Webinar Discussion Series - Community Dementia Care and Support:

Innovations supporting people living with dementia and care partners closer to home

May 4, 2021, Webinar Discussion Summary

May 4, 2021, Webinar Synopsis:

This webinar provided an overview of the Community Dementia Care and Support webinar discussion series. Participants discussed the innovations:

- Dementia Connections
- Primary Healthcare Dementia Toolkit

The moderators for the session were Mimi Lowi-Young (Chair of the Board of Directors: AGE-WELL Network Centre of Excellence INC.) and Mary Beth Wighton (Chair & Co-founder: Ontario Dementia Advisory Group (ODAG) and Dementia Advocacy Canada (DAC); Member - Federal Ministerial Advisory Board on Dementia), who provided insights throughout the session, including these two quotes:

"9 years ago, when I was diagnosed with probable frontotemporal dementia, I wanted to speak with someone who had the same diagnosis as me. The value of connection of peers is a simple one and it's the key to living well with dementia. It helps with mental stimulation, reduction in loneliness and isolation and it increases our ability to manage and deal with symptoms. It also increases our confidence to engage and venture into our communities which benefits the wider community by challenging stigma."

- Mary Beth Wighton

"I think that the Covid experience has highlighted to us that it's not just one virtual solution. There are multiple virtual solutions to support providers in making a diagnosis and supporting their patients who are living with dementia. There are also technologies that could assist primary care physicians to monitor the progress of dementia for each patient."

- Mimi Lowi-Young

May 4, 2021, Discussion Highlights:

Presentation 1: Dementia Connections

- The program has been operating for 33 years, serves 80,000 people and is funded by the provincial and municipal government.
- The program brings local community driven preventive and social services together to enhance the wellbeing of individuals, families and the community as a whole.
- Town of Stony Plain Family and Community Support Services (FCSS) has 4 key initiatives:
    - Reducing poverty
    - Mental Wellness
    - Healthy Relationships
    - Inclusion
- Works in collaboration with the Primary Health Care Integrated Geriatric Services Initiative (PHC IGSI) in Alberta.
- Dementia Friendly Community Project
    - Phase 1
        - Expand community's awareness and incorporate strategies to create a friendly environment for people living with dementia
        - Produce a video series to increase awareness of the challenges of living with dementia
    - Challenges for people living with dementia identified as part of phase 1
        - Accessible recreational and social opportunities
        - Access to respite
        - Transportation alternatives
    - Phase 2
        - Dementia connection project was launched in August of 2020
            - A community champion volunteer program that connects people living with dementia to resources and community activities
                - Individual supports
                - Building connections
                - Shifting perspectives
                - Increasing awareness
            - Volunteers are matched with a person living with dementia and their family. The matched volunteer invites them to community events and attend with them if possible.
            - Due to the COVID-19 pandemic the program had to adjust the ways they encourage social connections. Volunteers are encouraged to call

or have a virtual meet up with their match on a regular basis. The switch of focus was positive as it allowed the volunteers to build a better connection with their match and allowed them to perform wellness checks with the person living with dementia and their care partner.

- Volunteers partake in a series of training such as the senior connect web-based modules, dementia awareness training and a volunteer orientation.
- Family and Community Support Services (FCSS) completes a comprehensive intake with the family and then the family is matched with a caring volunteer who acts as a friendly visitor who continues to provide support.
- FCSS has an active referral network that includes their collaborative partners and allied agencies that refer to the dementia connections project.
- Outcomes: Participants report that they now know more about what is happening in their community, that they have participated in things that interest them, and that they feel more connected.
- Goal: Reach 50 families living with dementia over the next 2 years.

  - Community Connector for Older Adults
    - Dementia Service Navigator
    - Forms Assistance
    - Community connecting
  - Increasing awareness about dementia in the community
    - Public awareness campaigns
    - Work in partnership to host development and training opportunities for local service providers
    - Offer dementia workshops to the general public
  - Social and Recreational Opportunities
    - Residents are co-creating programs that interest them
    - Trail explorers is a new opportunity beginning this week which is a dementia-friendly walking group
    - Goals: signing program, memory café, and art program

- To learn more about Dementia Connections visit their website.

Presentation 2: Primary Healthcare Dementia Toolkit

- This project was created to better support collaborative family practice teams to diagnose and manage the dementia of their patients.
- The pilot project was developed in partnership with the department of health and wellness in Nova Scotia and the Nova Scotia Health Authority.
- This project was initiated in 2019 in both a rural (North Queens Community Health Centre, Caledonia) and urban (Sydney Collaborative Practice Team, Sydney) setting.
- The project grew from the 2015 provincial dementia strategy workshop recommendations.
- The project involves 13 clinicians (8 completed all study components)
- Evaluation is built into the project plan
    - Initial focus group is formative to inform process planning
    - Nurse Practitioner available for clinical support
    - Move to virtual care presented opportunity to examine quality
- Education plan
    - Independent learning modules via 8 podcasts over a 2-week timeframe
        - Comprehensive geriatric assessment & Frailty
        - CGA Practice
        - Delirium
        - Depression in Older Adults
        - Drug Review and Rational / Prescribing for Older Adults
        - Cognitive Assessment
        - Understanding Dementia
        - Falls Assessment
    - Improve team member's familiarity with 10 endorsed dementia screening tools
- Timeline:
    - March 2019: Held two 'think tank' events, building on the Nova Scotia Dementia Strategy Towards Understanding
    - June 2019: Pilot design complete – Enhancing Comprehensiveness of Dementia care in Primary Health Care Setting: A model to support access to dementia care
    - Summer 2019: Consultations with Centre for Health Care for the Elderly and Dalhousie Faculty of Medicine
    - Nov 2019: Finalized tools and education plan, confirmed billing options and EMR compatibility
    - Dec 2019: Education plan delivered, surveys and focus groups completed
    - Jan 2020: Pilot launched, use of screening tools tracked
    - Dec 2020: Pilot patient enrolment completed
    - Jan-April 2021: Collect patient level data (patient charts, individual interviews)

- Jan-May 2021: Complete evaluation report and recommendations
- Evaluation: Logic Framework
  - Results: What we want to achieve
  - Actions: How we'll achieve results
  - Indicators: How we'll know we're successful
- Refining Results
  - Patient/Caregivers
    - Earlier dementia diagnosis
    - Improved support for dementia patients and their families/caregivers in their community and within the collaborative Primary Health Care team
    - Timely access to home supports for eligible patients
    - Improved quality of life for dementia patients and families/caregivers
    - More equitable outcomes for Nova Scotians living with dementia
  - System
    - Engage stakeholders early in the process of model development
    - Limit the increase in workload/administrative burden for participating patients/staff/clinicians
    - Increase awareness, knowledge, skills and confidence of clinicians to identify, assess, diagnose, and manage dementia care of patients in the primary care setting
    - Better identification of patients who would benefit from early dementia diagnosis
- Defining indicators
  - A mix of quantitative and qualitative indicators to signal the extent to which results are being achieved:
    - Surveys and focus groups with clinicians (pre- and post-pilot): knowledge, skills, confidence to identify, diagnose, manage, satisfaction
    - Screening tools: usage, variability in diagnosis rates, quality of administration, chart inclusion
    - Administrative data: early diagnosis rates, treatment within Primary Health Care, referrals to home supports, average length of time dementia patients remain in community
    - Patient level data (individual interviews, chart information): screening quality, gaps in support, next steps after diagnosis
- Preliminary results (Dec 2019 – April 2021)
  - Pre- and Post-Clinical Education Survey (Completed: 10)
    - Participating clinicians: MD & NP in Queens & 3 MD, LPN & FPN in Sydney

        - Increased knowledge and confidence caring for patients with dementia symptoms
    - Collaborative Family Practice Team Focus Groups (2 Dec 2019) – formative
        - Both sites receptive to education program and online format
        - Reported readiness to initiate using tools and tracking their use
    - Screening tool usage:
        - 65 patients screened (35% rural, 65% urban)
        - Screening primarily administered by NP/LPN/FPN
        - Most commonly used tools: MMSE (36x), MOCA (19x), GDX (10x)
    - Follow-up clinical education survey (completed: 8)
        - Participating clinicians: MD & NP in Queens & 3 MD, LPN & FPN in Sydney
        - Clinicians retained increased knowledge and confidence caring for patients with dementia symptoms
    - Follow-up Collaborative Family Practice Team Focus Groups (Feb-April 2021) – summative
        - 2 of 2 sites completed
        - Feedback included: the toolkit did not significantly change practice, suggested the education program be more interactive, administered screening virtually over phone and video
- Next Steps
    - Patient level data capture and analysis (target completion May 2021)
    - Complete follow-up clinician focus group (April 2021)
    - Analyze MSI administrative data 2020 (April-May 2021)
    - Patient chart review (May 2021)
    - Patient individual interviews (April-May 2021)
    - Evaluation report (Spring 2021)
- Limitations
    - COVID-19 pandemic has affected the pilot and its evaluation:
        - Fewer patients in Collaborative Family Practice Team
        - Challenges with soliciting patient/caregiver feedback may limit the ability to report on benefits related to improved supports and QOL
        - Move to virtual care occurred during pilot
    - Small sample size: 65 patients, 14 health providers (8 completing all components)
    - Some challenges with capturing and reporting on administrative data as billing codes do not always reflect components of visit
- Benefits and Possibility for Spread
    - Collaborative Family Practice Team members at both sites were receptive to the education program content and digital/online format

- Pre-post survey results demonstrated increased knowledge and confidence of Collaborative Family Practice Team members in utilizing the tools and caring for patients with a memory impairment/dementia diagnosis
- When considering the use of EMR generated screening tools must ensure tools are fillable and print in correct format
- Patient/caregivers reported satisfaction with care provided
- Patient reported they did not have a problem doing the screening tests