Key Lessons Learned in the Strategic Implementation of the Primary Care Collaborative Memory Clinic Model: A Tale of Two Regions

Principales leçons à retenir de la mise en œuvre stratégique du modèle des cliniques collaboratives de la mémoire en soins primaires : l'histoire de deux régions

LINDA LEE, LORETTA M. HILLIER, KELLY LUMLEY-LEGER, FRANK J. MOLNAR, KELLY KAY, DENYSE NEWTON, LINDA STIRLING AND KELLY MILNE

TABLE 1. Demographic and health service information for the Central East and Champlain Local Health Integration Networks

Demographic information	Champlain LHIN	Central East LHIN
Land area (square kilometers)	17,714**	16,667.8*
Total population	1,230,655†	1,498,650***
Median age (years)	40.5	41.1
Population over 65 years	250,395	224,400
% total population	20.4	15.0
Population density (persons per square kilometer)	89.91	69.5
Projections of population size in 2038††	1,689,363	2,057,181
Health services	20 hospitals 60 long-term care homes 86 community support services 62 community mental health & addiction services 11 community health centres±	Eight hospital corporations operating on 14 sites 68 long-term care homes 36 community support services Three acquired brain injury services 16 assisted living services and supportive housing 21 community mental health and addictions programs†††
Health services for older adults	Core geriatric services include: • Geriatric Assessment and Outreach Team (GAOT), community-based geriatric assessors providing in-home comprehensive geriatric assessment, supported by case conferencing with a geriatrician, resulting in referrals and care recommendations • Primary Care – Geriatric Assessment Clinics, geriatric assessors from GAOT providing monthly geriatric assessment clinics in collaboration with primary care that are focused on cognition and falls • Geriatric Emergency Management (GEM) plus nurses, working in collaboration with emergency department staff to provide targeted geriatric assessment on older adults and referrals to Specialized Geriatric Services and Community Support Services as needed • Specialized Geriatric Clinics, geriatrician-led clinics providing assessment and management for high-risk, complex older adults with a greater concentration in the rural communities • Geriatric Day Hospitals, outpatient program providing multidisciplinary assessment and/or treatment for patients who are experiencing a change in function, memory, mood, mobility or have complex medical issues	Core geriatric services include: • Geriatric Assessment and Intervention Network (GAIN), community-based interprofessional teams, collaborating with geriatricians and other specialists to provide comprehensive assessments and care plans • Geriatric Emergency Management (GEM) nurses working in hospital emergency departments to assess and support older adults with acute health concerns • Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT), serving older adults in long-term care homes experiencing acute health concerns to prevent hospitalization • Behavioural Supports Ontario (BSO) program, providing assistance related to responsive behaviours within long-term care and community settings • Seniors Friendly Care, promoting senior-friendly organizational care

TABLE 1. Demographic and health service information for the Central East and Champlain Local Health Integration Networks (cont'd)

Demographic information	Champlain LHIN	Central East LHIN
Health services for older adults (cont'd)	• Nurse-Led Outreach Team (NLOT), nurse practitioners serving older adults in long-term care homes experiencing acute health concerns to prevent hospitalization • Specialized Geriatric Services Central Intake, providing a streamlined intake process for referrals that is triaged by a healthcare professional to direct the patient to the right specialized geriatric service the first time • Home and Community Services Geriatric Assessors, rural-based, community-registered nurses, collaborating with geriatricians to provide comprehensive assessments and care plans • Behavioural Supports Ontario program, providing assistance related to responsive behaviours within long-term care, acute care and community settings • Dementia and Alzheimer Societies, providing dementia-related information, education and support • Bruyère Memory Program, providing diagnosis and treatment for patients with memory problems focusing on younger patients and atypical dementias • Geriatric Psychiatry Community Services of Ottawa (GPCSO), interdisciplinary team providing expertise and leadership in the practice of community-based geriatric psychiatry with the aim of enhancing the mental health and well-being of the elderly in their own environment • Geriatric Psychiatry – Royal Mental Health, providing assessment and active treatment of patients aged 65 and over who are experiencing mental health problems • The Geriatric Mental Health Outreach Teams – providing comprehensive assessment for persons over 65 years of age experiencing mental health problems located in Renfrew and Eastern Counties	Other geriatric services in this region that partner with the Seniors Care Network include: • Alzheimer Society, providing dementia-related information, education and support • Assess and Restore program, providing targeted rehabilitation therapy to improve the functional independence of older adults experiencing frailty • Behavioural Supports Ontario, supporting older adults with challenging behaviours resulting from complex mental health • Geriatric and Neuropsychiatry Outpatient Services (GNOS), a geriatrician-led memory clinic providing assessment and management for high-risk, complex older adults • Psychiatric Assessment Services for the Elderly (PASE), providing a specialty geriatric mental health outreach service • Geriatric Mental Health Outreach Teams (GMHOT), providing geriatric mental health outreach services for long-term care home residents and frail seniors in the community • Regional Tertiary Geriatric Mental Health Services, providing various in-patient and outpatient services for older adults living with dementia in the community and in long-term care as offered through Ontario Shores Centre for Mental Health Sciences, Peterborough Regional Health Centre and the Scarborough and Rouge Hospital. Outpatient services include outreach teams to assist long-term care homes with complex psychiatric concerns, a specialized neurocognitive disorders clinic and an outreach program designed to meet the education needs of healthcare providers related to geriatric psychiatric conditions. In-patient services include geriatric dementia, geriatric transitional and geriatric psychiatry units and neuropsychiatry service, focusing on patients with serious mental illness or challenging behaviours

Sources:

* Central East Local Health Integrated Network 2016

** Champlain Local Health Integrated Network 2014

*** Statistics Canada 2013a

† Statistics Canada 2013b

†† Ontario Government 2017

††† Central East Local Health Integrated Network 2016

‡ Champlain Local Health Integration Network 2015

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TABLE 2. Process of developing and implementing PCCMCs across two regions

Implementation process	Champlain LHIN	CELHIN
Key drivers	• Increasing number of persons living with dementia in the region • Increasingly long wait times for specialized services • A published scoping review on dementia *care and several reports,** which highlighted the important role that primary care should play in early detection and management of dementia	• Projected increases in the number of frail seniors in the region • Regional Dementia Action Plan†, which highlighted the need for earlier diagnosis and management of memory concerns in the region
Enabling structures	• Planning and Implementation Team consisting of representatives from key organizations • Regional Geriatric Program focus on dementia • Established Champlain Dementia Network • Leadership from the Advanced Practice Nurse, Community Geriatrics	• Planning group consisting of representatives from key organizations • Program leadership: PCCMC Program Manager and Alzheimer Society, with support from the Seniors Care Network
Planning process	• Systems thinking approach • Situation analysis of primary care practices in the region • Review of the PCCMC model and other complementary models • Identification of opportunities for collaboration with existing primary care practice structures (i.e., Family Health Teams, Family Health Organizations) • Alignment with the strategic directions of the LHIN, Ministry of Health's Regional Geriatric Program and Champlain Dementia Network • Observation of a PCCMC in practice • Presentations on the PCCMC model to geriatric specialists, primary care physicians and administrators from local practice settings, representatives of the Champlain LHIN and healthcare providers at the local Regional Geriatric Program rounds	• Identification of regional needs for improved integration of the Alzheimer Society (First Link Program)†† and Behavioural Supports Ontario††† in primary care • An education needs assessment, which highlighted needs for more dementia care-related education within the region± • Development of a business proposal to support the clinics in collaboration with Seniors Care Network and identified physician leads
Funding allocation	• Funding provided for the memory clinic training program, annual continuing education events for a three-year period (Booster Days)*** • Allocation of an Alzheimer Society program staff for each PCCMC • In-kind contributions: advanced practice nurse from the Regional Geriatric Program for clinical time and planning and implementation, geriatricians for the specialist support for the clinics, primary care practices for PCCMC team members and space, community pharmacists and Winchester Hospital for clinical services of a social worker and pharmacist	• Funding provided for the PCCMC Program Manager, memory clinic training program, for clinic team members and healthcare providers working in dementia care and development of an interprofessional mobile team • In-kind contributions: space provided by Alzheimer Society (to house mobile team) and by primary care practice settings

TABLE 2. Process of developing and implementing PCCMCs across two regions (cont'd)

Implementation process	Champlain LHIN	CELHIN
Recruitment of clinic sites	• Awareness-raising campaign using multiple strategies including e-mail and phone notifications, continuing medical education events and promotion through existing primary care initiatives • Presentations on the PCCMC model to interested primary care physicians, teams and management • A readiness assessment questionnaire gathered information about the unique attributes of the organization, including patient population, supporting programs, availability of resources (space, staff) and level of primary care physician interest • Recruitment of geriatricians to support clinics	• Clinic lead physicians were self-identified and initiated proposals for clinic development • Local geriatricians supported this initiative
Training/personnel	• Training started in February 2014, targeting five new clinic teams over a three-year period • A total of 137 healthcare providers were trained	• Training was delivered in March 2016 to 70 healthcare providers (33 representing primary care, 37 representing the programs of the Seniors Care Network) for the creation of four new clinic teams
Ongoing development and sustainability	• Establishment processes for communication, consultation, referral and mentorship with geriatricians • Ongoing quality improvement initiatives to streamline and formalize clinic processes, and identification and resolution of challenges/ threats • Identification of processes for integration with specialized services • Coordination of booster days • Coordination of geriatrician support for clinics • Advocacy for operational funding • Development of a collaborative framework to guide specialist–family physician interactions • Development of strategies for ongoing training needs	• Establishment of processes for referrals, documentation and access to clinical records across services • Ongoing quality improvement initiatives to streamline and formalize clinic processes, and identification and resolution of challenges/ threats
Clinic characteristics: Practice settings	• Ten Family Health Teams (121 physicians[±]; patient base = 123,423) • Three Community Health Centres (12 physicians; patient base = 14,000) • Two Family Health Organizations (13 physicians; patient base = 30,500) • Total: 15 practice settings (152 physicians; patient base = 167,923)	• One Family Health Team (open to 563 physicians in the region; patient base = 65,000) • One Community Health Centre (open to all physicians within its county; patient base estimated at 85,598[§]) • Two Family Health Organizations (seven physicians; patient base = 125,000) • Total: four practice settings (>570 physicians; patient base = 275,598)

PCCMC = primary care collaborative memory clinic.

Sources:

* Aminzadeh et al. 2012

** Canadian Consensus Conference on Dementia 2007

*** Lee et al. 2017b

† Central East Local Health Integrated Network 2016

†† McAiney et al. 2012

††† Gutmanis et al. 2015

± Statistics Canada 2013b

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TABLE 4. Impacts associated with the PCCMCs: themes generated from the interview analysis, with illustrative quotes

Theme	Illustrative quotes
1) Earlier identification and intervention The PCCMCs were credited with timelier access to assessment than otherwise would have been the case, as wait times to be assessed by specialized services were quite lengthy. Timelier access to the PCCMC was believed to have resulted in: • earlier identification and treatment; • earlier and greater access to community supports; and • greater opportunities for patients to participate more actively in care planning	"This is the opportunity for early diagnosis and early investigation and early linkages, so that's pretty important. We've heard clearly from people living with dementia that that's pretty important." [CELHIN Leadership] "What we've seen is that if you can upstream identify patients and diagnose with dementia sooner than later, you can also create more options available for them so kind of proactive system rather than reactive. That allows them then to maybe make more informed decisions in a more timely manner and one that fits with making some choices that at the end of the day probably create better results for everyone involved." [Champlain LHIN Leadership]
2) Increased capacity for dementia care in primary care The PCCMCs were described as having increased capacity in primary care to manage dementia, as evidenced by: • enhanced physician ability to assess and manage dementia; • more patients being managed at the primary care level, rather than being referred to specialists; and • greater access to interprofessional supports in primary care	"I didn't think that primary care was really able to manage their own patients with dementia because that was sort of the standard. They got sent to a geriatrician or they got sent to some sort of specialized service ... I think that's changed 100%. The capacity of family physicians to be able to do this work has absolutely changed; it is that possibility, it is that future, and I see that now whereas I didn't before." [CELHIN Leadership] "I think the building of capacity within the primary care multidisciplinary team certainly has been realized here. The fact that patients don't have to travel, those in the rural areas don't have to travel for the specialized assessments." [Champlain LHIN Leadership]
3) Better patient and caregiver experience with care PCCMC care was described as offering better patient and caregiver experience with care as related to: • care closer to home, often in a familiar environment with familiar care providers; • increased access to interprofessional care; • increased access to information and early care planning; and • coordinated follow-up and support throughout the course of the disease	"I think the opportunity to stay within their physicians' practice to a large degree and receive their care by someone who knows them well, I think is pretty important." [CELHIN Team member] "I think sometimes caregivers are surprised that we're asking about their thoughts and observations and how they are managing. I don't think anyone ever really focuses on this, it's all about the patient ... We focus a lot more on caregivers." [Champlain LHIN Team member]

TABLE 4. Impacts associated with the PCCMCs: themes generated from the interview analysis, with illustrative quotes (cont'd)

Theme	Illustrative quotes
4) Improved continuity, integration and coordination and care The introduction of the PCCMCs within the existing system of care for older adults was credited with improving care coordination and integration because of improved triaging so patients access the most appropriate services. In the CELHIN, increased collaboration between sectors and services was attributed, partly, to the recruitment of health professionals for the PCCMCs from the Seniors Care Network services, so there were previously established working relationships among the services. In both regions, partnerships with the Alzheimer Society were described as having increased access to education, support and community services for patients and caregivers.	"I think it is going to be actually a real benefit for both services [Specialized Geriatric Services and memory clinics] and for clients getting the right service at the right time, right, so I think that'll be a big benefit. " [CELHIN Team member] "I think the biggest window of opportunity here was to bring together players and bring it around a specific focus to really look at how we can have a conversation to maybe change how we behave and function to still create maybe the right result for what our patients need. And bring together players that maybe normally might not have connected or if they did connect, it was either by chance or kind of in a crisis moment. Instead this is trying to put things a bit more upstream or a bit more forward thinking ... If we break it into two camps of community services and specialized geriatric services, it's definitely been some kind of increased collaboration." [Champlain LHIN Leadership]
5. System efficiencies The PCCMCs were credited with creating system efficiencies by: • assessing patients who would have otherwise been referred to specialists; • reducing the wait times for assessment by specialized services by maintaining the bulk of dementia care in primary care; • reducing crises that result in emergency department visits and hospital admissions; and • reducing referrals to specialized services for low-risk, low-complexity cases, allowing them to focus on more complex referrals	"These people [persons with dementia] once they go to a memory clinic just don't show up in ED." [CELHIN Specialized Geriatric Services] "Cutting down wait times, I'm sure that our wait times with specialized geriatrics have been reduced thanks to the primary care-based memory clinics trying to see more routine cases in primary care so that more complex patients can be seen sooner at a specialized geriatric level." [Champlain LHIN Team member]