QUADISC) consists of 10 items

For each item is assigned a score of 0, 5, or 10 (for non-target, partially or fully achieved). The sum produces an overall score (maximum 100) that is directly proportional to the effectiveness of the care of the patient. To calculate the score or each patient load in the project will be built in a clinical database that integrates demographic informations and clinical data provided by the GPs. For every General Practitioner will be refunded reporting with the values obtained from their patients.

Expected Results: The QuADisC will be validated by correlating with an indicator of the effectiveness of care based on: a) the number of accesses in the ER, b) admissions to hospital and nursing-home because of specific cause or death.

Conclusions: Primary care physicians have the competencies to address the problem of dementia and correctly manage the patient and family over the course of the disease. This experimental protocol permits better integration of the Primary Care Physician with the network of specialists, social workers and both in- and out- patient services for dementia.

The introduction of a measurable indicator of appropriateness of care to patients with dementia by GI can become a tool for assessment of the quality of care in the context of primary care.

Keywords

dementia; primary care; integrated model

PowerPoint presentation

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