

# Developing a Shared–Care Model for Community Dementia Services

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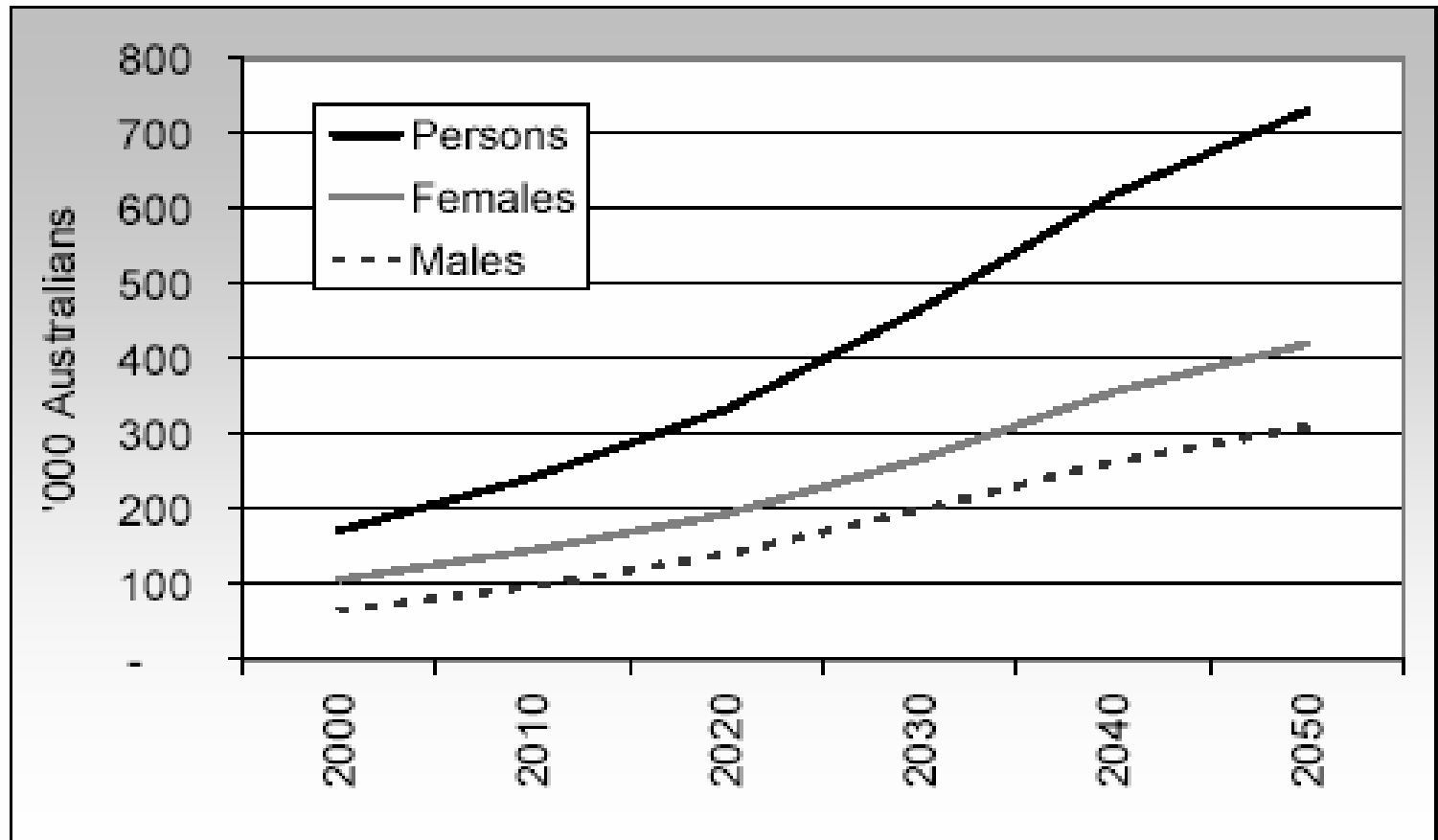
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# Overview

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- Background
- The need for community dementia care in the Hunter
- The model of care
  - Case coordination model
- Challenges

# Figure 1: Dementia prevalence, Australia, by gender 2000-2050



# NSW HEALTH CLUSTER MAP



LEGEND	
▲	Mental Health Hospital
■	Community Health Service
✕	Community Hospital & MPS
★	District Health Service
●	Rural Referral Hospital
○	Tertiary Referral Hospital

# Hunter Region

Expected to experience larger increase in prevalence than average

Of population of 562, 409 (2001 Census)

14.4% over 65

Expected growth to 26% by 2021

Compared to NSW

13.1% over 65

Expected growth to 16% in 2021

# Innovative Models of Care

- Educate and support **clients** to self manage for as long as possible
- Inform, educate and support **carers** to facilitate community care and delay the need for residential placement
- Develop and support **health care providers** in the use of evidence-based practice

# Innovative Models of Care

- Co-ordinate care across client conditions, health care providers and settings over time
- Monitor and evaluate the quality of services and outcomes
- Use a cooperative and collaborative approach involving primary care and specialist aged care
- Establish links between resources in the broader community

# Dementia context

- Need for a primary care approach as the focus of future service development in order to provide long term, client centred health care

For dementia:

- General practitioner
- Community-based nurse with expertise in dementia assessment and management
- Supported by a geriatrician, a range of allied health professionals and mental health

# The HNE Experience

## Implementation:

- Appointment of a Clinical Nurse Consultant and 4 .6 FTE Registered Nurses
- Part of ACAT teams located in Community Health Centres - integration of Aged Care and Community Health services
- The use of CHIME: Shared medical record
- One point of access: Referral and Information Centre

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## Provide:

- Link to primary care through liaison with GP's to provide assistance and support through the diagnostic process
- Feedback and follow up
- Case coordination for people with dementia and their carers across the dementia continuum

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- Nursing input in geriatrician clinics, comprehensive assessment, completion of ADAS- Cog
  - Carer support, education through groups such as the AA Living with Memory Loss program and individual contact in the home

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To provide a coordinated service:

- Need to maintain close links with the Central Dementia Unit that provides neuropsychological testing
- DAS jointly co-ordinates dementia education, support groups and community awareness
- Important to continue to develop and promote dementia services in the community

# Case Coordination

## Case Coordination Objective

The main objectives are to provide:

- Continuity of care to ensure the client and carer needs are met
- Services that are comprehensive, coordinated and adaptable as the client needs change. This is crucial for the client with dementia

# Case Coordination

## **Case Coordination components:**

Assessment Home based, comprehensive

Planning to ensure service provision is coordinated and comprehensive

Management plan devised with the carer and client and other service providers

# Case Coordination

Linking with other services to ensure needs are met

Case conference with key stakeholders

Clinical review of implementation of care and to determine timeframe of care intervention

# Shared care model

- Identifies 3 categories of client need
- Clients will move between these
- As the condition fluctuates need for contact and input will vary

# Category 1

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- Clients who are able to self manage in partnership with a health professional
- Develop an agreed plan of care and provide information/education and contact as needed for support.
- Encompass approximately 20% of clients seen by the dementia nurse.
- Provided with ongoing support as needed – 6 monthly visit &/or support groups monthly
- May be discharged and advised to contact case co-ordinator as required

# This Allows:

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- A process to provide a single point of contact for clients who can self manage
- Clients are encouraged to co-ordinate their own care plan
- Clients receive assistance in self-management of the illness
- Potential to initiate early planning for PoA, appointment of a guardian, ACD

# Category 2

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- Clients who are identified as needing support to manage their illness or the person they care for.
- Has the potential to self-manage with increased input from a case co-ordinator – education and information, contact for support.
- Approximately 60% of clients seen by the dementia nurse.

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- Referrals made to community services
  - GP liaison as needed
  - Monitoring in monthly support group or home visit, 1-2 hour visits 2<sup>nd</sup> monthly
  - Client advised to contact case co-ordinator as required

# This Allows:

- Co-ordinator to plan and follow-up client's care
- Clients do not wait until crisis stage before help is provided
- Care co-ordinator makes referrals and ensures that the referrals have been accepted

# This Allows:

- Client and service providers know who to contact for information
- Encourages self-management, health promotion and prevention
- Client's & carers feel that support, education and guidance is provided according to their needs and goals

# Category 3

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- Clients identified as having chronic and complex needs.
- Behaviours of concern such as aggression, multiple medical problems, marked carer stress, need for residential respite/ permanent care & support
- Advanced dementia/palliative care, multiple service involvement
- Not seen at early stage with little advance planning achieved
- Approximately 20% of clients seen by the dementia nurse.

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- Regular support and counselling, including grief and loss as appropriate
  - Monitoring of situation – referral for respite, need for increased services
  - Fortnightly/monthly contact 1-2 hour visits, regular contact by phone as needed, increase if there is a crisis
  - Regular contact with other agencies, GP

# This allows:

- Case conferencing and multidisciplinary care planning
- Identification of clients needing highly skilled case management bodies such as Community Options
- Regular monitoring of at risk clients
- Support for the care workers

# This allows:

- Access to higher level of service in home
- Reduction of duplication
- Liaison between acute and community services that recognises the need to move between these services

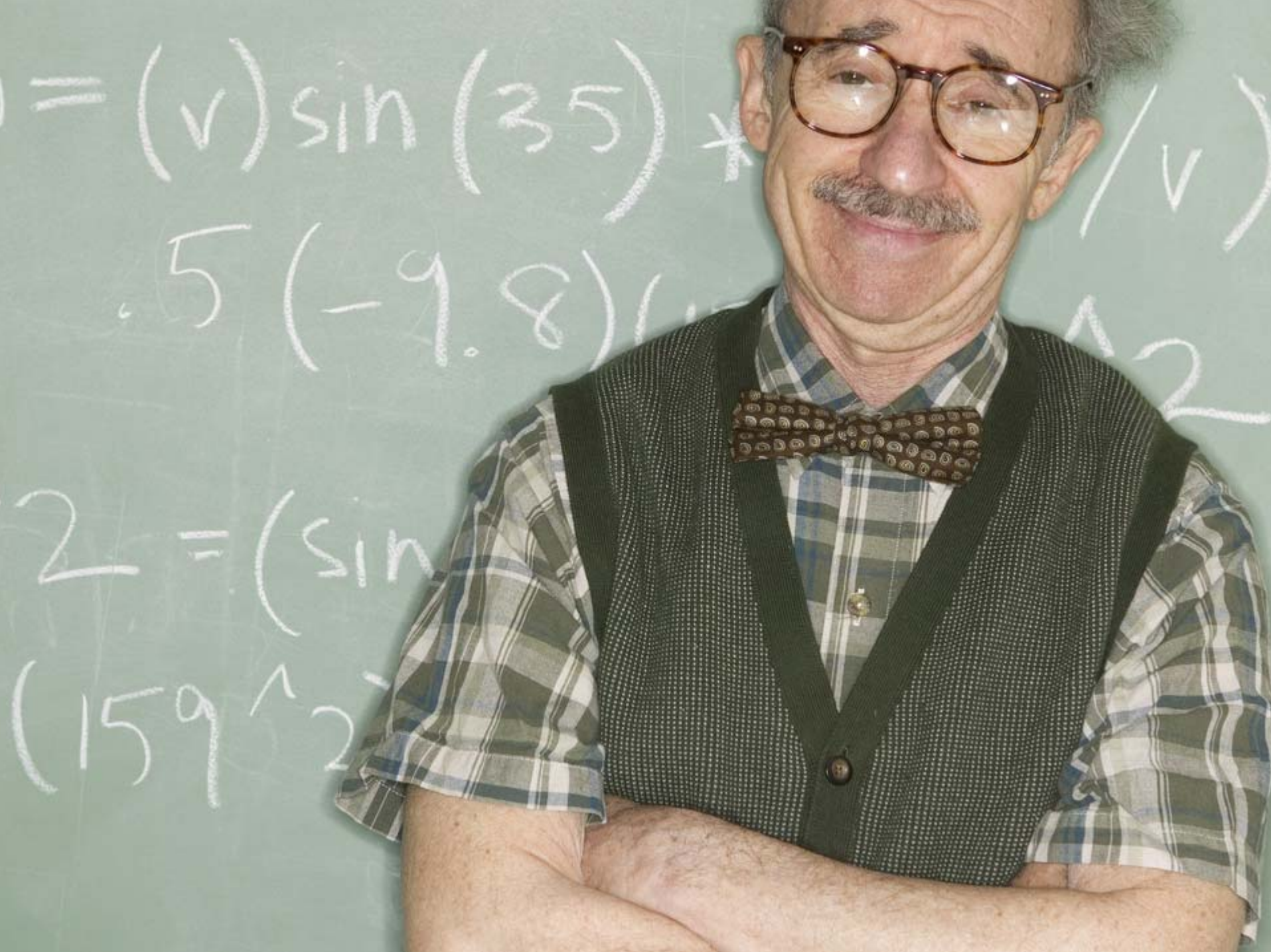
# Challenges

- Managing workloads and maintaining focus on dementia as part of an ACAT
- Education and collaboration with GP's
- Importance of early diagnosis – planning ahead, access to treatment, support and education
- Maintaining collaborative partnerships

# Challenges

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- Professional development – maintaining and upgrading skills, clinical supervision
- Multidisciplinary approach
- Assessment of younger onset dementia
- Believing that this model can be implemented in full, KPIs



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